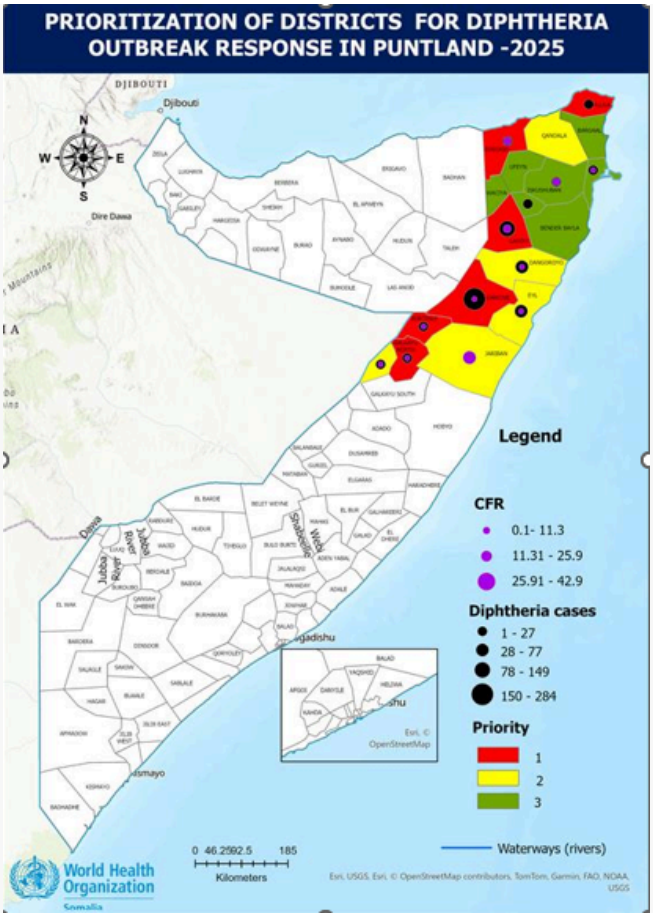
DREF Operational Update

Somalia - Diphtheria Outbreak

SRCS deployed mobile health teams and launched diphtheria vaccination drives

Appeal: **MDRSO024**	Total DREF Allocation: **CHF 499,911**	Crisis Category: **Yellow**	Hazard: **Epidemic**
Glide Number: **-**	People Affected: **682,300 people**	People Targeted: **590,000 people**	
Event Onset: **Slow**	Operation Start Date: **07-08-2025**	New Operational End Date: **28-02-2026**	Total Operating Timeframe: **6 months**
Reporting Timeframe Start Date: **07-08-2025**		Reporting Timeframe End Date: **15-09-2025**	
Additional Allocation Requested: **123,355**		Targeted Regions: **Bari, Mudug, Sanaag, Sool**	

Description of the Event



DIPHTERIA AFFECTED AREAS IN PUNTLAND - 2025

Date when the trigger was met

07-09-2025

What happened, where and when?

Somalia is facing a sharp surge in diphtheria cases. The Ministry of Health confirmed more than 1,600 cases and 87 deaths have been reported so far in 2025, alone, nearly double the total number of cases reported in 2024.

In Puntland

As of July 2025, Puntland regions of Mudug, Nugal and Bari were grappling with a sustained and intensifying diphtheria outbreak. The disease, a highly contagious yet vaccine-preventable illness, continues to spread at alarming rates, placing an immense strain on Puntland's already overstretched healthcare system. By September 2025, for the Epic week37, a total of 27 new suspected cases, with 2 death have been reported in wk37. Since January 2025 (Week 1), there have been 1054 suspect cases and 42 deaths, with a case fatality rate (CFR) of 4% have been reported.

These high mortality rates point to serious gaps in clinical care and limited access to diphtheria antitoxin, highlighting the urgent need for strengthened case management and timely treatment availability.

Transmission trends between January and May 2025 revealed a worrying trajectory, with suspected cases surging by 18.2% compared to the previous epidemiological week at one point. Cases were reported consistently over 27 weeks, with notable peaks. The highest number of suspected cases occurred in week 27 with 50 cases, followed by weeks 25 and 17 with 30 cases each, and the latest week 37, which reported 27 new cases. The reduction in cases is attributed to the deployment of mobile health teams, who have been providing routine immunization in these hotspot areas.

The current crisis is rooted in events dating back to January 2023, when Puntland first began experiencing a resurgence of diphtheria. The outbreak was initially detected after a suspected case referred from south-central Somalia was admitted to Mudug Referral Hospital, followed by the death of another child in the same week. That same year, suspected cases also emerged in the Bari and Sanag regions. Throughout 2024, the outbreak gradually expanded, with confirmed cases appearing in Nugal, especially within Garowe's internally displaced persons (IDPs) camps and host communities alike.

In Somaliland

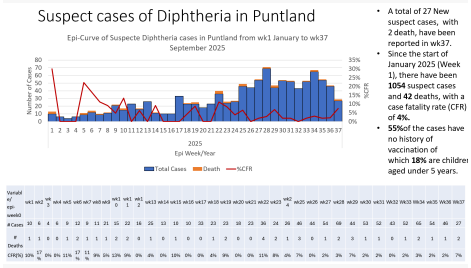
The Ministry of Health Development (MoHD) has officially declared a diphtheria outbreak in the Sanaag regions, which is placing a considerable burden on both affected communities and the health system. Epidemiological surveillance by the MoHD indicated a concerning upward trend in diphtheria cases, with the Sanaag region reporting 18 suspected cases and 3 deaths as of August 27, 2025, reflecting a high case fatality rate of 16.7%. Further assessments conducted by SRCS staff and volunteers identified 20 suspected cases with 2 deaths in the Sanaag region, corresponding to a CFR of 10%, while the SRCS Lasanod branch reported 30 suspected cases with 1 death in the Sool region, equivalent to a CFR of 3.3%.

