United Nations CERF Central Emergency Response Fund

RESIDENT / HUMANITARIAN COORDINATOR REPORT ON THE USE OF CERF FUNDS NIGERIA RAPID RESPONSE LASSA FEVER 2016

RESIDENT/HUMANITARIAN COORDINATOR	**Edward Kallon**

REPORTING PROCESS AND CONSULTATION SUMMARY

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

7 December 2016, participants were from UNICEF, UNHCR, FAO, OCHA, WFP and WHO.

a. 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 ☐

b. 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 ☐

I. HUMANITARIAN CONTEXT

TABLE 1: EMERGENCY ALLOCATION OVERVIEW (US$)		
Total amount required for the humanitarian response: 2,000,000		
Breakdown of total response funding received by source	**Source**	**Amount**
	CERF	399,741
	COUNTRY-BASED POOL FUND (*if applicable*)	-
	OTHER (bilateral/multilateral)	300,000
	TOTAL	**699,741**

TABLE 2: CERF EMERGENCY FUNDING BY ALLOCATION AND PROJECT (US$)			
Allocation 1 – date of official submission: 27 April 2016			
Agency	**Project code**	**Cluster/Sector**	**Amount**
WHO	16-RR-WHO-024	Health	399,741
TOTAL			399,741

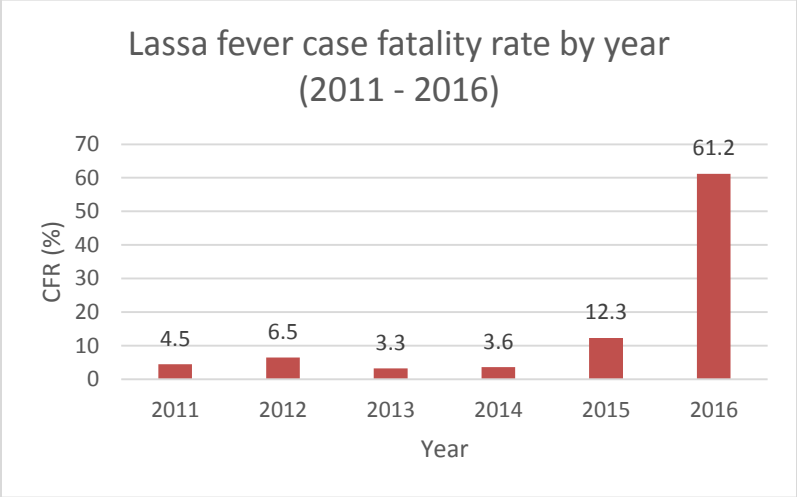
TABLE 3: BREAKDOWN OF CERF FUNDS BY TYPE OF IMPLEMENTATION MODALITY (US$)	
Type of implementation modality	**Amount**
Direct UN agencies/IOM implementation	399,741
Funds forwarded to NGOs and Red Cross / Red Crescent for implementation	-
Funds forwarded to government partners	-
TOTAL	399,741

HUMANITARIAN NEEDS

Nigeria was experiencing a Lassa fever outbreak in early 2016 with about 270 cases reported affecting men, women, girls and boys of all ages (including a two-week old child). Response activities were required in all 23 affected states of Bauchi, Nasarawa, Niger, Taraba, Kano, Rivers, Edo, Oyo, Plateau, Osun, Ogun, Ondo, Ekiti, Lagos, Delta, Akwa Ibom, Ebonyi, Imo, Gombe, the FCT, Kogi, Kaduna and Katsina with an estimated total population of about 110,033,201. Particularly vulnerable groups were health care workers who treat the patients and patients' close relatives who care for them, plus the whole population living in the area. This would usually include wives, mothers and children who could become infected by coming in contact with infected rats or with body fluids of an ill patient.

Lassa fever is an acute viral haemorrhagic illness caused by infection of the single stranded RNA arenavirus. Lassa is endemic in Nigeria. Transmission of Lassa virus is primarily from rodents to humans through ingestion of food or materials contaminated by infected rodent excreta, urine or saliva, catching and preparing Mastomys rat as a food source and inhalation of aerosolized virus. Secondary transmission occurs between humans through direct contact with blood, tissues, secretions or excretions of infected humans, needle stick or other contaminated sharps injuries. Lassa virus affects people of all ages and gender and has bioterrorism significance.

