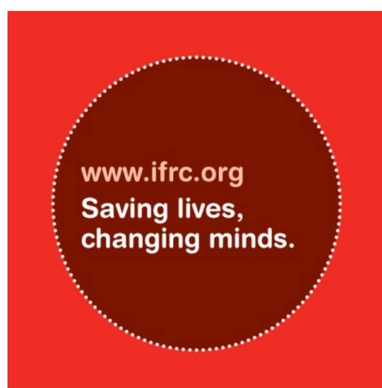
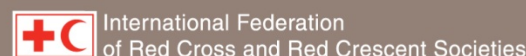


Emergency Plan of Action (EPoA)

Sudan: Cholera Outbreak



DREF Operation n° MDRSD027	**Glide n°** EP-2019-000113-SDN
Date of issue: 30 September 2019	**Expected timeframe:** 3 months **Expected end date:** 31 December 2019
Category allocated to the of the disaster or crisis: Yellow	
IFRC Point of Contact: Andreas SANDIN, Operations Coordinator, East Africa CCST, is responsible for project management and reporting of this operation.	**NS Point of contact:** Eng. Osman Gaffar Abdullahi Essa, Secretary General, SRCS
Overall operation budget: CHF 256,404	
Number of people affected: 187 people	**Number of people to be assisted:** 144,000 representing 24,000 Household (HH)[1]
Sudanese Red Crescent presence: 6 Branches, 7 staff and 180 volunteers in the Blue Nile, Sennar, White Nile, Gedaref, Kassala and Khartoum states.	
Red Cross Red Crescent Movement partners actively involved in the operation: ICRC, Danish RC, German RC, Netherlands RC, Spanish RC, Swedish RC, Saudi Arabia RC, Swiss RC and Qatar RC.	
Other partner organizations actively involved in the operation: Government ministries, mainly Federal Ministry of Health (FMoH) and State Ministry of Health (SMoH) and State Ministry of Water Resources; Humanitarian Aid Commission (HAC), National and International Non-Governmental Organizations (ONGs / IONGs), UN agencies (WHO, UNHCR, OCHA, WFP, UNFPA & UNICEF).	

