



United Nations

**CENTRAL
EMERGENCY
RESPONSE FUND**



A SOUND HUMANITARIAN INVESTMENT

**RESIDENT / HUMANITARIAN COORDINATOR
REPORT ON THE USE OF CERF FUNDS
ETHIOPIA
RAPID RESPONSE
DISEASE**

RESIDENT/HUMANITARIAN COORDINATOR

Mr. Eugene Owusu

REPORTING PROCESS AND CONSULTATION SUMMARY

- a. Please indicate when the After Action Review (AAR) was conducted and who participated.

The Ethiopia Humanitarian Country Team (HCT), in its November and December 2013 meetings, discussed the use of CERF Rapid and Under-Funded support. The forum noted not only the manner in which funds were distributed, those of allocation and “merit-based” interventions, but also the fact that this infusion of funding enabled critical programme coverage at a time of year when needs were highest. Furthermore, the HCT noted that CERF ensured immediate mobilization of resources to provide the seed money to instigate response and also spurred donors to provide additional contributions.

- b. Please confirm that the Resident Coordinator and/or Humanitarian Coordinator (RC/HC) Report was discussed in the Humanitarian and/or UN Country Team and by cluster/sector coordinators as outlined in the guidelines.

YES NO

WHO compiled the draft report and shared it with OCHA for review and clearance by the HC. The guidelines and components of reporting were shared with WHO prior to the compilation process.

- c. Was the final version of the RC/HC Report shared for review with in-country stakeholders as recommended in the guidelines (i.e. the CERF recipient agencies and their implementing partners, cluster/sector coordinators and members and relevant government counterparts)?

YES NO

The final draft compiled report was shared with WHO for clearance prior to review by the HC.

I. HUMANITARIAN CONTEXT

TABLE 1: EMERGENCY ALLOCATION OVERVIEW (US\$)		
Total amount required for the humanitarian response: 4,200,000		
Breakdown of total response funding received by source	Source	Amount
	CERF	1,255,769
	COMMON HUMANITARIAN FUND/ EMERGENCY RESPONSE FUND (if applicable)	-
	OTHER (bilateral/multilateral)	950,000
	TOTAL	2,205,769

TABLE 2: CERF EMERGENCY FUNDING BY ALLOCATION AND PROJECT (US\$)			
Allocation 1 – date of official submission: 30-May-13			
Agency	Project code	Cluster/Sector	Amount
WHO	13-WHO-036	Health	1,255,769
TOTAL			1,255,769

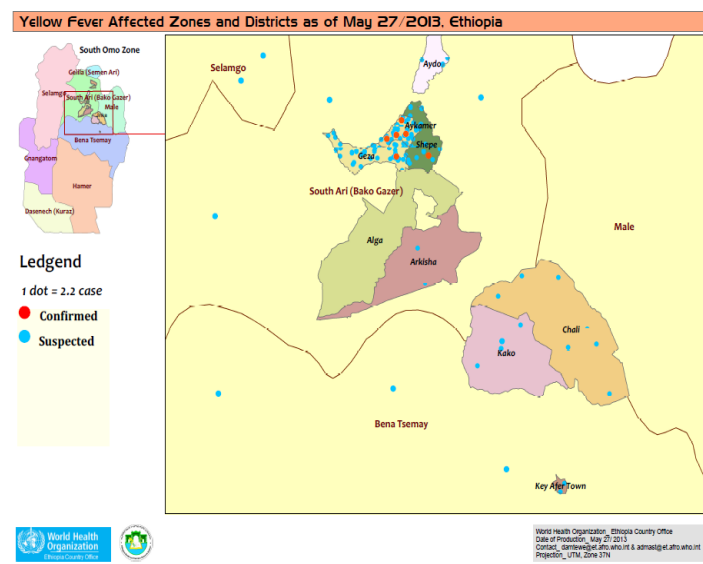
TABLE 3: BREAKDOWN OF CERF FUNDS BY TYPE OF IMPLEMENTATION MODALITY (US\$)	
Type of implementation modality	Amount
Direct UN agencies/IOM implementation	1,149,769
Funds forwarded to NGOs for implementation	0.00
Funds forwarded to government partners	106,000
TOTAL	1,255,769