The outbreak has exposed severe gaps in Somalia's routine immunization coverage, leaving many children vulnerable to diphtheria, measles, and pertussis. The reduction of humanitarian funding have further weakened the country's fragile health system. With fewer resources for vaccination campaigns, medical supplies, and mobile health teams, children remain unprotected while vaccine shortages and poor health infrastructure fuel a rapid rise in cases. Without urgent, sustained intervention, the outbreak's impact will continue to escalate nationwide.

The new hotspots areas in Sool and Sanaag regions calls for an urgent scale up of response activities. In this context, the Somali Red Crescent Society, with support from IFRC, will initiate a request for an additional DREF fund allocation to scale up the deployment of the additional mobile health teams conduct rapid roll out Diphtheria vaccination campaign, expand risk communication and community engagement activities. This operational scale-up is essential to contain the spread Diphtheria outbreak and prevent the emergence of new hotspots in surrounding areas.

SRCS Mobile Health Teams conducting Vaccination Campaings

Volunteers trained in eCBHFA, CBS, and diphtheria awareness to boost response



Epic surveillance date in Puntland

Scope and Scale

The diphtheria outbreak in Puntland, peaking between January and June 2025, has caused severe and multifaceted impacts on the health sector, livelihoods, community well-being, and public infrastructure, with 1,054 suspected cares confirmed cases and 42 deaths reported by the 37th Epi-week with a case fatality rate (CFR) of 4%. Schools and IDP camps have emerged as major transmission zones due to high population movement, overcrowding, and low vaccination coverage, with 65% of cases occurring among unvaccinated individuals and 24% among children under five, highlighting critical immunization gaps among the most vulnerable.

As of September 2025, new hotspots have been identified in Somaliland, particularly in the Sool and Sanaag regions, with 50 suspected cases and 3 deaths documented, indicating that the outbreak from Puntland's Bari and Nugaal regions is spreading into neighboring areas.

The most severely affected populations include internally displaced persons (IDPs), pastoralist families, children under five, pregnant women, and the elderly. These groups often live in overcrowded IDP camps, informal settlements, and marginal rural areas, where access to healthcare is either extremely limited or entirely absent. Historical patterns of displacement caused by conflict and climate shocks such as droughts and floods have concentrated vulnerability among these populations. The situation is further exacerbated by the repeated collapse of mobile health services, including SRCS teams, and reduced functionality of existing health facilities. Currently, 125 health facilities face funding gaps, particularly in Mudug and Bari regions, while 40 facilities in Sool and Sanaag regions also struggle with inadequate resources, magnifying health risks for these already vulnerable communities.

People with disabilities, chronic illnesses, and single-headed households particularly female-headed households face compounded barriers due to mobility limitations and reduced access to timely health information. The temporary closure of Qur'an schools and other learning institutions, while necessary for containment, also interrupts education and safe spaces for children, contributing to increased psychosocial stress among families.

Puntland and Somaliland health systems are now severely strained. Supply chains for vaccines and the cold chain system are disrupted due to funding gaps, leading to immunization outreach interruptions. Laboratory testing capacity remains limited to a single referral center. The outbreak has rendered the SRCS's currently functioning 11 fixed clinics in Puntland and 9 fixed clinics in Somaliland insufficient to cope with the rising caseloads in the affected areas.

Data are derived from SRCS surveillance reports, Ministry of Health epidemiological updates, referral laboratory confirmations, and Epi-week tracking systems. The involvement of WHO and active coordination with health cluster partners enhances data credibility and

enables transparent planning.
The situation remains dynamic, requiring a scale-up of surveillance, case management, and risk communication to contain the outbreak and protect vulnerable populations. These developments highlight the immediate need for intensified vaccination campaigns, strengthened surveillance and case management in high-risk areas, and coordinated cross-regional efforts to prevent further transmission.

Source Information

Source Name	Source Link
1. Disease Surveillance Report - Puntland	https://ifrcorg-my.sharepoint.com/:b:/g/personal/gemechissa_mustefa_ifrc_org/EbJABRBtIZJJr7CaWda04qIB7oJBvc7G9BpEvKXElwdj3Q?email=gemechissa.mustefa%40ifrc.org&e=L9H1dS
2. Urgent Appeal from MoH	https://ifrcorg-my.sharepoint.com/:b:/g/personal/gemechissa_mustefa_ifrc_org/EciUO7o3lChCk8hGfVEaHUcB_R1TijQmI3ytsGtEcYqYCA?email=gemechissa.mustefa%40ifrc.org&e=NWrPfv
3. SRCS Assessment Report	https://ifrcorg-my.sharepoint.com/:b:/g/personal/gemechissa_mustefa_ifrc_org/ETrWeEJweJdGj6VADtYuzSQBe73ZNbKDNbLbphjdac4vAg?email=gemechissa.mustefa%40ifrc.org&e=5nrAke

Summary of Changes

Are you changing the timeframe of the operation	No
Are you changing the operational strategy	Yes
Are you changing the target population of the operation	Yes
Are you changing the geographical location	Yes
Are you making changes to the budget	Yes
Are you requesting an additional allocation?	Yes

Please explain the summary of changes and justification:

The Diphtheria outbreak cases have been steadily increasing, with new hotspots emerging in Badhan and Boocame districts in the Sanaag and Sool regions. On 07 September, the Ministry of Health Development in Somaliland issued a letter declaring the Diphtheria outbreak and requesting humanitarian partners to respond, including implementing a vaccination campaign to curb the disease.

