IFRC

DREF Final Report

Somalia_Leishmaniasis Outbreak

SRCS mobile health teams treating patients.

Appeal: **MDRSO021**	Total DREF Allocation: **CHF 328,505**	Crisis Category: **Yellow**	Hazard: **Other**
Glide Number: **-**	People Affected: **220,546 people**	People Targeted: **27,000 people**	People Assisted: **27,000 people**
Event Onset: **Slow**	Operation Start Date: **15-03-2025**	Operational End Date: **31-07-2025**	Total Operating Timeframe: **4 months**
Targeted Regions: **Sanaag**			

Description of the Event

Figure 1. Locations for the leishmaniasis assessment *Source: UN OCHA*

Map of Leishmaniasis Outbtreak in Sanaag region

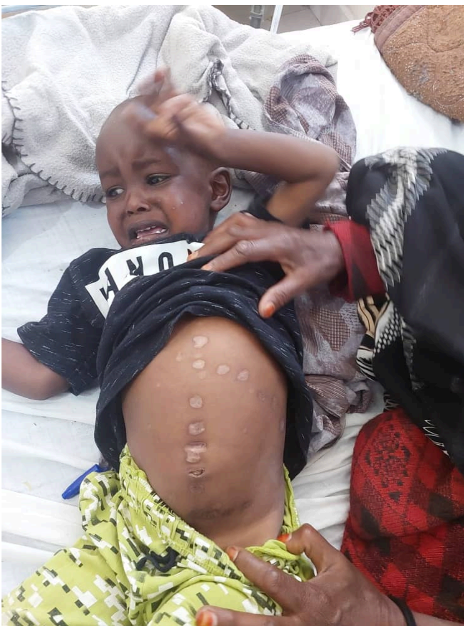
Date when the trigger was met

02-03-2025

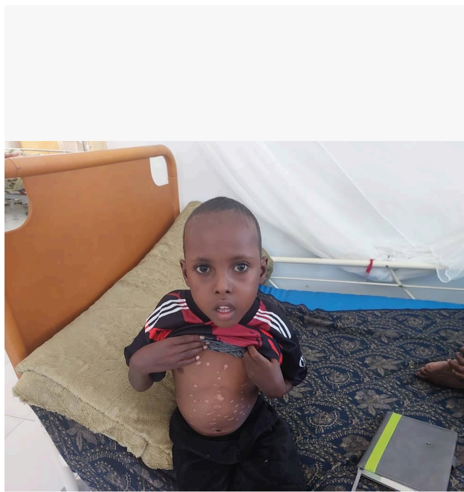
What happened, where and when?

Since January 3, 2025, Erigavo Regional Hospital in the Sanaag region of northeastern Somaliland has reported five cases of visceral leishmaniasis, also known as Kala-azar, a disease not historically prevalent in the area. Among these cases, four tested positive for Leishmania IgG using Rapid Diagnostic Tests (RDTs), raising concerns about the potential emergence of a localized outbreak. Laboratory analysis confirmed two fatalities from Rugay and Cirshiida in Erigavo district, highlighting the severity of the situation. The most recent case was confirmed on February 26, 2025, as a Kala-azar type, indicating ongoing transmission. Between January and July 2025, a total of 140 people were tested, of whom 39 were positive and 12 had died. Erigavo District, the administrative and most populous locality in Sanaag, experienced a notable surge in suspected and confirmed cases of this neglected tropical disease, which is caused by protozoan parasites of the genus Leishmania and transmitted through the bite of infected female Phlebotomine sandflies. Clinical manifestations include persistent high-grade fever, pronounced hepatosplenomegaly, progressive weight loss, anemia, and pancytopenia, consistent with advanced-stage infection.

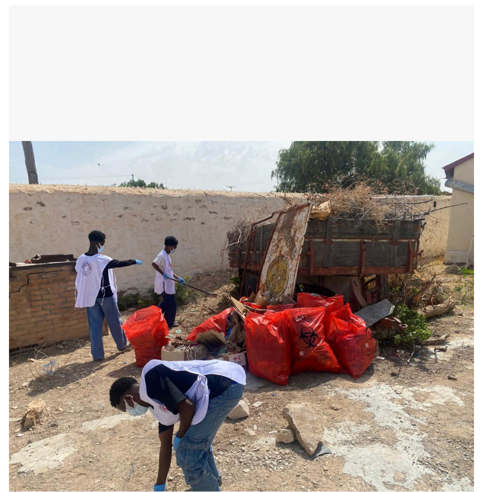
In response to the outbreak, the Ministry of Health Development (MoHD) officially declared the situation a public health emergency on March 2, 2025, and activated its public health department. The MoHD issued urgent notifications to humanitarian partners, highlighting the critical need for intervention. The Somali Red Crescent Society (SRCS), in collaboration with government authorities, mobilized support from the International Federation of Red Cross and Red Crescent Societies (IFRC). A request for financial assistance was submitted to the Disaster Relief Emergency Fund (DREF), enabling the rapid implementation of targeted interventions in the most affected areas. These interventions included intensified case detection, treatment of confirmed cases, vector control, and community awareness campaigns. Efforts continue to prevent further transmission, reduce morbidity and mortality, and maintain vigilance in high-risk areas of the Sanaag region. The implementation of this DREF, combined with the efforts of other response actors, contributed to reversing the epidemic trend, with a noticeable decline in cases across all affected districts.



