www.ifrc.org
Saving lives, changing minds.

Emergency Plan of Action Final Report

Nigeria: Meningitis

International Federation of Red Cross and Red Crescent Societies

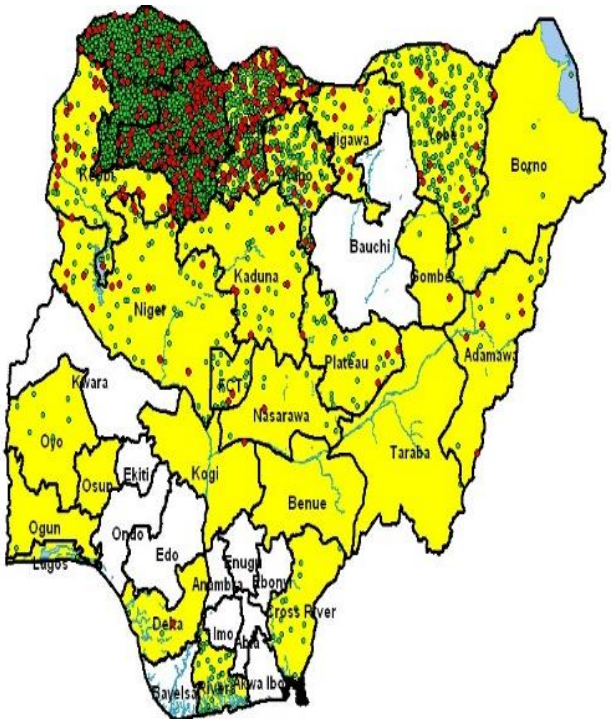
DREF operation	**Operation n MDRNG021**
Date of Issue: 23 August 2018	**Glide number:** EP-2017-000030-NGA
Date of disaster: November 2016	
Operation start date: 18 April 2017.	**Operation end date:** 31 July 2017
Host National Society: Nigeria Red Cross Society	**Operation budget:** CHF 234,843.
Number of people affected: Zamfara (3,259,846); Katsina (5,792,578); Sokoto (3,696,999).	**Number of people assisted:** ○ **1,332,419 people** benefitted from the operation through awareness creation, case detection • **54,130** of suspected cases referred to the health facilities.
N° of National Societies involved in the operation: One (1) Nigeria red Cross Society	
N° of other partner organizations involved in the operation: Federal Ministry of Health (FMOH), State Ministry of Health (SMOH), Nigeria Centre for Disease Control (NCDC), National Primary Health Care Development Agency (NPHCDA), WHO, UNICEF, MSF, US-CDC and E-Health Africa.	

A. SITUATION ANALYSIS

Description of the disaster

The northern part of Nigeria is seated on the meningitis belt, which like other Sub African countries continue to experience cerebrospinal meningitis (CSM) during the dry season, where temperatures can go above 35 degrees Celsius. In 1996 the country recorded about **109,580** cases with **11,717** deaths were recorded, followed by the one in **2003 (4,130** cases and **401** deaths) then in **2,008 (9,086** cases and **562** deaths) and in **2009**, it recorded 9,086 cases and **562** deaths. In 2017, most Local Government Authorities in the northern part of the country were affected with *Neisseria meningitis* type C for the first time. These outbreaks occur in the dry season, due to low humidity and dusty conditions and usually ends with the onset of the rainy season.

Meningitis is an acute severe infection of the central nervous system (CNS) associated with significant



The map above indicates severity of the outbreak in north-western Nigeria

morbidity and mortality. Highest burden occurs in parts of sub-Saharan Africa known as the "Meningitis Belt". Meningitis is a serious viral or bacterial disease in which an outside layer of the brain or spinal cord becomes affected and swollen, and can lead to death of the patient. Symptoms of the disease include neck stiffness, high fever, rash, headache, vomiting and confusion. *Neissera Meningitides C* was the major cause of the 2017 outbreak in Nigeria. The last major outbreak was in 2009 due to *Meningitides A* (*Source: NCDC 2017*).