In response, the Somali Red Crescent Society has requested support to expand activities in health, hygiene promotion activities in these regions. The operational strategy has been updated to specifically address the outbreak in these newly affected areas, including deploying mobile health teams to deliver comprehensive, high-quality health care services to children, women, and the wider population. The health services providing by the mobile health teams will include routine immunizations, nutrition screenings, and maternal health care, such as antenatal check-ups, postnatal care, and delivery support. Teams will also engage communities in awareness-raising activities on preventing vaccine-preventable diseases, promoting infant and young child feeding (IYCF) practices, maternal and child nutrition education, and appropriate hygiene practices to reduce the risk of malnutrition and related diseases among populations most vulnerable to Diphtheria.

The geographical expansion and increased deployment of mobile health teams will raise the target population to 590,000 people through health and hygiene promotion activities, PGI, and CEA interventions.

IFRC Network Actions Related To The Current Event

Secretariat	International Federation of Red Cross and Red Crescent Societies (IFRC) maintains offices in both Garowe and Hargeisa, with staff from the Nairobi cluster stationed between the two locations in Garowe and in Hargeisa. This includes a WASH delegate, and two Operations Officers. These in turn are supported by the Nairobi Cluster office with dedicated logistics, finance, communication, PMER and SPRM support. IFRC has supported SRCS in the development of the DREF request and will continue to provide technical assistance for the planned intervention.
Participating National Societies	On July 2, 2025, the SRCS convened an urgent coordination meeting with its Movement partners to discuss the escalating diphtheria outbreak in Puntland, assess operational needs and gaps, and align support efforts. During the meeting, several Partner National Societies (PNS) expressed their commitment to supporting the SRCS response. The Norwegian Red Cross pledged USD 43,000 to fund a clinic catchment vaccination campaign across six clinics in Puntland four located in Mudug province and two in Bari province. The Finnish Red Cross committed USD 6,000 to support a similar campaign at Dangoroyo Clinic in Nugal province. These contributions are aimed at strengthening immunization coverage in high-risk areas and reducing transmission among vulnerable populations. PNS are currently supporting the operation remotely, providing financial assistance and technical coordination through the SRCS Mogadishu Coordination Office. While no PNS are physically present on the ground in Puntland at this time, their engagement through funding and strategic planning is critical to enabling SRCS to scale up its response.

ICRC Actions Related To The Current Event

The ICRC maintains a physical presence in both Garowe, Puntland, and Hargeisa, Somaliland, and continues to implement its regular programmatic activities in the region. However, to date, the ICRC has not made any formal commitment to support the ongoing diphtheria outbreak response. The National Society (NS) is planned to conduct a meeting with the ICRC and other Movement partners to coordinate assistance and strengthen collective efforts to contain the diphtheria outbreak.

Other Actors Actions Related To The Current Event

Government has requested international assistance	Yes
National authorities	Puntland A mass vaccination outreach campaign has been conducted over a period of 3 months in 118 health centers in the Mudug, Nugal, and Bari regions, covering all villages within their 5 km radical catchment areas. Similarly, the Ministry of Health scaled up the routine vaccination through the provision of sufficient vaccine supply at the clinic level across Puntland and raised the awareness of the communities in those areas and in the bigger towns as well. However, the gaps remain in the remote areas, which are beyond 5 km away from the clinics, due to the funding gap; the government doesn't have the ability to deploy mobile clinics to support vaccination campaigns in the remote communities where there are existing routine vaccination gaps. Somaliland On 10 September 2025, the Ministry of Health Development held an emergency meeting in response to the diphtheria outbreak in the Sool and Sanaag regions. During the meeting, the Ministry requested support for routine vaccination campaigns to assist the

	affected populations. The meeting was attended by representatives from the UN, international organizations, NGOs, and the Somali Red Crescent Society (SRCS) The Ministry of Health Development in Somaliland has established quarantine and care centers in the districts most affected by the diphtheria outbreak
UN or other actors	In Puntland UNICEF and WHO have taken active roles in supporting the government-led response to the diphtheria outbreak in Puntland. Both agencies are contributing to the ongoing clinic catchment outreach campaign, which is currently operational across all regions. In Puntland: In addition to supporting vaccination efforts, UNICEF and WHO are providing human resources to strengthen service delivery in government-run health facilities. They are also leading risk communication and community engagement (RCCE) activities to raise awareness and promote preventive behaviors within affected communities. Moreover, both agencies are supporting the cold chain system by ensuring the supply and distribution of vaccines, and are facilitating transportation mechanisms to enable the delivery of essential health services to remote and underserved areas. These coordinated efforts are critical in enhancing the reach and effectiveness of the outbreak response across all regions of Puntland. In addition to this, both agencies are providing critical support to government-run health facilities through the deployment of human resources, including healthcare personnel. Their contributions also include risk communication and community engagement (RCCE) activities within catchment areas to raise awareness and promote preventive behaviors. In Somaliland: WHO and UNICEF are supporting the cold chain systems by ensuring the and distribution of vaccines and are facilitating transportation mechanisms to enable the delivery of essential health services to remote and underserved areas.

Are there major coordination mechanism in place?

In Puntland
Coordination mechanisms in Puntland are well-established and involve multiple platforms to ensure effective response and collaboration among health and humanitarian actors. These include:
Health Cluster Meetings: Held monthly, these meetings provide a platform for health partners to exchange information, analyze gaps and challenges, and coordinate both ongoing and planned operations.
Ad-hoc Emergency Health Meetings: Led by the Ministry of Health, these are convened in response to public health emergencies to facilitate rapid decision-making and coordination.
Inter-Agency Coordination Meetings: Facilitated by UNOCHA, these meetings bring together sectoral actors to discuss response activities, identify gaps, and address challenges at the Puntland level.
Area-Based Coordination: Conducted jointly by UNOCHA and regional administrations, this mechanism focuses on monitoring hotspot areas and supporting regional authorities in managing localized operations.
Regional Health Ad-hoc Emergency Meetings: Coordinated by regional health officers, these meetings engage regional health partners and stakeholders to share updates, identify gaps, and plan next steps. They also serve as a tool for resource mobilization and advocacy.