HUMANITARIAN NEEDS

Geographically, Ethiopia lies in the so-called 'yellow fever belt', which ranges from 150N to 100S of the equator and includes 34 countries in Africa with a combined population of 468 million who are at risk. Yellow Fever (YF) has been on the rise in Africa, with an increase both in the number of cases reported and in the number of countries reporting cases (WHO, 2011). Cases also occurred in areas that had not confirmed cases in decades (Central African Republic, Chad, Congo, Liberia, Sierra Leone (WHO, 2010). Outbreaks of Yellow Fever in Kenya (1992–1993) and Sudan (2003 and 2005) are also important because each of these outbreaks have involved the re-emergence of a Yellow Fever Virus YFV genotype (East Africa) that remained undetected for nearly 40 years and was previously unconfirmed in a clinically apparent outbreak (Ellis and Barrett, 2008). These countries in the East African region which have had Yellow Fever outbreaks are either direct neighbor to Ethiopia and/or share similar ecologies with the country.

The actual rates of YFV transmission, YF disease, and case fatality are unknown, due to inherent and practical problems with surveillance of this complex disease, which is often asymptomatic or misdiagnosed (Staples et al., 2010), leading to underreporting of cases. It has been suggested that the true incidence of YF infection in Africa might be ten to fifty-fold higher than reported (WHO, 2008a).

In Ethiopia, available data shows the occurrence of last Yellow Fever outbreak in 1966, which recorded 100,000 cases with 30,000 deaths around the western part of the country. Thereafter, there were no subsequent cases that had been laboratory confirmed and there were no other outbreaks documented in the country.



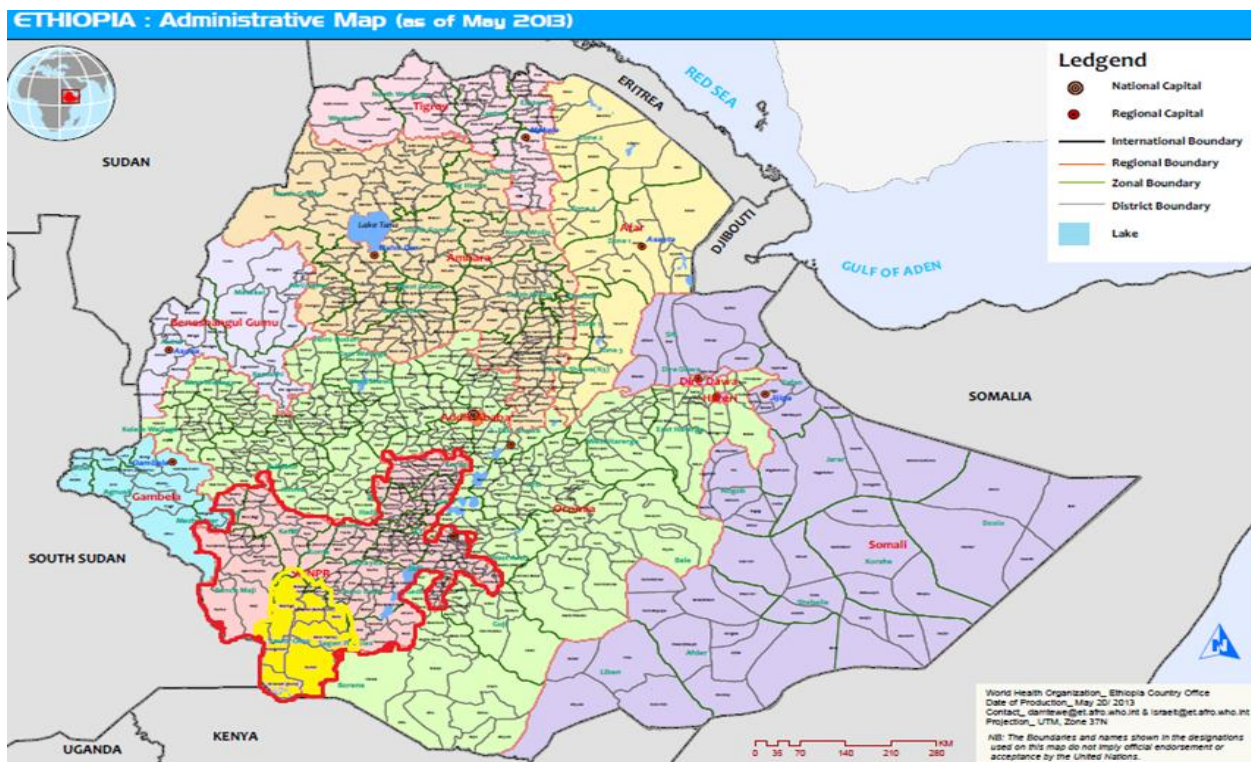
Yellow Fever outbreak was reported from South Ari district of South Omo zone in the Southern Nations and Nationalities Peoples Region (SNNPR) on 15 May 2013, following the confirmation of YF cases in WHO collaborating center in Dakar, Senegal, after two month of the index case. The laboratory result revealed six confirmed YF cases (one confirmed case is an outbreak by definition), which necessitated immediate response actions to timely respond and contain the outbreak at the local level with minimum morbidity and mortality. A total of 110 cases, with close to 40 cases, were reported in the week of May 20-26 from three woredas in South Omo (S. Ari, Bena Tsemay and Salamago). In addition, high level experts from Federal Ministry of Health(FMOH, Regional Health Bureau and WHO verified 39 reported deaths (CFR=35 per cent). The WHO/AFRO also sent team of experts (Epidemiologists and Entomologists) to conduct further outbreak investigation and verification of surveillance report in the affected Woredas.

