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Revised Emergency appeal
Madagascar: Plague (Epidemic)

International Federation of Red Cross and Red Crescent Societies

Revised Emergency Appeal ***n° MDRMMG013***	***1,200,000 people*** *to be assisted*	*Appeal launched* ***16 October 2017***
Glide n° ***EP-2017-000144-MDG***	***1,000,000 Swiss francs*** *DREF allocated*	*Revision n° 1 issued* ***04 December 2017***
	2,191,472 Swiss francs *Revised Appeal budget (reduced from 5.5 m)*	*Appeal ends* ***17 Jun 2018***
	1,297,334 ***Swiss francs funding gap***	***IFRC Budget Holder/Project Manager:*** *Youcef Ait Chellouche*

This revised Emergency Appeal seeks a total of 2.19 million Swiss francs to enable the International Federation of Red Cross and Red Crescent Societies (IFRC) to support the Malagasy Red Cross Society (MRCS) to deliver assistance to **some 1.2 million people over 9 months** (until June 2018), **to contribute to the reduction in mortality and morbidity due to the plague outbreak in 10 priority regions** (reduced from 22) **through effective prevention, response and capacity building activities**. The focus of the appeal is on Health promotion and Community Engagement and Accountability (CEA) for behavior change, Community-Based Surveillance (CBS), Clinical Case Management through running the Plague Treatment Unit (PTU) and vector control, sanitation and hygiene support. Capacity building activities and trainings are also to be carried in the areas of Psychosocial Support (PSS) and Safe and Dignified Burials (SDB). Details are available in the Emergency Plan of Action (EPoA) *<click here>*

The disaster and the Red Cross Red Crescent response to date

August 2017: First death is recorded of a patient infected with plague in Madagascar.

September 2017: Malagasy Red Cross (MRCS) is responding with initial actions in sensitization, identification of suspected cases and training in affected communities.

03 October 2017: Plague cases are quickly escalating. A total of 20 districts across Madagascar report cases with cumulative number of 194 with 50 deaths recorded. By 12 October, a total of 31 districts report cases of the plague, with 684 cases and 57 deaths recorded. 474 of these cases are pneumonic transmission.

MRCS volunteers talk to villagers about the plague outbreak, 30 miles west of Antananarivo, Madagascar, Monday, Oct. 16, 2017

06 October 2017: 1,000,000 Swiss francs is allocated from IFRC's Disaster Relief Emergency Fund (DREF).
09 October 2017: Field Assessment and Coordination Team (FACT) arrives in country.

16 October 2017: IFRC launches an Emergency Appeal for 5.5 million Swiss francs and a surge team is deployed: Head of Emergency Operations, Regional Disaster Response Teams (RDRT), FACT and IFRC-led Emergency Response Unit (ERU).

04 December 2017: The Revised Emergency Appeal is launched with a reduced budget and shortened timeframe to be adjusted to the epidemic situation and changing needs.

Summary:

With the plague caseload decreasing over the last few weeks and the epidemic currently under control, the operational strategy was modified to meet the actual needs on the ground. Therefore, the Emergency Appeal has been revised with budget reduction and scaling down of some immediate response activities, while the capacity building component is being scaled up and trainings increased to reach over 900 volunteers who will carry out community based and preparedness activities to be able to respond in case of new epidemic peaks.

The highlights of this revision are as follows:

- ✓ The operation will focus on ten regions (see list below) instead of the 22 regions originally intended.
- ✓ The timeframe has been decreased from 18 to 9 months (until 17 June 2018)
- ✓ The budget has been reduced from CHF **5,5 m** to CHF **2,19 m**
- ✓ The 6 pillar-response strategy will now focus on 4 pillars which are:
    1. Health promotion and Community Engagement and Accountability for behavior change.
    2. Community-Based Surveillance.
    3. Clinical Case Management and running the Plague Treatment Unit (PTU) at the Andohatapenaka Hospital which will be kept on alert, with core staff ready to welcome plague patients and organize training in plague treatment, prevention and control.
    4. Vector control, sanitation and hygiene activities.

Psychosocial Support (PSS) capacity building, PSS activities and anti-stigma campaigns will also be carried out alongside the four main pillars above. In terms of Safe and Dignified Burials (SDB), 30 staff and volunteers will be trained in SDB preparedness training. However, at this time, burials will only be initiated in case of a high number of plague deaths that the authorities would be unable to handle and subject to the SDB protocol being approved by the authorities.

