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Emergency Plan of Action (EPoA) Kenya: Marburg

 International Federation
of Red Cross and Red Crescent Societies

DREF n° MDRKE041	Glide n° N/A for preparedness
Date of issue: 6 November 2017	Expected timeframe: 3 months, Expected end date: February 2018;
Category allocated to the of the disaster or crisis: Yellow / Orange / Red	
DREF allocated: CHF 90,066	Budget holder/project manager IFRC: Sheila Chemjor, EAIO CCST is responsible for implementation, compliance and reporting.
Total number of people affected: 1,413,623 (total population across 3 target counties)	Number of people to be assisted: 1,413,623 (707,623 females, 706,000 males)
Host National Society (ies) presence (n° of volunteers, staff, branches): KRCS is the single largest humanitarian organisation in Kenya, with presence across the country (with 64 branches and sub branches supporting a network of 98,000 volunteers). 75 volunteers will be mobilized for the DREF response.	
Red Cross Red Crescent Movement partners actively involved in the operation: IFRC	
Other partner organizations actively involved in the operation: MOH (National and County govt), WHO, CDC, UNICEF and KEMRIs	

A. Situation analysis

Description of the disaster

On 17 October, 2017 a case of Marburg Virus Disease (MVD) was confirmed in Kween District, Uganda. To date, there have been a total of 4 cases (1 suspect, 1 probable, and 2 confirmed), where the 2 confirmed and 1 probable cases have resulted in death. The current outbreak in Uganda has since spread, affecting three districts of Kween, Kapchorwa and, most recently, Bukwo district where contacts of the last confirmed case are yet to be traced. Bukwo has porous borders with Kenya, and intense cross-border activities. The index case is a 35-year-old herdsman, who has been known to frequent caves in the Kaptum region (with known presence of bats). He presented with high fever, vomiting, and diarrhea. He died two days after hospital admission. No tissue samples were tested for this initial patient. The second confirmed case was a 50-year-old woman, sister to the index patient. She nursed and participated in the burial of the index patient. This second case was admitted to the hospital on 5 October with high fever and bleeding manifestations.

She died 13 October (eight days after admission) and received a supervised burial. Tissue samples were collected and MVD was confirmed using RT-PCR.

On 29 October, the Kenyan MoH and WHO were notified of a suspected Marburg case in Trans Nzoia County, Kenya, through an assessment conducted by the Uganda Ministry of Health. The suspected case was a 73 years old woman, who provided traditional healing treatment to the third confirmed case in Uganda. Clinically, she did not have symptoms suggestive of MVD, no fever, no diarrhea, no vomiting. Her only symptom was joint and muscle pain which she says she has had for the past two years. The County health team, in collaboration with the local administration, has quarantined the suspected case in her house awaiting transfer to the identified temporary center. The sample tested negative for MVD, but she will be monitored for symptoms within the 21 days incubation period.

Marburg Virus Disease (MVD), also known as Marburg hemorrhagic fever, is caused by Marburg virus – member of the Filoviridae family (filovirus), often compared to the Ebola virus. The case fatality ratio for MVD can be as high as 88%. Initial transmission of the disease can occur as a result of prolonged exposure to caves or mines containing Rousettus bat colonies (natural hosts to the virus). Human-to-human transmission of MVD occurs through direct contact with blood, secretions, or other bodily fluids of infected people (or through contact of surfaces containing these bodily fluids). The incubation period for the disease is between 2 and 21 days, with fatal cases ending about 8 to 9 days after on-set of symptoms. Symptoms of MVD include: high fever, headache, diarrhea, abdominal pain or cramping, nausea, vomiting, lethargy, and lack of appetite. After 5 to 7 days of initial symptoms, fatal cases may develop severe hemorrhaging, including: fresh blood in vomit and feces, bleeding from the gums, nose, or genitals. During this severe phase of the disease, sustained high fever, confusion, irritability, and aggression can occur. Severe blood loss and shock usually occur before death in fatal cases.

Treatment of MVD includes administering fluids either orally or intravenously, and care for specific symptoms. There are currently no proven treatments or vaccines for MVD. In the healthcare setting, certain precautions are necessary to avoid infection of healthcare workers. Such precautions include: hand hygiene, respiratory hygiene, personal protective equipment, and safe injection practices. Health facilities in the affected areas may face challenges due to a lack of running water and relative remoteness of facilities. Additionally, cultural burial practices, which may include handling of the dead body, may increase risk of disease transmission.