A child regains health with SRCS care after severe Leishmaniasis illness



SRCS cares for a child recovering from severe Leishmaniasis illness



SRCS volunteers conducting environmental cleaning campaign

SRCS mobile health teams provide essential healthcare services to the community

Scope and Scale

Leishmaniasis remained a significant public health problem in the Sanaag Region. Classified as a neglected tropical disease (NTD), it posed a serious challenge to communities already vulnerable due to limited resources and competing health priorities. The risk was compounded by the likelihood of deprioritization, which could have further worsened its impact on affected populations.

The disease was most prevalent in the mountainous areas of Sanaag, particularly where artisanal gold mining took place. These locations provided a natural environment conducive to the survival of sandflies, the vector that transmitted leishmaniasis. Environmental factors such as cracked clay soil, Acacia and Heglig trees, along with human activities including farming and fishing, created ideal breeding sites for sandflies and placed the local population at heightened risk.

Children, especially those under five years of age, were among the most vulnerable due to their developing immune systems and the added burden of malnutrition. Elderly people, whose immunity was often weakened, and displaced populations (IDPs), particularly in Erigabo and surrounding villages, were also highly susceptible. IDPs faced overcrowded conditions, inadequate sanitation, and limited access to healthcare. Women and girls, who carried the burden of caregiving, experienced disproportionate impacts due to their restricted access to health services and other resources.

The impact of leishmaniasis was severe. By 15 July 2025, the Ministry of Health reported 140 suspected cases at the Erigabo health facility, of which 39 were confirmed positive and 12 resulted in death. These figures reflected only hospital-reported cases, excluding community-level cases. An assessment conducted by the SRCS and the Ministry of Health Development (MoHD) confirmed that visceral leishmaniasis (VL) was endemic in several communities in Erigabo District, particularly within the Guban corridor and nearby rural and nomadic settlements. Cases were clustered in ecologically fragile areas such as dry riverbeds, caves, and thickets near settlements, underscoring the role of environmental and housing conditions in sustaining transmission.

The situation was further aggravated by ongoing conflict in Erigabo District, which had displaced around 43,000 people. Recurrent droughts, El Niño-induced flash floods, and high levels of child malnutrition increased population vulnerability. Poor sanitation facilities and overcrowding in displacement camps heightened the risk of transmission, while widespread food insecurity constrained households' ability to implement preventive measures. Between January and June 2025, approximately 78,400 people in Sanaag faced high levels of acute food insecurity, and more than 88,000 children required urgent treatment for malnutrition.

Source Information

Source Name	Source Link
1. Assessment Report	https://doi.org/10.3389/fitd.2022.965609
2. Leishmaisases	https://www.who.int/news-room/fact-sheets/detail/leishmaniasis.
3. Support request letter from Ministry of health development	https://ifrcorg-my.sharepoint.com/:b:/r/personal/gemechissa_mustefa_ifrc_org/Documents/Desktop/GEM%20HARGESA/IFRC%20GEM/2025%20IFRC/2025-26%20IFRC%20SUPPORTED%20PROJECT/LISHI%20-%20DREF/SRCS/MoHD%20Leishmaniasis%20Letter.pdf?csf=1&web=1&e=siZ1PC

National Society Actions

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

IFRC Network Actions Related To The Current Event

Secretariat	The IFRC maintains two coordination offices in Somaliland (Hargeisa) and Puntland (Garowe), with staff from the Nairobi cluster equally stationed between the two locations—50% in Garowe and 50% in Hargeisa. In addition, operations officers seconded to SRCS are based in both coordination offices, providing technical support to the National Society. Through these field-based officers and delegates from the Nairobi cluster, the IFRC supported SRCS in developing the DREF request and in providing technical assistance for the planned intervention.
Participating National Societies	The German Red Cross, Norwegian Red Cross, Danish Red Cross, Finnish Red Cross, Canadian Red Cross, and Icelandic Red Cross were present in-country. The Partner National Societies (PNS) were engaged in Movement coordination platforms and were consulted on all response decisions, including the recommendation for a DREF request. At the time of compiling the DREF, no PNS had made direct financial contributions, but they actively participated in coordination meetings facilitated by SRCS to ensure effective information sharing.

ICRC Actions Related To The Current Event

The ICRC is present in the country, and, like the PNSs, SRCS informed the ICRC, ensuring coordination through established platforms. In Sanaag region, in response to population movements caused by clashes since 2025, the ICRC has been supporting SRCS in health interventions by providing materials and additional resources to the clinic. These efforts do not overlap with the proposed DREF, and movement coordination ensures effective alignment and optimal resource utilization. Additionally, the ICRC is supporting the National Society in communication, protection, and health services, including first aid and pre-hospital care in the region.

Other Actors Actions Related To The Current Event

Government has requested international assistance	Yes
National authorities	The Ministry of Health Development (MoHD) officially declared outbreaks of leishmaniasis and urged the public to remain vigilant and report any suspected cases. The following interventions were undertaken: (i) The response was coordinated through a whole-of-government and multi-agency approach, led by MoHD's Department of Disease Surveillance and Epidemic Response together with the respective regional Departments of Health. (ii) MoHD deployed a technical team to assess the leishmaniasis outbreak in the Sanaag region. (iii) On-the-ground response activities included regular coordination meetings, field investigations, enhanced surveillance and laboratory testing, risk communication and community engagement, and environmental sanitation measures to prevent further spread of the disease. (iv) MoHD established a coordination framework with partners across multiple sectors, including the Somaliland Red Crescent Society (SRCS), WHO, UNICEF, and other NGOs, to develop a leishmaniasis preparedness and response plan.
UN or other actors	WHO supported the Ministry of Health Development by supplying laboratory testing materials, treatment items, and essential equipment to strengthen the capacity of the laboratory at Erigabo Regional Hospital, and trained the team on their proper use.

