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Emergency Plan of Action Preliminary Final Report

South Sudan: Cholera

International Federation of Red Cross and Red Crescent Societies

DREF operation Preliminary Final Report	**Operation n°** MDRSS004
Date of Issue: 26 January 2016	**Glide number:** EP-2015-000073-SSD
Date of disaster: 23 June 2015	
Operation start date: 6 July 2015	**Operation end date:** 20 October 2015
Host National Society: South Sudan Red Cross (SSRC)	**Operation budget:** CHF 225,368
Number of people affected: Population of Juba and Bor[1]	**Number of people assisted:** 233,718 (38,953 households)
N° of National Societies involved in the operation: International Committee of the Red Cross (ICRC), International Federation of the Red Cross and Red Crescent Societies (IFRC) and Partner National Societies (PNS) present in the country: Austrian, Canadian, Danish, Netherlands, Norwegian, Swedish and Swiss Red Cross societies. Other PNS partners: British, German and Finnish Red Cross societies.	
N° of other partner organizations involved in the operation: Action Against Hunger, IMA, Médecins Sans Frontières, Ministry of Health, Save the Children, United Nations Children's Fund, United Nations Office for the Coordination of Humanitarian Affairs, World Food Programme, World Health Organization.	

A. Situation analysis

Description of the disaster

On 3 November 2015, four and a half months after a cholera outbreak was declared on 23 June, the government of South Sudan, through its Ministry of Health, declared an end to the outbreak[2]. At final tally, the emergency recorded 1,818 laboratory-confirmed cases and claimed 47 lives in Central Equatoria State and Jonglei State[3]. Juba County in Central Equatoria was, by far, the most-affected, accounting for 89 per cent (1,622) of cases in seven *payams*[4].

The DREF operation supported SSRC's social mobilization campaign, reaching almost a quarter of a million people during the cholera outbreak. Photo: IFRC

Timeline

26 June

- **SSRC begins mobilization of volunteers and NFI, three days after the cholera outbreak is declared.**
- **The National Society submits a request for a DREF application.**

[1] Population numbers by the government and other agencies proved to be hugely underestimated. At the launch of the DREF operation, the population of Juba was set at 300,000 people based on these estimates. However, blanket coverage by SSRC in only seven locations in Juba – approximately a third of area coverage Juba – reached almost a quarter of a million people.
[2] On the basis of 10 consecutive days with no new cases confirmed, twice the maximum cholera incubation period of five days.
[3] RoSS Ministry of Health press statement, 3 November 2015.
[4] Second-lowest administrative sub-division, below county.

Generally, the outbreak was characterized by predictable epidemiological patterns, peaking in late July when case fatality rate reached 6.6%, before tapering off after a secondary peak in August. Potentially triggered by heavy rains which normally arrive mid-year, the worst was over within the first two months, with only 100 new cases recorded since 5 September, largely due to concerted intervention efforts from the government and international agencies.

The emergency response took place as an ongoing internal conflict entered its twentieth month in August, although the outbreak was largely confined to Juba, away from the fighting that continued to rage farther north in the states of Jonglei, Unity and Upper Nile.

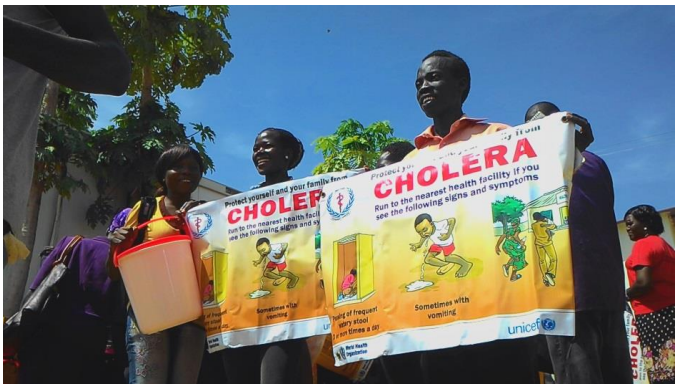
Timeline **3 July**

- **SSRC Juba branch conducts social mobilization refresher workshops for 50 volunteers.**
- **The next day, household visits begin at Mauna and New Site.**
- **Volunteers visit 192 households on their first day.**

