SIMPLIFIED EARLY ACTION PROTOCOL

Somalia | Cholera

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EAP №: **sEAP2025SO02** MDRSO023	Total Budget **CHF - 219,904**	Readiness: **CHF – 65,029**	Prepositioning: **CHF – 70,929**	Early Action: **CHF – 83,947**
People to be assisted: **24,700 People**	sEAP Approved: **24/06/2025**	sEAP timeframe: **2 Years**	EAP lead time for the early action **10 days**	
Prioritized geographical areas: Garowe and Bosaso (Puntland), Borama and Burao districts (Somaliland)				

RISK ANALYSIS

Prioritized hazard and its historical impact.

Cholera remains a significant public health threat in Somalia, with recurrent outbreaks over the past decade (see Annex 1, Figure 1). The country has experienced continuous transmission since 2016, with notable surges following droughts[1], during the Gu (April-June) and Deyr (October-December) rainy seasons. In 2017, Somalia faced one of its most severe cholera epidemics, reporting approximately 78,000 cases and 1,159 deaths, with a case fatality rate (CFR) of 1.5%.[2] Climate disasters, including droughts, floods, rising temperatures and El Niño phenomena, have exacerbated the cholera situation since 2022, with further escalation in 2023, when over 18,304 cases were reported, disproportionately affecting children under five. By March 2024, cholera had spread to 32 districts, recording a CFR of 1.2%, surpassing the acceptable emergency threshold (See also Annex 1, Figure 2).[3]

Disaggregated data on CFR by age group is limited. However, available reports indicate that children under five years old were significantly affected and high rates of malnutrition among children lead to high CFRs.[4] In epidemiological week 2 (8-14 January 2024), 67.8% of the 474 new cholera cases were among children below five years, with an overall CFR of 1.2% during that period (WHO). Similarly, in week 3 (15-21 January 2024), 66.7% of the 108 new cholera cases were among children below five years, with an overall CFR of 0.9% (WHO). In week 6 (5-11 February 2024), 57.1% of the 429 new cases were in children under five (WHO). As of August 2024, approximately 17,000 cholera cases were recorded across 30 districts in all seven states of Somalia, with children comprising a substantial proportion (59%) of those affected (UNICEF). These trends highlight the heightened vulnerability of young children to cholera during the outbreak. However, specific CFR data segmented by detailed age groups beyond under-five children were not available in the reviewed sources. [5]

The Somalia Humanitarian needs and response Plan projects AWD/Cholera cases "to reach similar or slightly higher levels in 2025, compared to 2024" and points out a historically above average CFR. [6]

The impacts of cholera on mortality and morbidity are profound. The rapid transmission of the disease, particularly in settlements and urban areas, coupled with gaps in surveillance, delays in diagnosis and treatment, has led to significant impacts, disproportionally affecting vulnerable groups. Cholera outbreaks have overburdened the already fragile health system in Somalia, stretching resources thin and limiting access to care for other conditions, further undermining health outcomes.

Several factors contribute to the endemic nature of cholera in Somalia. Limited access to clean water and sanitation forces communities to rely on contaminated sources, driving transmission. Poor sanitation facilities, especially in rural areas, lead to environmental contamination, while high population mobility due to seasonal factors, conflict, drought, and floods exacerbates the spread. Overcrowded settlements, particularly in internally displaced persons (IDP) camps, lack adequate water, sanitation, and hygiene (WASH) infrastructure, creating conditions conducive to outbreaks.[7]

Somalia's National Cholera Strategy emphasizes a multisectoral approach to cholera prevention and control, with key pillars including WASH improvements, strengthened healthcare services, and community engagement.[8] The Somali Red Crescent (SRCS), aligning with this strategy, in collaboration with its movement partners, has

[1] GSURR_Somalia DINA Report_Volume I_180116_Lowres.pdf
[2] The Somali strategy for Cholera prevention and control 2020-2024 - Somalia | ReliefWeb
[3] Somalia: 2024 AWD/Cholera outbreak Flash Update No.2 (As of 24 March 2024) | OCHA
[4] Cholera-Week-2-2024.pdf; Cholera-Week-3-2024.pdf; Cholera-Week-6-2024.pdf
[5] Cholera Response Plan - UNICEF Somalia
[6] Somalia 2025 Humanitarian Needs and Response Plan (HNRP) - Somalia | ReliefWeb page 21
[7] Cholera – Somalia
[8] The Somali strategy for Cholera prevention and control 2020-2024 - Somalia | ReliefWeb

prepared for and responded to frequent disasters[9], including cholera outbreaks (e.g., most recent DREF Operation MDRSO017[10]). However, challenges persist, as response activities often face delays due to gaps in resources for better preparedness, including prepositioning, and readiness for early actions.

The IFRC emphasizes the importance of anticipatory actions to prevent cholera outbreaks. These efforts align with the Global Task Force on Cholera Control's (GTFCC) strategy to reduce cholera deaths by 90% by 2030.[11] Strengthening WASH infrastructure, enhancing healthcare access, and further building on SRCS community-based surveillance (CBS) system[12] are critical measures to mitigate cholera's devastating impact and to support the national ambitions in the cholera prevention and control.

Prioritized risks to be addressed by the early actions and their link to the hazard

The prioritized impacts addressed by this sEAP are morbidity and mortality of affected and at-risk populations due to cholera and acute watery diarrhoea (AWD). Cholera outbreaks in Somalia are exacerbated by poor access to clean water and sanitation, inadequate hygiene practices, and displacement-driven overcrowded settings. The primary transmission pathway is ingestion of food or water contaminated by faecal matter. Vulnerable populations include children, particularly malnourished children, communities in urban slums, IDPs, and migrants, particularly during seasonal droughts and floods, which significantly disrupt water quality and hygiene practices.

Seasonal dynamics play a critical role, with dry seasons characterized by water scarcity and rainy seasons by water contamination, creating acute health risks in general and risks for cholera in particular. IDP camps and migration exacerbate these vulnerabilities, as crowded living conditions and poor sanitation increase exposure.

Aligning with the national strategy and global guidelines, this sEAP prioritizes WASH and Health and Care interventions. Readiness activities and early actions focus on selected priority locations and vulnerable communities at heightened risk during critical seasonal periods – Gu (April-June) and Deyr (October-December), aiming to reduce transmission and prevent severe outbreaks.[13,14,15]

Describe the selected early actions and explain how they will address the risks and lead to the intended outcomes

The early actions for cholera readiness and response were selected following a comprehensive process that involved a series of workshops with SRCS and its health partners the IFRC, Norwegian Red Cross and Finnish Red Cross to identify the impacts and risks associated with cholera and prioritize interventions accordingly. The German Red Cross was involved to benefit from their experience in EAP development and ensure effective linkage to the existing drought EAP.

The process was informed by the national strategy for cholera prevention and response[16], regional epidemics preparedness and response plans, prior working sessions with the MoH and consultations with the communities, SRCS's existing epidemic preparedness and response (EPR) guidelines, discussions with the Ministry of Health (MoH) in the focused regions, and the lessons learned workshop of the recent Cholera DREF operations.

[9] All Appeals
[10] IFRC GO - Emergency
[11] Roadmap 2030 – Global Task Force on Cholera Control
[12] Somalia | Community Based Surveillance
[13] The Somali strategy for Cholera prevention and control 2020-2024 - Somalia | ReliefWeb
[14] Roadmap 2030 – Global Task Force on Cholera Control
[15] Cholera
[16] The Somali strategy for Cholera prevention and control 2020-2024 - Somalia | ReliefWeb

Recommendations from global guidelines, including those of the GTFCC[17] and the World Health Organization (WHO)[18], further guided the selection to ensure alignment with best practices and evidence-based approaches.