The Nigerian Centre for Disease Control (NCDC), an arm of the Federal ministry of Health (FMOH) notified WHO Nigeria about the Lassa fever outbreak on 7th January 2016 requesting support to respond to the outbreak. Outbreak investigation revealed that the outbreak started on 4 November 2015 (Epidemiologic week 45). Lassa fever virus, which incidentally was first isolated in Nigeria in 1969, is endemic in the country and causes outbreaks almost every year in different parts of the country but more in some states than others particularly around the dry season. The last major outbreak was in 2012 when 1,723 cases and 112 deaths (CFR 6.5%) were reported. As at 14th February 2016, a total of 183 cases (suspected, probable and confirmed) has been reported with 112 deaths and Case Fatality Rate (CFR) of 61.2%. The highest ever recorded national CFR in the country since 2011.



The Lassa fever outbreak in 2016 presented a different pattern from what had been observed over the years with 23 states reporting confirmed cases as of 15 April 2016. Meanwhile, as of 7 January 2016, only 10 states had confirmed cases but the outbreak has spread to 96 Local Government Areas (LGAs) in 23 states within a very short time exceeding the number of LGAs and states that reported cases in 2014 and 2015 combined. In addition, non-endemic states also reported confirmed cases in the outbreak. Since 2013, no health worker infection had been reported but eight health workers were confirmed to have Lassa fever, five of whom died from the disease, indicating high risk of person-to-person transmission in the outbreak. Unlike the previous years, over 60% of the cases reported during the outbreak resulted in mortality and the country health authorities had difficulties understanding the cause of the unusually very high case fatality rate. Furthermore, the current outbreak spread to Benin Republic which in turn had spread to some districts in Benin bordering some non-endemic states in Nigeria, increasing the risk of spread to those non-endemic states around the Benin border. In addition to the Lassa fever outbreak, the country was also dealing with outbreaks of measles, cholera and meningitis in many states of the federation.

II. FOCUS AREAS AND PRIORITIZATION

The outbreak investigation and response reports and analysis carried out by NCDC, WHO and other partners showed gaps in the response. The following areas of the response were prioritized for urgent attention to contain the outbreak, quickly reduce the deaths and reverse the panic among health care workers and the general population:

a. **Surveillance:** Absence of a comprehensive outbreak database for analysis, monitoring and decision making. There was an absence of a robust coordinated contact tracing mechanism to ensure that persons who were exposed to the virus and had a risk of becoming ill are monitored daily so that if they eventually become ill, they are promptly detected and evacuated to the pre-identified treatment facilities. This will reduce the risk of infecting others and commence treatment early to reduce case fatalities.

b. **Case Management and Infection Prevention and Control:** The very high case fatality emphasized the poor capacity in the states to manage Lassa fever cases. Scarcity of Infection Prevention and Control commodities in the identified treatment facilities posed a huge risk of infection to health care workers which caused panic among the medical community and eroded the confidence of the general public in health facilities which in turn increased the chance of seeking help in alternative/unorthodox health practitioners who are not conversant with standard precaution and spread of the disease could significantly increase with dire consequences.

c. **Community Sensitisation:** There was a demonstrated need for community sensitization as there were infrequent and inappropriate public health messaging**.**

d. **Laboratory Diagnosis:** Only two of the five national laboratories which were conducting sample analysis for diagnosis at the beginning of the outbreak are functional; due to stock out of reagents and other laboratory supplies.

III. CERF PROCESS

The minister of health called an Emergency National Council on Health meeting which is the highest health decision-making body in the country involving all the 36 commissioners of health and health partners (WHO, CDC, UNICEF, UNFPA, EU, INGOs) with the minister as chair to review the outbreak response at the state level and adopt effective strategies for early containment of the outbreak. However, many of these states are largely dependent on the FMoH and WHO to support most areas of the outbreak response. Due to the large number of states having Lassa fever outbreak at the same time, as well as outbreaks of other epidemic-prone diseases, the ministry's capacity for outbreak response was overstretched.

Prioritization criteria included the number of cases reported, endemic status of state for Lassa fever, case fatality rate and state's capacity for response. Katsina and Kaduna are non-endemic states with little capacity for response. Kaduna for instance has recorded the highest number of health worker infection. Lassa fever is endemic in Edo and Bauchi and they part of the states with high number of cases and having the most challenges compared to the other endemic states with high number of cases. Due to limited availability of funding for response a critical analysis to identified 10 states that required urgent response. These were further categorised based on total number of cases, availability of local capacity and funding and non-endemicity of the disease as indicated below.