Key activities to date: 900 volunteers have/ are being trained in CEA, out of which 600 are trained in CBS, 300 in vector control activities, 100 in PSS and 30 staff and volunteers in SDB. Since the plague season usually goes to April, plague cases are still possible to occur, and vigilance must be maintained with a MRCS core national team[1] in place at the PTU ready to treat plague patients and able to continue to train medical and para-medical staff. Overall, the funds of all operational partners are running low whilst support is still needed to maintain the capacity at the PTU at least to the end of the plague season, to strengthen outbreak and vector control and to focus on capacity building of MRCS in community preparedness and reinforce prevention measures.

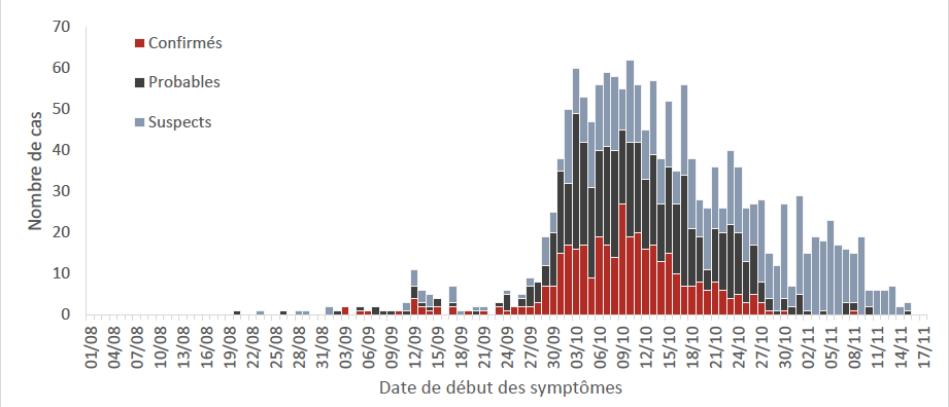
The operational strategy

Context

Plague and particularly bubonic plague, is endemic in Madagascar; however, this year's outbreak is the first to affect its two major cities, Antananarivo and Toamasina with over 70 percent of the cases being pneumonic plague, a more virulent form of plague that can be spread through the air, through coughing, sneezing or spitting and is almost always fatal if left untreated. Plague is an infectious disease caused by the bacterium *Yersinia pestis* usually found in small mammals, mainly rats. Pneumonic plague has an extremely high fatality rate and is very infectious, although antibiotics can treat it if it is caught early - between 12 to 24 hours.

In bubonic infections, plague-causing bacteria can be transmitted between animals and fleas, with infected fleas then passing the disease on to people through bites. Infected people may then develop pneumonic plague once their bubonic infection advances. The lung-based pneumonic plague can then be transmitted between sufferers and person-to-person.

[1] Additional surge capacity is being discussed between the MoH and the IFRC-MRCS.



According to WHO latest situation report [2] of 27 November, from 1 August to 24 November 2017, a cumulative total of 2 384 confirmed, probable and suspected cases of plague, including 207 deaths (case fatality rate 9%), have been reported from 57 of 114 (50%) districts in Madagascar. Analamanga Region in central Madagascar has been the most affected, with 68% of all recorded cases. Since the start of this outbreak, the vast majority of cases have been treated and have recovered. As of 24 November 2017, only 11 people were hospitalized for plague. There has been no international spread outside the country. The majority of the reported cases (1,828-77%) have been clinically classified as pneumonic plague, 347 have been classified as bubonic plague (15%), one was septicemic, and 208 have not yet been classified (further classification of cases is in process). Eighty-one (81) healthcare workers have had illness compatible with plague, but none have died. Thirty-three isolates of Yersinia pestis have been cultured and are sensitive to all antibiotics recommended by the National Plague Control Programme.

While the number of new cases and hospitalizations of patients due to plague is declining in Madagascar, WHO anticipates additional cases to be reported until the typical plague season ends in April 2018. Based on available information and response measures implemented to date, the potential risk of further plague outbreak is still of concern. The risk of international spread is mitigated by the short incubation period of the pneumonic plague. The implementation of exit screening measures and advice to travelers to and from Madagascar have been put in place, with the scaling up of preparedness and operational readiness activities in neighboring Indian Ocean islands and other southern and east African countries. The IFRC also launched several DREF operations to support the preparedness efforts of National Societies in neighboring countries.