The selection criteria focused on several key factors. The interventions were chosen for their alignment with Somalia's and regional contingency plans, ensuring consistency with national cholera control strategies and policies. Evidence of effectiveness was a critical consideration, as these actions have been shown to reduce cholera transmission and mitigate associated morbidity and mortality. Practicality, including access to affected locations, resource availability, and scalability within Somalia's context, was also evaluated. Social acceptability was prioritized to ensure the interventions resonate with the communities and foster behaviour change. The SRCS's existing capacity, including its network of community health volunteers and mobile health teams, further ensured the feasibility and sustainability of these actions.

The selected early actions for cholera readiness and early response include e.g.

- Providing risk communication and community engagement (RCCE), incl. rumour management
- PGI and CEA are cross cutting and will be integrated in all interventions.

SURVEILLANCE

- Enhanced and active CBS for early detection and early warning,
- Enhanced surveillance through aggregated reporting for improved outbreak monitoring and resources allocation,
- Active case finding

CASE MANAGEMENT

- Community Case Management (CCM):
    - mobile outreach Oral Rehydration Therapy (ORT): providing ORS and Zinc (children ages 6 months to 5 years) at the household/village level (ORT corners)
    - static Oral Rehydration Points (ORPs) [19]

EMERGENCY WASH and DISINFECTION

- Providing access to clean water through aqua tabs and targeted hygiene kit distributions as well as rehabilitation of water sources and sanitation facilities.
- Improve access to sanitation through the rehabilitation and desludging of existing latrines, particularly in urban and IDP settlement areas. SRCS has planned PPEs for that and will consider safety measures (incl. where to dispose).

Additionally, community-based WASH tools such as:

- Branch Transmission Intervention Teams that respond to disease outbreaks to break transmission routes in health facilities, case households, communities through Branch Outbreak Response Training (BORT)/ Case area targeted interventions (CATI) in close collaboration with authorities and in locations where no other actors conduct these activities.[20]
- Disinfection of communal and household water sources and latrines will be utilized, along with early referrals and strengthened community engagement efforts.

By focusing on these early actions, the sEAP aims to mitigate the impacts of cholera by improving access to clean water, improve sanitation facilities, enhancing hygiene practices, and ensuring timely detection and treatment close to home. These efforts prevent strain on healthcare services and ultimately reducing morbidity and mortality among the most vulnerable and at-risk populations and contribute to the broader goal of controlling cholera outbreaks in Somalia.

[17] Roadmap 2030 – Global Task Force on Cholera Control
[18] Cholera
[19] Static ORPs will be set up with increased case load, based on data analysis and agreement with the MoH once the need arises.
[20] The authorities might conduct these activities (e.g., Somaliland locations) and SRCS will engage to assess which support is needed form their side.

EARLY ACTION INTERVENTION

Overall objective of the intervention

Reduce morbidity and mortality of AWD/Cholera outbreaks in priority locations in Somalia through timely and quality anticipatory actions defined by a phased trigger mechanism of observed environmental/climatic shocks that are linked to Cholera outbreaks[21] (floods, heavy rainfall or droughts) and/or observed increases in health vulnerability (displacement, increased malnutrition rates) with disease surveillance data of suspected cholera cases.

Justification for receiving funding for this sEAP

The SRCS seeks funding for anticipatory action to complement its contingency and response plans, to address critical gaps in cholera readiness and early response. Despite Somalia's long history of cholera outbreaks, responses have often been delayed due to late declarations by the Ministry of Health (MoH), insufficient resources and prepositioning of supplies. These delays have allowed outbreaks to escalate, causing significant morbidity, mortality, overburdened health systems and economic disruption in affected communities.

This sEAP will not replace the already well functioning routine and annual cholera readiness activities but will instead enable SRCS to act earlier with appropriate resources to mitigate risks, aligning its efforts with national and regional emergency preparedness initiatives under the MoH.

Cholera in Somalia follows seasonal patterns, peaking after droughts followed by heavy rains, during the rainy seasons due to flooding that contaminates water sources and compromises sanitation systems. During the dry season, water scarcity forces reliance on unsafe water sources, further increasing transmission risks. Climate change exacerbates these vulnerabilities, compounding existing challenges such as limited WASH infrastructure, restricted access to healthcare, displacement due to conflict and drought, and overcrowded IDP camps.

The MoH's mapping approach[22] of high-risk districts and regions, based on profiling assessment criteria, provides a robust evidence base for targeted interventions, ensuring resources are directed where they are most needed.

SRCS has extensive experience in early detection and response to disease outbreaks, including implementing community-based surveillance (CBS) in many locations[23] and has been demonstrated to be a key pillar for anticipatory actions to epidemics. Numerous examples have been documented by SRCS, where the first case or first few cases of a disease outbreak have been detected through CBS and have enabled SRCS with its volunteers and through a well-established collaboration with the MoH to respond rapidly to control the outbreak at its early stage.[24,25,26] For instance, with the Covid19 pandemic reaching the Africa region, SRCS in Somaliland trained their volunteers in early detection and reporting of COVID 19 symptoms through CBS that enabled swift actions in collaboration with the health authorities.[27] In 2022, a large scale dengue outbreak in Somaliland hit unprepared as dengue was rather a newly emerging epidemic in the region. However, the lessons learned enabled SRCS in neighbouring Puntland to anticipate and control the outbreak effectively.[28]

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[21] Drought-related cholera outbreaks in Africa and the implications for climate change: a narrative review - PMC; GSURR_Somalia DINA_Report_Volume_I_180116_Lowres.pdf; ghoa-food-insecurity-and-health-sitrep-8.pdf; Situation Report: Greater Horn of Africa Food Insecurity and Health - Grade 3 Emergency — 01 November - 31 December 2023

[22] Comparable with Priority Areas for Multisectoral Interventions (PAMI) and will be further referred as such in the document

[23] Somalia | Community Based Surveillance

[24] News | Community Based Surveillance;

[25] Dengue Fever in Somalia - Epidemics That Didnt Happen

[26] IOA Field Exchange Volume 4, September 2022 - World | ReliefWeb

[27] Preparedness_COVID_SuccessStory_Somaliland_EN.pdf

[28] Community-based surveillance programme evaluation using the platform Nyss implemented by the Somali Red Crescent Society—a mixed methods approach - PMC

Despite SRCS's strong capacity in early detection and response to AWD/cholera, critical gaps remain in CBS coverage, response capacity, and particularly in prepositioning of essential supplies. The sEAP will add significant value by scaling up SRCS's readiness capabilities. A recent lessons-learned workshop on the Cholera DREF highlighted these areas as critical challenges requiring better preparedness and readiness.

SRCS ambition to enhance anticipatory actions for Cholera prevention and control align with the MoH's national and regional cholera strategy and global guidelines from the WHO and the GTFCC. By securing additional and pre-agreed funding, SRCS can strengthen its capacity to detect and respond to cholera outbreaks at its initial stages, thereby reducing transmission and preventing deaths, particularly among the most vulnerable populations who have been most affected by previous outbreaks.

Potential geographical high-risk areas that the sEAP would target

In alignment with the national cholera prevention and control strategy[29], this sEAP adopts a two-tiered geographical targeting approach. The primary focus centres on the Priority Areas for Multisectoral Interventions (PAMIs), identified through Somalia's cholera risk profiling criteria. This approach aligns closely with the methodology used by the GTFCC's for PAMI identification.

These locations were selected based on historical cholera burden, environmental vulnerability, socio-economic and displacement factors that facilitate disease transmission. The previous national exercise considered data only until 2019. For the selection for this sEAP, we included further data and experiences since, particularly the most recent large-scale outbreak in 2023/2024 (see Annex 1, Figure 2 and table 1). The identified locations represent areas where cholera persists or regularly resurfaces, locations neglected in previous preparedness interventions (e.g., IDP camp in Bosaso), and areas with limited partner access that have played a crucial role in the broader spread of the disease. The final selection of locations was done jointly with the MoH in the respective regions.

