DREF Operation

Kenya Polio Outbreak 2026

Oral Polio vaccination in IFO 2 during routine vaccination

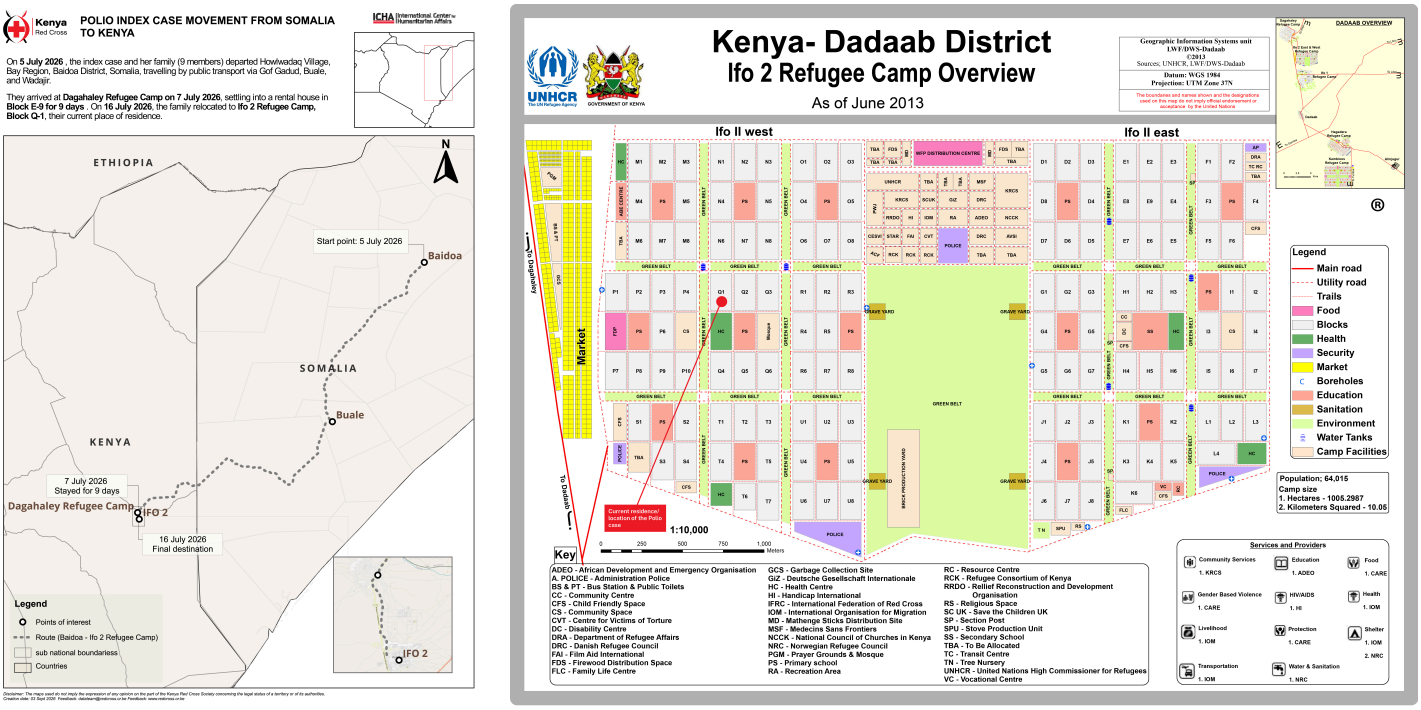
Appeal: **MDRKE073**	Hazard: **Epidemic**	Country: **Kenya**	Type of DREF: **Response**
Crisis Category: Yellow	Event Onset: **Slow**	DREF Allocation: **CHF 149,885**	
Glide Number: -	People Affected: **420,058 people**	People Targeted: **176,067 people**	
Operation Start Date: **14-09-2026**	Operation Timeframe: **3 months**	Operation End Date: **31-12-2026**	DREF Published: **18-09-2026**

Targeted Regions: **Garissa**

Description of the Event

Date when the trigger was met

27-08-2026



Movement of Case from Somalia to Kenya and current residence.

What happened, where and when?

A laboratory-confirmed case of circulating Vaccine-Derived Poliovirus Type 2 (cVDPV2) was detected in a 48-month-old female child from a newly arrived Somali refugee household residing in the Ifo 2 West in Dadaab refugee camp. The case was confirmed on 18 August 2026 and is genetically linked to the Beledweyne emergence group (SOM-BAY-1) in Somalia. The child was identified as a zero-dose case during arrival screening, with no documented receipt of OPV3, IPV, or booster doses. Initial assessments found poor household WASH conditions, including open defecation, inadequate water storage, low health-seeking behaviour, and limited awareness of polio prevention and symptoms. Although classified as an orphan case with no identified chain of transmission, the detection prompted an epidemic response due to significant immunity gaps in the affected community.

