DREF Final Report

Somalia_Acute Watery Diarrhea/Cholera

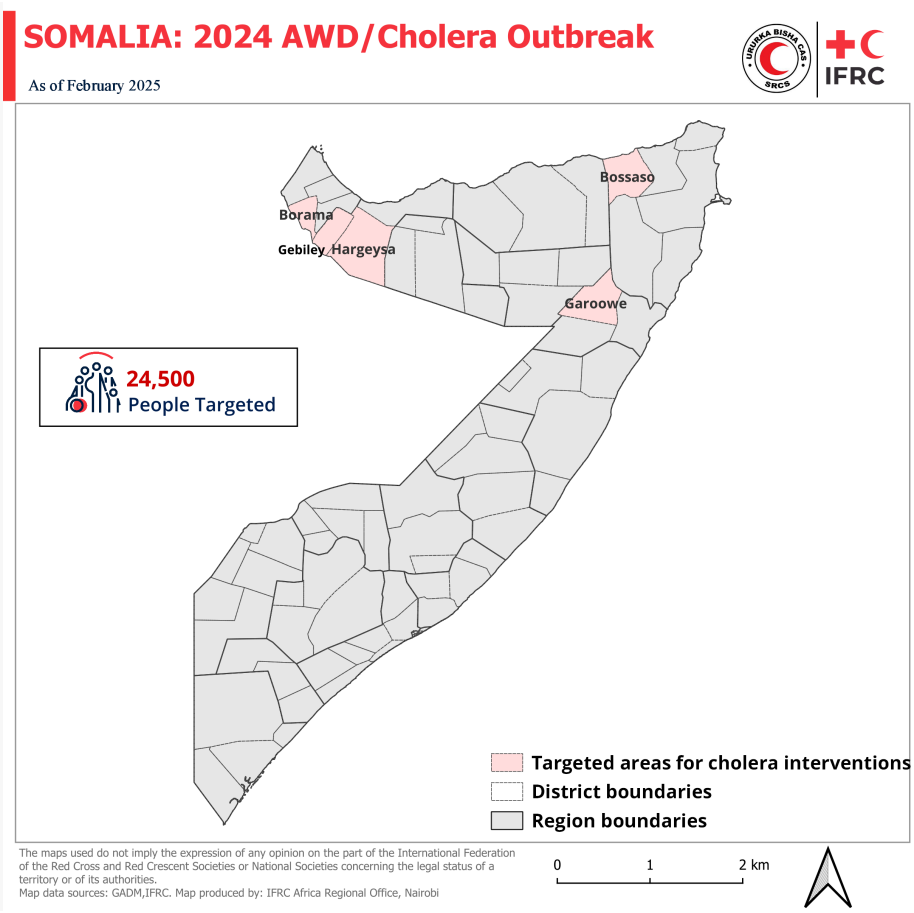
ORP Kits deployment in Gabiley district under the Maroodi-jeh region

Appeal: **MDRSO017**	Total DREF Allocation: **CHF 499,964**	Hazard: **Epidemic**	Crisis Category: **Yellow**
Glide Number: **-**	People at Risk: **240,430 people**	People Targeted: **24,500 people**	People Assisted: **-**
Event Onset: **Slow**	Operation Start Date: **15-02-2024**	Operational End Date: **31-08-2024**	Total Operating Timeframe: **6 months**

Targeted Regions: **Awdal, Bari, Nugaal, Woqooyi Galbeed**

The major donors and partners of the IFRC-DREF include the Red Cross Societies and governments of Australia, Austria, Belgium, Britain, China, Czech, Canada, Denmark, German, Ireland, Italy, Japan, Luxembourg, Liechtenstein, Malta, Norway, Spain, Sweden, Switzerland, Thailand, and the Netherlands, as well as DG ECHO, Mondelez Foundation, and other corporate and private donors. The IFRC, on behalf of the National Society, would like to extend thanks to all for their generous contributions.

Description of the Event



Date when the trigger was met

19-03-2024

What happened, where and when?

The Acute Watery Diarrhea (AWD)/Cholera outbreak was first declared in Somaliland, Maroodijeh region, in December 2023 then spread to other regions of Somaliland and Puntland. From January to 24th March 2024, 32 districts were affected within more than 08 regions of both Somaliland and Puntland. [Source 1]. The Red Cross launched an IFRC-DREF operation to support the response. The operation was scaled-up in March to help contain the outbreak evolution in Somaliland & in Puntland, based on the gaps highlighted by MoH following the different assessments conducted.

Somaliland
The first suspected AWD outbreak in Somaliland was reported on December 6, 2023, in the Maroodijeh region. From December 2023 to first quater of 2024, the number of reported cases steadily increased, as documented in regular updates from the Ministry of Health and Development (MoHD). The outbreak subsequently spread to other areas, including the Awdal region, Maroodijeh, Awdal, Sahil, Togdheer, Wajaale (Tog-Wajaale, border town between Somaliland and Ethiopia), Hargeisa district (October village).

On February 17 and 18, 2024, 15 suspected AWD/Cholera cases was identified in Wajaale, a border town between Somaliland and Ethiopia. These cases were reported by SRCS community volunteers through the Nyss Platform and were referred to the Wajaale government hospital for further evaluation and treatment. Following an investigation by the MoHD, out of the 14 cases tested using Rapid Diagnostic Tests (RDT) and culture analysis, four tested positive for AWD/Cholera via RDT, while three cases were confirmed through culture tests. The case positivity rate was 29% by RDT and 21% by culture. One fatality was reported from the Hargeisa district in early December 2023. The deceased individual, from October village, died in transit before reaching a healthcare facility.

Puntland
Puntland outbreak was reported in February, while the response was already ongoing in Somaliland. The first AWD case in Puntland was reported on February 4, 2024, in Bosaso town and evolution was quick with new cases and fatalities reported by the end of the month.

On February 29, 2024, the outbreak was declared in Bosaso.

As of 24th march, a total of 2,280 cases of AWD/Cholera were recorded in Puntland, including 75 deaths. A significant proportion of these cases were reported in internally displaced persons (IDP) camps, where access to clean water and sanitation remains limited.

SRCS and IFRC team assessing in Wajaale, Somaliland–Ethiopia border

Oral Rehydaration Points Deployed in Gabiley district

Puntland patient received in the early stage of the outbreak

Scope and Scale

The first outbreak was reported in December 2023 in Somaliland, for which this DREF was launched. In February 2024, a second outbreak was reported in Puntland. The outbreak spread quickly. 4,383 Cases recorded from 1 January-18 March and 54 deaths.

1) Somaliland affected regions.
The Cholera outbreak started on 04 February 2024 in the Wajaale and Borama districts and quickly accelerated. As of the 14th of September 2024, Acute Diarrhea (2,188 suspected cases and confirmed 29 death cases) has been recorded in Somaliland. There was a high possibility of having the outbreak spreading to most parts of the country. The outbreak trend in Somaliland went from Maroodijeh, Awdal & Hargeisa district –with cases from December 2023 to Sahil, Togdheer & Wajaale – Reported cases identified from February 2024 assessment.

2) Affected Regions in Puntland and Reported Cases
The Ministry of Health compiled a cumulative report spanning from February 4th, 2024, till to-date, documenting a total of 2,280 cholera cases and 75 deaths.
After the first case was reported from Bosaso IDPs on 4th of February 2024, the outbreak was scaling up in Bosaso IDPs while spreading out to the other districts and provinces in Puntland like Qardho and Garowe district particularly in the IDP settlements until June,2024.
trend of the outbreak in Puntland affected regions. The outbreak trend in Somaliland went from Bosaso – 2,280 AWD/Cholera cases, including 75 deaths as of the latest report at the closure of this DREF to Nugal – Initially affected but no new cases reported as of August 2024. In Qardho – 1,003 reported cases and 22 deaths since February 29, 2024 (cases include those in 15 IDP and refugee camps)

In response of outbreak in Puntland and Somaliland, assessments were conducted to understand the driven causes of the escalating outbreak and priority for interventions.

