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Emergency appeal operation update

Viet Nam: Hand, foot and mouth disease

Emergency appeal n° MDRVN010
GLIDE n° EP-2012-000045-VNM
Operation update n°4
23 November 2012

Period covered by this operations update: 16 August to 15 November 2012

Appeal target (current): CHF 758,416

Appeal coverage: 82 per cent

Appeal history

- 23 November 2012: A no-cost extension of the operational timeframe up to 31 January 2013 is made to accommodate end-line surveys and evaluation of this operation.
- 3 April 2012: This emergency appeal was launched for CHF 758,416 to assist 752,255 beneficiaries, including 196,200 direct beneficiaries, for nine months.
- **Disaster Relief Emergency Fund (DREF):** CHF 100,000 was initially allocated to support the initial response of the national society to the emergency.

Mrs. Le Thi Kim Sa from an informal daycare centre in Can Giuoc Town, Can Giuoc District in Long An Province together with the children met with a Red Cross volunteer in a session on HFMD prevention in September 2012. (Photo: Thuan Nguyen, IFRC)

<click here to see the financial report[1]; current donor response or contact details>

Summary
Viet Nam has experienced unprecedented increase in cases of hand, foot and mouth disease (HFMD) since 2011. There have been two peaks in HFMD during 2012. The first one occurred between March and July, with the weekly caseload reaching its peak in the 16th week (from 15 to 21 April) with more than 4,000 new cases of infection in that week alone. The second started in August, with the highest weekly caseload in the 38th week, reaching more than 6,000 cases – the highest weekly caseload between January 2012 to 4 November 2012. From April to September 2012, Viet Nam Red Cross (VNRC) has focused on prioritized interventions covering 292 communes in 20 districts in eight selected provinces[2]. Activities implemented during this period include project orientation in provinces, selection of in-community volunteers, provision of refresher training for active trainers, and promoting behaviour change through house-to-house visits to the families of children under five years old, and public awareness raising campaigns.

[1] Attached financial report up to end-October 2012.
[2] An Giang, Dong Thap, Long An, Soc Trang, Vinh Long, Ben Tre, Da Nang and Quang Ngai

Up to 15 November 2012, multilateral donors have contributed to cover 82 per cent of the appeal. IFRC would like to thank Canadian Red Cross, Danish Red Cross/Danish government, European Commission Humanitarian Aid and Civil Protection (DG ECHO), Hong Kong branch of Red Cross Society of China, Japanese Red Cross Society, Red Cross of Monaco, Singapore Red Cross and Swedish Red Cross for their contribution to the appeal and thus, have enabled timely response.

In the remaining period of the operation, IFRC continues to support VNRC in the implementation of planned activities in accordance with 82 per cent of the total appealed budget. All of the field activities, particularly behaviour change communication (BCC), will be finalized by the end of December 2012 as planned. To enable VNRC to properly carry out end-line surveys and operational evaluation, as well as to allow VNRC to train an additional number of trainers on epidemic control (using the adapted epidemic control for volunteers' toolkit) for possible future outbreaks, a month-long extension has been sought, extending the operational timeframe to end-January 2013.

