RESIDENT / HUMANITARIAN COORDINATOR REPORT ON THE USE OF CERF FUNDS
KENYA
RAPID RESPONSE
POLIO

HUMANITARIAN COORDINATOR	**Mr. Marcel Rudasingwa**

REPORTING PROCESS AND CONSULTATION SUMMARY

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

Discussions on the implementation of the CERF rapid response (RR) grant were undertaken with the Inter-Sector Working Group (ISWG), as well as between partners directly involved in the implementation of the project. These covered results achieved, value-added of CERF RR funding, and challenges.

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 ☐

The report was discussed at the ISWG meeting and shared with the Kenya Humanitarian Partnership Team (KHPT)

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 report was shared for review with implementing partners, ISWG and KHPT.

I. HUMANITARIAN CONTEXT

TABLE 1: EMERGENCY ALLOCATION OVERVIEW (US$)		
Total amount required for the humanitarian response: **US$ 7,783,866**		
Breakdown of total response funding received by source	**Source**	**Amount**
	CERF	1,532,872
	COMMON HUMANITARIAN FUND/ EMERGENCY RESPONSE FUND (*if applicable*)	0
	OTHER (bilateral/multilateral) Bill and Melinda Gates, ECHO, SIDA, German Government, USAID	6,127,083
	TOTAL	**7,659,955**

TABLE 2: CERF EMERGENCY FUNDING BY ALLOCATION AND PROJECT (US$)			
Allocation 1 – date of official submission: 19 June 2013			
Agency	**Project code**	**Cluster/Sector**	**Amount**
UNICEF	13-CEF-073	Health	320,603
UNHCR	13-HCR-041	Health	290,774
WHO	13-WHO-038	Health	921,495
TOTAL			**1,532,872**

TABLE 3: BREAKDOWN OF CERF FUNDS BY TYPE OF IMPLEMENTATION MODALITY (US$)	
Type of implementation modality	**Amount**
Direct UN agencies/IOM implementation	1,190,030
Funds forwarded to NGOs for implementation	188,942
Funds forwarded to government partners	153,900
TOTAL	**1,532,872**

HUMANITARIAN NEEDS

Acute Poliomyelitis is a highly infectious disease caused by the poliovirus, which can cause paralysis and even death. There is no cure for polio and the disease can only be prevented by immunization. The polio virus causes severe morbidity among children less than 15 years and high mortality among adults and life-long disability among survivors of the disease.

On 9 May 2013, the Regional Polio Reference Laboratory in Nairobi (Kenya Medical and Research Foundation, KEMRI) reported the isolation of wild polio virus type 1 (WPV1) from a 32 month old child in the Benadir region of Somalia. A week later on 17 May 2013,

KEMRI reported another WPV1 case in the Dadaab refugee camp in North-Eastern Kenya. The genetic analysis of the virus indicated that they were closely related and had been recently introduced to the Horn of Africa. Since the first case was confirmed in the Hagadera camp in Kenya in May 2013, the Ministry of Health confirmed 14 other polio cases; and the country conducted a total of seven 7 polio vaccination campaigns (five rounds of sub national immunization days and two rounds of national immunization days), targeting specifically the high-risk and vulnerable population and areas including the Dadaab and Kakuma refugee camps and the Dadaab-Nairobi-Kakuma refugee movement corridor.

The Kenya Ministry of Health declared a public health emergency on 17 May 2013, following the confirmation of the Acute Wild Poliomyelitis Virus (WPV) outbreak in the Dadaab refugee camps, home to more than 424,000 people at the time (216,618 female) with 96 per cent originating from Somalia. The outbreak took an alarming turn over a couple of days with a teenager confirmed as paralytic polio in Mogadishu and a 19 year old case confirmed in one of the camps in northeastern Kenya in one of the refugee camps. Dadaab had been hosting refugees since 1991 when the crisis in Somalia erupted. The Kakuma Refugee camp is located in Turkana West District of Turkana County, about 1000 km from the capital city, Nairobi. The refugee population as at 1 June 2013 was 119,537. The refugees are from 15 different countries, primarily Somalia (44.2 per cent) and South Sudan (34.0 per cent).

In order to respond to the declaration of the wild polio emergency, a target of 5,400,000 persons, children (boys and girls) from 6 months to less than 15 years, and all refugees in the two refugee camps of Dadaab and Kakuma were targeted for vaccination. There was an urgent need to mobilize resources to conduct the campaigns in order to interrupt transmission of the wild polio virus in order to control and halt the spread to the sub-regions within the countries in the horn of Africa which were at risk.

