DREF Final Report

Somalia - Diphtheria Outbreak

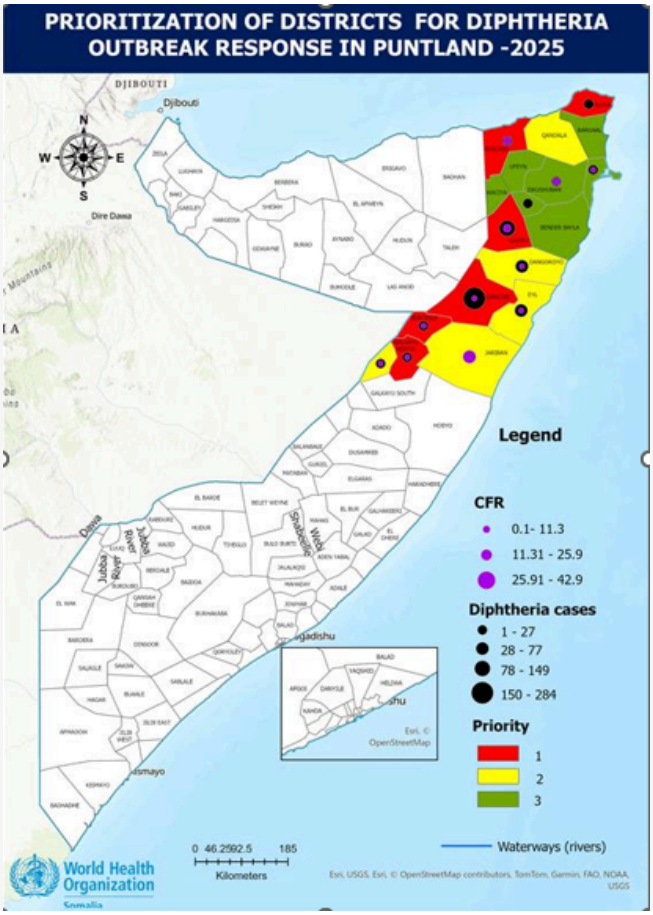
SRCS volunteer undertaking door-to-door vaccination in Puntland, Somalia

Appeal: **MDRSO024**	Total DREF Allocation: **CHF 499,911**	Crisis Category: **Yellow**	Hazard: **Epidemic**
Glide Number: **MDRSO024/PSO528**	People Affected: **682,300 people**	People Targeted: **590,000 people**	People Assisted: **590,000 people**
Event Onset: **Slow**	Operation Start Date: **07-08-2025**	Operational End Date: **28-02-2026**	Total Operating Timeframe: **6 months**

Targeted Regions: **Bari, Mudug, Sanaag, Sool**

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



DIPHTHERIA AFFECTED AREAS IN PUNTLAND - 2025

Date when the trigger was met

07-09-2025

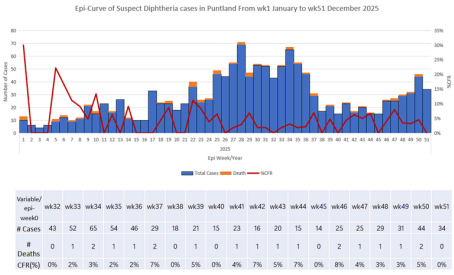
What happened, where and when?

Somalia has experienced a sharp surge in diphtheria cases in recent years. In 2025, the country reported 1,811 suspected cases and 89 deaths, marking a significant increase compared to previous years and underscoring the ongoing outbreak and urgent need to strengthen vaccination coverage and healthcare systems.
The outbreak continued to spread across 52 districts. Between epidemiological weeks 1–9 of 2026, a total of 871 clinically confirmed cases and 24 deaths were reported through health facilities via DHIS-2, resulting in a case fatality rate (CFR) of 3%. A majority of cases (66.7%) had no history of vaccination, while 73% occurred in individuals over five years of age.

Puntland:
Over the past three years, Puntland has faced recurrent armed conflict, climate-related displacement, and chronic underfunding of its healthcare system. These challenges have left communities particularly in Mudug, Karkaar, and Bari regions highly vulnerable to public health emergencies. The situation has been further exacerbated by shortages of medical supplies and qualified health personnel, as well as the closure or under-resourcing of health facilities.
As of June 2025, 125 health facilities (75 in Mudug and 50 in Karkaar) were experiencing severe funding gaps, affecting an estimated 300,000 people, including internally displaced persons (IDPs), marginalized populations, and remote pastoralist communities.
The disruption of essential health services has significantly weakened routine immunization systems. Irregular vaccine supply and frequent cold chain interruptions have created dangerous immunity gaps, contributing to outbreaks of vaccine-preventable diseases such as diphtheria, measles, and pertussis.
In June 2025, the Puntland Ministry of Health declared a diphtheria outbreak, reporting 1,386 cases and 54 deaths. Most of those affected had never received a single dose of the diphtheria vaccine. Overall, 55% of cases had no history of vaccination, including 16% among children under five years of age.

The most affected areas, particularly Galkacyo, were characterized by low vaccination coverage, fragile health infrastructure, population displacement, and limited availability of diphtheria antitoxin in referral health facilities.

Somaliland:
The Ministry of Health Development (MoHD) declared a diphtheria outbreak in the Sanaag region, placing considerable strain on both communities and the health system. Surveillance data indicated a concerning upward trend in cases. A total of 49 confirmed cases and 6 deaths were reported, resulting in a high case fatality rate of 13%.
Sool Region
In Sool region, the Ministry of Health reported 135 suspected cases and 5 deaths, corresponding to a case fatality rate of 3.7%.
Overall, the outbreak exposed critical gaps in Somalia's routine immunization coverage, leaving many children vulnerable to vaccine-preventable diseases such as diphtheria, measles, and pertussis. Continued reduction in humanitarian funding have further weakened the already fragile health system. Limited resources for vaccination campaigns, medical supplies, and mobile health teams have left many children unprotected, while vaccine shortages and poor health infrastructure have fueled the rapid rise in cases. Without urgent and sustained intervention, the impact of the outbreak is likely to continue escalating nationwide.
Overall, the diphtheria outbreak in Somalia showed a significant upward trend between 2025 and early 2026, driven by low routine immunization coverage, displacement, fragile health systems, and chronic funding shortages. However, the response interventions contributed to improving outbreak detection, case management, and access to vaccination services in the most affected districts. Through strengthened surveillance, deployment of mobile health teams, community engagement, targeted vaccination campaigns, and improved referral and treatment capacity, transmission was progressively reduced in several hotspot areas. The interventions also supported earlier identification and management of cases, contributing to a reduction in case fatality rates in affected communities. Importantly, the operation resulted in a marked decline in reported cases in the targeted intervention areas, and no new diphtheria cases were reported during the final month of the operation, indicating that the response successfully helped interrupt local transmission in those locations. Despite these achievements, persistent immunity gaps and weak health infrastructure continue to pose a risk for future outbreaks, underscoring the need for sustained investment in routine immunization and essential health services nationwide.