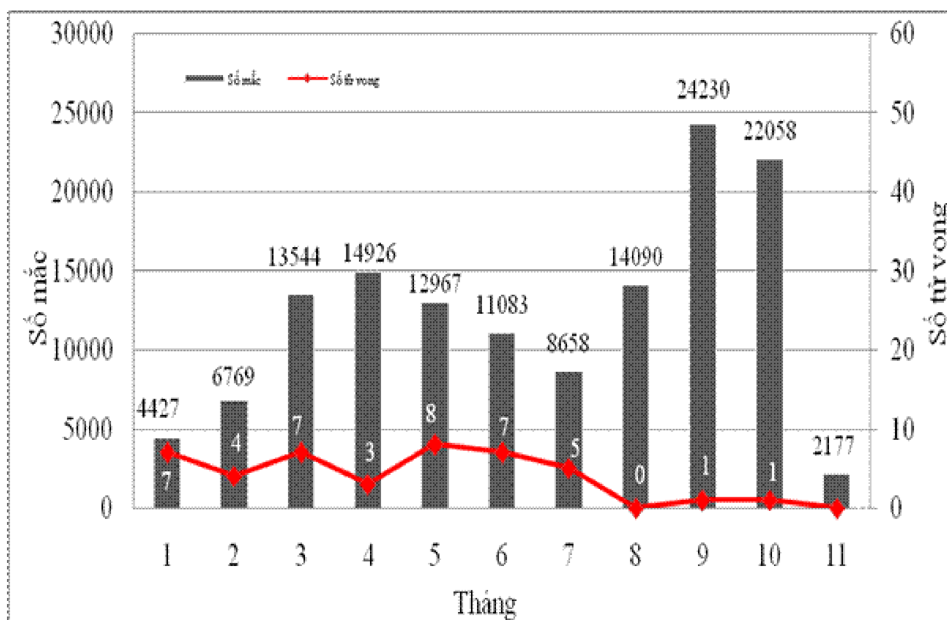
During the past few months, VNRC has observed an increase in HFMD cases in non-target districts among the eight provinces under this operation. In addition, the situation of HFMD in Ba Ria – Vung Tau, one of the 13 priority provinces, has become a matter of concern considering marked increases in both HFMD cases and deaths reported. Therefore, since September, VNRC has quickly provided training of volunteers and rolled out behaviour change communication (BCC) activities to target populations in 130 communes in 11 districts, including four new districts in Ba Ria-Vung Tau. Up to November, the VNRC operation covers 31 districts in nine provinces including An Giang, Dong Thap, Long An, Soc Trang, Vinh Long, Ben Tre, Da Nang and Quang Ngai, and Ba Ria-Vung Tau.

The situation

As of 4 November 2012, the General Department of Preventive Medicine (GDPM) in Viet Nam's Ministry of Health (GDPM/MOH) confirmed that there have been 134,929 cases of HFMD in 63 provinces since the beginning of 2012, with 43 deaths occurring in 15 provinces and cities.

New reported cases of HFMD have increased sharply in Viet Nam since the beginning of 2012. Reports from the MOH showed that HFMD reached its first peak in April, with an average of more than 3,700 cases per week. In the period between April and July, the weekly caseload decreased after the 16th week, reducing from 4,000 cases per week to 1,700 per week in week 27 (1-7 July 2012). However, since August, HMFD infections appeared to be on the rise again, with more than 5,500 cases recorded per week. The 38th week of 16-22 September had the highest caseload from January 2012, with more than 6,000 reported cases. By the middle of November 2012, the total number of HFMD cases from the start of the year reached 134,929, which is 60 per cent higher than the total 84,153 cumulative cases in the same period in 2011. On the other hand, the total of deaths recorded this year is 43, which is less than one-third compared to the same period of last year.

The Southern provinces continue to be areas most affected by the epidemic, both in 2011 and 2012, as most of the cases and deaths occurred in this region: accounting for 90.7 per cent of all deaths. The total incidences of HFMD and resulting deaths of each month from 1 January to 4 November 2012 are shown in the graph below:



Source: General Department of Preventive Medicine, Viet Nam's Ministry of Health
(Note: Grey column: number of cases, represented by the numbers on the left; Red dot: number of deaths, represented by the number on the right; "Thang" means "Month")

However, it is noticeable that cases of infection in the Northern provinces have increased sharply, despite no deaths reported in this region to date. Up to the end of August, the Northern region recorded the second highest number of cases (31,351) which accounts for 37.49 per cent of HFMD cases in the country. These provinces include Ha Noi, Hai Phong, Thai Binh, Nam Dinh, Ha Nam, Ninh Binh, Bac Giang, Bac Ninh, Phu Tho, Vinh Phuc, Hai Duong, Hung Yen, Thai Nguyen, Bac Can, Quang Ninh, Hoa Binh, Lai Chau, Lang Son, Tuyen Quang, Ha Giang, Cao Bang, Yen Bai, Lao Cai, Son La, and Dien Bien.