II. FOCUS AREAS AND PRIORITIZATION

Kenya is amongst the countries committed to the 1988 World Health Assembly resolution of global poliomyelitis eradication. Towards polio eradication initiative, the country has been implementing the four recommended strategies: Acute Flaccid Paralysis (AFP) surveillance, routine immunization, national/sub-national immunization days and mop up vaccination campaigns. A lot of progress has been made in the performance of AFP surveillance and increasing population immunity in the country since commencement of this initiative. However, gaps still exist at sub-national level with sub-counties yet to attain the polio certification targets and coverage of less than 80 per cent of Oral Polio Vaccine (OPV)3 and 95 per cent Supplementary Immunisation Activities (SIA) coverage. The last indigenous wild poliovirus in Kenya was in 1984. However, the country suffered importations of WPV from Somalia and Sudan in 2006 (2 cases in Garissa County) and 2009 (19 cases in Turkana County), respectively. Kenya was able to detect, promptly respond, and contain the outbreaks following the implementation of WHO recommendations.

Following discussions and agreement with the Kenya Humanitarian Partnership Team (KHPT), three UN Agencies, WHO, UNHCR and UNICEF, made an appeal to the Central Emergency Response Fund (CERF) for rapid response funding to support the Ministry of Health in an effort to control the polio situation. Urgent response was needed for the most vulnerable group, the refugees in the two camps of Dadaab and Kakuma and their immediate host communities, to quickly interrupt transmissions as further resources were sought for the rest of the population at risk in twenty-two counties. With the prompt availability of CERF funding, two polio vaccination campaigns were conducted with coverage of more than 97 per cent. Other cases and contacts were investigated and samples sent too regional reference laboratories globally for sequencing. Wild Polio virus was interrupted and the outbreak controlled. Since 14 July 2013 no new cases have been reported.

III. CERF PROCESS

Given the rapidly evolving nature of the outbreak and the impact of similar outbreaks in the past, an urgent, strategic and synchronized response was required to curtail the outbreak and prevent the escalation of what was already a public health emergency. This was a coordinated action led by the Ministry of Health (MoH) and the World Health Organization (WHO) as the co-lead. As Kenya is a country frequently affected by disasters, the Humanitarian Coordinator and the sector coordination structures were in place. The MoH also had a multi-partner and sector coordination structure and mechanism. The Health and Nutrition sector partners, the highest level of technical advisors to the MoH, jointly monitors disasters and emergency response.

After the declaration of the outbreak by the MoH, and under the leadership of the Ministry of Health supported by WHO, the health and nutrition sector group developed the multi-partner wild polio virus outbreak response plan. Kenya activated the polio outbreak preparedness and response plan which focussed on outbreak investigation, communication, coordination, surveillance and vaccination response. Other implementation partners included UNICEF, UNHCR, Kenya Red Cross Society, and Non-governmental Organization (NGO) partners in the refugee camps and along the refugee corridor, County Governors, County health teams, and other local NGOS. The strategies in the response plan included: coordinated multi-partner and sector wide response planning, implementation and

monitoring of the outbreak response, synchronization of polio outbreak response activities with Kenya, Somalia and Ethiopia, focusing on the refugee camps and host community, based on risk profiling and mapping. The outbreak was first reported in Somalia, and then thereafter cases were detected in Kenya and Ethiopia. The Horn of Africa (HoA) was considered as one epidemiological zone and hence the overall outbreak response plan was drawn out as one. Vaccination response targeting all countries in HoA (Kenya, Somalia, Ethiopia) was coordinated and synchronized through support of WHO Regional and Country offices.

In the Emeregency Humanitarian Response Plan 2013 (EHRP), disease outbreaks and other disasters were identified as critical areas that must be addressed. Thus WHO as the sector coordinator conveyed health sector partners meeting to identify the urgent needs for the most vulnerable groups and resources to kick start the outbreak response to the acting RC/HC through the KHPT. The Humanitarian Coordinator delegated WHO, UNICEF and UNHCR who were already supporting the response to come out with a joint start up plan and budget for potential funding by CERF to support the MoH. The agencies identified critical and key areas of support of government based on their mandates and comparative strengths and advantages.

The MoH coordinated the response at the national level, and county health teams also did the same in the affected counties. The MoH availed adequate vaccines and through internal mobilization of resources for round one of the campaign conducted in the Dadaab refugee camp and nine host districts from the 27-31 May 2013.

The comprehensive emergency polio response plan was developed under the leadership of the MoH. Health Sector partners had three working sessions to identify the problem and the appropriate strategies. Within the plan, critically vulnerable populations, strategies and activities were identified and agreed upon by all the partners. Thus a separate start up plan within the comprehensive plan was developed for start-up funding by CERF. The three UN Agencies were tasked to mobilize the resources in collaboration with the Resident Coordinator.

WHO was tasked to operationalize the wild polio outbreak response plan, provide technical re-orientation for field workers and vaccinators, and also provide field technical support for implementation of the vaccination campaign, monitoring and reporting the response activities. Other tasks included: logistical support for the distribution of vaccines, the cold chain system, printing of guidelines and their distribution, financial support for vaccinators, vehicles rental for vaccination teams etc. Active surveillance for AFP cases in high risk areas were intensified through active case search using district health teams. Active case search continued during the response period and, to facilitate detection of wild poliovirus cases, the number of contacts to be investigated for an AFP case was increased from three to five.