In Somaliland
In Somaliland, the Ministry of Health Development plans to establish a regular coordination mechanism for responding to the diphtheria outbreak. Coordination meetings will be held as needed, with line ministers of Somaliland and UNOCHA coordinating to ensure accurate targeting and avoid duplication. Various clusters, particularly in health, are active, with NS and movement partners participating to share information on different sectoral approaches.
Regional Health Ad-hoc Emergency Meetings: Coordinated by regional health officers, these meetings engage regional health partners and stakeholders to share updates, identify gaps, and plan next steps. They also serve as a tool for resource mobilization and advocacy.

Needs (Gaps) Identified

Health

In Somalia, particularly in Puntland and Somaliland, significant health system gaps continue to hinder an effective response to diphtheria outbreaks, especially among vulnerable populations. A large number of zero-dose children ,those who have never received any routine immunizations are found in remote rural and pastoralist communities, notably in parts of Bari, Nugal, Mudug, Sool and Sanaag regions. These areas often suffer from insufficient health infrastructure, and families are highly mobile due to recurring climatic shocks, armed conflicts, and nomadic lifestyles, making consistent service delivery extremely difficult. Routine immunization services in these regions have been frequently interrupted by a combination of chronic underfunding, climate-related emergencies, and increased population movement. There is also poor continuity of care between the first and third doses of the pentavalent (Penta) vaccine, resulting in incomplete immunity among many children. This challenge is compounded by weak referral systems, especially in districts with minimal transportation infrastructure, where patients may not be referred in time for diagnosis or life-saving treatment. Stockouts of critical supplies, including Diphtheria Antitoxin (DAT) and essential antibiotics, are common in high-risk areas, particularly during disease surges. These shortages often lead to preventable complications and deaths, especially in remote health posts and mobile clinics. Additionally, many frontline health workers in Puntland lack the necessary training and clinical skills to effectively identify, isolate, and treat diphtheria cases. Infection prevention and control (IPC) practices are often inadequate due to limited supplies and insufficient understanding of transmission risks.

Meanwhile, community awareness remains low, with widespread misinformation, mistrust, and vaccine hesitancy, especially in underserved and conflict-affected areas. Local beliefs, rumors, and lack of engagement with trusted community leaders further reduce vaccine uptake. Puntland also lacks updated, diphtheria-specific outbreak preparedness and response plans, and health emergency response mechanisms remain severely underfunded, with minimal operational support for rapid response teams, case management, or community mobilization during outbreaks.

Addressing these systemic gaps is urgent to prevent further morbidity and mortality from diphtheria, particularly among children, IDPs, pastoralist families, pregnant women, the elderly, and people with disabilities, groups who are most likely to be affected due to their limited access to healthcare and heightened vulnerability.

Protection, Gender And Inclusion

Protection gaps during Diphtheria outbreak are often marked by the limited access to health services in the drought, armed conflict affected areas where vulnerable populations struggle to reach vaccination or treatment centers. Additionally, many villages who had functioning clinics have no active health care services at the moment as many of them were closed due to the recent funding cut leading to a huge health care gap in Puntland and Somaliland.

Gender-related challenges also undermine effective health responses. Health campaigns overlook gender dynamics, failing to consider that women are typically primary caregivers or that men's movement patterns may influence access, leading to reduced vaccine uptake. The underrepresentation of women in decision-making bodies such as health committees limits the inclusivity of outbreak responses.

Pregnant and lactating women face additional barriers, including fear of side effects and services that don't address their specific needs. On the other hand, gaps regarding inclusion persist for persons with disabilities who often encounter inaccessible health infrastructure and a lack of assistive communication tools. Ethnic and linguistic minorities and people who are just displaced from remote areas like Celmiskaat, which was in control of non-state actors for a number of years and had no experience of vaccination whatsoever, may also be marginalized or left out when the healthcare service is not provided in a culturally appropriate format or in a simple language that they understand resulting mistrust and misinformation. The absence of disaggregated data by age, gender, and disability hinders efforts to identify and support the most at-risk populations.

Community Engagement And Accountability

During the ongoing Diphtheria response in Somalia, initial feedback from communities in Bari, Mudug, and surrounding areas has highlighted significant gaps in information, communication, and community participation. Many community members expressed the need to better understand the roles of various actors involved in the response and to be more engaged in decisions affecting them, particularly in relation to access to services and preventive activities such as vaccination. This lack of engagement has contributed to mistrust. Moreover, when service delivery is delayed or inadequate for example, in the provision of vaccines or essential medical supplies

there is often little explanation or follow-up, and community perspectives are rarely incorporated into monitoring and evaluation efforts.

Health messages, particularly those related to Diphtheria and other vaccine-preventable diseases, are often poorly adapted to local languages and cultural contexts, reducing their clarity and effectiveness. Communities are rarely trained or empowered to conduct surveillance or report suspected cases, resulting in missed opportunities for early warning, especially among displaced or nomadic populations who are often excluded from outreach efforts. On the accountability side, there is a lack of safe and accessible channels for communities to voice concerns or complaints, while decision-making processes tend to be opaque, further contributing to mistrust.

