DREF Final Report

Kenya_ MVD Readiness

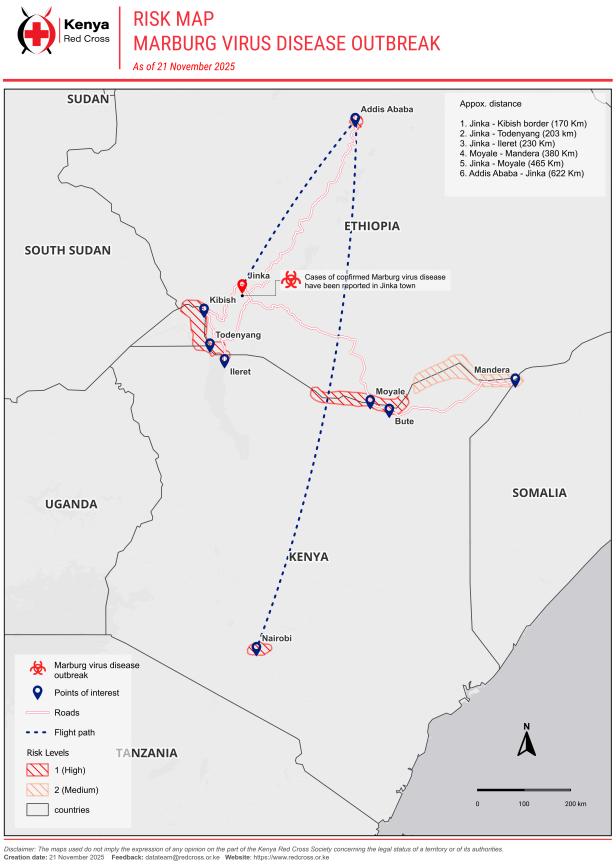
MoH/KRCS SDB team training - 2024 Eldoret, Kenya

Appeal: **MDRKE069**	Total DREF Allocation: **CHF 150,000**	Hazard: **Epidemic**	Crisis Category: Yellow
Glide Number: -	People Affected: -	People Targeted: **111,444 people**	People Assisted: **129,018 people**
Event Onset: **Slow**	Operation Start Date: **25-11-2025**	Operational End Date: **28-02-2026**	Total Operating Timeframe: **3 months**

Targeted Regions: **Marsabit, Turkana, Nairobi**

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, German, 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



Date when the trigger was met

15-11-2025

What happened, where and when?

On 15 November 2025, the Ethiopia Public Health Institute (EPHI) confirmed an outbreak of Marburg virus disease (MVD) following laboratory testing of samples collected from a cluster of suspected viral hemorrhagic fever cases in Jinka Town, located in the southwestern part of Ethiopia. This marked the first recorded occurrence of MVD in the country. Genetic analysis conducted by EPHI indicated that the virus strain was consistent with those reported in recent outbreaks in other countries within the East African region. A total of nine cases had been reported at the time.

Jinka Town was located approximately 170 km and 203 km from the Kenya–Ethiopia border points of Kibish and Todonyang, respectively (both in Turkana County), and approximately 230 km from Ileret and 465 km from Moyale Town (both in Marsabit County). Turkana and Marsabit counties were identified as being at high risk due to their shared border with Ethiopia. These areas, along with surrounding regions, have numerous informal and non-designated border crossing points that were not monitored by security or health officials. The geographical proximity of these entry points underscored the heightened risk of cross-border transmission driven by frequent social and economic interactions.

In addition, frequent travel between Addis Ababa Bole International Airport and Jomo Kenyatta International Airport increased the vulnerability of Nairobi, the capital city. This situation necessitated the implementation of immediate preparedness and readiness measures to mitigate the risk of importation and potential spread of Marburg virus disease in Kenya.

Focus Group Discussion session during risk assessment

Community Review meeting in Lomadang village in Telesgaye CU in Ileret

Community sensitization on MVD in Illeret , Marsabit county

Scope and Scale

Following the confirmation of MVD in Jinka, Ethiopia, neighboring countries, including Kenya, took steps to initiate measures to prepare for and respond to the potential spread of the virus. In Kenya, the Kenya National Public Health Institute (KNPHI) placed all counties on alert through the issuance of an MVD advisory that provided a situational update and outlined guidance on preparedness and readiness measures to be implemented by county governments. The most vulnerable counties were those bordering Ethiopia, due to cross-border trade and road access facilitating movement between the two countries, thereby increasing the risk of MVD importation. An additional risk factor was access through Jomo Kenyatta International Airport, as Jinka town was frequently visited by tourists, some of whom traveled onward to Addis Ababa by air after visiting nearby national parks.

KNPHI profiled five counties—Turkana, Marsabit, Nairobi, Mandera, and Wajir—out of the 47 counties in the country, identifying them as being at risk of potential impact in the event of MVD entry into Kenya. These counties were selected based on their proximity to Ethiopia and the level of cross-border interaction among communities. The Kenya Red Cross Society (KRCS) planned to implement anticipatory actions in three of the identified high-risk counties: Turkana, Marsabit, and Nairobi.

The proposed DREF operation focused on preparedness and early response actions in high-risk border counties, particularly Turkana, Marsabit, and Nairobi. Specific attention was given to communities around Kibish, Todonyang, Ileret, and Moyale, where регуляр cross-border movement increased the likelihood of virus introduction into Kenya. The scope included the prepositioning of critical capacities such as Safe and Dignified Burial management, strengthening community-based surveillance, enhancing screening and referral mechanisms, and supporting risk communication and community engagement (RCCE) as well as WASH activities targeting populations and counties most at risk.

As at the closure of this operation in late February 2026, the Marburg virus disease (MVD) situation along the Kenya–Ethiopia border and related points of entry was characterized by no active transmission, but continued heightened preparedness and surveillance.

Kenya sustained measures such as:

• Screening and triage at points of entry
• Rapid response team readiness
• Isolation and referral preparedness

These actions reflected a transition from emergency response to preparedness and vigilance, rather than active outbreak response.

Source Information

Source Name	Source Link
1. WHO Marburg virus Disease Outbreak Alert_ Ethiopia	https://www.afro.who.int/countries/ethiopia/news/ethiopia-confirms-first-outbreak-marburg-virus-disease
2. Kenya National Public Health Institute Advisory Alert	https://kenyaredcross-my.sharepoint.com/:b:/g/personal/gathagu_isaac_redcross_or_ke/IQD8M_YqyVgOT76k5593Pla5AZE19NxfJqaMOYJ_H5VYy9c

National Society Actions

Have the National Society conducted any intervention additionally to those part of this DREF Operation?	Yes
Please provide a brief description of those additional activities	KRCS had been conducting routine Community Based Surveillance in the high-risk areas.

IFRC Network Actions Related To The Current Event

Secretariat	The IFRC maintains a Country Cluster Delegation (CCD) for Kenya and Somalia, as well as a regional office for Africa, both based in Nairobi. Through the Delegation and the Regional Office, the IFRC provides resource mobilisation and technical support to the Kenya Red Cross Society (KRCS) for emergency response and longer-term programming. The IFRC CCD supported KRCS in developing this DREF operation. In addition, the IFRC monitored the operation jointly with KRCS and provided financial management and reporting support.
Participating National Societies	There is no PNS that supported.

ICRC Actions Related To The Current Event

The ICRC Nairobi regional office is based in Kenya however they were not part of this operation.

Other Actors Actions Related To The Current Event

Government has requested international assistance	Yes
National authorities	The Kenya National Public Health Institute (KNPHI) convened two partner Task Force meetings to deliberate on the Marburg virus disease (MVD) situation analysis and assess the level of preparedness within the country. Kenya prioritized the updating of its Viral Hemorrhagic Fever (VHF) contingency plan, standard operating procedures (SOPs), and training materials to reflect the evolving MVD threat. Risk assessments were ongoing, with findings from the Kenya Red Cross Society (KRCS) epidemic readiness landscape assessment—supported by the PREPARE project—incorporated into risk mapping for Turkana and Marsabit counties. In addition, KNPHI issued alerts to all counties, calling for heightened vigilance and the implementation of preventive measures. Health service delivery in Kenya operates under a devolved system of government,

	with county health departments responsible for the provision and management of health services. As such, county authorities played a central role in the implementation of preparedness and response measures.
UN or other actors	The World Health Organization (WHO), UNICEF, Africa CDC, the International Organization for Migration (IOM), and FHI360 were in coordination with the Kenya National Public Health Institute (KNPHI) on preparedness measures. WHO deployed a team of technical experts to support the viral haemorrhagic fever outbreak response in Ethiopia, alongside the provision of medical supplies and equipment. At the time, the specific scope of support from individual partners had not yet been fully defined, but further clarity was expected in the subsequent weeks as coordination and planning processes advanced.