UNICEF was tasked to coordinate the social mobilization and communication component of the integrated plan through the development of the outbreak communication plan. The plan was to cover strategic intervention areas such as advocacy, mass media/promotion, community engagement/social mobilization, behaviour change/participatory communication, and capacity building. It was also to cover special strategies, such as messages targeting expanded vaccination age groups and the need for every child to be vaccinated. The plan was to target the public sector, private and NGOs were engaged on the social mobilization. Within the plan UNICEF was tasked to supplement government's efforts in the procurement of additional vaccines.

UNHCR was tasked to lead the coordination and funding of the partners working in the refugee camps with all the activities planned under the immunization campaigns.

IV. CERF RESULTS AND ADDED VALUE

TABLE 4: AFFECTED INDIVIDUALS AND REACHED DIRECT BENEFICIARIES BY SECTOR				
Total number of individuals affected by the crisis: 4,447,451				
The estimated total number of individuals directly supported through CERF funding by cluster/sector	**Cluster/Sector**	**Female**	**Male**	**Total**
	Health	595,809	476,689	1,072,498

BENEFICIARY ESTIMATION

The total number of people affected was 4,447,451 individuals. However, for the CERF grant, only critical and most vulnerable groups (refugees children in camps and host communities) needing immediate response and totalling 1,072,498 were targeted for a start.

In the refugees camps UNHCR provided the population and demographic statistics of the refugee population in all the camps. In addition they provided the routine immunization coverage in the camps and the settlement arrangements in the camps. For the host community, the population and demographic information was collected from the last census and the Kenya Demographic Health Survey. Analysis and triangulation was done by the teams to estimate the population at risk using the WHO guidelines.

TABLE 5: PLANNED AND REACHED DIRECT BENEFICIARIES THROUGH CERF FUNDING

	Planned	Estimated Reached
Female	500,000	595,809
Male	400,000	476,689
Total individuals (Female and male)	900,000	1,072,498
Of total, children under age 5	200,000	460,000

CERF RESULTS

Coordinated wild polio outbreak response results

- The planning for the outbreak response was very collaborative and was coordinated by the Ministry of Health at national level and the County Directors at the county level. A one-day planning session was devoted at each level by all stakeholders.. WHO and UNICEF deployed technical personnel in the three (3) key strategic areas, namely: sector leadership, technical support, and advocacy, and social mobilization. UNHCR facilitated similar arrangements in collaboration with other partners in the two refugee camps. This enabled the fast development of the national wild polio outbreak response plan and the micro plans at the county and the refugee camps.

- In light of the timely availability of the CERF funds, the MoH availed adequate vaccines and through internal mobilization of resources, one round of campaign was conducted in the Dadaab refugee camp and nine host districts from the 27-31May 2013. Subsequent campaigns were conducted when other funds were mobilized.

- UNHCR funding partners working in the refugee camps implemented activities following the joint plan for immunization campaigns. All other partners provided personnel for the field vaccination activities.

- CERF facilitated the collaboration and partnerships among all the response partners in and around the refugee camps. The campaign achieved more than the planned targets.

- WHO used CERF funds to support health and nutrition sector partners to operationalize the wild polio outbreak response plan. WHO and MoH provided technical re-orientation for field workers by making technical guidelines and campaign tools available and by organizing a half-day reorientation for the vaccinators. The campaigns were also launched by high level government officials and the WHO Representative.

- Active Surveillance for AFP cases in high risk areas was intensified through active case and contact tracing by the vaccination teams and the district health teams. Technically to facilitate the detection of wild poliovirus cases, the number of contacts to be investigated for an AFP case was increased from three to five. The samples were tested in the Kenya Medical Research Institute and South Africa and Centre for Disease Control (CDC) in Atlanta for confirmation, typing and quality control. In all 332 alerts and rumours, 53 close contacts were investigated and there were 14 confirmed cases.

- Information on daily activities was managed by the full time WHO Epidemiologist and the MoH. Vaccination data was analysed at all levels up to the national level where WHO Epidemiologist supported the MoH on a full time basis. Daily situational reports and weekly outbreak bulletins were published and disseminated.

- At the end of each campaign, WHO and MoH supported the independent monitoring teams to conduct an independent coverage surveys to determine the real coverage of the campaign.

- WHO supported the high level multi partner stakeholders to conduct the "Three-Month Wild Polio Virus Outbreak Response Assessment in Kenya" that made recommendations for further improvement.

Table: Target, Vaccinated Population and Independent Monitoring results

Location	Target Population	Population Vaccinated	Administrative vaccination coverage (=vaccinated/Target)	Per cent (%) coverage by Independent Monitoring
Refugees	567,876	659,028	116%	99%
Host community	332,124	413,470	124%	96%
Total	900,000	1,072,498	119%	97.6%

Independent monitoring (IM): This is an end process evaluation conducted by an impartial third party entity to determine the vaccination by sampling vaccinated populations. All sampled children are examined for finger marking a sign of vaccination. All those children with finger marking are counted and the coverage calculated as: those with finger mark/sampled population. The minimum acceptable target IM to suggest good coverage is 95%. It is a more reliable coverage indicator since the administrative coverage can differ much depending on the reliability of the denominator and how well the numerator is controlled in the settings. Children from other locations cannot be denied the service if they willingly came for it and this can increase the administrative coverage.