The case originated from Howlwadag Village, Baidoa District, Bay Region, Somalia. Following displacement, the family crossed into Kenya and initially settled in Block E-9, Dagahaley Refugee Camp before relocating to Block Q-1, Ifo-II West Refugee Camp, Dadaab Sub-County, Garissa County, Kenya, where the case was identified. The virus was genetically linked to an environmental poliovirus isolate detected in Beledweyne, Somalia, highlighting the cross-border nature of the public health risk.

The family departed Somalia on 5 July 2026 and arrived in Dadaab on 7 July 2026. A stool sample was collected on 10 July 2026, sent for laboratory testing on 23 July 2026, and laboratory confirmation of cVDPV2 was received on 18 August 2026.
Since the confirmation of the current case, another one suspected case was reported in IFO 1 on 25th August 2026. The child started presenting with AFP signs on 25th August necessitating further investigations. The stool sample was taken on 30th August and submitted for futher dispatch to KEMRI for confirmation. The results are yet to be out. Seven alerts for AFP have been raised through Community Health Promoters in Ifo Camps but have been ruled out through initial alert confirmation mechanisim at the sub county level.

Upon receiving this additional suspsected case and alerts, the County Government of Garissa, through the Office of the County Director of Health, issued an urgent request on 27 August 2026, for support to the cVDPV2 response in the Ifo Refugee camps. This formal request serves as the trigger date for the emergency response. The request was made against a backdrop of persistent polio transmission in Garissa County, particularly within the Dadaab refugee complex, where recent investigations in Ifo-II West identified critical immunity

gaps, and a history of wild and vaccine derived polio outbreaks in the past decade underscoring the need for immediate response measures.

Data review in Ifo 1 Health Facility during assessment of routine immunization

Multiagency polio outbreak case and social investigation

Scope and Scale

While no deaths, injuries, or additional confirmed cases have been reported, the event poses a significant public health risk to a wider susceptible population. Of the 1,693 new arrivals tracked in the Dadaab refugee complex, 905 children (53.5%) were identified as zero-dose, including 282 in Dagahaley, 293 in Hagadera, 196 in Ifo 2, and 134 in Ifo 1, highlighting a large population vulnerable to further transmission.

The event is affecting the Dadaab refugee complex in Garissa County, Kenya, with the highest concern in Ifo 2 (West) Refugee Camp where the confirmed case was identified. The risk extends across Dagahaley, Hagadera, Ifo 1, and Ifo 2 camps due to population movement and low immunization coverage. The virus is genetically linked to the SOM-BAY-1 emergence group circulating in Somalia, underscoring the cross-border nature of the outbreak risk.

The most affected and vulnerable population are children under 15 years of age who are zero-dose or under-immunized, particularly among newly arrived refugee households. Their vulnerability is driven by low vaccination coverage, overcrowding, high rates of malnutrition, inadequate WASH conditions, limited access to health services, and continuous population movement across the Somalia-Kenya border.

The main sectors affected are Health and WASH. The health sector faces increased demands for surveillance, laboratory investigations, supplementary immunization activities, contact tracing, community engagement, and outbreak response. The WASH sector is affected by poor sanitation, inadequate water storage, open defecation practices, and underdeveloped infrastructure, particularly in Ifo 2 (West), which increase the risk of poliovirus transmission.

The situation is complicated by significant immunity gaps among new arrivals, overcrowded living conditions, high population mobility, malnutrition, weak WASH infrastructure, and limited health service coverage. The detection of an orphan virus suggests possible surveillance gaps and the potential existence of undetected transmission chains within the camps.

Without rapid intervention, there is a high likelihood of continued poliovirus transmission within Dadaab refugee camps and possible spread to surrounding host communities. The large number of zero-dose children, ongoing cross-border movement, and low vaccination coverage create conditions for additional cases. Immediate vaccination campaigns, strengthened surveillance, risk communication, and targeted WASH interventions are therefore required to contain the outbreak.

This outbreak occurs in a county with a long history of poliovirus transmission. Garissa County recorded Wild Poliovirus cases in 2006 (3 cases) and 2013 (13 cases, including 7 in Dadaab), while cVDPV2 outbreaks occurred in 2012 (2 cases), 2021 (3 cases and 1 environmental detection), 2023 (14 cases and 6 environmental detections), and 2024 (1 case). Similar to previous outbreaks, the current event is concentrated in the Dadaab refugee complex and is associated with persistent immunization gaps. Initial investigations in Ifo 2 (West) found only 36.2% SIA coverage and 65.7% nOPV2 coverage, indicating that the vulnerabilities that contributed to previous outbreaks remain present.