Variable/ epi-week0	wk32	wk33	wk34	wk35	wk36	wk37	wk38	wk39	wk40	wk41	wk42	wk43	wk44	wk45	wk46	wk47	wk48	wk49	wk50	wk51
# Cases	43	52	65	54	46	29	18	21	15	23	16	20	15	14	25	25	29	31	44	34
# Deaths	0	1	2	1	1	2	0	1	0	1	1	1	1	0	2	1	1	1	2	0
CFR(%)	0%	2%	3%	2%	2%	7%	0%	5%	0%	4%	7%	5%	7%	0%	8%	4%	3%	3%	5%	0%

Weekly graphic report of the Diphtheria outbreak in Puntland

SRCS health promotion session

vaccination roll out in Roox village in Mudug province

SRCS staff immunizing children against diphtheria in the Sool region.

Scope and Scale

Puntland

The diphtheria outbreak in Puntland spread across multiple regions and districts, reaching a total of 1,386 reported cases and 54 deaths. The distribution of cases showed a clear concentration in a few high-burden areas, with the majority of transmission occurring in densely populated or well-connected districts. In contrast, smaller and remote districts reported fewer cases but, in some instances, higher case fatality rates.

The Mudug region accounted for the largest share of the outbreak. Within Mudug, Galkacyo reported 610 cases, making it a hotspot. Galdogob and Jarriban districts contributed additional clusters, though at a smaller scale. The high number of cases in Galkacyo indicated sustained community transmission, likely driven by high population mobility and widespread exposure across urban neighborhoods. However, the relatively lower case fatality rate suggested comparatively better access to health services than in remote areas.

Another major epicenter was in Nugal, particularly Garowe district, which reported 419 cases despite being the political and economic hub of Puntland. Frequent population movement in this area contributed to the rapid spread of the outbreak within and around the district. Eyl district in Nugal also reported 108 cases, representing significant focus of transmission. This demonstrated that the outbreak was not confined to a single urban center but affected the region more broadly.

Overall, the outbreak in Puntland demonstrated both geographic expansion and concentration. While nearly all regions were affected, the vast majority of cases were concentrated in a small number of districts. High case numbers in Galkacyo, Garowe, and Eyl indicated ongoing transmission and escalation. At the same time, the emergence of cases in smaller and more isolated districts suggested that the outbreak was no longer confined to traditional transmission corridors and had spread into harder-to-reach communities.

Somaliland

The diphtheria outbreak in Somaliland also expanded across multiple regions and districts. In the Sanaag region, 49 cases and 6 deaths were reported, resulting in a case fatality rate of 13%. The distribution of cases showed a clear concentration in high-burden areas, particularly Badhan and Erigabo districts, with Badhan identified as the primary epicenter of the outbreak.

In the Sool region, 135 cases and 5 deaths were reported, corresponding to a case fatality rate of 3.7%. Cases were distributed across Buhodle, Taleh, and Hudun districts.

The most severely affected populations included internally displaced persons (IDPs), pastoralist families, children under five, pregnant women, and the elderly. These groups often lived in overcrowded IDP camps, informal settlements, and remote rural areas where access to healthcare was extremely limited or entirely absent.

Historical patterns of displacement due to conflict and climate shocks, including droughts and floods, increased vulnerability among these populations. The situation was further exacerbated by repeated disruptions of mobile health services, including those provided by SRCS teams, as well as reduced functionality of existing health facilities.

At the time, 125 health facilities faced funding gaps, particularly in Mudug and Bari regions, while an additional 40 facilities in Sool and Sanaag regions also struggled with inadequate resources. These shortages significantly increased health risks for already vulnerable communities.

People with disabilities, chronic illnesses, and single-headed households—especially female-headed households—faced compounded challenges due to mobility constraints and reduced access to timely health information.
The temporary closure of Qur'an schools and other learning institutions, although necessary for outbreak control, disrupted education and reduced safe spaces for children, contributing to increased psychosocial stress among families.
Health systems in both Puntland and Somaliland were severely strained. Supply chains for vaccines and cold chain systems were disrupted due to funding gaps, leading to interruptions in immunization outreach. In addition, laboratory testing capacity remained limited to a single referral center.
Situation post DREF Operation:
Somalia/Somaliland remained in an active and ongoing diphtheria outbreak phase, with transmission continuing across multiple regions.
Puntland:
Status: Ongoing transmission with persistent hotspots
Puntland remained one of the key hotspots for diphtheria in Somalia post this DREF operation.
Active cases were still being reported, particularly in: Galkacyo (Mudug) & Garowe (Nugal)
The outbreak showed:
(i) Persistent community transmission, especially among school-age children
(ii) Continued spread linked to population movement and urban centers
Epidemiological characteristics:
(i) High proportion of unvaccinated ("zero-dose") individuals (≈73–87%)
(ii) Children under 15 remained the most affected group (~80%)
(iii) Case fatality rates varied, reaching higher levels in remote districts (up to ~15%) due to limited access to treatment.
Despite response efforts (mobile teams, vaccination campaigns), control was constrained by: Shortages of diphtheria antitoxin, Weak health infrastructure &Funding cuts affecting service delivery
Somaliland:
Status: Localized but concerning outbreaks
Somaliland continued to report diphtheria cases, particularly in northern regions such as Sanaag, where outbreaks had been declared earlier.
The outbreak remained:
- Geographically localized compared to Puntland
- Concentrated in specific districts (e.g., Badhan, Erigabo, and parts of Sool)

Key feature:
- Continued upward trend or persistence of cases noted in surveillance reports.

The response improved access to immunization services in targeted areas through outreach campaigns and mobile clinics, leading to increased vaccine uptake compared to the baseline situation of very low or zero-dose coverage in many communities. However, no full endline coverage data were available, and improvements are based on routine service delivery and uptake trends. Despite these gains, overall vaccination coverage remains insufficient to achieve herd immunity, and significant immunity gaps persist, indicating the need for continued strengthening of routine immunization systems beyond the operation period.
At the end of the DREF operation, the exit strategy focused on ensuring continuity of key outbreak response activities through gradual handover to the Ministry of Health and regional health authorities. Mobile vaccination services, surveillance, and community engagement activities were integrated into routine health systems, with trained health workers and community volunteers continuing implementation under local structures. Existing coordination and DHIS-2 surveillance mechanisms were also maintained to support ongoing monitoring of diphtheria cases, although sustainability remains constrained by limited resources and vaccine supply challenges.