Are there major coordination mechanism in place?

One of the key coordination mechanisms established in the Sanaag region, was facilitating collaboration between the Ministry of Health Development (MoHD) and humanitarian partners, including the Somali Red Crescent Society (SRCS), in responding to the outbreak. Through its Public Health Department, MoHD convened regular coordination meetings to guide and align response efforts, with active participation from SRCS.
The SRCS Hargeisa Coordination Office worked closely with MoHD and other organizations to ensure that its actions were aligned with the national response plan. At the same time, SRCS coordination offices engaged with government and local authorities, while the IFRC Nairobi Cluster provided regional and international coordination support.
Coordination mechanisms were also established at national, regional, and local levels to strengthen information sharing and prevent duplication of interventions. Both SRCS and the IFRC delegation played an active role in these systems to minimize overlapping assistance. A multi-sectoral approach was adopted for the initial outbreak assessments across the country. MoHD led assessments in identified hotspot regions, with the findings consolidated at the national level to determine the number of confirmed cases.

Needs (Gaps) Identified

Health

The Leishmaniasis outbreak in the Sanaag region posed significant public health challenges, requiring urgent intervention. One major concern was the region's limited diagnostic capacity, which delayed the timely detection and treatment of infected individuals. Compounding this issue was a shortage of essential medications, which made it difficult to provide adequate care to those affected. Without swift and coordinated action, the outbreak risked further escalation and increased morbidity in the region.
The assessment conducted by the SRCS and Ministry of the Health Development (MoHD) revealed several critical health gaps that are fueling the persistence and spread of the disease. At the health system level, diagnostic and treatment capacity is extremely limited, with most facilities lacking confirmatory diagnostic tools, clear treatment protocols, and a consistent supply of anti-leishmanial medicines. Case detection, recording, and reporting remain weak, as leishmaniasis is not systematically captured in the health information system, leading to underreporting and delayed responses. Human resource capacity is also a major gap; many health workers have little awareness or training on visceral leishmaniasis, resulting in frequent misdiagnosis of cases as malaria or typhoid, while reliance on external partners for specialized interventions highlights the lack of sustainable local expertise.
At the community level, awareness about the disease is low, and misconceptions are widespread, with many believing the illness is caused by mosquito bites, contaminated food, or even witchcraft. This, combined with stigma and reliance on traditional healers, contributes to delayed health-seeking behavior and worsens outcomes. Vector control and surveillance are almost nonexistent, with no entomological monitoring or targeted control measures such as spraying or widespread use of insecticide-treated nets, leaving communities highly

exposed.
Logistical and access challenges such as the remoteness of villages, poor infrastructure, irregular supply chains, and inadequate laboratory services further limit timely diagnosis and treatment. These challenges are severely exacerbated by the ongoing conflict in Erigavo District, which has displaced approximately 43,000 people. In addition, the freezing of USAID funds has led to the closure of many fixed and mobile healthcare facilities, leaving affected populations with little to no access to healthcare services and forcing them to travel long distances for even basic care.

Furthermore, the SRCS remained committed to strengthening community-based health interventions, including disease prevention and hygiene promotion, through trained frontline health workers and community-based volunteers.

Water, Sanitation And Hygiene

The Sanaag region of Somaliland faced significant Water, Sanitation, and Hygiene (WASH) challenges that contributed to the risk of Leishmaniasis outbreaks. Limited access to clean water forced communities to rely on unsafe sources, increasing exposure to disease-carrying sandflies. Poor sanitation, including inadequate waste disposal and open defecation, created breeding grounds for vectors, while a lack of hygiene awareness and resources hindered disease prevention efforts.

Addressing WASH needs during the Leishmaniasis outbreak was essential to prevent the spread of the disease and protect the well-being of affected communities. A comprehensive approach required addressing two key priorities. First, a thorough vector control strategy was implemented in close coordination with the Ministry of Health. Secondly, protection, sanitation, and hygiene practices were improved by promoting awareness and eliminating vector breeding sites. This included insecticide spraying against sandflies, conducting community clean-up campaigns, cutting trees that provided hiding places for sandflies, and using smoke as a natural repellent.

Protection, Gender And Inclusion

Significant gaps in Protection, Gender, and Inclusion (PGI) affected the response to Leishmaniasis, particularly in healthcare access, awareness, and support for vulnerable groups. Women, children, the elderly, disabled, and marginalized populations faced higher risks due to socio-economic and gender disparities, limited outreach, and culturally inappropriate communication.
SRCS prioritized protection and ensured that vulnerable groups received medical care, while incorporating a gender approach in prevention strategies. Both women and men were included in decision-making and implementation, and gender inequalities influencing the disease's impact were addressed. Integrating PGI principles made interventions more equitable, relevant, and effective.