Are there major coordination mechanism in place?

The Kenya Red Cross Society (KRCS) was a key member of the national Viral Hemorrhagic Fever (VHF) Taskforce and its various sub-committees, led by the Kenya National Public Health Institute under the Ministry of Health (MoH-KNPHI). KRCS actively participated in joint planning, information sharing, and coordination of preparedness and response activities at the national level.
However, coordination gaps were identified at the sub-national level, which required urgent strengthening to ensure effective implementation of preparedness and response interventions across counties.

Needs (Gaps) Identified

Health

1. Insufficient Community-Based Surveillance (CBS) Capacity for Early Detection
All three at-risk counties had an inadequate number of trained Community-Based Surveillance (CBS) volunteers to support early detection, escalate MVD-related alerts, and facilitate timely referral to health facilities. With the exception of Moyale One-Stop Border Post (OSBP) in Marsabit County, the Kenya Red Cross Society (KRCS) did not have established CBS capacity at other profiled high-risk points of entry in Turkana and Marsabit. This gap significantly limited early warning and rapid response capacities along the Kenya–Ethiopia border.

2. Inadequate Safe and Dignified Burial (SDB) and IPC Readiness
Strengthening Safe and Dignified Burial (SDB) and Infection Prevention and Control (IPC) capacities, alongside reinforced community-level behaviour change, was identified as essential for immediate preparedness and rapid containment of the virus. While KRCS and the Ministry of Health had previously trained and pre-positioned SDB teams, these efforts had been undertaken several years prior, necessitating urgent updates to SDB and IPC readiness.
National SDB and IPC Standard Operating Procedures (SOPs) and training materials required review, updating, and dissemination to priority counties to ensure effective implementation. In addition, formal agreements between KRCS and the Kenya National Public Health Institute (KNPHI) on SDB roles and responsibilities required updating.
During the previous outbreak response under MDRKE052, SDB teams had been trained and training and intervention kits procured. However, most of the training kits had been depleted through prior trainings and simulation exercises. There was therefore a need to procure new training kits and initial SDB starter kits to enable immediate deployment in the event of confirmed cases. Previously trained SDB teams could be reactivated and pre-positioned but required refresher training. In the three targeted counties, Rapid Response Teams (RRTs), including staff from priority health facilities, also required training on IPC and SDB protocols.

3. Limited Pre-Positioning, Laboratory Surge Readiness, and Coordination Gaps
There was limited pre-positioning of critical supplies, inadequate laboratory surge capacity, and weak linkages between community-level early detection systems and facility-level IPC mechanisms, which delayed the activation of containment measures. KNPHI coordination meetings confirmed gaps in the mapping of high-risk facilities, referral pathways, IPC stock levels, and coordination structures required to effectively manage a Marburg-level event.

4. Limited Trained Human Resources on the EPiC Module
There was a limited number of volunteers trained on the Epidemics Preparedness and Response in Communities (EPiC) module, resulting in insufficient community-level preparedness support for Marburg. Capacity building was therefore required for KRCS volunteers, Community Health Promoters (CHPs), and Community Disaster Responders (CDRs) along the Kenya–Ethiopia border, with a focus on Viral

Hemorrhagic Fevers (VHFs).
In 2024, the Ministry of Health operationalized the Kenya National Public Health Institute, devolving most national public health functions to the Institute. During the 2023 Ebola Virus Disease (EVD) preparedness efforts, KRCS developed EVD preparedness SOPs and draft agreements, which required review and formalization. As the national lead agency for SDB interventions, KRCS sought to formalize its engagement with MoH-KNPHI through a renewed agreement to clarify mandates and coordination mechanisms.

5. Limited Risk Communication and Community Engagement (RCCE) Coverage
Border communities demonstrated limited knowledge of Marburg symptoms, transmission risks, and the importance of early reporting. Existing RCCE teams were not sufficiently trained nor fully integrated into CBS structures, reducing the effectiveness of community sensitization and timely behaviour change interventions. Intensified and targeted community sensitization on MVD was therefore required.

6. Limited Emergency Operations Center (EOC) Readiness for Cross-Border Event Monitoring
Emergency Operations Center (EOC) systems required strengthening to ensure timely verification of alerts, coordinated cross-border data sharing, and rapid activation of preparedness actions related to cross-border event monitoring.

7. Mental Health and Psychosocial Support (MHPSS) Gaps
Mental health and psychosocial support (MHPSS) was identified as a critical component for both response teams and affected communities in the context of a potential Marburg outbreak. There was a need to establish clear linkages and referral pathways for mental health services. Strengthening this component would enhance the capacity of KRCS volunteers, staff, CHPs, and CDRs to provide psychological first aid, emotional support, and reassurance to affected individuals, families, and communities.

Water, Sanitation And Hygiene

The Marburg virus disease (MVD) event in Jinka, Ethiopia exposed critical Water, Sanitation and Hygiene (WASH) vulnerabilities across Kenya's high-risk counties, particularly Turkana, Marsabit, and Nairobi. The proximity of Jinka to porous border areas, coupled with frequent cross-border trade, travel, and pastoral migration, significantly elevated the risk of MVD importation and spread into Kenya. Despite Kenya's prior experience in preparedness and response to cholera, COVID-19, and Mpox, systems required for filovirus-level containment remained under-resourced and unevenly distributed.

At the community level, WASH vulnerabilities were more pronounced. High-mobility populations—including pastoralists, traders, fisherfolk, and religious groups—had limited access to safe water and sanitation services and often depended on shared water points used by both humans and animals, as documented across the five at-risk counties.

Across healthcare facilities, waste management remained a weak component of IPC systems. Many facilities lacked color-coded waste bins, sharps containers, biohazard bags, and functional incinerators required for Viral Hemorrhagic Fever (VHF)-level waste management. In several instances, disposal practices relied on shallow pits or open burning, which were unsafe and inconsistent with recommended IPC standards. Training gaps among cleaners, porters, and frontline healthcare workers further increased the risk of occupational exposure, reflecting the limited epidemic preparedness confidence expressed in the PREPARE KAP findings.
Health facilities in two of the three mapped at-risk counties continued to experience severe and recurrent water shortages, driven by chronic drought, damaged water infrastructure, and unreliable supply systems. Low uptake of handwashing and safe caregiving practices, particularly in areas characterized by low literacy levels and limited access to soap or water treatment products, further increased the risk of household and community transmission in the event of cross-border spread. These challenges were consistent with findings from the PREPARE Knowledge, Attitudes, and Practices (KAP) assessment, which indicated that communities relied on shared and often contaminated water sources, had inadequate sanitation facilities, and continued to practice open defecation—factors contributing to recurrent disease outbreaks.

Limited pre-positioning of supplies, weak laboratory capacity, and poor linkages between community detection and facility IPC delayed containment, while KNPHI confirmed gaps in facility mapping, referral pathways, IPC stocks, and coordination.

These gaps directly undermined essential Marburg Infection Prevention and Control (IPC) functions, including safe handwashing, chlorine preparation, environmental cleaning, and the establishment of isolation spaces. Many health facilities lacked adequate water storage capacity, backup supply mechanisms, and the resilience required to sustain high-intensity case management in the event of suspected cases. Strengthening WASH, waste management, SDB, IPC, and community behaviour change was therefore essential to ensure preparedness and rapid response.

Protection, Gender And Inclusion

There was limited Protection, Gender and Inclusion (PGI) training among staff and volunteers in the three mapped at-risk counties. Strengthening gender sensitivity and inclusivity capacities was identified as critical to emergency preparedness, to ensure that staff and volunteers delivered care that was culturally appropriate, non-judgmental, and non-discriminatory.
Where responders demonstrated an understanding of how gender roles, power dynamics, and cultural norms influenced health-seeking behaviour, they were better positioned to create safe and respectful environments in which women, men, girls, and boys felt confident to seek services and support. These competencies were particularly relevant in the context of outbreaks such as Marburg, where stigma, fear, and misinformation could deter early reporting and timely care-seeking.
The proposed training aimed to equip staff and volunteers with the skills to communicate effectively with empathy, uphold privacy and confidentiality, and identify the distinct barriers faced by different population groups. This approach was expected to strengthen community trust, enhance early detection and reporting, and support an inclusive response that ensured equitable access to services for all affected populations.