Source Information

Source Name	Source Link
1. Urgent Appeal from MoH	https://ifrcorg-my.sharepoint.com/:b:/g/personal/gemechissa_mustefa_ifrc_org/EciUO7o3lChCk8hGfVEaHUcB_R1TijQmI3ytsGtEcYqYCA?email=gemechissa.mustefa%40ifrc.org&e=NWrPfv
2. SRCS Assessment Report	https://ifrcorg-my.sharepoint.com/:b:/g/personal/gemechissa_mustefa_ifrc_org/ETrWeEJweJdGj6VADtYuzSQBe73ZNbKDNbLbphjdac4vAg?email=gemechissa.mustefa%40ifrc.org&e=5nrAke
3. Somalia: Health Cluster Bulletin, February 2026	https://reliefweb.int/report/somalia/somalia-health-cluster-bulletin-february-2026
4. Disease Surveillance Report - Puntland	https://ifrcorg-my.sharepoint.com/:b:/g/personal/gemechissa_mustefa_ifrc_org/

	EbJABRBtIZJJr7CaWda04qIB7oJBvc7G9BpEvKXElwdj3Q?email=gemechissa.mustefa%40ifrc.org&e=L9H1dS

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	Puntland In collaboration with the Ministry of Health and with support from Norwegian Red Cross, SRCS launched a rapid vaccination outreach campaign in the most affected areas of Bari and Mudug. The campaign aimed to quickly increase vaccination coverage among high-risk populations, particularly children and underserved communities, in order to contain the diphtheria outbreak. It focused on closing immunity gaps, strengthening community awareness on timely immunization, and reinforcing the capacity of local health systems through coordinated vaccination, surveillance, and community engagement activities. In August 2025, a Diphtheria DREF was officially approved, enabling the deployment of five emergency mobile clinics two in Bari region and three in Mudug region. These mobile clinics delivered the full package of routine EPI vaccines in accordance with the national immunization schedule, while also integrating outpatient (OPD) and nutrition services. During the initial phase of the outbreak, prior to the activation of the DREF, SRCS community volunteers conducted awareness-raising activities on diphtheria prevention and control measures at the community level. These activities reached a total of 92 villages across Bari, Mudug, and Nugal regions.

IFRC Network Actions Related To The Current Event

Secretariat	The International Federation of Red Cross and Red Crescent Societies (IFRC) maintains offices in both Garowe and Hargeisa, with staff from the Nairobi cluster equally stationed between the two locations 50% in Garowe and 50% in Hargeisa. This includes a WASH delegate, a security delegate, and two Operations Officers. These, in turn, are supported by the Nairobi Cluster office, with dedicated logistics, finance, communications, PMER, and SPRM support. IFRC supported SRCS in the development of the DREF request and continued to provide technical assistance for the planned intervention.
Participating National Societies	Coordination and Partnerships: This operation was implemented in close collaboration with key stakeholders to ensure a coordinated and effective response. Puntland • The Norwegian Red Cross (NorCross) supported existing health facilities by strengthening outreach activities and disseminating information, education, and communication (IEC) materials. It also expanded its medical supply support, including additional outpatient department (OPD) kits, to meet the needs of four newly deployed mobile health clinics. • With support from NorCross, SRCS initiated outreach immunization campaigns in the most affected communities, covering nine health facility catchment areas—two in Bari and seven in Mudug. • The intervention contributed to the rollout of Risk Communication and Community Engagement (RCCE) activities across Mudug and Bari regions. • Capacity-building activities were conducted for health professionals and SRCS

	community volunteers to enhance service delivery, surveillance, and community mobilization. Finnish Red Cross • The Finnish Red Cross supported the rollout of RCCE campaigns at the Puntland level through community-based volunteers, strengthening awareness and community engagement efforts. Danish Red Cross • The Danish Red Cross enhanced health campaigns by focusing on message dissemination and strengthening case referral mechanisms in high-risk areas. Somaliland In Somaliland, with support from NorCross, the diphtheria response reached a total of 114,217 people through community engagement and risk communication activities, including 62,819 females and 51,398 males. These efforts significantly improved awareness of prevention measures, symptoms, and the importance of early care-seeking. At the same time, the immunization campaign successfully vaccinated 5,914 children under five years of age, surpassing the planned target of 5,460 and helping to close critical immunity gaps among high-risk populations. In addition, 11 suspected diphtheria cases were identified and referred for appropriate clinical management. Overall, the extended intervention directly reached more than 120,000 individuals, strengthening population immunity and contributing to the interruption of disease transmission in the targeted regions.

ICRC Actions Related To The Current Event

The ICRC maintained a physical presence in both Garowe (Puntland) and Hargeisa (Somaliland) and continued implementing its regular programmatic activities in the region. However, at the time, ICRC had not made a formal commitment to directly support the ongoing diphtheria outbreak response.
Nevertheless:
• The ICRC provided targeted support to the Wisil and Iskushuban health centers, assisting with community outreach and health messaging aimed at vulnerable populations.
• First Aid and Pre-Hospital Emergency Care (FAPHEC) was integrated into the diphtheria response, supporting the timely referral of suspected and affected individuals to the nearest health facilities for appropriate care.

Other Actors Actions Related To The Current Event

Government has requested international assistance	Yes
National authorities	Puntland A mass vaccination outreach campaign was conducted over a period of three months in 118 health centers in the Mudug, Nugal, and Bari regions, covering all villages within their 5 km radial catchment areas. Similarly, the Ministry of Health scaled up routine vaccination by providing sufficient vaccine supply at the clinic level across Puntland and raised awareness among communities in those areas as well as in the larger towns. Somaliland On 10 September 2025, the Ministry of Health Development held an emergency meeting in response to the diphtheria outbreak in the Sool and Sanaag regions. During the meeting, the Ministry requested support for routine vaccination campaigns to assist the affected populations. The meeting was attended by representatives from the UN, international organizations, NGOs, and the Somali Red Crescent Society (SRCS).

	The Ministry of Health Development in Somaliland established quarantine and care centers in the districts most affected by the diphtheria outbreak.
UN or other actors	In Puntland: UNICEF and WHO took active roles in supporting the government-led response to the diphtheria outbreak in Puntland. Both agencies contributed to the ongoing clinic catchment outreach campaign, which operated across all regions. In addition to supporting vaccination efforts, UNICEF and WHO provided human resources to strengthen service delivery in government-run health facilities. They also led risk communication and community engagement (RCCE) activities to raise awareness and promote preventive behaviors within affected communities. Moreover, both agencies supported the cold chain system by ensuring the supply and distribution of vaccines and facilitated transportation mechanisms to enable the delivery of essential health services to remote and underserved areas. These coordinated efforts were critical in enhancing the reach and effectiveness of the outbreak response across all regions of Puntland. In Somaliland: WHO and UNICEF supported the cold chain systems by ensuring the supply and distribution of vaccines and facilitated transportation mechanisms to enable the delivery of essential health services to remote and underserved areas. WHO provided some supplies for the diphtheria response. UNICEF also supported the Ministry of Health's awareness campaigns for the diphtheria outbreak response. Save the Children deployed two additional mobile health teams to respond to the diphtheria outbreak.

Are there major coordination mechanism in place?

In Puntland
Coordination mechanisms in Puntland were well-established and involved multiple platforms to ensure effective response and collaboration among health and humanitarian actors. These included:

Health Cluster Meetings:
Held monthly, these meetings provided a platform for health partners to exchange information, analyze gaps and challenges, and coordinate both ongoing and planned operations.