Summary of the current response

Overview of Host National Society

As soon as the MVD outbreak was declared in Uganda, the Kenya Red Cross Society (KRCS) put its branches in Westpokot, Trans Nzoia and Bungoma Counties on alert. The Kenya Red Cross was incorporated in the National taskforce on MVD convened by the MoH. The Task force consists of MoH, WHO, CDC, UNICEF and KRCS. The task force main role is to provide support in the preparedness and response to the outbreak. So far one suspect case with two contacts have been identified in Trans Nzoia County. The MoH took the specimen from the suspect case and the specimen was transported the Kenya Red Cross E plus Ambulance to the Kemri Labs in Nairobi. The sample was confirmed negative, but monitoring is critical within the 21-day incubation period of the virus. National level and County level task force meetings have been ongoing as heightened surveillance and contact tracing has been done in the said counties.

WHO									
KRCS									
UNICEF									

Needs analysis, targeting, scenario planning and risk assessment

Needs analysis

Kenya has never reported active transmission of Marburg virus in its population before. This outbreak comes at a time after the huge outbreak of Ebola Viral Disease (EVD) in West Africa. These situations create large fears in the general public, when reflecting on the devastating effects of these previous outbreaks.

The current outbreak in Uganda has spread and affected the districts of Kween, Kapchorwa and, most recently Bukwo district, where contacts of the last confirmed case are yet to be traced. Bukwo has porous borders with Kenya and intense cross-border activities. The risk of exportation of the outbreak into Kenya through Kitale, Endebess and other communities neighboring Bukwo district is high, with some potential contacts already identified on the Kenyan side.

The risk of cross border transmission of Marburg from neighboring Uganda's Kween district remains high as per case contact tracing, where a high-risk individual sought treatment across the Kenyan border. This requires intensified cross-border surveillance between the two Governments as well as within Red Cross National Societies. Health care workforce and surveillance mechanisms do not have adequate experience with the management of Marburg hemorrhagic fever. There are however lessons learnt from the Ebola response as Kenya deployed a significant number of its health workforce in west Africa to support in the response.

Targeting

The project will target high risk persons living in Counties bordering Kween and Kapchorwa Districts of Uganda. These are Trans Nzoia County (in its entirety, because of population movement from Uganda to its urban centre of Kitale); West Pokot County (North Pokot Sub County covering Suam ward, Kiwawa ward, Alale ward, Kapchok ward and Kodich ward); Bungoma County (Mt Elgon Sub County covering Kaptama ward, Chepyuk ward, Cheptais ward). The total population targeted is 1,413,623 (707,623 females and 706,000 males)

County	Subcounty	Population
Trans Nzoia	All the Sub Counties	1.1 million
West Pokot	North Pokot	141,246
Bungoma	Mt Elgon	172,377

Due to cultural burial rituals and a lack of knowledge of disease transmission and proper hygiene management, person-to-person transmission can occur very rapidly. Additionally, many communities in the affected regions believe in superstitions regarding the disease's origin and mode of infection. Due to these superstitions, proper interventions can be challenging due to community aversion to health workers and aid groups.

Those at greatest risk for infection include health workers, family members of infected patient, and mourners of a deceased patient. As the disease is transmitted via contact with the bodily fluid of an infected individuals, those who are responsible for the care and clean-up of infected individuals are at the greatest risk for infection.

Scenario planning

Current risk for the outbreaks extension focuses on the success of contact tracing and isolation of suspected cases. The potential for unknown contacts in the area is relatively high in the border areas of the affected districts in Uganda. The best-case scenario is based on assumption that there is only one person who came into contact and exposed to the infection, and thus with good contact tracing and surveillance interventions, all key contacts with this single case will be traced, closely followed up and immediately isolated for treatment before they continue to infect others. This will presumably stop the outbreak in the next generation. Alternatively, the case identified is negative.

On the other hand, the most likely scenario is that some of contacts from the current probable and confirmed cases have not been traced, but will be isolated quickly once they become symptomatic and the outbreak is controlled in the next two generations, with a case count under 40. The need for prevention and control on both sides of the border is key, and ongoing successful community engagement is critical to success.

More seriously is the worst-case scenario where it is assumed that there were more than one index cases who got exposed to the animal reservoirs, coupled to the fact that the population is living in remote locations with great fear of seeking formal health care systems, in preference for traditional healers who expose many people to infections through high risk procedures of bleeding through incisions with same unsterilized sharp instruments. This will leave potentially hundreds of people exposed, thus allowing the disease to spread further into the communities, including outside the current 3 districts, with contacts spread all over the country and potentially across the border.

This plan of action is based on a best-case scenario (as all cases are epidemiologically linked and come from one family, and all suspected cases have so far been negative). As such, the DREF focuses on preparedness activities.