- Somaliland, SRCS conducted a rapid assessment in February 2024 across the Marodijeh, Awdal, Sahil, and Togdheer regions. Main critical challenges identified were in healthcare facilities, including shortages of medical supplies, inadequate infection prevention measures, and deficiencies in water quality control. Additionally, a lack of community awareness regarding AWD/Cholera transmission and control was noted. Poor water quality, inadequate sanitation facilities, and substandard hygiene practices in households, health clinics, and shared community spaces.
- Puntland, WASH cluster partners and local government authorities conducted an assessment, on February 18, 2024, focusing on water quality tests in boreholes supplying water to areas where AWD cases had been reported. The assessment revealed contamination in four main boreholes, with elevated levels of coliform bacteria detected. In collaboration with the World Health Organization (WHO), the Puntland MoH collected water samples for further investigation.

In addition to the above findings, there were some communalities on the evolution of the outbreak.

- Groups highly affected and at risk included children under 5, Displaced communities. Around 62% of affected cases were among children under five years old. The high burden was among displaced populations while further risks were anticipated with the projected GU season. The cases escalation was indeed witnessed at with the rainy season progress. A total of 23,732 household were reportedly living in the effected IDPs in Bosaso, Gardo and Garowe Districts.
- The main contributing factors to the outbreak include inadequate access to clean water, poor sanitation & hygiene practices, gaps in public health awareness and gaps in response capacity.
- Border movements and border transmission risks. Since the disease expanded in both Ethiopia and Somaliland, there was an

increased risk of local transmission in the borders. The border area between Somaliland and Ethiopia is also particularly vulnerable due to recurrent drought, flash floods, high rates of malnutrition among children under 5, and limited access to toilets and sanitation services.
- Existing vulnerabilities and parallel impact to social and wellbeing. Somalia ranks among the countries with the lowest health indicators globally. Decades of civil war have severely weakened Somalia's health system, leading to the displacement of 3,860,000 people within the country. Furthermore, the outbreak has spread to communities, posing a risk to the broader population. It has resulted in widespread illness, death, social disruption, increased pressure on health services, and socio-economic disruption, affecting all age groups but particularly impacting children and the elderly. Women and girls, often responsible for caregiving and with limited healthcare access, have been disproportionately affected.

Government health agencies, in collaboration with Somaliland and Puntland Red Crescent societies, IFRC, WHO, and other partners, have been supporting the response and continue to be active. The IFRC-DREF allocation to National society has greatly contribute to measures to contain the outbreak. These efforts included improving water quality through decontamination of boreholes, support on strengthening healthcare facilities, providing essential medical supplies, and increasing community awareness of AWD/Cholera prevention and control measures.

Source Information

Source Name	Source Link
1. UNOCHA_Outbreak data 24.03.2024	https://www.unocha.org/publications/report/somalia/somalia-2024-awdcholera-outbreak-flash-update-no2-24-march-2024

National Society Actions

Have the National Society conducted any intervention additionally to those part of this DREF Operation?	Yes
Please provide a brief description of those additional activities	On February 4th, 2024, another cholera case was confirmed, leading to an outbreak being declared in Somalia's Puntland by the Ministry of Health of Puntland. Cholera cases had been spreading in Somaliland and the southern part of the country for a few months prior to this. The Ministry of Health, along with the WASH cluster in Puntland, carried out a rapid assessment as the outbreak intensified in Bosaso IDPs, Qardho IDPs, and Garowe IDPs following the first confirmed case. This assessment aimed to identify the root cause and manage the outbreak. Eventually, the Ministry of Health, through its EOC, issued an appeal letter to humanitarian partners to support the government in managing the outbreak.

IFRC Network Actions Related To The Current Event

Secretariat	The IFRC has been offering technical assistance to the National Society (NS) through its Regional Office for Africa and Delegation office in Somalia. This ongoing support includes a long-term Program Coordinator, a WASH delegate based in Somaliland, and surge delegates mobilized to support the Hunger Response Operation (Health, Food Security and Livelihoods, Communications, PMER/IM). As part of the response, they have been helping the NS to secure funds through the Disaster Relief Emergency Fund (DREF). On August 11, 2024, a meeting was held at the Puntland Regional Health Office with representatives from the IFRC team, SRCS health team, Operations Officer, and the Regional Health Officer to discuss the AWD/Cholera outbreak response. During this meeting, the Regional Health Officer reported that since the initial outbreak declaration on February 29, 2024, there have been 1,003 reported cases and 22 deaths. The MoH, in collaboration with SRCS and other partners, has been actively engaged in response efforts, including case management, surveillance, and WASH interventions. Notably, there have been no recent reports of AWD/Cholera cases in Nugal province, where the outbreak initially began.

	On August 15, 2024, another meeting was held at the Qardho District Regional Health Office, bringing together IFRC, SRCS, and local health authorities to discuss the ongoing response. The Regional Health Officer acknowledged SRCS's efforts in addressing the outbreak and requested additional support in terms of healthcare services and medical supplies. The request specifically focused on assisting 15 IDP and refugee camps in the Qardho district, which accommodate displaced individuals from Ethiopia and Yemen.
Participating National Societies	Icelandic RC supported the NS in training volunteers on IPC, case management and procedures of AWD/Cholera outbreak, 32 frontline health workers and staff (20 female, 12 male) were trained. This training aimed to equip these volunteers with the essential skills and knowledge required for IPC case management and AWD/Cholera outbreak response protocols within their communities. The training was a vital element of a broader strategy to control the spread of AWD and cholera. Vehicle mounted loudspeakers for dissemination information were deployed in the key hotspots districts and SRCS volunteers conducted door-to-door awareness-raising campaigns to reduce the risk of an AWD/Cholera outbreak while preserving the dignity of residents. A total 36,900 people were reached disseminated key behavioral change messages to help prevent the spread and transmission of diarrheal diseases. German RC supported the NS in Somaliland to response the Acute Watery Diarrhea (AWD), with support from the GRC the NS SRCS deployed seven vehicles mounted with loudspeakers, each accompanied by a community mobilizer or volunteer, to conduct awareness-raising activities over a 15-day period. Additionally, 1,160 culturally appropriate A3 posters were printed and distributed, promoting sanitary and hygienic practices crucial for preventing AWD and Cholera. During the campaign, a total of 13,668 individuals (7,810 in Togdheer and 5,858 in Marodijeh) were reached with vital health messages. GRC facilitated the distribution of 227,800 water purification tablets and aqua tabs to 2,278 households in both regions, ensuring that affected communities could disinfect water at the household level. This intervention was critical in reducing the spread of AWD/Cholera by preventing waterborne transmission GRC's support, enhanced sanitation infrastructure in schools and health clinics. A total of 100 handwashing water tanks, each with a 300-liter capacity, were provided to 30 schools in Togdheer and 15 schools in Marodijeh, with two tanks per school to ensure gender-sensitive access to handwashing stations at latrines. Ten additional tanks were distributed to seven health clinics in Marodijeh and three in Togdheer. Complementing this initiative, 6,100 bars of 200g laundry soap were distributed to the 45 schools and 10 clinics involved in the AWD/Cholera outbreak response, further promoting hygiene practices to curb the spread of the disease. These combined efforts underscore the critical support of GRC in strengthening community resilience and safeguarding public health in Somaliland.

ICRC Actions Related To The Current Event

The ICRC is present in the country but did not support this DREF operation.