Community Engagement And Accountability

During the Leishmaniasis outbreak, accessing accurate information was particularly challenging for the most vulnerable populations, which hindered effective communication with affected communities and limited opportunities to gather essential feedback. Implementing Effective Risk Communication and Community Engagement (RCCE/CEA) was critical for building trust, addressing misconceptions, and ensuring the adoption of protective and preventive behaviors, playing a central role in controlling and containing the outbreak. Two-way feedback mechanisms were established to counter rumors and dispel myths. The outbreak response actively engaged communities in the planning, implementation, and monitoring of prevention and control strategies, promoting participatory decision-making and ensuring that community voices were heard and integrated into program design. Clear and transparent accountability mechanisms were put in place, allowing health authorities and organizations to report progress and outcomes back to the community, fostering trust and empowering communities to assess the effectiveness of interventions and suggest necessary adjustments. Community participation also involved training local leaders and health promoters, who served as vital agents in disseminating accurate information, identifying sandfly breeding sites, and promoting preventive measures. By involving communities and strengthening local capacities, outbreak response efforts were made more effective, sustainable, and resilient.
The health system, however, lacked sufficient healthcare personnel to carry out communication and behavior-change activities aimed at improving community knowledge and organizing a coordinated response to Leishmaniasis. During the assessment, SRCS and the Ministry of Health and Development (MoHD) identified these challenges. To address this gap, SRCS engaged Radio Hargeisa to disseminate recorded messages to raise awareness and promote preventive and protective measures against Leishmaniasis outbreaks.

Operational Strategy

Overall objective of the operation

The objective of this DREF was to reduce morbidity and mortality from the leishmaniasis outbreak in Erigabo District of the Sanaag region by enhancing disease awareness, strengthening the local health system, and supporting early detection. Over a four-month period, the DREF reached 27,000 people (4,500 households) through activities in health, WASH, protection, PGI, and community engagement.

Operation strategy rationale

To address the needs of the targeted population, the SRCS's role and intervention through this DREF were aligned with the Ministry of Health Development (MoHD) strategy and the auxiliary mandate of the National Society (NS) in epidemic situations. The SRCS DREF operation focused on Supplementary Immunisation Activity (SIA) from community mobilization to in-camp support, complementing existing responses. It leveraged SRCS's access to hard-to-reach areas while enhancing hygiene promotion and health messaging.
Strategy and Interventions:
Health Intervention:
Community Awareness and Risk Communication
SRCS prioritized community-based surveillance (CBS) and risk communication in its leishmaniasis response. A total of 100 volunteers and 5 staff members were trained and deployed across Erigavo District to detect and report suspected cases. Training covered symptom recognition, case detection protocols, referral pathways, and the use of the SRCS Nyss digital platform for real-time reporting. The CBS network referred 150 suspected cases to Erigavo Hospital, of which 32 were confirmed. Five fatalities among referred cases highlighted the need for stronger referral systems and timely health-seeking behavior.
School-Based Prevention
SRCS trained 45 schoolteachers (above the initial target of 40) on leishmaniasis prevention and control. Teachers cascaded the knowledge through schools and communities, working with Community Education Committees (CECs) and promoting health literacy, early detection, and sustainable behaviors. Their efforts reached 27,000 people and helped institutionalize disease education.
Community Action Plans
Thirty community members were trained over three days to develop Community Action Plans (CAPs) on prevention, protection, and control of leishmaniasis. These members became local health champions, promoting hygiene, eliminating breeding sites, strengthening referrals, and fostering multi-stakeholder collaboration.
House-to-House Health Education
Through four campaign rounds, 100 trained volunteers conducted household-level education, reaching 27,000 people (4,500 households). Using IEC materials, visual aids, and local dialects, they clarified misconceptions, reduced stigma, and promoted early treatment.
Mental Health and Psychosocial Support (MHPSS)
SRCS trained 100 staff and volunteers in MHPSS, improving their ability to recognize distress, provide psychological first aid, and maintain workforce resilience.
Behavior Change Communication (BCC)
Using radio, TV, social media, and community meetings, SRCS reached 27,000 people with culturally relevant messaging, survivor testimonials, and local leader endorsements.
Strengthening Health System Capacity
Health Worker Training
In collaboration with MoHD, SRCS trained 50 frontline health workers (36 male, 14 female) on leishmaniasis diagnosis, treatment, and case management based on national and WHO protocols.
Referral Pathways
Referral mechanisms between community volunteers and health facilities were strengthened, resulting in 78 suspected cases being referred for diagnosis and care.
Laboratory Capacity
Nineteen laboratory professionals from 11 health centers and Erigavo Hospital were trained in RDTs, microscopy, biosafety, and quality assurance. Facilities were upgraded to serve as diagnostic hubs, improving detection and treatment.
Mobile Health Teams
Two mobile teams operated for four months in remote areas, reaching 10,787 people. They identified six suspected cases (five confirmed), screened 6,746 children for malnutrition (1,600 acute cases), and delivered maternal, child health, and vaccination services. The teams also provided 218 safe deliveries and reached 6,545 people through health education.
Mining Area Interventions
SRCS, Ministry of Health Department and the mining agency worked in tandem to facilitate the access to mining sites and ensured workers collaborated with SRCS. The collaboration also strengthened efforts aimed at disease prevention and awareness raising campaigns. SRCS deployed two mobile health teams worked with local authorities and mining operators to reduce sandfly exposure among artisanal miners. Interventions included health education, improved shelters, vector control, and distribution of treated nets and repellents.
WASH Intervention

