



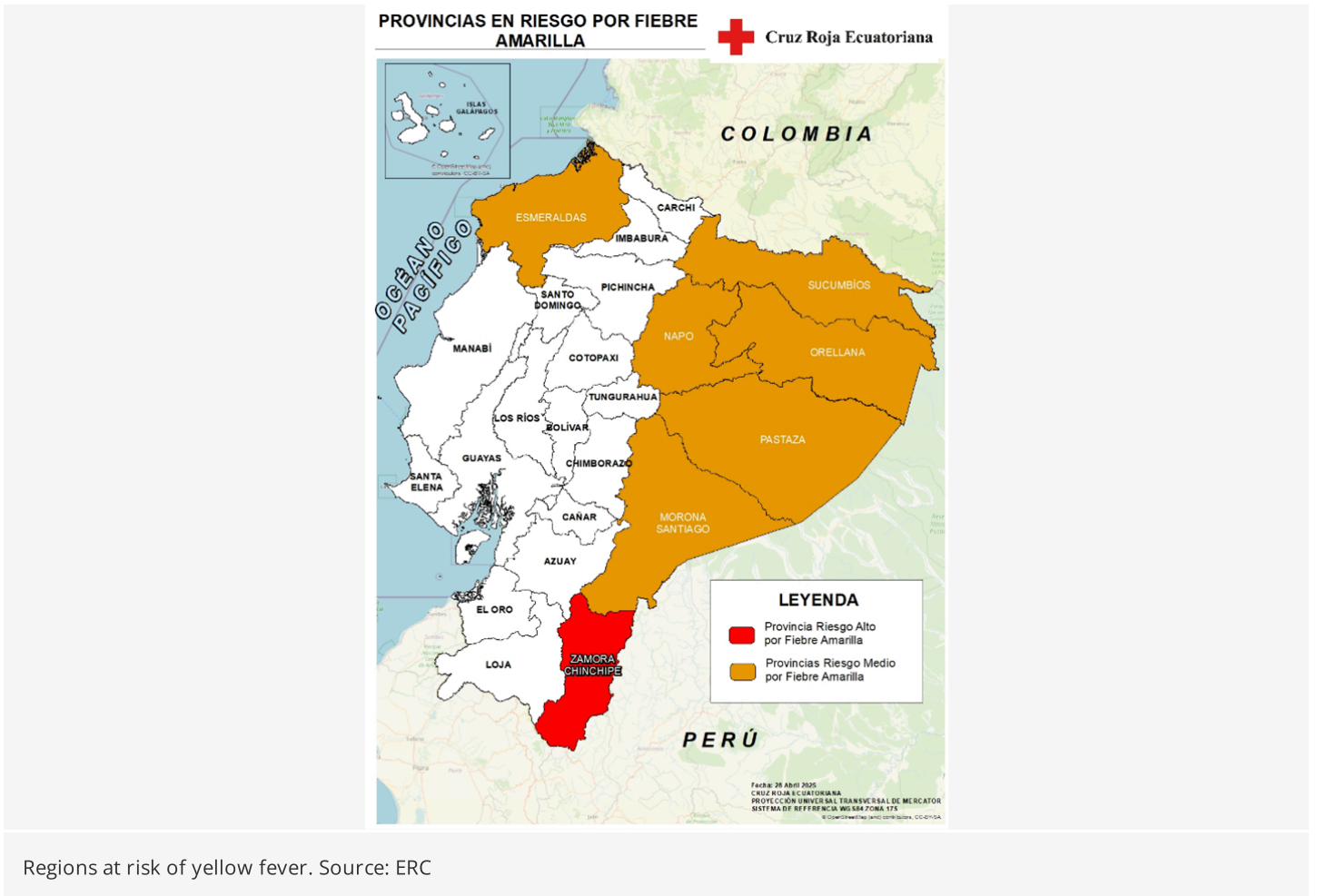
Vector control kits distribution, Pastaza, August 2025. Source: ERC

Appeal: <b>MDREC028</b>	Total DREF Allocation: <b>CHF 137,064</b>	Crisis Category: <b>Yellow</b>	Hazard: <b>Epidemic</b>
Glide Number: -	People Affected: <b>14,852 people</b>	People Targeted: <b>5,440 people</b>	People Assisted: <b>5,666 people</b>
Event Onset: <b>Slow</b>	Operation Start Date: <b>14-05-2025</b>	Operational End Date: <b>30-09-2025</b>	Total Operating Timeframe: <b>4 months</b>

Targeted Regions: **Morona Santiago, Pastaza, Zamora Chinchipe, Sucumbios**

*The major donors and partners of the IFRC-DREF include the Red Cross Societies and governments of Australia, Austria, Belgium, Britain, China, Czech, Canada, Denmark, Germany, Ireland, Italy, Japan, Luxembourg, Liechtenstein, Malta, Norway, Spain, Sweden, Switzerland, Thailand, and the Netherlands, as well as DG ECHO, Mondelez Foundation, and other corporate and private donors. The IFRC, on behalf of the National Society, would like to extend thanks to all for their generous contributions.*

# Description of the Event



## Approximate date of impact

April 2025, corresponding to the detection of the first severe yellow fever case in Ecuador. The patient was hospitalized on 10 April 2025, marking the start of the epidemiological event that later led to the confirmation of local transmission and the implementation of reinforced public health measures.

## Provide any updates in the situation since the field report and explain what is expected to happen.

### EMERGENCE OF THE OUTBREAK

On 24 April 2025, the Ministry of Public Health of Ecuador (MoPH) confirmed the first locally transmitted case of yellow fever in the country since 2017. The case involved a 26-year-old man from Loja who had been working in Zamora Chinchipe Province. The patient was hospitalized on 10 April 2025 and died one week later. By epidemiological week (EW) 17 (20–26 April 2025), three confirmed cases had been reported, all associated with occupational exposure in forested areas of Zamora Chinchipe.

The event occurred in a context of increased regional transmission. On 26 March 2025, the Pan American Health Organization (PAHO) issued a regional epidemiological alert following outbreaks in Brazil, Bolivia, Colombia and Peru. By mid-2025, more than 200 confirmed cases had been reported across the Region, prompting countries to reinforce vaccination, surveillance and clinical preparedness measures.

### PUBLIC HEALTH RESPONSE

Following confirmation of the initial case, the MoPH activated reinforced epidemiological surveillance in the Amazonian provinces of Sucumbios, Orellana, Napo, Pastaza, Morona Santiago and Zamora Chinchipe. These provinces, together with Esmeraldas, are historically considered endemic for yellow fever due to the presence of sylvatic mosquito vectors *Haemagogus* spp. and *Sabethes* spp.



Yellow fever vaccination has been included in Ecuador’s national immunization schedule since 2009 and is provided free of charge. Although national vaccination coverage was estimated at approximately 96% in 2024, coverage in several Amazonian provinces remained below the 95% threshold required to prevent transmission. To address these gaps, the MoPH launched targeted vaccination campaigns in May 2025, prioritizing unvaccinated residents, mobile populations aged 2 to 59 years and travellers entering endemic areas.

The epidemiological context was further complicated by the simultaneous circulation of dengue. By late April 2025, Ecuador had reported more than 18,000 dengue cases nationwide. The co-circulation of arboviruses increased pressure on health services and highlighted the need for strengthened surveillance, vector control and community risk communication.