Yellow Fever is a mosquito-borne severe acute viral infection of short duration and varying severity, characterized by acute onset of fever, chills, headache, and backache, generalized muscle pain, prostration, nausea and vomiting. Fifteen percent of the patients enter into toxic phase in ≤ 1 day of initial recovery and presenting with fever, jaundice, epistaxis, gingival bleeding, hematemesis (i.e., vomiting of blood, usually coffee-ground or black in color), Melina, and liver and renal failure. 20 to 50 per cent of jaundiced cases are fatal. There is no treatment that can cure the disease. Yellow Fever can be prevented through immunization with the 17D YF vaccine, which is safe, inexpensive and reliable.

Yellow fever is one of the notifiable diseases according to the International Health Regulation (2005) considering its transmissibility, causing massive outbreaks and high case fatality. Countries are required to report cases and deaths to WHO within 24 hours of being notified of a case of YF in their territory. The Ethiopian Ministry of Health has listed Yellow Fever as an immediately reportable disease and is monitoring the disease through the weekly disease surveillance reporting system.

WHO reports from the global alert response states that Yellow Fever can cause an epidemic affecting up to 20 per cent of the population, of those 5-20 per cent will enter the more toxic phase. When the epidemic occurs in unvaccinated population like the cases in S. Omo of SNNP Region, case fatality may exceed 50 per cent with a record of 35 percent in the current outbreak. Given the above projection, allowing the epidemic in South Omo zone of SNNP Region to take a natural course (without undertaking reactive vaccination), an estimate of 137,433 people (i.e. 20 per cent 687,164 people in the high risk Woredas of S. Omo) will be infected, between 6,872 and 27,487 (5 - 20 per cent of the infected population) will enter the toxic phase and between 3,436 and 13,744 people will die of the disease (50 per cent CFR). This is based on the immediate threat of the outbreak in only South Omo zone.

Basing the estimation on the previous attack, the impact of the current epidemic in neighbouring countries, the outbreak requires the initiation of urgent and robust control measures , which is the conduct of reactive vaccination, to minimize period of communicability and transmission of the disease to the wider population which are labelled to live in the high risk zones. The CERF funding is therefore needed urgently for responding to the Yellow Fever outbreak through the procurement of vaccine and initiation of timely reactive vaccination that can stop transmission in the population at high risk for exposure to the disease and minimize mortality.