Selection of hotspots and PAMIs

Somaliland

Borama and Burao have been identified as priority locations for early cholera action due to their history of outbreaks, cross-border transmission risks, and high vulnerability factors. Borama has experienced repeated cholera outbreaks, with major epidemics recorded in 2017/2018 and again in 2024. The district's location near the Ethiopian border and the frequent cross-border movement of people have played a key role in disease transmission, as seen in the 2024 outbreak. Additionally, Borama serves as a significant transit point for migrants, further increasing the risk of cholera introduction and spread.

Burao also has a history of cholera outbreaks and remains a high-risk area due to its status as the second most populous city in Somaliland and a key hub for the eastern regions. Poor WASH conditions in both IDP settlements and densely populated urban areas contribute to cholera transmission. The limited presence of humanitarian organizations with the capacity to respond to cholera outbreaks further compounds the risks, making early intervention essential.

Puntland

Garowe and Bosaso have been identified as the most affected areas, experiencing a surge in cholera cases in 2024. Both locations are highly vulnerable due to a combination of environmental, demographic, and socio-economic factors that contribute to the persistence and spread of cholera. Garowe has recorded the highest number of cholera cases in Puntland this year, with children and internally displaced persons (IDPs) being particularly affected. The city is prone to flooding from Sool and Ethiopia, exacerbating poor sanitation conditions and increasing the risk of disease transmission. As a regional hub with a dense population and significant trade

[29] The Somali strategy for Cholera prevention and control 2020-2024 - Somalia | ReliefWeb

activity, Garowe facilitates the spread of cholera. Limited access to clean water and the contamination of existing water sources further poses a persistent public health threat. Bosaso, a major port city, has reported over 850 cholera cases in 2024, with IDPs and coastal communities among the most affected. The first cholera case of the year was reported in an IDP settlement in Bosaso. The city faces severe water and sanitation challenges, with many residents relying on unsafe water sources. Recurring floods and extreme temperatures create an environment conducive to cholera outbreaks. Additionally, Bosaso's role as a key trade and migration hub increases the risk of cholera importation and rapid transmission.

While those locations form the core focus of the sEAP, the protocol maintains operational flexibility to respond to emerging needs within the broader regions where PAMIs are located. This flexibility enables SRCS to address urgent needs in adjacent areas where other response capacity may be limited, adapt to rapid changes in risk factors or disease patterns, and prevent the spread from PAMIs to neighbouring areas.

The decision to activate early actions outside of the PAMIs will be guided by several factors, including the current response capacity of other health actors in the areas, assessment of changing risk factors and vulnerability indicators, available resources and operational feasibility, and coordination with regional health authorities and partners. This approach ensures both targeted intervention in known high-risk areas while maintaining the adaptability needed to address emerging needs across the broader geographic scope of cholera risk and SRCS's operational area.

Which groups of people will be assisted through this operation and what criteria will be used for their selection?

The targeting approach for this sEAP acknowledges that all residents within the selected priority locations and other PAMIs are vulnerable to cholera transmission due to the environmental and socio-economic conditions that facilitate disease spread. While the entire population in these areas will be assisted through preventive and curative measures, data from CBS and previous disease surveillance data indicate that certain groups face heightened vulnerability, particularly children aged 0-4 years who show significantly higher case numbers (as evidenced in Annex 1, Figure 3 and 8) and higher risk of CFR.[30] (See background section for more data regarding morbidity and mortality of vulnerable population.)

Within the PAMIs, special consideration will be given to households with children under 5 years old, who are disproportionately affected by cholera and face higher mortality risks.

This targeting approach aligns with both the epidemiological evidence of disease burden and the national cholera risk profiling assessment methodology, while maintaining operational flexibility to respond to emerging transmission patterns within the broader regions where PAMIs are located.

Trigger(s) statement

The trigger mechanism for this sEAP follows a two-step approach that combines amplifying factors and surveillance data to activate early action interventions, aligned with Approach B of the Movement's conceptional framework.[31]

For both coordination office, the readiness activities at roll out of the sEAP, will start with the development and dissemination of a context specific SOP for effective monitoring of the triggers.

Decision flow chart to be included once approved/feedback received

[30] Somalia 2025 Humanitarian Needs and Response Plan (HNRP) - Somalia | Relief Web

[31] AH-Working-Paper_Epidemics_FINAL.pdf

The **first trigger T1**, activates low-cost early actions:

T1 can consist of the following scenarios identified as drivers of AWD/cholera epidemics in Somalia based on historical patterns:

1. A confirmed cholera case or spikes in AWD cases in a neighboring location to the selected PAMIs.
2. Activation of the SRCS drought EAP (MDRSO019)[32]
3. The following amplifying factors occur in a selected PAMI, based on previous scenarios in 2017 and 2024, that led to large scale outbreaks.
    a. Flooding and extensive rains
    b. Drought followed by heavy rains
    c. Drought EAP is activated
    d. Increased malnutrition rates (GAM cases reaching the threshold of >10%)[33] coinciding with heavy rains, flooding, or droughts

Sources of information:

SRCS has already existing branches and volunteers in the selected locations. Staff and volunteers have been reporting proactively in the past when mentioned amplifying factors were accruing. As part of the EAP drought, they have been trained in reporting signs of droughts which can be built on for the other identified amplifying factors. This will be included during the readiness interventions. Reporting from the communities to the volunteers and/or branches on amplifying factors will results in CBS reporting where feasible (heavy rains and flash floods as unusual event – a, b) and through communicating directly to the SRCS Emergency operations centre (EoC), following the drought EAP example. In addition, EoC staff are in regular contact with national authorities related to disasters

e.g., Ministry for Agricultural Development for the metrological data and National Disaster and Food Reserve Authority (NADFOR). Additionally, to monitor malnutrition (d), data from SRCS supported health facilities (Puntland) will be utilised. Where this is not appliable (Somaliland locations), SRCS branches and HQ are in regular cluster/review meetings with MoH where information is shared. Somalia Acute Malnutrition Projection dashboard will be monitored by the EoC team and the health and nutrition department.[34]

The lead time from T1 activation to the likely activation of T2 is max. three months.

The **second trigger T2**, activates full range of early actions[35] :

T2 is based on epidemiological and surveillance data.

Historical cholera outbreak data and SRCS CBS (suspected cholera/AWD) data have been analysed descriptively to establish the foundation for predicting outbreaks (e.g., Annex 1, Figure 4-7). Contextual adjustments were made to align with findings from other anticipatory action initiatives.[36]

SRCS has progressively implemented CBS for Early Warning since 2018, covering increasing numbers of locations, partially including in the selected hotspots. Though gaps remain to be addressed by the sEAP.

[32] IFRC GO - Emergency

[33] FSC Indicators Hand will be utilized, along with early referrals and strengthened community engagement efforts book

[34] Somalia: Acute Malnutrition Projection Update for April - June 2025 | IPC - Integrated Food Security Phase Classification; Somalia | Global Nutrition Cluster

[35] Activation of certain activities will depend on the scale of the outbreak based on surveillance data (see in the interventions section below).

[36] Anticipatory Action - Democratic Republic of the Congo | OCHA

CBS system implementation

Before CBS implementation in any locations, assessments are conducted to evaluate needs and feasibility. Community Case Definitions (CCDs) are adapted to align with the Ministry of Health's strategy, local terminology, and volunteer capacity.[37] Cholera has been designated as a priority disease for CBS across all locations, though thresholds[38] and definitions vary slightly between regions.

In Puntland, AWD is defined as *watery diarrhea occurring three or more times in one day, with or without vomiting.* The MoH has set an alert threshold of five true signals/events within three days and within a five km radius.[39]

In Somaliland, ADD is defined as *three or more loose or liquid stools in 24 hours*. The MoH has set an alert threshold of five true signals/events within five days and within a five km radius.