Source Name	Source Link
1. WHO Disease outbreak situation report	https://kenyaredcross-my.sharepoint.com/:b:/g/personal/gathagu_isaac_redcross_or_ke/IQCnR8GWWWMzRJY8BDS7ZRR_ATIs5atYy-YTXhHqLeky5O0
2. Dagahaley & Ifo2_cVDPV2 OB_Investigation Report	https://kenyaredcross-my.sharepoint.com/:w:/g/personal/gathagu_isaac_redcross_or_ke/IQByLmddmCGbQ7qQW74Fi2xmAbdW-G_-bMUHP_0c0G7LNFY
3. Official Urgent Request support	https://acrobat.adobe.com/id/urn:aaid:sc:EU:7d5d07b1-b0d9-4663-82db-aec39bf07f7e

Previous Operations

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

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

-

Lessons learned:

Previous responses have demonstrated the importance of early detection, strong coordination with MoH and partners, community engagement and timely vaccination. The current assessment further highlights the need for early identification and tracking of new arrivals, strengthened AFP/VPD surveillance, adequate CHP coverage, targeted catch-up vaccination and intensified community sensitization. Strong engagement of community and religious leaders and tailored communication for minority and mobile populations are also critical to ensuring that no eligible children are missed.

Did you complete the Child Safeguarding Risk Analysis in previous operations, what was risk level?	No

Current National Society Actions

Start date of National Society actions

21-08-2026

Health	As part of the polio outbreak response, the Kenya Red Cross Society (KRCS) Dadaab implemented household-level risk communication and community engagement activities in the affected areas to strengthen community awareness and promote practices that reduce the risk of disease transmission. KRCS volunteers and CHPs delivered key messages on what polio is, life long impacts of polio, prevention and control, handwashing at critical times, proper sanitation, and maintaining a clean household environment. In addition, KRCS facilitated community sensitization sessions and health talks to enhance awareness of polio prevention and control measures. These engagements emphasized the importance of good hygiene and sanitation practices, timely health-seeking behaviour, and community participation in preventing the further spread of the disease. Through these interventions, KRCS contributed to strengthening community ownership and reinforcing protective behaviours at household and community levels as part of the broader polio outbreak response. Since the family moved to IFO 2 refugee camp primarly supported by Kenya Red Cross, surveilance actions were put in place, including puting the family under active survellance and close monitoring and contact tracing.
Water, Sanitation And Hygiene	KRCS volunteers have conducted house-to-house visits within the affected blocks, providing households with practical information on hygiene and sanitation and encouraging the adoption of appropriate preventive behaviours. The visits also provided an opportunity to engage directly with community members, address concerns and misconceptions, and reinforce key polio prevention messages.

IFRC Network Actions Related To The Current Event

Secretariat	The IFRC is providing KRCS with technical support in developing a DREF through its country cluster delegation and regional office in Nairobi. Financial support is also sought through this DREF funding to ensure KRCS commences in the refugee operations.
Participating National Societies	Partners of national society including Danish, Italian, Norwegian, Amercan Red Cross are present in Kenya however non has confirmed support for this operation.

ICRC Actions Related To The Current Event

ICRC is in country however no official support has been confrimed from them for this response action.

Other Actors Actions Related To The Current Event

Government has requested international assistance	Yes
National authorities	The national Authorities led by the MOH continue to provide overall technical leadership and coordination. Despite the Dadaab Refugee complex health care services being supported by partners such as Kenya Red Cross, International Rescue commitee (IRC) and MSF, the MOH provides national technical guidance on outbreak investigation, epidemiological assessment, passive surveillance for Acute flaccid Paralysis(AFP) and community based surveillance, routine vaccination strategies, case management and reporting. MOH also coordinates national response, support risk assessment and provide guidance on the prioritization of high risk and under immunized populations. Also leads coordination among national and sub national authorities. Currently MOH has not allocated specific funds for a response action to the current polio outbreak. However, they have coordinated initial investigation and confirmation actions currently coordinating difrent partners in development of SIA microplan and its implementatation on 5th -9th October and a follow up round on 2nd - 5th November 2026. They will be providing vaccines and some of the associated consumables and have sent out request for partners to support vaccine logistics, vaccination and demand creation activities for the two rounds of SIA. Kenya Medical Reserch institute (KEMRI)-Supports laboratory investigation including testing of stool specimen and confirmation of poliovirus. It also provides laboratory evidence to guide the response. Timely laboratory investigations also supports surveillance and helps inform the ongoing assessment of polio transmission. Refugee management in the country is done through the Department of Refugee services (DRS). DRS leads refugee registration, settlement of new arrival, and camp coordination.
UN or other actors	WHO, UNHCR, UNICEF, and other Key Stakeholders are coordinating with the Kenya National Public Health Institute on preparedness measures, and WHO has deployed a team of technical experts to support outbreak investigation. Within Garissa County and the Dadaab camp complex, the following partners are engaged in roles directly relevant to this response: UNHCR –, Leads overall protection of refugee population including provisson of essential services through implementing partners including KRCS, IRC and others. WHO – Technical guidance, case classification, laboratory confirmation (in coordination with KEMRI), and AFP surveillance oversight. UNICEF – Vaccine supply, cold chain support, and risk communication and community engagement (RCCE). MSF (Médecins Sans Frontières) – Operates Health Post 4 and other health posts in Dagahaley camp, providing routine immunization, catch-up vaccination, and referral services. Vision Corps Initiative (VCI) / Core Group Partner Project (CGPP) – New-arrival tracking,