In the 13 provinces initially targeted in the appeal, the HFMD caseload for 2012 remains high, accounting for about a third of the national caseload. The local preventive medicine departments have shared with VNRC chapters surveillance data since April. The death toll is lower in target provinces in comparison to the same period in 2011; however, it still accounts for the majority of deaths countrywide (25 fatal cases out of a total of 43, or 58 per cent). Specifically, by the end of October 2012, the cumulative HFMD cases and deaths in the 13 provinces were as below:

Name of province	January-October 2011		January-October 2012	
	Total cases	Total deaths	Total cases	Total deaths
Central region				
Da Nang	567	1	2,947	1
Quang Ngai	6,657	5	1,696	0
Southern region				
Ba Ria-Vung Tau	2,974	10	6,326	3
Long An	2,443	8	2,412	3
Can Tho	870	1	1,313	2
Soc Trang	2,368	5	1,492	0
An Giang	1,659	4	4,478	10
Ben Tre	3,374	2	4,213	1
Vinh Long	1,949	0	2,219	1
Dong Thap	5,067	6	5,885	3
Kien Giang	1,461	3	1,970	0
Ca Mau	2,564	4	2,337	0
Hau Giang	879	5	1,326	0
Total 13 provinces	***32,832***	***54***	***38,614***	***24***
National total				
Total 63 provinces	***84,153***	***148***	***134,929***	***43***

Coordination and partnerships

In the past months, with the help of IFRC, VNRC has been working with national health authorities to closely monitor the situation and coordinate national response efforts. Updates on the situation have been regularly shared by the MOH at national and provincial levels through effective collaboration between the VNRC headquarters (VNRC HQ) and chapters, and their respective counterparts. The VNRC headquarters and chapters also frequently update their counterparts on the progress of the operation for complementary actions and to avoid duplication of interventions. VNRC has also shared baseline survey results with the MOH and other stakeholders, in order to assist in future preventive and response efforts.

In terms of coordination around disseminating preventive messages through national TV, VNRC has worked together with GDPM and the National Centre for Health Education and Communication (NCHEC) on expansion of broadcasting for a TV clip in the local TV channels in nine target provinces. The key messages that VNRC has finalized in the operation are consistent with national guidelines and have been improved with illustrated images suitable for community members. The VNRC HQ and chapters have worked in coordination with national and local TV channels on broadcasting the clips on HFMD prevention in order to reach more people since October.

National Society capacity building

Through the HFMD response in priority provinces, VNRC has continued to fulfill its role as auxiliary to the government in response to epidemics, as well as to further raise its profile in emergency health response. Trained instructors and volunteers have been able to lead response activities at community level and deliver BCC sessions to families with children under five-years-old during the period from April to July – when cases of HFMD were high in target provinces. The Ministry of Health started several campaigns at provincial level and using mass media in the peak weeks, while VNRC volunteers organized HFMD prevention campaigns at district level, including peer education through small group discussions and house-to-house visits. In this regard, the operation is aligned and complementary to the national action plan, and contributes to greater impact in HFMD behaviour change communication.

A VNRC officer discussing HFMD prevention measures with mothers in Long An through a monitoring visit in September. Photo: Thuan Nguyen, IFRC

In addition, through regular sharing of surveillance information by MOH, and through a monitoring system to measure progress in knowledge and practices among target groups, VNRC has strengthened its capacity to run an emergency health operation. The experience in HFMD has also contributed to further develop VNRC's capacity in emergency response from a project management perspective, with better informed decisions that are evidence-based. Specifically, in September, based on surveillance data and in discussion with the IFRC country office, VNRC was able to identify new districts where cases was increasing, for inclusion in the operation.

Red Cross and Red Crescent action

Overview

Up to date, with 82 per cent of funding response for the appeal, to maximize the resources for the intended impacts, VNRC has chosen to focus on carrying out interventions where there are most reported cases, deaths and high population density. Specifically, VNRC has interventions covering 421 communes of 31 most affected districts in nine provinces. This is an adjustment from the original appeal, which planned to intervene in 540 communes in 30 districts in 13 provinces. Affected districts were selected based on criteria such as high numbers of infection and death, and high population density as well as currently having gaps in emergency health response at local level.

Currently, the national society's BCC activities have reached some 126,000 families with children under five years of age and about 2,000 day care workers in 995 informal day care centres (IDCs) in the 421 target communes. Target groups have received key preventive messages through printed IEC materials distributed during door-to-door visits or small group discussions, and soap (for IDCs and those parents who attend group sensitizations).

BCC activities aim at reinforcing behaviour that the baseline survey shows community members need to improve, including regular hand-washing at critical times, checking the child for early-stage symptoms and separating the sick child from others, and using separate spoons and bowls. Other practices the volunteers reinforce among the target group are cleaning children's toys and the floor, as they found many households in poor settings, with floors unpaved or bit tiled, and that not all children had toys to play with.