II. FOCUS AREAS AND PRIORITIZATION

The proposal for Yellow Fever reactive vaccination campaign and surveillance strengthening focused on the South Omo zone in the Southern Nations and Nationalities Region (SNNPR). The intervention targeted close to 657,144 people in every age group of the affected zone.

The affected Zone shares borders with Southern Sudan and Kenya regionally and with the Oromia Region in-country. The borders are porous with a lot of social activities. This outbreak therefore had a very high potential of spreading both in-country and regionally.

III. CERF PROCESS

The issue was first raised and discussed at the Public Health Emergency Management PHEM technical taskforce and later communicated to the members of the command post at the FMOH as well as SNNP Regional Health Bureau Head. As per the guidance received from these levels, the proposal to implement the described activities were presented to Health, Population and Nutrition HPN groups, in May, 2013 which recognized Yellow fever as an emergency and in agreement with the necessity to respond to the outbreak in SNNPR.

It is also noted well in the prioritization process, the presence of risk factors (i.e. the presence of the Yellow Fever virus, Mosquito vector and vertebrate hosts in the country; favourable climatic conditions; large population of non-immune individuals) presumed to be responsible for the rapid spread of the infection and the outbreak to other woredas if a timely and urgent intervention is not instituted. Moreover, the presence of mega projects in the high risk woredas and the nature of the population which is highly mobile (predominantly pastoralist) are also considered as a contributing factors in the Zone which could easily fuel the transmission.

The Ethiopian Humanitarian Country Team (EHCT) also discussed the confirmed Yellow Fever outbreak in Ethiopia in its 16 May 2013 meeting and the need to mobilize immediate response. The CERF Rapid Response window was prioritized to access immediate funding. WHO informed partners that the response capacity of the country was significantly reduced due to the absence of confirmed presence of the disease since the past 35-40 years in Ethiopia.

The need for CERF funding was triggered by the recorded high case fatality rate due to the outbreak, high transmissibility of the disease, the absence of immunity in the population, the presence of favourable factors in the environment (the mosquito and the host vertebrate) and the absence of the disease in the community for the past 50 years requiring enhancing surveillance for timely detection

and the need for procurement of Yellow Fever vaccine for the rapid initiation of reactive vaccination that can ensure the rapid containment of the outbreak thereby minimizing morbidity and mortality.

The coordination process involved two levels of forums which include the cluster leads meeting whereby the WHO presented the issue for discussion after the application was approved and cleared by the FMOH at the Cluster taskforce meeting. The issue was also formally presented at the HCT meeting whereby the evolution of the outbreak, its impact and needs were presented. Based on discussions made at these forums and the presented fact related to the outbreak, the decision was made for allocation of Fund from CERF for the timely procurement of vaccine and medical supplies to ensure the rapid containment of the outbreak

IV. CERF RESULTS AND ADDED VALUE

TABLE 4: AFFECTED INDIVIDUALS AND REACHED DIRECT BENEFICIARIES BY SECTOR				
Total number of individuals affected by the crisis: 657,144				
The estimated total number of individuals directly supported through CERF funding by cluster/sector	Cluster/Sector	Female	Male	Total
	Health	335,143	322,001	657,144

BENEFICIARY ESTIMATION

The project aimed to protect a total of 657,144 people considered at high risk of contracting yellow fever, which has no cure and is spread by mosquitoes.

TABLE 5: PLANNED AND REACHED DIRECT BENEFICIARIES THROUGH CERF FUNDING		
	Planned	Estimated Reached
Female	335,143	335,143
Male	322,001	322,001
Total individuals (Female and male)	657,144	657,144
Of total, children <u>under</u> age 5	86,468	86,468

CERF RESULTS

The key outcomes of the project include Yellow Fever vaccination campaign with high quality and coverage (>90 per cent). The disease surveillance is also enhanced with high quality, meeting international standards. The total beneficiaries targeted were 657,144 for the surveillance and other control activities. The target beneficiaries for the vaccination were 607,973 leaving out children below the age of 9 months as they are not eligible for Yellow Fever vaccine because of the contraindication of vaccine administration with Measles vaccine. As a result, it was made possible to deliver the below major outcomes:

- Yellow Fever reactive vaccination campaign for 563,558 eligible individuals with high quality and coverage (92.7 per cent) from the targeted 607,973 eligible beneficiaries for vaccination out of the total 657,144 target beneficiaries.
- Daily and weekly surveillance system enhanced with > 80 per cent timeliness and completeness in the zone targeting the 657,144 beneficiaries.
- Community sensitization and environmental management conducted.