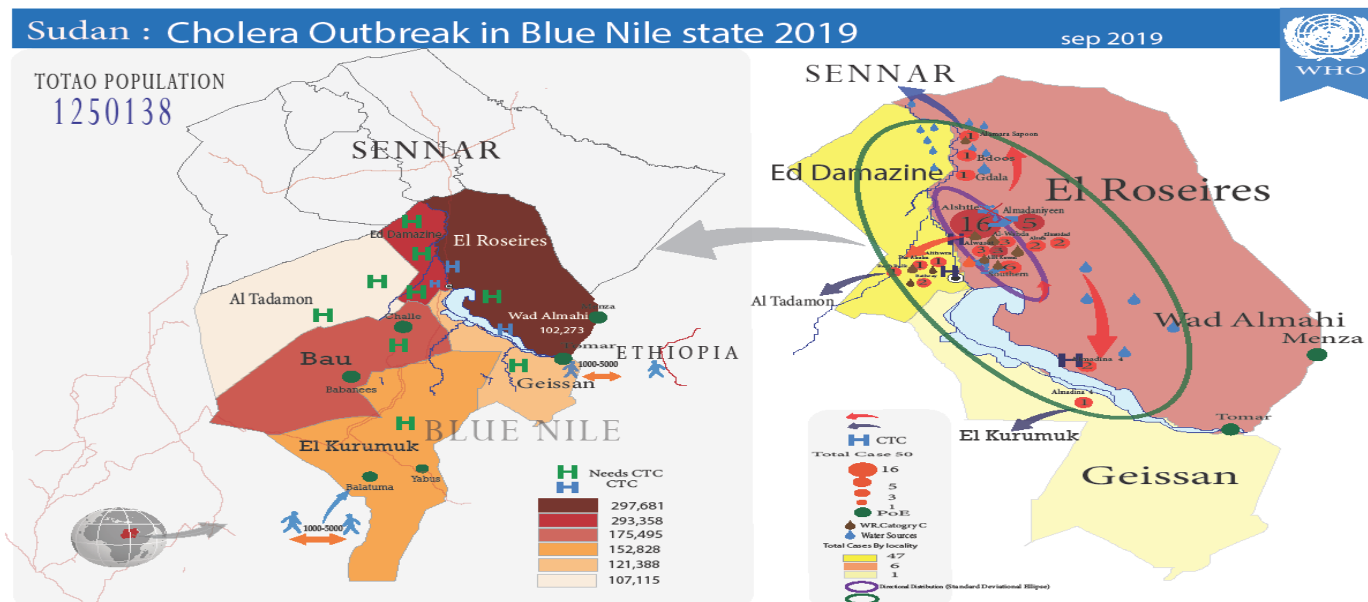
A. Situation analysis

Description of the disaster

On 8th September 2019, Sudan's Federal Ministry of Health (FMoH) confirmed four (4) cases of cholera in the Blue Nile State. Further on 19th September, an additional 124 suspected cholera cases were reported with seven (7) deaths: 6 in the Blue Nile and 1 in the Sennar States. The Ministry of Health (MoH) identified the White Nile, Gedaref, Sennar, Kassala and Khartoum as States that have the highest risks of cholera outbreak[2]. On 22nd September the number of suspected cholera cases reached 158[3] and continued to rise reaching on 25th September 187 cases, including eight (8) deaths reported in the Blue Nile and Sennar States.

SRCS volunteer conducting health promotion activities in the Blue Nile state ©SRCS

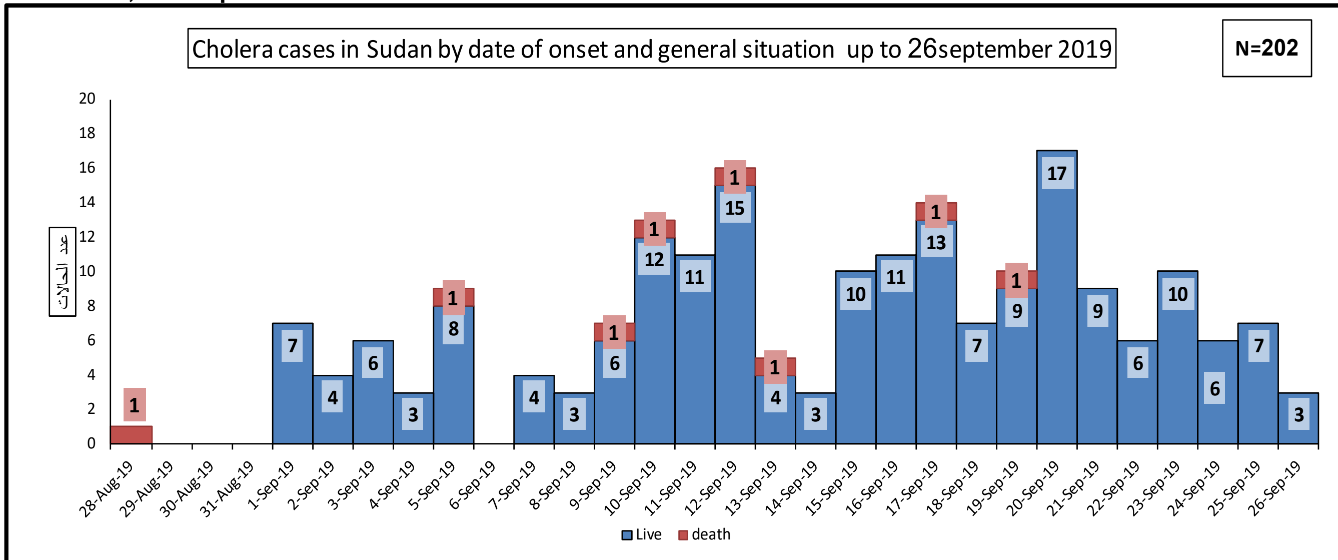
[1] An average of six (6) people per household.
[2] https://reliefweb.int/sites/reliefweb.int/files/resources/Situation%20Report%20-%20Sudan%20-%2018%20Sep%202019_0.pdf
[3] Power Point Presentation, The Cholera Epidemic Situation in Sudan States, National Committee for Health Emergency Response, 21st September 2019.