SRCS, in collaboration with Erigabo Municipality, implemented four rounds of environmental cleanup campaigns in high-risk areas. Bulldozers and volunteers removed waste, cleared stagnant water, trimmed vegetation, and promoted proper disposal. The campaigns, combined with health education, reached 27,000 people (4,500 households).
Community Engagement and Accountability (CEA)
SRCS trained 115 staff and volunteers on CEA principles. Local leaders were engaged to build trust, while feedback and rumor-tracking mechanisms addressed misinformation. Radio Hargeisa broadcast prevention messages, reaching 59,274 people across 9,879 households.
Protection, Gender, and Inclusion (PGI)
PGI principles were mainstreamed throughout the operation. A total of 147 frontline personnel (100 refresher-trained, 47 newly trained) were equipped to address gender and protection concerns. Vulnerable groups—women, children, older persons, persons with disabilities, IDPs, and minorities—were prioritized. Volunteers applied safe referral mechanisms and ensured cultural sensitivity, strengthening inclusivity, dignity, and community resilience.

Targeting Strategy

Who was targeted by this operation?

To address the risk of Leishmaniasis transmission, emphasis was placed on protecting children, women, the elderly, people living with chronic diseases, both foreign and national artisanal gold miners, and other vulnerable groups within the community. By addressing the needs of these special groups and the broader community, the goal was to provide effective support, prevention, and protection against Leishmaniasis outbreaks. This approach was aligned with the risk analysis conducted by the Ministry of Health (MoH), which had prioritized the Sanaag region based on their assessment. The SRCS, in close coordination with the Ministry of Health Development and local authorities, followed up to ensure that assistance was provided to the most affected populations.

Explain the selection criteria for the targeted population

Although the Somali Red Crescent Society provided support to all people in need, special emphasis was placed on:
• Targeted response: Districts, communities, and households in areas or villages with reported cases, final numbers were confirmed in coordination with the Ministry of Health Development (MOHD) and partners.
• Outreach services: The Erigavo district and surrounding villages involved in artisanal gold mining. This priority was due to the outbreak being reported in these areas, which also experienced high population movement for reasons including displacement, business transactions, access to social services, foreign travel, and more.
• Groups with specific vulnerabilities and exposure to the vector: Children, pregnant women, the elderly, and people with pre-existing medical conditions, considering their increased susceptibility to Leishmaniasis

Total Assisted Population

Assisted Women	8,919	Rural	47%
Assisted Girls (under 18)	7,421	Urban	53%
Assisted Men	5,779	People with disabilities (estimated)	5%
Assisted Boys (under 18)	4,881		
Total Assisted Population	27,000		
Total Targeted Population	27,000		

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?	**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**
Fighting in Erigabo could spill into the surrounding region and is likely to happen at no or very short notice	Liaised and kept in contact with SRCS branches and volunteers on the ground, ICRC, INSO and the UN networks to get early warnings.
Community needs may exceed the capacity of this operation.	SRCS advocated as necessary to partner organizations to meet unmet needs.
Local beliefs and myths	• SRCS Encouraged community participation in the planning and implementation of interventions. This included training processes for Leishmaniasis prevention and mobilization of local leaders to advocate for preventive practices. • Increased community awareness on EPIC and its spread. Provide a clear community case definition which would exhibit as to how serious this unknown Epidemic disease could be if someone gets infected.
Expansion of the affected area outside the Erigabo district and beyond the neighboring regions	Staff and volunteers in various areas and branches were trained on Leishmaniasis prevention and control. Additionally, refresher trainings were Conducted for SRCS teams in the high-risk districts identified by the Ministry of Health and Defense (MoHD), ensuring that personnel were updated on disease surveillance, vector control, patient referral procedures, and community outreach.
Deployed staff and volunteers could get infected	Staff and volunteer were provided with PPEs and insurance. Apart from these, volunteers were supervised, briefed and debriefed throughout the response.

Please indicate any security and safety concerns for this operation:

Starting 14th of December 2024, violent clashes broke out in Erigabo, the capital of the Sanaag region in Somaliland, resulting in casualties and widespread displacement. With intense fighting particularly in the town's southern areas and nearby locations, an estimated 43,000 people fled and sought refuge in nearby towns such as Ceel Afweyn and Laasqoray, as well as in areas such as Bossaso and Burco. The violence was linked to clan and territorial conflicts in the region.
To reduce the risk of RCRC personnel falling victim to conflict, crime, extremism, health threats, and road hazards, active risk mitigation measures were adopted. Security orientations and briefings were conducted for all teams prior to deployment to help ensure their safety and security.
Standard security protocols on general norms, cultural sensitivity, and the overall code of conduct were put in place. Minimum security requirements were strictly maintained. All personnel had insurance coverage. The minimum required security equipment included functional satellite phones, reliable communication tools, advanced first aid kits, PPE kits, hibernation stocks, safe accommodation, and fully kitted vehicles. Movements were undertaken only after road assessments had been completed.
All NS and IFRC personnel involved in the operations successfully completed the mandatory IFRC security e-learning courses prior to deployment, including Level 1 (Fundamentals), Level 2 (Personal and Volunteer Security), and Level 3 (Security for Managers).
The IFRC security plans were applied to all IFRC staff throughout the operation. Area-specific security risk assessments were carried out for each operational location where IFRC personnel were deployed, and appropriate risk mitigation measures were identified and implemented.