Epidemiological data throughout the outbreak identified children below five to be the most vulnerable: cumulative weeks saw the rate of transmission among this group grow steadily from its starting 14 per cent to its high of 24 per cent, even as the outbreak was in decline. At the peak of fatalities, case fatality rate (CFR) for this group was almost double that of the general population[5].

Timeline **DREF Day 1 6 July**

- **The DREF application is approved for CHF 225,368.**
- **SSRC reaches 800 households in two locations.**



SSRC volunteers prepare to head out for the first day of household visits on 4 July. Photo: IFRC

On 6 July 2015 the International Federation of Red Cross and Red Crescent Societies (IFRC) released CHF 225,368 from the Disaster Relief Emergency Fund (DREF) to support the South Sudan Red Cross Society (SSRC) respond to the needs of the affected population. The DREF operation was intended to support 60,000 people (10,000 households[6]) in Juba County Central Equatoria State over a period of three months. The DREF operation met approximately half of the proposed overall SSRC Plan of Action for the cholera outbreak budgeted at CHF 552,000, with Movement partners in-country also supporting portions of that.

The National Society expanded its operations to Bor in Jonglei State and began preparedness activities in Torit in East Equatoria State (the worst-affected area in 2014's cholera outbreak), with support from ICRC and partner national societies (PNS). Bilateral contributions stand at EUR 27,000 (including in kind) from the Austrian Red Cross for activities for Torit, USD 1,500 from the German Red Cross for Torit, EUR 3,000 from the Finnish Red Cross for Torit, EUR 20,000 from the Netherlands Red Cross for Juba, and CHF 92,832 from the Swiss Red Cross for Juba and Torit.

Two weeks before the end of the operation, major activities (household visits, awareness sessions and distributions) planned were completed, modestly exceeding targets revised in the final weeks of implementation (refer to Figure 1):

Figure 1: Key Emergency Plan of Action (EPoA) output indicators as of 20 October 2015

Indicator	Revised Target (Original target in brackets)	Value	Variance
# of volunteers trained at refresher workshops	84 (60)	84	0 %
# of house-to-house awareness visits conducted	37,500 (10,000)	38,953	3.9 %
# of items distributed: Water purification (PUR) at 14 packets per household	N/A	544,460	

[5] Based on data from RoSS Ministry of Health and WHO, *Cholera in South Sudan* SitRep #14, 6 July 2015
[6] The average household size in South Sudan is six individuals.

Oral rehydration salt solution (ORS) at 2 sachets per household Soap bars at 1 per household, cut into four pieces		77,780 21,760	3.9 %*
# of hand washing facilities installed	10	10	0 %

***Note: variance based on PUR and ORS; soap supply was exhausted**

A review of the DREF operation took place over the final two weeks, with the participation of a Regional Disaster Response Team (RDRT) member from Malawi Red Cross.

This DREF has been replenished by the Canadian Red Cross/Government and Netherlands Red Cross/Silent Emergencies Fund. The major donors and partners of the DREF include the Red Cross Societies and governments of Australia, Austria, Belgium, Canada, Denmark, Ireland, Italy, Japan, Luxembourg, Monaco, the Netherlands, Norway, Spain, Sweden and the USA, as well as DG ECHO, the UK Department for International Development (DFID) the Medtronic and Zurich and other corporate and private donors. The IFRC, on behalf of the South Sudan Red Cross Society, would like to extend its thanks to all partners for their generous contributions.

Please note that this Preliminary Report is issued in advance of the Final Report.