Affected localities in Blue Nile State, Health Cluster, 26th September 2019

Since the declaration of the outbreak on 8th September all relevant health bodies started monitoring the situation. Lifesaving activities started been implemented both by MoH and stakeholders. Inter-agency coordination meetings and Water Hygiene and Sanitation (WASH) and Health cluster meetings started being organized both at National and State levels. Clearer information and indications on the cholera outbreak situation and its potential development started being provided on 19th September in occasion of WASH & Health cluster meetings lead by the World Health Organization (WHO) and the MoH. Needs and gaps were communicated to partners, which were called upon to contribute with response and prevention actions to contain the current outbreak and avoid its expansion. Localities of intervention started being defined between partners, along with activities to implement, in order to ensure the coverage of the most affected areas, as well as complementarity of actions and no duplication of efforts. Although a complete 4W Matrix[4] with main activities has not been disseminated, WHO and MoH guarantee a constant overview on the positioning of partners in the field and on their activities and provide updates in occasion of weekly coordination meetings. The SRCS, as actor responding to the cholera outbreak, is actively engaged in the coordination mechanisms in place and ensure its representation both at national and state levels. So far only an overview of actors engaged in chlorination activities was shared at Emergency Response Committee, organizes on 27th September[5].

<u>Figure 1:</u> Cholera cases in Sudan at the onset of the cholera outbreak up to 26th September. Emergency Response Committee, 27th September.



[4] Tool organized around 4 questions: who, what, when and where, that serves to coordinate activities in a timely and effective manner.

[5] See Overview of non-Red Cross actors in country.

To note as the main cause of this outbreak, 16 states across Sudan were affected by heavy rains and flash floods in August. The water levels of River Nile increased significantly, impacting the states along the river path, especially Khartoum state, resulting in the destruction of 41,514 homes, damaging another 27,242, and displacing approximately 350,000 people. The main affected states are While Nile, Kassala, Khartoum, Gazeera, and North Kordofan. Furthermore, 51 areas in the states of Gazeera, Sennar and White Nile were surrounded with water and became inaccessible.

The floods destroyed around 11,000 latrines resulting in contamination of drinking water sources. In the same way, the increased turbidity of water has rendered standard chlorination measures and procedures ineffective, exposing the population to high risk of waterborne diseases. In addition to that, stagnant water offers a breeding ground for mosquitoes, increasing the incident rate of Malaria cases and posing a risk for vector borne diseases. Concentrations of mosquito larva has reached its highest in While Nile, Khartoum, North and Southern Kordofan states.

The Sudanese Red Crescent Society (SRCS) and the FMoH are working together to strengthen disease surveillance, provide medical treatment for patients, distribute laboratory supplies, monitor water quality and chlorinate public water supplies, as well as promote health education and hygiene among affected and at-risk communities[6]. Two Cholera Treatment Centres (CTC) are serving patients in the Blue Nile state, and two dedicated Isolation centres have been established for cholera case management in the Blue Nile State.

The response efforts conducted by Government authorities, United Nations (UN) agencies, International Non-Governmental Organizations (INGOs), NGOs and other stakeholders present gaps, resulting in lack of assistance to people in need. Specifically, in the White Nile, Sennar, Khartoum and Gedaref states an estimated 36,000 people are still in need of WASH assistance. In the White Nile, Sennar and Gazeera states around 107,000 people are in need of health assistance. In the White Nile, Khartoum, Sennar and Kassala states an estimated 45,000 people are lacking Emergency Shelters and basic Household (HH) items . There has in general been limited education assistance provided. Moreover, as more and more areas become accessible as the water dries up, the number of affected people in need of assistance increases.

Table 1: Epidemiological situation of cholera from 29th August to 9th September 2019

State	Date	Total of Cases	Death
Blue Nile	**29th August – 9th September**	**41**	**2**
Blue Nile and Sennar	**18th September**	**124**	**7**
	22nd September	**158**	**7**
	25th September	**187**	**8**

Summary of the current response

At the onset of cholera cases detection, the FMoH activated a Cholera Task Force in Khartoum composed by WHO, INGOs, NGOs, UN agencies and the SRCS. Similar coordination systems were established at State level in localities affected or at risk of cholera outbreaks.