#### CURRENT EPIDEMIOLOGICAL SITUATION

Throughout 2025, Ecuador reported a total of 11 laboratory-confirmed yellow fever cases and eight deaths, mainly concentrated in the Amazonian provinces of Zamora Chinchipe, Sucumbíos and Morona Santiago. The most recent confirmed case was reported in Taisha (Morona Santiago) during epidemiological week (EW) 31 (27 July–2 August 2025).

Since that time, no additional confirmed cases have been reported according to epidemiological bulletins issued by the MoPH. By early October 2025, the epidemiological situation had stabilized, with no evidence of sustained transmission beyond the initial affected areas.

#### TRANSITION OF THE DREF OPERATION

Based on official epidemiological data reported by the MoPH and continuous monitoring conducted by the Ecuadorian Red Cross (ERC), the outbreak remained limited in geographic spread and case numbers. As a result, the epidemiological situation remained below the escalation thresholds that would have triggered a transition to a DREF response operation.

These thresholds included a sustained increase in confirmed cases, expansion of transmission to additional provinces or evidence of potential urban transmission. The combination of targeted vaccination campaigns, strengthened surveillance and risk communication measures contributed to containing the outbreak.

Although the situation stabilized during the second half of 2025, reinforced epidemiological surveillance continues in endemic areas to ensure early detection of new cases and prevent re-emergence of transmission.



Community sensitization, Sangay, August 2025. Source: ERC



Vector control kit distribution, Tuutinetza, September 2025. Source: ERC



Vector control kit distribution, Taisha, September 2025. Source: ERC



Vector control kit distribution, Tuutinetza, September 2025. Source: ERC

## Scope and Scale

The yellow fever event unfolded in Ecuador's Amazon region, where approximately 928,251 people live according to the National Institute of Statistics and Census (INEC). The first confirmed cases were reported in Zamora Chinchipe Province in April 2025, an area characterized by dense forest ecosystems and intense human activity linked to agriculture, mining and forestry. Following confirmation of locally transmitted cases, concerns quickly emerged regarding the potential spread of the virus to neighbouring Amazonian provinces, including Orellana, Sucumbíos, Pastaza, Napo and Morona Santiago.

These territories have historically been classified as endemic for yellow fever due to the presence of sylvatic mosquito vectors (*Haemagogus* spp. and *Sabethes* spp.), which maintain the virus cycle in forest environments. Similar ecological conditions across these provinces meant that the detection of cases in Zamora Chinchipe represented not only a localized health event but also a potential risk for wider transmission across the Amazon basin.

The region is characterized by structural conditions that increase vulnerability to vector-borne diseases. Poverty measured through unmet basic needs affects approximately 59.7% of the population, and many communities live in geographically isolated areas with limited access to health services. These conditions increase the likelihood that infectious diseases may spread before cases are detected and controlled.

Certain population groups were considered particularly exposed to infection. Indigenous communities such as Kichwa, Shuar and Achuar live in forest environments where sylvatic transmission occurs, while migrant and seasonal workers linked to oil extraction, forestry and agricultural activities frequently work in areas where contact with mosquito vectors is more likely.

Regional dynamics also contributed to heightened epidemiological concern. During 2025, yellow fever outbreaks were reported in neighbouring countries including Brazil, Bolivia, Colombia and Peru, increasing the risk of cross-border introduction of the virus. Population mobility along international borders further amplified this risk. In the north of the country, the Putumayo–Sucumbíos corridor along the Ecuador–Colombia border registers significant daily population movement through both formal and informal crossings. In the south, the Huaquillas–Aguas Verdes and Macará border complexes, located along the Ecuador–Peru border in the provinces of El Oro and Loja respectively, also experience high levels of cross-border mobility.

At the same time, Ecuador was experiencing a dengue epidemic that further complicated the public health situation. By epidemiological week (EW) 17 (20–26 April 2025), the country had reported 18,486 dengue cases and 28 deaths. The simultaneous circulation of dengue and yellow fever increased pressure on health services, complicated the differential diagnosis of febrile illnesses and raised concerns about the potential for wider transmission.

## Source Information

Source Name	Source Link
1. MoH – Yellow Fever Vector Gazette, EW 23 – August 16, 2025	<a href="https://www.salud.gob.ec/wp-content/uploads/2025/06/Eventos-Fiebre-amarilla-DNVE-SE-23_2025.pdf">https://www.salud.gob.ec/wp-content/uploads/2025/06/Eventos-Fiebre-amarilla-DNVE-SE-23_2025.pdf</a>
2. ERC Situation report- April 24, 2025	<a href="https://go.ifrc.org/emergencies/7485/details">https://go.ifrc.org/emergencies/7485/details</a>
3. Ministry of Public Health of Ecuador- Key messages- Yellow Fever	<a href="https://www.salud.gob.ec/fiebre-amarilla/">https://www.salud.gob.ec/fiebre-amarilla/</a>
4. PAHO. Epidemiological Update on Yellow Fever in the Region of the Americas - 24 April 2025	<a href="https://www.paho.org/es/documentos/actualizacion-epidemiologica-fiebre-amarilla-region-americas-24-abril-2025">https://www.paho.org/es/documentos/actualizacion-epidemiologica-fiebre-amarilla-region-americas-24-abril-2025</a>
5. WHO and UNICEF Estimates of National Immunization Coverage (WUENIC). Ecuador. 2023 revision	<a href="https://cdn.who.int/media/docs/default-source/country-profiles/immunization/2024-country-profiles/immunization-2024-ecu.pdf?sfvrsn=4f29d8fb_3&amp;download=true">https://cdn.who.int/media/docs/default-source/country-profiles/immunization/2024-country-profiles/immunization-2024-ecu.pdf?sfvrsn=4f29d8fb_3&amp;download=true</a>
6. MSP - Yellow Fever Vector Gazette – August 2, 2025	<a href="https://www.salud.gob.ec/wp-content/uploads/2025/08/Fiebre-amarilla-DNVE-SE-31_.pdf">https://www.salud.gob.ec/wp-content/uploads/2025/08/Fiebre-amarilla-DNVE-SE-31_.pdf</a>
7. PAHO. Epidemiological Alert - Yellow fever in the Americas Region - 26 March 2025	<a href="https://www.paho.org/en/documents/epidemiological-alert-yellow-fever-americas-region-26-march-2025?utm_source=chatgpt.com">https://www.paho.org/en/documents/epidemiological-alert-yellow-fever-americas-region-26-march-2025?utm_source=chatgpt.com</a>



# National Society Actions

<p>Have the National Society conducted any intervention additionally to those part of this DREF Operation?</p>	<p>Yes</p>
<p>Please provide a brief description of those additional activities</p>	<p>Through its National Health and Community Development Programme, the Ecuadorian Red Cross (ERC) complemented the DREF-funded intervention by implementing additional actions aimed at strengthening institutional capacities and promoting intersectoral coordination in public health. These efforts focused on enhancing preparedness, coordination and operational readiness in the context of epidemiological emergencies.</p> <p>The ERC strengthened coordination with the Ministry of Public Health (MoPH) at the zonal coordination level and engaged with key strategic actors, including the International Organization for Migration (IOM), Fundación Lunita Lunera, the Armed Forces, the National Police, Fire Brigades and the Ecuadorian Institute of Social Security (IESS), among others. Through this engagement, the ERC supported the establishment of the Southern Border Health Coordination Platform, an inter-institutional technical coordination space developed jointly with the MoPH. The platform aimed to facilitate more timely, coordinated and territorially adapted responses to health emergencies in border areas.</p> <p>In parallel, the ERC identified capacity gaps among health personnel related to outbreak and epidemic management, particularly at administrative and coordination levels. To address these gaps, the ERC developed technical scripts and operational scenarios for simulation and drill exercises scheduled for implementation in late October 2025. These exercises were designed to strengthen the competencies of health personnel and improve inter-institutional coordination during epidemiological emergencies, contributing to longer-term preparedness beyond the scope of the IFRC-DREF operation.</p>