S/No.	States with highest number of cases	No. of cases	CFR (%)	Availability of local outbreak response capacity and resources	Endemic state
1	Niger	36	53		Yes
2	Taraba	28	50		Yes
3	Edo	19	53		Yes
4	Kano	19	84		Yes
5	Bauchi	18	67		Yes
6	Kaduna	13	31		No
7	Nasarawa	11	82		Yes
8	Ondo	11	73		Yes
9	Ebonyi	11	27		Yes
10	Katsina	8	25		No

Based on the prioritization, four states (4) namely, Bauchi, Edo, Kaduna and Katsina were selected for CERF interventions. The CERF funded project would support for surveillance including contact tracing, case management, Infection Prevention and Control, strengthen laboratory capacity for Lassa fever diagnosis as well as mentoring of health care workers in each of the four states including doctors, nurses, laboratory scientists, environmental health officers, surveillance personnel and local health authority managers.

Of the $2,000,000 required for outbreak response and other health interventions, US $399,741 was requested from CERF to implement critical lifesaving interventions in the prioritized states. 300,000 women, men, girls and boys living in the immediate communities of the 17 LGAs in the four prioritized states were targeted.

IV. CERF RESULTS AND ADDED VALUE

TABLE 4: AFFECTED INDIVIDUALS AND REACHED DIRECT BENEFICIARIES BY SECTOR[1]

Total number of individuals affected by the crisis: 110,033,201

Cluster/Sector	Female			Male			Total		
	Girls (< 18)	Women (≥ 18)	Total	Boys (< 18)	Men (≥ 18)	Total	Children (< 18)	Adults (≥ 18)	Total
Health	70,344	69,545	**139,889**	86,200	81,622	**167,822**	156,544	151,167	**307,711**

[1] *Best estimate of the number of individuals (girls, women, boys, and men) directly supported through CERF funding by cluster/sector.*

BENEFICIARY ESTIMATION

A total of 307,711 men, women, boys and girls were reached with the CEFR funds in 4 states affected by Lassa fever outbreak. Through an enhanced surveillance system 273 cases of which 165 were confirmed Lassa fever were detected and treated. Of these, 89 mortalities were recorded in confirmed cases. A total of six health worker infections were recorded in these states. Over 1,000 contacts were listed and monitored for 21 days. Training of clinicians on infection prevention and control were conducted using funds from other sources to prevent further health worker infections.

TABLE 5: TOTAL DIRECT BENEFICIARIES REACHED THROUGH CERF FUNDING[2]

	Children (< 18)	Adults (≥ 18)	Total
Female	70,344	69,545	139,889
Male	86,200	81,622	167,822
Total individuals (Female and male)	**156,544**	**151,167**	**307,711**

[2] *Best estimate of the total number of individuals (girls, women, boys, and men) directly supported through CERF funding. This should, as best possible, exclude significant overlaps and double counting between the sectors.*

CERF RESULTS

A total of 307,711 benefited from the outbreak response. Medicines and medical supplies were procured for case management. Five virology laboratories were strengthened to conduct test for Lassa fever diagnosis. Availability of diagnostic test close to the affected states helped to reduce turnaround time for laboratory results. This facilitated early commencement of treatment which is associated with improved patient outcome. Early interruption of the Lassa fever transmission reduced the risk of further spread of the disease especially among close contacts and health workers.

CERF's ADDED VALUE

The CERF funds were used to quickly initiate response for the unprecedented outbreak. This helped to prevent spread of the disease. The capacity built during the first wave of the outbreak was used to start response during the second wave of the outbreak. This capacity could also be used for response to other viral haemorrhagic fever outbreaks.

a) Did CERF funds lead to a fast delivery of assistance to beneficiaries?
YES ☒ PARTIALLY ☐ NO ☐

The CERF fund was used to quickly initiate outbreak response. It provided opportunity to quickly procure medicines for the treatment of patients. The early initiation of treatment for the patients contributed to reduction of the case fatality rate. Items like thermometers were also procured to monitor the contacts for 21 days. In addition, availability of personal protective equipment gave the clinicians the confidence to manage the patients without fear of contracting the infection.