	referral linkage, and community-based surveillance. MSF supported the administration of Vitamin A supplementation and deworming to all eligible children, including the index case, upon the household's arrival at Dagahaley Refugee Camp. FilmAid conducted a public address campaign on the polio outbreak, reaching approximately 8,000 people with key polio prevention and awareness messages. KRCS's role through this DREF is positioned to complement these existing partner mandates, focusing specifically on the SIA, RCCE, WASH, and surveillance support gaps identified in Ifo 2 (West) that fall outside current partner coverage.

Are there major coordination mechanism in place?

KRCS is a key member of the national disaster response taskforce and its various sub-committees, led by the Kenya National Public Health Institute – Ministry of Health (MOH-NPHI), with ongoing joint planning, information sharing, and coordination of preparedness and response activities at both county and national level.
At the Dadaab operational level, however, coordination has not kept pace with the scale of this response, and gaps here need urgent attention. As an implementing partner already supporting medical services in the Ifo camps including Ifo 2 (West), where the confirmed case resides, KRCS is well placed to help close this gap, but doing so will require dedicated coordination support at the field level.

Needs (Gaps) Identified

Health

Under-immunization among new arrivals. County-level tracking recorded 1,693 new arrivals to Garissa County, of whom 905 (56.1%) were zero-dose children, concentrated among children aged 0–5 years across Dadaab's camps (Dagahaley: 282, Hagadera: 293, Ifo 2: 196, Ifo 1: 134). This scale of under-immunization among incoming populations points to a need for targeted catch-up immunization activities for new-arrival households camp-wide.

Camp-level immunization coverage gaps. Household social investigation found low immunization uptake, driven by higher population mobility and weaknesses in the health system that reflects in the access and utilization of routine child immunization services across Dadaab's refugee camps. This points to a need for supplementary immunization activities (SIAs) to catch up on missed opportunities in the routine immunization especially in the new-arrival-heavy camp sections.

Insufficient community-based disease surveillance capacity. Community-level and entry-point surveillance systems in Dadaab require strengthening to ensure earlier detection of AFP cases and under-immunized new arrivals, particularly at informal reception points where screening is inconsistent. This supports a resource request for community-based surveillance (CBS) training and deployment, including points of entry, across camps rather than a single site.

Limited risk of communication and community engagement (RCCE) integration. from the initial case investigation, low household-level awareness of polio transmission, signs, and symptoms was noted broadly among new-arrival populations, alongside limited integration of RCCE activities into surveillance and immunization structures. This was also reflected in the low household-level hygiene awareness and health-seeking behavior. Limited awareness of safe water storage, handwashing, and sanitation practices at household level compounds transmission risk across new-arrival households, pointing to a need for hygiene promotion sessions and behavior change communication delivered alongside immunization outreaches. This points to a need for intensified, targeted community sensitization on polio and routine immunization across Dadaab camps.

Water, Sanitation And Hygiene

Poliovirus is transmitted primarily through the faecal-oral route, making water, sanitation and hygiene conditions a direct determinant of transmission risk alongside immunization coverage. The index case's household lacks a functioning latrine and practices open defecation, while broader household social investigation findings show that Ifo 2 (West), the camp where the case now resides carries greater WASH-related vulnerability than other camps in Dadaab. Addressing WASH gaps at both the household and camp level is therefore essential not

only to reduce the immediate risk of further faecal-oral transmission around the index case, but also to close a structural vulnerability that leaves newly arrived and highly mobile households in Ifo 2 (West) disproportionately exposed.
There is need to support sanitation facilities.

Protection, Gender And Inclusion

There is limited Protection, Gender and Inclusion (PGI) training among staff and volunteers involved in this response across Garissa County. Gender sensitivity and inclusivity training are crucial in emergency preparedness to ensure staff and volunteers provide care that is culturally safe, non-judgmental, and non-discriminatory. When responders understand how gender roles, power dynamics, and cultural expectations shape health-seeking behaviors particularly within the forcefully displaced and stateless persons within the context of Dadaab they are better placed to create environments where women, men, girls, and boys feel respected and safe to engage with vaccination and health services.

This is especially relevant given that 90% of respondents in the household social investigation were female, underscoring the central role women play as caregivers and decisionmakers in children's immunization within these households. PGI training will help teams communicate with empathy, maintain privacy, and recognize the specific barriers different groups face in accessing polio prevention and response services including new-arrival households navigating an unfamiliar camp system. Strengthening PGI capacity will ultimately build trust, improve early reporting of AFP symptoms at community level, and help ensure no child, regardless of household circumstance, is left behind in this response.