SRCS volunteers are reporting the health risk signals from the community via coded SMS to the CBS platform Nyss which enables real-time reporting, notification, analysis, and information sharing with all stakeholders, particularly with MoH for further investigation and recording into their surveillance tools (EWARN and DHIS2). This also means that CBS AWD/ADD signals/alerts are not confirmed Cholera or other potential diarrheal diseases. However, an increase in true alerts can be a strong indication that community transmission is taking place.

Once the alert threshold for AWD/ADD is reached, the SRCS supervisor, linked to the respective volunteer, will be promptly notified and is required to crosscheck the event within a maximum of 12 hours to ensure it aligns with the established CCD. The supervisor will escalate the alerts of true events to the MoH for further action. Nyss captures automatically captures all true signals on AWD/ADD automatically in graphs (see Annex1, Figure 4 and 5), which can be filtered down to the village level. This functionality enables detailed, location-specific analysis of AWD/ADD trends at community level, providing critical insights for timely and effective decision-making during outbreaks.

In addition to providing early warning through CBS, volunteers play a critical role in first response by supporting affected individuals, their families, and communities. These efforts include hygiene promotion, and distribution of homemade or if available ready-made ORS, provision of Zinc for children under five, distribution of Aqua Tabs, facilitating referrals, and engaging in risk communication and community engagement (RCCE).

Further actions are determined collaboratively by SRCS and the MoH, based on the results of outbreak investigations and continuous epidemiological monitoring of integrated disease surveillance data (incl. data from health facilities). This data-driven approach ensures that interventions are adapted to the evolving dynamics of the outbreak, allowing for targeted and effective measures to mitigate its spread and impact.

Based on this background, T2 may be triggered by:

1. A spike in AWD/ADD CBS true signals, such as:
    a. Doubling of alert thresholds – from at least 5 to at least 10 signals (see alert threshold explanation above) within one week.
2. Confidential information from the MoH indicating a rise in AWD/ADD cases[40]

[37] Global List of Community Health Risks for Community-based Surveillance within the Red Cross Red Crescent Membership | Community Based Surveillance

[38] At CBS implementation, the MoH determined an alert threshold for AWD/ADD. An 'alert threshold' is the number of signals that trigger an alert. Since Cholera is endemic in Somalia, numerous reports must be received, in a certain period and area, before an 'alert threshold' is reached, indicating a potential AWD/Cholera outbreak to facilitate further investigation by the MoH. 39 Volunteers are registered with their phone numbers within a map in the Nyss platform whereby the system can estimate the distance between the villages where volunteers are reporting from.

[40] E.g., in locations where CBS is not implemented (yet)

3. MoH confirmation of AWD/Cholera

Sources of information:

As described above under 'CBS system implementation', CBS data will be monitored by the SRCS supervisor who has been trained in CBS and Nyss. Once signals trigger the threshold, an automated notification is sent to the supervisor to follow up on the CCD with the volunteer and to get further information on the situation in the community. If it is a true alert, supervisors will notify SRCS management, MoH and other defined alert recipients through an automated process in Nyss. Managers at SRCS HQ also have access to the same data and can monitor data in maps, graphs and tables.

Where CBS is not implemented, volunteers simply call their supervisor to report on AWD/ADD cases and unusual events who then alerts the SRCS management, EoC and authorities. However, the aim of the sEAP is to implement CBS in all priority locations. Other locations that might be affected but neither part of this protocol or having CBS implemented, are already utilising the informal approach and branches have close contact to volunteers in the community where existing or else a well-defined community engagement with leaders has been established in many communities.

Beyond this, particularly in Puntland and Somaliland, close collaboration with the MoH in the regions has been established with good collaboration, SRCS participating in regular review meetings where surveillance data is shared.

The lead time from T2 activation to the implementation of early actions is 10 days.

Notably, T2 can be activated independently of T1.

PLANNED INTERVENTION

	**Water, Sanitation and Hygiene**	**Budget –**	**63,178 CHF**
		Targeted persons	SL: 13,000 PL: 11,700 **Total: 24,700**
Indicator:	*# of SRCS volunteers trained on WASH modules (BORT/CATI) (n =SL 200; PL 90)* *# of people reached hygiene and sanitation promotion (n= SL 13,000 T2; PL 11,700)* *# of environmental cleaning campaigns conducted (n= SL 4)* *# of Hygiene and sanitation promotions conducted (n=SL 4)* *# of the AWD/Cholera Community Action Plans developed (n= PL 3)*[41] *# of latrines rehabilitated or dislodged (n=125)*[42] *# of WASHNFIs distributed* [43] *(n= SL 25, PL 250)*		
Readiness activities	*As part of routine seasonal readiness* ***YEAR 1*** 1. Development and roll out SOPs for monitoring the triggers and activation of the protocol (incl. focal points at EoC/DRR and health departments; aligned with drought system) 2. Train volunteers and staff on WASH, incl. PGI, hygiene promotion, etc. 3. Train volunteers and branch staff in water quality testing and safe water treatment, incl. Identification and disinfection of infected boreholes and HH disinfection. 4. Train branches in rapid risk and needs assessments 5. BORT/CATI training (4 days) training ***YEAR 1-2*** 6. Refresher trainings (BORT/CATI, hygiene promotion, water testing/treatment) 7. Engagement with traditional healers, religious leaders, local leaders 8. Promote SRCS feedback hotline where available 9. Develop AWD/Cholera Community Action Plans 10. Participate in WASH cluster meetings 11. Conduct routine hygiene promotion activities and other WASH interventions (incl. schools and health facilities) – following PGI and CEA approaches - e.g., appropriate use visual material and messages, ensure interaction, utilize demonstrations – diverse IEC materials established, incl. flipcharts, posters, radio spots, HH, marketplace interventions, school activities		

[41] In Somaliland, this action has already been implemented during routine activities
42 NA for Somaliland
43 Targets depend on respective needs (based on assessment)

Pre-positioning activities	1. Purchase and appropriate storage of WASH NFIs with adequate shelf life (PPE, sanitizers, soap, etc.), and NFI kits. 2. Purchase Environmental cleaning tools kits such as wheelbarrows, shovels, forks, gloves. 3. Water purification chemicals with adequate shelf life such aqua tab, Chlorine and others). 4. Warehouse storage or (local, regional) frameworks agreements with suppliers for the items above.
Prioritized Early Actions	***With T1*** 1. Conduct (one/half day) refresher training for NS and Govt staff and volunteers on WASH (if relevant[44]) 2. Intensify targeted RCCE using IEC material on cholera prevention and control, incl. environmental factors contributing to cholera transmission (e.g. drought, floods) and hygiene 3. Engage local community leaders and community water management committees on AWD/Cholera prevention and control 4. Water quality testing/monitoring in collaboration with other stakeholders ***T2 triggered*** 5. (Latest after 10 days lead time - preferably earlier with T2 activated): Conduct rapid WASH assessment (water quality testing/monitoring) in collaboration with incl. authorities (jointly with health assessment) in priority locations where T2 was activated + neighbouring locations –> rank the risk of spread, magnitude and potential impact -> conduct needs assessment of available and required resources and plan the actions with MoH 6. Mobilize the WASH kits and equipment from HQ to the cholera location 7. Targeted cleaning campaigns in priority locations at marked places, in IDP camps (depending on needs): Identification and disinfection of infected boreholes; disinfection of communal and household water sources and latrines, jerry cans, by engaging the community 8. Intensify RCCE, hygiene awareness – shift to daily activities: affected households, neighbouring HHs, schools, radio/media campaigns, mobile cinema 9. Distribute WASH NFI – incl. training of community members in use 10. Activate BORT/CATI (includes rapid HH assessment) 11. Rehabilitation/desludging of latrines

[44] E.g., time between initial training and T1 would make it necessary to refresh certain aspects.

