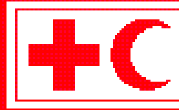
PROGRAMME UPDATE



MEASLES AND POLIO – AFRICA HEALTH INITATIVE

14 August 2006

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In Brief

Appeal No. MAA60001;
Programme Update no. 1;
Period covered: 1 January to 30 June 2006;
Appeal target for 2006-2007: CHF 3,011,000 (USD 2,447,967 or EUR 1,917,834);
Appeal coverage: 10%;
Outstanding needs: CHF 2,707,869 (USD 2,201,519 or EUR 1,724,757).

(Click here to go directly to the interim finance report)

Related Emergency or Annual Appeals:
- **Health & Care (MAA00001)**

Programme summary:
Despite tremendous progress in reducing the incidence of polio and the high global commitment to its eradication, polio still exists. Polio will continue to threaten children, and even adults, everywhere as long as it exists somewhere. This threat became a reality for Namibia in May 2006 when the country experienced its first outbreak of polio in more than a decade, affecting more adults than children and resulting in at least 15 deaths. The polio virus was genetically traced back to India, one of the four remaining endemic countries in the world. The other endemic countries include Nigeria, Pakistan, and Afghanistan. Measles outbreaks remain a threat to children. A recent measles outbreak in the Nakuru district of Kenya killed at least 10 children and underscored the need for the global coalition to fight both measles and polio. Participation of national societies in immunization campaigns was extremely reduced during this first half of the year due to lack of funding for this appeal. The national societies of Angola, Burundi, Eritrea, Swaziland and Zimbabwe could not participate fully in the campaigns because of financial constraints. Integrated measles campaigns have been planned for the second half of 2006 in Rwanda, Ethiopia, Uganda, Cameroon, Nigeria Sierra Leone, Democratic Republic of Congo, Ghana, Senegal and Guinea Conakry.

For further information specifically related to this operation please contact:
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All International Federation assistance seeks to adhere to the Code of Conduct and is committed to the Humanitarian Charter and Minimum Standards in Disaster Response in delivering assistance to the most vulnerable. For support to or for further information concerning other Federation programmes or operations in specific countries, please access the Federation's website at http://www.ifrc.org

Overall programme objective: To support national societies' involvement in community mobilization for polio and measles immunization activities, and to contribute towards the achievement of the highest-possible coverage, reaching the most vulnerable and difficult-to-access children.

Polio eradication – context

Poliomyelitis is a highly contagious, incurable viral infection of the nervous system that can cause crippling paralysis or death within hours of infection. It was once considered a global menace, but dramatic progress has been made since the formation of the Global Polio Eradication Initiative in 1988. The number of polio endemic countries has decreased dramatically from 125 countries in 1988 to four in 2006 (Nigeria, India, Afghanistan and Pakistan) a reduction of more than 99 per cent. Polio is now mainly a disease of poverty. Spreading through water or food contaminated with human waste, it is particularly devastating in crowded urban slums, where sanitation is poor and children are malnourished and out of reach of basic health services. The four remaining polio endemic countries remain a potential threat to re-establishment of the disease in neighbouring countries, and even other regions. This threat became a reality for Namibia in May 2006 when the country experienced the first outbreak of polio in more than a decade. The disease affected mainly adults, and this is unusual as polio is predominantly a disease that affects children under five years of age. The Namibia polio outbreak has been genetically traced to India and appears to have been transported via Angola. The outbreak affected 109 people and resulted in 15 deaths. In previous years, polio outbreaks in Botswana, Sudan and Somalia were linked to Nigeria, underscoring the need to eradicate the disease.

In 2006, the highest and most urgent priority for the Global Polio Eradication Initiative and for the International Federation is the rapid interruption of wild polio virus transmission in the four remaining endemic countries and in newly affected countries. At ministerial meetings on polio eradication, convened in Geneva in early 2005 by the World Health Organization (WHO), ministers of health from the most polio-affected countries in Africa and Asia signed the Geneva Declaration for Polio Eradication. They agreed to an unprecedented intensification of supplementary immunization activities to reach every child under five years of age with multiple doses of oral polio vaccine, to stop polio transmission, and to ensure that polio transmission is interrupted. The declaration includes a strategic plan of action until 2008, with indicators and milestones for interrupting transmission and for eventual achievement of global certification of polio eradication.

Success in interrupting the transmission of the wild polio virus depends on:

- The number of supplemental immunization activities conducted in each country reaching children with multiple doses of oral polio vaccine; and,
- The quality of supplemental immunization activities conducted (i.e. the percentage of target population reached).