CERF's ADDED VALUE

a) Did CERF funds lead to a fast delivery of assistance to beneficiaries?

YES PARTIALLY NO

The timely funding received from CERF contributed to the speedy procurement and provision of required vaccines. It also helped to rapidly deploy technical experts to support the outbreak investigation, micro planning of the vaccination campaign, strengthening of case management, improvement in disease surveillance, rapid case detection, timely information exchange, and coordination and monitoring of control interventions. Hence, it was made possible to provide timely and quality treatment to all affected and this resulted in bringing down mortality as well as early containment of the outbreaks at the local level.

b) Did CERF funds help respond to time critical needs¹?

YES PARTIALLY NO

The project had a major component of reactive vaccination and provided a single most important control measure against Yellow Fever outbreak. The intervention provided life time protection/immunity within one week for 90 per cent of persons prioritized for urgent protection in the affected Woredas and their neighbouring kebeles in South Omo Zone.

c) Did CERF funds help improve resource mobilization from other sources?

YES PARTIALLY NO

The CERF fund acted as a catalyst to advocate for more funds from WHO and ECHO to support the Yellow Fever outbreak response. Additional fund amounting USD 900,000 (WHO-USD400,000 and ECHO-USD500,000) was secured for implementing identified prevention and control measures

d) Did CERF improve coordination amongst the humanitarian community?

YES PARTIALLY NO

In order to avoid duplication and coordinate resource mobilization for timely response through application to CERF funding partners in the health cluster convened and identified their areas of intervention. The need to coordinate their effort starting from assessment, identifications of sectors' need, as well as prioritizing areas of intervention based on agencies comparative advantage was given adequate attention . This helped greatly to establish and maintain an effective coordination platform amongst humanitarian community.

e) If applicable, please highlight other ways in which CERF has added value to the humanitarian response

The timely release of the CERF fund has greatly helped in the urgent initiations of reactive vaccination through the timely procurement of Yellow Fever Vaccine. This has contributed very much in the local containment of the outbreak and prevention of its transmission to the neighbouring high risk Regions including – Benishnagul Gumuz, Gambella, Western Oromia and Western Amhara which harbours close to 40,000,000 susceptible/unimmunized populations.

V. LESSONS LEARNED

TABLE 6: OBSERVATIONS FOR THE CERF SECRETARIAT

Lessons learned	Suggestion for follow-up/improvement	Responsible entity
The timely release of fund as per prioritized needs enabled to minimize morbidity and mortality through availing required support to affected population	Maintain the responsiveness to the country and to affected population's need	CERF secretariat
The lack of emergency preparedness fund contributed focus on response rather than minimizing risk	Consider to integrate some preparedness/risk reduction budget line	CERF secretariat

¹ Time-critical response refers to necessary, rapid and time-limited actions and resources required to minimize additional loss of lives and damage to social and economic assets (e.g. emergency vaccination campaigns, locust control, etc.).

TABLE 7: OBSERVATIONS FOR COUNTRY TEAMS

Lessons learned	Suggestion for follow-up/improvement	Responsible entity
The recruitment and assignment of field consultants in affected areas supported the Regional Health Bureaus RHBs in assessment, supervision, monitoring, coordination, planning and capacity strengthening resulting in a positive impact in outbreak response in the affected zones.	Maintenance of WHO field officers	WHO
There was a lack of regular coordination fora for the health cluster due to inadequate staffing and occurrence of multiple outbreaks that drove health authorities away from their duty stations to hold regular meetings. This impacted the preparedness and response measures at regional level	Advocate for expansion of assignment of focal points and increase partner representations in the technical TF and working groups	Humanitarian country team