The index cases of meningitis were reported in week 50 of 2016 and within a short time not less than 4,255 suspected cases were reported with 455 deaths with case fatality rate (CFR) of 10.7% from 128 Local Government Areas (LGAs). Within that short while five States reached epidemic proportion. These States were Zamfara, Sokoto, Kebbi, Katsina and Niger States. However, the Red Cross chose to launch its Disaster Relief and Emergency Fund (DREF) operation in the most affected states in the north-western States which include Sokoto, Zamfara and Katsina. As at July 2017, a total 14,518 cased reported and 1,166 deaths recorded with case fatality rate of 8%.

A rapid assessment was conducted in April to prioritize the needs of the affected population using RAMP. The assessment considered beneficiary exposure to risks, age group most affected and the capacity of the affected families to cope.

Summary of response

Overview of Host National Society

The Nigerian Red Cross Society (NRCS), which as an auxiliary to the Government of Nigeria, provides support to the Government in the fight to contain outbreaks since its inception. Following the continued spread of cases, the NRCS scaled-up its activities targeting those communities in the most affected LGAs as well as those surrounding LGAs identified to be at high risk. These included social mobilization activities for preventive and reactive campaigns, disease case detection, referrals and risk mapping as well as Psychosocial Support (PSS) services to the affected families in Sokoto, Kasina and Zamfara States. At the National and State level, the NRCS was actively involved in coordination meetings as well as the Emergency Operations Centre (EOC) led by the Nigerian Centre for Disease Control (NCDC). At the EOC, the NRCS was assigned the responsibility to support the Social mobilization and Surveillance Working groups.

In April 2017, a DREF operation of 234,843 Swiss francs was launched to reduce health risk of meningitis outbreak in Zamfara, Sokoto and Katsina States. The target for this operation was 810,000 persons (135,000 families). In July 2017, the operation received a one month no-cost timeframe extension through an Operations Update, to complete remaining activities including a lessons learnt workshop. Under the DREF operation, **1,332,419 people** were reached with social mobilization, preventive and reactive vaccination campaigns, disease surveillance and awareness campaigns and **54,130 suspected cases** were referred to the health facilities.

Key activities accomplished in the DREF operation-

- NRCS participated in the Emergency Operation Centre (EOC) meetings led by Nigerian Centre for Disease Control (NCDC) and Local Government Areas (LGA) stakeholders meeting for awareness campaign.
- The National Society deployed **three NRDTs** to the operational States to support in the training and to ensure weekly supervision and update to the NHQ. These NDRTs were on the field for 20 days to support

in follow up on volunteer activities in the LGA and Wards ensuring volunteers were delivering the right information.

- **Four hundred and sixty-five (465)** volunteers (150 volunteers and 5 supervisors per State) were trained and deployed to create awareness among community people against the outbreak and need for vaccination. They engaged communities with meningitis prevention messages as means of creating awareness on the outbreak.
- Volunteers conducted 54 public sensitization sessions (2 per month by nine LGAs within three months) in Mosques, churches, markets and lorry parks in all the three states. A total of **1,332,419** beneficiaries benefited from the operation through awareness creation, case detection and referrals.
- Volunteers held 54 advocacy sessions (2 per month by nine LGAs by three months) with Local Authorities including ward and family heads on dissemination of information on meningitis and ensure compliance to vaccination
- The Red Cross adopted the house to house strategy to engage the affected households. Cultural and religious practices of affected communities were considered in adopting this strategy.
- 6-day house-to-house visits were carried out by volunteers to engage affected families who lost their loved ones. Over **150 households** were assisted through one-on-one with PSS messages.
- A lesson learnt workshop was conducted by the IFRC in Abuja to bring all stakeholders to assess the implementation process in relation to its appropriateness and effectiveness, efficiency, coherence and sustainability.

Overview of Red Cross Red Crescent Movement in country

The International Federation of Red Cross and Red Crescent Societies (IFRC), through its Country Cluster Support Team (CCST) in-country in Abuja, worked closely with the NRCS to provide technical support during the operation. A Regional Disaster Response Team (RDRT) member was also deployed to assist in the operation. Through posting of two alerts on the IFRC's Disaster Management Information System (DMIS) platform, the IFRC facilitated an operations call and a follow-up, which led to the development of the Plan of Action for the DREF.

The International Committee of the Red Cross (ICRC) has presence in Nigeria which focused on the North East and Southern parts of the country where there are recurrent situations of violence and armed conflict. The NRCS also worked closely with the ICRC for security briefings.