	12. Engagement closely with local community leaders and community water management committees on WASH 13. Establish regular community feedback sessions (during daily activities and regular supervision visits) to address needs/gaps, effectiveness of interventions and potential rumours. 14. Deploy additional volunteers if needed (higher caseload) – provide refresher training on WASH if required (1 day)

	Health & Care	**Budget**	**122,894 CHF**
		Targeted persons	SL: 12,000 PL: 11,700 **Total: 23,700**
Indicator (target)	*# of volunteers and staff trained in relevant packages (ECV +ORT, CBS, PFA, PGI (volunteers n=SL 200; PL 90)* *# of healthcare personnel trained in Infection Prevention and Control (IPC) and cholera case management: n HCWs= SL 10* *% of targeted people reached with health and hygiene awareness messages on Cholera (>90%)*[45] *% of villages covered through active CBS volunteers (>90%)* *# of AWD/ADD alerts escalated to the health authorities (NA)* *# of people treated with mobile ORT: ORS (and Zinc)*[46]*at the HH level (NA)* *Initial outbreak response early actions:* *# of mobile outreach ORT teams/ ORP deployed (n= SL 10, PL 4)*[47] *# of people received treatment at the ORP (NA)*		
Readiness activities	*As part of routine seasonal readiness* ***YEAR 1*** 1. Implement CEA, ECV, incl. ORT, CBS in hotspot districts where not done yet. 2. Training of supervisors and volunteers Include amplifying factors (heavy rains, floods, high malnutrition rates[48]) as "unusual event" in CBS for Early Warning of these events – training of volunteers and supervisors in the new health risk where CBS has been already established. 3. Train volunteers and staff in ORP management.		

[45] The denominator is people targeted for the campaign – based on volunteers' reach
[46] Disaggregated by age group and sex
[47] For this and following indicators, targets depend on respective needs (based on assessment)
[48] To be explored if data can be accessed at health facility level or should be included in CBS; Somaliland CBS has malnutrition included as health risk itself. However, there are challenges with this approach.

	YEAR 1 to 2 1. 1-day refreshers. 2. Continuously report health risks and amplifying factors, including AWD/ADD through CBS; conduct routine health and hygiene promotion activities – following PGI approaches, incl. promotion of healthy nutrition for children and PLWs, including breastfeeding.
Pre-positioning activities Annual	1. Printing IEC materials for awareness raising (e.g. hand hygiene practices, homemade ORS preparation). 2. Procure ORS/Zinc (2-3 years lifetime) for mobile ORT and exchange of expired item. 3. Purchase and appropriate storage of ORP kits (2-3 years lifetime). 4. Visibility for volunteers. 5. PPE relevant for activities. 6. Warehouse storage or local frameworks agreements with suppliers on the items above.
Prioritized Early Actions:	***With T1*** 1. Intensify health and hygiene promotion related to AWD/Cholera, incl. promotion of healthy nutrition for children and PLWs, including breastfeeding. 2. Engage local community leaders and community health committees on AWD/Cholera prevention and control *T2 triggered - initial outbreak response early actions:* 3. Follow up on and support alert investigation by MoH 4. Communicate with neighbouring locations (branches, volunteers) to be alert and potential early actions/readiness activities. 5. Conduct active CBS (daily follow up of community and leaders) 6. Intensify health and hygiene awareness/RCCE – shift to daily activities at affected HHs and neighbourhood, focus on HHs with children under 5 and PLWs 7. IEC material distribution 8. Provide ORS (and zinc) to the sick or/and train community in homemade solution – mobile ORT 9. Refer severe dehydrated cases and children to the health facility. 10. Support MoH in conducting rapid risk assessment with MoH[49] 11. Deploy additional volunteers if needed! – provide refresher on ECV and CBS related to cholera (1 day)

[49] See above under WASH activities for details

	With increased case load 12. Intense engagement of local community leaders and community health committees on AWD/Cholera prevention and control 13. Add volunteers and staff/volunteer leads – refresh/train 14. Conduct active case finding – HH or through engagement with community leaders – conduct daily CBS reporting (aggregated) 15. Provide ORS to the sick through mobile outreach ORTs at HH/village level or refer to ORPs if applicable 16. Implement ORPs in collaboration with MoH (on the job training – experienced volunteers/staff support newly trained) 17. Refer severe cases to health facility 18. Mass media campaigns on cholera transmission, prevention and control measures 19. Daily data review meetings with health facilities, and joint supervision with MoH 20. Participate in cluster meetings/coordinate with partners on additional resource mobilization 21. Develop a DREF under response pillar or EA for further Cholera response[50]

	**Community Engagement and Accountability**	**Budget (CHF)**	**2,285 CHF**
		People targeted	80% of target population reached with materials 90% of key messages disseminated through multiple channels
Indicator		1. Establish community consultation and feedback mechanism. 2. % of key messages disseminated through at least 3 communication channels.	
Prepositioning activities:		1. None	
Prioritized Early Actions:		1. Distribution of CEA materials, key messages and feedback channels.	

[50] The EAP will only provide the possibility of initial response to the outbreak. This provides time to apply for further funding and response measures (e.g., CTUs, CTCs, increased number of ORPs, CVA).

ENABLING APPROACHES

	Coordination and Partnerships	**Budget (CHF)**	**3,515 CHF**
		People targeted	
Indicator:	# of lesson learned Workshop conducted	**Target:**	1
Prepositioning activities:	1. None		
Prioritized Early Actions:	1. Conduct lesson learned Workshop		

	Secretariat services	**Budget (CHF)**	**21,882 CHF**
		People targeted	
Indicator:	# of technical missions by the IFRC Delegation	**Target:**	2
Prepositioning activities:	1. None		
Prioritized Early Actions:	1. Support coordination with stakeholder and authority 2. Pro vision of technical supporting during the implementation 3. Support operation management and reporting		

	National Society Strengthening	**Budget (CHF)**	**6,151 CHF**
		People targeted	
Indicator:	# of monitoring and supervision conducted	**Target:**	2
Readiness activities:	1. Anticipatory action focal point to deliver on the readiness and early action activities. 2. Conduct coordination meeting with stakeholders.		
Prioritized Early Actions:	1. Mobilize BDRT to support early action and prepare for early response. 2. Conduct monitoring and supervision.		

CONDITIONS TO DELIVER THE EARLY ACTION

Experience and/or capacity to implement the early actions.

The SRCS is a key actor in Emergency Preparedness and Response EPR in Somalia, with extensive experience in cholera preparedness and response. SRCS staff and volunteers have been trained in ECV, CBS, WASH, ORT and ORPs. The organization has implemented cholera prevention and control activities across multiple regions, including RCCE and CBS, and has provided ORP support during recent cholera outbreaks, as well as Cholera

Treatment Center (CTC) support in 2017/2018. Furthermore, the EAP for droughts has already been developed, and the sEAP for cholera will be linked to it, ensuring that early actions for drought also integrate cholera-specific early actions when triggers are reached[51].

SRCS has strong community trust, as it has ongoing health programs in the selected locations and a history of effective emergency response. Additionally, SRCS benefits from its established auxiliary role in health, facilitating coordination with authorities, and its experience in navigating security and access challenges in high-risk areas.

Scale down mechanism

The scaling down of the sEAP will follow a phased and time-bound approach, ensuring flexibility to re-scale if specific triggers are met again. Scaling up will follow a staggered approach for readiness, including T1, T2, further scaling within T2 for related Early Actions, based on data driven analysis, and in coordination with the Ministry of Health (MoH), using CBS data and shared HMIS data. For instance, ORPs without reported cases over seven consecutive days may be deactivated[52]. Attack rate (AR) thresholds—ranging from <0.1% to 2% in rural areas with low population density and <1% to 5% in crowded urban settings or IDP/refugee camps—will determine outbreak status and guide the implementation and continuation of relevant early actions. As ARs decrease, active case finding may transition back to passive CBS.