# IFRC Network Actions Related To The Current Event

<p>Secretariat</p>	<p>The International Federation of Red Cross and Red Crescent Societies (IFRC) provided the Ecuadorian Red Cross (ERC) with comprehensive technical, operational, logistical and reporting support throughout the operation. This support was delivered through the IFRC Country Cluster Delegation for the Andean Countries, based in Lima, which maintained close coordination with the ERC and continued to provide regional support to Bolivia, Ecuador and Peru.</p> <p>In addition, the IFRC deployed two specialized Public Health Emergency delegates from the Canadian Red Cross, who provided targeted technical assistance to the ERC's national health team. This support focused on strengthening public health preparedness and response capacities in the context of epidemiological emergencies, complementing the actions implemented under the IFRC-DREF operation.</p>
<p>Participating National Societies</p>	<p>The Ecuadorian Red Cross received institutional support and funding from the Spanish Red Cross, Italian Red Cross, German Red Cross and Norwegian Red Cross through the National Preparedness and Response Plan developed in 2024. This plan includes a coordination module that defines the support capacities and areas of intervention of each partner National Society. However, for this specific IFRC-DREF operation, no additional operational or financial support was provided by these Partner National Societies beyond the framework of the existing preparedness plan.</p>



# ICRC Actions Related To The Current Event

The International Committee of the Red Cross (ICRC) is a standing Movement partner of the Ecuadorian Red Cross (ERC) within the framework of the National Preparedness and Response Plan and the 2025 Cooperation Agreement. Through this framework, the ICRC maintains regular coordination with the ERC and provides technical advice to strengthen institutional capacities, emergency preparedness and protection of health care services.

The ICRC did not provide direct support to this IFRC-DREF intervention. However, it continues to collaborate with the ERC through other operational frameworks, including the ongoing Emergency Appeal (Floods & Environmental Contamination) implemented in Amazonian provinces, contributing to broader Movement coordination and complementarity in addressing humanitarian needs in these areas.

## Other Actors Actions Related To The Current Event

<b>Government has requested international assistance</b>	No
<b>National authorities</b>	<p>The Ministry of Public Health (MoPH), as Ecuador's national authority responsible for public health, led the response to the yellow fever epidemiological alert. In accordance with established health containment protocols, the MoPH activated its epidemiological surveillance technical teams to conduct case investigations, trace and monitor close contacts, and carry out detailed assessments of locations visited by confirmed cases prior to symptom onset in order to identify potential sources of infection.</p> <p>Throughout the event, the MoPH maintained active surveillance in coordination with regional health zones, issuing continuous alerts through official memoranda. Specific strategies were implemented to increase immunization coverage in identified high-risk areas, including rapid door-to-door vaccination monitoring. In parallel, the national and provincial directorates of epidemiological surveillance conducted active case finding, prioritizing individuals presenting symptoms consistent with the suspected case definition and acute febrile-icteric syndrome in high-risk areas.</p>
<b>UN or other actors</b>	<p>The Pan American Health Organization (PAHO), as the specialized health agency of the United Nations system in the Region, provided continuous technical support to the Ministry of Public Health (MoPH) through advisory services related to epidemiological surveillance and the strengthening of immunization coverage in areas identified as vulnerable.</p> <p>During the period of the alert, PAHO issued epidemiological warnings regarding the increase in yellow fever cases in the Americas and recommended intensifying vaccination efforts in endemic and high-risk areas. In parallel, international health agencies maintained continuous global and regional monitoring of the yellow fever situation, contributing to risk analysis, situational awareness and evidence-based public health recommendations.</p> <p>This sustained technical support reinforced national capacities for surveillance, prevention and preparedness in the context of yellow fever and other emerging public health threats.</p>

### Are there major coordination mechanism in place?

Coordination was ensured through Technical Working Group No. 2 (Health and Pre-Hospital Care), which served as the primary inter-institutional platform for information sharing and joint decision-making. Through this mechanism, the confirmed yellow fever case and the regional epidemiological alert were formally communicated, with particular emphasis on Colombia's declaration of a national health emergency. In response, coordination meetings were held with the National Directorate of Immunization and the National Directorate of Epidemiological Surveillance of the Ministry of Public Health (MoPH), facilitating the timely and coordinated implementation of risk reduction and preventive measures.



Building on an established history of collaboration, the Ecuadorian Red Cross (ERC) worked closely with the MoPH under the Framework Agreement for Inter-Institutional Cooperation to strengthen community-based health capacities. This coordination framework supported the training of volunteers, humanitarian personnel and community members on prevention, detection and response to vector-borne diseases. As part of these preparedness efforts, a joint health simulation exercise was conducted in November 2024 in the Estrella del Oriente community, Sucumbíos Province. The exercise assessed the functioning of the community epidemiology strategy, particularly the identification and notification processes led by Community Committees and MoPH health centres, in the context of increasing dengue transmission in the Amazon region.

At territorial level, coordination with the MoPH in Pastaza, Zamora Chinchipe, Napo and Morona Santiago enabled the implementation of complementary community-based actions, including community clean-up campaigns, distribution of mosquito breeding site elimination kits and awareness-raising activities aimed at reducing the risk of dengue transmission. These actions reinforced existing prevention mechanisms and supported integrated surveillance and vector control efforts at community level.

## Needs (Gaps) Identified



Based on information from the Ministry of Public Health (MoPH) and the Pan American Health Organization (PAHO) epidemiological alert issued on 26 March 2025, several health-related needs were identified in Ecuador's Amazonian provinces. These needs were primarily linked to immunity gaps, geographic barriers to healthcare access, environmental conditions favourable to vector transmission and limitations in community-level surveillance capacity.

- **Immunity gaps in endemic areas:** Although yellow fever vaccination has been included in Ecuador's national immunization schedule since 2009 and is provided free of charge, immunity gaps persisted in several Amazonian territories at the time the event occurred. While national vaccination coverage was estimated at approximately 96% in 2024 according to the MoPH, average coverage across prioritized Amazonian provinces remained closer to 88%, below the 95% threshold recommended to interrupt transmission.

Subnational disparities further illustrated these gaps. In Zamora Chinchipe, which concentrated the highest number of confirmed cases, the provincial population reached 110,973 in 2024. While overall reported coverage approached 100%, two-thirds of cantons remained below the 95% threshold. Coverage was particularly low in Centinela del Cóndor, where vaccination coverage reached approximately 74% among 7,882 inhabitants, while Zamora canton, with 30,186 residents, reached around 94%.