The main needs identified in terms of community engagement and accountability include:
a) Clarify the role of Red Cross volunteers and partners involved in the response.
b) Strengthen localized communication through culturally appropriate messages, disseminated via reliable and accessible channels.
c) Promote community dialogue and feedback mechanisms, including through the green line and community committees
d) Support social cohesion by promoting inclusive messages and ensuring equitable access to services for all affected persons, including mobile or marginalized populations.

These priorities will help build community trust, promote meaningful participation, and ensure that the response to the epidemic is perceived as fair, appropriate, and rooted in community realities.

Operational Strategy

Overall objective of the operation

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

Operation strategy rationale

Operation strategy rationale remains focus on the same pillars as initially planned, just extending the capacity and resources deployment to the newly affected areas. This approach is aligned with the continued response efforts led by Government on the Diphtheria outbreak. The additional allocation from IFRC-DREF will enable the SRCS to scale up its action in support of efforts led by the national health authorities. The intervention will maintain an integrated approach focused on health, PGI as well as CEA.

1) Health:
To date, SRCS has progress well on the response in the Mudug and Bari initially affected areas. Branches have:
- Conducted a kick-off workshop with branch staff (last week of August 2025) to align on implementation, DREF financial reporting, and cash requests.
- Trained and deployed five integrated mobile health clinics (three in Mudug and two in Bari). These clinics provided comprehensive primary health care services to hard-to-reach communities, with three clinics deployed in the Mudug region and two in the Bari region. The mobile health teams reached over 86,000 people, and they are scheduled to operate for six months, delivering essential health care services throughout this period.
- SRCS mobile health teams utilized the existing prepositioned stock of essential drugs and medical supplies available in their warehouses while awaiting the internationally planned procurement of OPD kits through the IFRC Nairobi office. These supplies will be replenished through the DREF allocation to ensure uninterrupted service delivery and maintain preparedness for future interventions
- As part of the diphtheria outbreak response, SRCS implemented a range of community-focused activities. A total of 168 Community Health Volunteers (104 females and 64 males) were trained on enhanced Community-Based Health and First Aid (eCBHFA) and Community-Based Surveillance (CBS), with a special emphasis on raising awareness about diphtheria.

Building on this, SRCS will keep the same priorities and scale-up to newly affected areas.
- Scale up mobile health coverage by deploying five additional mobile clinics in Sool and Sanaag, raising the total to ten. These teams will expand services to immunization, nutrition screening, antenatal/postnatal care, and delivery support.
- In addition, the mobile health teams will engage communities in awareness-raising activities on the prevention of vaccine-preventable diseases, promotion of infant and young child feeding (IYCF) practices, maternal and child nutrition education, and hygiene practices to prevent malnutrition and related diseases, particularly among those most vulnerable to diphtheria.
- Strengthen case management. For case management, the mobile clinics will collaborate closely with the existing health infrastructure by referring suspected diphtheria cases to the nearest district hospitals during the operation.
- In regards to the expansion of the outbreak to newly affected areas, SRCS will train additional 100 additional community health

workers on Community-Based Health and First Aid (eCBHFA) and Community-Based Surveillance (CBS), with a special emphasis on raising awareness about diphtheria. These volunteers will extend the coverage for the awareness campaigns, ensuring to cover 90 additional community sessions on diphtheria outbreak response, focusing on prevention, early detection, and care-seeking behaviors. These RCCE activities will be carried out across in Bari, Mudug, Sool and Sanaag region to ensure community awareness, reduce misinformation, and strengthen local preparedness and response.

Community-Engagement and Accountability (CEA), and Protection Gender and Inclusion (PGI)
SRCS has so far achieved the following:
- A total of 150 volunteers involved in the operation were trained in feedback mechanisms. Since the beginning of the operation, seven meetings have already been held across all target communities, with the participation of some community leaders.
- The SRCS has established feedback systems to gather community opinions, suggestions, and complaints regarding the services and activities.
- All SRCS staff and volunteers involved in the operation were briefed and signed the Code of Conduct.
NS mapped and identified referral pathways through mobile clinics in collaboration with the Ministry of Health and the Ministry of Health Development.
- All Volunteers and staff were oriented on SRCS safeguarding policies, including Protection from Sexual Exploitation and Abuse (PSEA), for both volunteers and other stakeholders.

SRCS will scale up integrated Protection, Gender, and Inclusion (PGI) and Community Engagement and Accountability (CEA) interventions across the response, building on existing experience and structures. PGI will remain a cross-cutting priority, with a dedicated focal person ensuring the inclusion of vulnerable groups, strengthening GBV referral pathways with local partners, and supporting trained volunteers to raise awareness on SGBV and available services. At the same time, CEA will be embedded across all sectors, with communities actively engaged through feedback desks, hotlines, focus groups, and household visits to guide decision-making and enhance transparency. To boost vaccination coverage, SRCS mobile clinics and community volunteers will follow up with beneficiaries through reminders, tracing of defaulters, and linking displaced households to nearby facilities. In addition, 100 staff and volunteers will be trained on PGI and CEA to expand capacity and sustain quality implementation. These combined efforts will reinforce accountability, ensure timely access to protection services, and strengthen community trust and participation throughout the response.

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

Sustainability:
For sustainability, the exit strategy will focus on strengthening local capacities, fostering community partnerships, transferring knowledge through mobile health teams and volunteers, and ensuring continuity of care beyond the DREF period.

Community consultations and lessons-learned workshops will inform future responses, while regular coordination with national systems will support a smooth transition from emergency response to recovery and resilience-building.
The National Society is exploring a transition plan beyond the six-month DREF, with close linkage to the complex EA under discussion. If the outbreak continues, the complex EA would allow mobile health teams to keep providing essential services, while coordination with the Ministry of Health ensures alignment with national vaccination efforts. This approach aims to shift from immediate outbreak response to a more sustainable health and epidemic preparedness strategy, avoiding gaps once the DREF ends.