As the organizations with the greatest presence at the community level, the national Red Cross and Red Crescent societies have a critical role in community mobilization and awareness raising in relation to polio.

More than 1,000 volunteers have been trained to work with local leaders and to conduct community mobilization, targeting 2,078,266 children in hardest-to reach-areas. The appeal intends to contribute to the last phase of eradicating polio by supporting national society participation in community mobilization for supplemental immunization activities, to contribute to the achievement of the highest possible coverage and to reach the most vulnerable and hard-to-reach children. Funding from this appeal is used to support the mobilization of volunteer networks including training, materials, coaching, incentives and transport. Similar to previous operations, the Federation will provide support to those few countries where wild polio virus still exists or where resurgence occurs.

Expected results:

- Children in hard-to-reach areas are vaccinated;
- Interruption of wild polio virus transmission by the end of 2008;
- National societies are actively participating in the national inter-agency coordination committees; and,

- Enhanced national society capacity in volunteer management and as a partner for other health initiatives.

Polio eradication activities:
- Financial and technical support to be provided to 15 national societies;
- Mobilization of volunteer networks, including coaching, training, incentives and transport and other logistic support;
- Community social mobilization and education to increase the knowledge about poliomyelitis, its consequences and the benefits of immunizations;
- Institutional capacity building of the national societies participating in the campaigns;
- Participation of national societies in micro-planning for the campaigns with partners that include the ministry of health, Rotary, UNICEF, WHO, and others;
- Volunteer participation in surveillance to report suspected cases to relevant authorities; and,
- Media coverage, reporting, monitoring and evaluation of the activities.

Red Cross and Red Crescent response

Namibia Red Cross Society (NRCS) was requested by its government to take a lead in community mobilization and education activities following a polio outbreak in June this year. To curb the disease, the ministry of health (MoH) decided to immunize the whole population of two million in three phased campaigns. The first campaign took place from 21-23 June 2006. The second was scheduled from 18-20 July 2006 while the third and final phase will be held from 22-24 August 2006. For this campaign Namibia Red Cross was funded from the Federation's Disaster Emergency Relief Fund (DREF) as there were no funds received towards the appeal budget. The national society participated with the MoH and other partners at all levels of the campaign from micro-planning to implementation. A total of 300 volunteers participated in the campaign. A regional health delegate and health officer from the regional delegation in Harare traveled to Namibia and worked with the national society in the field. UNICEF provided the 2.5 million doses for the first round of the campaign.

NRCS action on the ground included:
- Dissemination of information on how to identify the symptoms and where to go for assistance;
- Distribution of 17,000 basic hygiene messages and polio fact sheets nation-wide;
- Door-to-door community social mobilization to ensure that the people received vaccinations;
- Administering of oral polio drops at immunization points, health centers and during house-to-house vaccination; and,
- Namibia Red Cross Society provided 14 vehicles to assist the ministry of health and social services in transporting vaccines.

Nigeria: Lack of funding prevented the Nigerian Red Cross Society from taking part in a meaningful way in the four rounds of polio vaccination that took place in February, March, May and June. This is a cause f real concern as the role of the Nigerian Red Cross is critical in reaching the hardest to reach and most vulnerable populations in this country, the last polio endemic county in Africa.

Measles mortality reduction

Measles remains an important leading cause of death among young children, despite the availability of a safe and effective vaccine for the past 40 years. Estimated measles deaths on the African continent approximated 250,000 in 2005. Most these measles deaths occur in disadvantaged populations where regular health services are not available for various reasons, including cultural and geographical barriers. Morbidity from measles is higher and the complications are worse in malnourished children and those with other underlying conditions such as HIV infection and vitamin A deficiency. The high coverage required for measles elimination, and the need to achieve high routine immunization coverage for every birth cohort, are challenging. Addressing that challenge, and providing regular immunization services for the disadvantaged populations can provide the foundation for other life-saving public health interventions. Measles elimination will be of greatest benefit to disadvantaged and vulnerable populations who have the greatest disease burden. Measles elimination is not only a health issue but also an issue of justice and fairness.

The good news is that, globally, consolidated efforts by the Measles Initiative Partnership and governments have resulted in a 39 per cent reduction in measles deaths, from 873,000 in 1999 to an estimated 530.000 in 2003. The largest reduction occurred in Africa the region with the highest burden of the disease where measles deaths decreased by 46 per cent. With more than 200 million vaccinations in more than 40 countries since 2000, high coverage is achieving population immunity with reduced measles transmission. Elimination of measles in Africa and Asia is possible. Elimination does not mean zero cases, but it does imply:

- that the measles virus is no longer circulating and that following occurrences of "importation" any further spread is very limited; and,
- that once elimination is achieved, it must be maintained by keeping practically every person immune to measles.