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Summary of response

Overview of Host National Society

As soon as the outbreak was declared on 23 June 2015, SSRC began mobilizing its resources to prepare for its response. An initial plan of action was drafted, largely based on a review of capacities already available as a result of the previous response in 2014. Following the National Cholera Taskforce allocation of intervention areas for agencies, SSRC identified seven locations in Juba to intervene with social mobilization and WASH activities for 60,000 people (10,000 households) with direct implementation starting on 3 July 2015. Although the outbreak spread to Bor County in neighbouring Jonglei State, the situation was quickly brought under control, as the state was well-covered by existing contingency planning that led to a well-organized response from external actors and the government. A key component in Torit branch preparedness activities was in water production, through the M40 water plant handed over to the branch by the Water and Sanitation Emergency Response Unit (ERU) deployed in 2014. SSRC operated the plant under a Memorandum of Understanding with the Torit Municipal Council and the State Ministry of Physical Infrastructure to share management and maintenance responsibilities, with a costing mechanism for water obtained used to help sustain operations.

By early September 2015, operations in Juba had more than tripled original targets and a revision to the budget and EPoA was drafted by mid-September 2015, with the formal revision launched on 5 October 2015.

Overview of Red Cross Red Crescent Movement in country

The IFRC through its East Africa and Indian Ocean Islands (EAIOI) representation based in Nairobi, Kenya; and South Sudan country representation in Juba has been providing technical assistance in the implementation of the DREF operation. The International Committee of the Red Cross (ICRC) also has a country delegation, with its interventions located in the conflict-affected states. In addition PNS with in country presence include: Austrian, Canadian, Danish, Netherlands, Norwegian, Swedish and Swiss Red Cross National Societies, which are providing bilateral support, including in response to the cholera outbreak, complementary to the DREF operation.

Overview of non-RCRC actors in country

Under the joint guidance of the Ministry of Health and WHO, the National Cholera Task Force provided technical leadership and coordinated the various health and water, sanitation and hygiene (WASH) cluster partners involved in surveillance; laboratory support; case management; WASH; social mobilization and Logistics. Other than the government, Catholic Relief Services were the only other agency apart from SSRC implementing social mobilization under the coordination of the task force.

Agencies such as MSF, with the Ministry of Health, also set up treatment points for receipt, screening and treatment of all suspected cholera cases. These included: three cholera treatment centres at Juba Teaching Hospital, Munuki, and

Bor State Hospital; two cholera treatment units at Juba 3 Protection of Civilian camp (PoC) and Gumbo; and six oral rehydration points in Nyakuron, Kator, Gurei, Munuki, Al Sabah, and Lologo.

The government, with support from WHO, UNICEF, MSH, IOM, Medair, IMC and other health cluster partners, provided cholera buffer stocks, other medical supplies and necessary equipment.

In order to prevent the continued spread of cholera in the high risk areas, the MOH with support from WHO, UNICEF, IOM, IMC and MSF conducted oral cholera vaccination campaigns in several cholera hot spots in Juba, reaching more than 290,000 people.

Needs analysis and scenario planning

The needs analysis, risk assessments and scenario planning remain the same as in the original EPoA with refinements identified from ongoing monitoring of the interventions.

The National Cholera Task Force social mobilization and WASH sub-groups allocated intervention areas for agencies responding to the outbreak, as information on the outbreak developed and gaps in coverage were identified. SSRC was initially allocated seven locations in Juba County for its activities, all located within the Northern Bari, Munuki, and Rejaf *payams*: Dar es Salam, Giada, Hai Tarawa, Mauna, New Site, Rock City and Seminary.

Although the epidemic followed a predictable declining trend, lesser spikes of cases in August driven by community transmission in previously unaffected *payams* led to SSRC considering awareness activities in new locations. However, funding and time constraints, as well as the specific life-saving priorities of DREF meant that SSRC's area of intervention was not expanded.