- UNICEF supported social mobilization and communication component of the integrated plan. An outbreak communication plan was developed within the wild polio outbreak response plan which addressed strategic intervention areas such as advocacy, mass media/promotion, community engagement/social mobilization, behaviour change/participatory communication, and capacity building. It also focused on special strategies, such as messages targeting expanded vaccination age groups and the need for every child to be vaccinated. Also, the plan included strategies designed to reach special populations such as those in informal settlements in major towns, those in gated communities and those in hard to reach areas. Both the public sector, private and NGOs engaged to support advocacy, communication and social mobilization activities. UNICEF also supported government's efforts in the procurement of additional vaccines.

- At least 95 per cent of caregivers of children less than 15 years old in 127 districts (22 counties) targeted for immunization are aware of and demand for polio vaccination by end of August polio immunization campaign. This contributed to high levels of coverage.

- Support from CERF contributed to creating awareness amongst communities in August and September with 89 per cent reporting awareness of the campaign and minimal resistance. This contributed to 94 per cent of the 5.1 million children and adults in 22 counties including all ages in Dadaab refugee camps and under 15 year olds in host districts receiving the oral polio vaccine.

- Communication and social mobilization through community and religious leaders, radio, TV and social media: 25 per cent of caregivers received messages through TV and 45 per cent through radio.

- Social mobilization was carried out through public address system, health workers, community health workers, civil society organizations, pupils, volunteers and houses of worship. Below is summary of proportion of caregivers who received polio related messages by channel of communication deployed in August and September:

Communication Channel	% Reached in August SIA	% Reached September SIA
Radio	45 per cent	45 per cent
TV	17 per cent	25 per cent
Mega phones	30 per cent	32 per cent
Health workers	29 per cent	34 per cent
Neighbours	18 per cent	21 per cent
Community Leaders	30 per cent	33 per cent

- Advocacy meetings were held with community and religious leaders resulting in religious sermons in all mosques and churches prior to the campaign to create supportive environment and reinforcement of benefits of vaccination. In July, the First lady launched the campaign together with newly appointed polio ambassador, himself a polio survivor.

- Successful advocacy efforts by the UNICEF and WHO Country Representatives also led to government declaring polio outbreak as a public health emergency. Implementation of the activities greatly contributed to stopping wild polio virus transmission within 4 months as per the WHO guidelines.

CERF's ADDED VALUE

a) Did CERF funds lead to a fast delivery of assistance to beneficiaries?
YES ☒ PARTIALLY ☐ NO ☐
An early positive indication from CERF funds enabled the agencies to promptly mobilize internal resources for the crucial immediate preparatory activities with partners. The availability of the funds enabled quick response in the high risk areas, including the refugee camps and immediate host communities, before response was conducted in other areas of the country.

b) Did CERF funds help respond to time critical needs[1]?
YES ☒ PARTIALLY ☐ NO ☐
The CERF funds enabled the Government to immediately avail vaccines. Laboratory investigations were also conducted in a timely manner. Allowances were made available for the volunteers using CERF funds. Social mobilization to raise awareness among the refugees and host communities was also achieved using CERF funds.

c) Did CERF funds help improve resource mobilization from other sources?
YES ☒ PARTIALLY ☐ NO ☐
The total budget for the overall response was $7,783,866. The availability of the CERF funds encouraged both in-country and external resource mobilization from other donors. Other donors included ECHO and Bill & Melinda Gates Foundation, SIDA, German Government and USAID.

d) Did CERF improve coordination amongst the humanitarian community?
YES ☒ PARTIALLY ☐ NO ☐
One of the key activities in the CERF process was joint planning, monitoring and implementation. It created a forum for stakeholder meetings, consultations, gap analyses and discussions with prompt filling of the gaps identified.

e) If applicable, please highlight other ways in which CERF has added value to the humanitarian response
Prompt release of the CERF funds created a global and in-country awareness for stakeholders that there is a need to respond to the crisis urgently.