New arrivals and other vulnerable groups, including minority groups, orphans, children with disabilities and nomadic host communities, face barriers to timely access to health and vaccination services. Gaps include limited tracking and follow-up of mobile/newly arrived populations, inadequate CHP coverage, language and communication barriers, limited male involvement, and physical access challenges during rainy seasons. Tailored, inclusive communication and community engagement are therefore required to ensure equitable access to the polio response

Any identified gaps/limitations in the assessment

Limited health facility coverage in IFO 2
Underdeveloped WASH infrastructure, that together create conditions conducive to sustained cVDPV2 transmission if not urgently addressed.

Assessment Report

Operational Strategy

Overall objective of the operation

The DREF operation aims to support the implementation of an integrated polio outbreak response in Ifo 1 and Ifo 2 refugee camps in order to interrupt the transmission of poliovirus, increase uptake of polio vaccination, and strengthen community-level prevention and preparedness among 176,067 people at risk from the polio outbreak. The operation will provide support for two rounds of Polio Supplementary Immunization Activities (SIA) using oral polio vaccine (OPV), risk communication and community engagement (RCCE), hygiene promotion, and demand creation for vaccination, while promoting timely access to preventive health information and services, community ownership, protection, dignity, and resilience throughout the 3 months operation period.

Operation strategy rationale

The confirmation of a cVDPV2 case in Dadaab, genetically linked to the SOM-BAY-1 emergence group circulating in Somalia, presents a credible and ongoing transmission risk given continuous population movement across the Kenya-Somalia border and persistent under-immunization among new arrivals. This DREF will support KRCS in strengthening SIA delivery, surveillance, WASH, Risk Communication and community engagement within the Dadaab operation, in Garissa County.

Health:

Training of KRCS volunteers and 133 Community Health Promoters (CHPs) will be conducted on Acute Flaccid Paralysis/AFP/ case definitions, community-based surveillance, and new-arrival screening protocols across Ifo 1 and Ifo 2 operation site. Surveillance and reporting will be reinforced specifically at new-arrival reception points. Additionaly, KRCS is the primary essential health service provider in Ifo 1 and Ifo 2, including child immunization. Through this DREF KRCS will collaborate with MOH and UNHCR in rolling out two rounds of SIA targeting 94,714 children below 15 years on 5th - 9th October 2026 for round one and 2nd - 5th November 2026 for round two. However, coverage for the last polio SIA in IFO 2, was substantialy low (65.7%) and currently coverage for routine immunization is at 51.1%. This low immunization coverage coupled with the influx of aslylum seekers and refugees from Somalia has significantly increased the risk for Polio outbreak. The health system has in the past year been weakened following reduced funding for critical health services including child immunization and community health services limiting demand access and utilization.
KRCS will support community level RCCE initiatives through CHPs, IEC materials and radion engegement to mobilize communitiesa for SIA and enhance demand for child immunization. This initiatives will be intergrated in ongoing programs to ensure heard immunity and community resilience for polio even with ongoing reduced funding and refugee population influx.

Water, Sanitation and Hygiene:
The operation will complement the polio outbreak response by strengthening hygiene practices in IFO 1 and IFO 2 refugee camps, particularly among newly arrived households and other high-risk populations.

KRCS volunteers will be sensitized and supported to conduct community-based hygiene promotion and awareness activities focused on handwashing, safe water handling, sanitation, and polio prevention. These activities will reinforce vaccination efforts by increasing community awareness of disease prevention and promoting healthy behaviours.

To address identified household-level WASH gaps, including poor hygiene conditions, the operation will support the procurement and distribution of soap and other essential hygiene supplies to vulnerable households. Portable handwashing stations will also be procured and installed at high population volume areas, border entry points and transit centres to improve access to hand hygiene facilities for mobile populations. In addition, support will be provided for the movement of KRCS volunteers to facilitate the timely delivery of hygiene promotion, community sensitization, across the targeted locations.

Protection, Gender, and Inclusion (PGI):
KRCS volunteers and staff will be trained on PGI to strengthen inclusive humanitarian response and safeguard vulnerable groups within the Dadaab operation, given that 90% of household respondents in the social investigation were female reflecting women's central role as caregivers and immunization decision_makers. Training will improve teams' ability to identify and address protection risks among new-arrival households by navigating an unfamiliar camp system.

Community Engagement and Accountability (CEA):
Training of volunteers and staff on CEA and rumor tracking will strengthen communication and trust with communities across the Dadaab operation. A structured feedback mechanism will be established to support community review meetings and culturally appropriate IEC materials on polio transmission, signs, and symptoms.