Similar disparities were observed in other Amazonian provinces. In Morona Santiago, with approximately 192,508 residents, vaccination coverage reached 79% in Morona canton and 86% in Palora canton. In Pastaza, the most populous of the prioritized provinces with 111,915 inhabitants, coverage in Mera canton reached approximately 93%. These immunity gaps increased concern that localized transmission could expand if the virus circulated in these areas.

- **Barriers to timely detection and healthcare access:** Many communities in the Amazon region are located in remote territories accessible mainly by river transport. Geographic isolation, dispersed settlements and limited health infrastructure reduce the likelihood of early detection of suspected cases and timely access to diagnosis and treatment. In several cantons, the density of health facilities is as low as 6.5 facilities per 10,000 inhabitants, which can delay case identification and referral during outbreaks.

- **Limitations in community-based epidemiological surveillance:** The epidemiological alert highlighted the importance of early detection and immediate notification of suspected cases and epizootic events to prevent further spread of the virus. However, community-level surveillance mechanisms in several Amazonian territories faced capacity limitations. Community Committees and local structures required strengthened technical and operational capacity to support early identification of unusual health events, timely reporting and effective coordination with health authorities, particularly in epidemiological corridors such as Putumayo–Sucumbíos.

- **Environmental conditions favourable to vector transmission:** The presence of sylvatic mosquito vectors (*Haemagogus* spp. and *Sabethes* spp.) in forest ecosystems creates favourable conditions for yellow fever transmission. Human activities such as agriculture, forestry and oil extraction increase exposure to these vectors, particularly among workers operating in forested areas. The potential presence of the urban vector *Aedes aegypti* also raised concerns about possible urban transmission if the virus were introduced into densely populated areas.

- **Barriers to risk communication and preventive behaviours:** In several Amazonian communities, misinformation and vaccine hesitancy were identified as factors that could hinder prevention efforts. Cultural, linguistic and geographic barriers affect access to reliable health information, particularly among Indigenous populations. Communication efforts therefore require adaptation to local languages and community practices to ensure understanding and acceptance of preventive measures.

- **Psychosocial impacts associated with the outbreak:** The confirmation of yellow fever cases generated fear, emotional distress and stigma in affected communities, particularly in Zamora Chinchipe, Morona Santiago and Pastaza. These concerns were amplified by the high case



fatality rate associated with yellow fever and the concurrent dengue outbreak. Indigenous populations such as Kichwa and Shuar, who face multidimensional poverty and barriers to healthcare access, were particularly affected by these psychosocial pressures.

In response to these identified needs, the MoPH formally requested the support of the Ecuadorian Red Cross (ERC) through Official Letter No. MSP-SVPCS-2025-0252-O dated 22 April 2025, and reiterated this request during Technical Working Table No. 2 following confirmation of the yellow fever case.

# Operational Strategy

## Overall objective of the operation

Through this IFRC-DREF operation, the Ecuadorian Red Cross (ERC) aimed to support national efforts to prevent yellow fever transmission by strengthening community readiness and promoting preventive measures in high-risk areas, including Zamora Chinchipe, Morona Santiago, Pastaza and Sucumbíos.

Over a four-month period, the operation focused on monitoring immunization coverage, strengthening community-based surveillance and delivering culturally appropriate risk communication to promote preventive behaviours. It also aimed to strengthen the capacities of health personnel and community health committees to improve coordination between communities and health centres in support of prevention and health promotion activities. Basic equipment was provided to facilitate community participation and support local engagement.

By the end of the operation, the Ecuadorian Red Cross had reached 5,666 people through prevention and preparedness activities in the prioritized areas.

## Operation strategy rationale

The operational strategy was designed to support national yellow fever prevention efforts in Ecuador by reducing transmission risk and strengthening community readiness in high-risk Amazonian provinces, including Zamora Chinchipe, Morona Santiago, Pastaza and Sucumbíos. The strategy responded to a context characterized by immunity gaps, geographic isolation, population mobility and the concurrent circulation of arboviral diseases, which increased the likelihood of localized transmission if preventive measures were not reinforced.

Implementation followed a decentralized coordination model combining technical oversight from the Ecuadorian Red Cross (ERC) National Headquarters with the territorial presence of Provincial Branches and their established community networks. This approach allowed the operation to leverage local knowledge and volunteer capacity while ensuring alignment with national public health priorities and technical standards established by the Ministry of Public Health (MoPH).

### HEALTH

The health strategy focused on strengthening prevention, early detection and community readiness in territories exposed to yellow fever transmission risk. In Amazonian areas where geographic isolation and occupational exposure in forest environments are common, community-based preparedness plays a critical role in supporting the national epidemiological surveillance system.

A central element of the strategy was strengthening Community Health Committees as locally rooted structures capable of supporting community epidemiological surveillance, health promotion and timely referral. Reinforcing their capacities helped improve the early identification and reporting of unusual health events while strengthening coordination between communities and local health services in high-risk areas.

The strategy also prioritized strengthening the capacities of health personnel and Red Cross volunteers in the targeted provinces, recognizing their role as frontline actors supporting prevention, community awareness and surveillance efforts.

In parallel, the operation supported community-level prevention measures by facilitating access to basic vector control and prevention materials in communities exposed to yellow fever and dengue transmission risks. The health strategy also incorporated psychosocial considerations to address fear, stress and uncertainty associated with the outbreak, promoting community well-being and supporting volunteers and frontline responders.

### COMMUNITY ENGAGEMENT AND ACCOUNTABILITY (CEA)

Risk communication and community engagement constituted a central component of the operational strategy. In several Amazonian communities, misinformation, vaccine hesitancy and limited access to reliable health information had the potential to undermine prevention efforts.

To address these challenges, the operation adopted an intercultural CEA approach designed to build trust and promote health-seeking



behaviours. Communication strategies were adapted to the linguistic, cultural and territorial contexts of Amazonian communities, particularly among Indigenous populations.

Drawing on lessons learned from previous public health responses, including the COVID-19 pandemic, the strategy emphasized dialogue with communities and the integration of community feedback into communication efforts. This approach allowed the ERC and national health authorities to better understand community perceptions and address concerns related to vaccination and disease prevention.

#### NATIONAL SOCIETY STRENGTHENING

The strategy also aimed to reinforce the operational capacities of the Ecuadorian Red Cross at the territorial level. Provincial Branches in Zamora Chinchipe, Morona Santiago, Pastaza and Sucumbíos already maintained trained volunteer representatives specialized in epidemiological surveillance and health promotion, supported by established community committees.

The operation therefore built upon these existing structures to strengthen the role of volunteers and community networks in prevention, surveillance and health promotion efforts. By reinforcing local capacities and strengthening coordination between Provincial Branches and the National Headquarters, the strategy contributed to enhancing the ERC's preparedness to support public health responses in remote territories.

#### STRATEGIC COORDINATION

The operation was implemented through continuous coordination between the ERC National Headquarters, Provincial Branches and the Ministry of Public Health (MoPH). This coordination ensured that the intervention complemented national public health efforts and remained aligned with the official epidemiological response.

Technical guidance, operational monitoring and documentation were supported through the ERC Situation and Monitoring Room, which facilitated real-time monitoring of the epidemiological situation and ensured alignment with operational objectives and national response priorities.

#### OPERATIONAL SCALE-UP CONSIDERATIONS

Given the evolving epidemiological context, the operational design incorporated provisions for potential scale-up. The strategy allowed for the transition from preparedness support to a broader emergency response should the Ministry of Public Health determine that conditions for a sanitary or epidemic emergency were met.

