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Emergency Plan of Action Final Report

Kenya: Marburg

 International Federation
of Red Cross and Red Crescent Societies

DREF operation n° MDRKE041	Glide N°:
Date of Issue: 23 May 2018	Date of disaster: 17 October 2017
Operation start date: 8 November 2017	Operation end date: 8 February 2018
Host National Society: Kenya Red Cross Society	Operation budget: CHF 90,066
Number of people affected: 1,413,623 (707,623 Females and 706,000 Males) across three targeted counties	Number of people assisted: 1,413,623 (707,623 Females and 706,000 Males)
N° of National Societies involved in the operation: KRCS is the single largest humanitarian organization in Kenya, with presence across the country (with 64 branches and sub branches supporting a network of 98,000 volunteers).	
N° of other partner organizations involved in the operation: MoH (National and County govt), WHO, CDC, UNICEF and KEMRIs	

A. SITUATION ANALYSIS

Description of the disaster

Marburg Virus Disease (MVD), also known as Marburg haemorrhagic fever, is caused by Marburg virus – member of the Filoviridae family (filovirus), often compared to the Ebola virus. The case fatality rate for MVD can be as high as 88%. Initial transmission of the disease can occur because 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, diarrhoea, abdominal pain or cramping, nausea, vomiting, lethargy, and lack of appetite. After 5 to 7 days of initial symptoms, fatal cases may develop severe haemorrhaging, including: fresh blood in vomit and faeces, 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.

The outbreak of Marburg Virus Disease (MVD) in Uganda's Kween district with 4 cases (1 suspect, 1 probable and 2 confirmed) with 1 death posed a risk of the outbreak in Kenya's districts bordering with Uganda. The outbreak in Uganda had spread to three districts i.e. Kween, Kapchorwa and Bukwo. Bukwo district has porous borders with Kenya, and intense cross-border activities. On 17 October 2017 a case of Marburg Virus Disease (MVD) was confirmed in Kween District, Uganda. The index case was a 35-year-old herdsman, who had been known to frequent caves in the Kaptum region (with known presence of bats). He presented with high fever, vomiting, and diarrhoea. 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 on 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 Ministry of Health (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 diarrhoea, 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 quarantined the suspected case in her house awaiting transfer to the identified temporary centre. The sample tested negative for MVD but she was monitored for symptoms within the 21 days incubation period.

Following the declaration of the MVD outbreak in Uganda, the Kenya Red Cross put its branches in West Pokot, Trans Nzoia and Bungoma (Mt. Elgon sub-county branch) Counties on alert. The Kenya Red Cross was incorporated in the National taskforce on MVD convened by the MoH. The Task force consisted of MoH, WHO, CDC, UNICEF and KRCS. The task force's main role was to provide support in the preparedness and response to the outbreak. One suspected case with two contacts was identified in Trans Nzoia County. The MoH took the specimen from the suspect case and the specimen was transported in the Kenya Red Cross E plus Ambulance to the Kemri Labs in Nairobi. The sample was confirmed negative, but monitoring was critical within the 21-day incubation period of the virus. National level and county level task force meetings were conducted as heightened surveillance, community sensitization/awareness campaigns and contact tracing were being carried out in the said counties.

The major donors and partners of the DREF include the Red Cross Societies and governments of Australia, Austria, Belgium, Britain, Canada, Denmark, Finland, Ireland, Italy, Japan, Luxembourg, Monaco, the Netherlands, Norway, Spain, Sweden and the USA, as well as DG ECHO, the UK Department for International Development (DFID), AECID, the Medtronic and Zurich Foundations and other corporate and private donors. On behalf of Kenya Red Cross Society, the IFRC would like to extend its gratitude to all partners for their generous contributions.

Summary of response

Overview of Host National Society

Following the MVD outbreak declaration in Uganda, the Kenya Red Cross 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. This task force consisted of MoH, WHO, CDC, UNICEF and KRCS. The main role of this task force was to provide support in the preparedness and response to the outbreak. KRCS medical services supported the safe transportation of samples to the laboratory in the capital. National level and County level task force meetings were activated, and a heightened surveillance and contact tracing was done in counties at risk.