Overview of non-RCRC actors in country

As the lead agency, the Nigerian Centre for Disease Control (NCDC) led a multi-agency CSM outbreak Control Team to coordinate the response aimed at containing the outbreak. Members of the team included the Federal Ministry of Health (FMOH), NCDC, National primary Health Care Development Agency (NPHCDA), WHO, Nigerian Red Cross and other partners (UNICEF, MSF, US-CDC and E-Health Africa). The Outbreak Control Team focused on vaccination, communicating prevention messages, strengthening surveillance, case detection, verification and management as well as communication and coordination across the affected States. Vaccines that provide protection

to Neisseria meningitis serogroup C (NmC) were not commercially available and had to be acquired through a special process managed by WHO. A total of five hundred thousand (500,000) doses of vaccines were granted by the International Coordinating Group (ICG) to Zamfara and Katsina States, whilst the British Government also supported with 800,000 doses. However, these vaccines were not enough to cover all the affected states. NPHCDA worked closely with WHO to ensure access to vaccines needed to respond to the outbreak and prevent further cases.

At the EOC, five (5) pillars were constituted with partners participating as team members as follows:

- Surveillance and Risk Assessment
- Case Management and Lab Diagnosis
- Epidemiology and Guideline Development
- Vaccines Needs Assessment and Campaign Management
- Communication and Social Mobilization

UNICEF provided support to the NPHCDA for social mobilization and communication (social and traditional media) in four states of Sokoto, Kebbi, Zamfara and Katsina. MSF deployed mobile teams to camps and sites in Sokoto and Zamfara for case management.

Needs analysis and scenario planning

During the outbreak partners focused mainly on case management and vaccination. Little efforts were put into dissemination of preventive messages and early detection and this gap contributed to worsening of the spread of the outbreak. This lack of dissemination of information, coupled with physical contacts with infected persons due to overcrowding and/or minimal ventilation mainly in the cases of children, as well as delays in identifying the disease and accessing medical facilities compounded the situation. The high temperatures, extremely dusty wind, precarious hygienic conditions and practices in these states were also contributing factors.

Based on this, awareness raising campaigns were highly needed to raise community awareness, case detection and referrals. With the DREF support, the NRCS mobilized and trained 625 volunteers to conduct rapid assessments using RAMP to inform social mobilization and awareness creation.

From the results of the assessments, 2,825 people indicated that they had been vaccinated with type A vaccine at the early stage of the outbreak. This was most especially done in Sokoto State. This worsened the cases as those who had the vaccine felt they were protected and did not take precautions and early treatment. Volunteers used this information to conduct education sessions, targeting more of those who were vaccinated with the type A vaccine to go out for the type C vaccine.

The assessment revealed that most of the affected people were aged between two to ten years (2-10 years). This information was very useful for the NRCS to target mothers and care givers during sensitization, most especially at household level.

The assessment indicated that over 367 affected beneficiaries interviewed did go to the hospitals when the outbreak was on its peak while 19 of them bought medicine from the pharmacy when they experienced symptoms of headaches.

Risk Analysis

The North-Western part of the country is relatively safe and volunteer activities and actors in the outbreak worked without any interruption. Volunteers were extensively briefed on the Standard Operating Procedures (SOPs) and vaccinated before they were deployed. Volunteers and staff deployed as part of the operation were given personal protective equipment such as hand sanitizers, gloves, and masks.

B. OPERATIONAL STRATEGY

Overall objective

The project aimed at contributing to immediate reduction in the health risks of the affected populations, specifically in relation to the meningitis outbreak, through social mobilization for preventive and reactive vaccination campaigns, disease surveillance and awareness campaigns, targeting 810,000 persons (135,000 families) in Zamfara, Sokoto and Katsina States.

However, the targeted numbers were surpassed during the implementation of the operation. As such a total number of **1,332,419** individuals were reached and a total number of **54,130** of suspected cases referred to the health facilities. The Operation achieved 164% of target planned. This number was achieved because the outbreak was devastating, and community members readily accepted the work of volunteers and in some cases motivated them to reach communities that were not in the original plan.