Potential triggers for scale-up included increases in confirmed cases, geographic expansion of transmission or significant pressure on the health system. However, these conditions were not reached during the implementation period. Epidemiological monitoring conducted by national authorities and the ERC indicated that the situation remained contained, and transmission levels did not meet the predefined thresholds required to escalate the intervention to a full IFRC-DREF response operation.

As a result, the operation remained focused on preparedness and prevention measures, supporting national efforts to mitigate transmission risk without transitioning to a DREF response phase.

## Targeting Strategy

### Who was targeted by this operation?

The operation directly reached 5,666 people, corresponding to approximately 1,771 families, living in rural and peri-urban communities with high epidemiological risk of yellow fever in the Amazonian provinces of Morona Santiago, Pastaza, Zamora Chinchipe and Sucumbíos. For planning and reporting purposes, an average household size of 3.2 people per family was applied.

The targeted population included Indigenous communities, dispersed rural settlements and communities located near forested areas, which are particularly vulnerable to vector-borne diseases due to sustained exposure to sylvatic transmission cycles, suboptimal vaccination coverage and limited access to timely health services and immunization.

The prioritization of these provinces was aligned with the national strategy of the Ministry of Public Health (MoPH), which identified these territories as high-risk areas based on vaccination coverage below the 95% threshold required to prevent sustained transmission, ecological conditions favourable to vector circulation and the presence of confirmed yellow fever cases.

### Explain the selection criteria for the targeted population

The selection of the targeted population was based on a combination of epidemiological, social and logistical vulnerability criteria, defined in coordination with the Ministry of Public Health (MoPH). Priority was given to:



- Communities located in areas identified by the MoPH as high risk for yellow fever transmission, based on epidemiological surveillance and risk mapping.
- Populations living in communities with insufficient vaccination coverage, particularly those reporting coverage below the 95% threshold required to prevent sustained transmission, according to the most recent Expanded Programme on Immunization (EPI) reports.
- Communities with limited response capacity and restricted access to health services, including areas with scarce medical personnel, limited equipment, historical gaps in the reach of public health promotion activities and geographical remoteness.
- Communities located in border regions or near identified epidemiological corridors, particularly along the Ecuador–Colombia border, where suspected or confirmed cases increased the risk of virus introduction and spread.

## Total Assisted Population

Assisted Women	2,009	Rural	37%
Assisted Girls (under 18)	897	Urban	63%
Assisted Men	1,908	People with disabilities (estimated)	1%
Assisted Boys (under 18)	852		
Total Assisted Population	5,666		
Total Targeted Population	5,440		

## Risk and Security Considerations (including "management")

Does your National Society have anti-fraud and corruption policy?	Yes
Does your National Society have prevention of sexual exploitation and abuse policy?	Yes
Does your National Society have child protection/child safeguarding policy?	Yes
Does your National Society have whistleblower protection policy?	No
Does your National Society have anti-sexual harassment policy?	Yes

Please analyse and indicate potential risks for this operation, its root causes and mitigation actions.

Risk	Mitigation action
Likelihood of assaults or retention of volunteer and contract staff	Prior coordination with community leaders, dissemination of the auxiliary role of the ERC, and clear communication of safe practices to staff. Despite the low risk due to familiarity with the area and the community, safety and security plans were developed to



	safeguard volunteer and humanitarian personnel in this context. These plans integrate operational security measures while ensuring respect for health care protocols.
Logistical delays due to shortages or limited availability of inputs	Updating the database of national suppliers and early management of key acquisitions.
Risk of traffic incidents	Traffic safety was reinforced through verification of vehicle documentation, driver training, and continuous monitoring by the Situation Room.
Probability of disturbances in the areas of intervention	Implementation of the ERC Operational Security Plan and contextual assessment prior to deployment in the field.
Effects on staff health	Vaccination was arranged for Ecuadorian Red Cross (ERC) staff and volunteers who have not previously received the yellow fever vaccine, prior to their deployment. All ERC personnel had free access to the vaccine through the national immunization program.  Additionally, insect repellent was provided to all deployed staff and volunteers to reduce exposure to vector-borne diseases during field activities.
Likelihood of sexual harassment or violence against deployed personnel	Mandatory mixed teams, socialization of safety standards, knowledge of the nearest Community Police Unit, and compliance with safe operating hours.
Likelihood of assaults on or retention of volunteer and hired staff	- Prior coordination with community leaders, dissemination of the auxiliary role of the ERC, and socialization of safe behaviours to staff. - Despite the low risk due to familiarity with the area and community, security and protection action plans were developed to safeguard volunteer and humanitarian personnel in this context. These plans integrate operational security measures while ensuring respect for health care protocols.
Connectivity constraints for community reporting and coordination	Delivery of physical formats and activation of asynchronous channels between National Headquarters and Provincial Boards.
Access limited by adverse weather or geographical conditions	Permanent climate monitoring, planning with alternative routes and flexible scheduling of activities.
Psychosocial risk of humanitarian workers and emotional crises in communities	Activation of psychological first aid protocols

**Please indicate any security and safety concerns for this operation:**

The operation was implemented in a complex and evolving security environment in Ecuador, shaped by a combination of structural violence, social unrest and environmental factors that affected humanitarian access and operational conditions during 2025.

**NATIONAL SECURITY CONTEXT**

During 2025, Ecuador continued to experience high levels of violence associated with the presence and expansion of organized criminal groups involved in drug trafficking, extortion, kidnapping and other illicit activities. Between January and April 2025, 2,361 intentional homicides were recorded nationwide, the majority linked to criminal violence. By August 2025, the national homicide rate reached 46.1 per 100,000 inhabitants, reflecting a significant deterioration in public security.

This context increased risks related to mobility restrictions, exposure to violent incidents and operational constraints for humanitarian actors, particularly in provinces with elevated levels of criminal activity, including Sucumbíos and Orellana.



## SOCIAL UNREST AND POLITICAL INSTABILITY

During the last quarter of 2025, the operational context was further affected by a multidimensional crisis combining political, social and economic factors. The removal of the diesel subsidy under Executive Decree No. 126, which increased fuel prices from USD 1.80 to USD 2.80 per gallon, triggered nationwide protests led by Indigenous movements and rural organizations.

From 18 September 2025, national strike actions resulted in road blockades across more than 12 provinces, including key transport corridors. These events led to mobility restrictions, disruptions to public services, clashes with security forces and temporary suspension of transport in several areas, directly affecting access to communities and the continuity of field activities.

The State response included declarations of states of exception in several provinces, reflecting broader governance challenges and increasing social tensions, particularly in rural and Indigenous territories.

## PROVINCIAL CONTEXT IN AREAS OF OPERATION

In the provinces targeted by the operation, security risks were generally lower than in national hotspots but remained present within the broader context of insecurity.

Between January and April 2025, Morona Santiago reported 4 intentional homicides, while Zamora Chinchipe reported 8 cases, most linked to criminal violence. In Pastaza, no homicides were recorded during the same period, reflecting relatively lower levels of lethal violence compared to other regions.

Environmental factors also affected the operational context. Heavy rainfall during the implementation period led to flooding and access constraints in Morona Santiago and Zamora Chinchipe. In response, the National Secretariat for Risk Management declared a yellow alert through Resolution SNGR-046-2025, increasing risks related to road safety, mobility and temporary isolation of communities.