Overview of Red Cross Red Crescent Movement in country

The IFRC has a Cluster Office for Eastern Africa and Indian Ocean Islands (EAIOI) and a Regional Office for Africa, in Nairobi. ICRC has a regional delegation in Nairobi, from which it supports operations in several countries in Eastern and Central Africa. There are also several Participating National Societies Supporting regional operations from Kenya, and these include the British Red Cross, Danish Red Cross, Finnish Red Cross, German Red Cross, Italian Red Cross, Japanese Red Cross and the Norwegian Red Cross. The IFRC EAIOI Cluster office supports operations in 12 countries in the region, including KRCS. KRCS will continue sharing situation reports with other Movement partners and update information on the operation progress through DMIS.

Overview of non-RCRC actors in country

The Kenya Ministry of Health took the lead with the support from WHO, UNICEF, KRCS and Kenya Medical Research Institute (KEMRI) and CDC in intensifying surveillance in the border counties of Trans Nzoia, West Pokot, Bungoma, Busia and Turkana. There was intensified contact tracing for the 24 contacts identified (9 in Pokot North and 15 in Trans Nzoia), samples were taken to KEMRI Nairobi, though results were negative, but tested individuals were isolated and monitored for the next 21 days. The MoH and WHO deployed a team to the Counties to support the outbreak investigation and response, including case contact tracing. The national and county taskforces were activated, with weekly meetings and joint field missions. National and County outbreak response plans were developed and utilized to mobilize required resources for response. Key interventions and activities done by KRCS were as outlined in the Emergency Plan of Action (EPoA) mirrored onto the 2017 Multi-hazard contingency plan and or outbreak preparedness plans leveraging on the comparative advantage in community social mobilization and logistics including ambulance services.

Main partners, with respective technical sector of support were as listed in table below:

Actor	Surveillance	Laboratory	Case management	Community engagement and Social mobilisation	Logistics	Psychosocial support	Coordination	WASH	SDB
MOH									
CDC									
WHO									
KRCS									
UNICEF									

Needs analysis and scenario planning

Kenya has never reported any case of active transmission of Marburg virus in its population before. This outbreak occurred after the huge outbreak of Ebola Viral Disease (EVD) in West Africa, creating intense fear in the public, when reflecting on the devastating effects of the previous epidemics.

The outbreak in Uganda had spread and affected the districts of Kween, Kapchorwa and Bukwo district, where contacts of the last confirmed case were traced to Kenya (Alale and Kacheliba in North Pokot and Bwaya Village in Trans Nzoia). The risk of exportation of the outbreak into Kenya through Suam to Kitale via Endebess and Chepkitale, Gitwamba, Saboti and other communities in Mt. Elgon neighbouring Bukwo district was high, with some potential contacts already identified on the Kenyan side.

The risk of cross border transmission of Marburg from neighbouring Uganda's Kween district was high as per case contact tracing, where a high-risk individual sought treatment across the Kenyan border. This required intensified cross-border surveillance between the two Governments as well as the National Societies and non-state actors. Health care workforce and surveillance mechanisms did not have adequate experience with the management of Marburg haemorrhagic fever. There were however, lessons learnt from the Ebola response as Kenya deployed a significant number of its health workforce to West Africa to support in the response; which included MoH staff from Trans Nzoia County and the Kenya Red Cross.

Targeting

The KRCS response activities targeted high risk population living in Counties bordering Bukwo Kween and Kapchorwa Districts of Uganda. These are Trans Nzoia County (due to population movement from Uganda to its urban centre of Kitale); West Pokot County (North Pokot Sub County covering Kacheliba, 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 by this DREF operation was 1,413,623 (707,623 females and 706,000 males).

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

Risk Analysis

Although the outbreak in Uganda was limited in size, it however presented significant risk of spread given its proximity to the Kenya border. Burial practices and a lack of knowledge of disease transmission and proper hygiene

management, person-to-person transmission was a high-risk factor. 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 could be challenging due to community aversion to health workers and aid groups.