Operation Risk Assessment

There have already been reports of hostility and threats towards health workers responding to MVD. If the situation continues, hostility may continue and prevent health workers from providing adequate treatment. Some of those who object to health interventions includes those who are case contacts, and thus potential cases or causes of transmission. More community awareness creation and engagement with provision of PSS to the identified contacts will mitigate this risk. Additionally, the cross-border challenges on contact tracing, without proper coordination in place, may enable further transmission of MVD. This will be mitigated through the support of the cross-border coordination mechanism. There is a risk that staff and volunteers being incidentally infected with the virus. This risk will be mitigated through proper training by WHO experts and experienced RDRT who will be deployed to support the operation. In addition, the IFRC volunteer insurance scheme will be provided to lift off the costs of compensation on the part of the National Society.

B. Operational strategy¹

Overall Operational objective: To prevent the cross-border transmission of MVD in Kenya

The current outbreak in Uganda, although limited in size now, presents a significant risk for extension given its proximity to the Kenya boarder. The intention of the operation is to achieve effective control measures to curb further spread of suspected MVD across the border to Kenya. The Kenyan Ministry of Health, the Kenya Red Cross and in country partners have vast and good experience with dealing with infectious disease outbreaks. The operation will mainly focus

¹ The plan should be prepared by the National Society, with support from the Secretariat technical departments and support services.

on activating a preparedness system by engaging community-based volunteers to undertake intensified health education and promotion campaigns at household levels. Use of Mass media, social media and other forms of media to communicate. The operation will also utilize the mobile messaging to reach bigger populations. This will improve on community knowledge of the symptoms and signs of the disease and the procedure to follow while protecting the household members and ensure appropriate referral of suspected cases.

The operation will also focus on contact tracing, where the contacts of the suspected cases will be monitored daily by health workers, assisted by volunteers, and those developing symptoms will be immediately referred.

To reduce risk of wide transmission of the epidemic, the mass media and other forms of culturally acceptable and context-specific IEC campaigns will be employed to promote a wide knowledge and awareness about the disease, its risks of transmission, actions for to take for suspected cases and preventive measures. This will target the 3 sub Counties in 3 counties along the Kenya-Uganda border (Endebess in Trans Nzoia, Kapenguria in West Pokot and Mt Elgon in Bungoma) and surrounding areas since there is a lot of a population movement to and from the area affected. The total population of the mapped at-risk area will be targeted with the IEC and mass media messages.

The KRCS will work with the Ministry of Health to coordinate the county and national level control measures including: contact tracing, social mobilization, health promotion and education, and cross-border surveillance. The KRCS Health and Social Services, as well as the Disaster Response Teams will be incorporated to provide guidance and support on the field activities. Further, there will be a need to coordinate closely with the Ministry of Health from both Uganda and Kenya to enhance surveillance across the border.



Health

People targeted: 1,413,623

Male: 706,000

Female: 707,623

Needs analysis:

A focus on preventing cross border transmission is now the priority and preparing for actual outbreak containment in case of confirmation of cases. Working with key partners the NS will support key pillars of control including Social mobilization, risk communication and community engagement to ensure contact tracing and early identification of cases.

Immediate needs:

There is need to sensitize the Volunteers on Social mobilization and Health promotion with a keen focus on prevention and control of viral hemorrhagic fevers (VHFs). There is also need to support the MoH by providing 3 tents for temporary isolation sites – one in North Pokot in West Pokot, one in Endebess in Transzoia County and third to be identified. The communities in Kapenguria Sub County in Westpokot, Endebess Sub County in Trans Nzoia and Mt Elgon Sub County in Bungoma County need to be taken through intensified awareness creation and education sessions. Cross border coordination is paramount in this response for effective containment of the outbreaks.

Population to be assisted:

The population of the Kapenguria Sub County in Westpokot, Endebess Sub County in Trans Nzoia and Mt Elgon Sub County in Bungoma County that have potential contacts from the cases in Uganda and also border the affected Districts in Uganda with a very porous border.

Programme standards/benchmarks

The response interventions are in line with the MoH and WHO guidelines.