B. Operational strategy and plan

Overall Objective

The revised overall objective was to provide immediate assistance to 225,000 people affected by the cholera outbreak in Juba through health and hygiene promotion to help reduce the risk of waterborne and water-related diseases for the population at risk.

The main social mobilization activity of household visits aimed to cover the entire population of the seven identified locations and this activity alone exceeded targets, reaching 233,718 people (38,953 households). Although complementary activities such as public awareness sessions and installation of handwashing facilities were also successfully carried out, additional beneficiaries were not added to the total target as these activities were conducted in the same locations, presumably to the same populations.

Proposed strategy

Please refer to the revised EPoA published in Operations Update no. 1 for information on this section, which remains unchanged since the last update.

Operational support services

Please refer to the original EPoA for information on operational support services, and to the revised EPoA for information on human resources.

C. Detailed Operational Plan

Quality programming/ Areas common to all sectors	
Outcome 1: Response is evidence-based and demonstrates accountability to key stakeholders	
Output 1.1: Regular monitoring of context, health information and of the response activities is carried out	
Activities planned	
1.1.1	Develop a monitoring framework for the operation.
1.1.2	Measurement of transmissions rates in targeted locations.
1.1.3	Daily reporting of volunteer activities to Juba Branch.
1.1.4	Daily incentive for Cholera Focal person.
1.1.5	Weekly reporting of Juba Branch to HQ.
1.1.6	Compilation and analysis of the reports to adapt strategy as needed
1.1.7	Final review of operation.
Output 1.2: SSRC has effective coordination with other actors involved in the cholera response	
Activities planned	
1.2.1	Attend MoH and Juba State taskforce meetings.
1.2.2	Attend cluster meetings
1.2.3	Share information through SSRC and RCM taskforce meetings.

Achievements

<u>Output 1.1: Regular monitoring of context, health information and of the response activities is carried out</u>

Timeline **DREF Day 9 14 July**

- **Monitoring visits begin at new site with improved tools under finalized monitoring plar**
- **Water and sanitation assessments begin.**

Previous monitoring, especially in emergencies, was limited to the use of a simple reporting form and supervision checklist by volunteers. This tool was limited to measuring quantitative indicators, such as beneficiaries reached and items distributed, with the branch collating cumulative data.

Prior to implementation of activities for this operation, a supplementary monitoring sheet was designed to assess and monitor other values such as environment context, health information and beneficiary feedback. Volunteers were trained to use these, with regular reflections held during debriefings to continuously adapt the tool for appropriateness. Programme staff, as well as IFRC and PNS conducted random supervision visits twice weekly to ensure the monitoring tools were used properly.

Information from monitoring formed the basis of a “trending baseline” for the operation in the absence of assessments, which helped inform the operation of priorities and challenges. As a result, many of the issues faced by volunteers throughout the three months of implementation were quickly identified and responded to, as detailed in the challenges and lessons learnt sections below.

Transmission rates were not independently measured at the targeted locations. All data on transmission relied on Ministry of Health/WHO Cholera Situation Reports, which received data from official cholera treatment centres (CTCs) around Juba. However, SSRC monitoring visits to CTCs serving its intervention areas found that some cases registered and treated were not reflected in the official data but could not determine if this was because of stricter confirmation tests (such as laboratory positive testing which is not conducted at CTC level) at national level. In any case, SSRC's informal strategy was to conduct follow-up visits with public awareness campaigns in areas reporting new cases of cholera as discovered by monitoring visits to CTCs.

A woman at New Site shows a monitoring team the process of purifying water, as demonstrated earlier by SSRC volunteers during household visits. Photo: IFRC

The IFRC Africa zone, East Africa and Indian Ocean Islands (EAIOI) regional representation in collaboration with the IFRC South Sudan country representation and SSRC conducted a DREF review from 9 October to 16 October 2015, joined by an RDRT member from Malawi Red Cross. This activity concluded the DREF operation. The review used the Open Data Kit (ODK) software for mobile data collection, which required a full day of training and testing for volunteers at Juba branch.