The measles elimination strategy includes ensuring that 95 per cent of children get two doses of measles vaccine, that surveillance detects all suspected cases of measles, and that laboratory support is available to confirm diagnosis. Achieving measles elimination requires sustained political and financial commitment, technical capacity and high quality supplemental immunization activities.

Objectives (measles):

- To work towards the achievement of the Millennium Development Goal of reducing child mortality;
- To assist in the reduction of measles deaths among vulnerable children; and,
- To work towards the interruption of indigenous measles transmission in targeted countries.

Expected results (measles):

- Increased community awareness of the importance of immunization;
- National societies increasingly participating in in-country coordination committees;
- Community involvement and communities helping themselves;
- Improved volunteer management and other national society capacity filtering down to other programmes; and,
- Selected districts with Red Cross capacity, emphasizing quality over quantity.

Activities:

- Measles community control efforts coordinated and integrated with national immunization efforts to "reach the un-reached";
- Participation of selected national societies in measles campaigns;
- Follow-up activities to maintain a high level of immunization coverage and use of insecticide treated mosquito nets where this is the case;
- Strengthening of partnerships for planning activities and implementation at national, regional and global levels;
- National society participation in in-country coordination committees, and henceforth preparation of planned activities that are in line with the national programme;
- Institutional capacity building of the national societies participating in the campaigns;
- Participation of national societies in micro-planning for the campaigns with partners including the ministry of health, Rotary, UNICEF, WHO and others;
- Volunteer participation in surveillance to report suspected cases to relevant authorities; and,
- Logistics support plus media coverage, reporting, monitoring and evaluation of activities.

Red Cross and Red Crescent response

- National societies of Kenya, Central African Republic, Chad, Rwanda, and Burundi were assisted with the preparation of proposals;
- Advocacy on behalf of the national societies at global and regional levels resulted in Nigeria Red Cross and Rwanda Red Cross accessing funding from the Measles Partnership and the American Red Cross;
- Funding was provided to the national societies of Kenya, Chad and Central African Republic to enable them to participate in the national immunization campaigns; and,

- Representation of the Federation at global level through participation in related inter-agency telephone conference calls.

Angola Red Cross Society (ARC) participated in the National Measles Immunization Campaign from 13-17 July 2006. More than 860 staff and volunteers from Angola Red Cross worked together with partners in both urban and rural areas. The ARC volunteers conducted house-to-house visits to disseminate information and persuade the communities to participate fully in the campaign. Twenty one Angola Red Cross health posts functioned as vaccination centres where children received measles and polio vaccines, in addition to mebendazole, a de-worming treatment, and vitamin A supplements.

Central African Republic Red Cross Society received funding from this appeal to support the ministry of health's nationwide measles campaign conducted between 30 January and 5 February. In total 1,699,549 children between six months and 14 years of age were vaccinated representing 92.1 per cent of the target populations. Red Cross volunteers targeted 444,000 children slated to be vaccinated.

Implementation structure

- Each volunteer worked within a 500-metre radius around their home;
- Chairpersons of CAR Red Cross local committees acted as team leaders;
- Four coaches selected from the technical executives of the national society followed up the volunteers in four towns (Bambari, Bria, Mobaye and Bangassou);
- A supervisor from CAR Red Cross toured the four towns jointly with representatives of the ministry of health and WHO;
- A coordinator was given the responsibility of summarizing and analyzing data for the final report; and,
- The CAR Red Cross ambulance was used for the operation.

A total of 350 volunteers were mobilized for the campaign. The Federation supported the mobilization of 150 volunteers, while other partners, the ministry of health, UNICEF and WHO, supported the mobilization of 200 volunteers.

Kenya Red Cross Society teamed up with partners to fight measles and malaria. The timeline for the planned campaign targeting five million children was moved forward and accelerated due to a measles outbreak that killed at least 10 children in Nakuru district and the re-emergence of polio in neighboring Somalia. The government of Kenya divided the campaign into two phases, and launched the first phase in 16 districts on 29 April, which was followed by a second phase conducted between 8-12 July for the rest of the country.