The population groups at greatest risk included health workers, family members of infected patients and mourners. As the disease is transmitted via contact with the bodily fluids of infected individuals and or dead bodies, those who were responsible for the care and clean-up of infected individuals and burials were most at the risk to contract the infection.

Kenya Red Cross Society was requested to implement community sensitization activities targeting Pokot North Sub County using trained KRCS volunteers and Community Health Volunteers from November 2017 to February 2018. The objective of community sensitization was to raise awareness and reach communities along Kenya-Uganda border about MVD, precautionary measures (IPC), signs & symptoms and mode of transmission to prevent further infections/transmissions and loss of lives. Communities at risks of infection were targeted to ensure an increased knowledge on MVD infection prevention and control. The interventions also aimed at improving the knowledge of health care workers on case management and IPC (Infection Prevention & Control).

B. OPERATIONAL STRATEGY

The objective of the operation was to implement effective control measures to curb further spread of suspected MVD across the border to Kenya.


The MoH, KRCS and in country partners supported the response efforts in the three at risk counties. The operation mainly focused on activating a preparedness system by engaging community-based volunteers to undertake intensified health education and promotion campaigns at household levels. Use of Mms media (Local FM radio stations), social media and other forms of media to communicate. This strategy increased the level of awareness in at risk communities as well as the adoption of appropriate mitigation measures to protect themselves from contracting the disease and seeking treatment in case of infection. The operation also focused on contact tracing, where the contacts of the suspected cases were monitored daily by health workers and RC volunteers.

To reduce the risk of wide transmission of the epidemic, mass media and other forms of culturally acceptable and context-specific IEC campaigns were employed to increase knowledge and awareness about the disease, its risks of transmission, actions to take for suspected cases and preventive measures. Three sub Counties in three counties along the Kenya-Uganda border (Endebess in Trans Nzoia, Kapenguria in West Pokot and Mt Elgon in Bungoma) and surrounding areas where cross border population movement is high were targeted for the response.

The team also worked closely with the Ministry of Health from both Uganda and Kenya to enhance surveillance across the border. Health workers in affected counties were trained on precautionary control measures to support identification, referrals, treatment, management, and surveillance of MVD cases.

KRCS worked with the Ministry of Health to coordinate the county and national level control measures including: training on contact tracing, social mobilization, and health promotion and education. The KRCS Health and Social Services, as well as the Disaster Response Teams were incorporated to provide guidance and support on the field activities.

C. DETAILED OPERATIONAL PLAN

	<p>Health People reached: 1,130,898 Male: 566,098 Female: 564,800</p>			
Health Outcome 1: The immediate risks to the health of affected populations are reduced				
Indicators:	<table border="1" style="width: 100%;"> <tr> <td style="width: 50%;"></td> <td style="width: 25%; text-align: center;">Target</td> <td style="width: 25%; text-align: center;">Actual</td> </tr> </table>		Target	Actual
	Target	Actual		