Community Engagement And Accountability

Community Engagement and Accountability (CEA) was recognized as an integral component of outbreak management and emergency preparedness. However, the engagement of marginalized groups—particularly pastoralist communities in Northern Kenya—remained limited during discussions and community forums, potentially resulting in misrepresentation, exclusion, and mistrust. Key community influencers in the at-risk counties included religious leaders, traditional healers, traders, and boda boda operators, all of whom played a critical role in information dissemination and shaping community perceptions.
There was a clear need to strengthen community engagement and accountability mechanisms to ensure that community priorities were systematically identified, concerns were addressed, and barriers to behaviour change were effectively mitigated.

The Kenya Red Cross Society (KRCS) identified that a Knowledge, Attitudes, and Practices (KAP) survey in at-risk border areas of Turkana and Marsabit counties was critical. The scope was intended to essentially focus on burial practices as these were newly identified at-risk areas where Safe and Dignified Burial (SDB) activities had not previously been implemented. Understanding socio-cultural practices was therefore essential to inform context-specific preparedness and response interventions.

KAP Survey findings showing gaps in communities:
• Two Knowledge, Attitudes and Practices (KAP) assessment were conducted in Todonyang & Kibish (Turkana County) and North Horr (Marsabit county) to assess community awareness, perceptions & behavior related to Marburg Virus Disease (MVD).
• Findings of the KAP survey indicates that 90% (616) of the respondents reported being aware of the Marburg Virus Disease outbreak. The high level of awareness suggests that information about the outbreak has reached most members of the community through different communication channels. Desk reviews also indicate that CHPs had done sensitization to community members on the disease after being trained by KRCS team.
• The demographic profile of respondents indicates that the survey captured younger populations, with the majority aged between 25–29 years (73%, 501). Women constituted a proportion of respondents, reflecting their central role in household health decision-making and caregiving. However, the assessment revealed substantial socio-economic vulnerabilities, with high unemployment levels and low educational. 73%, (501) of the respondents reported having no formal education.
• In terms of the most trusted sources of information, 73% (502) of respondents indicated that they receive information from CHPs & health workers at 59% (409). KRCS and community leaders were each mentioned as trusted sources by 29% each (202) of respondents, Respondents reported using Mass media and informal networks less frequently but still contribute to information flow. 14% (96) of respondents cited Radio, while friends and family accounted for 11% (78). 8% (58) of the respondents indicating trusting home visits. Relatively few respondents mentioned other channels such as mobile SMS (5%, 34), television (2%, 14) and other sources (2%, 12).

Operational Strategy

Overall objective of the operation

The IFRC-DREF operation aimed to strengthen early preparedness, enhance detection, and enable timely response to prevent and contain the potential spread of Marburg virus disease (MVD) in at-risk counties in Northern Kenya and Nairobi. Nairobi was considered particularly vulnerable due to its connectivity and proximity to the outbreak epicenter through travel routes.

Planned intervention areas included Marsabit, Turkana, and Nairobi counties, targeting an estimated population of 111,444 people.

Operation strategy rationale

The confirmation of Marburg virus disease in Jinka near the Kenya–Ethiopia border posed a credible cross-border risk prompting a preparedness for a likely scenario of escalation of the outbreak to Kenya. A three-month DREF operation was launched focusing on intitutional NS Readiness, targeted capacity strenghtening, enhanced coordination in-country and cross-border while ensuring SoPs are in place.

The main outputs of the intervention included: Community-Based Surveillance (CBS), Risk Communication and Community Engagement (RCCE), Water, Sanitation and Hygiene (WASH), Safe and Dignified Burial (SDB), Infection Prevention and Control (IPC), and coordination mechanisms. These interventions were designed to ensure comprehensive disease outbreak preparedness over a three-month implementation period. The DREF significantly strengthened epidemic preparedness in high-risk border areas across 3 counties by improving community awareness, enhancing surveillance and health response capacity, reinforcing coordination mechanisms, and building institutional readiness for over 215 health workers and volunteers. While some material gaps remained due to delayed SDB procurement, the operation substantially reduced the risk of undetected transmission and improved the ability of communities and systems to prevent and respond to a potential Marburg outbreak.

1) Health

- Evaluations: KRCS, in collaboration with County Ministries of Health and KNPHI, conducted MVD risk assessments and evaluated preparedness levels at key border points in Turkana and Marsabit. Training of KRCS volunteers and Community Health Promoters (CHPs) on the EPiC package—comprising CBS, IPC, and Community Engagement and Accountability (CEA) modules—was conducted across four priority sites (Kibish, Todonyang, Ileret, and Moyale), with 25 participants per site over a five-day period.
- RCCE: Risk Communication and Community Engagement (RCCE) activities were intensified in Kibish, Todonyang, Ileret, Moyale, and at Jomo Kenyatta International Airport (JKIA) to enhance awareness and preparedness. These activities were conducted through house-to-house sensitization, community forums (barazas), engagement with religious institutions, and use of public address systems. Target populations included cross-border traders, business communities, local households, religious leaders, and travellers passing through JKIA.
- SoPs harmonisation/signing and dissemination: KRCS, with support from MoH-KNPHI, reviewed Safe and Dignified Burial (SDB) and Infection Prevention and Control (IPC) Standard Operating Procedures (SOPs) and initiated the formalization of operational agreements. Dissemination of SDB and IPC SOPs was conducted among County Rapid Response Teams (RRTs), County Health Management Teams (CHMTs), and targeted Sub-County Health Management Teams (SCHMTs) in Turkana and Marsabit.
- SDB training materials were reviewed and updated jointly by KRCS and MoH-KNPHI. Refresher training was conducted for two national KRCS and MoH SDB teams (Nairobi and Eldoret), followed by one-day simulation exercises to strengthen readiness. Procurement of SDB kits—including three training kits and one starter kit—was completed to support training and ensure pre-positioning for rapid deployment at the onset of a potential outbreak.

2) Water, Sanitation and Hygiene (WASH)

The operation prioritised strengthening community hygiene practices, enhancing IPC readiness, and ensuring the availability of essential disinfection supplies. Hygiene promotion activities targeting high-risk communities were implemented to reinforce safe behaviours and reduce transmission risks.

Chlorine products (HTH and liquid bleach) were procured and pre-positioned to support IPC simulations and ensure immediate response capacity if required. In addition, IPC SOPs were disseminated and integrated into the operational frameworks of County Rapid Response Teams (RRTs), County Health Management Teams (CHMTs), and Sub-County Health Management Teams (SCHMTs) in Turkana and Marsabit.

3) Protection, Gender and Inclusion (PGI)

KRCS volunteers and staff were trained on Protection, Gender and Inclusion (PGI) to strengthen their capacity to deliver inclusive, safe, and non-discriminatory humanitarian assistance. The training enhanced understanding of PGI principles and supported their integration across all programme areas.

It also equipped participants with basic skills in psychosocial support, gender and sexual and gender-based violence (SGBV), and basic case management. Safeguarding mechanisms were established in line with KRCS policies and operational structures, with linkages to relevant government protection services.

4) Community Engagement and Accountability (CEA)

- KRCS volunteers and staff received training on Community Engagement and Accountability (CEA) and rumor tracking to strengthen effective risk communication and community trust. The operation utilised existing National Society feedback mechanisms, including a toll-free hotline and suggestion boxes, to facilitate timely collection and response to community concerns.
- Community review meetings and focus group discussions were conducted to gather feedback, promote transparency, and support

participatory decision-making. Information, Education, and Communication (IEC) materials were procured and distributed widely across the targeted counties.

- KRCS engaged key community influencers, including religious leaders, traditional healers, traders, and boda boda operators, to strengthen outreach and message acceptance. In addition, a Knowledge, Attitudes, and Practices (KAP) survey was conducted in at-risk border areas of Turkana and Marsabit, with a focus on burial practices, to inform context-specific preparedness interventions.

5) National Society Capacity

A total of 90 KRCS volunteers and 12 staff members were deployed to support implementation across the targeted counties. Their roles included supporting community-based surveillance and event reporting, participating in Rapid Response Teams, facilitating cross-border coordination, and monitoring, documenting, and reporting on activities.

The operation ensured insurance coverage for volunteers and provided internet connectivity support to enable timely communication, coordination, and reporting.

Targeting Strategy

Who was targeted by this operation?