The sEAP may transition to the response pillar if the outbreak escalates into an epidemic that exceeds the sEAP's capacity due to limited resources. Another scenario for scaling down certain activities could involve other partners increasing their support.

Once an outbreak is declared over, lessons learned should be documented, and adjusted activities should be integrated into SRCS contingency plans and the country plan, informing national strategies and future preparedness efforts.

A full EAP for Cholera will be developed as the next step to strengthen future preparedness and response mechanisms.

Stakeholders involved in the development of the sEAP

The development of this protocol was a collaborative effort involving multiple stakeholders, each playing a crucial role.

The SRCS led the process with the Norwegian Red Cross (NoRC) as the lead support in developing the protocol. The IFRC provided inputs and coordination throughout the entire process, ensuring alignment with global frameworks. The Finnish Red Cross (FinRC) contributed technical support, while the German Red Cross (GRCS) shared lessons learned from previous EAP drought responses to help frame the approach.

The Ministry of Health/Development (MoH/D) ensured alignment with national protocols and plans, reviewing and approving key aspects such as location selection, identification of vulnerable populations, trigger mechanisms, and early actions.

The SRCS branches, volunteers, and communities played a critical role by contributing local knowledge, engaging in preparedness efforts, and supporting the implementation of activities on the ground.

During implementation, the IFRC continues to support coordination, while NoRC and FinRC will provide technical support. The GRCS collaborates on linkages with the drought EAP, and the MoH/D serves as a direct partner in planning, implementation, risk and needs assessments, coordination, protocol activation, evaluation, and linking with other partner support.

Lessons learned workshops will be conducted per each of the two SRCS coordination office to allow joint workshops with stakeholders like MoH in the regions where the EAP will be rolled out.

[51] While writing this sEAP, the EAP droughts is already activated.

[52] As per CCMC protocol

Stakeholder Involvement in Cholera Preparedness and Response

Mapping stakeholders involved in cholera preparedness, readiness and response is critical to ensuring effective coordination, resource allocation, and alignment with national strategies. The Ministry of Health (MoH) is leading coordination and collaboration among all actors involved in both preparedness and response efforts. Recent developments in U.S. funding gaps may impact the ability of several actors to fulfil their previous roles at the same scale. This could lead to challenges in maintaining cholera response activities, making it even more important to strengthen coordination and resource mobilization among remaining stakeholders.

Key Stakeholders identified during the process include a mix of local, national, and international actors, each playing a role in cholera prevention, early action, and response. These include:

National and Local Actors:

- Ministry of Health (MoH), Ministry of Water (MoWater)
- SRCS (including its partners IFRC, NoRC, FinRC, German RC)
- Community Health Committees (CHCs) and local communities

International Humanitarian and Health Organizations:

- UNICEF, WHO GOARN, MSF, OCHA, Save the Children (SCI), World Vision
  INGOs and other humanitarian partners

Contact information

For further information, specifically related to this simplified EAP please contact:

- **National Society Contact**: Yusuf Hassan Mohamed, President SRCS, yhmohameds@gmail.com; +254 722144284

- **IFRC Project Manager:** Gemechissa MUSTEFA; Delegate, Water, Sanitation and Hygiene, Nairobi Cluster, Kenya and Somalia; gemechissa.mustefa@ifrc.org; +252638178488

- **IFRC focal point for the emergency:** Patrick Elliott, Roving Ops Manager, patrick.elliott@ifrc.org; +254 733620770

For IFRC Resource Mobilization and Pledge support:

- **IFRC Regional Office for Africa:** Louise Daintrey, Head of Strategic Engagement and Partnerships; louise.daintrey@ifrc.org; +254 110 843 978

For In-Kind donations and Mobilization table support:

- IFRC Africa Regional Office for Logistics Unit: Allan Masavah, Head, Global Humanitarian Services & Supply Chain Management, Africa Region, allan.masavah@ifrc.org Phone: +254 (0) 113 834 921.

For Performance and Accountability support (planning, monitoring, evaluation, and reporting enquiries)

- **IFRC Regional Office for Africa** Beatrice Okeyo, Regional Head of PMER & QA, beatrice.okeyo@ifrc.org, Phone: +254 732 404022

Annex

Annex 1 – AWD/Cholera surveillance data

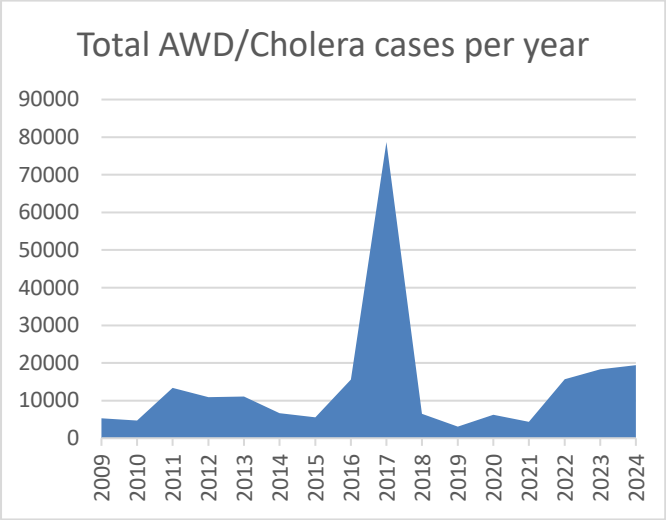

Figure 1: Number of AWD/Cholera cases in Somalia since 2009[1]

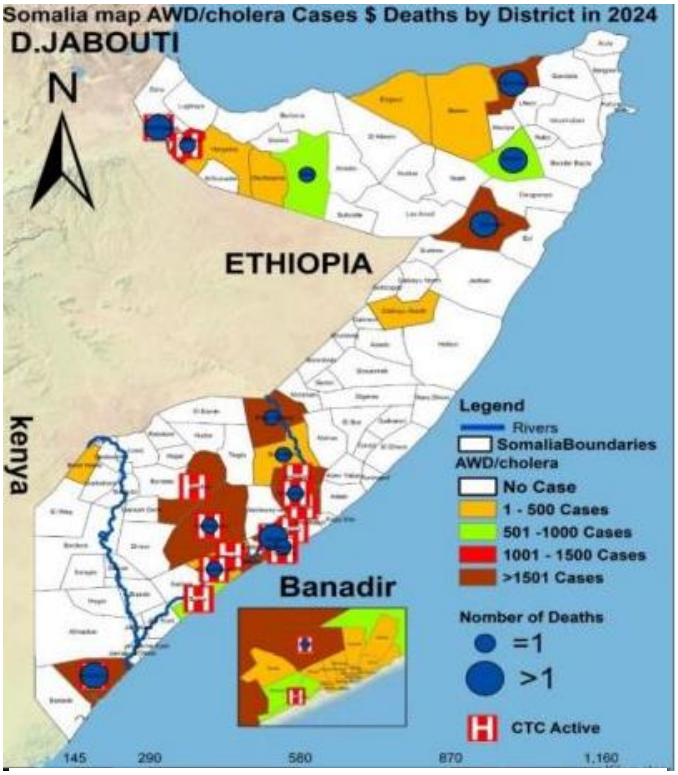

Figure 1: AWD/Cholera affected locations in Somalia 2024[1]