P&B Output Code	Health Outcome 1: The immediate risks to the health of affected populations are reduced	# of people reached with community-based epidemic prevention and control activities															
	Health Output 1.1: Community-based disease prevention and health promotion is provided to the target population	# of people reached by NS with services to reduce relevant health risk factors															
	Activities planned Week / Month	Wk1	Wk2	Wk3	Wk4	Wk5	Wk6	Wk7	Wk8	Wk9	Wk10	Wk11	Wk12	13	14	15	16
AP021	Conduct community engagement sessions through key opinion leaders in the community	x	x	x	X	x	x	x	x	x	x	x	x				
AP021	Conduct House to House risk communication and Psychosocial support to the communities identified with contacts	x	x	x	X	x	x	x	x	x	x	x	x				
AP021	Mass media messaging targeting the affected areas	x	x	x	X	x	x	x	x	x	x	x	x				
AP021	Establish rumour monitoring mechanism for effective communication	x	x	x	X	x	x	x	x	x	x	x	x				
P&B Output Code	Health Output 1.2: Epidemic prevention and control measures carried out.	# of volunteers trained															
	Activities planned Week / Month	Wk1	Wk2	Wk3	Wk4	Wk5	Wk6	Wk7	Wk8	Wk9	Wk10	Wk11	Wk12	13	14	15	16
AP021	Volunteers are trained in Infection Prevention and Control measures to ensure their safety	x	x	x	X	x	x	x	x	x	x	x	x				
AP021	Registration and mapping of the contacts	x	x	x	X												
AP021	Volunteers are trained in and community surveillance	x	x	x	X	x	x	x	x	x	x	x	x				
AP021	Support surveillance outreach activities for MVD in the affected villages through daily follow-up of 50 contacts of probable & confirmed cases of for	x	x	x	x	x	x	x	x	x	x	x	x				

	21 days each to monitor development of symptoms & timely isolation																
AP021	Support the MoH in setting up of Temporary Isolation ward in Kaisagat health centre in Trans Nzoia County through provision of three tents for isolation of suspected cases.	x	x	x	x	x	x	x	x	x	x	x	x				
P&B Output Code	Health Output 1.3: Psychosocial support provided to the target population	% of households & RC volunteers provided with psychosocial support therapy are able to overcome trauma & stigma related to MVD															
	Activities planned Week / Month	Wk1	Wk2	Wk3	Wk4	Wk5	Wk6	Wk7	Wk8	Wk9	Wk10	Wk11	Wk12	13	14	15	16
AP023	Provide Psycho-Social Support to 50 possible contacts of MVB				x	x	x	x	x								

Strategies for Implementation Requirements (CHF)

P&B Output Code	S1: National Society capacity building and organizational development objectives are facilitated to ensure that KRCS has the necessary legal, ethical and financial foundations, systems and structures, competences and capacities to plan and perform	# of volunteers insured															
	Output S1.1: KRCS has effective and motivated volunteers who are protected	# of volunteers reached by psychosocial support															
	Activities planned Week / Month	w1	w2	w3	w4	w5	w6	w7	w8	w9	w10	w11	w12	13	14	15	16
AP040	Ensure that volunteers are insured	x	x	x	x	x	x	x	x	x	x	x	x				

AP040	Provide complete briefings on volunteers' roles and the risks they face	x	x	x	x	x	x	x	x	x	x	x	x				
AP040	Provide psychosocial support to volunteers	x	x	x	x	x	x	x	x	x	x	x	x				
AP040	Ensure volunteers are aware of their rights and responsibilities	x	x	x	x	x	x	x	x	x	x	x	x				
AP040	Ensure volunteers' safety and wellbeing	x	x	x	x	x	x	x	x	x	x	x	x				
AP040	Ensure volunteers are properly trained	x	x	x	x	x	x	x	x	x	x	x	x				
AP040	Ensure volunteers' incentives are paid in time and they remain well motivated	x	x	x	x	x	x	x	x	x	x	x	x				
P&B Output Code	S2: Effective and coordinated international disaster response is ensured	Ratio of people reached by the IFRC disaster response operations to the people affected by these emergencies															
	Output S2.1: Effective response preparedness and NS surge capacity mechanism is maintained																
	Activities planned Week / Month	Wk1	Wk2	Wk3	Wk4	Wk5	Wk6	Wk7	Wk8	Wk9	Wk10	Wk11	Wk12	13	14	15	16
AP058	Initial operational start up support implemented by IFRC for the host national society and participating national societies and other common services such as ops centre and basecamp costs	x	x	x	x												
P&B Output Code	S3: The IFRC secretariat, together with National Societies uses their unique position to influence decisions at local, national and international levels that affect the most vulnerable.	# of people reached by NS with services to reduce relevant health risk factors															
	Output S3.1: IFRC and NS are visible, trusted and effective advocates on humanitarian issues																
	Activities planned Week / Month	Wk1	Wk2	Wk3	Wk4	Wk5	Wk6	Wk7	Wk8	Wk9	Wk10	Wk11	Wk12	13	14	15	16