Targeting Strategy

Who will be targeted through this operation?

This operation targets 590,000 people (98,333 families) who are at risk to the diphtheria outbreak in Puntland and Somaliland particularly in Mudug, Bari, Sool and Sanaag provinces. Given the presence of functioning health clinics and the extensive outreach campaigns currently supported by the Damal Caafimaad government-led project, SRCS will focus its diphtheria response operations exclusively in Bari, Mudug, Sool and Sanaag provinces, targeting remote areas and villages lacking health infrastructure. This intervention will target population at risk in affected areas with interventions including risk communication and community engagement through radio broadcasting, community sessions, house to house visitations and OPD services. The vaccination campaign during this outbreak response will be targeting children under 14 years in the effected and at-risk communities.

This intervention will target the estimated population at risk in affected areas with interventions including risk communication and

community engagement through radio broadcasting, community sessions, house to house visitations and OPD services. The vaccination campaign during this outbreak response will be targeting children under 14 years in the effected and at-risk communities.

Explain the selection criteria for the targeted population

The targeting strategy for this operation is based on a needs-based approach, prioritizing the worst-affected districts and villages in Puntland and Somaliland. These areas have been identified as either already deeply affected by the diphtheria outbreak where schools have been forced to close or as areas where the outbreak is rapidly increasing.

The operation specifically targets communities experiencing the highest levels of disease prevalence and vulnerability, with particular emphasis on populations in locations where health care services are active but overstretched. A gap analysis will be conducted to map existing interventions, identify underserved areas, and ensure resources are directed to communities with the least access to services, thereby avoiding duplication and maximizing impact.

In the Somaliland and Puntland context, the selection criteria will take into account:
- Geographic disparities: Remote rural and nomadic populations often lack reliable health infrastructure and are less likely to benefit from ongoing health interventions.
- Socioeconomic vulnerabilities: Poor households and marginalized groups are disproportionately affected due to limited resources for preventive measures and care-seeking.
- Health system capacity: Areas with weak surveillance and low vaccination coverage will be prioritized to contain the outbreak and prevent further spread.
- Cross-border mobility: Given the movement of people, especially pastoral communities, targeting will also focus on high-transit areas that pose a risk for further transmission.

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

Total Targeted Population

Women	**182,251**	Rural	**0.4%**
Girls (under 18)	**142,249**	Urban	**0.6%**
Men	**143,769**	People with disabilities (estimated)	**0%**
Boys (under 18)	**121,731**		
Total targeted population	590,000		

Risk and Security Considerations (including "management")

Does your National Society have anti-fraud and corruption policy?	**Yes**
Does your National Society have prevention of sexual exploitation and abuse policy?	**Yes**
Does your National Society have child protection/child safeguarding policy?	**Yes**
Does your National Society have whistleblower protection policy?	**Yes**
Does your National Society have anti-sexual harassment policy?	**Yes**

Please analyse and indicate potential risks for this operation, its root causes and mitigation actions.

Risk	Mitigation action
Negative perceptions of relief efforts and health care delivery through the mobile clinics may arise due to unmet expectations or perceived inequities.	Maintain open communication channels. Conduct satisfaction surveys. Implement community grievance redress mechanisms.
Corruption and fraud continue to pose a risk in humanitarian activities.	SRCS will develop a communication plan to inform the communities on all aspects of the project and sensitize them on the need to prevent corruption. Communities will be informed of their entitlement and notified that assistance is provided free of charge, where they will not be required to pay anything in order to access assistance. Communities will also be notified of existing mechanisms to report in case they experience corruption of any kind suspected or actual.
The security environment in Somalia remains complex and volatile, with varying levels of risk across regions.	Continuous risk assessments will be conducted in coordination with the IFRC Security Unit, ICRC, and local partners to stay informed about evolving threats. As indicated, Minimum Security Regulations will be followed for the responders and as part of the general administration of the involved branches.
Community needs may exceed the capacity of this operation as the drought situation deteriorates, particularly this time where humanitarian aid is facing funding gap due to the effect USAID funding halt.	SRCS will advocate for more humanitarian assistance as necessary to partner organizations to meet the unmet needs.

Please indicate any security and safety concerns for this operation:

In Puntland, the Islamic State (ISIS) has maintained a presence, particularly in the Cal Miskaad and Golis Mountains of the Bari region. However, recent months have seen intensified counterterrorism operations by Puntland security forces, supported by international partners.

To reduce the risk of RCRC personnel falling victim to conflict, crime, extremism, health, and road hazards, active risk mitigation measures must be adopted. Security orientation and briefing for all teams prior to deployment should be undertaken to help ensure the safety and security of response teams.

Standard security protocols about general norms, cultural sensitivity, and an overall code of conduct should be put in place. Minimum security requirements will be strictly maintained. Personnel must have insurance. Minimum security equipment required: functional satellite phones, communication tools, advanced first aid kits, PPE kits, hibernation stocks, safe accommodation, and fully kitted vehicles.

Movement should be undertaken after road assessments. All NS and IFRC personnel actively involved in the operations must successfully complete, prior to deployment, the respective IFRC security e-learning courses (i.e., Level 1 Fundamentals, Level 2 Personal and Volunteer Security, and Level 3 Security for Managers). The IFRC security plans will be applicable to all IFRC staff throughout the operation. Area-specific security risk assessments will be conducted for any operational location where IFRC personnel are deployed, with appropriate risk mitigation measures identified and implemented.