## OPERATIONAL RISKS AND MITIGATION MEASURES

The combination of insecurity, social unrest and environmental constraints created a challenging operational environment, including risks related to restricted access, exposure of personnel and volunteers to security incidents and increased stress among responders.

Despite these conditions, no major security incidents affecting Ecuadorian Red Cross (ERC) personnel or volunteers were reported during the implementation of activities in Sucumbios, Pastaza and Zamora Chinchipe. This was achieved through the consistent application of the ERC National Security Policy and safe behaviour protocols.

Risk mitigation measures included reinforcement of institutional visibility, appropriate use of uniforms and emblems, adherence to movement protocols, deployment in coordinated teams and continuous security briefings. Awareness of local protection structures, such as Community Police Units (UPC), also contributed to safer field operations.

Has the child safeguarding risk analysis assessment been completed?

Yes

# Implementation



**Budget:** CHF 93,787

**Targeted Persons:** 5,440

**Assisted Persons:** 5,666

**Targeted Male:** -

**Targeted Female:** -

## Indicators

Title	Target	Actual
Number of people receiving health promotion in support of MOH	3,000	3,436



immunization campaigns		
Number of Community Committees trained in Community Epidemiological Surveillance and equipped	8	12
Number of health workers and ERC volunteers trained in clinical practice guidelines for Yellow Fever.	120	464
Number of vector control kits distributed	1,700	1,771
Number of people reached with psychosocial support activities	400	2,388

## Narrative description of achievements

### • I. Health promotion in support of immunization

Health activities were implemented in close coordination with, and in support of, the national immunization strategy led by the Ministry of Public Health (MoPH). The operation began with the collection of community perception data on vaccination in Amazonian territories, generating evidence that informed local-level immunization planning and outreach strategies.

Based on these findings, a structured workplan and implementation schedule were developed, enabling coordinated visits to prioritized communities. The Ecuadorian Red Cross supported health facilities through community mobilization, vaccination promotion and operational support to outreach processes, contributing to increased access and uptake of immunization services.

Barriers to vaccination, including hesitancy and misinformation identified during implementation, were addressed through health promotion and community outreach efforts integrated into the health response, contributing to improved acceptance of immunization services. Further details on risk communication and community engagement approaches are presented under the CEA component.

As a result, a total of 3,436 people were reached through health promotion activities across the targeted provinces, including 1,097 in Pastaza, 1,035 in Zamora Chinchipe, 839 in Morona Santiago and 465 in Sucumbíos.

### II. Strengthening community epidemiological surveillance

The operation strengthened the capacities of Community Health Committees linked to local health facilities through practical training on vector-borne disease prevention and timely reporting of public health alerts. A total of 12 committees were trained and equipped across Morona Santiago (6), Zamora Chinchipe (4) and Pastaza (2), reinforcing community-based surveillance structures.

The provision of basic identification and visibility equipment enabled these committees to function as local surveillance focal points, improving communication with health centres and facilitating the early identification and reporting of unusual health events.

### III. Strengthening health workforce capacities

Recognizing the high turnover of rural health personnel in the Amazon region, the operation prioritized strengthening technical capacities at the frontline level. In coordination with the MoPH and with technical support from the Pan American Health Organization (PAHO), training sessions on yellow fever clinical guidelines, early identification of warning signs and community surveillance were delivered.

A total of 464 health workers and Red Cross volunteers were trained across the targeted provinces, including 232 in Sucumbíos, 122 in Zamora Chinchipe, 70 in Morona Santiago and 40 in Pastaza, strengthening field-based clinical and surveillance competencies.

### IV. Vector control and environmental health

Disease prevention efforts were reinforced through the distribution of 1,771 vector control kits to families across the targeted provinces, including Morona Santiago (498), Zamora Chinchipe (485), Pastaza (479) and Sucumbíos (309).

Each kit included essential items to support household-level vector control and environmental sanitation, including 1 insect repellent, 4 packs of 10 garbage bags, 2 pairs of rubber gloves, 1 powdered detergent, 3 brushes for cleaning water storage containers, and 1 plastic container. These inputs supported the elimination of mosquito breeding sites and reinforced preventive practices in communities exposed to yellow fever and dengue transmission risks.

In Zamora Chinchipe, community-based vector control actions implemented over a three-month period resulted in the elimination of 9,598 water reservoirs and 3,598 discarded tyres, significantly reducing potential mosquito breeding sites.



## V. Psychosocial support and community well-being

The operation incorporated psychosocial support as part of the health response to address the emotional impact associated with the outbreak and concurrent public health risks. A total of 2,388 people were reached through psychosocial support activities in Zamora Chinchipe (1,016), Morona Santiago (773) and Pastaza (599).

These actions contributed to promoting emotional well-being and supporting volunteers and community members in managing stress and uncertainty during the health alert.

### Lessons Learnt

- Health preparedness and prevention interventions in remote Amazonian contexts require a minimum implementation period of six months. Shorter timeframes limit the ability to conduct adequate socialization, implementation and follow-up, particularly in contexts where trust-building and cultural adaptation are essential.
- Culturally adapted educational and risk communication materials should be available from the outset of the operation. Early availability facilitates timely communication, helps address language barriers and supports engagement with communities where cultural perceptions and mistrust may affect health behaviours.
- Interventions in culturally diverse contexts require the early integration of intercultural approaches. Understanding local belief systems, incorporating Indigenous languages and engaging community leaders are essential to bridge gaps between ancestral and clinical health practices, improve acceptance of vaccination and strengthen trust in health services.

### Challenges

The implementation of health activities faced several operational and contextual challenges, particularly in remote Amazonian territories:

- Geographic dispersion and difficult access conditions limited mobility and outreach. Long distances, third-order roads and reliance on river or irregular transport increased operational costs and affected the continuity and frequency of community engagement.
- Cultural, ethnic and linguistic diversity influenced the effectiveness of interventions. Language barriers, particularly in Kichwa-speaking communities, and the coexistence of ancestral and clinical health practices affected understanding of disease risk and the perceived importance of vaccination.
- Resistance to vaccination and limited acceptance of Western medicine were observed in some communities. These challenges were linked to cultural perceptions, previous experiences and a lack of alignment between community practices and institutional health approaches.
- Mistrust towards health services affected community engagement. Weak relationships between communities and health centres limited confidence in vaccination and prevention efforts, requiring additional time to build trust.
- Gender dynamics within communities influenced participation. In several cases, community structures prioritized male leadership, affecting equitable access to information and participation in health-related activities.
- Coordination with the Ministry of Public Health (MoPH) required additional time. Internal processes were affected by political changes, staff turnover and limited availability of equipment, resulting in delays in joint planning and implementation.



## Community Engagement And Accountability

**Budget:** CHF 13,790  
**Targeted Persons:** 30  
**Assisted Persons:** 2,532  
**Targeted Male:** -  
**Targeted Female:** -

### Indicators

Title	Target	Actual
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Number of volunteers strengthened with training CEA approach	30	30
Number of communities reached through baseline surveys assessing perceptions, barriers, and misinformation related to vaccines.	8	8

## Narrative description of achievements

CEA actions reached approximately 2,532 people directly through community engagement and perception surveys in prioritized Amazonian provinces.