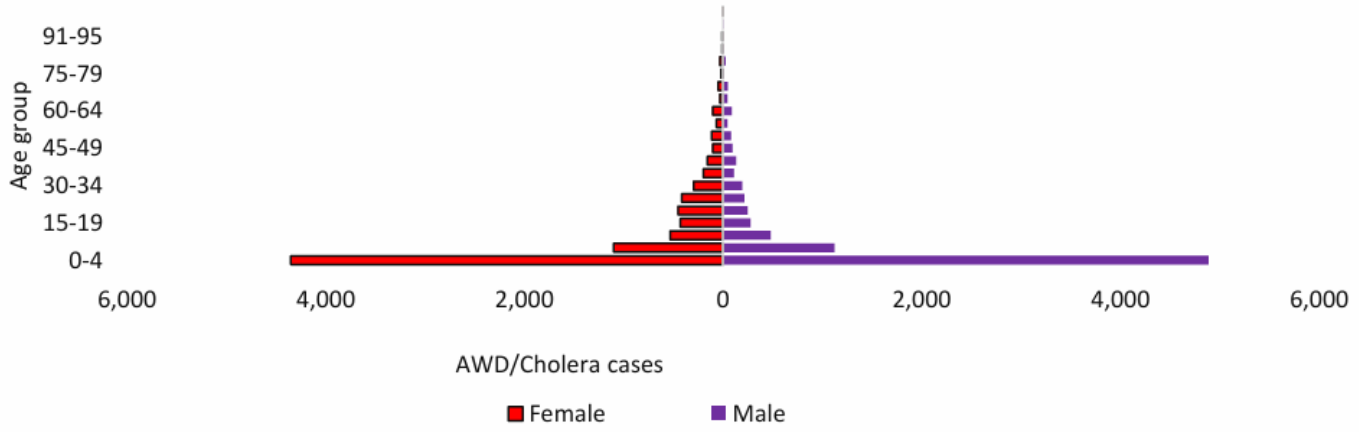

Figure 2: Distribution of AWD/Cholera cases by age and gender in Somalia 2024[1]

MOHD HMIS Data on AWD/Cholera from 2017-2024										
Region	**Districts**	**2017**	**2018**	**2019**	**2020**	**2021**	**2022**	**2023**	**2024**	**Total**
Sool	Ainabo District	543	646	2,527	1,752	2,885	4,432	1,257	2,551	16,593
	Taleeh District	4,388	3,651	2,262	1,916	1,215	1,240	238	0	14,910
	Laasaanod District	8,574	11,917	11,707	10,706	7,223	6,424	87	0	56,638
	Hudun District	964	4,097	2,583	2,048	1,507	1,505	106	0	12,810
	Sub-total	**14,469**	**20,311**	**19,079**	**16,422**	**12,830**	**13,601**	**1,688**	**2,551**	**100,951**
Marodijeh	Baligubadle District	1,348	2,348	2,954	2,170	2,034	2,582	799	1,464	15,699
	Gabiley District	1,817	3,447	3,777	5,293	7,208	10,693	3,836	7,442	43,513
	Hargeisa District	7,769	8,769	10,023	10,567	10,586	15,204	5,883	25,242	94,043
	Sub-total	**10,934**	**14,564**	**16,754**	**18,030**	**19,828**	**28,479**	**10,518**	**34,148**	**153,255**
Sanaag	Badhan District	1,012	873	3,113	1,886	1,966	3,372	1,349	3,259	16,830
	El-Afweyn District	905	729	1,427	1,118	1,102	2,111	757	1,606	9,755
	Erigavo District	5,083	4,581	6,746	7,800	6,663	7,750	3,122	7,713	49,458
	Garadag District	957	602	965	1,576	1,580	3,023	946	2,616	12,265
	Dhahar District	859	52	1,482	1,795	1,537	1,286	0	1,316	8,327
	Las-qoreh District	0	0	120	251	307	460	193	389	1,720
	Sub-total	**8,816**	**6,837**	**13,853**	**14,426**	**13,155**	**18,002**	**6,367**	**16,899**	**98,355**
Awdal	Zeila District	5,453	5,550	3,202	3,851	3,617	3,549	1,241	2,916	29,379
	Borama District	8,169	6,570	7,488	8,155	8,205	9,959	3,569	7,021	59,136
	Lughaya District	2,962	2,678	1,957	3,982	3,262	3,418	930	1,487	20,676
	Baki District	3,467	2,738	3,210	5,305	4,726	4,057	1,382	3,010	27,895
	Sub-total	**20,051**	**17,536**	**15,857**	**21,293**	**19,810**	**20,983**	**7,122**	**14,434**	**137,086**
Sahil	Sheikh District	2,329	2,685	3,028	2,738	3,106	3,435	1,394	1,557	20,272
	Berbera District	7,683	9,110	8,578	8,480	7,929	8,590	2,613	3,923	56,906
	Sub-total	**10,012**	**11,795**	**11,606**	**11,218**	**11,035**	**12,025**	**4,007**	**5,480**	**77,178**
Togdheer	Buhodle District	2,629	7,960	6,707	8,296	9,655	10,025	4,084	883	50,239
	Buroa District	7,026	8,021	15,378	11,370	14,834	23,235	6,226	13,247	99,337
	Odweine District	1,765	1,805	4,165	3,112	3,549	6,693	1,999	3,819	26,907
	Sub-total	**11,420**	**17,786**	**26,250**	**22,778**	**28,038**	**39,953**	**12,309**	**17,949**	**176,483**

Table 1: HMIS data on AWD/Cholera in Somaliland from 2017-2024[1]

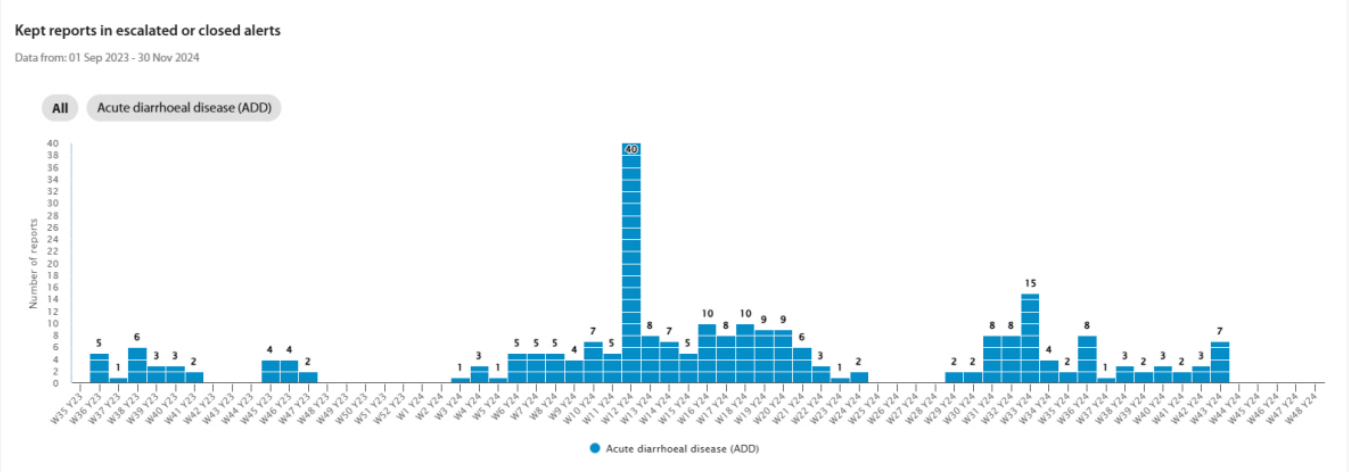

Figure 3: Distribution of true ADD signals from CBS reports in Awdal region epi week 35, 2023 to epi week 48, 2024[1]