Output 1.2: SSRC has effective coordination with other actors involved in the cholera response

As an active member of national and state-level cluster sub-groups in social mobilization and WASH which met regularly (weekly during the cholera outbreak), SSRC's strategy was to respond in areas and locations which best met gaps identified by the National Cholera Taskforce. SSRC enhanced its social mobilization campaigns by distributing cholera information, education and communication (IEC) materials produced by the WHO and UNICEF, distributed to all actors through the Ministry of Health. These materials, mainly in the form of posters and banners, were used by volunteers during the household visits as part of their hygiene promotion demonstrations. Using information collected by its monitoring activities, SSRC continued to share updates on its own operation at these cluster and taskforce meetings, attended by the headquarters health coordinators and head of programs.

SSRC also participated in joint campaigns with the government and other agencies such as MSF, complementing vaccination programs with hygiene promotion. A total of 12 joint campaigns were conducted from 19 August to 2 September 2015 in public areas, civilian and military housing outside the National Society's seven targeted locations. During these campaigns, volunteers also provided informal hygiene promotion training to health officials as part of capacity building for cluster partners.

Challenges

Timeline
DREF Day 15 20 July

- **Cholera focal point for Juba branch appointed from volunteers.**
- **SSRC reaches 4,080 households in three locations, during the week where the highest epidemic peak was recorded, with 258 cases confirmed.**

Designated reporting roles

Despite existing reporting mechanisms and tools, there was no SSRC programme staff responsible for compiling the data from volunteers and reporting on progress. The immediate result is that daily reporting from the volunteers to the branch was not well managed and a monitoring plan and indicator tracking were not in place. The belated appointment of a branch focal person and a headquarters focal person dedicated to the operation solved this issue.

Monitoring indicators

The existing volunteer reporting form only tracked numbers of households visited and distribution items for the social mobilization activities, while a supervision checklist only verified activities. A second monitoring form was introduced which, among other objectives, aimed to track simple hygiene and sanitation indicators as an attempt to add to qualitative information collected from the field.

Literacy

While the volunteers were experienced and highly capable social mobilizers, a significant number of them had literacy issues[7]. With this in mind, the monitoring form was designed to capture simple responses and volunteer team leaders were instructed to debrief with the teams at the end of each day to ensure that more detailed observations were recorded in their reports.

Limited resources
Given the many existing priorities of SSRC, particularly for the health programme, it was at times difficult to ensure that activities were sufficiently monitored and managed. The appointment of a branch focal person (from an existing volunteer) for the operation eased most of the early difficulties in volunteer management, although throughout the three months, even this resource was forced to attend to non-emergency work, temporarily leaving volunteers to themselves. Various other events, such as the Maridi fuel tanker explosion in September, relied heavily on volunteers otherwise active in the cholera operation for several days to assist with treatment of burn patients.

Lessons learnt

Dedicated resources to emergency operations
Dedicated cholera response staffing must be ensured by SSRC. This ensures sufficient management of the operation and volunteer management, while allowing managers to devote time to attend cluster and sub-group meetings for consistent coordination.

SSRC must be well represented and information shared to ensure visibility and good coordination with other actors on the ground. In last year's operation in Torit, the programme manager identified coordination meetings as one of the major activities that affected implementation in the early days of response in the context of understaffing.

The Movement cholera task force and operational meetings were well represented by partners. However, it was noted that the implementing branch was sometimes not represented, leading to lengthened decision-making in some areas of operation.

IFRC tool, Movement support
Acknowledging the weak monitoring system in emergencies, a monitoring framework was designed and its tools agreed upon in consultation with the SSRC head of programmes, health and CBHFA coordinators and Juba branch director on 13 July 2015. In the absence of a formal pre-operation assessment, the tools were adapted from IFRC's PHAST baseline survey tool and attempted to form basic "trending" baseline indicators on using retrospective questions.