Other Actors Actions Related To The Current Event

Government has requested international assistance	Yes
National authorities	The Ministry of Health Development in Somaliland coordinated efforts with various partners, including SRCS, WHO, UNICEF, and other NGOs, to develop a cholera preparedness and response plan. A crisis cell was established to oversee the implementation of activities aimed at providing clean water, monitoring water quality, and ensuring access to adequate sanitation, with a focus on vulnerable populations in informal settlements. Collaboration with relevant ministries—particularly those

	responsible for water, interior affairs, municipalities, and the environment—played a crucial role in delivering safe water and sanitation services. In Puntland, - The Ministry of Health engaged humanitarian partners to mitigate and respond to the rapid spread of diseases that affected communities in Bosaso, Garowe, Qardho, and Carmo. - The Ministry of Health (MoH) convened an urgent meeting to mobilize resources and coordinate containment efforts in february following the outbreak declaration and first infirmation of the rapid evolution of the outbreak.
UN or other actors	The United Nations and other stakeholders have been actively involved in responding to the outbreak. Through existing coordination platforms, consensus has been reached, resulting in the development of comprehensive contingency plans at the cluster level. Cluster leads are required to share their respective contingency plans, highlighting their existing resources and identifying gaps using the MoH/OCHA template. MoH/OCHA provided the template to be used by cluster leads for their submissions. Clusters are also expected to participate in meetings focused on cholera preparedness and contingency planning. On 19th March 2024, Puntland WASH cluster with the support of the UNICEF Puntland and country team conducted WASH cluster meeting in Bosaso on AWD/Cholera response and IPC briefing for the partners at WFP Bosaso office. The WASH cluster, through PMWDO, handed over 7 drums of chlorine transported from the Adado supply hub to Puntland Water Development agency (PWDA) in Garowe. The cluster shared Information, Education, and Communication (IEC) materials and necessary hygiene and health promotion cholera outbreak prevention messages in the Somali language, including video and audio forms, with the support of the SBC UNICEF section. Following up on the activities completed with the support of the support of UN/ other stakeholders include. • UNICEF, NRC, MoH, distributed 2,000 HHs hygiene kits and 500 additional treatment hygiene kits in Bosaso and Garowe IDPs. • UNICEF/MoH distributed 500 HH water treatment items and conducted hygiene promotion activities in Garowe IDPs. • UNICEF/MoH/PWDA conducted water chlorination activities in Bosaso IDPs. • UNICEF/MoH distributed 1,000 household hygiene kits in Bosaso IDPs.

Are there major coordination mechanism in place?

The Ministry of Health coordinated the outbreak response during cluster meetings. The government, along with the UN and other actors, collaborated and developed a comprehensive plan for timely action and preparedness. This collaboration minimized the potential impact of the outbreak on communities by pooling resources, expertise, and knowledge.

The focus is on implementing a robust preparedness and response plan across various sectors. SRCS Somaliland's Health and Nutrition Department actively participates in all coordination meetings, aligning its plan with that of the MoH and requesting support for existing gaps. There is a strong coordination mechanism between the MoH and SRCS for organizing training for staff and volunteers on cholera response.

In Somaliland, the Ministry of Health Development plans to establish a regular coordination mechanism for responding to the outbreak. Coordination meetings will be held as needed, with line ministers of Somaliland and UNOCHA coordinating to ensure accurate targeting and avoid duplication.

Various clusters, particularly in health, are active, with NS and movement partners participating to share information on different sectoral approaches.

In Puntland, the active coordination mechanisms are WASH and health cluster along with the leadership of the ministry of health.

Needs (Gaps) Identified

Health

Based on assessment conducted, the 2024 outbreak was attributed to limited access to safe water, proper sanitation, primary health care services, and social and pre-existing vulnerabilities exposing to lower immunity or high risks.
The affected population urgently requires
- Access to safe water, sanitation, and hygiene facilities to prevent further spread of the disease. Cholera is an acute intestinal infection that spreads through contaminated food and water, often from feces. Factors like poverty, conflict, and extreme climate events such as floods and droughts contribute to outbreaks by reducing access to clean water. Despite the preventable nature of AWD type of disease with safe water and proper sanitation, a significant portion of Somali families lack functional sanitation facilities, practice open defecation, and lack handwashing facilities.
- Strengthening the health system and health capacity with the provision of medical supplies and trained personnel to treat those infected.
- AWD/Cholera is a highly treatable disease with timely and adequate care. However, early reports suggest that Somaliland' and Puntland's healthcare system, already strained by multiple crises, was struggling to manage AWD/cholera cases and a support from partners was needed. Limited material for cholera response team in facilities was a big challenge, especially Puntland and South West States. It was also highlighted the limited trained staff among health workers for cases management.
- Based on MoH, it was identified that outbreak escalation was also the fact of the lowered immunity, especially among children experiencing high levels of acute malnutrition.
- Managing cholera in Somaliland's health system posed significant challenges due to limited resources and capacities. These limitations contributed to the rapid spread of the epidemic, particularly during the Gu rainy season when flooding increased the likelihood of the outbreak spreading to neighboring countries.
- Underlying factors

The increased population in some of the affected districts, driven by the impacts of drought and flash floods, overwhelmed municipal water and sanitation facilities. This worsen the poor hygiene practices and limited access to sanitation facilities, resulting in widespread open defecation—conditions that created an ideal environment for cholera transmission.
- Community knowledge about disease prevention interventions was also a significant barrier. This issue was compounded by insufficient logistical and health promotion capacities among staff and volunteers from both the Somaliland Red Crescent Society (SRCS) and the Ministry of Health (MOH). The gaps on awareness in such context, especially for remote communities and IDPs was posing a significant threat to any effort containing the outbreak. There was an urgent need to intensify prevention messaging to address health risks and halt the spread of the outbreak, necessitating the acceleration of response operations.

Border districts faced several gaps that heightened the risk of the epidemic spreading quickly. As transborder areas, they faced movements, limited structure and systems for all entry points. This was the case for Wajaale, Gabiley, and Borama districts. In similar remote areas, the assessments conducted highlighted a limited access to basic health services, latrines, safe water, and adequate healthcare facilities. These challenges significantly affected case management, with rising case numbers outstripping the available capacities to respond effectively to the outbreak.

Somalia is endemic to cholera and the country has been experiencing cholera outbreaks regularly in the past years with similar rapid escalation, especially during the rainy periods. However, when launching this operation, the number of reported cases was three times higher than the last three-year average, according to the World Health Organisation (WHO). 4,383 cases recorded from 1 January-18 March. The above situation combined with the upcoming rainy season was increasing the need to contain the outbreak and strengthen the prevention. In 2023, 18.3K cases were reported across Somalia.

The likely to see the outbreak escalate was high in a complex humanitarian setting for most of the affected regions. Persistent droughts, floodings, conflict displacement, poor access to health, water and sanitation services, poor socio-economic conditions and acute food insecurity weakening the efforts to address the outbreak.

Given the recent escalation of the outbreak, the SRCS has intensified its efforts to mobilize resources and collaborate with communities and the government to provide emergency relief and support community preparedness and recovery. Other actors, including the UN, international organizations, and NGOs, are also committed to providing support to those affected by the outbreak.

