Ethiopia
Emergency type: Complex
Reporting period: 1-30 June 2019

HIGHLIGHTS

- Cumulatively 990 cases of cholera, with 33 confirmed by culture have been reported since April 2019. WHO, UNICEF, SCI, MSF-E are supporting the cholera outbreak response in different locations.

- Ethiopia has embarked on the cholera control and elimination roadmap. A high level advocacy meeting is scheduled on 23 July 2019 where the plan will be rolled out to stakeholders, in line with GTFCC 2030 strategy.

- The government-led IDP return exercise was completed. In some locations, there is limited access to health services, with health facilities completely destroyed, and shortages of medicines and medical supplies reported.
**Situation update**

Cumulatively 990 cases of cholera, with 33 confirmed by culture have been reported since April 2019. Addis Ababa, Oromia, Afar and Tigray have active outbreak. The outbreak in Amhara and Somali was recently called off by EPHI after no cases were reported for more than 30 days. WHO, UNICEF, SCI, MSF-E are supporting various elements of the cholera outbreak response in different locations. IMC, IRC, MCMDO, AAH will also provide some support starting soon.

![National cholera cases as of Week-27,2019](image)

With the ongoing rains, and unchanged underlying risks across the country, the cholera outbreak is far from over. These factors include congestion in the slums and secondary displacement locations, poor sewage and sanitation facilities, low access to clean drinking water, poor regulation and standards for commercial farms and eateries around construction areas that have large numbers of casual laborers. The outbreak has been migratory, with an irregular epi-curve, hence calling for greater response preparedness in all hotspot areas.

The government-led IDP return exercise was completed. Recent Protection monitoring assessments have revealed that due to insecurity in areas of return, large numbers of people who were returned to their places of origin have gone back to the communities in which they were hosted as IDP. Many houses, schools and health facilities were completely burned down. In some locations, there is limited access to health services, with shortages of medicines and medical supplies, and returnees are fetching water from unprotected water sources with no water treatment chemicals. People are being accommodated under very crowded communal shades. No NFI has been distributed in some areas of return. There have been complaints from IDP who remained behind claiming that they have been denied access to any services except in the area of return.

**Public Health risks, priorities, needs and gaps**

**Health risks**

- Conflict and population displacement leading to increased health demands to the facilities, due to new and pre-existing conditions and diseases, mental health burden, sexual and gender based violence, and other sexual and reproductive health needs.

- Communicable disease outbreaks due to low literacy levels, poor and congested living conditions, poor WaSH facilities and practices, mass gatherings and activities, and low vaccination coverage for vaccine preventable diseases.

- Food insecurity and malnutrition which contribute to higher vulnerability of children and other people to infectious diseases and other disease conditions.
**Priorities**

- Delivery of essential life-saving emergency health services to vulnerable populations by ensuring sufficient quantities of quality medicines and medical supplies, and health workers teams to perform the work.

- Work with and strengthen the capacity of the existing health system by training health workers and establishing humanitarian-development linkages.

- Enhance quality of the response through field level coordination, monitoring and support to partners with the main focus on IDP locations and new incidents.

- Improve the collection and collation of data and information from partners, present it in information products and use it for decision making, resource mobilization and guiding the response.

- Support joint and integrated approaches with other Clusters targeting the same locations and populations with humanitarian response.

**Needs and gaps**

- Significant shortages of qualified health staff to implement the response in emergency affected locations, in an already strained health system, and partners’ inability to recruit adequately.

- There have been ruptures in the core pipeline for essential drugs and vaccines, due to systemic bottlenecks. No new emergency stocks for the Cluster have arrived this year, but plans for restocking are on course.

- Partially constituted Cluster coordination team, with inconsistency due to short deployments, and lack of sub-national presence in the areas with active incidents.