# of people reached with community-based epidemic prevention and control activities	1,413,623	1,130,898
Health Output 1.1: Community-based disease prevention and health promotion is provided to the target population		
Indicators:	Target	Actual
# of people reached by the NS with services to reduce relevant health risk factors	1,413,623	1,130,898
# of Community leaders supporting community engagement activities	57	57
# house to house visits conducted	139,552	139,552
% of target population reached with mass media messaging	57% ¹	80%
# Number of community health Units with rumour monitoring mechanism established	50	50
Narrative description of achievements		
<p>A total of 57 opinion leaders (27 in Trans Nzoia and 30 in Pokot North) were sensitized on MVD. They consisted of church elders, chiefs, motorcycle (boda-boda) association officials, business community representatives, herbalists, midwives, Constituency Development Fund (CDF) representatives and representatives of members of county assembly offices at ward level. The opinion leaders are well regarded in their areas of jurisdiction and the information they obtained was vital in disseminations to the population in the areas of implementation.</p> <p>The Red Cross and Community Health volunteers who were trained in MVD prevention and control mechanism sensitized 139,552 households and reached a population of 837,312 people in Konyau, Alale, Kodich and Kapchok Wards) in Pokot North and Saboti, Bwayi, Kimilili, Endebebbes, Suam Cherangani, Kipsongo and Kitalale wards in Trans Zoia.</p> <p>Health risk communication using mass media was undertaken using public address system and radio talk shows on local FM radios (Kalya FM in West Pokot and Imani and Mitume FM Radios in Trans Nzoia) in the counties. The Radio talk shows had a penetration in the counties of 80%. Public address system mobilization and awareness campaigns were done over twenty (20) days targeting population convergence areas (main Markets) during market days that included: Kipsongo, Suam, Noigam, Kiminini, Maili Saba, Maili Nane, Endebebbes, Kabomboi, Kitalale, Gitwamba and Chepchoina in Trans Nzoia and Kacheliba, Alale, Kodich and Konyau in Pokot North. The campaigns were coupled with distribution of IEC materials.</p> <p>The discussions centred on MVD transmission and prevention and control mechanisms. The main messages geared towards sensitizing communities on how to:</p> <ul style="list-style-type: none"> • Identify the signs and symptoms of the Marburg disease • Know the modes of transmission of the Marburg virus • Be knowledgeable on the methods of prevention and control of the Marburg virus within the community • Identify the most at risk populations within the community • Knowledge on the intervention strategies <p>To entrench the interventions and minimized possible disease transmission in the communities a rumour monitoring mechanism for effective communication was established through the existing community health unit structures where a total of 50 community units and their volunteer networks were reached.</p>		
Challenges		
<p>The extremely porous and vast border between Kenya and Uganda without security and port health officers to support screening was a notable challenge. However, the establishment of rumour monitoring in at risk borders aided in collecting relevant information that supported interventions. Secondly, the nomadic pastoralist nature of the community impeded the follow up between Uganda and Kenya, posing high risk of outbreak importation especially in</p>		

¹ Radio penetration

North Pokot. This was overcome through sensitization of community resource persons among the nomadic population who in turn were in charge of monitoring events that posed risks to these communities.

Lessons Learned

The use of community-based resource persons, especially in the nomadic communities, was instrumental in improving population access to information and MVDs interventions. This would be instrumental if used in the future especially in such settings.

Health Output 1.2: Epidemic prevention and control measures carried out.

Indicators:	Target	Actual
# of volunteers trained	524	524
# of health workers trained	189	189
# of isolation/holding areas set up for suspected cases	3	3

Narrative description of achievements

The Community Health Volunteers (CHV) and Red Cross Volunteers (RCV) were essential in this response and their capacity was enhanced through training in Infection Prevention and Control measures that enhanced their safety during the response. A total of 524 volunteers were trained, including 209 (125 males and 84 females) in Pokot North and 315 (146 males and 169 females) in Trans Nzoia. The training also provided the volunteers with information and knowledge that enabled them to conduct community-based surveillance for MVD and implement contact tracing. A total of 189 health care workers were sensitized on MVD by the County and Sub County Health Management teams that were supported by KRCS.

Registration and mapping of contacts were spearheaded by disease surveillance teams. A total of 26 contacts (10 in North Pokot and 16 in Trans Nzoia) were line listed. Contact tracing and routine temperature check for all contacts were done (which remained normal) with no signs and symptoms of MVD observed. The response also supported surveillance outreach activities for MVD in the affected villages through daily follow-up of 50 contacts of probable & confirmed cases for 21 days each to monitor development of symptoms & timely isolation. This also included transportation of blood samples to KEMRI Nairobi.

KRCS provided support to the MoH in setting up of three (3) temporary isolation units in Suam in Trans Nzoia and Alale and Konyau facilities in Pokot North Sub-County through provision of three tents for isolation of suspected cases. MSF supported the setting up of an Isolation unit in Kaisagat health Centre in Trans Nzoia.