Ad-hoc Emergency Health Meetings:
Led by the Ministry of Health, these were convened in response to public health emergencies to facilitate rapid decision-making and coordination.
Inter-Agency Coordination Meetings: Facilitated by UNOCHA, these meetings brought together sectoral actors to discuss response activities, identify gaps, and address challenges at the Puntland level.
Area-Based Coordination: Conducted jointly by UNOCHA and regional administrations, this mechanism focused on monitoring hotspot areas and supporting regional authorities in managing localized operations.

Regional Health Ad-hoc Emergency Meetings:
Coordinated by regional health officers, these meetings engaged regional health partners and stakeholders to share updates, identify gaps, and plan next steps. They also served as a tool for resource mobilization and advocacy.

In Somaliland
In Somaliland, the Ministry of Health Development planned to establish a regular coordination mechanism for responding to the diphtheria outbreak. Coordination meetings were held as needed, with line ministers of Somaliland and UNOCHA coordinating to ensure accurate targeting and avoid duplication. Various clusters, particularly in health, were active, with NS and movement partners participating to share information on different sectoral approaches.

Regional Health Ad-hoc Emergency Meetings:
Coordinated by regional health officers, these meetings engaged regional health partners and stakeholders to share updates, identify gaps, and plan next steps. They also served as a tool for resource mobilization and advocacy.

Needs (Gaps) Identified

Health

In Somalia, particularly in Puntland and Somaliland, significant health system gaps continued to hinder an effective response to diphtheria outbreaks, especially among vulnerable populations. A large number of zero-dose children those who had never received any routine immunizations were concentrated in remote rural and pastoralist communities, notably in parts of Bari, Nugal, Mudug, Sool, and Sanaag regions. These areas often lacked adequate health infrastructure, while families were highly mobile due to recurrent climate shocks, armed conflict, and nomadic livelihoods, making consistent service delivery extremely challenging.

Routine immunization services in these regions were frequently disrupted by chronic underfunding, climate-related emergencies, and increased population movement. There was also poor continuity of care between the first and third doses of the pentavalent (Penta) vaccine, resulting in incomplete immunity among many children. This challenge was further compounded by weak referral systems, particularly in districts with limited transportation infrastructure, where patients were often not referred in time for diagnosis or life-saving treatment.

Stockouts of critical supplies including diphtheria antitoxin (DAT) and essential antibiotics were common in high-risk areas, especially during disease surges. These shortages often led to preventable complications and deaths, particularly in remote health posts and mobile clinics. In addition, many frontline health workers in Puntland lacked the training and clinical capacity required to effectively identify, isolate, and manage diphtheria cases. Infection prevention and control (IPC) practices were frequently inadequate due to limited supplies and insufficient understanding of transmission risks.

During the operation, the SRCS also identified key operational gaps, including the closure of many health facilities due to funding cuts, which further reduced access to essential services. Population movement linked to drought conditions disrupted continuity of care and outreach activities, while low levels of community awareness contributed to poor health-seeking behavior and low uptake of vaccination services. Overall, these interconnected systemic and operational challenges have left the health system fragile, increasing population vulnerability and sustaining the risk of recurrent outbreaks and preventable deaths.

At the community level, SRCS also identified persistently low awareness, widespread misinformation, mistrust, and vaccine hesitancy, particularly in underserved and conflict-affected areas. Local beliefs, rumors, and limited engagement with trusted community leaders further reduced vaccine uptake. In addition, there were no updated diphtheria-specific outbreak preparedness and response plans, while health emergency response systems remained severely underfunded, with minimal operational support for rapid response teams, case management, and community mobilization during outbreaks.

Protection, Gender And Inclusion

Protection gaps during the diphtheria outbreak were largely driven by limited access to health services in areas affected by drought and armed conflict, where vulnerable populations struggled to reach vaccination and treatment centres. Many villages that had previously had functioning clinics no longer had active healthcare services due to funding cuts, creating significant service gaps across Puntland and Somaliland.

Gender-related challenges further undermined the effectiveness of the health response. Health campaigns often overlooked gender dynamics, failing to recognize that women were typically the primary caregivers, while men's movement patterns influenced access to services. This contributed to reduced vaccine uptake. In addition, the underrepresentation of women in decision-making structures, such as health committees, limited the inclusiveness and responsiveness of outbreak interventions.

Pregnant and lactating women faced additional barriers, including concerns about vaccine side effects and limited availability of services tailored to their specific needs. Persons with disabilities also encountered persistent challenges, such as inaccessible health infrastructure and the lack of assistive communication tools. Ethnic and linguistic minority groups, as well as recently displaced populations from remote areas—such as Celmiskaat, which had previously been under the control of non-state actors and had limited exposure to vaccination—were often marginalized when services were not delivered in culturally appropriate formats or in simple, understandable languages. This contributed to mistrust and the spread of misinformation.

The absence of disaggregated data by age, gender, and disability further constrained efforts to accurately identify and effectively target the most at-risk populations.

Community Engagement And Accountability

During the recent diphtheria response in Somalia, initial community feedback from Bari, Mudug, Sool, Sanaag, and surrounding areas highlighted significant gaps in information dissemination, communication, and community participation. Community members reported a need for clearer understanding of the roles and responsibilities of the various actors involved in the response and emphasized the importance of greater engagement in decision-making processes related to service access and preventive interventions, including vaccination. The absence of meaningful engagement contributed to mistrust.

In addition, delays or shortfalls in service delivery such as the provision of vaccines and essential medical supplies were often not

accompanied by adequate communication or follow-up. Community perspectives were rarely incorporated into monitoring and evaluation processes. Health messages, particularly those concerning diphtheria and other vaccine-preventable diseases, were frequently not sufficiently adapted to local languages and cultural contexts, reducing their clarity, relevance, and overall effectiveness.
During the extended campaign period, vaccine hesitancy and community misconceptions persisted in some isolated and previously unreached communities. Limited exposure to routine immunization services, low levels of health literacy, and reliance on informal information channels contributed to ongoing doubts about vaccine safety and efficacy. In several areas, mistrust toward external health interventions and concerns about potential side effects initially hindered caregiver acceptance. These challenges were especially pronounced in communities with minimal prior engagement from health authorities or humanitarian actors.
During the DREF operation, the Somali Red Crescent Society (SRCS) implemented comprehensive community mobilization and awareness initiatives to address vaccine hesitancy and misconceptions. Community-based volunteers, elders, and other trusted local actors were actively engaged in outreach efforts, which helped to address gaps in knowledge, improve understanding, and increase acceptance of vaccination. SRCS also developed and distributed culturally appropriate information, education, and communication (IEC) materials through trusted and accessible communication channels.

Operational Strategy

Overall objective of the operation

The IFRC-DREF operation aimed to reduce diphtheria-related morbidity and mortality among vulnerable populations in Puntland and Somaliland, specifically in the high-risk regions of Mudug, Bari, Sool, and Sanaag, by strengthening community-level outbreak response. Over a six-month period, the operation reached approximately 590,000 people through targeted health services, improved disease surveillance, strengthened community engagement, and facilitated access to essential medical supplies, while promoting protection, dignity, and resilience.