**Health Cluster Action**

**2019 HRP dashboard**

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Jan</th>
<th>Feb</th>
<th>Mar</th>
<th>Apr</th>
<th>May</th>
<th>June</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 OPD consultations in IDP locations</td>
<td>25,981</td>
<td>36,676</td>
<td>70,178</td>
<td>38,352</td>
<td>49,759</td>
<td>43,521</td>
<td>264,467</td>
</tr>
<tr>
<td>2 OPD consultations for CU5 in IDP locations</td>
<td>13,933</td>
<td>11,125</td>
<td>16,536</td>
<td>13,068</td>
<td>20,158</td>
<td>14,627</td>
<td>89,447</td>
</tr>
<tr>
<td>3 Normal deliveries attended by skilled birth attendants</td>
<td>348</td>
<td>402</td>
<td>209</td>
<td>150</td>
<td>370</td>
<td>301</td>
<td>1,780</td>
</tr>
<tr>
<td>4 WCBA receiving comprehensive RH services (modern contraceptives)</td>
<td>1,911</td>
<td>1,525</td>
<td>1,242</td>
<td>1,026</td>
<td>2,248</td>
<td>2,576</td>
<td>10,528</td>
</tr>
<tr>
<td>5 Epidemic prone disease alerts verified and responded to in 48 hours</td>
<td>4</td>
<td>3</td>
<td>22</td>
<td>21</td>
<td>3</td>
<td>-</td>
<td>53</td>
</tr>
<tr>
<td>6 Children 6 months to 15 years receiving emergency measles vaccine</td>
<td>3,060</td>
<td>390,277</td>
<td>257,164</td>
<td>779,126</td>
<td>55,500</td>
<td>396,286</td>
<td>1,881,413</td>
</tr>
<tr>
<td>7 Health facilities providing CMR services for SGBV survivors</td>
<td>54</td>
<td>29</td>
<td>120</td>
<td>12</td>
<td>196</td>
<td>180</td>
<td>-</td>
</tr>
<tr>
<td>8 Health facilities addressing health needs of persons with disabilities</td>
<td>36</td>
<td>17</td>
<td>7</td>
<td>0</td>
<td>195</td>
<td>174</td>
<td>-</td>
</tr>
<tr>
<td>9 Health facilities providing MHPSS services in IDP locations</td>
<td>26</td>
<td>33</td>
<td>21</td>
<td>4</td>
<td>75</td>
<td>64</td>
<td>-</td>
</tr>
<tr>
<td>10 Referrals to higher level and specialized services completed</td>
<td>49</td>
<td>125</td>
<td>235</td>
<td>170</td>
<td>72</td>
<td>78</td>
<td>734</td>
</tr>
</tbody>
</table>

**Strategy and response processes**

The national cholera outbreak response is coordinated at the EPHI’s EOC, with regional and zonal health bureaus activating their EOC too. The response has so far focused on case management, social mobilization and risk communication, logistics and supplies, surveillance and laboratory investigation, and WaSH. Amibara’s outbreak provides an opportunity for forward planning, since the casual laborers come from SNNPR. Led by the EPHI and support from partners, there are ongoing interventions targeting the areas of origin of the casual laborers with risk communication messages to reduce the probability of the outbreak spreading. In the coming weeks, there will be religious events with gatherings of hundreds of thousands of people expected. Several preventive and mitigation activities including a cholera sensitization meeting with church leaders have been scheduled beforehand. The EPHI/FMoH with support from WHO and other partners has embarked on the cholera control and elimination plan. There will be a high level advocacy meeting on 23 July 2019, where stakeholders will be briefed on the current cholera outbreak in the country and response, hotspot mapping, and the roadmap towards the Global Taskforce for Cholera Control’s (GT FCC) target of eliminating cholera by 2030.

The Health Cluster continued to emphasize to 9 partners whose EHF SA1 projects were accepted, that the emergency health services should move with the IDP to the areas of return. Support to health facilities and mobile teams should mostly be directed towards the return locations. This level of flexibility is also expected with partners supporting the cholera response.
Health Cluster coordination

In June, the Health Cluster held the strategic advisory group (SAG) and monthly coordination meetings, focussing on support to cholera outbreak response and new proposal for partners to report on HRP indicator at woreda level.

At the sub-national level, weekly coordination meetings continued in West Wellega, East Wellega, Gedeo, West Guji zones, Amhara and Somali regions. These meetings are conducted by the Health authorities and co-chaired by WHO.