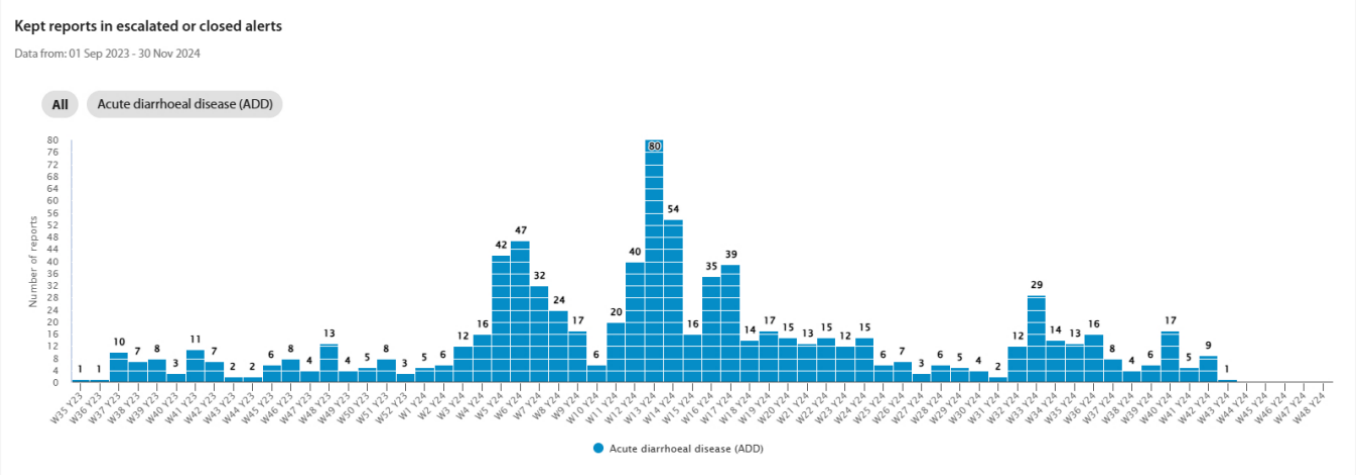

Figure 5: Distribution of true ADD signals from CBS reports in Marodije region epi week 35, 2023 to epi week 48, 2024

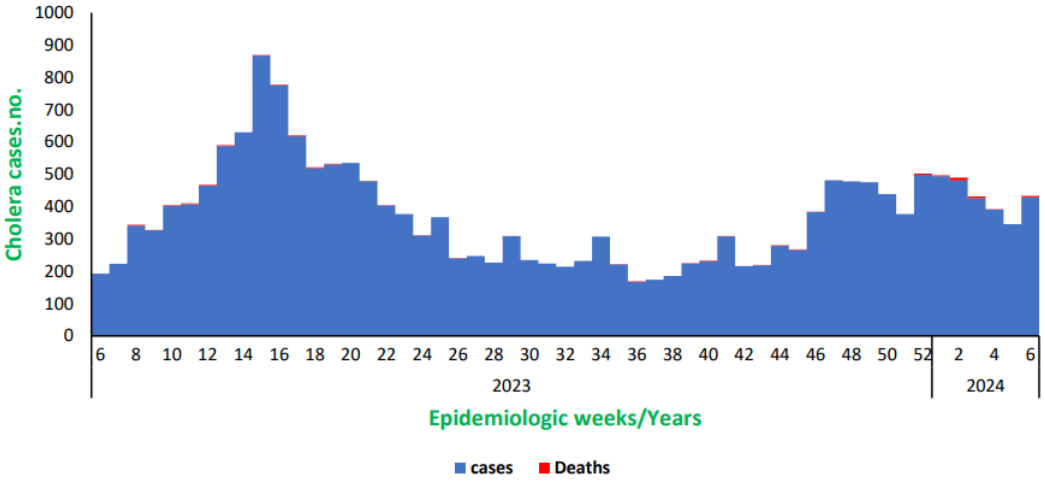

Figure 4: Trends of AWD/Cholera cases in Somalia 2023-2024[1]

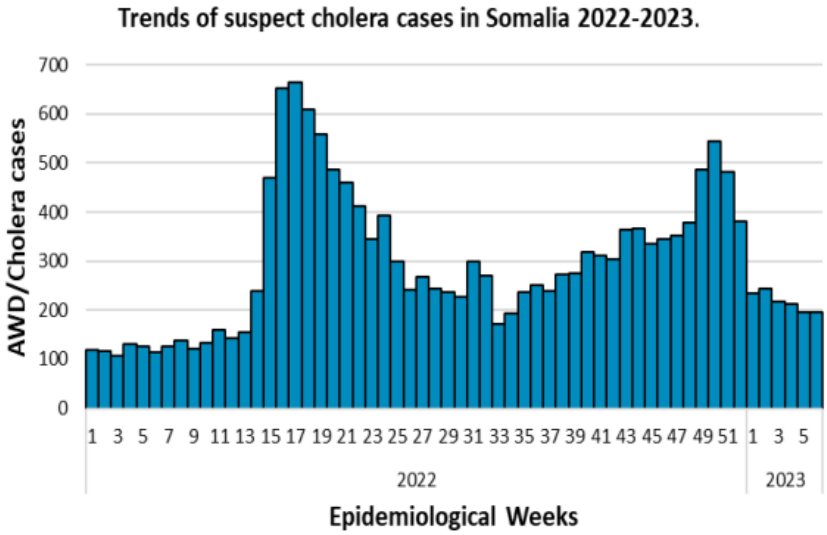

Figure 5: Epidemiological curve for Cholera in Somalia 2022-2023

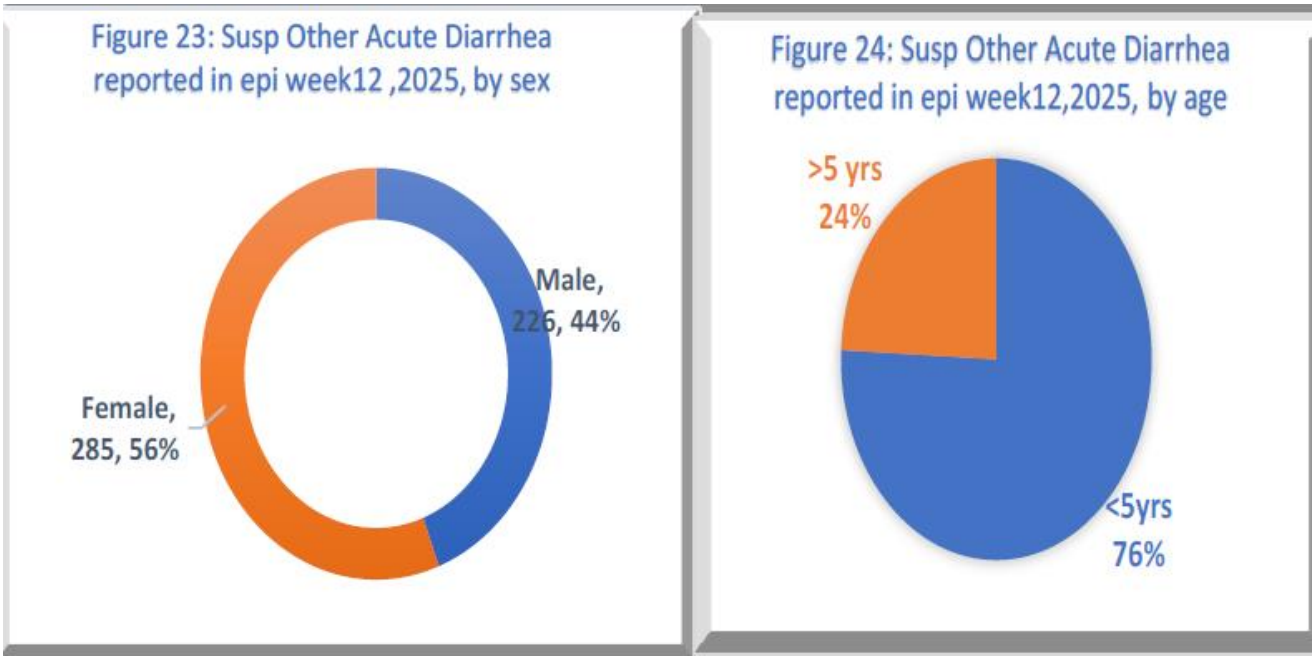

Figure 6: MoHD HMIS_ Surveillance weekly Bulletin as of Epi-Week 12 (date: 17th- March 23rd March- 2025): Chart showing new cases in epi WK 12, 2025 by sex and age