Operation strategy rationale

To address the needs of the targeted population, the SRCS's role and interventions 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 DREF operation complemented ongoing government-led response efforts to the Diphtheria outbreak. Operations were implemented using an integrated approach, with a focus on health, Protection, Gender and Inclusion (PGI), as well as Community Engagement and Accountability (CEA).

In Puntland:
From September 2025 to February 2026, SRCS mobile clinics in Puntland provided comprehensive health services, reaching 35,310 people (17,496 female, 17,814 male) with OPD consultations and health promotion. Vaccination efforts covered 7,205 individuals, including 5,060 children who received BCG, pentavalent (Penta I–III), and measles vaccines, and 2,145 women vaccinated against tetanus, with additional doses provided to 4,671 women. Safe motherhood services reached 3,077 mothers with antenatal care, 462 assisted deliveries, 360 postnatal visits, and support for exclusive breastfeeding; 763 women received micronutrient supplementation. Nutrition screening covered 5,281 children under five, identifying 287 severely malnourished and 1,201 moderately malnourished children, while 748 received Vitamin A and 1,690 received deworming treatment. Despite a 25% Penta dropout rate due to the mobile, hard-to-reach nature of the project, the clinics significantly contributed to child and maternal health in the targeted areas.

In Somaliland:
From October 2025- February 2026, SRCS deployed in Sool and Sanaag regions for five months in remote areas, targeted children under one year of age while those over one year of age who had received Penta 1 or Penta 2 but did not complete their subsequent scheduled doses (Penta 2 or Penta 3). These partially immunized children remain inadequately protected against diphtheria and other vaccine-preventable diseases. Therefore, they are entitled to complete their remaining Penta doses to ensure full protection. The mobile health teams reached 57,018 people. 2,465 children under five years of age reached BCG vaccinations, 3,645 children under one year age completed all three doses of the Pentavalent vaccine and Oral Polio Vaccine, IPV (Inactivated Polio Vaccine) children were 2315, while 3,996 children under on year received measles vaccination, screened 14,443 children for malnutrition (2,986 acute cases), 13,159 pregnant women were provided antenatal care visits. The teams also provided 622 safe deliveries and reached, 10,672 people thought health education.

Somaliland and Puntland:
Epidemic Control for Volunteers using Community-Based Health and First Aid and Community-Based Surveillance (CBS) Training.
SRCS trained 323 (124 female, 199 male) community health volunteers for the community health volunteers in trained eCBHFA and CBS support diphtheria response by identifying symptoms early, raising community awareness, promoting vaccination, referring suspected cases, and reporting health data quickly helping prevent and control the spread of the disease.

Psychosocial support and basic first aid Training:
SRCS trained 192 (153 female, 39 male) volunteers on psychosocial support and basic first aid to strengthen their capacity to respond effectively to the diphtheria outbreak, enabling them to provide emotional support, deliver essential care, and assist affected communities.

RCCE:
Conducted Risk Communication and Community Engagement activities through 56 community sessions, reaching 200,675 (112,479 female, 88,196 male) people with key messages on prevention, early detection, and community participation in the diphtheria response.

IEC Materials:
SRCS produced and distributed IEC materials to 90 community-based volunteers to support diphtheria awareness-raising activities over a six-month period, reaching 102,390 people with key health messages.

Community Engagement and Accountability (CEA) and Protection, Gender, and Inclusion (PGI):
The SRCS trained 323 volunteers (124 female, 199 male) involved in the operation were trained on CEA and PGI. Since the beginning of the operation, seven meetings have been conducted across all target communities with the participation of community leaders. Feedback systems were established to collect community opinions, suggestions, and complaints regarding services and activities. All SRCS staff and volunteers were briefed and signed the Code of Conduct, while referral pathways were mapped and identified through mobile clinics in collaboration with the Ministry of Health Development. In addition, all volunteers and staff were oriented on SRCS safeguarding policies, including Protection from Sexual Exploitation and Abuse (PSEA). Volunteers were also trained on PGI awareness-raising, focusing on issues of violence, discrimination, and exclusion. Psychosocial support was provided to families affected by diphtheria, including families of persons with disabilities and those experiencing fear related to the outbreak, reaching approximately 91,564 people. Furthermore, IEC materials on PGI and CEA were distributed, reaching 109,254 people.

Coordination:
SRCS implemented a comprehensive coordination system, led by the Ministry of Health Development, to avoid duplication and ensure complementarity with internal projects and the interventions of key partners, including the WHO and UNICEF. Coordination included joint gap analysis, information sharing across SRCS projects, and close monitoring of case detection, reporting, vaccine coverage, supplies, and RCCE effectiveness. This was supported by outbreak data reviews, field visits, health cluster findings, key informant interviews, and rapid assessments.

Sustainability:
For sustainability, the exit strategy focused on strengthening local capacities, fostering community partnerships, and transferring knowledge through mobile health teams and trained community-based volunteers, ensuring continuity of care beyond the DREF period. SRCS requested the Ministry of Health to allocate budget support and link with humanitarian agencies to continue the interventions. Community-based volunteers were trained and transferred their knowledge to local communities, which enhanced long-term preparedness, health promotion, and outbreak response capacity.

Targeting Strategy

Who was targeted by this operation?

The operation targeted approximately 590,000 people (98,333 families) at risk of the diphtheria outbreak in Puntland and Somaliland, particularly in the Mudug, Bari, Sool, and Sanaag regions. Given the presence of functioning health clinics and ongoing outreach supported by the Damal Caafimaad government-led project, SRCS focused its response operations on remote areas and villages lacking health infrastructure. Interventions included risk communication and community engagement through radio broadcasts, community sessions, house-to-house visits, and OPD services. The vaccination campaign specifically targeted children under 14 years in affected and at-risk communities.

Explain the selection criteria for the targeted population

The targeting strategy for this operation was based on a needs-based approach, prioritizing the worst-affected districts and villages in Puntland and Somaliland. These areas were identified as either already deeply affected by the diphtheria outbreak, with schools forced to close, or as areas where the outbreak was rapidly increasing.
The operation specifically targeted communities experiencing the highest levels of disease prevalence and vulnerability, particularly in locations where health services were active but overstretched. A gap analysis was conducted to map existing interventions, identify underserved areas, and ensure resources were directed to communities with the least access to services, avoiding duplication and maximizing impact.

In the Somaliland and Puntland context, selection criteria considered:
1. Geographic disparities: Remote rural and nomadic populations lacking reliable health infrastructure.
2. Socioeconomic vulnerabilities: Poor households and marginalized groups disproportionately affected due to limited resources for preventive measures and care-seeking.
3. Health system capacity: Areas with weak surveillance and low vaccination coverage prioritized to contain the outbreak.
4. Cross-border mobility: High-transit areas frequented by pastoral communities were targeted to reduce the risk of further transmission.