Water, Sanitation And Hygiene

The ongoing complex crisis in Somaliland has had detrimental impacts on WASH conditions in the country, which represents a major risk factor for cholera transmission. The rural population is the most vulnerable to cholera, as they are characterized by the highest WASH

challenges, including damage to water points and lack of maintenance of water points, leading to people using unclean water. Some activities (where facilities are not present and lack proper hand washing, and water testing kits) represent most of the hotspots.
Following the needs assessment done in Awdal, Maroodi-jeh, Sahil, Togdheer, Sanaag and Sool regions, lack of adequate WASH services is posing serious challenge for effective prevention and control of Cholera. Most people are getting drinking water from unprotected sources such as shallow wells. Hygiene practices are also compromised due to inadequate access to hygiene promotion information, lack of safe water and inadequate hand washing facilities in institutions and at the household level. It is, therefore, critical not only to sustain the existing water, sanitation and hygiene services but also to scale up these to reach the unserved and under-served vulnerable population, as well as meet the increased demand. Water quality testing is needed as WASH concerns is the main challenges, especially with water quality being more deteriorated during this floods season.

Maroodi-jeh and Awdal regions share a porous border with Ethiopia respectively where cross-border travel is common, open defection is high, and poor water and sanitation coverage, thereby pausing a greater risk of cholera.

In Bosaso and Garowe IDPs, the AWD/cholera outbreak affected nearly 21 internally displaced persons (IDP) camps, where water, sanitation, and hygiene (WASH) facilities were contaminated, as indicated by water quality tests. The priority interventions needed include providing safe water through trucking to the affected communities, distributing jerrycans to households for safe water storage, and treating water through chlorination and the distribution of Aqua tabs.

The Gu rains were still ongoing and floods, including flash floods which have been recorded in over districts across the country, were further jeopardizing sanitation conditions and access to WASH facilities for millions of vulnerable people. The situation was posing already a risk for thousands of people across affected districts and further surrounding districts.

Protection, Gender And Inclusion

The cholera epidemic primarily affected women and children, placing these vulnerable groups at heightened risk of exploitation, psychosocial trauma, and sexual and gender-based violence (SGBV). To address these concerns, Protection and Gender Inclusion (PGI) measures were integrated throughout the intervention. Volunteers received comprehensive briefings as part of their refresher courses, ensuring they were equipped to prioritize protection issues and create a safe and supportive environment for individuals of all ages, genders, and abilities.
The Somaliland Red Crescent Society (SRCS) conducted awareness-raising and orientation sessions on protection for volunteers. To promote inclusivity, engagement with individuals at settlement sites was carried out to ensure equitable and impartial distribution of assistance provided by PNSs, IFRC, and ICRC. Gender considerations were factored into scheduling distribution times and dates, as well as in hygiene promotion activities.
The needs assessment adhered to the minimum standards for Protection and Gender Inclusion (PGI). Volunteers responsible for implementing activities received training in PGI and CEA, which enhanced their capacity to conduct thorough needs assessments and effectively communicate relevant information to communities.
Additionally, a gender and diversity analysis was incorporated into all sector responses, including Health, CEA, and WASH. This analysis provided insights into how different groups were affected by the outbreak and informed necessary revisions to the operational strategy.

Community Engagement And Accountability

During outbreaks such as AWD/cholera, accessing information becomes a significant challenge for the most vulnerable individuals, making it difficult to communicate effectively with affected populations and gather their feedback. Effective Risk Communication and Community Engagement (RCCE/CEA) play a vital role in controlling and containing cholera outbreaks within communities.
A critical strategy involves identifying key entry points, such as community leaders or other influential figures, to support outbreak control efforts. Additionally, addressing rumors and myths is essential for effective response and can be achieved by implementing a two-way feedback mechanism.

Operational Strategy

Overall objective of the operation

This DREF aimed at supporting 12,000 people affected by AWD/cholera in Somaliland and 12,500 people in Puntland through the provision of health, Water, Sanitation and Hygiene (WASH) support in the Maroodijeh, Awdal, Bari and Nugal regions for 6 months.

Specific objectives were:

1. Contribute to the prevention and control of the spread of AWD/cholera Outbreak in the communities of affected districts.
2. Facilitate improved case management of AWD/cholera outbreak at facility and community levels in the affected districts.
3. Improve basic sanitation and good hygiene practices and access to safe drinking water in AWD/cholera hotspots.

Operation strategy rationale

Given the limited healthcare access and the challenges faced by response actors, SRCS adopted a tailored approach to reduce the case fatality rate, limit the spread, and minimize the transmission of the outbreak. SRCS leveraged its extensive network of community volunteers and staff to reach at-risk populations effectively.

1. Access to Cholera Oral Rehydration Points (ORP):
(i) SRCS trained 200 volunteers (120 female and 80 male) from Borama, Gabiley, Wajaale, and Hargeisa in managing Oral Rehydration Points (ORPs). The training equipped volunteers with the necessary skills and knowledge to manage ORPs and respond to the ongoing Acute Watery Diarrhea (AWD) and cholera outbreak.
(ii) Fifty ORPs were deployed in Borama, Wajaale, Gabiley, and Hargeisa.
(iii) The 200 trained volunteers were deployed to hotspot districts in Somaliland, significantly enhancing community health capabilities during this critical period.

2. Prevention and Control:
(i) Volunteers actively worked to prevent and control cholera by distributing printed IEC materials, conducting door-to-door campaigns, and promoting preventative measures such as waste management, the use of latrines, and avoidance of open defecation. These activities reached more than 31,600 people (17,696 females and 13,904 males), surpassing the initial target of 24,500 individuals.
(ii) A mobile cinema campaign in Wajaale, Gabiley, Borama, and Hargeisa districts educated the public about the causes, symptoms, and prevention of AWD and cholera. Culturally relevant content was presented, followed by interactive sessions with health workers and volunteers.
(iii) Environmental cleaning campaigns were conducted in Wajaale, Gabiley, Hargeisa, and Borama districts to improve sanitation and hygiene within communities.

3. Enhanced Cholera Prevention Activities by strengthening the hygiene and sanitation but also the access and management of safe water.
(i) SRCS distributed WASH NFI kits, including jerrycans, buckets, soap, and water purification tablets, to 2,000 households (12,000 people) in cholera-affected hotspots.
(ii) To improve access to safe sanitation, SRCS constructed seven community gender-sensitive latrine blocks in Wajaale and Borama districts. Each block contained three units, two disaggregated by sex, with handwashing stations. These facilities were designed to be inclusive of age, gender, disability, and elderly needs.

4. Protection, Gender, and Inclusion (PGI):
(i) Volunteers were trained and mobilized to integrate protection, gender, and inclusion into all priority activities, ensuring vulnerable groups felt safe and supported throughout the intervention.

5. Community Engagement and Accountability (CEA):
(i) SRCS adopted Community Engagement and Accountability tools tailored to the Somaliland context to collect feedback and foster community ownership during the cholera operation. Feedback was actively used to refine approaches and enhance community engagement.

6. Psychological Support Service (PSS):
(i) Mental health and psychosocial support were provided to recovered patients, families, and communities, addressing stigma and promoting reintegration. Volunteers were trained to engage communities sensitively during awareness campaigns, focusing on reducing fear and improving understanding.
(ii) In addition, SRCS mobilized 55 volunteers through its Puntland branches to conduct house-to-house visits, reaching 2,500 households with tailored support.

Targeting Strategy

Who was targeted by this operation?

The Somali Red Crescent Society's cholera response prioritized around 24,500 people. Approximately 12,000 people in two regions through the Hargeisa coordination office and 12,500 people in Bari and Nugal provinces through the Mogadishu coordination office.

Priority target were Gabiley, Hargeisa, Wajaale, and Borama in Marodijeh and Awdal regions for Somaliland and

Specific targeted districts with highest cases and vulnerabilities. Include:
- Bordering Ethiopia, where the new strain of the cholera outbreak originated, specifically Wajaale and Borama districts. These districts reported new cases and required urgent support. Efforts focused primarily on women and caregivers, particularly in Wajaale (Marodijeh region) and Borama (Awdal region), as they bore the primary responsibility for household tasks, including cooking and childcare.
- In Puntland, the response targeted internally displaced persons (IDP) camps affected by the outbreak.