All of the BCC activities and other activities in the field will be carried out by the end of December 2012 as planned. The one-month extension is intended to enable VNRC to carry out end-line surveys as well as to allow for better evaluation and review of the project. Post-project evaluation will be carried out in order to assess the results of the HFMD operation. Comprehensive evaluation is valuable for VNRC's long-term capacity building in order to prepare its response to future epidemics. The extension will also permit VNRC to train an additional number of trainers on epidemic control for possible future outbreaks.

Progress towards outcomes

<table>
<tr><th>Emergency health</th></tr>
<tr><td>Goal: Illness and deaths due to hand, foot and mouth disease (HFMD) in 13 priority affected provinces in Viet Nam are reduced in the next six months.</td></tr>
<tr><td>Outcome: Target groups in 540 communes have improved knowledge and practices that lead to the prevention and control of HFMD</td></tr>
<tr><td>Output 1. At least 196,200 people in 540 communes (30 districts from 13 provinces) have improved knowledge and practices that contribute to HFMD prevention and control

Key activities
1.1. Update and broadcast key messages via national TV channels in six months
1.2. Disseminate TV clips to 13 chapters for further broadcasting and dissemination of key messages via provincial radio and newspapers
1.3. Update key messages in existing information, education and communication (IEC) materials in consultation with the Ministry of Health (MOH) and World Health Organization (WHO)
1.4. Print and deliver 700,000 leaflets and 6,000 posters
1.5. Distribute 38,160 bars of soaps for 19,440 informal day-care centres and target beneficiaries at campaigns in the first three months
1.6. Organize 30 public campaigns on HFMD prevention at district level
1.7. Conduct door-to-door visits to 90,000 beneficiary families in three months
1.8. Conduct 16,200 group sensitizations with mothers and members of families with children under five years of age
1.9. Monitor behaviour change among target groups</td></tr>
<tr><td>Output 2. VNRC's capacity to respond to emerging diseases like HFMD is improved.

Key activities
2.1 Deploy national disaster response team (NDRT) to assist selected provinces with rapid assessment, finalize provincial action plan, and support the implementation of knowledge, attitude and practices (KAP) survey
2.2 Set up and maintain weekly and monthly reporting for district/provincial and headquarters project team during this nine-month operation
2.3 Participate in relevant coordination meetings on HFMD prevention and emerging diseases at national, provincial and district levels
2.4 Conduct baseline survey
2.5 Organize refresh training and training of trainers for 50 provincial instructors on HFMD
2.6 Update/train 5,400 selected commune volunteers on HFMD knowledge, community mobilization and provision of adapted HFMD training, and visibility items.
2.7 Conduct an operations review to capture good practices and lessons learnt to inform VNRC organizational strengthening in emergency health
2.8 Coordinate with the ministry of Health and relevant partners to ensure continued alignment of the operation with national efforts as well as to maximize complementary efforts.</td></tr>
</table>

Progress towards output 1:

At the start of November, VNRC's interventions have reached 129,474 families (126,000 through household visits; 3,474 through group discussions) with children under five years of age and 2,000 day care workers in 995 IDCs in 421 communes of 31 districts in An Giang, Dong Thap, Long An, Vinh Long, Soc Trang, Ben Tre, Ba Ria – Vung Tau, Quang Ngai and Da Nang. During implementation, the project team found that in urban areas, the number of informal daycare centres is higher than in rural areas. Similarly, in areas with a high number of factories and manufacturing facilities, there are more informal daycare centres than in areas that emphasize agricultural production. For each identified household, the volunteer has visited them on an average of two to three times so far. The purpose of the first visit was to understand the household's baseline knowledge, and

practices and to give key messages appropriate to their motivation and conditions. The later visits are to follow up on the practices with focus on monitoring and supporting beneficiary households to practice correct behaviour.

Together with interventions at household level, VNRC continues with activities under the BCC strategy to use other communication channels such as public campaigns, TV, radio and newspapers to raise awareness of public in the prevention of HFMD as well as to inform the public on the progress of the operation. Coordination and advocacy to the authorities have been implemented through monthly meetings at national, provincial and other levels, in which VNRC update stakeholders on the progress of the operation and share feedback from community level to the communication campaigns in HFMD response.

Starting from October, the adapted TV clip with messages highlighting HFMD prevention has been broadcasted through local TV channels in nine most-affected provinces. This has been done thanks to the agreement between chapter, provincial authorities and the TV station in order to air the clip at a suitable time for the majority of parents and care givers of young children. A copy of the clip has been made available for the chapter to replay at public events and to share with other stakeholders for further dissemination.