Challenges

At the operational level at the health facilities, there was inadequate knowledge and skills on MVD response mechanisms. The response supported sensitization of 189 health workers; that was not sufficient to meet knowledge gaps within the counties, considering the porous nature of borders and nomadic pastoral life. There would be need in future to train health workers on IPC, case management, safe burial, contact tracing and follow up, as well as setting up and managing isolation facilities.

Lessons Learned

Essential health care workers training especially at the operational level will be critical in future responses. The training should also be linked with interventions being implemented at the community level to synergize response efforts.

Health Output 1.3: Psychosocial support provided to the target population

Indicators:	Target	Actual
# of households & RC volunteers provided with psycho-social support therapy who can overcome trauma & stigma related to MVD	50	199

Narrative description of achievements

A total of 40 KRCS volunteers and 159 CHVs received psychosocial counselling in North Pokot. 10 families of the 10 established contacts in North Pokot were also reached with counselling services in the area. In Trans Nzoia, counselling services mainly concentrated on the primary contact's family, where the 3rd case had visited (the traditional herbalist and her family; herbal practitioner's daughter, son and 2 grandchildren and contacts). In addition, counselling services

reached frontier officers at Suam border point. Since there was no positive case recorded in Kenya, there was no major trauma load received by the team.

Challenges

Knowledge gaps on disease transmission gives leeway for stigma related to viral haemorrhagic fevers that may be prevented by targeted sensitization of communities served by the volunteers and health workers. There is need also to sensitize traditional healers on the VHF as they have formed the first contacts in most VHF emergencies. This will improve management and response and reduce stigma associated with the disease.

Lessons Learned

Tailored sensitization interventions at all levels in communities at VHF sigma associated risks.

Strengthen National Society

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

Output S1.1: KRCS has effective and motivated volunteers who are protected

Indicators:	Target	Actual
# of volunteers insured	75	75
# of volunteers provided with psychosocial support	50	199
# of volunteer briefings conducted	12	12
# of volunteers trained and engaged	75	75

Narrative description of achievements

A national task force was established by the Ministry of Health at National level. Similarly, a response coordination mechanism was established at county level. The coordination teams in the two counties met on a daily basis at county level before the joint supervision/ field missions to review the response, address resource/technical gaps and or appeal for support from partners and the national taskforce.

Partners in the county response coordination taskforce included: MoH, WHO, County directors of Health (chairs of the meetings), MSF, UNICEF regional representative, KRCS, and Sub-county MoHs.

KRCS deployed surge teams from the region and HQ to support the three KRCS branches in Bungoma, Kapenguria and Trans Zoia. They supported the branch teams and volunteers as well as the Ministry of Health volunteers (CHVS) in coordination with the sub county and county health management teams.

Challenges

The sub county health staff experienced logistical limitations to efficiently support some of the response efforts and joint implementations arrangements were organized with support from partners. This could pose a challenge especially if the scale of outbreak had increased.

Lessons Learned

Lobby for increased allocation of contingency funds from county governments to support health departments in response to disease outbreak emergencies. This can improve on the effectiveness of response efforts in the future.

Effective, credible and accountable IFRC

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.

Output S3.1: IFRC and NS are visible, trusted and effective advocates on humanitarian issues

Indicators:	Target	Actual
# of people reached by NS with services to reduce relevant health risk factors	1,413,623	1,130,898

Narrative description of achievements

KRCS played a key role in coordination of the response efforts in the affected counties and its efforts was acknowledged by both the county and the sub county teams.

D. THE BUDGET

The overall budget for this operation was CHF 90,066 of which CHF 88,079 (97.79%) were spent. The balance of CHF 1,987 will be returned to the DREF.

Contact information

Reference documents



Click here for:

- Previous Appeals and updates
- Emergency Plan of Action (EPoA)

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

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For IFRC Resource Mobilization and Pledges support:

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For Performance and Accountability support (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.