Explain the selection criteria for the targeted population

The criteria for selecting the targeted population was determined by the severity of the outbreak, the vulnerability of the communities, and the areas most impacted by cholera. SRCS concentrated on areas with the highest reported cases and those facing the greatest risk of transmission. To ensure that the most vulnerable individuals receive assistance in the AWD/cholera response operation, the primary selection criteria are based on a combination of factors. These include prioritizing those most in need of assistance, assessing the severity of the impact, considering the existing vulnerabilities of certain groups, and understanding the social dynamics between different groups in terms of protection.
1. Beneficiary selection also included communities that had reported recent outbreaks.
2. Specific vulnerabilities, social vulnerabilities & marginalized groups: Women, children, women/child headed households, people living with disabilities, pregnant and lactating mothers, the elderly (over 65), and low-income households.
3. Households moving to relatives' houses, where resources were already limited, and the hosting communities were taking another burden by hosting families.
4. Families with people with disabilities.
5. Specific priority to migrants and IDPs.

Total Assisted Population

Assisted Women	-	Rural	**70%**
Assisted Girls (under 18)	-	Urban	**30%**
Assisted Men	-	People with disabilities (estimated)	**5%**
Assisted Boys (under 18)	-		
Total Population Assisted	-		
Total Targeted Population	24,500		

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?	**Yes**
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
Community needs may exceed the capacity of this operation.	SRCS advocated as necessary to partner organizations to meet unmet needs.
Deployed staff and volunteers get infected. SRCS is using volunteers who live in this region. Volunteers will be interacting with untested people during their community surveillance. A volunteer might be infected while at home form family members as well as during activities.	Staff and volunteers were provided with PPEs and insurance. Apart from these, volunteers were supervised, briefed, and debriefed throughout the response.
Community myths and misconceptions about cholera may make the disease to spread.	Increased community awareness on cholera and its spread. Provided a clear community case definition which showed how serious cholera could be if one gets infected. Improved collection of community complaints and feedback.
Contributing to the presence of contaminated water resulting in increased cholera cases	SRCS responded on disinfection of contaminated water, conduct environmental cleaning campaigns and sensitized on disease surveillance so that they could detect any of the early signs of the likely diseases. SRCS also continued to share and raise awareness on key health and sanitation in its flood awareness sessions.

Please indicate any security and safety concerns for this operation:

In Somaliland:
The security environment in Somaliland's target regions for this operation remained peaceful, providing an enabling environment for SRCS and other actors' personnel to adequately and freely implement their program activities. Monitoring was continuously conducted to inform travel and operational activities. Consequently, there were no effects on the cholera DREF implementation areas, and the Maroodijeh and Awdal regions were considered safe for SRCS personnel.

In Puntland:
In Puntland, the areas affected by cholera were primarily IDP communities in Bosaso, Qardho, and Garowe, located near the towns. However, due to the presence of possible non-state actors in Bosaso town, only SRCS staff and volunteers carried out the implementation and monitoring. These activities were conducted alongside carefully planned missions by international delegates.

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

Implementation

Health

Budget: CHF 224,688
Targeted Persons: 24,500
Assisted Persons: 20,517
Targeted Male: 8,207
Targeted Female: 12,310

Indicators

Title	Target	Actual
# of people reached through awareness campaign about AWD/Cholera causes, symptoms and prevention measures.	24,500	14,500
# of HHs reached with ORS, Zinz tabs distributed.	4,500	5,348

# of HHs reached through house-to-house health and hygiene promotion activities.	4,500	5,500
% of escalated alerts responded to and investigated within 24hrs	80	100
# of volunteers trained on Infection prevention control (IPC) procedures	375	139
# of Number of people reached with messages on AWD/Cholera prevention and control	24,500	25,517

Narrative description of achievements

The response efforts focused on capacity building, community outreach, medical treatment, and awareness campaigns, resulting in significant achievements in controlling the AWD/Cholera outbreak.

1) Somaliland
Skills development and deployment
- 200 National Society staff and volunteers from Gabiley, Hargeisa, Wajaale, and Borama were trained in Oral Rehydration Point (ORP) management, dehydration assessment, early detection, and referral systems.
- In July 2024, 100 trained community volunteers were mobilized to support 50 ORP sites in Marodijeh and Awdal regions, with 25 sites per region. Their deployment lasted one month (August 2024).

Support to cases management
A total of 13,000 individuals were reached (male: 3640 and female:9360) through the ORP during the operations. The number of reached exceed the initial target in Somaliland 12,000 individuals, mainly due to the high need for medical service in the affected areas.
- Awdal Region (including Borama): 1,869 individuals treated, with 70 (3.75%) referred to healthcare facilities. Among them, 517 males were aged 0–4 years, while 460 males were 5 years or older. Female patients consisted of 483 in the 0–4 years age group and 409 in the 5 years or older category. From this group, 70 individuals were referred to healthcare facilities for further care, representing 3.75% of the total treated cases in the region.
- Marodijeh Region (including Wajaale and Gebiley): 1,025 individuals treated, with 38 (3.71%) referred for advanced care. This included 272 males aged 0–4 years and 234 males aged 5 years or older. The female patients were composed of 269 in the 0–4 years category and 250 aged 5 years or older. A total of 38 patients, or 3.71%, were referred to healthcare facilities for more advanced care, showing a close alignment with the referral rates in Awdal. 4,500 HHs were reached with ORS and Zinc tabs distribution.
Total across both regions: 2,894 patients treated, with 108 (3.73%) requiring further care.
- 50 ORP sites were deployed and supported with additional trained team in Marodijeh and Awdal regions, with 25 sites per region. 13,000 individuals were reached through ORP sites (male: 3640 and female:9360), surpassing the initial target of 12,000 due to increased medical needs. Another 50 were stored for future outbreak response.
- 4,500 households received ORS and Zinc tablets to aid in the treatment and prevention of dehydration.

Awareness and Community Engagement reached 14,500 people.
Done by volunteers through visits, mass awareness in public places, loudspeakers messages. The below programs covered topics such as disease prevention, symptoms, treatment, and hygiene practices. The posters also contained visual and textual information on topics such as handwashing, safe water storage, sanitation practices, and recognizing the signs of cholera. The distribution of these materials contributed to increasing awareness and promoting positive behavior change within the target districts
- 14,500 individuals accessed IEC materials on cholera prevention through printed posters, flyers, and brochures displayed in public places (schools, clinics, markets, mosques, etc.).
- 12,000 people participated in Mobile Cinema campaigns conducted in Wajaale, Gabiley, Borama, and Hargeisa, educating communities on AWD/Cholera causes, symptoms, and prevention.
- 4,500 community members in Somaliland and 6,017 individuals (1,000 households) in Puntland received hygiene promotion training through house-to-house awareness campaigns.
- 2,000 posters were printed and distributed in public spaces, reaching 6,000 individuals with visual health messages in mass public spaces and visual for the door-to-door .
- Vehicule loudspeaker awareness campaigns were conducted in collaboration with the MoH, reaching even larger populations in affected areas with crucial health information.

Infection Prevention and Control (IPC) Measures
- 139 individuals trained, including 102 in Somaliland and 37 in Puntland, covering hospital staff, school principals, teachers, and community committees, to enhance early detection and treatment.

- Medical supplies were distributed to Gabiley, Wajaale, and Borama hospitals in collaboration with the Ministry of Health Development.
- Two (02) mobile health teams from SRCS (Borama branch) were deployed to the border towns of Waraqa and Cunaqab (Somaliland-Ethiopia entry points) for early detection of AWD cases, working alongside Ethiopian health teams.