In addition to measles vaccinations, the campaign provided other life-saving health interventions, including polio vaccinations (in select districts), vitamin A and de-worming medicine. Residents of Nyanza in the western provinces, as well as Malindi and Lamu districts in the coastal province, also received insecticide-treated nets, proven to be one of the most effective and cost-efficient means of preventing malaria. The campaign was supported by the Federation and the Measles Initiative, a partnership formed to reduce measles deaths in sub-Saharan Africa (which is led by the American Red Cross, United Nations Foundation, WHO, UNICEF and U.S. Centers for Disease Control and Prevention). In addition, the Global Fund to Fight AIDS, Tuberculosis, and Malaria provided long-lasting insecticide treated nets. The Kenya Red Cross Society mobilized 2,317 volunteers who worked in 17 districts out of a total of 62 campaign districts. In addition the national society provided 25 trucks and 10 four-wheel drive vehicles to cover the 17 districts.

Tasks for the volunteers included:

- Conducting social mobilization and delivering education messages about vaccination and why it is important that all children under five complete the routine vaccination schedule;
- Helping in crowd control to ensure easy and smooth flow of people from one intervention table to the next;
- Assisting with registration of the children; and,
- Identifying beneficiaries of and distribution of long-lasting insecticide nets.

Chad Red Cross Society worked with partners in planning a measles campaign that was conducted in February. A total of 500 volunteers participated in a nation-wide social mobilization campaign to inform all parents, other

caregivers, teachers and social workers, the private sector, community, political, and religious leaders about the need to have their children vaccinated against measles and polio. A total of 2,735,760 children were reached out of a targeted 2,712,011, a coverage rate of over 100 per cent.

Baphalali Swaziland Red Cross Society volunteers supported the July measles campaign in collaboration with the ministry of health and other partners. All three of the Red Cross clinics were used as vaccination centres. The clinic staff and volunteers participated in the campaign. The Red Cross volunteers also conducted community mobilization through house-to-house visits.

Bangladesh Red Crescent Society provided valuable assistance to the March 2006 mass nationwide measles campaign funded by the American Red Cross and the Measles Initiative Partnership. From February 25 through March 16, the Bangladesh government was assisted in vaccinating more than 33.5 million children between nine months and 10 years of age. The Bangladesh campaign was the largest measles mass vaccination of its kind in history. In order to accomplish this feat, the Bangladeshi Ministry of Health recruited more than 800,000 volunteers and promoted the campaign via radio, television, print and door-to-door canvassing. More than 600 volunteers from the Bangladesh Red Crescent Society mobilized people and helped coordinate the campaign. Funds from this appeal enabled volunteers to increase the outreach to the most vulnerable groups in Bangladesh.

Challenges

- The greatest challenges faced during the first part of this year related to very limited funding to support the Red Cross national societies to fully participate in the national immunization campaign.
- In addition, the national societies of Nigeria, Kenya, Rwanda, Burundi and Angola in particular, also experienced difficulties in accessing Measles Partnership funding at country level. This, coupled with lack of available funding from the Federation, led many national societies to reduce activities which would contribute to a reduction in child mortality and morbidity.
- The national societies of Angola, Eritrea, Burundi and Zimbabwe were eager to participate fully in the measles and malaria prevention campaigns conducted in their countries but failed to do so due to lack of funding, presenting further missed opportunities to eradicate these diseases among the most vulnerable.
- Participation of the Nigeria Red Cross in the last phase to eradicate polio is crucial as this is the last polio endemic country in Africa and Red Cross volunteers have been instrumental in increasing polio vaccination coverage in the most difficult areas.
- Reduced visibility of the national societies at country level planning and implementation of activities is detrimental to their image.

Integrated measles campaigns are planned for the second half of 2006 in Rwanda, Ethiopia, Uganda, Cameroon, Nigeria Sierra Leone, Democratic Republic of Congo, Ghana, Senegal and Guinea Conakry. Funding is required to support these national societies. Namibia will conduct the third round of polio vaccination, integrated with administration of vitamin A, in August.

Conclusion

Despite tremendous global progress that has been made in reducing the incidence of polio, the threat of polio transmission from the remaining polio endemic countries of Nigeria, India, Pakistan, and Afghanistan to other parts of the world remains real. This has been demonstrated by the June outbreak of polio in Namibia, a country that had been polio-free for more than a decade. The disease was unusual in that it affected more adults than children and resulted in 106 cases and at least 15 deaths, prompting the neighbouring countries to be on high alert. In general, measles outbreaks have also been significantly reduced but outbreaks with case fatalities are still being detected in developing countries among underprivileged populations where access to health facilities is limited. A June measles outbreak in Kenya killed at least 10 children underscoring the need for the global coalition to fight both diseases forcefully.