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

Planned Intervention

Health

Budget: CHF 360,604

Targeted Persons: 590,000
Targeted Male: -
Targeted Female: -

Indicators

Title	Target	Actual
# of health staff trained on clinical management of Diphtheria	10	168
# of emergency mobile clinics deployed	10	5
# of health promotion campaigns conducted on the prevention and control of diphtheria in the targeted communities.	10	3
# of community sessions organized to deliver RCCE in the diphtheria response	56	12
# of people reached by mobile health teams with essential health services, including immunization.	590,000	86,000

Progress Towards Outcome

The Ministry of Health (MoH) and the Somali Red Crescent Society (SRCS) have undertaken a joint assessment of the Expanded Programme on Immunization (EPI) and current outreach services to identify gaps, evaluate community engagement, address discrepancies between target populations and achievements, and develop solutions to existing challenges. In response to diphtheria outbreaks and to expand access to primary healthcare, SRCS deployed five integrated mobile health clinics three in Mudug and two in Bari regions. Mobile health teams in these regions received training in psychosocial support and basic first aid, with 15 staff trained in Mudug (10 women, 5 men) and 10 in Bari (8 women, 2 men). Additionally, 168 Community Health Volunteers (CHVs) were trained on Enhanced Community-Based Health and First Aid (eCBHFA) and Community-Based Surveillance (CBS) with a focus on diphtheria awareness, including 132 in Mudug (74 women, 58 men) and 36 in Bari (30 women, 6 men), strengthening community capacity to detect, prevent, and respond to health risks. A total of 86,000 people were reached by mobile health teams with essential health services, including immunization.

Going forward, SRCS will give the priority to the same health intervention pillars identified during the initial planning. The main actions pending or to be implemented/scaled-up include:

1) Mobile health clinic maintained and coverage to be scaled-up to new affected areas
Scale up mobile health coverage by deploying 5 additional mobile clinics in Sool and Sanaag, raising the total to 10. These teams will expand services to immunization, nutrition screening, antenatal/postnatal care, and delivery support.

2) Health prevention continuous efforts and extension to new affected areas
Intensify community health promotion, covering prevention of vaccine-preventable diseases, IYCF practices, maternal-child nutrition, and hygiene promotion. Target for this activity is revised from 508,844 people to 590000 people. At least 90 visits/sessions to be covered by the volunteers across the affected areas to reach the maximum number of people. The default messages will permanently been deliver by volunteers. Include: promotion of diphtheria prevention, early detection, care-seeking behaviors. Local community systems are being evaluate and used/leverage to reach more people. The feedback collected from community meetings will orient on the best approach and the key priority messages to emphasize on.

- Intensify community health promotion, covering prevention of vaccine-preventable diseases, IYCF practices, maternal-child nutrition, and hygiene promotion.

3) Case management is maintained and extended to new affected areas.
Strengthen case management by formalizing referral pathways to district hospitals for suspected diphtheria cases.

1) RCCE
- Additional 44 RCCE sessions to be organized as 12 are now completed. The additional sessions will cover priority areas such Bari,

Mudug, Sool, and Sanaag to promote diphtheria prevention, early detection, and care-seeking behaviors.
- Train an additional 100 CHWs in eCBHFA and CBS to broaden surveillance and awareness.

Protection, Gender And Inclusion

Budget: CHF 9,386
Targeted Persons: 590,000
Targeted Male: -
Targeted Female: -

Indicators

Title	Target	Actual
# of volunteers trained on PGI awareness raising on issues of violence, discrimination and exclusion	250	150
# IEC gender sensitive materials printed and distributed for PGI awareness	500	0
Conducting PGI assessment	1	0
% of community sessions/messages delivered with gender sensitive approach	100	100
Add # of people reached with awareness sessions on PGI to stakeholders	590,000	86,000

Progress Towards Outcome

- All SRCS Staff and volunteers involved the operation were briefed and signed the Code of Conduct
_ The SRCS mapped and identified referral pathways through mobile clinics in collaboration with the Ministry of Health.
During the reporting period, several key Protection, Gender and Inclusion (PGI) indicators were partially achieved. A total of 150 volunteers were trained on PGI awareness-raising around issues of violence, discrimination, and exclusion. No IEC gender-sensitive materials were printed or distributed against the target of 500, and the planned PGI assessment was not conducted and will be reported in the final report. 100% of community sessions and messages were delivered using a gender-sensitive approach, fully meeting the target. Awareness sessions on PGI reached 86,000 people, out of the intended 590,000 people.

SRCS continued to strengthen PGI as a cross-cutting priority with a focal person ensuring inclusion of vulnerable groups. Following the referral pathways identification and briefings conducted for the response team on PGI minimum standards, NS will keep the priorities as follows for the coming months:
- Reinforce GBV referral pathways in coordination with local partners.
- Scale up awareness-raising on SGBV and access to services through trained volunteers. 500 IEC material to be printed to support the awareness raising.
- Train 100 more staff and volunteers in PGI and CEA to expand capacity in newly affected areas were we aim to extend the intervention.

Community Engagement And Accountability

Budget: CHF 8,095
Targeted Persons: 508,844
Targeted Male: -
Targeted Female: -

Indicators

Title	Target	Actual
# of the volunteers trained on Community engagement and accountability	250	150
% of complaints or feedback about the DREF operation which receive a response through established community communication	85	90
#of Community Engagement and Accountability (CEA) training conducted	2	1

Progress Towards Outcome

A total of 150 volunteers involved in the operation were trained on feedback mechanisms. Since the beginning of the operation, 7 meetings have already been held across all target communities, with the participation of some community leaders.
The SRCS has established feedback systems to gather community opinions, suggestions, and complaints regarding the services and activities. These feedback have been collected through direct visits, group/community meetings (07 held so far).
During the reporting period, 90 % of complaints or feedback related to the DREF operation received a response through established community communication channels, surpassing the target of 85 %. One Community Engagement and Accountability (CEA) training session was conducted out of the planned two, achieving 50 % of the target.
Planned efforts ahead include:
- Maintaining the feedback systems and ensure consolidate reports of community feedbacks inform the intervention priorities, approaches and design.
- Embed CEA in all interventions, including feedback desks, hotlines, focus groups, and household visits.
- Ensure transparency and trust-building through continuous community consultation.
- Support vaccination coverage through reminder systems, tracing defaulters, and linking displaced households to facilities.