The operation primarily targeted populations residing in or operating within high-risk cross-border areas in Turkana (including Todonyang, Kibish, and surrounding areas), Marsabit (including Ileret and Moyale), and high-traffic travel hubs in Nairobi, particularly Jomo Kenyatta International Airport (JKIA). In total, 129018 people were rechaed by the various activities, exceeding the taerget of 111,444 people. The people reached include include 215 health teams mobilised, trained and ready (Health Workers, CHPS, CDRS, KRCVs and staff).

The specific target groups included:

(i) Cross-border mobile populations and traders travelling to and from Ethiopia.

(ii) Transport operators using the Ethiopia–Kenya corridor.

(iii) Airport screening teams and frontline responders at points of entry.

(iv) Community members residing in proximity to informal and non-designated border crossing points.

(v) Kenya Red Cross Society (KRCS) volunteers, Community Health Promoters (CHPs), Community Disaster Responders (CDRs), and county surveillance teams. 215 reached.

Explain the selection criteria for the targeted population

The rationale for geographical targeting was based on the fact that the selected counties are located along the Kenya–Ethiopia border, while Nairobi County hosts major international airports, including Jomo Kenyatta International Airport (JKIA), with direct flight connections to Addis Ababa, Ethiopia.

In addition, the selection was guided by the following risk considerations:

(i) Epidemiological risk: Communities and locations with direct road and air linkages to the MVD outbreak epicentre in Jinka were prioritised due to the increased likelihood of disease importation.

(ii) Operational readiness: Counties with the greatest need for strengthened Infection Prevention and Control (IPC) and surveillance capacities were prioritised to enhance early detection and response.

(iii) Socio-economic risk: High-mobility populations, including cross-border traders and pastoralist communities with limited access to formal health services, were prioritised due to their increased vulnerability and potential role in disease transmission dynamics.

Total Assisted Population

Assisted Women	65,799	Rural	65%
Assisted Girls (under 18)	-	Urban	35%
Assisted Men	63,219	People with disabilities (estimated)	2%
Assisted Boys (under 18)	-		
Total Population Assisted	129,018		
Total Targeted Population	111,444		

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?	Yes
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
Late procurement of SDB Kits	The International Federation of Red Cross and Red Crescent Societies (IFRC) and the Kenya Red Cross Society (KRCS) convened to proactively source required kits for the operation. Existing kits available within the region were identified for potential borrowing, and joint replenishment strategies were planned to ensure adequate stock levels for immediate deployment and ongoing preparedness activities.
PSEA and child safeguarding	Staff and volunteers were sensitized on Protection from Sexual Exploitation and Abuse (PSEA) and child safeguarding, and required to formally acknowledge and sign these commitments

	alongside the organizational Code of Conduct to ensure adherence to protection standards during the operation.
Low levels of MVD awareness at the community and health facility level may result to fear and panic of infection thus resulting to prolonged timeframe for surveillance and case management. This would escalate community transmission.	Continuous sensitization and Risk Communication and Community Engagement (RCCE) activities were conducted targeting both communities and healthcare workers. The National Society leveraged the existing Kenya Red Cross Society Monitoring, Evaluation, Accountability, and Learning (MEAL) Management Information System (MIS) to capture, analyze, and respond to emerging information related to MVD at the community level.
Porous border points of entry that are not manned	Training and sensitization were conducted for security personnel, public health officers, and disease surveillance officers on effective screening procedures at porous and informal points of entry to enhance early detection and prevent cross-border transmission of MVD.
Cultural practices (unsafe burial practices and traditional health seeking behaviors) and cross-border inter-marriages	Continuous sensitization activities were conducted to raise awareness on the risks associated with population movement and to inform communities about the potential consequences of improperly managed MVD cases or deaths, emphasizing the importance of safe practices to prevent transmission.
Occupational health hazard- Risk of transmission of MVD to frontline workers if PPE is not worn properly or if infected bodies are not handled with correct care	Frontline healthcare workers and Safe and Dignified Burial (SDB) teams were trained and oriented on the critical importance of Infection Prevention and Control (IPC) measures. Concurrently, IPC and SDB commodities were ensured to be adequately stocked to support effective outbreak response and safe handling of cases and burials.
Limited isolation facilities.	Engagement was undertaken with County and National Ministry of Health (MoH) authorities, as well as relevant partners, to establish well-equipped Mobile Treatment Units (MTUs) and holding facilities to ensure timely isolation, case management, and containment of suspected MVD cases.
Psychological distress and exploitation of trauma - fear, isolation, and grieving make people more susceptible to manipulation.	Mental health and psychosocial support (MHPSS) was integrated into outbreak preparedness measures. Staff were trained in Psychological First Aid (PFA) and trauma-sensitive communication to enable them to provide immediate emotional support and respond effectively to the psychosocial needs of affected individuals, families, and communities.

Please indicate any security and safety concerns for this operation:

Northern Kenya was prone to insecurity, including armed attacks and cross-border resource-based conflicts, particularly in Marsabit and Turkana counties. These risks were primarily driven by limited natural resources, competition over livelihoods, and the presence of armed militia groups operating along border areas.
Mitigation Measures:
(i) To address these risks, the operation incorporated several mitigation measures. These included conducting regular security assessments, strengthening coordination with local security agencies, establishing clear evacuation protocols, and promoting community acceptance. In addition, comprehensive risk monitoring and reporting systems, as well as robust emergency communication protocols, were put in place to enhance operational safety.
(ii) The Kenya Red Cross Society (KRCS) also leveraged community-based volunteers who were familiar with the local context and geographical terrain, thereby improving access, acceptance, and operational effectiveness in insecure and hard-to-reach areas.

Has the child safeguarding risk analysis assessment been completed?	No

Implementation

Health

Budget: CHF 116,784
Targeted Persons: 111,444
Assisted Persons: 129,018
Targeted Male: 63,219
Targeted Female: 65,799

Indicators

Title	Target	Actual
# of KRCS Volunteers and CHPs trained on EPIC and CBS module	90	67
# of Community members sensitized on MVD prevention and control	111,444	129,018
# of Health Workers, CHPS, CDRS, KRCVs and staff sensitized on Mental health and PFA	90	215
# of debrief sessions carried out	9	10
# of hospitals identified and linked to provide mental health distress support for MVD cases.	3	3
# of SDB SOPS reviewed and signed agreements with KRCS and MoH	1	1
# of SDB training materials updates conducted	1	1
# of SDB Teams refreshed based on the updated guidelines	2	2
# of simulation exercise conducted by National SDB teams	2	2
# of at risk counties disseminated on the revised SDB/IPC SOP	2	2
# of SDB kits procured	4	0
# of Risk Assessments conducted	2	2

Narrative description of achievements

• Two of the targeted risk assessments were conducted in Turkana and Marsabit counties.
• 67 KRCS Volunteers and CHPs (30M, 37F) were trained on Epidemic Preparedness and Response (EPIC) and community-based surveillance (CBS) modules. This was against a target of 90 CHPs. The difference resulted in the removal of Nairobi County from the list of targeted counties which thereby reduced the number of required CHPs and volunteers.
• Through intensified risk communication and community engagement (RCCE) by KRCS aimed at disease containment; 129,018 people (63,219 male 65,799 female) community members were sensitized on marburg virus disease (MVD) prevention and control. The reach was above the 111,444 people targeted owing to continuation of door-to-door sensitization efforts by volunteers and CHPs supported by the government.
• KRCS sensitized 215 health workers against a target of 90, community health promoters (CHPS), community disaster responders (CDRS), and Kenya Red Cross volunteers (KRCVs) on Mental health and psychological first aid (PFA). The additional 125 health workers trained above the targeted 90 were supported by the Ministry of Health during the assessment phase of this operation.
• The operation entailed conducting debrief sessions with the response teams to ensure efforts were well coordinated. 9 out of the planned 10 debriefs were held.
• Owing to the likelihood of psychological distress among the at-risk communities, 3 hospitals (Illeret dispensary in Marsabit county and Kibish health centre & Todonyang' dispensary in Turkana County) were identified and linked to provide mental health distress support for MVD cases.
• The operation ensured a safe and dignified burial standard operating procedures (SOPs) were reviewed and validated by KRCS and the Ministry of Health (MoH). This also included updating the SDB training materials. Two SDB teams in Marsabit and Turkana counties underwent refresher training on updates SOPs.
• The updated safe and dignified burial SOPs were then cascaded to relevant teams during a refresher training in Marsabit and Turkana counties.
• The national SDB teams undertook two simulation exercises as part of preparedness efforts.
At the time of compiling this report, SDB kits had not been procured. The procurement was initiated by IFRC and waiting for delivery. KRCS utilized borrowed resources from the Ministry of Health Kenya during the trainings and simulation exercises with MOH awaiting reimbursement.
• Additionally, the Ministry of Health (MOH) leveraged the National Society's technical expertise and field presence to conduct targeted sensitization, which significantly contributed to achieving extensive community awareness across the identified sites.
• The readiness activities were guided by a unified national emergency preparedness and response plan, in which partners were assigned lead roles based on their respective strengths. For example, KRCS led efforts in SDB/IPC and RCCE capacity strengthening, while also playing supportive roles in case management, logistics, and coordination/planning.
• Earlier assessments highlighted several key gaps, including low risk perception in over 80% of targeted areas, weak or non-existent local surveillance systems, and limited IPC and case management knowledge among frontline healthcare workers. In response, joint capacity-strengthening efforts led by KRCS—combined with targeted RCCE approaches leveraging its extensive volunteer network—significantly improved outcomes. These efforts contributed to enhanced surveillance through the rollout of targeted CBS, increased risk perception, and greater adoption of precautionary behaviours among community members, among other gains.