V. LESSONS LEARNED

TABLE 6: OBSERVATIONS FOR THE CERF SECRETARIAT

Lessons learned	Suggestion for	Responsible
The timely arrival of the CERF funding enabled the prompt interruption of transmission of the wild polio virus in line with international standards	Similar timely funding to be maintained	CERF
CERF funding is a reliable start up emergency fund	To be maintained as such	CERF

[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**
Inclusive CERF proposal development helps to build and sustain collaboration among UN agencies	Maintain the good practice	RC/HC and Heads of Agencies
All inclusive monitoring of activities especially by the UN and partner Heads of Agencies (KHPT) was very positive	To be maintained in similar emergency situations	RC/HC and Heads of Agencies
• The weak health care delivery system in the host communities affected and around the refugee camps (human resource, infrastructure and logistics) will continue to be a challenge for some time to come. • Insecurity to the field officers (vaccinators, supervisors and monitors); for example there were shooting incidences at three locations; at Liboi, Garissa and Dadaab refugee camps. In addition access was challenging in remote and inaccessible areas. • Inadequate vaccine stocks within country and cold chain storage systems in the remote areas, poor resources including human resource for rapid and effective vaccination campaign and mobilization.	• The Government of Kenya, partners and the donor community should be commended for their prompt outbreak response • The current polio outbreak should be declared a public health emergency, and all necessary human and material resources should be mobilized to increase public awareness and improve the quality of SIAs and AFP surveillance • Social mobilization and advocacy should be immediately strengthened to create a sense of urgency in non-outbreak but high risk areas and sustain demand for vaccine delivered in the routine immunization program as well as in SIAs	
Development of the CERF proposal facilitated collaboration within the partners from the onset of the response	Encourage RC/HC to maintain the practice	All UN agencies-WHO, UNHCR and UNICEF
Independent monitoring report (Kenya humanitarianresponse.info	Recommendations for improving the SIAs in the fututre	MOH and KHPT

VI. PROJECT RESULTS

TABLE 8: PROJECT RESULTS

CERF project information

1. Agency:	UNICEF	5. CERF grant period:	17 Jul. 2013 – 16 Jan. 2014]
2. CERF project code:	13-CEF-073	6. Status of CERF grant:	☐ Ongoing
3. Cluster/Sector:	Health		☒ Concluded
4. Project title:	Response to Outbreak of Wild Polio Virus in Kenya		

7.Funding				
	a. Total project budget:	US$ 1,019,737	d. CERF funds forwarded to implementing partners:	
	b. Total funding received for the project:	US$ 400,000	▪ *NGO partners and Red Cross/Crescent:*	US$ 0
	c. Amount received from CERF:	US$ 320,603	▪ *Government Partners:*	US$ 109,900

Results

8. Total number of direct beneficiaries planned and reached through CERF funding (provide a breakdown by sex and age).

Direct Beneficiaries	*Planned*	*Reached*	*In case of significant discrepancy between planned and reached beneficiaries, please describe reasons:*
a. Female	500,000	595,809	No major discrepancy.
b. Male	400,000	476,689	
c. Total individuals (female + male):	900,000	1,072,498	
d. Of total, children under age 5	200,000	460,000	

9. Original project objective from approved CERF proposal

To create awareness and demand for polio vaccination amongst caregivers of 900,000 children in 127 high risk districts of Kenya during August polio immunization campaign.

10. Original expected outcomes from approved CERF proposal

At least 95 per cent of caregivers of 900,000 children under 15 years old in 127 districts targeted for immunization are aware of and demand for polio vaccination by end of August polio immunization campaign contributing to high levels of coverage.

11. Actual outcomes achieved with CERF funds

At least 95 per cent of caregivers of children under 15 years old in 127 districts (22 counties) targeted for immunization are aware of and demand for polio vaccination as of the end of the August polio immunization campaign. This contributed to high levels of coverage.

Support from CERF contributed to creating awareness amongst communities in August and September with 89 per cent reporting awareness of the campaign and minimal resistance. This contributed to 94 per cent (846,000) of the 900,000 of all ages in Dadaab refugee camps and under 15 year olds in host districts receiving the oral polio vaccine. Campaign was extended to all ages in the Dabaab refugee camps due to the fact that two of the cases were adults (one death); hence the country immunization team used evidence in response during subsequent rounds of the campaign, aimed at containing the outbreak was necessary. The following evidence based advocacy communication and social mobilization activities were undertaken with financial support from CERF to achieve the above results:

1. Communication and social mobilization through, radio and TV and social media: 25 per cent of caregivers received messages through TV and 45 per cent through radio.

2. Social mobilization through public address system, health workers, community health workers, civil society organizations, pupils and volunteers. Below is summary of proportion of caregivers who received polio related messages by channel of communication deployed in August and September:

Communication Channel	Per cent (%) Reached in August SIA	Per cent (%) Reached September SIA
Radio	45%	45%
TV	17%	25%
Mega phones	30%	32%
Health workers	29%	34%
Neighbours	18%	21%
Community Leaders	30%	33%

3. Advocacy meeting: Advocacy meetings were held with community and religious leaders resulting in religious sermons in all mosques and churches prior to the campaign to create a supportive environment and reinforcement of benefits of vaccination. In July, the First lady launched the campaign together with newly appointed polio ambassador, himself a polio survivor.