VI. PROJECT RESULTS

TABLE 8: PROJECT RESULTS			
CERF project information			
1. Agency:	WHO	5. CERF grant period:	[24 June – 23 December 2013]
2. CERF project code:	13-WHO-036	6. Status of CERF grant:	<input type="checkbox"/> Ongoing
3. Cluster/Sector:	Health		<input checked="" type="checkbox"/> Concluded
4. Project title:	Yellow Fever Outbreak Response		
7. Funding	a. Total project budget:	US\$ 4,200,000	d. CERF funds forwarded to implementing partners:
	b. Total funding received for the project:	US\$ 2,205,769	▪ <i>NGO partners and Red Cross/Crescent:</i> US\$ 0.00
	c. Amount received from CERF:	US\$ 1,255,769	▪ <i>Government Partners:</i> US\$ 106,000
Results			
8. Total number of <u>direct beneficiaries</u> planned and reached through CERF funding (provide a breakdown by sex and age).			
<i>Direct Beneficiaries</i>	<i>Planned</i>	<i>Reached</i>	<i>In case of significant discrepancy between planned and reached beneficiaries, please describe reasons:</i>
a. <i>Female</i>	335,143	335,143	
b. <i>Male</i>	322,001	322,001	
c. <i>Total individuals (female + male):</i>	657,144	657,144	
d. <i>Of total, children <u>under</u> age 5</i>	86,468	86,468	
9. Original project objective from approved CERF proposal			
To interrupt transmission of Yellow Fever in high risk areas through instituting vaccination campaigns and enhancing the surveillance system for early case detection, reporting and monitoring of disease trend and intervention/response operation.			
10. Original expected outcomes from approved CERF proposal			
<ul style="list-style-type: none"> Implement Yellow Fever campaign with high quality and coverage (>90 per cent). Surveillance with high quality, meeting international standards. 			
11. Actual outcomes achieved with CERF funds			
<ul style="list-style-type: none"> Yellow Fever reactive vaccination campaign for 563,558 eligible individuals (607,462) with high quality and coverage (92.7 per cent). Daily and weekly surveillance system enhanced with > 80 per cent timeliness and completeness in all affected woredas. 			
12. In case of significant discrepancy between planned and actual outcomes, please describe reasons:			
None			
13. Are the CERF funded activities part of a CAP project that applied an IASC Gender Marker code?			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

If 'YES', what is the code (0, 1, 2a or 2b):

If 'NO' (or if GM score is 1 or 0):

The response interventions which included the vaccination strategy were designed based on the immunological facts of the vaccine. The response targeted all children over 1 year old, while based on epidemiological fact, the most affected age groups below 45 years were targeted equally for all gender category. Vaccination is not contraindicated in person with HIV, in fact as person with HIV are particularly vulnerable to infection, this group benefitted particularly. Pregnant women could also be included. For treatment of cases, all age and sex groups were targeted to receive medication with no disparity.

14. M&E: Has this project been evaluated?

YES NO

A regular monitoring at all levels with weekly report sharing was done collectively during the outbreak that made it possible to obtain adequate information to assess the evolution of the outbreak and the performance of the response operation. Hence, it was not necessary to conduct a separate evaluation of this project.

ANNEX 1: CERF FUNDS DISBURSED TO IMPLEMENTING PARTNERS

CERF Project Code	Cluster/ Sector	Agency	Implementing Partner Name	Partner Type	Total CERF Funds Transferred to Partner US\$	Date First Instalment Transferred	Start Date of CERF Funded Activities By Partner	Comments/ Remarks
13-WHO-036	Health	WHO	FMoH, EPHI, SNNP RHB	GOV	\$106,000	10/07/2013	15/07/2013	

ANNEX 2: ACRONYMS AND ABBREVIATIONS (Alphabetical)

EHCT	Ethiopian Humanitarian Country Team
FMoH	Federal Ministry of Health
HPN	Health , Population and Nutrition
PHEM	Public Healht EMrgecny Management
YF	Yellow Fever
YFV	Yellow Fever Vaccine
RHB	Regional Health Bureau