Lessons Learnt

• Initiation of procurement of the SDB kits on time and follow up on delivery by KRCS is critical for effcective delivery within preparednes time, to ensure pre-positionning and training kits acquisition reamin relevant to the risk.

Challenges

• Late delivery of the SDB kits. None of the kits were delivered to KRCS by the time the project was ending.

Water, Sanitation And Hygiene

Budget: CHF 198
Targeted Persons: 111,444
Assisted Persons: 129,018
Targeted Male: 63,219
Targeted Female: 65,799

Indicators

Title	Target	Actual
# of people reached with hygiene promotion.	111,444	129,018
# of chlorine (HTH or liquid bleach) procured and pre-positioned (in 20-liter units)	3	3

Narrative description of achievements

• Hygiene promotion is critical in response owing to the highly contagious nature of the disease. The MVD is transmitted through contact with blood, bodily fluids, contaminated surfaces, or unsafe burial practices. Therefore, KRCS incorporated promoting proper hygiene to reduce transmission, protect communities, and support outbreak containment efforts. Up to 129,018 people (63,219 male 65,799 female) people were reached by hygiene promotion activities. The reach was above the 111,444 people targeted owing to continuation of door-to-door sensitization efforts by volunteers and CHPs supported by the government.
• KRCS procured and pre-positioned 3 chlorine (HTH or liquid bleach) (in 20-litre units), a highly effective disinfectant that inactivates contaminants on surfaces, equipment, and in contaminated water. The chlorine was used by both communities and responders to counter virus transmission.

Lessons Learnt

• Illeret in Marsabit county, Todonyang' and Kibish in Turkana county suffer from severe water shortages. As an adaptation measure, the communities use ash as a substitute for soap.

Challenges

• Both Marsabit and Turkana counties continue to face chronic water scarcity, which limits hygiene practices at the household level and poses a potential vulnerability in the event of an outbreak.

Protection, Gender And Inclusion

Budget: CHF 3,982
Targeted Persons: 111,444
Assisted Persons: 32,328
Targeted Male: 63,220
Targeted Female: 65,799

Indicators

Title	Target	Actual
# of KRCVs and staff trained on PGI.	44	67
# of individuals sensitized on PGI in communities.	5,000	129,018
# of gender and disability sensitive feedback raised and addressed.	100	100

Narrative description of achievements

• KRCS trained 67 (30M, 37F)volunteers and staff on protection, gender and inclusion, aimed at strengthening adherence to “do no harm” principles and improving overall protection awareness. The training involved establishing safe and accessible feedback mechanisms, which proved critical in ensuring interventions were responsive to community needs and reducing protection concerns. Actively including women in decision-making and community consultations enhanced the quality of the response and surfaced issues affecting women, children, and persons with disabilities.
• The operation trained 67 volunteers and staff on PGI an over-achievement against the set target of 44. The operation leveraged on the same 67 that trained on EPiC under health activities.
• During house-to-house and community review interventions, 129,018 people (63,219 male 65,799 female) people were reached with Protect gender and inclusion messaging. Turkana and Marsabit counties are inhabited by nomadic and patriarchal lifestyle where cases related to protection and gender issues against women are common.
• A clerical error led to the overall target of individuals sensitised on PGI being set as 5,000 rather than 111,444, causing a significant difference between the target and achievement.
All the disability sensitive feedback raised during the implementation period were addressed. Among the common gender related feedback received was; an incident of sexual and gender-based violence (SGBV) reported by a community health assistant in Illeret; Marsabit county with the victim being a persons with disability child. Cases of domestic violence between married couples were also reported.

Lessons Learnt

• Persistence during dissemination of protection gender and inclusion ensured that KRCS volunteers reached the target group.

Challenges

• Resitance of the male on gender and protection issues. Turkana and Marsabit counties are inhabited by nomadic people who do not embrace matters protection and gender and inclusion especially in women.

Community Engagement And Accountability

Budget: CHF 11,145
Targeted Persons: 40
Assisted Persons: 67
Targeted Male: 30
Targeted Female: 37

Indicators

Title	Target	Actual
# of volunteers trained on CEA and tracking rumors	40	67
# of community feedback system set up	1	1
% of community feedback addressed	100	100
# of Community Review Meetings Conducted	3	11
# of IEC material produced	1,500	2,300
# of KAP Surveys conducted	2	2

Narrative description of achievements

• A total of 67 KRCS Volunteers and CHPs (30M, 37F) were trained on CEA, Epidemic Preparedness and Response (EPIC) and community-based surveillance (CBS). The operation trained 67 volunteers and staff on trained on CEA and tracking rumors against the set target of 40. The operation leveraged on the same 67 that trained in health and PGI activities. KRCS leveraged on their toll free hotline (1199) and community review meetings to gather/receive community feedback.

Procurement and distribution of IEC materials;
•A total of 2,300 IEC materials were procured and delivered in Marsabit and Turkana Counties. The IEC material conveyed messaging geared towards signs and symptoms of Marburg, prevention measures and defining the Marburg virus. The budget included an allocation for the development of digital IEC material, however, the Ministry of Health (MoH) procured and developed these digital IEC material, therefore, KRCS repurposed their funds and printed out paper IEC material hence the overachievement by 800.

• Two KAP surveys were conducted in Turkana and Marsabit to assess community awareness, perceptions, and behaviours related to Marburg Virus Disease. Findings showed high awareness (90%), with community health promoters and health workers identified as the most trusted sources of information, despite underlying socio-economic vulnerabilities.
The KAP survey informed implementation by prompting KRCS to adopt a targeted RCCE approach rather than broad, general awareness campaigns. This required realigning message dissemination methods to better suit the context and enhance impact—for example, shifting from megaphone announcements in open gatherings to more focused house-to-house sensitization, complemented by the use of radio and other channels.

• KRCS with funding from IFRC conducted Community Review Meetings (CRMs) on Marburg Virus Disease (MVD) in Turkana and Marsabit Counties. The main purpose of the CRMs was to identify the summary of activities conducted under the response, document lessons learnt and best practices on Marburg preparedness and response in the community. A total of 460 community members (353 Males, 107 Females) in Ileret, Kibish and Todonyang were reached through the CRMs. Across the three sites, community members recommended:

- Continuous sensitisation on Marburg and other emerging diseases
- Strengthening surveillance, including temperature screening at entry points
- Improved hygiene and sanitation practices
- Provision of WASH items and water treatment chemicals
- Strengthening health facilities with drugs, IPC supplies, and functional laboratories
- Training community gatekeepers and frontline responders

The overachievement in CRMs resulted from an error in targeting. Initially, this operation targeted 3 counties and eventually was implemented in 2. The assumption was one each county would conduct one CRM, however, Marsabit and Turkana ended up having CRMs conducted in different sites, resulting in 11 CRMs.

Information dissemination on Marburg prevention was confirmed through the community review meetings
• In Marsabit, Illeret Site, participants reported that information reached the community through KRCS volunteers, CHPs, churches, barazas, health facilities and radio. Groups reached included women groups, elders, students and religious leaders.
• In Kibish, Turkana, participants reported information reached the community through barazas and door-to-door sensitization. Participants reported that the whole village was informed, and all groups present during the meetings were reached. No specific group was identified as left out, although those absent during barazas may have relied on secondary information from others.
• In Todonyang, Turkana, information coverage varied. Nayenaye village reported receiving information through barazas, radio, phone calls, and social media, while Kapedor and Apas villages reported receiving no formal prevention messaging. Elderly people and those grazing livestock in remote areas indicated that they were often excluded.