By combining epidemiological data with social and geographic vulnerability indicators, this approach ensured that the response reached the most at-risk populations in both rural and urban areas of Puntland and Somaliland.

Total Assisted Population

Assisted Women	330,400	Rural	0.4%
Assisted Girls (under 18)	-	Urban	0.6%
Assisted Men	259,600	People with disabilities (estimated)	0%
Assisted Boys (under 18)	-		
Total Assisted Population	590,000		
Total Targeted Population	590,000		

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
Community needs exceeded the capacity of the operation as the drought situation deteriorated, particularly during this period when humanitarian aid faced a funding gap due to the USAID funding halt.	SRCS advocated to partner organizations for additional humanitarian assistance as necessary to address unmet community needs.
Negative perceptions of relief efforts and health care delivery through the mobile clinics arose due to unmet expectations or perceived inequities.	Open communication channels were maintained, satisfaction surveys were conducted, and community grievance redress mechanisms were implemented to ensure feedback from the populations served and address concerns effectively

Corruption and fraud continued to pose a risk in humanitarian activities	SRCS developed a communication plan to inform communities about all aspects of the project and to sensitize them on the importance of preventing corruption. Communities were informed of their entitlements and notified that assistance was provided free of charge, with no payments required to access services. They were also made aware of existing mechanisms to report any suspected or actual cases of corruption.
The security environment in Somalia remained complex and volatile, with varying levels of risk across regions.	Continuous risk assessments were conducted in coordination with the IFRC Security Unit, ICRC, and local partners to stay informed about evolving threats. Minimum Security Regulations were followed for responders and incorporated into the general administration of the involved branches.

Please indicate any security and safety concerns for this operation:

In Puntland, the Islamic State (ISIS) maintained a presence, particularly in the Cal Miskaad and Golis Mountains of the Bari region. In recent months, intensified counterterrorism operations by Puntland security forces, supported by international partners, reduced some of the risks. To protect RCRC personnel from conflict, crime, extremism, health, and road hazards, active risk mitigation measures were adopted. Security orientation and briefings were conducted for all teams prior to deployment to ensure the safety of response teams. Standard security protocols covering general norms, cultural sensitivity, and overall code of conduct were put in place, and minimum-security requirements were strictly maintained. Personnel were insured, and essential security equipment including functional satellite phones, communication tools, advanced first aid kits, PPE kits, hibernation stocks, safe accommodation, and fully kitted vehicles was provided. Movement was undertaken only after road assessments. All NS and IFRC personnel involved in operations successfully completed the IFRC security e-learning courses (Level 1 Fundamentals, Level 2 Personal and Volunteer Security, and Level 3 Security for Managers) prior to deployment. IFRC security plans were applied to all IFRC staff throughout the operation, and area-specific security risk assessments were conducted at operational locations, with appropriate mitigation measures identified and implemented.

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

Implementation

Health

Budget: CHF 360,604
Targeted Persons: 590,000
Assisted Persons: 590,000
Targeted Male: 259,600
Targeted Female: 330,400

Indicators

Title	Target	Actual
# of health staff trained on clinical management of Diphtheria	10	168
# of emergency mobile clinics deployed	10	10
# of health promotion campaigns conducted on the prevention and control of diphtheria in the targeted communities.	10	10

# of community sessions organized to deliver RCCE in the diphtheria response	56	56
# of people reached by mobile health teams with essential health services, including immunization.	590,000	590,000

Narrative description of achievements

From September 2025 to February 2026, SRCS mobile clinics in Puntland and Somaliland (5 in each of the regions) provided essential health services to remote and hard-to-reach populations.
In Puntland, the clinics reached 35,310 people through outpatient consultations and health promotion, vaccinating 7,205 individuals including 5,060 children and 2,145 women, and providing maternal and newborn care to 3,077 mothers with assisted deliveries, postnatal visits, and breastfeeding support. Nutrition services were delivered to 5,281 children through micronutrient supplementation and malnutrition screening, despite a 25% Pentavalent dropout rate.
In Somaliland's Sool and Sanaag regions, 57,018 people were reached, with children under one completing BCG, Pentavalent, OPV, IPV, and measles vaccinations; 14,443 children were screened for malnutrition, 13,159 pregnant women received antenatal care, and 622 safe deliveries were conducted. Across both regions, SRCS trained 323 volunteers in epidemic control and surveillance and 192 volunteers in psychosocial support and first aid, conducted 40 community engagement sessions reaching 200,675 people, and distributed IEC materials through 90 volunteers reaching 102,390 people. Refresher training was provided to mobile health clinic staff, initial stocks of ODP kits were utilized and later reimbursed, and radio talk shows were conducted to raise awareness of diphtheria outbreaks, prevention, and control measures, reaching an estimated 590,000 people. These combined efforts enhanced vaccination coverage, maternal and child health, nutrition, and community-based diphtheria prevention in both regions.
The overachievement in the number of health staff trained on the clinical management of diphtheria reaching 168 against a target of 10 was primarily due to the scale-up of operations across Somaliland and the availability of additional funding, which enabled broader training coverage and strengthened the overall outbreak response.
In addition, SRCS volunteers conducted 10 extensive health promotion and community awareness campaigns on diphtheria prevention and response, reaching 176,908 people across affected communities. To further address behavioral challenges, misinformation, and rumors related to the outbreak, SRCS also facilitated 56 Risk Communication and Community Engagement (RCCE) sessions. These community-based interventions focused on enhancing public awareness, promoting early health-seeking behavior, and strengthening community trust and participation in the response, ultimately reaching approximately 278,097 people.•

Lessons Learnt

1) Early and continuous engagement with mothers and caregivers through trusted local actors (e.g. community leaders and trained volunteers), including addressing concerns about side effects, significantly reduced vaccine hesitancy and improved completion of immunization schedules. Future operations should integrate caregiver-focused communication strategies from the outset.
2) Community concerns about vaccine side effects were identified as a major cause of dropout (e.g. 25% Penta dropout rate). Providing practical guidance on managing fever and other mild side effects increased caregiver confidence and improved follow-up attendance. Future interventions should integrate side-effect communication into vaccination messaging
3) Collecting contact information enables follow-up for mobile and displaced populations;
4) Having preposition stock of the OPD kits and essential supplies readily available strengthens service delivery
5) Regular coordination with the Ministry of Health and health cluster partners enabled geographic targeting of underserved areas and reduced overlap with clinic-based vaccination campaigns, allowing mobile clinics to focus on remote populations. Future operations should formalize coordination mechanisms to support gap-based targeting

6) Delays in OPD kit procurement initially constrained mobile clinic deployment. Prepositioning essential medical supplies before scale-up significantly improved readiness and continuity of services. Future epidemic responses should include prepositioning as part of preparedness planning

Challenges

During the mobile clinic operations in Puntland and Somaliland, several challenges affected service delivery, including:
(i) Vaccine hesitancy among mothers.
(ii) Concerns about post-vaccination fever in children.
(iii) High population movement due to drought, which made it difficult to ensure complete immunization coverage.