Proposed strategy

Volunteer mobilization and training

A total number of 450 volunteers including supervisors 15 supervisors (150 volunteers and 5 supervisors per state) were mobilized and trained in all the three states and actively participated on the operation. Volunteers were trained on simple key meningitis messaging relating to the causes, transmission and prevention as well as case detection and referral. Some selected volunteers were further trained on Psychosocial Support (PSS) to offer support to bereaved families to cope with the death of loved ones.

Volunteers role play on how to engage households during training session using the IEC material.

Volunteers were also trained on how to fill home visit forms and on correct hand washing methods at critical times to promote personal hygiene. Training was conducted in Hausa with volunteers' role plays as they would do in a household setting, mosques, churches, market places, schools and other public places.

Each volunteer was scheduled to work five days per week with a weekly target of 27 households for four weeks. The picture above shows volunteers' role play on how to engage households during training session using the IEC material.

Health education and promotion activities

Volunteers were grouped into pairs for health education and promotion activities in households, mosques churches, schools, markets and lorry parks. As the cultural norms of Hausa communities, if a man enters their home it is viewed as invading that household`s privacy hence it is restricted but it is normal for ladies to enter and engage a household. In respect to the norms, ladies in the groups entered and engaged with households while their male counterparts engaged community members gathered under trees or sheds. Due to the timing of the season, community gathering was common especially during the hot afternoon as people sought shades under trees and sheds making it easier for volunteers to reach a larger number of people with meningitis key messages at a time. Volunteers were accepted by the communities despite the cultural and religious beliefs. The good thing that made volunteers to be accepted most was the fact that over 85% of volunteers trained were Muslims and about 65% were ladies.

Volunteer used developed IEC material to demonstrate during educational sessions. They shared leaflets to those who could read. All the education sessions were done in Hausa both at the household and group educational sessions. A total number of **1,332,419** beneficiaries were reached and **54,130** of suspected cases referred to the health facilities within the three months period. .

Monitoring and supervision

After volunteers were deployed to the field, supervisors had the task to follow up on a daily basis to support them and address any difficulties they may have faced in the field.

To ensure quality control, the messages delivered by the volunteers both at the community and household levels were verified by finding out from beneficiaries what they learnt from the volunteers. Majority of beneficiaries interviewed could vividly recount the messages the volunteers passed on to them. Volunteers and superiors met after a day's activities to discuss challenges and plan for the following day. Social mobilization activities, specifically house-to-house visits, contributed significantly to the reduction in cases.

In operations like this, coordination and partnership are critical not only to reduce duplications and foster work relationships, but also to enhance success and future collaborations. During the operation the NS played a significant role with the Federal government during the EOC planning and coordinating meeting. The NRCS team including RDRT led by the Branch Secretary (BS) met with the Directors of Primary Health (DPH) and WHO officials at both the state and LGA levels. Authorities at all levels embraced the Red Cross intervention as timely and promised to work with the Red Cross volunteers.

Assessments

The NS on getting approval of the DREF mobilized and trained 150 volunteers (50 in each state) on RAMP to carry out rapid assessment. The RAMP was used as a tool for the assessment where questionnaires were uploaded into mobile phones. Volunteers were trained on how to administer questionnaires using mobile phones. They were also trained on how to upload after completing each round of interview.

The NS also put in place some feedback mechanisms, to get feedback from stakeholders, beneficiaries, volunteers and staff about the standards adopted and the activities undertaken during the operation. During monitoring and supervision, beneficiaries and staff regularly reviewed the messages delivered by the volunteers through questions and answers from both sides. Situational update reports were shared among stakeholders including Emirs. A lesson learnt workshop was organized towards the end of the operation to bring beneficiaries and stakeholders to evaluate and assess the implementation process and address issues that were encountered during the operation.