b) Did CERF funds help respond to time critical needs[1]?
YES ☐ PARTIALLY ☒ NO ☐

The CERF fund was used to initiate control measures early to interrupt transmission of the disease. It also helped to save a lot of lives that otherwise could have been lost if treatment was not commenced early. For Lassa fever, patients usually benefit from the treatment most when it is initiated within three days of contracting the disease. When treatment is delayed, the patient will develop complications which are difficult to reverse and this will eventually result in mortality. The Fund was also used to put in place infection prevention and control measures which helped to reduce the high rate of health worker infection which was recorded at the beginning of the outbreak.

c) Did CERF funds help improve resource mobilization from other sources?
YES ☒ PARTIALLY ☐ NO ☐

Starting the response and showing results in improvement of patient outcome using CERF fund helped to stimulate other partners to invest in the response and addressed some of the gaps that were critical to the response which was not covered by the CERF fund.

d) Did CERF improve coordination amongst the humanitarian community?
YES ☒ PARTIALLY ☐ NO ☐

There was an improvement in coordination among all partners involved in all aspect of the response at both national and state levels. The response was integrated with all the components including sectors outside health.

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

It helped to bring all actors together to break the transmission of the highly infectious disease. The government also appreciated the contribution of the UN in supporting the response.

[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.).

V. LESSONS LEARNED

TABLE 6: OBSERVATIONS FOR THE CERF SECRETARIAT		
Lessons learned	**Suggestion for follow-up/improvement**	**Responsible entity**
Availability of funds helped to kick start the outbreak response before government could mobilize resources to support the response.	This shows commitment from the UN side to complement and support Government's efforts, while acting immediately to the outbreak.	CERF secretariat
Non flexibility of the funds in terms of geographical coverage limits the ability to intervene in new areas affected by the Lassa virus. During the course of the response, other states with much more needs also had the outbreak but were not covered by the CERF funds.	Make CERF fund flexible especially in newly affected geophical areas by the same outbreak.	CERF secretariat

TABLE 7: OBSERVATIONS FOR COUNTRY TEAMS		
Lessons learned	**Suggestion for follow-up/improvement**	**Responsible entity**
Strong coordination among all actors involved in response helped to reduce duplication and contributed to the success of the outbreak response.	UN agencies can leverage on each other's strengths to maximize the limited resources. The government appreciates synergies among the UN agencies. This portrays the UN in a positive light.	HCT

VI. PROJECT RESULTS

TABLE 8: PROJECT RESULTS			
CERF project information			
1. Agency:	WHO	**5. CERF grant period:**	18/05/2016- 17/11/2016
2. CERF project code:	16-RR-WHO-024	**6. Status of CERF grant:**	☐ Ongoing
3. Cluster/Sector:	Health		☒ Concluded
4. Project title:	Emergency Response to Lassa Fever Outbreak in Nigeria		

7.Funding			
	a. Total funding requirements[2]:	US$ 2,000,000	d. CERF funds forwarded to implementing partners:
	b. Total funding received[3]:	US$ 699,741	▪ *NGO partners and Red Cross/Crescent:*
	c. Amount received from CERF:	US$ 399,741	▪ *Government Partners:*

Beneficiaries

8a. Total number (planned and actually reached) of individuals (girls, boys, women and men) directly through CERF funding (provide a breakdown by sex and age).

Direct Beneficiaries	***Planned***			***Reached***		
	Female	***Male***	***Total***	***Female***	***Male***	***Total***
Children (< 18)	70,200	85,800	**156,000**	70,344	86,200	**156,544**
Adults (≥ 18)	64,800	79,200	**144,000**	69,545	81,622	**151,167**
Total	**135,000**	**165,000**	**300,000**	**139,889**	**167,822**	**307,711**

8b. Beneficiary Profile

Category	***Number of people (Planned)***	***Number of people (Reached)***
Refugees		
IDPs		
Host population		
Other affected people	300,000	307,711
Total (same as in 8a)	**300,000**	**307,711**

[2] This refers to the funding requirements of the requesting agency (agencies in case of joint projects) in the prioritized sector for this specific emergency.

[3] This should include both funding received from CERF and from other donors.