Protection, Gender And Inclusion

Budget: CHF 9,386
Targeted Persons: 590,000

Assisted Persons: 590,000
Targeted Male: 259,600
Targeted Female: 330,400

Indicators

Title	Target	Actual
# of volunteers trained on PGI awareness raising on issues of violence, discrimination and exclusion	250	323
# IEC gender sensitive materials printed and distributed for PGI awareness	500	703
Conducting PGI assessment	1	0
% of community sessions/messages delivered with gender sensitive approach	100	100
Add # of people reached with awareness sessions on PGI to stakeholders	590,000	590,000

Narrative description of achievements

SRCS provided Protection, Gender, and Inclusion (PGI) training to equip 323 volunteers with knowledge needed to promote PGI principles during the Diphtheria response. This exceeded the initial target of 250 volunteers due to the scale-up of the Diphtheria response in Somaliland, which enabled additional funding and wider coverage of the training activities.
PGI was integrated across all operational activities, with approximately 590,000 people reached through PGI-related interventions. Volunteers also received refresher training on PGI awareness, focusing on issues such as violence, discrimination, and exclusion. In addition, child-friendly PGI IEC materials were developed and distributed. A total of 703 IEC materials for PGI training were produced and disseminated, exceeding the original target of 500 copies owing to additional funding.
Community leaders were engaged to support the effective dissemination of culturally accepted PGI information. To ensure IEC/PGI information is culturally acceptable, SRCS leveraged on its community feedback mechanisms. The messaging was aligned with local traditions and values which took 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. However, SRCS did not conduct PGI assessments as the operation did not receive budget allocation to conduct this activity. SRCS was able to mitigate PGI risks through PGI focal branches previously trained in to undertake similar operations such as during the leishmaniasis outbreak in 2025.

In close collaboration with the Ministry of Health, SRCS conducted mapping and identification of referral pathways and supported the transportation of patients to ensure timely access to health services.

Lessons Learnt

• In epidemic response operations, the early engagement of community leaders and use of community feedback mechanisms will ensure PGI messaging is tailored to align and fit the culture and religious context.

Challenges

• Lack of a budget to undertake PGI assessment. SRCS expected bilateral support from PNSs but it never materialised.

Community Engagement And Accountability

Budget: CHF 8,095
Targeted Persons: 590,000
Assisted Persons: 590,000

Targeted Male: 259,600
Targeted Female: 330,400

Indicators

Title	Target	Actual
# of the volunteers trained on Community engagement and accountability	250	323
% of complaints or feedback about the DREF operation which receive a response through established community communication	85	90
#of Community Engagement and Accountability (CEA) training conducted	2	2

Narrative description of achievements

A total of 323 staff and volunteers were trained in Community Engagement and Accountability (CEA), and also two Community Engagement and Accountability (CEA) trainings were conducted in Somaliland and Puntland. Although the initial target was to train 250 volunteers, a total of 323 volunteers were trained. The overachievement was mainly due to the high interest and commitment from additional volunteers who joined the trainings willingly to support the operation. This increased participation further strengthened the operational capacity and community engagement efforts in the targeted areas. IEC materials were distributed to support outreach. Radio campaigns and engagement with local doctors reached about 590,000 people across in Mudug, Bari, Sool and Sanaag regions increasing awareness of diphtheria prevention and management.
The trainings covered key topics including the Fundamental Principles of the Red Cross and Red Crescent Movement, two-way community communication, feedback and complaints mechanisms, rumor identification and management, accountability to affected populations, inclusion and protection, community-based awareness approaches, volunteer conduct, safeguarding, and building community trust.
SRCS established multiple feedback channels, that is, hot-lines, focus groups discussions, community engagement and feedback boxes which strengthened trust to better meet community needs. During community engagement activities, the primary feedback received centered on concerns and information needs related to the diphtheria outbreak in Somalia. Communities expressed a strong need for more information on the signs and symptoms of the disease, preventive measures, availability of treatment, the importance of early healthcare seeking, and vaccination.
Volunteers also reported instances of vaccine hesitancy, largely driven by fears and misconceptions about potential side effects. In response, SRCS staff and volunteers addressed these concerns through ongoing awareness-raising efforts, risk communication, community sensitization, and the dissemination of trusted health messages to counter rumors and misinformation.

Lessons Learnt

1) Continuous engagement through community meetings and local leaders increased acceptance of vaccination in previously resistant communities, particularly where initial mistrust and misinformation were reported. Engagement strategies that prioritized two-way communication proved more effective than one-way messaging

2) Establishing multiple feedback channels (e.g., helplines, focus groups, and feedback boxes) strengthened trust and allowed timely adjustments to better meet community needs.

Challenges

1) Vaccine hesitancy remained a significant challenge due to misinformation, cultural beliefs, and lack of trust in health interventions.

Secretariat Services

Budget: CHF 52,490
Targeted Persons: 4
Assisted Persons: 4
Targeted Male: 3
Targeted Female: 1

Indicators

Title	Target	Actual
#Of IFRC monitoring and support missions	2	0
# of movement coordination meetings organized, to provide updates to the movement partners	4	7

Narrative description of achievements

The IFRC played a key role in supporting the Somali Red Crescent Society (SRCS) in the launch and scale-up of the Diphtheria DREF response. The procurement and logistics teams assisted the National Society with the international sourcing of ODP kits, while the WASH Delegate based in Hargeisa provided technical support for overall DREF implementation. In addition, the Security Delegate offered guidance on the prevailing security situation to ensure safe operations.
The IFRC also supported SRCS in resource mobilization and coordination through its cluster delegation. Meanwhile, the Finance, PMERL, and Communications teams provided remote support to help ensure adherence to DREF guidelines and reporting standards.
However, due to security concerns in the operational areas, IFRC teams were unable to carry out field monitoring activities. The funds allocated to support with this mission were repurposed to support health activities.

Lessons Learnt

• The IFRC Africa regional office and Nairobi cluster delegation supported with resource mobilisation by working hand-in-hand with SRCS in drafting the initial DREF for allocation of funds. The presence of a WASH and Security delegates and in Hargeisa; Somaliland and seconded Operations Officers in Hargeisa; Somaliland and Puntland ensured SRCS received requisite support throughout this operation.