C. DETAILED OPERATIONAL PLAN

Health
People reached: 1,332,419 individuals
Male: N*ot available*
Female: N*ot available*

Outcome 2: Immediate risk and impact of meningitis on the health of the targeted population is reduced through social mobilization, prevention and surveillance activities in Zamfara, Sokoto and Katsina States, over a period of three months

Output 2.1: NRCS capacity to respond effectively and efficiently to support people affected by meningitis outbreak is strengthened

Indicators:	Target	Actual
One-day orientation for 4 NHQ technical teams and 6 NDRT (10 persons)	10	10
One-day training of 45 supervisors on data collection using mobile phones	45	45
Two days training of 450 volunteers on disease surveillance, health promotion and social mobilisation in the different branches	450	450
Procurement of PPEs (hand sanitizers, gloves, masks) for the volunteers	-	Done
Procurement of mobile phones and sim cards for the volunteer supervisors (45)	45	45
Procurement of visibility materials (Red Cross bibs, hijabs and fez caps (1,000 pieces)	1,000	1,000
Production of IEC materials- leaflets, posters and banners (10 banners, 3,000 posters, 30,000 leaflets and information cards)	33,010	33,010
Procure 45 megaphones for awareness campaigns	45	45

Output 2.2: Community knowledge on meningitis prevention, signs and symptoms as well as vaccination coverage is improved		
Indicators:	**Target**	**Actual**
Conduct door-to-door sensitization on disease prevention and control, early detection, community surveillance and referral (Target: 450 volunteers, 4 days a week for five weeks)	-	Done
Conduct advocacy visits to local stakeholders and decision makers to disseminate information on meningitis and ensure compliance to vaccination	-	Done
Carry-out public awareness at social and religious gatherings, street cinema and role play to disseminate information and create awareness on prevention and management of meningitis	-	54 sessions
Outcome 3: The psychosocial and mental health needs of affected families are addressed as part of an integrated and harmonized post-Meningitis recovery plan.		
Output 3.1: Enhanced NRCS capacity to deliver psychosocial support for survivors, bereaved families and frontline workers of Meningitis at community level		
Indicators:	**Target**	**Actual**
Train 60 NRCS staff and volunteers involved in the response on PSS activities	60	60
Produce 75 PSS handouts/books	75	75
Output 3.2: Strengthening psychosocial interventions at the community level		
Indicators	**Target**	**Actual**
Set-up a space for discussion within communities affected by Meningitis to strengthen educational talks and reduce stigma through community healing dialogue	-	Not done
Carry out house-to-house PSS to meningitis survivors and the bereaved families for six days	-	150

Narrative description of achievements

The Acting Health Coordinator and project team at the National Headquarters participated in the EOC meetings at the Federal level while the branches represented at the NS at State and LGAs Stakeholders meeting at all levels for the campaign.

A one-day orientation session was held to take 45 supervisors through processes of data collection using mobile phones and monitoring of volunteer activities in the LGAs.

The NS deployed three NRDTs to the operational States. The deployed NDRT were on the field for 20 days to support and follow up on volunteer's activities in the LGA and Wards. The contribution of NDRTs support to the operation cannot be underestimated as they were always on ground, ensuring volunteers were delivering the right information to the targeted communities.

Four hundred and fifty (450) volunteers were trained and deployed to create awareness and sensitize community members on the outbreak and need to be vaccinated. A total of 1,332,419 beneficiaries benefited from the operation through awareness creation, case detection whilst **54,130** were supported with referrals.

Volunteers conducted 54 public sensitization sessions (2 per month by nine LGAs by three months) in Mosques, churches, markets and lorry parks in all the three states. Volunteers held 54 advocacy sessions (2 per month by nine LGAs by three months) with Local Authorities including ward and family heads.

Sixty (60) volunteers were trained to engage affected families who lost their love ones to cope with the lost. Leaflets and hand outs were produced in collaboration with the Federal PSS department to facilitate household engagement by the volunteers. The Red Cross could not set-up spaces for community educational talks but adopted the house to house strategy to engage the affected households. Cultural and religious practices of affected communities considered in adopting this strategy.

Six-day house-to-house visits were carried out by volunteers to engage affected families who lost their love ones. Over 150 households were assisted through one-on-one with PSS messages. The state department responsible for PSS were involved and worked with the NS in carrying out this activity. According to the Program Officer in charge of PSS at the state levels, PSS was not well integrated in health outreach activities and the effort by the Red Cross was appreciated.

Challenges

Most volunteers were taken from different communities to carry out social mobilization activities and this caused delays in implementation of the social mobilization activities due to volunteers' transport challenges. The disperse nature of some communities and tough road conditions made access to certain areas difficult for the volunteers.

Poor communication network among partners during the operation. The EOC had a well-planned coordination and communication plan but this was not adhered to during the operation. The Red Cross managed to maintain good rapport with all the actors.