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

completed?	

Implementation

Health

Budget: CHF 196,502
Targeted Persons: 27,000
Assisted Persons: 27,000
Targeted Male: 10,660
Targeted Female: 16,340

Indicators

Title	Target	Actual
# of assessment conducted on the Leishmaniasis disease type and specific gaps	1	1
# of SRCS staff and volunteers trained and deployed on Community based surveillance (CBS).	105	105
# of frontline health workers trained on Leishmaniasis diagnosis, treatment protocols, and case management	50	50
# of schoolteachers trained to Leishmaniasis prevention, protection and control measures	40	45
# of the SRCS staff and volunteers provided on Psychosocial support	100	100
# of people reached out to with risk communication messages through group gatherings or meeting	27,000	27,000
# of the integrated mobile health team deployed	2	2
# of laboratory health centers with enhanced capacity in targeted areas.	2	2
# of people reached with education campaigns to increase awareness on the disease	27,000	27,000

Narrative description of achievements

The SRCS, in collaboration with the Ministry of Health Development (MoHD), conducted a comprehensive assessment of the leishmaniasis outbreak. The comprehensive leishmaniasis assessment conducted in the Sanaag region revealed a multifaceted and deeply concerning public health issue that required immediate, coordinated, and sustained intervention. The findings confirmed the presence of visceral leishmaniasis, with a particular concentration of cases among children under five, underscoring the urgency of targeted pediatric response and case management. While community awareness of the severity of leishmaniasis was moderate, there remained a profound gap in knowledge regarding its transmission, treatment, and prevention. Misconceptions such as confusing sandflies with mosquitoes or attributing symptoms to supernatural causes continued to hinder timely health-seeking behaviour.
A total of 100 volunteers and 5 staff members were trained and deployed on Community-Based Surveillance (CBS) using the SRCS Nyss platform to detect and report suspected cases. Through the Nyss platform, volunteers reported a total of 159 cases, of which 39 were confirmed positive and 5 resulted in death. As for the DHIS2, the platform is run by the Ministry of Health Department.
45 schoolteachers were trained on prevention and control measures to raise awareness among students, while 30 community members were trained to develop and implement community action plans focusing on prevention, protection, and disease control.

After the training on development of community action plans; the community members undertook the following activities:
Assessment & Mapping: Identified affected areas, high-risk populations, and sandfly breeding sites.
Capacity Building: Trained local health workers, volunteers, and community leaders in prevention and response.
Stakeholder engagement: After the developed community action plan, communities engaged other actors to support their action plan
To strengthen the response workforce, 100 staff and volunteers received training on Mental Health and Psychosocial Support (MHPSS). In addition, 50 frontline health workers were trained on leishmaniasis diagnosis, treatment protocols, and case management to ensure timely and effective care.
At the coordination level, SRCS actively participated in national and regional MoHD meetings and partner coordination forums, ensuring alignment and complementarity of interventions. Health promotion activities were reinforced through the dissemination of accurate health information by trained volunteers, as well as the development and distribution of IEC materials, including posters, banners, brochures, and leaflets.
• Over a four-month period, the Somali Red Crescent Society (SRCS) deployed two integrated mobile health teams to serve remote and underserved communities in Erigavo District. The teams, comprising nurses, laboratory technicians, and midwives, conducted active case finding, diagnostic testing, health education, and provision of basic clinical services. They reached 10,787 people, including 5,297 children under five, and identified six suspected leishmaniasis cases, five of which were confirmed and referred for treatment. Beyond disease detection, the teams screened 6,746 children for malnutrition, identifying 1,607 cases, provided 3,153 antenatal and 1,503 postnatal consultations, vaccinated 1,632 children, and supported 218 safe deliveries. Health promotion sessions reached 6,545 individuals, improving awareness on leishmaniasis, hygiene, nutrition, and care-seeking behaviors. The intervention enhanced early diagnosis, facilitated timely treatment, strengthened maternal and child health services, and reinforced community trust in healthcare, demonstrating the critical role of mobile health teams in reaching hard-to-access populations.
• 27,000 people were reached with risk communication messages and education campaigns through group gatherings, meetings and other fora on disease prevention and awareness.

Lessons Learnt

• Involving other stakeholders (Religious & Cultural leaders, Gate Keepers) among others in planning and implementation increased awareness and acceptance in the communities.
• CBS volunteers played an essential role in the early detection and referral of disease outbreaks, with their contributions proving critical to strengthening community-based surveillance and ensuring a timely response

Challenges

• Remote or Inaccessible Areas: some Regions such as arid and semi-arid lands (ASALs) and some parts of Sanaag region are difficult to reach due to poor roads, long distances, or lack of transport.