Despite the initial high alert and fear of a major plague outbreak throughout the country, the reality is that out of the 22 regions, 14 regions (64%) in Madagascar were affected by plague. MRCS is focusing its operations in 292 most affected fokotanys[3] across 10 regions.

Initial and Current Response

Since September MRCS has been responding with initial actions in sensitization, identification of suspected cases and training in communities affected. Transmission of key messages from volunteers to the population was carried out as well as sensitization at the level of the areas presenting suspect cases. Identification of suspected cases and referral to health structures for rapid case management was carried out in collaboration with the team from the Ministry of Public Health (MoH). From the originally 700 volunteers that were engaged in the initial response, training has and is being rolled out to a total of 900 volunteers from 292 fokontany of the 10 affected regions to implement activities in Community Engagement and Accountability, community mobilization, Community Based Surveillance, with the cross-cutting activities in Psycho Social Support, vector control and hygiene and sanitation. The training of trainers (ToT) started mid-November and will be cascaded down to staff and volunteers at community level.

To bring the adequate operational technical support for this plague operation, the IFRC has deployed its emergency tools: HEOps, FACT, ERU (an IFRC-financed deployment with personnel deployed by Finnish, German, French, Italian and Swiss Red Cross Societies), RDRT and deployed technical experts with strong operational coordination, public health, health promotion skills in epidemiology, in hygiene-infection, prevention and control (IPC) and a technician as well as surge support services in logistics, finance and PMER.

Drawing on the capacity of the Movement's membership, the Malagasy Red Cross, with technical and financial support from the IFRC opened the Plague Treatment Unit (PTU) at the Andohatapenaka Hospital on 2

[2] http://apps.who.int/iris/bitstream/10665/259514/1/Ex-PlagueMadagascar27112017.pdf
[3] A fokotany is a basic Malagasy administrative subdivision and include either hamlets, villages and neighborhoods.

November 2017. The hospital, with all the medical equipment, medical experts, personal protective equipment and medicine was set-up by the ERU team members. The PTU has a capacity of 20 beds, plus two extra beds available if needed. This unit center is functional and is currently managed by a mix of international and local doctors, nurses and hygienists, and has already screened and treated a total of five people (unconfirmed cases). Two children aged 3 and 5 suffering from painful lymphadenopathy and fever were treated and the people who escorted them received the necessary preventive medical treatments. Despite the decrease of the number of cases, the PTU will remain open and will monitor possible cases of plague and keep a core medical team trained and ready to respond. The PTU can expand its reception and treatment capacity in the event of another larger outbreak to 50 beds.

Madagascar is used to regular seasonal plague outbreaks between September to April, this year, however, three new characteristics of plague outbreak appeared:

1. the plague season started earlier;
2. the occurrence of the more dangerous pneumonic plague with cases that were higher than bubonic plague cases;
3. this outbreak saw a highest number of cases in cities than it has in the usual rural areas and in new areas that had not experienced plague cases before.

The knowledge and experience acquired from bubonic plague in Madagascar was insufficient for treating this more virulent pneumonic form and the testing mainly using rapid diagnostic testing (RDT) is different from bubonic testing and has led to several false results (false positive/false negative). From structural indicators, Madagascar is known to have a weak health and epidemiological surveillance systems. Institut Pasteur's capacity in Madagascar is recognized but the institute was not prepared to respond to this pneumonic form of epidemic outbreak; it is only last week that a new testing equipment the *QPSR* was provided to obtain results in 24 hours.

Needs assessment and beneficiary selection

The plague operation will focus on communities in the ten regions that have been affected, are at risk and are vulnerable to plague, these are: Alaotra Mangoro, Amoron'i Mania, Analamanga, Analanjirofo, Atsinanana, Boeny, Bongolava, Haute Matsiatra, Itasy and Vakinankaratra.