Feedback and response channels were incorporated throughout implementation, including community dialogue spaces, face-to-face and digital surveys, physical feedback boxes and local focal points within Community Committees. These mechanisms enabled communities to raise concerns, suggestions and feedback. The information collected was systematically organized and analyzed, allowing the operation to identify recurring concerns related to vaccine safety, low risk perception and information gaps, which were addressed through adapted communication and engagement strategies. While no cases requiring formal individual response were identified, feedback informed ongoing adjustments to the intervention.

### I. Strengthening capacities in CEA

The operation strengthened local capacities in the application of CEA approaches across health interventions. A total of 30 volunteers (15 women and 15 men) were trained in Morona Santiago (10), Zamora Chinchipe (10) and Pastaza (10), promoting the use of two-way communication, community participation and feedback mechanisms.

Community Committees and trained volunteers played a key role as local intermediaries, facilitating dialogue between communities and health actors, capturing community perceptions and contributing to the adaptation of response strategies based on local inputs.

### II. Community perception assessment to inform decision-making

A structured baseline perception assessment was conducted between 9 and 22 June 2025 to identify perceptions, barriers and misinformation related to vaccination. A total of 2,532 people were reached across Morona Santiago (763), Pastaza (763) and Zamora Chinchipe (1,006), providing a solid evidence base to guide the intervention.

Findings highlighted low risk perception, persistent doubts regarding vaccine safety and information gaps, while also confirming high levels of trust in the Ecuadorian Red Cross and health personnel.

Key trends identified included:

- Behavioural barriers as a primary driver of low vaccination uptake. While 15.2% of the population remained unvaccinated, 38% of respondents required more information on vaccine safety, 38% reported low concern about infection and 16% minimized disease severity.
- Trust dynamics shaping communication effectiveness. The Ecuadorian Red Cross (75%) and health professionals (72%) were identified as the most trusted sources, while distrust towards media (40%) and government authorities (34%) remained significant.
- Communication preferences influencing engagement. Social media (62%) and WhatsApp (40%) were identified as primary channels, while 76.4% of respondents preferred simplified messaging and 58.4% community-based storytelling.

These findings informed key operational adjustments, including the simplification of technical content, the use of Indigenous languages and the prioritization of trusted spokespersons such as volunteers and health personnel. Communication strategies shifted towards addressing safety concerns, strengthening risk perception and using culturally relevant approaches to improve acceptance of vaccination.

In parallel, basic rumor monitoring was conducted through Community Committees and volunteer networks, which identified recurring concerns related to vaccine safety and misinformation. These inputs were used to continuously adapt messaging and engagement approaches.

### III. Culturally adapted communication and community-led approaches

Communication materials were developed using culturally adapted approaches, local languages and inclusive formats. A participatory process was applied, involving volunteers, community members and local interpreters in the translation and adaptation of content into Kichwa, Shuar and Achuar, ensuring linguistic accuracy and cultural relevance.

Community members also acted as spokespersons in audiovisual materials, reinforcing peer-to-peer communication and strengthening trust. This approach promoted ownership of messages and improved their acceptance within communities, particularly in contexts where cultural perceptions influence health behaviours.



#### IV. Multi-channel dissemination and community-level reinforcement

Communication strategies combined digital dissemination with in-person engagement. Content was promoted through Facebook and Instagram to increase visibility, while printed materials and interpersonal communication were used during community activities.

Digital content generated high levels of visibility (+140,000 views) and interaction across prioritized provinces. In Pastaza, content in Kichwa and Spanish generated 66,872 views and 253 interactions; in Morona Santiago, materials in Spanish, Achuar and Shuar reached 33,955 views and 101 interactions; and in Zamora Chinchipe, content in Spanish and Shuar reached 41,670 views and 222 interactions.

At community level, key messages and prevention measures were shared through dialogue spaces, outreach activities and community engagement processes, ensuring that communities remained informed and reinforcing transparency and trust.

### Lessons Learnt

- CEA tools must be adapted to context and operational tempo. The application of perception surveys proved valuable for decision-making; however, their length generated fatigue and resistance among community members. Shorter, more focused instruments adapted to local literacy levels and cultural contexts are required to ensure higher participation and data quality.
- Early perception assessment is critical to inform evidence-based programming. The timely identification of mistrust, information gaps and behavioural barriers enabled the operation to adjust communication strategies and better target key drivers of vaccine hesitancy.
- Prior sensitization on accountability processes is essential. Limited familiarity with feedback and accountability mechanisms constrained community engagement. Future interventions should include early-stage sensitization to build trust and promote active participation.
- Feedback mechanisms need to be strengthened and formalized. While multiple channels were used to collect feedback, future operations would benefit from establishing formal Feedback and Response Mechanisms (FRM) to ensure systematic tracking, response and accountability.
- Closing the feedback loop is essential to strengthen trust and accountability. When community inputs are clearly reflected in operational decisions, such as the shift from printed materials to audiovisual formats and the use of WhatsApp as a primary dissemination channel, and these decisions are communicated back to communities, it reinforces transparency, builds trust and encourages continued participation.
- Stronger and sustained coordination with the Ministry of Public Health (MoPH) enhances impact. Closer and more continuous alignment is required to avoid duplication of efforts and maximize complementarity between community engagement and risk communication actions.
- Intercultural approaches and community leadership mapping are critical in Indigenous contexts. The presence of multiple leadership structures requires transparent and inclusive coordination with local authorities and representatives to ensure legitimacy, cultural respect and effective implementation.
- Pre-positioning of culturally adapted communication materials improves responsiveness. Having educommunication materials available from the outset facilitates faster deployment and ensures consistency in messaging during health emergencies.
- Rumor tracking and response should be systematically integrated. The identification of concerns related to vaccine safety highlighted the need for structured mechanisms to monitor and address misinformation in a timely manner.
- Stronger Social and Behaviour Change (SBC) approaches are needed. Addressing vaccine hesitancy requires moving beyond information dissemination towards behaviour-focused strategies that incorporate social norms, trusted influencers and community-led communication.
- Adequate resourcing for CEA is essential. Future operations should allocate sufficient resources for translation, transport, community engagement and intercultural facilitation, particularly in geographically dispersed settings.
- Volunteer care and workload management must be integrated into CEA planning. Sustained community engagement places significant emotional and operational demands on volunteers, requiring rotation mechanisms, psychosocial support and realistic workload planning.

### Challenges

- Cultural and linguistic diversity affected the effectiveness of engagement. The presence of multiple languages, worldviews and cultural practices across provinces required adapted communication approaches, which increased the time and effort needed to ensure messages were well understood and culturally appropriate.
- Geographic accessibility and travel time limited coverage. Long distances, limited transport options and difficult access conditions in



rural and Amazonian areas reduced the frequency of in-person engagement and made it more challenging to reach dispersed communities.

- Short operational timelines affected continuity. The duration of the operation limited the ability to carry out repeated engagement cycles, follow up on community feedback and consolidate accountability processes at local level.
- Sustained inter-institutional coordination required additional time. Although coordination mechanisms were in place, maintaining continuous alignment with health authorities, local governments and community leadership was challenging, affecting the continuity and scalability of CEA actions.