Water, Sanitation And Hygiene

Budget: CHF 36,986
Targeted Persons: 27,000
Assisted Persons: 27,000
Targeted Male: 10,660
Targeted Female: 16,340

Indicators

Title	Target	Actual
# of community clean-up campaigns for the eradication breeding sites completed	10	40
# of people reached through hygiene promotion campaign	27,000	27,000
# of communities or target sites that have experienced vector control interventions (both chemical and physical).	15	15

Narrative description of achievements

• The SRCS, in collaboration with the Erigavo Municipality (Erigabo, Ceershiida, Madar mugay, Huluul, Gudmo biyo cas, Daryare, and Kulmiye villages), conducted a four-round (each round consisted of 10 clean up campaigns) environmental cleaning and awareness campaign targeting sandfly breeding sites to reduce the risk of leishmaniasis in high-risk areas, including the Guban corridor and artisanal gold mining zones, across 15 intervention sites. These activities were undertaken by community-based volunteers, community leaders, women groups, youth associations and local authority staff, students and teachers. The local authorities also supported with bulldozers to support site clearance. The campaign successfully reduced immediate risks of vector-borne disease transmission, strengthened community resilience, and enhanced institutional capacity for sustainable leishmaniasis prevention through multi-sectoral collaboration and community-driven interventions.
• To support this, SRCS built the capacity of 100 volunteers and community health promoters on hygiene and sanitation to aid sensitization in the five targeted counties. The trained volunteers conducted hygiene promotion campaigns, including door-to-door activities, reaching 27,000 people in hotspot areas during the Leishmaniasis outbreak. They also used IEC materials translated into local dialects.

Lessons Learnt

• Use of IEC materials translated to local dialect proved to be effective in awareness creation and execution of WASH and Leishmaniasis response activities.

Challenges

• Water scarcity due to the prolonged drought in the Sanaag region posed a significant challenge for hygiene promotion, as the area was hot and dry. Communities often moved with their families in search of water and pasture, which also affected some volunteers and forced them to leave the area.

Protection, Gender And Inclusion

Budget: CHF 9,177
Targeted Persons: 27,000
Assisted Persons: 27,000
Targeted Male: 10,660
Targeted Female: 16,340

Indicators

Title	Target	Actual
# of volunteers oriented on PGI	100	147
% of orient Volunteers & staff involving the operation on the SRCS safeguarding policies (PSEA),	100	100
%of SRCS staff and volunteers involved the operation sing the code of conduct	100	100

Narrative description of achievements

• SRCS provided Protection, Gender, and Inclusion (PGI) training to equip 147 volunteers with the knowledge needed to promote PGI principles during house-to-house health education campaigns, environmental cleaning initiatives, and hygiene promotion activities. PGI cut across all other operations and 27,000 people were reached with PGI related activities. Volunteers also received refresher training on PGI awareness, including issues related to violence, discrimination, and exclusion. Child-friendly PGI-related IEC materials were developed and disseminated, alongside IEC materials specifically for PGI training. Community leaders were engaged to support the effective dissemination of culturally accepted PGI information. To ensure IEC/PGI information is culturally acceptable, SRCS leverages on its community feedback mechanisms. The messaging is aligned with local traditions and values which take into account the norms and

religion of the target audience. Additionally, SRCS sought support from Partner National Societies implementing PGI projects to assist with child safeguarding risk analysis, action planning, and the integration of PGI considerations into assessments.

Lessons Learnt

• Involvement of the caregivers and Leishmaniasis survivors as ambassadors played critical role in mobilizing the community members and raising awareness.

Challenges

• SRCS branches lacked PGI focal points to lead PGI related activities.

Community Engagement And Accountability

Budget: CHF 9,177
Targeted Persons: 27,000
Assisted Persons: 27,000
Targeted Male: 10,660
Targeted Female: 16,340

Indicators

Title	Target	Actual
# of CEA training conducted	1	1
# of people reached with CEA messages.	27,000	27,000
# of feedback mechanism in place	1	1

Narrative description of achievements

• Community engagement was central to the strategy, ensuring both acceptance of messages and sustained behavior change. Local leaders were actively involved throughout the process, enhancing trust and reinforcing volunteer outreach. The SRCS also implemented feedback and rumor-tracking mechanisms, enabling volunteers to address misinformation and adapt messaging to reflect community concerns.
As a result of this operation there was observed behavior change such as communities adopted the use of insect repellents, sleeping under mosquito nets to prevent sandfly bites and observable change in health-seeking behavior especially among suspected of leishmaniasis.
A CEA training was conducted and 105 staff and volunteers were trained in Community Engagement and Accountability (CEA) principles to facilitate inclusive dialogue, address behavioral drivers, and operationalize accountability mechanisms.
IEC materials for CEA training, highlighting key messages on the feedback mechanism, were printed and distributed to the community.
A Hotline and feedback mechanism during health outbreaks played a critical role in managing information and reducing rumors. By providing communities with direct access to timely and accurate guidance, these channels helped curb the spread of misinformation and reinforced public trust in health authorities. Communities were also able to seek healthcare through the SRCS mobile health teams and government hospitals, ensuring that accurate information was complemented by accessible medical support.
SRCS informed communities about the free hotline, allowing people to call without incurring charges. Volunteers were available during working hours to answer calls and direct inquiries to the appropriate health teams responsible for responding, ensuring communities received timely guidance and support. As a result of disseminating the SRCS hotline we experienced a surge in inquiries regarding the operation.

Lessons Learnt

• The involvement of community leaders in our activities greatly facilitated the implementation of community engagement initiatives.
• Regular coordination meetings SRCS-MOHD and other partners such WHO, UNICEF and local authorities minimized duplication of activities and provided efficient flow of information among partners.

Challenges

• Some traditional healers were not cooperative at the start of the response. SRCS leveraged on community volunteers and community engagement to alleviate misconceptions around the intervention to forge trust in the community. SRCS was keen on expressing respect and recognition of the traditional healers. The traditional healers were involved in project planning, community meetings, training on disease prevention and detection protocols.