4. Successful advocacy efforts by the UNICEF and WHO Country representatives also led to government declaring polio outbreak as a public health emergency

Figure 1: Polio Independent monitoring results by round-2013-2014

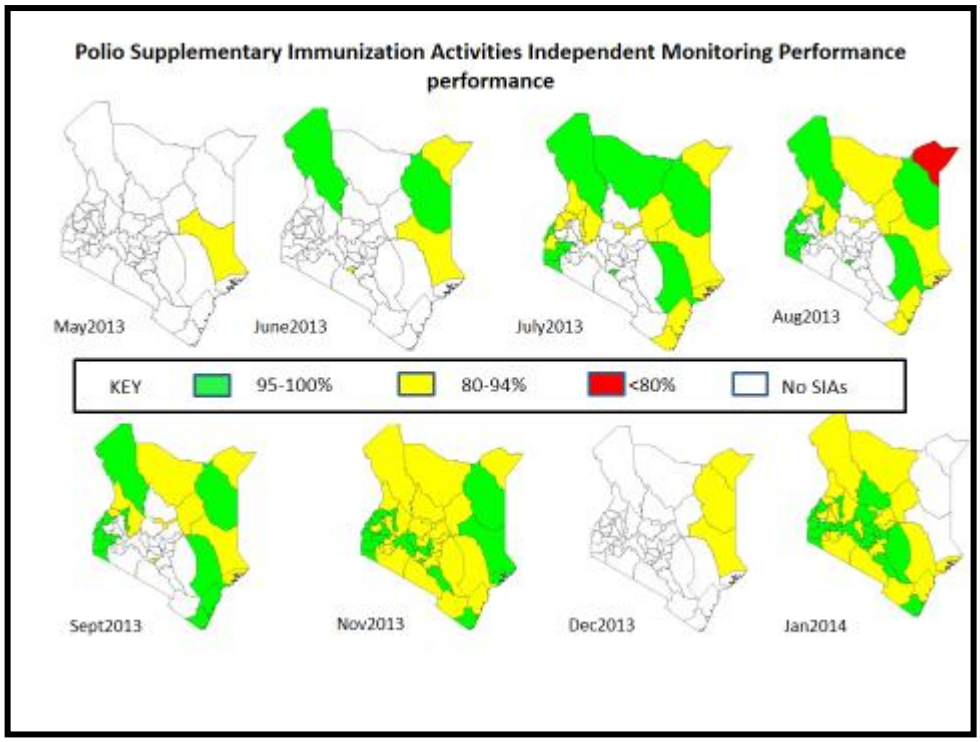

Figure 1 demonstrates improvement in Independent Monitoring coverage from May 13, 2013 (confirmation of first wild polio virus case) to January 2014 due to improved quality of campaigns, and the findings of independent monitoring were used to improve quality of subsequent rounds of polio campaign. Implementation of the activities greatly contributed to stopping wild polio virus transmission within 4 months as per the World Health Assembly guidelines.

12. In case of significant discrepancy between planned and actual outcomes, please describe reasons:

13. Are the CERF funded activities part of a CAP project that applied an IASC Gender Marker code?	YES ☐ NO ☒

If 'YES', what is the code (0, 1, 2a or 2b): 2b (project reference KEN-13/H/55390/R) **If 'NO' (or if GM score is 1 or 0):** Messages for immunization emphasised that all children should be vaccinated irrespective of sex of the child.
14. M&E: Has this project been evaluated? YES ☒NO ☐
The external 3 months outbreak response assessment was conducted in September 2013. The assessment reported a high quality of response in the outbreak zone but a lower quality in the high risk districts outside the refugee camp and host community.

TABLE 8: PROJECT RESULTS

CERF project information

1. Agency:	UNHCR	5. CERF grant period:	20 May 2013 – 19 Nov. 2013
2. CERF project code:	13-HCR-041	6. Status of CERF grant:	☐ Ongoing
3. Cluster/Sector:	Health		☒ Concluded
4. Project title:	Emergency Response to the Acute Wild Polio Virus Outbreak in the Kenya Refugee Camps		

7.Funding				
	a. Total project budget:	US$457,371[2]	d. CERF funds forwarded to implementing partners:	
	b. Total funding received for the project:	US$457,371	▪ *NGO partners and Red Cross/Crescent:*	US$188,943
	c. Amount received from CERF:	US$290,774	▪ *Government Partners:*	US$ -

Results

8. Total number of direct beneficiaries planned and reached through CERF funding (provide a breakdown by sex and age).

Direct Beneficiaries	*Planned*	*Reached*	*In case of significant discrepancy between planned and reached beneficiaries, please describe reasons:*
a. Female	302,573	302,923	The final beneficiary figure is the highest number of beneficiaries reached in one vaccination campaign (out of the total of 7 campaigns undertaken). This was campaign no. 3 undertaken in July which had a vaccination coverage of 96.1 per cent.
b. Male	278,565	278,865	
c. Total individuals (female + male):	581,138	581,788	
d. Of total, children under age 5	126,125	126, 361	

9. Original project objective from approved CERF proposal

The main objective of this CERF proposal will be to ensure that the transmission of the disease is halted and that new infections do not occur. This links with the overall objective in the health sector which aims to improve the health status of the population of concern and maintain the Crude Mortality Rateat 0.1/1000 population per month and Under five mortality rate at 0.1/1000 population per month.