Despite the DREF operation being an IFRC tool in disaster response, SSRC monitoring teams were supported by all Movement partners, including PNS and ICRC, who accompanied volunteers in the field, collecting information that continuously adapted programme design to improve the quality of intervention.

Future IFRC/SSRC operations should follow the precedent set by this DREF operation, which recognised the value of Movement partners in contributing towards quality programming through direct and technical assistance in monitoring activities.

Water, sanitation and hygiene promotion

Outcome 1: SSRC staff and volunteers contribute to the reduction of Cholera cases in vulnerable communities in seven locations in Juba.	
Output 1.1: SSRC undertakes cholera awareness activities in seven locations in Juba.	
Activities planned	
1.1.1	Recruitment of cholera focal point for Juba.
1.1.2	Confirmation of team leaders / supervisors in target areas
1.1.3	Training / refresher training of 84 volunteers in Juba
1.1.4	Conduct house-to house awareness visits in seven locations in Juba.
1.1.5	Awareness raising sessions conducted in public places (markets, schools, churches, mosques etc.).

[7] 70 per cent of adults in South Sudan cannot read or write.

1.1.6	Procurement of soap and PUR (ORS already in stock).
1.1.7	Distribution of ORS, soap and PUR in targeted locations.
Output 1.2: SSRC undertakes activities to improve sanitary conditions in targeted locations.	
Activities planned	
1.2.1	Installation of basic hand-washing facilities (buckets with soap)
1.2.2	Clean-up activities in markets, hospitals etc. with areas prioritized based on needs.

Achievements

Output 1.1: SSRC undertakes cholera awareness activities in seven locations in Juba.

Timeline
DREF
Day 44
18 August

- **Household visits begin in the sixth location, Rock City, SSRC having completed in four.**
- **New Site interventions enter the fourth and final week.**
- **Joint campaigns with MSF-Swiss and MoH begin the following day.**

After the initial batch of 50 trained and experienced volunteers (31 women and 19 men) participated in refresher workshops on 3 July, a second batch of 34 new volunteers (21 women and 13 men) were trained on 29 July. The 84 volunteers, forming around 35 teams, reached 38,953 households on the final day of household visits on 17 September. This meant that each team reached more than 1,000 households over the course of the operation. At each home, volunteers communicated with the household members, promoting hygiene and awareness on the signs and symptoms of cholera and conducted demonstrations of how to use the ORS, as well as of the PUR packets, each of which provides 10 litres of clean water at the end of the purification process.

Many of the beneficiaries saw the use of PUR for the first time, like in this instance during a public awareness session. Photo: IFRC

Around 15 volunteers also conducted 12 joint campaigns with external partners from 19 August to 2 September 2015, reaching an estimated 22,974 individuals (3,829 households)[8]. From late September to 6 October, SSRC completed seven daily public awareness sessions, once in each of its seven targeted locations. Around 15 volunteers travelled on a mobile stage, speaking to the public on loudspeakers and spreading cholera awareness through music, drama shows and demonstrations. Targeting public areas such as religious centres and markets, these sessions were estimated to reach between 300 to 500 people each day[9].

In total, 10 hand washing facilities (a water container on a stand with tap, bucket and soap) were installed by early September 2015. At New Site, three were installed at the John Garang Primary School, two at the Angels Nursery and Primary School and one at the Bright Future Nursery School. At Giada, three were installed at the Giada Model Primary School. An additional facility was also installed at the SSRC Juba branch compound for daily use of the volunteers returning from the field. Austrian Red Cross provided technical support for WASH assessment and trainings, including water quality testing.

SSRC as an effective partner in social mobilization

SSRC was one of only two agencies carrying out social mobilization in Juba, partly due to its recognition by the National Cholera Task Force as an organization most experienced and skilled in hygiene promotion in the communities. The National Society was solely assigned to at least two of the most at-risk locations: New Site and Giada, informal military settlements with cramped living conditions and a near lack of sanitation facilities.