Secretariat Services

Budget: CHF 19,602
Targeted Persons: 27,000
Assisted Persons: 27,000
Targeted Male: 10,660
Targeted Female: 16,340

Indicators

Title	Target	Actual
# of IFRC monitoring and support missions conducted	1	0
# of Movement coordination meetings organized and updates provided to Movement partners.	5	5

Narrative description of achievements

• The 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, facilitated the mobilization of Red Cross Red Crescent Movement surge capacity and other resources to support the scale-up of the operation.
Logistics provided support for other technical needs during the operations. The IFRC cluster finance team assisted with financial control, including one spot check.
Field monitoring activities were not conducted by the IFRC team due to security concerns in the Sanaag region.

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

• Field monitoring activities were not conducted by the IFRC team due to security restrictions in the Sanaag region.

National Society Strengthening

Budget: CHF 56,859
Targeted Persons: 27,000
Assisted Persons: 27,000
Targeted Male: 10,660
Targeted Female: 16,340

Indicators

Title	Target	Actual

# of lessons learned workshops developed	1	1
# of branches supporting the operation	1	1
# of monitoring and supervision visits conducted	5	5
# of coordination meeting for MoHD and SRCS conducted.	10	10
# of joint monitoring and supervision visits conducted by MoHD and SRCS.	5	5

Narrative description of achievements

• SRCS deployed 100 volunteers under the leadership of the Branch Health Officer at the field level, with direct supervision from the Community Health Manager and overall leadership from the Director of Health and Nutrition. In addition, SRCS deployed two mobile health teams, each comprising nurses, laboratory technicians, and midwives.
Both SRCS branch and coordination teams conducted 5 joint monitoring and supervision with the Ministry of Health development teams to ensure effective service delivery.
On 29 June 2025, a lessons learned workshop was held, with 50 participants including volunteers, community members, elders, frontline health staff, Ministry of Health representatives, and SRCS staff from both coordination and branch levels. This was in addition to 10 coordination meetings held between SRCS and MoHD.
• The operation was supported by one branch - Erigabo
• A lessons learnt workshop was conducted. The summary of lessons learnt is as indicated in the lessons learnt section below.

Lessons Learnt

Key Lessons Learned from the DREF Operations:
• Early detection and behavior change were achieved through community engagement, school outreach, and volunteer surveillance.
• Strengthening health systems with trained mobile teams and enhanced laboratory capacity enabled timely diagnosis and treatment, particularly in remote areas.
• Multi-channel awareness campaigns, community clean-ups, and partnerships with mining operators facilitated risk communication, vector control, and environmental management.
• The integration of Protection, Gender, and Inclusion (PGI) and Mental Health and Psychosocial Support (MHPSS) ensured equitable and culturally sensitive interventions.
• Key operational lessons included maintaining prepositioned medical stocks, utilizing Branch Disaster Response Teams, and fostering strong collaboration with the Ministry of Health and partners to improve outbreak response outcomes.

Challenges

• Poor road networks and lack of transportation in remote areas caused delay in deployment of volunteers and mobile teams.

Financial Report

bo.ifrc.org > Public Folders > Finance > Donor Reports > Appeals and Projects > DREF Operation - Standard Report

Selected Parameters			
Reporting Timeframe	2025/3-8	Operation	MDRSO021
Budget Timeframe	2025/1-12	Budget	APPROVED

DREF Operation

FINAL FINANCIAL REPORT

Prepared on 22/Sep/2025

All figures are in Swiss Francs (CHF)

MDRSO021 - Somalia - Epidemic Leishmaniasis Outbreak

Operating Timeframe: 15 Mar 2025 to 31 Jul 2025

I. Summary

Opening Balance	**0**
Funds & Other Income	**328,505**
DREF Response Pillar	328,505
Expenditure	**-307,939**
Closing Balance	**20,566**

II. Expenditure by area of focus / strategies for implementation

Description	Budget	Expenditure	Variance
AOF1 - Disaster risk reduction	20,050	12,238	**7,812**
AOF2 - Shelter			**0**
AOF3 - Livelihoods and basic needs			**0**
AOF4 - Health	184,509	184,341	**169**
AOF5 - Water, sanitation and hygiene	34,729	34,265	**464**
AOF6 - Protection, Gender & Inclusion	8,617	8,367	**250**
AOF7 - Migration			**0**
Area of focus Total	**247,904**	**239,210**	**8,694**
SFI1 - Strenghten National Societies	62,195	62,290	**-95**
SFI2 - Effective international disaster management			**0**
SFI3 - Influence others as leading strategic partners			**0**
SFI4 - Ensure a strong IFRC	18,405	6,439	**11,966**
Strategy for implementation Total	**80,600**	**68,729**	**11,872**
Grand Total	**328,505**	**307,939**	**20,566**

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Please explain variances (if any)

The NS recorded a forex gain of CHF 15,000 after transferring 100% of the PFA value to the National Society in USD (USD 327,056), which translated to CHF 274,707.86. This variance resulted from the budget being converted to CHF at the exchange rate prevailing at the time the DREF was approved, while transfers to the National Society were made using the bank rate on the day of transfer.

Field monitoring activities were not conducted by the IFRC team due to security concerns in the Sanaag region.

The balance of CHF 20,566 will be returned to the DREF pot.

Contact Information

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

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Click here for reference