Field support and monitoring

The Health Cluster coordination team visited West Hararge focusing on the local cholera response. On-site feedback was provided with a view to strengthening the response. It was observed that partners on the ground are working in close coordination with the Zonal Health Department and holding regular meetings to guide the response.

Provision of essential drugs and supplies

WHO distributed 8 cholera central reference kits in Addis Ababa, 4 to Oromia RHB.
UNFPA distributed 24 kits of post rape treatment kits in West Guji Zone 6 woredas to support the clinical management of rape survivor’s medical services.
UNICEF supported cholera outbreak response by prepositioning CTC kits in Tigray, Afar, Dire Dawa, Addis Ababa and Oromia regions.

Training of health workers

UNFPA conducted Minimum Initial service Package (MISP) training for 24 (10 female, 14 Male) health workers from MoH, EPHI and emergency affected health facilities in Gedeo, West Guji, West Hararge, Metekel and Central Gonder zones from 17-20 June 2019 in Adama.
WHO trained 69 health worker from Addis Ababa jointly with EPHI and AAHB on case management, IPC and case finding for cholera.
87 health workers drawn from the cholera affected woredas and more at risk woredas in West Hararge were trained on cholera case management, surveillance, cholera treatment center establishment, WaSH and risk communication.
32 health workers from West Guji were trained on emergency preparedness, outbreak investigation and response, data management and risk communication.
WHO with financial support from World Vision Ethiopia supported the training of 24 health workers in Gedeo zone in the management of SAM cases.

Child health

Measles vaccination was conducted for South Sudan refugees aged 6 month to 14 years at entry points in Gambella. 110 children at refugee camps and 1,283 children at points of entry were vaccinated against measles.

The SRHB with support from partners started measles SIA campaign targeting children 6 months to 15 years of age in 11 sites located in four zones—Fafan, Jarar, Afder and Liban IDP including two refugee sites. A total of 394,580 of which 34,404 refugees were vaccinated against measles.

Following the confirmed cVDPV2 outbreak in Ethiopia, there was joint tripartite micro-planning exercise in Hargeisa, Somalia for the purpose of conducting synchronized mass vaccination campaigns in Ethiopia Somali region, Somaliland and Puntland. The targeted under 5 years children for mOPV2 round zero SIA campaign in ESR’s 19 woredas was 204, 580 children. The coverage was 95.6% in Dollo and 96% in Jarar zones.
Communicable diseases control and surveillance