Interim financial report below;
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International Federation of Red Cross and Red Crescent Societies

MAA60001 - AFRICA HEALTH INITIATIVE: MEASLES AND POLIO

Interim financial report

Selected Parameters	
Reporting Timeframe	2006/1-2006/5
Budget Timeframe	2006/1-2007/12
Appeal	MAA60001
Budget	APPEAL

All figures are in Swiss Francs (CHF)

I. Consolidated Response to Appeal

	Health & Care	Disaster Management	Humanitarian Values	Organisational Development	Coordination & Implementation	TOTAL
A. Budget	3,010,871	0				3,010,871
B. Opening Balance	252,252	0				252,252
Income						
Cash contributions						
Norwegian Red Cross	*50,750*					*50,750*
Swedish Red Cross	*19,800*					*19,800*
C1. Cash contributions	*70,550*					*70,550*
Outstanding pledges (Revalued)						
Swedish Red Cross	*-19,800*					*-19,800*
C2. Outstanding pledges (Revalued	*-19,800*					*-19,800*
Reallocations (within appeal or from/to another appeal)						
IOC/CIO	*0*					*0*
New Zealand Red Cross	*0*					*0*
Norwegian Red Cross	*0*					*0*
Swedish Red Cross	*0*					*0*
C3. Reallocations (within appeal or	*0*					*0*
C. Total Income = SUM(C1..C6)	50,750	0				50,750
D. Total Funding = B +C	303,002	0				303,002

II. Balance of Funds

	Health & Care	Disaster Management	Humanitarian Values	Organisational Development	Coordination & Implementation	TOTAL
B. Opening Balance	252,252	0				252,252
C. Income	50,750	0				50,750
E. Expenditure	-160,610					-160,610
F. Closing Balance = (B + C + E)	142,392	0				142,392

International Federation of Red Cross and Red Crescent Societies

MAA60001 - AFRICA HEALTH INITIATIVE: MEASLES AND POLIO

Interim financial report

Selected Parameters	
Reporting Timeframe	2006/1-2006/5
Budget Timeframe	2006/1-2007/12
Appeal	MAA60001
Budget	APPEAL

All figures are in Swiss Francs (CHF)

III. Budget Analysis / Breakdown of Expenditure

Account Groups	Budget	Expenditure						Variance
		Health & Care	Disaster Management	Humanitarian Values	Organisational Development	Coordination & Implementation	TOTAL	
	A						B	A - B
BUDGET (C)		3,010,871	0				3,010,871	
Supplies								
Food		135					135	-135
Teaching Materials		1,601					1,601	-1,601
Other Supplies & Services		65					65	-65
Total Supplies		1,801					1,801	-1,801
Transport & Storage								
Storage		10					10	-10
Transport & Vehicle Costs	500,000	7,369					7,369	492,631
Total Transport & Storage	500,000	7,379					7,379	492,621
Personnel Expenditures								
Delegates Payroll	1,011,164	1,731					1,731	1,009,433
Regionally Deployed Staff	300,000							300,000
National Staff		197					197	-197
National Society Staff		49,487					49,487	-49,487
Consultants	150,000							150,000
Total Personnel Expenditures	1,461,164	51,415					51,415	1,409,749
Workshops & Training								
Workshops & Training	300,000	22,522					22,522	277,478
Total Workshops & Training	300,000	22,522					22,522	277,478
General Expenditure								
Travel	200,000	11,811					11,811	188,189
Information & Public Relation	100,000	9,357					9,357	90,643
Office Costs	100,000	5,750					5,750	94,250
Communications	100,000	1,100					1,100	98,900
Financial Charges		3,442					3,442	-3,442
Other General Expenses	54,000	46					46	53,954
Total General Expenditure	554,000	31,506					31,506	522,494
Federation Contributions & Transfers								
Cash Transfers National Societies		45,171					45,171	-45,171
Total Federation Contributions & Tr		45,171					45,171	-45,171
Program Support								
Program Support	195,707	7,504					7,504	188,203
Total Program Support	195,707	7,504					7,504	188,203
Operational Provisions								
Operational Provisions		-6,688					-6,688	6,688
Total Operational Provisions		-6,688					-6,688	6,688
TOTAL EXPENDITURE (D)	3,010,871	160,610					160,610	2,850,261
VARIANCE (C - D)		2,850,261					2,850,261	