In full consultation and agreement with the Malagasy authorities, WHO and other major implementing partners, the MRCS and IFRC have revised the plague response strategy to maintain high vigilance and surge capacity and in case of major outbreak will continue to focus on four main pillars in the ten regions as follows:

1. **Community Engagement and Accountability:** this current plague epidemic has entailed a lot of rumors, stigma and generated a lack of trust between the messengers and the communities; also, when faced with contradicting message between the scientific community on one hand and some political leaders on the other. The role of the Red Cross, through CEA activities is to ensure dialogue with the community, establishing trust in an enabling environment and integrating the community as a partner to the program rather than simply being a listener; moving with them from "this is what you should do" to an approach of "to what can we do together" and contribute to stop the transmission of the plague.
2. **Community Based-Surveillance:** a community health approach, with early surveillance and detection leading to early treatment that fits perfectly to respond to any form of plague. When detected early, plague is easily treated if antibiotics are provided on time[4]. A short course can cure the plague.
   The referral system, being able to inform and direct people where to receive treatment, is crucial and has been recommended during the WHO partners' platform. With the epidemic curve going down it is important to maintain vigilance on bubonic cases that, if not treated appropriately or on time could evolve into pneumonic plague.
3. **Case Management/Plague Treatment Unit** (see below for more detail) was opened on 2 November and the local recruitment of a core competent trained medical team is being secured for a smooth handover to continue to run and maintain a fully operational and functional recognized PTU to support the stretched national treatment capacity in Antananarivo. The PTU has a 20-bed capacity and can expand in case of surge needs to receive up to 50 plague affected patients. A total of 80 doctors and medical staff have been trained by the IFRC-ERU team.

4 Twenty-five isolates of *Yersinia pestis* have been cultured and are sensitive to all antibiotics recommended by the National Plague Control Program. (Source: WHO).

4. **Vector control, hygiene and sanitation:** An essential element of plague control is vector control for fleas and rats. Vector control for plague response includes separating humans from rats, chemical control of fleas, and pest control. As they are undertaken at the household level, these activities are time and labor intensive. A great deal of community engagement will be necessary to gain access to at-risk households. Staff and volunteers have been trained in the use of pesticides, insecticides and vector control activities to carry out spraying, placing rat raps and in sanitation activities to improve the hygiene of communities. This is required mainly in bubonic affected areas.

The two main capacity building activities are:

1. **Psychosocial Support:** provided in accompanying discharged patients from the PTU back into their family and community. PSS will also be provided in areas newly affected by pneumonic plague, to prevent and control stigma that has been appropriately assessed, and provided to staff of volunteers who have in turn suffered from stress and discrimination.
2. **Safe and Dignified Burials**: The SDB activities that were to be handled by the Red Cross have been put on hold due to two main reasons: the current low Case fatality rate (CFR of 8%) with plague cases decreasing due to good contact tracing rolled-out by the MoH and CBS, adequate prophylactic treatment, in addition to the SDB protocol has not yet been approved by the MoH. The MoU between the authorities and MRCS has been put on hold because of that specific approval clause. In addition, it must be noted that in the particularly sensitive context around traditional custom and specific cultural practices with the regular 'retournement des morts" (turning of the dead) in Madagascar, this practice is adding to particular precautions to take place around burials. Without formal approval by the authorities, SDB cannot be rolled-out. In the meantime, MRCS will be running minimum standard protocol SDB training, with in addition the orientation of the infection, prevention and control (IPC) delegate to assure the safety of staff and volunteers, around hygiene, the cleaning of the bodies, appropriate use of personal protective equipment (PPE) and body bags. Those components are common to all possible SDB guidelines and the PPE and bags used in the training are already in stock.

The transition and hand-over strategy of the Plague Treatment Centre and Core Medical Team

Currently the medical team is composed of a medical coordinator, a nurse and a technician. To ensure a smooth transition and hand-over of the PTU, Malagasy Red Cross has already assigned a medical coordinator, one nurse, one logistician and one technician. HR needs are now mainly focused on securing hygienists.

When the PTU was set-up, the MoH provided doctors, nurses and the Ministry of Water and Energy provided hygienists to follow the infection, prevention and control (IPC) rule. With the epidemic curve decreasing, some of the initial team members that were made available by the two ministries have recently been called-back. To ensure a stable core team in the PTU able to manage a small-scale epidemic outbreak, the Emergency Appeal budget will cover the salary costs of a core team that will be composed of: the medical coordinator, a medical doctor, two nurses, one logistician, one technician, one chief hygienist and four hygienists – all need to be maintained up to April 2018.

This core team is able to manage six to eight pneumonic patients and a little more if these are bubonic patients. However, as soon as this threshold is passed, the team will be extended to include already identified trained professional medical personnel. This means that the PTU was set-up as a **priority ward to treat plague patients** with another **priority focus for it to be a training reference center** able to train medical doctors and nurses specialized in plague infection treatment, which also can be extended to the other health structures in Madagascar.