Challenges

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

National Society Strengthening

Budget: CHF 69,336
Targeted Persons: 250
Assisted Persons: 323
Targeted Male: 226
Targeted Female: 97

Indicators

Title	Target	Actual
# of trained staff and volunteers mobilize.	250	323
# of lessons learnt workshops conducted and report submitted to IFRC and partners	2	2
# of monitoring missions conducted by coordination offices	6	9

Narrative description of achievements

The SRCS conducted a project kick-off meeting with SRCS implementing branches to discuss the implementation timeframe and duration and requirements of the DREF, mobilizing 323 volunteers (226 M, 97 F) and deploying 10 mobile health teams comprising nurses,

laboratory technicians, and mid-wives.
All staff and volunteers were insured, signed the Code of Conduct, and completed IFRC security e-learning courses. SRCS conducted nine (9) joint monitoring visits with the Ministry of Health and held ten (10) coordination meetings to ensure effective service delivery and prevent duplication.
2 lesson learned workshops were conducted in Galkacyo, Erigabo, and Lasanod involved 67 participants, including volunteers, community members, elders, frontline health staff, and Ministry of Health representative
Lessons Learned workshop summary:
1. Proper community engagement with mothers and caregivers increased vaccine acceptance.
2. Providing guidance on managing mild vaccine side effects encouraged families to complete immunization schedules.
3. Collecting contact information enabled follow-up for mobile and displaced populations.
4. Prepositioning OPD kits and essential supplies strengthened service delivery.
5. Coordination with the Ministry of Health prevented duplication and ensured effective coverage.
6. Strong collaboration with the Ministry of Health and partners improved outbreak response outcomes.

Challenges
1. Poor road networks and lack of transportation delayed volunteer and mobile team deployment.
2. Vaccine hesitancy among mothers affected service delivery during mobile clinic operations in Puntland and Somaliland.
3. Concerns about post-vaccination fever in children.
4. High population movement due to drought made it difficult to ensure full immunization coverage.

Lessons Learnt

• In future epidemic response operations, it would be imperative to ensure community mobilisation, coordination among partners and program staff , branch and volunteer supervision are executed in the best possible way to ensure timely, safe, and high-quality service delivery.
• During this operation, it was observed that volunteers with a health background and/or health-related training were better equipped to support epidemic response operations.

Challenges

• No challenges were documented in the NSD

Financial Report

Selected Parameters			
Reporting Timeframe	2025/8-2026/3	Operation	MDRSO024
Budget Timeframe	2025/01-2026/12	Budget	APPROVED

DREF Operation

FINAL FINANCIAL REPORT

Prepared on 05/May/2026

All figures are in Swiss Francs (CHF)

MDRSO024 - Somalia - Epidemic Diphtheria Outbreak

Operating Timeframe: 07 Aug 2025 to 28 Feb 2026

I. Summary

Opening Balance	**0**
Funds & Other Income	**499,911**
DREF Response Pillar	499,911
Expenditure	**-498,042**
Closing Balance	**1,869**

II. Expenditure by planned operations / enabling approaches

Description	Budget	Expenditure	Variance
PO01 - Shelter and Basic Household Items			**0**
PO02 - Livelihoods			**0**
PO03 - Multi-purpose Cash			**0**
PO04 - Health	338,595	367,094	**-28,499**
PO05 - Water, Sanitation & Hygiene		11,948	**-11,948**
PO06 - Protection, Gender and Inclusion	8,814	8,947	**-134**
PO07 - Education			**0**
PO08 - Migration			**0**
PO09 - Risk Reduction, Climate Adaptation and Recovery	30,511		**30,511**
PO10 - Community Engagement and Accountability	7,601	7,687	**-86**
PO11 - Environmental Sustainability			**0**
Planned Operations Total	**385,520**	**395,677**	**-10,156**
EA01 - Coordination and Partnerships			**0**
EA02 - Secretariat Services	44,435	32,440	**11,995**
EA03 - National Society Strengthening	69,956	69,926	**30**
Enabling Approaches Total	**114,391**	**102,366**	**12,025**
Grand Total	**499,911**	**498,042**	**1,869**

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[Click here for the complete financial report]

Please explain variances (if any)

A total of CHF 499,911 was received for this intervention, of which SRCS utilized 99% by the end of the operation. The remaining balance of CHF 1,869 will be returned to the DREF pot. The financial report is attached and provides a detailed breakdown of expenditures by cost category. The variances are explained below.

1. The expenditure reflected under WASH reflects payroll related costs for WASH delegate which should have been captured under AP122 in the secretariat services section. Taking into account the CHF 11,948 incurred under WASH should be here, hence variance would be CHF

47 only.
2. PSSR was coded under DRR.

Contact Information

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

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National Society Hotline: 358/3240

Click here for reference

Selected Parameters			
Reporting Timeframe	2025/08-2026/03	Operation	MDRSO024
Budget Timeframe	2025/08-2026/02	Budget	APPROVED

DREF Operation

FINAL FINANCIAL REPORT

Prepared on 05/May/2026

All figures are in Swiss Francs (CHF)

MDRSO024 - Somalia - Epidemic Diphtheria Outbreak

Operating Timeframe: 07 Aug 2025 to 28 Feb 2026

I. Summary

Opening Balance	**0**
Funds & Other Income	**499,911**
DREF Response Pillar	499,911
Expenditure	**-498,042**
Closing Balance	**1,869**

II. Expenditure by planned operations / enabling approaches

Description	Budget	Expenditure	Variance
PO01 - Shelter and Basic Household Items			**0**
PO02 - Livelihoods			**0**
PO03 - Multi-purpose Cash			**0**
PO04 - Health	338,595	367,094	**-28,499**
PO05 - Water, Sanitation & Hygiene		11,948	**-11,948**
PO06 - Protection, Gender and Inclusion	8,814	8,947	**-134**
PO07 - Education			**0**
PO08 - Migration			**0**
PO09 - Risk Reduction, Climate Adaptation and Recovery	30,511		**30,511**
PO10 - Community Engagement and Accountability	7,601	7,687	**-86**
PO11 - Environmental Sustainability			**0**
Planned Operations Total	**385,520**	**395,677**	**-10,156**
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DREF Operation

FINAL FINANCIAL REPORT

Selected Parameters			
Reporting Timeframe	2025/08-2026/03	Operation	MDRSO024
Budget Timeframe	2025/08-2026/02	Budget	APPROVED

Prepared on 05/May/2026

All figures are in Swiss Francs (CHF)

MDRSO024 - Somalia - Epidemic Diphtheria Outbreak

Operating Timeframe: 07 Aug 2025 to 28 Feb 2026

III. Expenditure by budget category & group

Description	Budget	Expenditure	Variance
Relief items, Construction, Supplies	**50,941**	**62,981**	**-12,041**
Medical & First Aid	50,941	44,819	6,122
Other Supplies & Services		18,162	-18,162
Logistics, Transport & Storage	**16,172**	**16,158**	**14**
Transport & Vehicles Costs	16,172	8,658	7,514
Logistics Services		7,500	-7,500
Personnel	**18,759**	**21,527**	**-2,768**
International Staff		13,602	-13,602
National Staff	18,759	7,925	10,834
General Expenditure	**25,676**	**17,843**	**7,833**
Travel	15,716	11,363	4,353
Communications		26	-26
Financial Charges	9,960	6,455	3,505
Contributions & Transfers	**357,853**	**349,136**	**8,716**
National Society Expenditure	357,853	349,136	8,716
Indirect Costs	**30,511**	**30,397**	**114**
Programme & Services Support Recover	30,511	30,397	114
Grand Total	**499,911**	**498,042**	**1,869**