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

1. Save lives, protect livelihoods, and strengthen recovery from disaster and crises.
2. Enable healthy and safe living.
3. Promote social inclusion and a culture of non-violence and peace

Disaster Response Financial Report

MDRKE041 - Kenya - Marburg

Timeframe: 08 Nov 17 to 08 Feb 18

Appeal Launch Date: 08 Nov 17

Final report

Selected Parameters

Reporting Timeframe	2017/11-2018/4	Programme	MDRKE041
Budget Timeframe	2017/11-2018/4	Budget	APPROVED
Split by funding source	Y	Project	*
Subsector:	*		

All figures are in Swiss Francs (CHF)

I. Funding

	Raise humanitarian standards	Grow RC/RC services for vulnerable people	Strengthen RC/RC contribution to development	Heighten influence and support for RC/RC work	Joint working and accountability	TOTAL	Deferred Income
A. Budget		90,067				90,067	
B. Opening Balance							
Income							
<u>Other Income</u>							
<i>DREF Allocations</i>		90,066				90,066	
C4. Other Income		90,066				90,066	
C. Total Income = SUM(C1..C4)		90,066				90,066	
D. Total Funding = B +C		90,066				90,066	

* Funding source data based on information provided by the donor

II. Movement of Funds

	Raise humanitarian standards	Grow RC/RC services for vulnerable people	Strengthen RC/RC contribution to development	Heighten influence and support for RC/RC work	Joint working and accountability	TOTAL	Deferred Income
B. Opening Balance							
C. Income		90,066				90,066	
E. Expenditure		-88,079				-88,079	
F. Closing Balance = (B + C + E)		1,987				1,987	

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Budget Timeframe	2017/11-2018/4	Budget	APPROVED
Split by funding source	Y	Project	*
Subsector:	*		

All figures are in Swiss Francs (CHF)

III. Expenditure

Account Groups	Budget	Expenditure					TOTAL	Variance
		Raise humanitarian standards	Grow RC/RC services for vulnerable people	Strengthen RC/RC contribution to development	Heighten influence and support for RC/RC work	Joint working and accountability		
	A					B	A - B	
BUDGET (C)			90,067			90,067		
Relief items, Construction, Supplies								
Water, Sanitation & Hygiene	2,000						2,000	
Medical & First Aid	2,940						2,940	
Total Relief items, Construction, Sup	4,940						4,940	
Logistics, Transport & Storage								
Distribution & Monitoring	4,000						4,000	
Transport & Vehicles Costs	8,700						8,700	
Total Logistics, Transport & Storage	12,700						12,700	
Personnel								
International Staff	7,200						7,200	
National Society Staff	3,000						3,000	
Volunteers	16,517						16,517	
Total Personnel	26,717						26,717	
Workshops & Training								
Workshops & Training	24,000						24,000	
Total Workshops & Training	24,000						24,000	
General Expenditure								
Travel	1,667						1,667	
Information & Public Relations	10,101						10,101	
Office Costs	4,444						4,444	
Total General Expenditure	16,213						16,213	
Contributions & Transfers								
Cash Transfers National Societies			82,703			82,703	-82,703	
Total Contributions & Transfers			82,703			82,703	-82,703	
Indirect Costs								
Programme & Services Support Recove	5,497		5,376			5,376	121	
Total Indirect Costs	5,497		5,376			5,376	121	
TOTAL EXPENDITURE (D)	90,067		88,079			88,079	1,988	
VARIANCE (C - D)			1,988			1,988		

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Split by funding source	Y	Project	*
Subsector:	*		

All figures are in Swiss Francs (CHF)

IV. Breakdown by subsector

Business Line / Sub-sector	Budget	Opening Balance	Income	Funding	Expenditure	Closing Balance	Deferred Income
BL2 - Grow RC/RC services for vulnerable people							
Disaster management	90,067		90,066	90,066	88,079	1,987	
Subtotal BL2	90,067		90,066	90,066	88,079	1,987	
GRAND TOTAL	90,067		90,066	90,066	88,079	1,987	