10. Original expected outcomes from approved CERF proposal

- Halt the transmission of the current outbreak
- Boost the immunity of the current population
- Improve the vaccination coverage for the <15 category to 95 per cent and 70 per cent for the adult population
- Enhance awareness of population of the importance of immunization.

11. Actual outcomes achieved with CERF funds

- The transmission of the outbreak was halted. The first case of current polio outbreak was identified in May 2013 in Hagadera camp and subsequently additional 13 cases were identified in the camps and neighbouring host community. The last case was identified on 14 July 2013.
- A series of 7 short interval mass campaigns were conducted with the first one done within 2 weeks of confirmation of outbreak, the last one in December 2013.
- Round 1 targeted children <15 years while Rounds 2-5 targeted whole population. Round 6 targeted children <5 years and in order to boost both humoral and mucosal immunity, Round 7 targeting <5 years using both Inactivated Polio Vaccine (IPV) and

[2]The final budget exceeded the original budget due to the need for additional vaccination rounds.

Oral Polio Vaccine (OPV) was conducted in Dec 2013 using alternative funding sources . All the campaigns achieved coverage over >90 per cent, the highest coverage was in Round 3 with 96.1 per cent.

- The campaigns used mixed strategy of fixed, mobile and household outreach and worked through community structures and teams to reach the target population.
- County leaders and senior staffs among humanitarian actors led by example by undergoing vaccination during the campaign and over 1,000 humanitarian workers were vaccinated for polio.

12. In case of significant discrepancy between planned and actual outcomes, please describe reasons:

It had not been foreseen that as many as 7 rounds of vaccination will be required. The result was therefore a significantly higher amount of resources was required for the intervention to be completed. The additional needs were covered through other funding sources.

13. Are the CERF funded activities part of a CAP project that applied an IASC Gender Marker code?	YES ☒ NO ☐

If 'YES', what is the code (0, 1, 2a or 2b): 2a
If 'NO' (or if GM score is 1 or 0):

14. M&E: Has this project been evaluated?	YES ☒ NO ☐

UNHCR has undertaken an internal evaluation of the polio response in Dadaab (which constitutes part of the CERF funded project). Key lessons learnt included: good logistic planning, community mobilization and micro-planning are critical to a successful campaign; flexibility in modifying the strategy (including targeting travelers at bus stops) from time to time helped to reach many people; the collaboration between agencies brought synergies that made implementation smooth; female staff had to be included in each team as women were refusing to open mouths to receive vaccine from men in public.

TABLE 8: PROJECT RESULTS

CERF project information

1. Agency:	WHO	5. CERF grant period:	12 Jul 1013 – 11 Jan. 2013
2. CERF project code:	13-WHO-038	6. Status of CERF grant:	☐ Ongoing
3. Cluster/Sector:	Health		☒ Concluded
4. Project title:	Emergency Response to the Acute Wild Polio Virus Outbreak in the Kenya		

7.Funding			
	a. Total project budget:	US$6,464,129	d. CERF funds forwarded to implementing partners:
	b. Total funding received for the project:	US$ 4,000,002	▪ *NGO partners and Red Cross/Crescent:* US$ 0
	c. Amount received from CERF:	US$ 921,495	▪ *Government Partners:* *USD 44,000*[3]

Results

8. Total number of direct beneficiaries planned and reached through CERF funding (provide a breakdown by sex and age).

Direct Beneficiaries	*Planned*	*Reached*	*In case of significant discrepancy between planned and reached beneficiaries, please describe reasons:*
a. Female	500,000	595,809	The campaign reached more children that initially targeted because parents wanted to take advantage of the early campaign especially in the host communities and also because of the high awareness created on the complications of the Wild polio virus outbreak
b. Male	400,000	476,689	
c. Total individuals (female + male):	900,000	1,072,498	
d. Of total, children under age 5	200,000	460,000	

9. Original project objective from approved CERF proposal

Support MoH and partners to interrupt wild poliovirus transmission, control the outbreak and prevent spread of the wild polio virus within Kenya and the Horn of Africa

10. Original expected outcomes from approved CERF proposal

- At least 95 per cent of boys and girls of less than fifteen years, and adults vaccinated against polio during the period
- Response plans available at all levels within 2 weeks
- 95 per cent of all alerts and rumours of AFP cases investigated within 48 hours
- 100 per cent close contacts traced investigated within 48 hours during campaign

11. Actual outcomes achieved with CERF funds

- WHO supported MoH and partners to promptly interrupt the wild poliovirus transmission, controlled the outbreak and prevented spread of the wild polio virus within Kenya and the horn of Africa. This was achieved through rapid coordination of health partners, rapid assessments, gap identification and local capacity building. WHO supported MoH to develop a