In addition to the procurement of communication materials for 20 target districts, in September and October, the following communication materials and soap have been procured additionally for the 11 extension districts, while distribution of materials and soap are ongoing at community level. The procured communication materials are summarized per province below:

Provinces	Leaflets for household beneficiaries	Posters for display at public places and IDCs	Flipcharts for volunteers in group sensitizations and household visits	Soaps for informal day care centre and households at group sensitizations
Danang	15,050	1,450	320	5,280
Ba Ria – Vung Tau	23,600	800	470	6,860
Long An	8,350	360	160	3,240
An Giang	13,500	424	280	3,876
Dong Thap	8,350	320	170	2,880
Total	**68,850**	**3,354**	**1,400**	**22,136**

In October and November, an additional 11 public campaigns on HFMD prevention have been organized at district level in the extension area, reaching about 3,300 people from target groups. The campaigns and organization of communication activities are possible thanks to another 1,300 volunteers newly trained in communication skills in HFMD in new 130 communes.

While the existing 2,910 volunteers continue to carry out follow-up visits to beneficiary households and IDCs, the newly trained volunteers start organizing communication sessions to 511 IDCs and 39,000 additional families with children under five years old.

When implementing behaviour change activities in the field, the project teams have provided volunteers with facilitation support to make sure they gain access to the informal day care centres from the local authorities. During the rainy season in Viet Nam, from April to November, the volunteers also face the challenge when conducting household visits. In project areas where parents work in factories, volunteers have to conduct household visits in the evening, most of time, when parents are at home. Thus, it was designed in the project that volunteers can have an option to work in teams so they can assist each other when working at night in the community. While most of the informal day care centres appreciate and find the information provided by the Red Cross volunteers useful, it is found challenging for the volunteers to precisely observe/monitor and document progress of behaviour change among target groups. To overcome this challenge, the VNRC project team has increased monitoring support in order to assist volunteers to better document progress in behaviour change.

In addition, while most of beneficiaries in the project have access to clean water sources following local standards (meaning water from wells, centralized sand-filter systems or equivalent systems), it is not guaranteed the water quality is safe for health. Also, the housing conditions of many beneficiaries are narrow (from 30-50m^2) for four to five people; with dirt floors – the basic water and sanitation conditions at household level are not always favourable for the beneficiaries to practice all hygiene measures to prevent HFMD. It remains a challenge for

volunteers when discussing with target groups on practicing hygiene practices in the house. As the project interventions focus on the short-term, concentrating on hygiene promotion and are not inclusive of water and sanitation hardware support to the beneficiaries, VNRC will continue to work with partners and stakeholders to integrate hygiene promotion in other long-term community development programmes.

Another challenge is around passing the key messages for hand-washing to the beneficiaries from volunteers. The current national messages for hand-washing endorsed by the Ministry of Health consist of six steps. When educating target groups, many parents and workers in daycare centres find it difficult to remember and apply all six steps in the correct order. To meet this challenge, the volunteers are guided by the VNRC project team to make hand-washing messages simpler for beneficiaries so that they feel confident in carrying out the necessary steps.

In the past three months, group sensitizations by volunteers have reached about 27,000 people, mostly mothers and grandmothers of children under five years old, in the communities. Through group sensitizations, the participants have been able to share their knowledge of the disease and their practices to prevent children from infection as well as clarify with Red Cross volunteers information for prevention, early detection and referral.

In the coming weeks, VNRC will continue to carry out interventions in BCC through household visits and group sensitizations in order to finish the rest of the target in the operation.

Progress toward output 2

In the past months, VNRC have mobilized the qualified trainers to train an additional 1,300 volunteers in-community in behaviour change communication skills and knowledge of HFMD. The volunteers have been given orientation and practical guidance on how to use the monitoring tools for knowledge and practice progress among target groups in HFMD. These trained volunteers have added capacity and human resources for VNRC to be able to reach further to the vulnerable population, and make an impact in limiting illness and fatality among small children due to HFMD in the 130 new communes.

Volunteers in Dong Thap Province receive certificates after attending a three-day training conducted by VNRC.