In response to cholera, the FMoH had as primary actions:

- issued an alert on September 8th to all affected or at-risk localities and advised all health care workers to step up surveillance of watery diarrheal disease in health facilities;
- conducted a rapid assessment in States affected or at risk of cholera outbreaks;
- set up two isolation centres in the Blue Nile State in El Roseires and Dmazin and planned for an additional one in the same State in Al Kurmuk;

[6] In terms of turbidity for chlorination of public water supply: drinking water sources are local solutions to water supply such as shallow wells, whereas public water supplies are more developed and thus do not suffer the turbidity problem.

- deployed a team of disease control experts to the Blue Nile State to provide technical assistance in conducting comprehensive outbreak investigation and response;
- deployed a team of medical personnel (medical doctors, nurses, clinical officers, public health officers and lab technicians) to provide clinical care for case management at the CTC set up in Al Kurmuk.

WHO, UNFPA and UNICEF, together with the SRCS have been involved from the onset of the cholera outbreak in the Blue Nile State in the response, as well as in the mitigation of malaria, dysentery and typhoid fever though the implementation of Health and WASH activities under the supervision of the FMoH.

Overview of Host National Society

The SRCS response and early actions has included:

- The provision of 10 volunteers trained by WHO and the FMoH working in shift in the two isolations centres;
- The mobilization of 300 Health and WASH technical volunteers experienced in Advocacy, Communication and Social Mobilization (ACSM) in the Blue Nile State for the realization of:
    a. case finding and referral;
    b. health promotion including dissemination of information on Acute Water Diarrhea (AWD) at Households (HH) and community level using Information, Education and Communication materials (IEC) developed by the FMoH
    c. spraying and water chlorination[7].

As outlined in the “Description of the disaster” section, the cholera was caused by heavy rains and flash floods stared in August. Due to the recurrences of such events, for which a DREF was launched in 2018 (MDRSD026, Sudan Floods) below an overview of actions in response to lessons learnt of the above mentioned DREF, which have been taken into consideration in the design of the current operation.

Challenges / Findings DREF MDRSD026	Lesson learnt DREF MDRD026	Actions current DREF
Over the last three (3) years, these two (2) areas (Elnohoud and Kassala) have been affected by seasonal floods due to high rains.	Further Vulnerability and Capacity Assessment (VCA) is recommended for a better future planning.	The participation in Coordination meetings will be ensured both at National and State levels to coordinate actions with other stakeholders and to triangulate information. The realization of 1 beneficiary selection assessment/State at the beginning of the operation will ensure a clear identification of beneficiaries on the base of agreed criteria. 2 subsequent reviews to be conducted in each State of intervention will allow to keep updated beneficiaries lists.
The procurement process took more time than expected due to changes in the procurement of DREF items from international procurement to local procurement. The DREF operation agreement between the SRCS and the IFRC was changed twice to accommodate local procurement.	The SRCS will in the future, go for international procurement through the IFRC logistic to facilitate the DREF operation management, implementation and smooth reporting	On the base of the items to be procured in the current operation (water chemicals, Oral Rehydration points elements and sanitary toolkits) the Regional Logistic Office advised on a local procurement due to: • typology of items to be procured; • availability of items to be procured in the local market;

[7] Activity not included in the DREF, but already implemented by SRCS among first actions following the outbreak. An analysis on its effectiveness will be outlined in the Operation Update.