[3] In order to facilitate funds transfer directly to the counties promptly, WHO used government money transfer structures to the counties to transfer $460,000 to the County Health teams and the volunteers under under WHO supervision and monitoring

national plan, micro plans at county and refugee camps and supported implementation and monitoring. Two rounds of vaccination campaigns were conducted

- The campaigns achieved coverage of 99 per cent (563,500) in the 2 refugee camps, 96 per cent(659,028) in the host community with an average total coverage of 97.6 per cent of boys and girls of less than fifteen years, and adults vaccinated against the wild polio during the period.
- National Outbreak response plan was developed within 2 weeks and micro planning facilitated at counties and refugee camps (including separate plans for each of the 5 sub-camps in Dadaab and 2 In Kakuma). In addition, two independent monitoring were conducted to statistically validate the true coverage.
- 14 cases were confirmed through laboratory testing in the country and in the global reference laboratories network. In addition, 252 110% of alerts and rumours of AFP cases were investigated within 48 hours and a 60-day follow ups conducted for all. 90 stool specimens from 31 contacts were collected and investigated. However, these suspected cases and contacts tested negative for wild polio virus. For quality control samples were also sent to South Africa and Atlanta for genotyping
- Investigation of rumours and alerts continued for six months. 100 per cent close contacts traced investigated within 48 hours during the six months period.

12. In case of significant discrepancy between planned and actual outcomes, please describe reasons:

N/A

13. Are the CERF funded activities part of a CAP project that applied an IASC Gender Marker code?	YES ☒ NO ☐

If 'YES', what is the code (0, 1, 2a or 2b): 2b (project reference KEN13/H/55950/R)
If 'NO' (or if GM score is 1 or 0): Vaccination emphasized that all children (boys and girls) should be vaccinated irrespective of sex or age of the child.

14. M&E: Has this project been evaluated?	YES ☒ NO ☐

https://kenya.humanitarianresponse.info/system/files/documents/files/Kenya%203%20month%20Outbreak%20Assessment%20Report%20-%209Sept2013.pdf

Recommendations

1. The Government of Kenya, partners and the donor community should be commended for their prompt outbreak response

2. The current polio outbreak should be declared a public health emergency, and all necessary

human and material resources should be mobilized to increase public awareness and

improve the quality of SIAs and AFP surveillance

3. Social mobilization and advocacy should be immediately strengthened to create a sense of urgency in non-outbreak but high risk areas and sustain demand for vaccine delivered in the routine immunization program as well as in SIAs

4. Active AFP surveillance should be established or strengthened to comply with national AFP surveillance guidelines. This must go beyond meeting the non-polio AFP detection rateindicators.5. To complement AFP surveillance, environmental surveillance for polioviruses must occur as soon as possible in multiple sites in Nairobi and other high risk areas where feasible.

6. Training should be conducted to ensure that immunization staff understands the importance of data in targeting program activities.

7. The immunization workforce should be trained on micro-planning tools and held accountable for their use. This training should include proper house and finger marking, revisiting missed children, and tracking refusals. SIA vaccination teams must use detailed maps. Staff with supervisory responsibilities in SIA, AFP surveillance, and routine immunization should receive regular training in supervisory techniques and be held accountable for the performance of their staff.

8. Consideration should be given to the role of IPV in the current polio eradication program, including its targeted use in high risk areas like the Dadaab refugee camp and host communities.

ANNEX 1: CERF FUNDS DISBURSED TO IMPLEMENTING PARTNERS

CERF Project Code	Cluster/Sector	Agency	Implementing Partner Name	Sub-grant made under pre-existing partnership agreement	Partner Type	Total CERF Funds Transferred to Partner US$	Date First Installment Transferred	Start Date of CERF Funded Activities By Partner	Comments/Remarks
13-CEF-073	Health	UNICEF	Ministry of Health	Yes	GOV	$109,900	12-Sep-13	21-Sep-13	
13-HCR-041	Health	UNHCR	Islamic Relief	Yes	INGO	$88,781	23-Sep-13	20-May-13	The partner was authorised to spend funds earlier disbursed in order to allow for implementation. Partnership agreement was subsequently revised to reflect new allocation.
13-HCR-041	Health	UNHCR	International Rescue Committee	Yes	INGO	$100,161	28-Aug-13	20-May-13	The partner was authorised to spend funds earlier disbursed in order to allow for implementation. Partnership agreement was subsequently revised to reflect new allocation.
13-WHO-038	Health	WHO	Ministry of Health	Yes	GOV	$44,000	29-Aug-13	20-May-13	

ANNEX 2: ACRONYMS AND ABBREVIATIONS (Alphabetical)

AFP	Acute Flaccid Paralysis
WHO	World Health Organisatoin
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
MoH	Ministry of Health
WPV1	Wild Polio Virus Type 1
KHPT	Kenya Humaitarian Partners Team
KEMRI	Kenya Medical and Research Foundation
ISWG	Inter-sector Working Group
AFP	Acute Flaccid Paralysis
SIA	Supplementary Immunisation Activities
CDC	Centre for Disease Control
HoA	Horn of Africa