A volunteer in Duc Hoa District, Long An Province using a flipchart to facilitate discussion with mothers on HFMD prevention. (Photos: Thuan Nguyen/IFRC)

Monitoring the status of the operation and support for the work of volunteers on the ground is a key activity that VNRC has prioritized in the past months. The project team has conducted monthly monitoring activities to the field to observe the progress in behaviour among target groups as well as volunteer performance and issues arising in the communities. Monitoring has enabled VNRC to find out and address challenges around the changes when working with workers at IDCs.

In Viet Nam, the operation of informal day care centres relies on whether or not parents continue sending their children to the centre. The target centres in the operation provide care for up to 30 children, mostly under three years of age, as state-managed centres receive children from the age of three and above only. The smaller the centres, the more likelihood the centre will close down due to the lack of children. This is because during the off-season, parents, who are factory workers, farmers, or non-contractual workers have less work opportunities. Similarly, during harvest season, there may be more centres operating in the communes due to increased need.

For the project management team, they have to update the number of informal day care centres very regularly and monitor any changes in the number of target centres as well as the progress in behaviour of beneficiaries.

In September, through monitoring, VNRC recently found that the local health authorities in some provinces also distributed soap to the IDCs with more than 15 children. Based on this information, VNRC was able to adjust the work plan to reach workers and IDCs that on average take care of three to five children. In addition, through keeping close watch on surveillance information that is shared by the Ministry of Health, VNRC was able to identify communes where HFMD cases continue to rise despite the Ministry of Health and Red Cross interventions.

In these communes, VNRC has decided to intensify its interventions through increasing group sensitization, and proactively involve other community leaders such as representatives of the Women's Union, monks, and teachers in disseminating preventive messages to wider target groups. For example, in Soc Trang province, the local Red Cross branches were able to engage Buddhist monks for support to use the pagoda to hold their weekly meeting with Buddhist practitioners to talk about HFMD prevention.

In August, with HFMD cases starting to increase again, the Ministry of Health organized a live video conference with persons in-charge in 63 provinces. VNRC joined this conference and was able to contribute to the dialogue about management of the epidemic at local level as well as sharing VNRC's complementary interventions on the ground. At provincial and lower levels, VNRC work in close partnership with the local authorities and health agencies to monitor the situation and coordinate responses in the existing and extension target communes.

Communications – advocacy and public information

In implementing its communication strategy, VNRC has been working with health authorities at both national and provincial levels on sharing information and the progress of the associated communication activities in HFMD prevention. Advocacy activities have been initiated by nine chapters with the provincial authorities around consistency in key messages, the coordinated communication plan and target areas as well as planned distribution of communication materials. As far as the project progress is concerned, duplication in communication activities has been avoided, thanks to coordination by all partners.

After communication efforts to broadcast information on the situation and VNRC's responses in international and national news, VNRC is now working closely with national new agencies including TV, newspapers and radio to broadcast the progress of the project via local news channels. Updates on project progress are also frequently provided through VNRC's website and the Humanitarian Magazine to further reach the general public.

VNRC also continues to participate in BCC workshops organized by the Partnership Secretariat on Avian and Human Pandemic Influenza (PAHI) in order to learn from best practices and share experience in BCC. This helps VNRC incorporate community lessons learnt into building the national BCC action plan for emerging diseases.

Logistics

The additional procurement of soap, IEC materials and visibility items for Red Cross staff and volunteers was made in September. Similar to the previous procurement, VNRC complies with the national standard procurement procedures for the purchase of these items. The call for quotations and the collection of competitive offers have been implemented. A procurement committee has been mobilized to take charge of procurement and to make sure all requirements are met. Selection criteria are inclusive of best offer, quality of service, and delivery in the shortest timeframe. The IFRC in-country office has provided support to VNRC by taking full charge of implementing procurement procedures and monitoring the progress of this activity.