National Society Strengthening:
133 CHPs will be supporting the response, and their responsibilities will include, demand creation, supporting vaccination teams on the ground, community-based surveillance and event reporting, support to SIA delivery and mop-up vaccination, and coordination with key stakeholders, across the Dadaab operation in Garissa County.

Targeting Strategy

Who will be targeted through this operation?

The operation will target residents of Ifo 1 and Ifo 2 camps as priority area. The primary direct health target is every eligible child aged 0–15 years living in the agreed campaign blocks, community health units as guided by the Ministry of Health. The two rounds of SIA will directly target a total of 94,714 children below the age of 15 years. The SIA target population has been guided by MOH risk profiling, current immunization coverage and population movement.
RCCE and hygiene promotion activities will indirectly target a total of 81,353 people. This includes mothers, fathers and other caregivers; community and religious leaders; teachers; community health promoters; refugee-led groups; and people whose disability, distance, safety concerns or social circumstances may prevent them from accessing services. Their inclusion is essential because caregivers determine whether and when a child is taken for vaccination, while community structures are critical for locating children who are absent during the vaccination campegn.

A child will be classified as a priority for immediate follow-up when at least one of the following criteria applies:

1. Residence in a listed Ifo 2 West block, with priority given to blocks identified by the County Ministry of Health as the outbreak catchment, areas with high household density and sites with frequent arrivals or departures.
2. No documented polio dose, incomplete routine immunization or a verified history of missing a previous supplementary immunization activity. Absence of a vaccination card alone will be recorded as “no documented dose” and will not automatically be classified as zero-dose without caregiver verification.
3. Arrival in Dadaab during the current campaign planning period, temporary movement between camps, cross-border mobility, sharing of shelter with another household or residence outside the normal community health follow-up network.
4. Referral from a health facility, community health promoter, surveillance focal point, school, religious leader, women’s group, disability focal point or refugee leadership structure indicating that the child was missed or faces a concrete access barrier.
5. A household-level barrier likely to prevent service access, including disability, caregiver illness, absence of an adult caregiver during campaign hours, distance, safety concerns or lack of information in an understandable language.
No child will be excluded because of registration status, nationality, sex, ethnicity, disability, religion or documentation

Explain the selection criteria for the targeted population

The targeted population has been determined based on the risk of poliovirus transmission and existing immunity gaps. Priority has been given to children under 15 years, particularly zero-dose and under-immunized children, newly arrived children from Somalia, mobile populations, and children living in underserved settlements in Ifo 1 and Ifo 2. Additional priority will be given to children in areas with low routine immunization and SIA coverage, particularly in Ifo 2, as well as children who may be missed due to limited access to health services, mobility, disability, language or other barriers.

Total Targeted Population

Women	**43,181**	Rural	**25%**
Girls (under 18)	**46,109**	Urban	**75%**
Men	**38,172**	People with disabilities (estimated)	**8%**
Boys (under 18)	**48,605**		
Total targeted population	176,067		

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
Population mobility/new arrivals	Strengthen tracking, surveillance and vaccination follow-up.
Zero-dose/under-immunized children	Targeted vaccination, SIA mop-up and defaulter tracing
Limited CHP coverage and communication gaps	Strengthen CHPs and tailored community engagement.
Poor WASH conditions	Hygiene promotion and coordination with WASH partners.
Weak AFP/VPD surveillance	Active case search and strengthened facility/community surveillance.
Inadequate consent and privacy during vaccination and data collection activities. Personal information may be disclosed without consent, or caregivers may not fully understand the purpose of activities.	Kenya Red Cross Society (KRCS) will integrate safeguarding measures across all interventions to ensure the safety, dignity, and protection of all affected populations.

Please indicate any security and safety concerns for this operation:

Dadaab is faces signicant security challenges primarily due to its proximity to Kenya-Somalia border, characterised by armed militia attacks. There is potential for military escalation, which may create substantial risks for humanitarian
operations. These security concerns may directly impact personnel safety during SIA, monitoring activities, and rick communication. The continuous refugee influx may further challenge the operations, which trigger resource-based conicts between host and refugee communities. Health and environmental safety concerns are evident through contaminated water sources, poor sanitation infrastructure, and the risk of disease outbreaks.
Despite KRCS being the lead health service delivery in IFO, there is need to mitigate these risks.
The operation requires regular security assessments, strong coordination with local security agencies, clear evacuation protocols, community acceptance building, comprehensive risk monitoring and reporting systems, careful identication of safe distribution points, and robust emergency communication protocols.