Lessons Learnt

a) Strengthen Risk Communication and Community Engagement (RCCE)
KRCS and MOH should implement targeted communication campaigns to address beliefs regarding Marburg Virus Disease transmission and prevention. Messaging should stress that the disease spreads through direct contact with infected body fluids and that no approved vaccine currently exists. Communication strategies should utilize trusted local channels such as community leaders, health workers, and local radio to reach wider audiences .

b) Expand Community Awareness and Training Programs
Government and Non-Governmental Organizations should expand awareness and training sessions to reach populations that have not yet participated in education activities, particularly in areas with lower levels of engagement such as Turkana North. 43% (260) of respondents during the KAP survey indicated not involving in awareness activities and thus regular community dialogue sessions and participatory learning approaches can be used to enhance understanding and encourage community ownership of disease prevention measures.

c) Promote Household Preparedness for Disease Outbreaks

Programs should promote basic household preparedness measures, including maintaining hygiene supplies such as soap and handwashing facilities. Community-based initiatives could support households in developing simple preparedness plans and adopting preventive practices as high percentage of respondents (27%, 183) indicated having no epidemic and pandemic response and prevention items.

d) Leverage Trusted Health Systems and Local Structures
Given high level of trust in health authorities, 65% (450), health facilities and community health workers should be strengthened as primary sources of information and guidance during outbreaks. Integrating RCCE activities into routine community health outreach can improve information dissemination and early reporting of suspected cases.

e) Address Barriers to Information Access
Communication materials should be adapted to accommodate low literacy levels using visual tools, community demonstrations, and local languages. This will ensure that critical health information is accessible and understandable to all community members.

Challenges

• The review meetings highlighted gaps in community knowledge and understanding of Marburg Virus Disease, with misinformation on transmission and symptoms still evident across different areas.
• Some high-risk groups e.g pastoralists, fishermen, elderly persons in remote areas and other mobile populations were not consistently reached with prevention information.
• Cross-border mobility and difficult local conditions were also identified as a challenge. Frequent movement for trade, grazing, fishing, and health seeking increased exposure risks, while drought, water scarcity, and poor sanitation affected community preparedness.

Secretariat Services

Budget: CHF 3,302
Targeted Persons: 1
Assisted Persons: 1
Targeted Male: 1
Targeted Female: 0

Indicators

Title	Target	Actual
# of Joint IFRC and KRCS field monitoring visits conducted.	1	0
# of lessons learnt workshops conducted.	1	0

Narrative description of achievements

• KRCS team conducted a monitoring visit to Ileret in Marsabit County, as well as Kibish and Todonyang in Turkana County, together with the Sub-county Community Health Assistants (CHA) to assess community preparedness and cross-border risks related to Marburg Virus Disease (MVD). IFRC was not represented at the monitoring visit as planned due to competing activities and a difference in the availability of time for the activity as per the workplan.
During the visit, it was noted that the initial knowledge gaps regarding MVD had significantly reduced. Community members demonstrated improved understanding of the modes of transmission and key preventive measures, reflecting the positive impact of risk communication and community engagement efforts.
However, both Marsabit and Turkana counties continue to face chronic water scarcity, which limits hygiene practices at the household level and poses a potential vulnerability in the event of an outbreak. Although no cases have been reported in Kenya, the frequent cross border interactions along the porous borders with Ethiopia present a continued risk should a confirmed case occur there. This underscored the importance of sustained surveillance, community awareness, and cross-border coordination to mitigate potential outbreak threats.
• A lessons learnt workshop was not conducted as KRCS were not allocated the budget.

• The IFRC Nairobi cluster office supported with the application and operational support of this DREF; including an operations manager, finance and PMER.

Lessons Learnt

Joint planning with the IFRC to conduct field visit is paramount to enhance joint understanding of the project implementation.

Challenges

• IFRC was not represented at the monitoring visit as planned due to competing activities and a difference in the availability of time for the activity as per the workplan.

National Society Strengthening

Budget: CHF 14,590
Targeted Persons: 90
Assisted Persons: 89
Targeted Male: 44
Targeted Female: 46

Indicators

Title	Target	Actual
# of volunteers insured	90	90
# of counties supported with internet	3	3

Narrative description of achievements

• A total of 90 (44M, 46F) volunteers and Community Health Promoters were insured against occupational risks while delivering Risk Communication and Community Engagement (RCCE) activities, including community sensitization sessions and review meetings. This measure safeguarded their safety and well-being as they operated on the frontlines and reinforced accountability and duty of care standards throughout the operation.
Additionally, the Kenya Red Cross Society (KRCS) staff in the Marsabit and Turkana branches, as well as the coordination team at Headquarters, were supported with internet connectivity and airtime to facilitate effective communication, timely reporting, and seamless coordination of response activities. This support enhanced real-time information sharing and strengthened overall operational efficiency.

Lessons Learnt

• No lessons came about this sector.

Challenges

• No challenges were experienced during implementation exception of the procurement not completed by the time the outbreak was over.

Financial Report

Selected Parameters			
Reporting Timeframe	2025/11-2026/4	Operation	MDRKE069
Budget Timeframe	2025/11-2026/2	Budget	APPROVED

DREF Operation

FINAL FINANCIAL REPORT

Prepared on 26/May/2026

All figures are in Swiss Francs (CHF)

MDRKE069 - Kenya - Marburg Virus Disease

Operating Timeframe: 25 Nov 2025 to 28 Feb 2026

I. Summary

Opening Balance	**0**
Funds & Other Income	**150,000**
DREF Response Pillar	150,000
Expenditure	**-112,017**
Closing Balance	**37,983**

II. Expenditure by planned operations / enabling approaches

Description	Budget	Expenditure	Variance
PO01 - Shelter and Basic Household Items			**0**
PO02 - Livelihoods			**0**
PO03 - Multi-purpose Cash			**0**
PO04 - Health	109,657	78,950	**30,707**
PO05 - Water, Sanitation & Hygiene	186	198	**-12**
PO06 - Protection, Gender and Inclusion	3,739	3,982	**-243**
PO07 - Education			**0**
PO08 - Migration			**0**
PO09 - Risk Reduction, Climate Adaptation and Recovery	9,155		**9,155**
PO10 - Community Engagement and Accountability	10,464	11,145	**-680**
PO11 - Environmental Sustainability			**0**
Planned Operations Total	**133,200**	**94,274**	**38,927**
EA01 - Coordination and Partnerships			**0**
EA02 - Secretariat Services	3,054	3,105	**-50**
EA03 - National Society Strengthening	13,745	14,639	**-893**
Enabling Approaches Total	**16,800**	**17,743**	**-944**
Grand Total	**150,000**	**112,017**	**37,983**

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Please explain variances (if any)

On the IFRC-DREF allocation of CHF 150,000 made to this readiness intervention, CHF 112,017 is spent and a closing balance of CHF 37,983 will returned to the DREF pot.

1) The underspent is largely due to lower-than-planned expenditure under Health (CHF 30,707 unspent amount) while only minor overspending occurred in the other sectors and cross-cutting areas. That sector represented the highest value of the planning (>70% of

the approved budget). The Significant variance on health is due to the fact that SDB kits were not purchased. As the procurement was not completed by the time the risk was declared over, the process was therefore cancelled.

2) The attached report includes the overall budget execution by the NS, totaling CHF 104,311 (70% of the total allocation) of which only CHF 2,046 was unspent as part of the overall balance above. As per IFRC working with project partner financial modality, KRCS details report remains with the National Society. Further financial breakdowns for the NS transfer remain internal. However, all expenses incurred by the KRCS align with the approved plan, budget and IFRC-DREF requirements.
3) PSSR was coded under DRR.