Contact information

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

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International Federation of Red Cross and Red Crescent Societies

MDRVN010 - Vietnam - Hand, Foot and Mouth Disease

Appeal Launch Date: 02 apr 12

Appeal Timeframe: 02 apr 12 to 31 dec 12

Interim Report

Selected Parameters	
Reporting Timeframe	2012/3-2012/10
Budget Timeframe	2012/3-2012/12
Appeal	MDRVN010
Budget	APPROVED

All figures are in Swiss Francs (CHF)

I. Funding

	Disaster Management	Health and Social Services	National Society Development	Principles and Values	Coordination	TOTAL	Deferred Income
A. Budget	**758,416**					**758,416**	
B. Opening Balance	**0**					**0**	
Income							
Cash contributions							
China Red Cross, Hong Kong branch	*25,296*					*25,296*	
Danish Red Cross	*76,667*					*76,667*	
European Commission - DG ECHO	*324,756*					*324,756*	
Japanese Red Cross Society	*25,000*					*25,000*	
Red Cross of Monaco	*6,007*					*6,007*	
Singapore Red Cross Society	*50,000*					*50,000*	
Swedish Red Cross	*66,543*					*66,543*	
The Canadian Red Cross Society	*45,586*					*45,586*	
C1. Cash contributions	***619,854***					***619,854***	
C. Total Income = SUM(C1..C4)	**619,854**					**619,854**	
D. Total Funding = B +C	**619,854**					**619,854**	
Coverage = D/A	**82%**					**82%**	

II. Movement of Funds

	Disaster Management	Health and Social Services	National Society Development	Principles and Values	Coordination	TOTAL	Deferred Income
B. Opening Balance	0					**0**	
C. Income	619,854					**619,854**	
E. Expenditure	-367,364					**-367,364**	
F. Closing Balance = (B + C + E)	252,490					**252,490**	

International Federation of Red Cross and Red Crescent Societies

MDRVN010 - Vietnam - Hand, Foot and Mouth Disease

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Reporting Timeframe	2012/3-2012/10
Budget Timeframe	2012/3-2012/12
Appeal	MDRVN010
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All figures are in Swiss Francs (CHF)

III. Expenditure

Account Groups	Budget	Expenditure						Variance
		Disaster Management	Health and Social Services	National Society Development	Principles and Values	Coordination	TOTAL	
	A						B	A - B
BUDGET (C)		**758,416**					**758,416**	
Relief items, Construction, Supplies								
Water, Sanitation & Hygiene		10,845					**10,845**	**-10,845**
Teaching Materials	63,950							**63,950**
Other Supplies & Services	14,310							**14,310**
Total Relief items, Construction, Su	**78,260**	**10,845**					**10,845**	**67,415**
Logistics, Transport & Storage								
Storage		5					**5**	**-5**
Distribution & Monitoring	41,000							**41,000**
Transport & Vehicles Costs		1,355					**1,355**	**-1,355**
Total Logistics, Transport & Storage	**41,000**	**1,360**					**1,360**	**39,640**
Personnel								
International Staff	56,000	6,406					**6,406**	**49,594**
National Staff	17,600	7,259					**7,259**	**10,341**
National Society Staff	214,374	20,576					**20,576**	**193,798**
Volunteers		6,263					**6,263**	**-6,263**
Total Personnel	**287,974**	**40,503**					**40,503**	**247,471**
Consultants & Professional Fees								
Consultants	7,000	2,868					**2,868**	**4,132**
Professional Fees		149					**149**	**-149**
Total Consultants & Professional Fe	**7,000**	**3,018**					**3,018**	**3,982**
Workshops & Training								
Workshops & Training	236,703	104,409					**104,409**	**132,294**
Total Workshops & Training	**236,703**	**104,409**					**104,409**	**132,294**
General Expenditure								
Travel		12,103					**12,103**	**-12,103**
Information & Public Relations	43,950	39,022					**39,022**	**4,928**
Office Costs	4,000	2,568					**2,568**	**1,432**
Communications	12,000	1,863					**1,863**	**10,137**
Financial Charges	1,240	-99					**-99**	**1,339**
Other General Expenses		2,029					**2,029**	**-2,029**
Shared Office and Services Costs		919					**919**	**-919**
Total General Expenditure	**61,190**	**58,404**					**58,404**	**2,786**
Operational Provisions								
Operational Provisions		125,746					**125,746**	**-125,746**
Total Operational Provisions		**125,746**					**125,746**	**-125,746**
Indirect Costs								
Programme & Services Support Recov	46,288	22,379					**22,379**	**23,910**
Total Indirect Costs	**46,288**	**22,379**					**22,379**	**23,910**
Pledge Specific Costs								
Pledge Reporting Fees		700					**700**	**-700**
Total Pledge Specific Costs		**700**					**700**	**-700**
TOTAL EXPENDITURE (D)	**758,416**	**367,364**					**367,364**	**391,052**
VARIANCE (C - D)		**391,052**					**391,052**	