Table 1: Number of cases reported during WHO Epi week 22-25, 2019, Ethiopia

<table>
<thead>
<tr>
<th>Region Name</th>
<th>Malaria</th>
<th>MM</th>
<th>SAM</th>
<th>AFP</th>
<th>Measles</th>
<th>NNT</th>
<th>Rabies</th>
<th>Cholera</th>
<th>Maternal</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Cases</td>
<td>Deaths</td>
<td>Cases</td>
<td>Deaths</td>
<td>Cases</td>
<td>Deaths</td>
<td>Cases</td>
<td>Deaths</td>
<td>Cases</td>
</tr>
<tr>
<td>Addis Ababa</td>
<td>176</td>
<td>1</td>
<td>11</td>
<td>-</td>
<td>286</td>
<td>1</td>
<td>1</td>
<td>-</td>
<td>41</td>
</tr>
<tr>
<td>Afar</td>
<td>1,746</td>
<td>-</td>
<td>1</td>
<td>-</td>
<td>264</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Amhara</td>
<td>36,961</td>
<td>1</td>
<td>17</td>
<td>-</td>
<td>1,951</td>
<td>3</td>
<td>10</td>
<td>-</td>
<td>263</td>
</tr>
<tr>
<td>Benishangul-Gumuz</td>
<td>12,580</td>
<td>2</td>
<td>21</td>
<td>-</td>
<td>68</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>6</td>
</tr>
<tr>
<td>Dire Dawa</td>
<td>50</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>153</td>
<td>-</td>
<td>-</td>
<td>1</td>
<td>11</td>
</tr>
<tr>
<td>Gambella</td>
<td>5,333</td>
<td>1</td>
<td>2</td>
<td>-</td>
<td>83</td>
<td>1</td>
<td>1</td>
<td>-</td>
<td>6</td>
</tr>
<tr>
<td>Harari</td>
<td>43</td>
<td>-</td>
<td>3</td>
<td>-</td>
<td>124</td>
<td>2</td>
<td>-</td>
<td>-</td>
<td>55</td>
</tr>
<tr>
<td>Oromia</td>
<td>8,584</td>
<td>-</td>
<td>115</td>
<td>4</td>
<td>8,428</td>
<td>13</td>
<td>15</td>
<td>-</td>
<td>663</td>
</tr>
<tr>
<td>SNPP</td>
<td>22,757</td>
<td>1</td>
<td>55</td>
<td>-</td>
<td>3,630</td>
<td>12</td>
<td>4</td>
<td>-</td>
<td>26</td>
</tr>
<tr>
<td>Somali</td>
<td>3,993</td>
<td>-</td>
<td>35</td>
<td>-</td>
<td>4,454</td>
<td>3</td>
<td>4</td>
<td>-</td>
<td>190</td>
</tr>
<tr>
<td>Tigray</td>
<td>4,158</td>
<td>-</td>
<td>4</td>
<td>-</td>
<td>169</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>4</td>
</tr>
<tr>
<td>Grand Total</td>
<td>96,381</td>
<td>6</td>
<td>264</td>
<td>4</td>
<td>19,610</td>
<td>35</td>
<td>35</td>
<td>-</td>
<td>1,268</td>
</tr>
</tbody>
</table>

On each epi week from 22 to 25, up to half of the regions fell short of the required 80% IDSR reporting completeness and timeliness, affecting the national average. EPHI is following up so that there is improvement in coming weeks.

Cumulatively 990 cases of cholera, with 33 confirmed by culture have been reported since April 2019. Addis Ababa, Oromia, Afar and Tigray have active outbreak. The outbreak in Amhara and Somali was recently called off by EPHI after no cases were reported for more than 30 days. WHO, UNICEF, SCI, MSF-E are supporting various elements of the cholera outbreak response in different locations. IMC, IRC, MCMDO, AAH will also provide some support starting soon. The EPHI conducted an OCV campaign in Addis Ababa.

There were increased caseloads of malaria in 13 woredas of Amhara and 5 woredas of SNNP regions, above thresholds of previous seasons. The health system is coping with the increased burden.

Support to health service delivery

UNICEF’s 49 MHNT in Afar and Somali regions conducted 45,410 medical consultations in June, of which 44% were children under five and 32% were women. UNICEF technical assistance supported the cholera and IDP operations in Oromia in planning, coordination and monitoring.

IOM continued to provide lifesaving health services for IDP and host communities through MHNT. The teams conducted 6,115 medical consultations and reached 10,626 beneficiaries. MHPSS services were provided for 4,908 clients. IOM also provided reproductive health services to 1,431 women.

MCMDO’s project facilitated conflict affected IDP/returnees and host communities to access essential health and nutrition service through the mobile teams. 5 MHNT and 2 CMAM teams were deployed in West Guji and West Wollega zones. Cumulatively 163,160 beneficiaries received services in West Guji and West Wollega. 15,143 consultations and treatment were conducted, including nutrition, ANC, FP, delivery, EPI services, vitamin A and deworming.

SCI in collaboration with Zonal health office conducted training on national PHEM guideline for 27 health professionals.
Health Cluster 3W map

Plans for future response
The Health Cluster through partners will implement essential life-saving health services for IDP, returnees and host communities in emergency locations. Conflict affected Kamashi, Dawa, Wellegas, Hararges, West Guji, Gedeo, and Borena/Moyale, will be prioritized. Response to on-going cholera, measles, and scabies outbreaks, as well as the early warning system will be considered. Surge support to the existing network of health facilities and outreach services will be preferred as much as possible, with mobile health and nutrition teams (MHNT) reserved for locations and populations of limited access.

Health Cluster meeting partners
National

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