Secretariat Services

Budget: CHF 52,490
Targeted Persons: 4
Targeted Male: -
Targeted Female: -

Indicators

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

Progress Towards Outcome

The IFRC provided significant support to the Somali Red Crescent Society (SRCS) in launching and scaling up the Diphtheria DREF response. The IFRC procurement and logistics teams assisting the National Society with the international procurement of ODP kits, while the WASH Delegate based in Hargeisa supporting the overall DREF implementation. The Security Delegate is providing the NS with guidance on the security situation. The IFRC also supporting the NS with resource mobilization and coordination through cluster delegation, while the Finance, PMERL, and Communications teams are supporting the NS remotely to ensure compliance with DREF guidelines.

National Society Strengthening

Budget: CHF 69,336
Targeted Persons: 250
Targeted Male: -
Targeted Female: -

Indicators

Title	Target	Actual
# of trained staff and volunteers mobilize.	250	150
# of lessons learnt workshops conducted and report submitted to IFRC and partners	2	0
# of monitoring missions conducted by coordination offices	6	0

Progress Towards Outcome

- The SRCS conducted a project kick-off meeting with SRCS implementing branches to discuss the implementation timeframe and recent changes in the DREF cash requests and financial reports.
- A total of 150 volunteers were mobilized to support the operation.
- All Staff and volunteers mobilized the operation were briefed and signed the Code of Conduct and completed IFRC security e-learning courses (i.e., Stay Safe Personal Security)."

About Support Services

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

This DREF operation supported key roles within the National Society to ensure effective and high-quality implementation. A total of 150 volunteers were mobilized to carry out community-based activities, including awareness-raising, relief distribution, and grassroots-level monitoring. Additionally, 28 health professionals were mobilized and trained to operate emergency mobile clinics.
For the scale-up of the DREF operation, SRCS will mobilize an additional 100 volunteers to support the expansion of the diphtheria DREF operation in Sool and Sanaag regions. Another 25 health professionals will be mobilized to deploy new mobile health teams, along with 28 staff from the branches and 5 staff from the coordination office. The incentives and salaries contribution for all these roles are included in the operation's budget.
The response will be coordinated by the SRCS Health and Nutrition Director, with support from the Deputy Health Director, PMERL, PGI, and Operations Officer, who will provide technical guidance, operational coordination, and supervision of all field activities.
IFRC personnel based in Hargeisa and Garowe, including the WASH Delegate and logistics staff, will provide ongoing technical and operational support throughout the intervention.

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, SRCS volunteers reflect the gender, age and cultural diversity in the Somali context they're supporting.

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

The procurement of the OPD kits will be carried out internationally by the IFRC, and the procurement process has already been initiated. Meanwhile, SRCS is deploying mobile health teams that are currently utilizing the existing stock of drugs available in their warehouses. The DREF allocation will be used to replenish the supplies as they are consumed.

How will this operation be monitored?

The operations team and NS leadership will oversee all operational, implementation, monitoring and evaluation, and reporting aspects of the DREF implementation.
The operations team will work closely with the IFRC Nairobi Cluster Delegation Office and will be responsible for performance-based management systems and overall quality. DREF progress monthly progress update reports will be compiled by the National Society, informing the IFRC on the progress and challenges of the operation, along with a monitoring plan/indicator tracking table to map out, ensure the collection, and keep track of the key indicators.

Monitoring and supervision will be further reinforced through a minimum of monthly missions conducted by IFRC teams from both the field and the Cluster office. They will serve as critical touchpoints for operational review, technical support, financial reconciliation, and coordination with local stakeholders. This hands-on presence helps to ensure that implementation remains on track, responsive to evolving needs, and in line with humanitarian standards.

Central to the above approach is the deployment of dedicated IFRC and NS staff to provide technical and operational oversight. Key IFRC personnel including the WASH Delegate from the IFRC field office in Somalia, along with Logistics, PMER, Finance, and Communications staff from the Nairobi Cluster Office will support the intervention based on their respective levels of effort. This engagement ensures that each area of the operation benefits from specialized guidance and support.

Please briefly explain the National Societies communication strategy for this operation

1. Empowerment of Community-Based Volunteers:
The SRCS Community Health Program has an active network of trained volunteers within the community. Throughout the project, these volunteers received capacity-building support to conduct health education, basic screenings, and referrals. Post-project, they will continue to serve as a frontline resource for promoting community health, disease prevention, and early identification of medical needs.
2. Integration with the Ministry of Health Services:
Coordination with the Ministry of Health will be reinforced to ensure that fixed health facilities and community-based health workers are linked with the target population. This includes aligning referral pathways and service delivery mechanisms, so that clinics can absorb the caseload previously managed by the mobile clinic.

3. Referral Support through SRCS Ambulance Services:
The SRCS FAPHEC ambulance service at the Galkayo Branch will remain engaged to support medical referrals from the community to the nearest functioning healthcare facilities. This will help bridge access gaps and ensure timely treatment for critical cases even after the mobile clinic has been phased out.

4. Community Ownership and Local Engagement:
Community leaders and local health committees will be sensitized and engaged to take ownership of health promotion activities. Their continued involvement will be vital in mobilizing resources and coordinating local responses.

Contact Information

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

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