Volunteers started activities in early July at New Site, at the time one of the areas with the highest number of cholera cases recorded. Data from WHO and Ministry of Health showed that case counts visibly dropped over the next few weeks in July and August. Beneficiary monitoring throughout the operation, as well as beneficiary and stakeholder surveys carried out during the DREF review in October, credited SSRC's intervention as pivotal towards this decline, with a high level of satisfaction expressed for the quality of intervention.

[8] Based on ORS, PUR and soap distributed in the same proportions as the household visits. These figures are not included in the overall beneficiary and distribution count.
[9] As the beneficiaries were from the seven targeted locations receiving blanket coverage of household visits, these figures are not included in the overall beneficiary count.

However, as the epidemiological patterns followed predictable cycles, this should not be seen as a direct impact of the operation. Nevertheless, the intervention and awareness-raising by SSRC volunteers almost certainly helped hasten the decline of the outbreak in these high-transmission locations.

The sheer number of beneficiaries reached by a relatively small group of volunteers served to demonstrate the commitment and dedication shown by the volunteers of Juba branch. In recognition of their efforts, SSRC and IFRC, supported by Swiss Red Cross, held a recognition ceremony at the SSRC headquarters on 21 November, awarding certificates to outstanding volunteers.

Members of the public gather round the SSRC mobile stage to listen during a public awareness session. Photo: IFRC

Timeline
DREF Day 59 2 September

- **SSRC completes final joint campaign with MoH.**
- **Soap supplies are completely exhausted for the third time. Replenishments do not arrive on time for remaining activities.**
- **30,873 households are reached.**

Challenges

External demands on the National Society

SSRC was widely seen as one of the most effective responders in social mobilization. Its success and effectiveness during the 2014 cholera outbreak further cemented this reputation, especially with the Ministry of Health, which co-chaired the National Cholera Task Force. When allocating locations to partners in this year's cholera response, SSRC was the "natural" partner to allocate to New Site and it was here that volunteers faced the most challenges.

Although initially unplanned, at the request of the National Cholera Task Force, SSRC also conducted joint social mobilization campaigns in Juba in areas outside the seven targeted locations, complementing oral vaccination campaigns by other partners. The National Society was also requested to provide training to government health officials. These ad hoc activities while important and conducted well, diverted valuable resources from the National Society's own priority activities.

Further requests from the government to expand SSRC's reach to areas where new cases were detected in September were unable to be met, mainly due to funding and time constraints of the DREF operation.

The DREF review also found that some beneficiaries felt that SSRC should have distributed more items, including medical supplies, although the activities were strictly limited to hygiene promotion. This expectation led to some disappointment among these beneficiaries.


Despite a language barrier, a group of volunteers are able to provide hygiene promotion through a beneficiary (in red) who acts as translator. Under volunteer guidance, she even demonstrates to her neighbours the process of purifying water. Picture: IFRC

Diverse, but not diverse enough

One of the major drivers for success in the 2014 cholera operation was the use of volunteers who themselves came from the very communities that SSRC was active in, allowing them to better communicate and connect with beneficiaries. That context was different during the 2015 cholera outbreak, when SSRC were allocated several locations in which it did not have volunteer bases, and the majority of the volunteers engaged there were from different communities. This bore importance in a country like South Sudan, whose people are made up of more than 50 indigenous ethic groups with a greater linguistic diversity. A minority of communities in Juba could not communicate either in English or local Arabic (the former the national language, and the latter the most commonly-used language in South Sudan).

At best, it meant that hygiene promotion may have been less effective. At worst, it caused tensions with communities who felt left out. This was experienced particularly at New Site, where tensions led to hostility towards volunteers, with some community leaders demanding to communicate with volunteers from their ethnic background. As a result, some households were not reached.