Contact Information

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

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National Societies' Integrity Focal Point: Reuben Momanyi, Head of MEA&L, momanyi.reuben@redcross.or.ke, +254 725 918 054

National Society Hotline: (254-20)3950000

Click here for reference

Selected Parameters			
Reporting Timeframe	2025/11-2026/4	Operation	MDRKE069
Budget Timeframe	2025/11-2026/2	Budget	APPROVED

DREF Operation

FINAL FINANCIAL REPORT

Prepared on 26/May/2026

All figures are in Swiss Francs (CHF)

MDRKE069 - Kenya - Marburg Virus Disease

Operating Timeframe: 25 Nov 2025 to 28 Feb 2026

I. Summary

Opening Balance	**0**
Funds & Other Income	**150,000**
DREF Response Pillar	150,000
Expenditure	**-112,017**
Closing Balance	**37,983**

II. Expenditure by planned operations / enabling approaches

Description	Budget	Expenditure	Variance
PO01 - Shelter and Basic Household Items			**0**
PO02 - Livelihoods			**0**
PO03 - Multi-purpose Cash			**0**
PO04 - Health	109,657	78,950	**30,707**
PO05 - Water, Sanitation & Hygiene	186	198	**-12**
PO06 - Protection, Gender and Inclusion	3,739	3,982	**-243**
PO07 - Education			**0**
PO08 - Migration			**0**
PO09 - Risk Reduction, Climate Adaptation and Recovery	9,155		**9,155**
PO10 - Community Engagement and Accountability	10,464	11,145	**-680**
PO11 - Environmental Sustainability			**0**
Planned Operations Total	**133,200**	**94,274**	**38,927**
EA01 - Coordination and Partnerships			**0**
EA02 - Secretariat Services	3,054	3,105	**-50**
EA03 - National Society Strengthening	13,745	14,639	**-893**
Enabling Approaches Total	**16,800**	**17,743**	**-944**
Grand Total	**150,000**	**112,017**	**37,983**

Selected Parameters			
Reporting Timeframe	2025/11-2026/4	Operation	MDRKE069
Budget Timeframe	2025/11-2026/2	Budget	APPROVED

DREF Operation

FINAL FINANCIAL REPORT

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All figures are in Swiss Francs (CHF)

MDRKE069 - Kenya - Marburg Virus Disease

Operating Timeframe: 25 Nov 2025 to 28 Feb 2026

III. Expenditure by budget category & group

Description	Budget	Expenditure	Variance
Relief items, Construction, Supplies	**33,480**		**33,480**
Medical & First Aid	33,480		33,480
Personnel		**2,915**	**-2,915**
National Staff		2,915	-2,915
General Expenditure	**3,054**		**3,054**
Travel	3,054		3,054
Contributions & Transfers	**104,311**	**102,265**	**2,046**
Cash Transfers National Societies	104,311	102,265	2,046
Indirect Costs	**9,155**	**6,837**	**2,318**
Programme & Services Support Recover	9,155	6,837	2,318
Grand Total	**150,000**	**112,017**	**37,983**

International Federation of Red Cross and Red Crescent Societies

5.1 PROJECT PARTNER EXPENDITURE CERTIFICATION

PROJECT PARTNER NAME	KENYA RED CROSS SOCIETY
PROJECT NAME	DREF,KENYA,MVD PREPAREDNESS
IFRC PROJECT CODE	MDRKE069
CURRENT REPORTING PERIOD	25/11/25-28/02/26

5.1.1 BUDGET & EXPENSES BY PROJECT PARTNER ONLY PER PLANNED OPERATIONS & ENABLING APPROACH(Local Currency)

	Planned Operations / Enabling Approaches	Budget Local Currency (A)	Prior Period Expenses Local Currency (B)	Current Period Expenses Local Currency (C)	Total (Year to date) Local Currency (D) (B+C)	Budget Balance Local Currency (E) (A-D)	Percentage budget spent (F) (D/A)	Explain implementation > 110% for interim and Final Report and < 90% for Final Report only (G)
	Shelter and Basic Household Items			0	0	0	0%	
	Livelihoods			0	0	0	0%	
	Multi-purpose Cash			0	0	0	0%	
	Health	17,686,541		11,835,716	11,835,716	5,850,826	67%	Balance Ploughed back to DREF pool
	Water, Sanitation & Hygiene	30,000		30,000	30,000	0	100%	
	Protection, Gender and Inclusion	603,000		559,226	559,226	43,774	93%	Balance Ploughed back to DREF pool
	Education	0		0	0	0	0%	
	Migration	0		0	0	0	0%	
	Risk Reduction, Climate Adaptation and Recovery	0		0	0	0	0%	
	Community Engagement and Accountability	1,687,800		1,686,862	1,686,862	938	100%	
	Environmental Sustainability	0		0	0	0	0%	
	Coordination and Partnerships	0		0	0	0	0%	
	Secretariat Services	0		0	0	0	0%	
	National Society Strengthening	2,209,605		1,968,039	1,968,039	241,566	89%	Balance Ploughed back to DREF pool
	Total	22,216,946	0	16,079,843	16,079,843	6,137,103	72%	

5.1.2 BUDGET & EXPENSES BY PROJECT PARTNER ONLY ACCORDING TO COST CATEGORIES (Local Currency)

SP No	Cost Categories	Budget Local Currency (A)	Prior Period Expenses Local Currency (B)	Current Period Expenses Local Currency (C)	Total (Year to date) Local Currency (D) (B+C)	Budget Balance Local Currency (E) (A-D)	Percentage budget spent (F) (D/A)	Explain implementation > 110% for interim and Final Report and < 90% for Final Report only (G)
	Personnel	8,333,300		7,567,214	7,567,214	766,086	91%	Balance Ploughed back to DREF pool
	Relief supplies, transportation and storage	5,675,000		5,555,051	5,555,051	119,949	98%	Balance Ploughed back to DREF pool
	Contributions to other organisations	0		0	0	0	0%	
	Other direct costs	7,139,667		1,888,600	1,888,600	5,251,067	26%	Balance Ploughed back to DREF pool
	Indirect cost recovery	1,068,979		1,068,978	1,068,978	0	100%	
	Total	22,216,946	0	16,079,843	16,079,843	6,137,103	72%	

5.1.3 BUDGET & EXPENSES BY PROJECT PARTNER ONLY PER STRATEGIC PRIORITY & ENABLER (CHF)

SP No	Strategic Priority & Enabler	Budget CHF (A)	Prior Period Expenses CHF (B)	Current Period Expenses CHF (C)	Total (Year to date) CHF (D) (B+C)	Budget Balance CHF (E) (A-D)	Percentage budget spent (F) (D/A)	Explain implementation > 110% for interim and Final Report and < 90% for Final Report only (G)
SP1	**Climate and environmental crises**			0	0	0	0%	
SP2	**Evolving crises and disasters**			0	0	0	0%	
SP3	**Growing gaps in health and wellbeing**	109,843		75,142	75,142	34,701	68%	Balance Ploughed back to DREF pool
SP4	**Migration and identity**			0	0	0	0%	
SP5	**Values, Power and Inclusion**	3,739		3,599	3,599	139	96%	Balance Ploughed back to DREF pool
E6	Engaged			0	0	0	0%	
E7	Accountable	0		0	0	0	0%	
E8	Trusted	24,164		23,524	23,524	640	97%	
	Total	137,745	0	102,265	102,265	35,480	74%	

5.1.4 BUDGET & EXPENSES BY PROJECT PARTNER ONLY PER RESULT OR OBJECTIVE (CHF)

Result No.	Result or Objective	Budget CHF (A)	Prior Period Expenses CHF (B)	Current Period Expenses CHF (C)	Total (Year to date) CHF (D) (B+C)	Budget Balance CHF (E) (A-D)	Percentage budget spent (F) (D/A)	Explain implementation > 110% for interim and Final Report and < 90% for Final Report only (G)
All results	Cost common to all results	137,745		102,265	102,265	35,480	74%	Balance Ploughed back to DREF pool
R1				0	0	0	0%	
R2				0	0	0	0%	
R3				0	0	0	0%	
R4				0	0	0	0%	
R5				0	0	0	0%	
R6				0	0	0	0%	
R7				0	0	0	0%	
R8				0	0	0	0%	
	Total	137,745	0	102,265	102,265	35,480	74%	

	5.1.5 CLOSING INCOME-EXPENSE BALANCE PROJECT PARTNER ONLY (CHF) - PER REPORTING PERIOD END DATE	**CHF**
	Funds received to date	102,265
	Year to date expenses	102,265
	Closing Balance	0
	Percentage reported vs. total amount transferred	100%

5.1.6 CERTIFICATION

The undersigned authorised officer of the above mentioned project partner hereby certifies that:

a) they have no knowledge of, nor suspicion of, any fraud and corruption connected in any way to the expenditures included in this report and that they have taken reasonable steps to minimise the risk of fraud and corruption
b) they have taken reasonable steps to minimise the risk of error and mistake in this report. This includes, but is not limited to exercising the appropriate internal controls and employing competent staff
c) Supporting documentation exists for the expenditure included in this report and shall be made available for examination when required and for a period of 8 years from the submission of this report
d) Expenditures have been incurred in line with the agreed project plan and the signed Project Funding Agreement and in accordance with the Project Partners standard procedures and financial regulations, as assessed by the
e) The planned expenditure figures and funds transfer request shown above represents estimated expenditures for the next two reporting periods in accordance with the agreed Project Plan