Cattle herdsmen posed a security threat in Birnin Magaji LGA in Zamfara State at the onset of the outbreak. However, State security was able to control situation which allowed volunteer supervisors at all levels to access the LGA for monitoring and supervision.

Misconception about the Red Cross Emblem. Most of the affected communities practice Islam and some people in these communities tend to see the Emblem as representing Christ Crucifix. About 95% of volunteers recruited were Muslims from the same communities who intensified education on what the Emblem represents and what the Red Cross stands for.

Lessons Learned

Working with locally recruited community volunteers would bring an added value and efficiency to future operations, as they better understand the terrain than anyone else.

There is a need to review and contextualize IEC materials for a better understanding by local communities.

It was important for the NS to deploy locally trained PSS volunteers in affected communities as this increases the level of confidence vis-à-vis the Red Cross, especially in these Muslim religion areas where the RC emblem can be easily misinterpreted.

Influence others as leading strategic partner

Outcome 1: On-going evaluation and coordination of activities to monitor the implementation process of the DREF operation

Output 1.1: Continuous planning, monitoring and reporting of the activities under DREF operation in the areas of implementation.

Indicators:	Target	Actual
Regular coordination meetings with stakeholders at National and State levels	-	Done
Orientation and briefing of supervisors on data collection and monitoring	45	45
Follow-up and monthly monitoring of planned activities by 3 NDRT members	3	3
Follow-up and monitoring by 3 NHQ technical team	-	Done
Lessons learnt workshop	1	1

Narrative description of achievements

The Acting Health Coordinator and project team at the National Headquarters participated in the EOC meetings at the Federal level while the branches represented at the NS at State and LGAs Stakeholders meeting at all levels for the campaign.

One-day orientation session was held to take 45 supervisors through processes of data collection using mobile phones and monitoring of volunteer activities in the LGAs.

The NS society deployed three NRDTs to the implementation areas to support in the training of volunteers and to ensure weekly supervision and update to the NHQ. The deployed NDRT were on the field for 20 days to support in follow up of volunteers' activities in the LGA and Wards.

A day's lesson learnt workshop was organized by the IFRC in Abuja to bring all stakeholders to assess the implementation process in relation to appropriateness and effectiveness, efficiency, coherent and sustainability.

Challenges

No challenges were encountered in the implementation of this outcome.

Lessons Learned

Coordination with other key stakeholders is important and it allows for the sharing of important updates and also to avoid duplication of efforts.

D. THE BUDGET

The NRCS received a total DREF funding of CHF 234,843. Out of the total funds received, a total amount of CHF 219,381 (93.41%) was utilized during the implementation of the DREF operation. The NS did not utilize about CHF 15,462 which will be returned to the DREF fund.

Within the project implementation, some variances on the budget were made but these were based on the actual needs on the ground. The variances are explained below:

Activity	Budget	Variance	Explanation
Teaching material	7,036	6,562	The budget was underspent by 93.26% as the materials that were budgeted under this line were printed using the information and public relations budget line.
International Staff	0	-9,625	There was no budget line to support the deployment of an RDRT. However, for effective implementation of the DREF operation, there was need for such a deployment hence there was a variance created under this budget line to cover costs for deployment of the RDRT.
National Staff	0	-2,770	There was no budget line for National staff, however, the NS had support from the Health assistant hence, the variance is related to the costs incurred from provision of this support.
Information & Public Relations	5,000	-7,893	The budget line for information and public relations overspent by 157% because it was under budgeted at planning. There were costs associated with visibility material for volunteers (Aprons and bibs), and message cards which went beyond the projected budget hence the variance.
Office Costs	0	-659	The budget did not include office costs yet there were necessary for the proper running of the operation. The variance created was to cover costs such as stationery, photocopying and fuel for the office generator.

Contact information

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

National Society

- **Nigeria Red Cross Society:** Secretary General, Abubakar Kende, Secretary General NRCS; Tel: +234 8089595095; Email: abukende@yahoo.com / abukende@gmail.com.