AP053	Communications related to the operation are produced and disseminated			x	x	x	x	x	x	x	x	x					
P&B Output Code	Outcome S4: The programmatic reach of the National Societies and the IFRC is expanded.	Number of reports submitted on time.															
	Output S4.1: Resource generation and related accountability models are developed and improved																
	Activities planned Week / Month	Wk1	Wk2	Wk3	Wk4	Wk5	Wk6	Wk7	Wk8	Wk9	Wk10	Wk11	Wk12	13	14	15	16
AP058	Work on reporting, accountability to communities, community engagement and accountability																



Budget

Marburg Kenya
MDRKE041

Budget Group		Multilateral Response	Appeal 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	2,000	2,000
540	Medical & First Aid	2,940	2,940
550	Teaching Materials	0	0
560	Utensils & Tools	0	0
570	Other Supplies & Services	0	0
571	Emergency Response Units	0	0
578	Cash Disbursements	0	0
Total RELIEF ITEMS, CONSTRUCTION AND SUPPLIES		4,940	4,940
580	Land & Buildings	0	0
581	Vehicles	0	0
582	Computer & Telecom Equipment	0	0
584	Office/Household Furniture & Equipment	0	0
587	Medical Equipment	0	0
589	Other Machinery & Equipment	0	0
Total LAND, VEHICLES AND EQUIPMENT		0	0
590	Storage, Warehousing	0	0
592	Distribution & Monitoring	4,000	4,000
593	Transport & Vehicle Costs	8,700	8,700
594	Logistics Services	0	0
Total LOGISTICS, TRANSPORT AND STORAGE		12,700	12,700
600	International Staff	7,200	7,200
661	National Staff	0	0
662	National Society Staff	3,000	3,000
667	Volunteers	16,517	16,517
669	Other Staff Benefits	0	0
Total PERSONNEL		26,717	26,717
670	Consultants	0	0
750	Professional Fees	0	0
Total CONSULTANTS & PROFESSIONAL FEES		0	0
680	Workshops & Training	24,000	24,000
Total WORKSHOP & TRAINING		24,000	24,000
700	Travel	1,667	1,667
710	Information & Public Relations	10,101	10,101

730	Office Costs	4,444	4,444
740	Communications	0	0
760	Financial Charges	0	0
790	Other General Expenses	0	0
799	Shared Office and Services Costs	0	0
Total GENERAL EXPENDITURES		16,213	16,213
		0	0
830	Partner National Societies	0	0
831	Other Partners (NGOs, UN, other)	0	0
Total TRANSFER TO PARTNERS		0	0
599	Programme and Services Support Recovery	5,497	5,497
Total INDIRECT COSTS		5,497	5,497
TOTAL BUDGET		90,066	90,066
Available Resources			
	Multilateral Contributions		0
	Bilateral Contributions		0
TOTAL AVAILABLE RESOURCES		0	0
NET EMERGENCY APPEAL NEEDS		90,066	90,066

Contact Information

For further information specifically related to this operation please contact:

- **Kenya, Red Cross Society:** Secretary General; Dr. Abbas Gullet, gullet.abbas@redcross.or.ke; Mobile phone; +254 722740789
- **IFRC Country Cluster Support Team office:** Getachew Taa, Head of EAIOI Country Cluster Support Team; email: getachew.taa@ifrc.org; mobile phone: +254202835000;
- **IFRC Regional Office for Africa DCPRR coordinator:** Farid Aiywar, Head of Disaster and Crisis Prevention, Response and Recovery Unit; email: farid.aiywar@ifrc.org; mobile phone +254731067489
- **IFRC Geneva:** Tiffany Loh, Senior Officer, Response and Recovery; phone: +41-79-251 8004; Email: tiffany.loh@ifrc.org
- **IFRC Region Logistics Unit (RLU):** Rishi Ramrakha, Head of Africa Region logistics unit; Tel: +254 733 888 022/ Fax +254 20 271 2777; email: rishi.ramrakha@ifrc.org

For Resource Mobilization and Pledges:

- **In IFRC Africa Regional Office:** Kentaro Nagazumi, Partnership & Resource Mobilization Coordinator; Africa Region; phone: 254 714 026 229; email: kentaro.nagazumi@ifrc.org

For Performance and Accountability (planning, monitoring, evaluation and reporting enquiries)

In IFRC Africa Regional Office: Fiona Gatere, Africa Region PMER Coordinator; Nairobi; phone: +254 731 688 230; email: fiona.gatere@ifrc.org

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.

The IFRC's work is guided by Strategy 2020 which puts forward three strategic aims:



Save lives.
protect livelihoods,
and strengthen recovery
from disaster and crises.



Enable **healthy**
and **safe** living.



Promote social inclusion
and a culture of
non-violence and **peace.**