Date Submitted 25.05.26

Name, Title & Signature of Project partner designated official Paul Olale-PHIE Manager

KENYA RED CROSS SOCIETY
P. O. Box 40712
NAIROBI

For IFRC internal use

Approved by IFRC Project Manager Naemi Patemoshela HEITA — Name & Title — Naemi Patemoshela HEITA (May 29, 2026 08:57:37 GMT+3) — Signature — **Date** 29-May-2026

Validated by IFRC Finance officer elmelda mokaya — Name & Title — elmelda mokaya (May 28, 2026 15:47:19 GMT+3) — Signature — **Date** 28-May-2026

5.3 PROJECT PARTNER FUNDING AND EXPENDITURE RECONCILIATION AND FUND TRANSFER REQUEST IN CHF

PROJECT PARTNER NAME	KENYA RED CROSS SOCIETY
PROJECT NAME	DREF,KENYA,MVD PREPAREDNESS
IFRC PROJECT CODE	MDRKE069
CURRENT REPORTING PERIOD	25/11/25-28/02/26
PLANNED EXPENDITURE PERIOD	

Bank Transfer Information

5.3.1 BUDGET VS. ACTUAL & FORECASTED EXPENSES	CHF
Overall Budget per Project Funding Agreement	137,745
Prior Period Expenditure - Approved	0
Current Period Expenditure	102,265
Sub-Total available Budget	35,480
Funds on hand Project Partner	0
Overall Budget Available	35,480
Funds for planned expenses (if more than fund on hand)	0
Budget Balance	35,480

Date	5.3.2 FUNDS RECEIVED VS ACTUAL & FORECASTED EXPENSES	CHF
	Fund Transfer 1	102,265
	Fund Transfer 2	
	Fund Transfer 3	
	Fund Transfer 4	
	Fund Transfer 5	
	Fund Transfer 6	
	Fund Transfer 7	
	Fund Transfer 8	
	Fund Transfer 9	
	Fund Transfer 10	

5.3.3 FORECASTED EXPENSES	CHF
Sa	
Total Forecasted Expenses	-

Total Received	102,265
YTD expenses (Prior and current expenses)	102,265
Funds Balance	0
Forecasted Expenses	0
Fund Balance after Forecast	0

Fund balance covers Forecast?	YES
Fund transfer Required	0
Budget Balance covers Fund transfer Required	YES - PROCEED

5.3.4 Fund Transfer Request - Approval

Date Submitted	25.05.26
Name, Title & Signature of Project partner designated official	Paul Olale-PHIE Manager

KENYA RED CROSS SOCIETY
P. O. Box 40712
NAIROBI

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Validated by IFRC Finance officer	elmelda mokaya Name & Title	elmelda mokaya (May 28, 2026 15:47:19 GMT+3) Signature	**Date** 28-May-2026

5.3.5 ***Accounting Transaction for Fund Transfer to National Society***

Account Code	Project / Activity / M Code: Indicate the set of Codes to cover the transfer of funds. If more than one Activity Code and M code indicate how much will be allocated to each set of codes:	
8307		
	Total	0.00

5.4 TRACKING THE EXCHANGE RATE FOR REPORTING PURPOSES

PROJECT PARTNER NAME	KENYA RED CROSS SOCIETY
PROJECT NAME	DREF,KENYA,MVD PREPAREDNESS
IFRC PROJECT CODE	MDRKE069
CURRENT REPORTING PERIOD	25/11/25-28/02/26

DATE	5.4.1 FUNDS AT HAND PROJECT PARTNER	Local Currency	CHF	EXC.RATE
	Fund Transfer 1	16,106,749	102,265	157.5000
	Balance transfer 1 - after report 1	0	0	157.5000
	Balance transfer 1 - after report XX	0	0	157.5000
	Balance transfer 1 - after report XX	0	0	157.5000
	Balance transfer 1 - after report XX	0	0	157.5000
	Fund Transfer 2		0	0.0000
	Balance transfer 2 - after report XX	0	0	0.0000
	Balance transfer 2 - after report XX	0	0	0.0000
	Balance transfer 2 - after report XX	0	0	0.0000
	Balance transfer 2 - after report XX	0	0	0.0000
	Fund Transfer 3		0	0.0000
	Balance transfer 3 - after report XX	0	0	0.0000
	Balance transfer 3 - after report XX	0	0	0.0000
	Balance transfer 3 - after report XX	0	0	0.0000
	Balance transfer 3 - after report XX	0	0	0.0000
	Fund Transfer 4		0	0.0000
	Balance transfer 4 - after report XX	0	0	0.0000
	Balance transfer 4 - after report XX	0	0	0.0000
	Balance transfer 4 - after report XX	0	0	0.0000
	Balance transfer 4 - after report XX	0	0	0.0000
	Fund Transfer 5		0	0.0000
	Balance transfer 5 - after report XX	0	0	0.0000
	Balance transfer 5 - after report XX	0	0	0.0000
	Balance transfer 5 - after report XX	0	0	0.0000
	Balance transfer 5 - after report XX	0	0	0.0000
	Fund Transfer 6		0	0.0000
	Balance transfer 6 - after report XX	0	0	0.0000
	Balance transfer 6 - after report XX	0	0	0.0000
	Balance transfer 6 - after report XX	0	0	0.0000
	Balance transfer 6 - after report XX	0	0	0.0000
	Fund Transfer 7		0	0.0000
	Balance transfer 7 - after report XX	0	0	0.0000
	Balance transfer 7 - after report XX	0	0	0.0000
	Balance transfer 7 - after report XX	0	0	0.0000
	Balance transfer 7 - after report XX	0	0	0.0000
	Fund Transfer 8		0	0.0000
	Balance transfer 8 - after report XX	0	0	0.0000
	Balance transfer 8 - after report XX	0	0	0.0000
	Balance transfer 8 - after report XX	0	0	0.0000
	Balance transfer 8 - after report XX	0	0	0.0000
	Fund Transfer 9		0	0.0000
	Balance transfer 9 - after report XX	0	0	0.0000
	Balance transfer 9 - after report XX	0	0	0.0000
	Balance transfer 9 - after report XX	0	0	0.0000
	Balance transfer 9 - after report XX	0	0	0.0000
	Fund Transfer 10		0	0.0000
	Balance transfer 10 - after report XX	0	0	0.0000
	Balance transfer 10 - after report XX	0	0	0.0000
	Balance transfer 10 - after report XX	0	0	0.0000
	Balance transfer 10 - after report XX	0	0	0.0000
	Total Received	16,106,749	102,265	

DATE	5.4.2 EXPENSE REPORT	Expense LC	Expense CHF	EXC.RATE
	Report 1	16,106,749	102,265	157.5000
	Report 2		0	157.5000
	Report XX		0	157.5000
	Report XX		0	157.5000
	Report 2		0	0.0000
	Report XX		0	0.0000
	Report XX		0	0.0000
	Report XX		0	0.0000
	Report XX		0	0.0000
	Report XX		0	0.0000
	Report XX		0	0.0000
	Report XX		0	0.0000
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	Report XX		0	0.0000
	Report XX		0	0.0000
	Report XX		0	0.0000
	Report XX		0	0.0000
	Report XX		0	0.0000
	Report XX		0	0.0000
	Report XX		0	0.0000
	Report XX		0	0.0000
	Report XX		0	0.0000
	Total Expense reported	16,106,749	102,265	

5.4.3. FUND RECEIVED LESS EXPENSE REPORTED	Local Currency	CHF
Balance	0	0

KENYA RED CROSS SOCIETY
P. O. Box 40712
NAIROBI

Transfer to KRCS as per the PFA was supposed to be CHF 137,745.07. However, the actual transfer amounted to KES 102,265.07, while the remaining balance was retained by IFRC to support the procurement of medical kits, which did not materialize. Consequently, the balance will be returned to the DREF pot.

MDRKE069 PKE554 Marburg Readiness Annex 5

Final Audit Report 2026-05-29

Created:	2026-05-28
By:	japheth lubanda (japheth.lubanda@ifrc.org)
Status:	Signed
Transaction ID:	CBJCHBCAABAAlwRno186JpsULS-_LCkcuOpcY4LP_uPa
Number of Documents:	2
Document page count:	4
Number of supporting files:	0
Supporting files page count:	0

"MDRKE069 PKE554 Marburg Readiness Annex 5" History

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Agreement completed.

2026-05-29 - 5:57:37 AM GMT