Coordination and partnerships

IFRC and MRCS will continue monitoring the situation and working with the authorities, WHO and all the relevant leading partners involved in the plague outbreak, take part in assessments. Our focus is on the four-pillar approach, capacity building, trainings, scaling up PSS activities and SDB, while burial activities will only be rolled-out if there are high cases of plague deaths that exceeds the capacity of the authorities.

Proposed Areas for intervention

MRCS is responding in the four main areas of focus in Health - CBS, CEA, the PTU for case management and vector control, sanitation and hygiene support. Capacity building, training and scaling up in PSS and preparedness training in SDB – are part of a coordinated response effort. Given the potential reoccurrence and surge of plague cases, the response activities have to be carefully monitored and revised to be able to respond and adapt to changing situations. All 900 volunteers have or are being trained in CEA, out of which 600 are trained in CBS, 300 in vector control activities, 100 in PSS and 30 staff and volunteers in SDB.

Areas of Focus

Health

People to be reached: 1,200,000
Male: # reached can be defined through the PTU, CBS and PSS in the next update
Female: # reached can be defined through the PTU, CBS and PSS in the next update

Outcome 1: **Reduced morbidity and mortality related to plague among 1.2 million people in 10 regions through CEA and social and behaviour change, disinfection and vector control activities, early case detection, provision of psychosocial support and training in safe and dignified burial protocols and case management**
Output 1.1: **Community knowledge and engagement in plague prevention and control is ensured through active CEA and social mobilisation to change harmful behaviours to prevent further spread of the plague.**
Activities planned
The development and dissemination of behavior change, and prevention messages and other public health communication related to the outbreak
Community workshop to ensure the integration of CEA principles in the response – involving 300 people – and door-to-door visits and community meetings are implemented and adapted based on epidemiological data
Knowledge attitude and practices (KAP) survey – the survey will allow to measure progress
Procurement of IEC, visibility and communication equipment and materials for social mobilization and CEA products and packages
Radio, TV interactive-shows as well as social medial promotion for prevention addressing communities at risk
Output 1.2: **Malagasy Red Cross staff volunteers are prepared, knowledgeable and trained in safe and dignified burial protocols**
Activities planned
Training of 30 staff and volunteers on safe and dignified burials
Quality and safety assurance of staff and volunteers
Distribution of prophylaxis treatments, protection equipment, boots, masks for volunteers and staff
Output 1.3: **Transmission of new cases is limited through early identification and referral of suspected cases through increased capacity in community-based surveillance**
Activities planned
Training 600 volunteers on community-based surveillance
Establish communication and engagement with communities related to case detection in affected districts
Community-Based Surveillance (CBS) of animal deaths
Output 1.4: **Those affected by the outbreak are supported through psychosocial support (PSS)**
Activities planned
Training of 100 volunteers in psychosocial support (in progress)
Provide PSS to targeted people, and family members (in progress)

Provide PSS to staff and volunteers
Community visits to reduce stigma and fear and provide support to those patients discharged from the PTU
PSS design and produce material (in progress)
Output 1.5: **Clinical management (through the Plague Treatment Unit) of identified cases is reducing the impact and spread of the outbreak**
Activities planned
Procurement and deployment of required equipment and medical supplies for plague treatment
Plague Treatment Centre – Set-up with 50[5] beds - Quality assurance of clinical services is being put in place and maintained. Suspect and confirmed cases are being referred and treated at the PTU (5 patients have been treated in November)
Securing human resources for the running of the PTU with local trained medical / paramedical team capable of managing from 6 to 10 patients with onward and ongoing training (in progress)
PTU – Ambulance for transportation of patients to and from the PTU
Output 1.6: **The immediate risks to the health of the population in Madagascar is reduced through vector control activities in 10 regions**
Activities planned
Training of 300 staff and volunteers in vector control (in progress)
Promotion of use of household rat traps (Kartman kits) and other mechanical methods to reduce the risk of fleas and pest contamination (being rolled-out)
Strengthening measures of protection of people by adopting new behavior keeping people safe from rats and fleas which promote rat-proofing (being rolled-out)

Strategies for Implementation

Based on the demand for the technical and coordination support required to deliver in this operation, the following program support functions will be put in place to ensure an effective and efficient technical coordination: **human resources, logistics and supply chain; information technology support (IT); communications; security; planning, monitoring, evaluation, and reporting (PMER); partnerships and resource development; and finance and administration**. More details are in the Emergency Plan of Action.