2) In Puntland:
- Up to 15 ORP centres were established (9 in Nugal and 6 in Bari) in collaboration with MoH.
- Up to 37 frontline volunteers and medical staff in Bosaso and Garowe branches were trained on ORP, IPC and CEA in emergencies.
- 3,090 people (1483 M, 1607 F) were referred to the nearest health facility for further investigation and treatment upon case finding.
- 5,090 persons (2443 M, 2647 F) (848 HHs) benefitted from the distribution of ORS and zin distribution exercises.
- Up to 6,017 people (1,000 HHs) were reached with key cholera/AWD key messages.
- Additionally, 5,090 people (848 HHs) benefitted from ORS and Zinc distribution.

• The combined efforts of the response in Putland led to significant improvements in disease awareness, early detection, and patient care. The community-based interventions on which NS played an active role highly contributed in improving hygiene practices, and strengthening the healthcare system's capacity to manage the outbreak and future outbreaks. NS efforts resulted in 12,500 people being reached with AWD/Cholera prevention and control messages, cholera cases management, contributing to a broader public health impact.
• 100% of escalated alerts responded to and investigated within 24 hours in both Puntland and Somaliland.

Lessons Learnt

• It is essential to have Cholera Kits or other essential medical supplies in preposition stock to respond timely to future epidemics, including cholera.
• Preparing posters/flyers beforehand to ensure immediate dissemination of awareness material in Somalia language.
• Regular health inspection and surveillance of potential cholera outbreaks in the community is important for averting future outbreaks in the communities.
•The community-based approach of identifying volunteers to intervene in emergencies within their own community set up was very important, in that it actively involved in the communities to address the issue and take responsibility of finding solutions and resources.
Consistent and proper Use of Personal Protective Equipment have helped prevention of infection towards volunteers properly trained and timely deployment of volunteers have helped to mitigate the epidemic.
• The ORP kits were incomplete, with crucial items such as water filters for water purification missing. This omission posed a major obstacle to the proper functioning of the ORP centers, as access to safe drinking water is critical in managing and preventing the spread of AWD/Cholera. As a result, SRCS had to procure additional materials, including jerrycans, to ensure the smooth operation of the ORP sites. This delay in procurement further strained the response efforts, as vital resources were not readily available to support affected communities.

Challenges

• The delay in the international procurement of the ORP Kits was a major challenge during the operation.
•Far apart distances from one house to another, especially in the rural areas.
• Delays in procuring ORP Kits hindered response efforts during the critical early stages of the outbreak, limiting the ORP centres' ability to provide timely and effective care to the affected communities. Additionally, the delays meant that out of the 115 ORP kits procured, 50 were deployed in Somaliland and 15 in Puntland owing to time constraints regarding the closure of the operation.
• The operation initially planned to procure 125 ORP kits. However, 115 ORP kits were procured instead owing to budgetary constraints.

Water, Sanitation And Hygiene

Budget: CHF 192,861
Targeted Persons: 24,500
Assisted Persons: 24,126
Targeted Male: 9,650
Targeted Female: 14,476

Indicators

Title	Target	Actual

# of HHs reached with WASH kits	4,500	6,126
# of community latrines constructed/rehabilitated in hotspot districts.	17	22
# of environmental cleaning and hygiene promotions campaigns conducted.	12	12
# of people reached through mobile cinema on AWD/Cholera prevention and control conducted.	2,000	12,000
# of dewatering activities on drainage channels and dislaging conducted	10	10
# Number of HHs receiving water purification chemicals(Aqua tab, Chlorine)	2,500	3,795
# of volunteers training on water treatment and hygiene	45	100
# of people reached through environmental cleaning and hygiene promotion campaign	24,500	24,126

Narrative description of achievements

To cascade the implementation of the DREF and to control the outbreak immediately, skills were enhanced for the team in all locations and deployed to support the hygiene, sanitation and distribution of kits to families.

1) Somaliland:
100 trained volunteers carried out WASH activities in the targeted communities, conducting community awareness and sensitization on cholera prevention and treatment, water purification and storage, safe excreta disposal, food hygiene and storage, hand washing with soap through house-to-house visits, community group discussions, sensitization at markets and other meeting points were conducted.

WASH Interventions:
- 2,000 households (12,000 people) in Awdal and Maroodijeh regions received WASH NFI kits, including jerrycans, buckets, soap, water purification tablets, and aqua tabs to improve hygiene practices.
- Seven new community latrines were constructed to enhance sanitation and hundreds others families were engaged and sensitized to upgrade their latrines and improve their waste management during the volunteers visits. This activity was highly promoted and pushed due to the observed lack of proper sanitation facilities that was identified as a driver to contaminated environments; bad sanitation & waste management, where waste from infected individuals can pollute land and water resources, heightening the risk of disease transmission within communities. Consequently, proper sanitation facilities, such as latrines, are vital for promoting health by enabling the safe disposal of waste, preventing environmental contamination, and reducing risks to individuals and their neighbors. According to community volunteers' house-to-house visits, awareness campaigns, and discussions, 94.68% of the targeted beneficiaries upgraded their latrines following the cholera intervention.
- 12 environmental cleaning campaigns were conducted, reaching 3,000 households with Aqua-tab water treatment chemicals.
- 10 dewatering activities, including drainage channel cleaning and dislodging, were carried out across Somaliland.
- Community Awareness & Outreach reached 12,000 people through the Mobile Cinema Campaign in Wajaale, Gabiley, Borama, and Hargeisa, educating them on AWD/cholera causes, symptoms, and prevention. SRCS implemented a mobile cinema campaign in the Wajaale, Gabiley, Borama, and Hargeisa districts, using audiovisual tools to screen educational films and documentaries. These materials raised awareness about the causes, symptoms, and prevention of Acute Watery Diarrhea (AWD) and cholera.

2) Puntland:
1. NFIs were procured and distributed to 500 households in Gardho and Garowe IDP camps. Environmental sanitation tools (Wheelbarrow, shovels, Rakes, heavy-duty gloves, etc) were procured and distributed to 4,126 households in IDP camps in Gardho and Garowe.
2. A total of 11 twin latrines and one 4-stance communal latrine were rehabilitated across various internally displaced persons (IDP) settlements in Bari and Nugal regions. The specific allocations and household count in each IDP settlement are as follows:
- Shabelle 1 IDP (Garowe): 2 twin latrines (serving 40 people)
- Shabelle 2 IDP (Garowe): 2 twin latrines (serving 40 people)
- Benadir IDP (Garowe): 2 twin latrines (serving 40 people)
- Jiingada IDP (Garowe): 2 twin latrines (serving 40 people)

- Yemeni IDP (Garowe): 1 four-stance communal latrine (serving 80 people)
- Ajuran IDP (Bosaso): 3 twin latrines (serving 60 people)

Up to 1,000 (20 litre) Jerrycans were procured and distributed to 500 of the most-affected households.
4,766 people (795 HHs) were reached with Aqua-tab water treating chemicals.
Demonstrated handwashing including hygiene and messaging was conducted reaching 6,017 people (1,000 HHs).

In general,
• Through the community engagement, direct feedback were used to evaluate the impact of the WASH activities in terms of messages reception, clarity and perception. Community members reported reduced disease prevalence due to improved hygiene practices and sanitation infrastructure. Beneficiaries received essential hygiene materials, latrines, and ORPs, significantly contributing to cholera prevention and control.
Several positve feedback were gather from the communities and from local authorities on the NS actions.

Lessons Learnt

• Sensitization sessions about hygiene and sanitation should continue within the target communities in future longer-term programmes to sustain the operation's gains.
• It was imperative for SRCS to continue disseminating hygiene messages in the community to further create awareness on appropriate health practices, more so water treatment at home.
• The operation pointed to the need for the construction of an oral rehydration and cholera treatment centre.