Logistics management
Logistical issues, particularly with vehicles and with procurement throughout the operation caused delays in implementation across activities.

In terms of fleet management, the operation was allocated two dedicated vehicles and drivers, whose main tasks were to transport volunteers and equipment. Due to unavailability of fixed drivers, two drivers were assigned daily according to a roster. However, the drivers were often unaware or confused, resulting in almost daily delays in transporting volunteers to the field. Furthermore, these vehicles and drivers were also performing other duties outside the operation. Volunteers were sometimes stranded in the field waiting for transport after completing the day's work. This was the single most frustrating challenge, according to many volunteers.

With regards to warehouse management, early issues with insufficient stocks of PUR, ORS and soap were quickly solved with a stock movement plan which ensured that stocks at Juba branch were enough for a week's distribution. Soap ran out at least three times throughout the operation (although the last time was not because of poor stock management but because supplies were completely used up).

There were also delays with procurement, although other factors such as market availability, constant price hikes and lack of technical specifications at SSRC were to be blamed. To minimise delays, IFRC logistics supported the procurement of volunteer aprons. The public awareness campaign, originally planned for 14 daily sessions over two weeks, could only be conducted for seven sessions over one week: a combined result of inflated rental costs of mobile stage and sound system and a lack of technical specifications for the necessary equipment.

Soap supplies – originally enough for 10,000 households – ran out three times throughout the operation. The DREF revision almost doubled the budget for soap but was made too late to ensure that more households received the item.

Lessons learnt

Expectations
An unintended result of its success, SSRC carried out its work under a weight of expectation. SSRC managed expectations from stakeholders and beneficiaries well, given its limited resources, adjusting its planning to meet certain requests while still completing its own objectives. It responded as well as it could to developing circumstances, for example, transporting people suspected with cholera to nearby treatment centres, despite not running a formal referral service.

Volunteers were given special sessions during debriefs, mutually coming up with ways to deal with expectations that the operation could not meet. For example, volunteers were told to remind beneficiaries that the soap, PUR and ORS distributed were only for demonstration and sampling purposes, and that people could rely on home-made ORS and ash in place of soap.

SSRC has noted the need to better inform beneficiaries in future operations of its specific activities and objectives prior to implementation, perhaps through a public announcement over radio or loudspeaker. This would not only better prepare beneficiaries to be available for activities but also would help set more accurate expectations in place.

Wider volunteer base
The need for volunteers from a wider range of backgrounds has long been recognised, but future operations will consider several options to ensure that volunteers with appropriate skill sets, particularly with language, are deployed in the communities. This includes direct recruitment and training of new volunteers from targeted locations, which should translate to better communication and increased acceptance. Another option is to create more volunteer bases in new communities, although this would exacerbate existing issues of funding and sustainability with the National Society in volunteer management.

Increased involvement/participation of support services
The Movement cholera task force and the informal operational meetings that took place weekly (then every fortnight from 20 August) were useful coordination and management tools, as operational challenges were discussed. However, there was little representation from departments such as volunteer management, logistics and communication, despite many issues requiring their attention.

Stronger ownership and decision-making from the implementing branch should also be a priority in future operations, with headquarters programme staff providing technical oversight.

Timeline **DREF Day 100 16 October**

The DREF review concludes with a volunteer learning workshop. It is the final activity under the DREF operation. Detailed review findings will be made available in a report, expected to be finalized in February 2016.

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How we work

All IFRC assistance seeks to adhere to the Code of Conduct for the International Red Cross and Red Crescent Movement and Non-Governmental Organizations (NGOs) in Disaster Relief and the Humanitarian Charter and Minimum Standards in Disaster Response (Sphere) in delivering assistance to the most vulnerable.

The IFRC's vision is to inspire, encourage, facilitate and promote at all times all forms of humanitarian activities by National Societies, with a view to preventing and alleviating human suffering, and thereby contributing to the maintenance and promotion of human dignity and peace in the world.

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

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