[5] The PTU has been set-up with all the material capacity of up to 50 beds - HR needs are being put in place to manage 6 to 10 patients (in order to manage 20 to 50 patients - medical/paramedical surge will need to be deployed).

Budget

REVISED EMERGENCY APPEAL

27/11/2017

MDRMG013 Madagascar Plague (Epidemic)

	Budget Group	Multilateral Response	Inter-Agency Shelter Coord.	Bilateral Response	Budget CHF
500	Shelter - Relief	0			0
501	Shelter - Transitional	0			0
502	Construction - Housing	0			0
503	Construction - Facilities	0			0
505	Construction - Materials	0			0
510	Clothing & Textiles	0			0
520	Food	0			0
523	Seeds & Plants	0			0
530	Water, Sanitation & Hygiene	119,432			119,432
540	Medical & First Aid	1,015,481			1,015,481
550	Teaching Materials	59,981			59,981
560	Utensils & Tools	0			0
570	Other Supplies & Services	55,481			55,481
571	Emergency Response Units	0			0
578	Cash Disbursements	0			0
	Total RELIEF ITEMS, CONSTRUCTION AND SUPPLIES	**1,250,374**	**0**	**0**	**1,250,374**
580	Land & Buildings	0			0
581	Vehicles Purchase	0			0
582	Computer & Telecom Equipment	10,000			10,000
584	Office/Household Furniture & Equipment	0			0
587	Medical Equipment	0			0
589	Other Machinery & Equipment	0			0
	Total LAND, VEHICLES AND EQUIPMENT	**10,000**	**0**	**0**	**10,000**
590	Storage, Warehousing	0			0
592	Distribution & Monitoring	0			0
593	Transport & Vehicle Costs	37,600			37,600
594	Logistics Services	0			0
	Total LOGISTICS, TRANSPORT AND STORAGE	**37,600**	**0**	**0**	**37,600**
600	International Staff	270,100			270,100
661	National Staff	21,000			21,000
662	National Society Staff	62,666			62,666
667	Volunteers	86,707			86,707
	Total PERSONNEL	**440,473**	**0**	**0**	**440,473**
670	Consultants	20,000			20,000
750	Professional Fees	12,500			12,500

	Total CONSULTANTS & PROFESSIONAL FEES	**32,500**	**0**	**0**	**32,500**
680	Workshops & Training	103,438			103,438
	Total WORKSHOP & TRAINING	**103,438**	**0**	**0**	**103,438**
700	Travel	9,000			9,000
710	Information & Public Relations	120,743			120,743
730	Office Costs	28,762			28,762
740	Communications	9,781			9,781
760	Financial Charges	2,400			2,400
790	Other General Expenses	0			0
799	Shared Support Services	12,649			12,649
		0			
	Total GENERAL EXPENDITURES	**183,335**	**0**	**0**	**183,335**
599	Programme and Supplementary Services Recovery	133,752	0		133,752
	Total INDIRECT COSTS	**133,752**	**0**	**0**	**133,752**
	TOTAL BUDGET	**2,191,472**	**0**	**0**	**2,191,472**
	Available Resources				
	Multilateral Contributions	894,138			894,138
	Bilateral Contributions				0
	TOTAL AVAILABLE RESOURCES	**894,138**	**0**	**0**	**894,138**
	NET EMERGENCY APPEAL NEEDS	**1,297,334**	**0**	**0**	**1,297,334**

Jagan Chapagain
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Reference documents

Click here for:

1. **Previous Appeals and updates**
2. **Emergency Plan of Action (EPoA)**

http://www.ifrc.org/en/publications-and-reports/appeals/?ac=&at=0&c=&co=SP164MG&dt=1&f=&re=&t=&ti=&zo=

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How we work

All IFRC assistance seeks to adhere to the **Code of Conduct** for the International Red Cross and Red Crescent Movement and Non-Governmental Organizations (NGO's) in Disaster Relief and the **Humanitarian Charter and Minimum Standards in Humanitarian Response (Sphere**) in delivering assistance to the most vulnerable. The IFRC's vision is to inspire**, encourage, facilitate and promote at all times all forms of humanitarian activities** by National Societies, with a view to **preventing and alleviating human suffering**, and thereby contributing to the maintenance and promotion of human dignity and peace in the world.