Challenges

• Transportation Constraints in several districts due to the state of the roads and infrastructure posed significant obstacles to reaching communities. The poor road network, especially during adverse weather conditions, made it difficult for teams to access remote areas.

Protection, Gender And Inclusion

Budget: CHF 5,374
Targeted Persons: 2,000
Assisted Persons: 2,000
Targeted Male: 500
Targeted Female: 1,500

Indicators

Title	Target	Actual
# of volunteers received refresher training on PGI awareness raising on issues of Violence, Discrimination, and Exclusion	100	100
# IEC materials produced and distributed.	500	600

Narrative description of achievements

1. NSs mainstreamed PGI in all sectors with special consideration to gender, age, disability to minimize any stigma and discrimination or additional risks and vulnerabilities. Representatively of all groups were ensured in the assessment and post evaluation but also all the focus group and community discussion.
2. Staff and volunteers engaged in the response were sensitized on PGI mainstreaming and ensuring protection in all response activities as well Internal as prevention and response to sexual and gender-based violence to be able to address any arising during as well as post implementation period.
• The SRCS trained 100 volunteers (50 male and 50 female) on PGI against a target indicator of 100. Their role extended beyond one-way PGI messaging and communication, as they actively captured community feedback, ensuring that the response remained adaptive and responsive to the evolving needs and concerns of the affected populations. This included production and distribution of 600 IEC material.
4. The volunteers also managed to spread the PGI messages during the door-to-door visits.
5. All the SRCS staff and volunteers involved this operation were briefed on SRCS Code of conduct, sexual exploitations and abuse and safe referral of SGBV cases including child protection concerns.

Lessons Learnt

• PGI messaging is dominantly a sensitive issue in most communities as many African communities have a tendency towards gender segregation. It is in this respect that every component of any intervention should have some PGI embedded within it to ensure no segregation.

Challenges

• There were no significant challenges worth reporting for this operation.

Community Engagement And Accountability

Budget: CHF 9,266
Targeted Persons: 16,000
Assisted Persons: 16,000
Targeted Male: 6,399
Targeted Female: 9,600

Indicators

Title	Target	Actual
% of people confirmed with improved health and hygiene practice.	70	95
% of feedback received and treated.	100	100
# of volunteers and staff trained on CEA in emergency.	100	150

Narrative description of achievements

1. A comprehensive community engagement strategy was implemented during the response effort, which involved conducting a total of 30 community meetings across the 2 districts in Wajaale and Borama. The primary focus of these meetings was to engage with community leaders and members, with the overarching goal of monitoring and addressing prevailing rumors and misconceptions related to AWD/cholera prevention, causes, treatment, and symptoms.
2. The community feedback mechanism (toll-free line and the volunteer's feedback forms) that was set up enabled the collection of rumors and feedback which was addressed either directly or indirectly through one-on-one engagement during door-to-door sensitization, and community engagement meetings. All (100%) of received community feedback was addressed.
3. As a pivotal component of this strategy, the response SRCS prioritized the training of 150 (90 males and 60 females) dedicated volunteers in Community Engagement and Accountability (CEA). These trained volunteers were strategically deployed to various communities to facilitate the dissemination of critical messages regarding AWD/cholera prevention. Their role extended beyond one-way communication, as they actively captured community feedback, ensuring that the response remained adaptive and responsive to the evolving needs and concerns of the affected populations.
• During these community meetings, a remarkable outreach was achieved, with a total of 2,350 individuals directly reached by this awareness and information-sharing sessions. This included 940 males and 1,410 females, demonstrating a significant impact on gender inclusive communication and engagement.
• A knowledge, attitudes and practices survey revealed that 95% of people indicated to improved health and hygiene practices.

4. Beneficiary Testimony:
• Mumtaz Mohamed Osman, a resident of Hayaabe IDP camp in Borama district (Awdal region), shared her experience as a beneficiary of the SRCS-IFRC Cholera Response Project. She noted that disease prevalence in the community had significantly reduced due to the project's interventions. She explained that community members were taught critical hygiene practices, such as proper handwashing, water treatment, safe water consumption, toilet use, and household cleanliness. Beneficiaries received jerrycans, hygiene materials, sanitary supplies, and water treatment chemicals.
• Mumtaz expressed deep gratitude to the SRCS staff and volunteers for their efforts, acknowledging the transformative impact of their work. She highlighted the community's improved understanding of cholera, attributing it to the education provided by SRCS volunteers. Additionally, she thanked the Red Crescent for supporting the construction of community latrines, distribution of WASH kits, provision of

water treatment chemicals, and establishment of Oral Rehydration Points (ORPs), all of which played a pivotal role in preventing the spread of cholera.•

Lessons Learnt

• Multi-pronged approach to community engagement not only contribute to dispelling myths and rumors but also foster a sense of ownership and participation among community members. It empowers them with accurate information and creates channels for them to voice their feedback and concerns, ultimately enhancing the effectiveness of the cholera prevention and response efforts.

Challenges

There were no significant challenges noted, worth for reporting.

Secretariat Services

Budget: CHF 15,332
Targeted Persons: 4
Assisted Persons: 4
Targeted Male: 3
Targeted Female: 1

Indicators

Title	Target	Actual
# of monitoring missions conducted.	1	1
# of financial spot checks conducted.	1	1

Narrative description of achievements

1. IFRC has a Country Cluster Delegation based in Nairobi, covering Somalia and Kenya, to support operations and response. The IFRC WASH Delegate based in the Hargeisa coordination office supported by mobilizing the Red Cross Red Crescent Movement surge capacity and other resources to support the scale-up of the operation.
IFRC Monitoring missions were conducted in Somaliland and Puntland to the Intervention sites of the Cholera response. They monitored the deployment of the ORP, Construction of community latrines, awareness raising, and a door-to-door volunteer campaign.
2. Logistics supported with international procurement of ORPs and WASH NFI kits and other technical supports required during the operations.
3. The IFRC cluster finance team supported with financial control and one spot check.
4. In July and August 2024, the IFRC cluster team and the SRCS team undertook monitoring activities in Somaliland and Puntland.

Lessons Learnt

It always gives value to have Secretariat support as it comes with both combined effort, additional hands and new way of resolving and viewing issues.

Challenges

Security restrictions in Puntland - under IFRC MSR Garowe town was orange and the rest of Puntland red, making some areas inaccessible.

National Society Strengthening

Budget: CHF 52,443

Targeted Persons: 275
Assisted Persons: 470
Targeted Male: 228
Targeted Female: 242

Indicators

Title	Target	Actual
# Cholera/IPC emergency meeting workshops and conference for MoH and SRCS staff conducted.	4	6
# of Joint monitoring and supervision cost for Ministry of Health Development and SRCS conducted.	5	9
# of volunteers who receive Personal Protective Equipment (PPE).	170	200