In the IFRC

- **IFRC Head of Cluster, West Coast:**, Dr M.Charles, Acting Head of Cluster, West Coast Region; Abuja, Nigeria; phone: +2348186730823; email: michael.charles@ifrc.org
- **IFRC Africa Region:** Adesh Tripathee, Head of DCPRR Unit; Nairobi;Kenya phone: +254 202835000 (; email: adesh,TRIPATHEE@ifrc.org
- **IFRC Zone Logistics Unit (ZLU):** Rishi Ramrakha, Head of zone logistics unit; Tel: +254 733 888 022/ Fax +254 20 271 2777; email: rishi.ramrakha@ifrc.org

In IFRC Geneva

- **IFRC Geneva**: Alma Alsayed, Senior Officer, Response and Recovery; phone: +41 22 730 4566; Email:alma.alsayed@ifrc.org

For IFRC Resource Mobilization and Pledges support:

- **In IFRC Africa Zone**: Kentaro Nagazumi, Head of Partnership and Resource Development, Nairobi; phone: +254202835155; email: kentaro.nagazumi@ifrc.org

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

- **IFRC Zone:** Fiona Gatere, PMER Coordinator; phone: +254780771139; 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:

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

MDRNG021 - Nigeria - Meningitis

Timeframe: 20 Apr 17 to 31 Jul 17

Appeal Launch Date: 20 Apr 17

Final Report

Selected Parameters			
Reporting Timeframe	2017/4-2018/7	Programme	MDRNG021
Budget Timeframe	2017/4-2017/7	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		**234,843**				**234,843**	
B. Opening Balance							
Income							
Other Income							
DREF Allocations		*234,843*				*234,843*	
C4. Other Income		***234,843***				***234,843***	
C. Total Income = SUM(C1..C4)		**234,843**				**234,843**	
D. Total Funding = B +C		**234,843**				**234,843**	

* 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		234,843				**234,843**	
E. Expenditure		-219,381				**-219,381**	
F. Closing Balance = (B + C + E)		15,462				**15,462**	

Disaster Response Financial Report

MDRNG021 - Nigeria - Meningitis

Timeframe: 20 Apr 17 to 31 Jul 17

Appeal Launch Date: 20 Apr 17

Final Report

Selected Parameters			
Reporting Timeframe	2017/4-2018/7	Programme	MDRNG021
Budget Timeframe	2017/4-2017/7	Budget	APPROVED
Split by funding source	Y	Project	*
Subsector:	*		

All figures are in Swiss Francs (CHF)

III. Expenditure

Account Groups	Budget	Expenditure						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	TOTAL	
	A						B	A - B
BUDGET (C)			**234,843**				**234,843**	
Relief items, Construction, Supplies								
Medical & First Aid	4,055		2,795				**2,795**	**1,261**
Teaching Materials	7,036		474				**474**	**6,562**
Total Relief items, Construction, Sup	11,091		3,268				**3,268**	**7,823**
Logistics, Transport & Storage								
Transport & Vehicles Costs	4,463		3,334				**3,334**	**1,128**
Total Logistics, Transport & Storage	4,463		3,334				**3,334**	**1,128**
Personnel								
International Staff			9,625				**9,625**	**-9,625**
National Staff			2,770				**2,770**	**-2,770**
National Society Staff	27,863		20,462				**20,462**	**7,401**
Volunteers	104,022		112,153				**112,153**	**-8,130**
Total Personnel	131,886		145,010				**145,010**	**-13,124**
Workshops & Training								
Workshops & Training	45,886		28,703				**28,703**	**17,183**
Total Workshops & Training	45,886		28,703				**28,703**	**17,183**
General Expenditure								
Travel	10,000		4,735				**4,735**	**5,265**
Information & Public Relations	5,000		12,893				**12,893**	**-7,893**
Office Costs			659				**659**	**-659**
Communications	10,684		6,914				**6,914**	**3,770**
Financial Charges	1,500		468				**468**	**1,032**
Other General Expenses			7				**7**	**-7**
Total General Expenditure	27,184		25,675				**25,675**	**1,509**
Indirect Costs								
Programme & Services Support Recove	14,333		13,389				**13,389**	**944**
Total Indirect Costs	14,333		13,389				**13,389**	**944**
TOTAL EXPENDITURE (D)	**234,843**		**219,381**				**219,381**	**15,462**
VARIANCE (C - D)			**15,462**				**15,462**	