## Secretariat Services

**Budget:** CHF 2,829

**Targeted Persons:** 0

**Assisted Persons:** 0

**Targeted Male:** -

**Targeted Female:** -

### Indicators

Title	Target	Actual
Number of monitoring visits made during the operation	1	0

### Narrative description of achievements

- Although the planned monitoring visit could not be conducted due to the national strike and the associated security constraints, remote monitoring mechanisms and regular virtual coordination meetings ensured continuity of oversight and adherence to the approved operational plan.
- The International Federation of Red Cross and Red Crescent Societies (IFRC) provided continuous technical, administrative and financial support to the Ecuadorian Red Cross throughout the operation, including remote coordination and review of financial and narrative reporting, ensuring alignment with DREF standards, compliance and overall operational quality.

### Lessons Learnt

- Remote technical accompaniment proved to be an effective alternative to field monitoring in contexts of restricted access and heightened security risks, allowing sustained supervision and support.
- Flexible planning and continuous communication between the Andean Countries CCD and the National Society facilitated timely operational adjustments without compromising the quality or accountability of the response.

### Challenges

- The cancellation of the field monitoring visit limited the ability to directly observe activities and conduct in situ verification of implementation progress.
- Security conditions and mobility restrictions related to the national strike caused delays in the execution of some planned activities and constrained opportunities for face-to-face technical follow-up.



## National Society Strengthening

**Budget:** CHF 26,658

**Targeted Persons:** 0

**Assisted Persons:** 0

**Targeted Male:** -



Targeted Female: -

## Indicators

Title	Target	Actual
Lessons learned workshops conducted	1	1
Number of volunteers and staff receiving Personal Protection Equipment	100	100

## Narrative description of achievements

### I. Lessons Learned Workshop (LLW)

The Ecuadorian Red Cross planned, convened, implemented and systematized the Lessons Learned Workshop (LLW) for the Yellow Fever DREF operation. The workshop was conducted in September 2025 in Puyo, Pastaza Province, with the participation of representatives from the Provincial Branches of Pastaza, Morona Santiago and Zamora Chinchipe. This space supported institutional learning by enabling structured collective reflection on the planning, coordination and implementation of the operation in Amazonian territories, generating key inputs to strengthen future preparedness and response capacities for public health emergencies.

### II. Volunteer Support and Institutional Visibility

A total of 100 sets of personal equipment were procured and distributed to volunteers, including waterproof boots, uniforms, t-shirts and caps. This support strengthened institutional visibility, facilitated the identification of personnel in the field and improved working conditions for volunteers during operational activities. Also, a laptop was procured to support communications and information management in the field. This enhanced the operational capacity of teams for data handling and reporting, while reducing the need for additional external communication services and associated costs.

## Lessons Learnt

- Timely and structured documentation of operational experiences through the Lessons Learned Workshop (LLW) proved to be an effective mechanism for capturing institutional learning and translating it into concrete improvements in protocols, coordination practices and operational procedures.
- Decentralized learning processes, involving Provincial Branches directly in reflection and analysis, strengthened ownership of lessons learned and enhanced local capacities for preparedness and response to public health emergencies.
- Volunteer support initiatives, such as the provision of uniforms, require early planning and phased implementation to ensure timely availability while aligning with administrative and procurement processes.
- Future operations should include dedicated resources for both salaried staff and volunteers. Adequate human resourcing supports operational continuity, reduces workload pressure and enhances the quality and sustainability of implementation.
- Early engagement with all relevant stakeholders is essential, including securing clear guidance and endorsement at ministerial level. This facilitates coordinated planning, decision-making and implementation at territorial level.
- Establishing rotation mechanisms and emotional decompression strategies for volunteers is critical to mitigate fatigue, emotional overload and burnout, particularly in prolonged or high-pressure public health emergency contexts.

## Challenges

- Coordinating schedules between technical teams and Provincial Branches for learning and reflection activities represented a logistical challenge, highlighting the need for earlier planning and flexible timelines.
- Administrative procurement timelines for volunteer uniforms exceeded initial estimates, causing delays in delivery and underscoring the importance of initiating procurement processes in advance to avoid operational constraints.
- Provincial Branches still require strengthened capacities in administrative management, financial processes and procurement. These capacities are critical to ensure timely implementation, compliance and effective coordination during emergency operations.



# Financial Report

## DREF Operation

### FINAL FINANCIAL REPORT

Selected Parameters			
Reporting Timeframe	2025/05-2025/12	Operation	MDREC028
Budget Timeframe	2025/05-2025/09	Budget	APPROVED

Prepared on 03/Mar/2026

All figures are in Swiss Francs (CHF)

### MDREC028 - Ecuador - Epidemic Yellow Fever

Operating Timeframe: 14 may 2025 to 30 sep 2025

#### I. Summary

<b>Opening Balance</b>	<b>0</b>
<b>Funds &amp; Other Income</b>	<b>137.064</b>
DREF Anticipatory Pillar	137.064
<b>Expenditure</b>	<b>-134.235</b>
<b>Closing Balance</b>	<b>2.829</b>

#### II. Expenditure by area of focus / strategies for implementation

Description	Budget	Expenditure	Variance
AOF1 - Disaster risk reduction	8.365		8.365
AOF2 - Shelter			0
AOF3 - Livelihoods and basic needs			0
AOF4 - Health	88.063	93.787	-5.724
AOF5 - Water, sanitation and hygiene			0
AOF6 - Protection, Gender & Inclusion			0
AOF7 - Migration			0
<b>Area of focus Total</b>	<b>96.428</b>	<b>93.787</b>	<b>2.641</b>
SF11 - Strengthen National Societies	37.979	40.448	-2.469
SF12 - Effective international disaster management			0
SF13 - Influence others as leading strategic partners			0
SF14 - Ensure a strong IFRC	2.656		2.656
<b>Strategy for implementation Total</b>	<b>40.635</b>	<b>40.448</b>	<b>187</b>
<b>Grand Total</b>	<b>137.064</b>	<b>134.235</b>	<b>2.829</b>

[Click here for the complete financial report](#)

## Please explain variances (if any)

A total of CHF 137,064 was allocated from the Disaster Response Emergency Fund (DREF) for the implementation of this operation. By the end of the operation, total expenditures amounted to CHF 134,235. The unspent balance of CHF 2,829 will be returned to the DREF.

Variances between budgeted and actual expenditures were mainly driven by operational adjustments and internal reallocations to ensure the full delivery of planned activities and to respond to evolving needs during implementation. These adjustments did not affect the achievement of technical indicators nor require additional funding.



Within this context, the allocation of vector control kits and edu-communication materials was adjusted to prioritize high-risk areas, including Sucumbíos province, in line with epidemiological developments and operational priorities.

In line with DREF procedures, limited budget adjustments were undertaken to better align available resources with actual implementation needs. This allowed flexibility to support key areas such as health promotion and prevention, community engagement, volunteer support and operational coordination, while maintaining the overall scope and objectives of the operation.

All adjustments were validated in accordance with IFRC procedures and remained within the approved budget flexibility thresholds. Expenditures were prioritized towards activities directly linked to implementation and the technical and financial closure of the operation.

Regarding procurement, no stock was prepositioned and no items remained undistributed. All procured goods were fully distributed and utilized within the framework of the DREF operation.

\*Financial technical note: Minor variations in the budget distribution per area in the attached financial report may occur due to recent updates to IFRC systems and expenditure classifications; however, these do not affect the overall execution of the operation.



# Contact Information

For further information, specifically related to this operation please contact:

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[Click here for reference](#)