Narrative description of achievements

In Somaliland:
1. To maintain a high level of accountability and quality in the response, numerous joint monitoring visits across the affected areas were conducted. These visits served multiple purposes, including assessing the implementation of hygiene promotion activities, evaluating the distribution of WASH items, and gathering feedback from communities
2. Regular monitoring helped in identifying challenges and make necessary adjustments to improve the interventions. Additionally, the MoH through the SRCS organized 7 national level monitoring visits to the AWD/cholera affected districts in Wajaale and Borama and the NS joined such missions to complement government efforts.
3. A total of 270 (108 M, 162 F) volunteers received visibility materials branded with the SRCS Red Crescent logo Wajaale and Borama districts.
4. Volunteers were regularly briefed on security, access, and potential risks.
5. Volunteers and staff were provided with adequate PPEs for their protection.
6. Training and feedback were conducted for the volunteers.
7. Lessons Learned Workshops: The lesson learnt workshop provided a platform for staff, volunteers, and stakeholders to reflect on the response efforts. Participants shared insights, experiences, and best practices, which contributed to a more informed and adaptive approach to addressing cholera outbreaks in the future. All the target districts were represented by MOH staff (facility, district, provincial and National level), members, NDRTS, Volunteers and staff from SRCS HQ and Branches with representation from the national MoH.
In Puntland:
The Ministry of Health has been providing daily updates on AWD/Cholera cases in Puntland, while health cluster partners have shared their response plans to avoid overlapping efforts. In a similar effort, SRCS developed a project monitoring plan that includes a weekly reporting format, where each region reports on key achievements and the number of people reached.
In the Bari and Nugal regions, SRCS branches worked closely with the Ministry of Health offices to conduct joint monitoring activities to assess the effectiveness of the response efforts. Additionally, SRCS branches and the Ministry of Health organized focus group discussions with affected communities to gather feedback and address their concerns about the interventions.
Towards the end of the project, in August 2024, SRCS SRCS Mogadishu Coordination team, along with delegates from the IFRC, and the Ministry of Health, conducted a joint field trip to assess the overall situation of AWD/Cholera-affected communities, focusing on WASH infrastructure, health, and livelihoods. A lessons learned workshop was also held, with participation from SRCS branches in Bosaso and Garowe and regional Health officers from the Ministry of Health, to discuss the main challenges and successes encountered during the project period.
SRCS invited teams from the Ministry of Health offices in the three affected regions: Bari, Karkaar, and Nugal. The SRCS Director of Primary Healthcare presented an overview of the project and the general situation of AWD/Cholera, as well as the interventions carried out.
• In totality, SRCS undertook 6 cholera/IPC emergency meeting workshops consisting of SCRS and MoH representatives. Additionally, SRCS undertook 9 joint monitoring and supervision visits with MoH. Additionally, 200 (120 male and 80 female) volunteers also received personal protective equipment.

Lessons Learnt

• There is need to have a pool and register of trained NDRTs available at any time so as to be able to effectively respond to any disaster.
• The capacity-development initiative targeting the front-line response teams worked well.

• The activation of a laboratory to aid with sample testing worked well and played a key role in the cholera response intervention.
• Existing resources were utilized to act timely like mobile clinics and CHWs, Volunteers and existing areas of CTCs.

Challenges

• Continued escalation in cases is posing a limitation of the resources
• Finding and mobilizing National Disaster Response Team (NDRT) members to support. NDRTs are crucial for coordinating various aspects of disaster response, including risk communication, community engagement, and logistics. However, the availability of trained NDRT members who could be deployed to support proved to be a significant challenge due to unavailability of trained members.
• Limited cholera case management training among frontline staffs and Volunteers.

Financial Report

Selected Parameters			
Reporting Timeframe	2024/2-2024/10	Operation	MDRSO017
Budget Timeframe	2024/1-12	Budget	APPROVED

DREF Operation

FINAL FINANCIAL REPORT

Prepared on 20/Mar/2025

All figures are in Swiss Francs (CHF)

MDRSO017 - Somalia - Cholera

Operating Timeframe: 15 Feb 2024 to 31 Aug 2024

I. Summary

Opening Balance	**0**
Funds & Other Income	**499,964**
DREF Response Pillar	499,964
Expenditure	**-498,795**
Closing Balance	**1,169**

II. Expenditure by area of focus / strategies for implementation

Description	Budget	Expenditure	Variance
AOF1 - Disaster risk reduction		304,184	**-304,184**
AOF2 - Shelter			**0**
AOF3 - Livelihoods and basic needs			**0**
AOF4 - Health	224,688	167,201	**57,487**
AOF5 - Water, sanitation and hygiene	192,861	4,747	**188,115**
AOF6 - Protection, Gender & Inclusion	5,374	4,747	**627**
AOF7 - Migration			**0**
Area of focus Total	**422,924**	**480,879**	**-57,955**
SFI1 - Strenghten National Societies	61,708	12,750	**48,958**
SFI2 - Effective international disaster management			**0**
SFI3 - Influence others as leading strategic partners			**0**
SFI4 - Ensure a strong IFRC	15,332	5,166	**10,165**
Strategy for implementation Total	**77,040**	**17,916**	**59,123**
Grand Total	**499,964**	**498,795**	**1,168**

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Please explain variances (if any)

The total funding allocated by IFRC-DREF to this intervention is CHF of which CHF 499,964 was transferred and implemented by NSs. The overall balance of CHF 1,169 is the result of small balances on the general expenditures or exchange rates.

The variances per cost category is not captured in the general DREF standard report. The reason being that Budget is recorded per budget category while execution of the budget going to the NS is not reported by cost category but appear as one line for all the budget to be implemented by NS. This report provides the overall expenses from NS on budget received as per agreement which stands at CHF 498,795. Further breakdown being internal.

The 50 ORP kits not deployed among the 100 planned remain a property of the DREF and will be used for future need.

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

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Selected Parameters			
Reporting Timeframe	2024/2-2024/10	Operation	MDRSO017
Budget Timeframe	2024/1-12	Budget	APPROVED

DREF Operation

FINAL FINANCIAL REPORT

Prepared on 20/Mar/2025

All figures are in Swiss Francs (CHF)

MDRSO017 - Somalia - Cholera

Operating Timeframe: 15 Feb 2024 to 31 Aug 2024

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AOF7 - Migration			**0**
Area of focus Total	**422,924**	**480,879**	**-57,955**
SFI1 - Strenghten National Societies	61,708	12,750	**48,958**
SFI2 - Effective international disaster management			**0**
SFI3 - Influence others as leading strategic partners			**0**
SFI4 - Ensure a strong IFRC	15,332	5,166	**10,165**
Strategy for implementation Total	**77,040**	**17,916**	**59,123**
Grand Total	**499,964**	**498,795**	**1,168**

DREF Operation

FINAL FINANCIAL REPORT

Selected Parameters			
Reporting Timeframe	2024/2-2024/10	Operation	MDRSO017
Budget Timeframe	2024/1-12	Budget	APPROVED

Prepared on 20/Mar/2025

All figures are in Swiss Francs (CHF)

MDRSO017 - Somalia - Cholera

Operating Timeframe: 15 Feb 2024 to 31 Aug 2024

III. Expenditure by budget category & group

Description	Budget	Expenditure	Variance
Relief items, Construction, Supplies	**211,018**	**31,359**	**179,660**
Water, Sanitation & Hygiene	148,901		148,901
Medical & First Aid	53,592	31,359	22,233
Teaching Materials	8,526		8,526
Land, vehicles & equipment	**7,395**		**7,395**
Land & Buildings	7,395		7,395
Logistics, Transport & Storage	**6,960**	**16,196**	**-9,236**
Distribution & Monitoring		15,696	-15,696
Transport & Vehicles Costs	6,960		6,960
Logistics Services		500	-500
Personnel	**161,820**		**161,820**
National Society Staff	24,360		24,360
Volunteers	137,460		137,460
Workshops & Training	**67,860**		**67,860**
Workshops & Training	67,860		67,860
General Expenditure	**14,396**	**13,149**	**1,247**
Travel	3,045		3,045
Communications		9,607	-9,607
Financial Charges	11,351	3,542	7,809
Contributions & Transfers		**407,649**	**-407,649**
National Society Expenses		407,649	-407,649
Indirect Costs	**30,514**	**30,443**	**71**
Programme & Services Support Recover	30,514	30,443	71
Grand Total	**499,964**	**498,795**	**1,168**