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

Planned Intervention

Health

Budget: CHF 80,895
Targeted Persons: 176,067

Indicators

Title	Target

# of under 15 years children vaccinated during SIA	94,714
# of KRCS Volunteers and CHPs sensitized on AFP, CBS and screening protocal	133
# of KRCS Volunteers and CHPs sensitized on polio RCCE and CEA	133
# of community members sensitized on polio prevention and vaccination	81,353
# of radio talk show supported	10
# of IEC materials printed and distributed (by type and location: border communities, refugee settings, transit centres)	4,200
% of trained volunteers/ community health incentive submitting health risk reports and/or activity reports on time	90
% of signals triaged, verified and cleared for joint investigation within 24 hours	80

Priority Actions

• Support two rounds of Supplementary Immunization Activity (SIA) in Ifo 1 and Ifo 2, deploying fixed-post and mobile vaccination teams targeting 94,714 children below 15 years.
• Sensitize 133 KRCS Volunteers and CHPs on AFP case definitions, community-based surveillance(CBS), RCCE, CEA and new-arrival screening protocols.
• Drive demand creation for vaccination through targeted community engagement, leveraging community and religious leaders and culturally appropriate messaging to convert existing vaccine confidence into completed immunization.
• Deploy 133 KRCS volunteers and CHPs to conduct active community-based surveillance across Ifo 1 and Ifo 2 as well as screening at camp health posts and entry points.
• Support vaccine logistsics for planned SIA rounds.
• Print and distribute targeted IEC materials to provide simple, culturally appropriate polio vaccination messages in relevant languages, focusing on campaign eligibility, OPV benefits, vaccination timing, access points and follow-up of missed children.
Conduct media campaigns through local FM radio stations: Deliver appropriate polio messages to trigger localized community dialogues, focusing on areas with low vaccination uptake, high mobility and identified information gaps.

Water, Sanitation And Hygiene

Budget: CHF 30,494
Targeted Persons: 81,353

Indicators

Title	Target
# of community members reached with hygiene sensitization sessions in Ifo.	81,353
# of households reached practicing safe excreta disposal.	11,000
# of hand-washing stations procured and distributed.	30

Priority Actions

• Conduct hygiene promotion to the affected households and neighboring blocks.
• Conduct household sensitization on appropriate use of sanitation facilities to improve sanitation knowledge and practices.
• Water treatment supplies (water purification/chlorination tablets or equivalent) for household-level use between the tap stand and point of consumption.
• Procurement and instolation of hand washing facilities in transit centers, high population areas, and humanitarian service points.

Protection, Gender And Inclusion

Budget: CHF 5,002
Targeted Persons: 6,097

Indicators

Title	Target
# of volunteers and CHPs sensitized on PGI and safegarding.	133
# of IEC materials on safeguarding printed and distributed	1,000

Priority Actions

• Sensitizations of volunteers and CHPs on PGI and safegarding.
• Print and distribute IEC materials on safegurding reporting mechanisms.

Community Engagement And Accountability

Budget: CHF 1,305
Targeted Persons: 81,353

Indicators

Title	Target
# of KRCS staff and volunteers trained/refreshed on CEA, RCCE and feedback management	133
# of Community Review Meetings (CRMs) conducted	10
% of community feedback cases addressed and feedback loops closed within 72 hours in line with the KRCS CEA Policy	90
# of people reached with CEA activities.	81,353

Priority Actions

• Mobilize and orient KRCS volunteers to provide household level engagement, identify missed children and support follow-up, particularly among new arrivals and mobile households.
• Establish community feedback channels in Ifo 2 West: Promote the KRCS toll-free line (0800 720 577), volunteer-based feedback

collection and the Digital Engagement Hub to ensure caregivers can raise concerns, ask questions and report missed children or access barriers.
• Conduct targeted rumor and misinformation management: Regularly collect and analyse rumors, caregiver concerns and reasons for non-vaccination and use the findings to adapt campaign messages and engagement approaches.
• Use community leaders and trusted influencers: Engage refugee leaders, women and youth groups, faith leaders, CHPs and other trusted community structures to support household mobilisation, identify missed children and address vaccination concerns.
• Link CEA findings to daily campaign monitoring: Review feedback, missed-child data, refusals, mobility patterns and access barriers during daily campaign reviews and use the findings to direct mop-up and additional mobilisation.
• Close the feedback loop: Ensure concerns and complaints are documented, referred to the responsible KRCS or Ministry of Health team, responded to and communicated back to the affected community within the established feedback management timelines.
• Conduct focused interpersonal communication with caregivers of children aged 0–15 years on OPV, campaign eligibility, vaccination locations and the importance of presenting children for vaccination.
• Strengthen mobilisation of new arrivals and mobile households: Establish a simple mechanism with community leaders, health teams and vaccination teams to identify households moving into or between Dagahaley and Ifo 2 West and link eligible children to vaccination.

Coordination And Partnerships

Budget: CHF 7,592
Targeted Persons: 160

Indicators

Title	Target
# of coordination meetings supported at the implementation level.	30
# coordination meeting between IFRC and KRCS conducted.	3

Priority Actions

• Conduct monthly coordination meetings with IFRC, KRCS Headquarters, regional and county teams.
• Hold bi weekly coordination meetings with implementation teams to review progress and address operational bottlenecks.
• Conduct bi monthly field supervision and provide technical support to implementation teams.
• Support weekly coordination meetings with government and humanitarian partners to ensure complementarity and avoid duplication.