In case of significant discrepancy between planned and reached beneficiaries, either the total numbers or the age, sex or category distribution, please describe reasons:	Please fill this in to elaborate on the over-achievement (target vs. accomplishment). Additional funding received from other sources contributed to reaching additional beneficiaries than earlier planned. Other aspects of the outbreak response that was not covered by CERF fund was addressed using funds from other sources which contributed significantly to the reduction and spread of the disease and early containment of the outbreak.

CERF Result Framework			
9. Project objective	To reduce avoidable morbidity and mortality associated with Lassa fever outbreaks in 17 affected LGAs in Bauchi, Edo, Kaduna and Katsina states		
10. Outcome statement	Well-coordinated and effective response to Lassa fever outbreak in Bauchi, Edo, Kaduna and Katsina states		
11. Outputs			
Output 1	300,000 persons (women, men, boys and girls) have improved surveillance and Laboratory support for Lassa fever outbreaks in Bauchi, Edo, Kaduna and Katsina states		
Output 1 Indicators	**Description**	**Target**	**Reached**
Indicator 1.1	Number of contact tracing teams supported to conduct contact tracing	34	37
Indicator 1.2	Number of thermometers procured for contact tracing	1,000	1,200
Output 1 Activities	**Description**	**Implemented by (Planned)**	**Implemented by (Actual)**
Activity 1.1	Provide transportation support for contact tracing teams	WHO/SMOH	WHO/SMOH
Activity 1.2	Procure and distribute thermometers to target states (Bauchi, Edo, Kaduna, Katsina)	WHO/FMOH	WHO
Output 2	300,000 persons (women, men, girls and boys) have improved case management for patients of Lassa fever in Bauchi, Edo, Kaduna and Katsina states		
Output 2 Indicators	**Description**	**Target**	**Reached**
Indicator 2.1	Number of treatment facilities supplied with case management and infection prevention and control supplies	4	6
Indicator 2.2	Number of laboratories supplied with reagents for Lassa fever diagnosis	5	5
Output 2 Activities	**Description**	**Implemented by (Planned)**	**Implemented by (Actual)**
Activity 2.1	Procure and distribute case management/IPC supplies	WHO/FMOH/SMOH	WHO/FMOH
Activity 2.2	Procure and distribute laboratory reagents to two reference laboratories	WHO/FMOH/SMOH	WHO/FMOH
Output 3	300,000 persons (women, men, boys and girls) have access to a well-coordinated Lassa outbreak response (Bauchi, Edo, Kaduna and Katsina states)		
Output 3 Indicators	**Description**	**Target**	**Reached**

Indicator 3.1	Number of monthly supportive supervision conducted	20	20
Output 3 Activities	**Description**	**Implemented by (Planned)**	**Implemented by (Actual)**
Activity 3.1	Provide supportive supervision to affected states	WHO/FMOH	WHO/FMOH

12. Please provide here additional information on project's outcomes and in case of any significant discrepancy between planned and actual outcomes, outputs and activities, please describe reasons:

There was an addition in the number of thermometers procured. This was as a result of a slight reduction in the initial price for the thermometers.

The teams used some innovative mechanisms learnt from other programs to reach additional population. There was commitment from some of the state governments which gave an opportunity to add additional treatment centers which was complemented by government's contribution to cover more population.

13. Please describe how accountability to affected populations (AAP) has been ensured during project design, implementation and monitoring:

The affected population were mobilized as community volunteers for outbreak or rumour reporting. Several rumours were reported by the community which were investigated and some of these rumours turned out to be true cases which were eventually evacuated from the community to the treatment centre.

14. Evaluation: Has this project been evaluated or is an evaluation pending?	EVALUATION CARRIED OUT ☐
No evaluation was planned at the outset. However, the project was monitored through regular daily updates and weekly meetings to review progress of the outbreak response. Monthly supportive supervisory visits to the states were also conducted to ensure adherence to project goals and national standards. The reports were shared with all stakeholders, while feedback was given to the state ministries of health including the state epidemiologists.	EVALUATION PENDING ☐
	NO EVALUATION PLANNED ☒

ANNEX 2: ACRONYMS AND ABBREVIATIONS (Alphabetical)

CFR	Case Fatality Rate
EOC	Emergency Operations Center
FMOH	Federal Minsitry of Health
IEC	Information Education and Communication
LGA	Local Government Area
NCDC	Nigeria Center for Disease Control
PPE	Personal Protective Equioment
SMOH	State Minsitry of Health
UNICEF	United Nations Children Fund
WHO	World Health Organization