Secretariat Services

Budget: CHF 4,809
Targeted Persons: 10

Indicators

Title	Target
# of IFRC monitoring and support missions	1

Priority Actions

• Conduct regular coordination meetings with IFRC, KRCS Headquarters, regional and county teams.
• IFRC monitoring and support missions.
• Coordinate with government and humanitarian partners to ensure complementarity and avoid duplication.

National Society Strengthening

Budget: CHF 18,692
Targeted Persons: 133

Indicators

Title	Target
# of KRCS volunteers deployed insured	133

Priority Actions

• Support insurance

About Support Services

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

KRCS will involve 133 CHPs and KRCVs to support RCCE, active community based surveilance, community mobilization during vaccination, identification of zero-dose/missed children and follow-up.
Public Health Officers, EPI nurses, Clinical Officers, Medical Health Officers, HIS Officers to support coordination of the polio outbreak response, active AFP/VPD surveillance, active case finding, SIA activities, data management, community engagement, monitoring and reporting.
Public Health manager - overall technical coordination, surveillance and response monitoring.
Data/Surveillance Assistant- data collection, analysis, reporting and tracking of vaccination/surveillance indicators.
Logistics/Support Officer - transport, supplies and operational support for outreach and surveillance activities.

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

Yes, KRCS volunteer team reflects the gender, age, and cultural diversity of the affected communities, including members who speak local languages and understand cultural norms. The CHPs and KRCS volunteers are from the refugee communities comprising both male and female.

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

Kenya Red Cross society has a functional procurement and regional/branches warehouses capacity across the country. The KRCS team will procure the items as stated in the budget within the project period according to the KRCS procurement policy and guidelines. Since this is an emergency response, KRCS will do emergency procurement since it also has prequalified suppliers who can restock the items as the response needs emerge.

How will this operation be monitored?

The operation will be monitored through a combination of real time field monitoring, household level verification, vaccination team reporting, community feedback and routine data review. Monitoring will focus on coverage, identification and follow up of missed children, quality of service delivery, adherence to the microplan and timely resolution of access barriers.

Daily monitoring will be conducted using team level and household level data from the agreed campaign blocks. Vaccination teams will record children reached, children vaccinated, children missed and reasons for non vaccination. Supervisors will review team performance daily and conduct spot checks and household verification in priority locations to confirm reported results and identify missed households and children.

Progress will be tracked against the verified child target for Dagahaley and Ifo 2 West. Key monitoring indicators will include the number and proportion of eligible children vaccinated, number of children missed, number of zero dose or children with no documented polio dose identified and followed up, reasons for missed vaccination, households visited, referrals generated and referrals completed.

Community health promoters, community leaders and other identified community structures will support active identification of missed children and households facing access barriers. Community feedback mechanisms will be used to identify concerns related to vaccination access, information gaps, safety, misinformation or service quality. Feedback requiring action will be documented, referred to the responsible team and followed up within the agreed timeframe.

The monitoring team will conduct routine field verification, including observation of vaccination activities, review of team registers and reconciliation of household listings against vaccination records. Any discrepancies between reported and verified figures will be investigated and corrected promptly.

A daily review mechanism will be used to analyse monitoring data, identify low performing blocks and emerging gaps and guide targeted mop up activities. A final review will consolidate coverage results, missed child findings, community feedback, lessons learned and recommendations for subsequent campaigns.

Please briefly explain the National Societies communication strategy for this operation

The National Society will implement a coordinated communication strategy focused on timely, accurate and context-specific polio information. This will include community sensitization through CHPs/volunteers, engagement of community and religious leaders, interpersonal communication, and dissemination of messages through appropriate community channels. Messages will be tailored to newly arrived, mobile and minority populations, including use of Somali and Af-Maay where appropriate, to promote vaccination, early reporting of suspected AFP cases and community participation in the response.

Budget Overview

IFRC

DREF OPERATION

MDRCCxxx - name of National Society (Country of operation)
name of operation as published

Operating Budget

Planned Operations	**118,791**
Shelter and Basic Household Items	0
Livelihoods	0
Multi-purpose Cash	0
Health	80,895
Water, Sanitation & Hygiene	30,494
Protection, Gender and Inclusion	6,097
Education	0
Migration	0
Risk Reduction, Climate Adaptation and Recovery	0
Community Engagement and Accountability	1,305
Environmental Sustainability	0
Enabling Approaches	**31,093**
Coordination and Partnerships	7,592
Secretariat Services	4,809
National Society Strengthening	18,692
TOTAL BUDGET	**149,885**

all amounts in Swiss Francs (CHF)

Internal 9/11/2026 #V2022.01

Click here to download the budget file

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Click here for the reference