		• number of items to be procured. However, as part of these items are medical ones, specific thresholds will be defined between IFRC and SRCS to guarantee fully adherence of IFRC standard procurement procedures.
The IFRC RDRT Logistics, deployed to Sudan to support the procurement processes, faced issues with visa application which was much more time consuming than expected. This delay affected the procurement, thus implementation.		To guarantee a timely implementation of the action, the EACCTS is in the process of appointing one of its members as Head of Mission ad interim in Sudan. This is in line with a decision paper issued in July. This person will be in charge of the supervision of the DREF. A visit of the EA Head of Cluster was conducted in September. A request of multiple entry visa was made by the Head of Cluster. A single-entry visa was requested by the DM Delegate in charge of Sudan operations.
One of the challenges facing SRCS during their WASH operations was living up to the expectations from the local communities.	As a result of the limits of the DREF funding, the SRCS was not able to assist everyone with provision of potable water.	Community Engagement and Accountability mechanisms will be put in place to ensure clear communication between beneficiaries and the SRCS.
The increased number of volunteers, which increased the volunteer costs. Moreover, SRCS was faced with issues of unclear guidelines on volunteer expenses related to the cover of transportation, food, allowances, and communication which fostered some frustrations	The SRCS, and more specifically the Volunteer Management Department, will work on improving volunteer management	The number of volunteers was kept on a manageable number (30 people/State). An induction will be realized for all volunteers involved in the actions at branch level in each State on intervention to clarify elements of volunteers' collaboration.
There were no lessons learned workshop conducted as initially planned for, as the political situation in Sudan affected the possibility to conduct the workshop	Despite not being able to conduct a lessons learned workshop following the operation, lessons learned came out of this response. SRCS acknowledges the need for a closer coordination with local authorities, and closer coordination on a national and regional level with other stakeholders. Moreover, SRCS will continue the engagement with humanitarian actors in future operations. Besides coordination and collaboration, SRCS will continue a close monitoring of the security situation for future operations, as the security situation affected this operation especially in the last stages	A lesson learnt workshop will be organized at end of the operation, with the participation of IFRC as well as Movement Partners involved in the response and/or interested in it. A DREF review will be carried out by the IFRC DREF team at the end of the operation.

Overview of Red Cross Red Crescent Movement in country

The SRCS is in constant contact with the IFRC Eastern Africa Country Cluster Support Team (EACCST) for monitoring the situation in country and for receiving technical support whereas needed. Moreover, the SRCS collaborates with the following in-country Movement Partners: ICRC, Danish RC, German RC, Netherlands RC, Spanish RC, Swedish RC, Saudi Arabia RC, Swiss RC and Qatar RC.

Below a Movement Partners 4W matrix dated April 2019:

	Sector of intervention	Region of intervention	Donor	Implementation period
Danish RC	Climate Change Adaption	River Nile (Shendy locality)	EU through Netherland RC lead consortium	June 2017 – May 2021
	PS & Protection / Refugee (ECHO)	White Nile	DG ECHO	April 2019 – Sep 2020
	PS & Protection / Migration	Kassala	DFID	April 2018 – Mar 2021
	PS & Protection / Migration	Kassala	British Red Cross	Jan 2019 – Dec 2019
	PS & Protection / Refugees/FbF / Floods (Emergency run costs)	White Nile	Danish MoFA	Jan 2018 – Dec 2021
	PS & Protection / Migration	Northern State, River Nile, Red Sea	Danish MoFA	Jan 2018 – Dec 2021
	PS & Protection / Migration (EUTFA)	Northern, River Nile, Red Sea, Khartoum (possibly Darfur)	EU TF	April 2018 – March 2021 (Awaiting Contract)
Swedish RC	Integrated Health, Wash, Livelihoods and protections Project Sectors: Health , WASH, livelihoods and Protection	West Kordofan State	SIDA	Jan - Dec 2019
	PS & Protection / Refugee	White Nile	ECHO Danish RC (Lead)	April 2019 – Sep 2020
	DRR-CCA Sector: DRR and Climate Change adaptation	Northern State, River Nile and NKordofan	Swedish RC	June 2017 – Dec 2021
	Climate Change Adaption	Northern State (Algolid locality)	EU through Netherland RC lead consortium	June 2017 – May 2021
	Civil unrest emergency response, Sector: DRR	12 states	Swedish RC	April – July 2019
Netherland RC	3FM Pneumonia (HEALTH) Project - Reduction of mortality and morbidity rates of Acute Respiratory Infections (ARI) among u-5	Kassala State (Hamashkoreib, North Delta, Telkok, Rural Aroma Localities).	3 FM (Public Funds)	Jan 2017-Dec 2020

	Emergency support of 4 Primary Health Care Facilities in West Darfur State	West Darfur (Sirba, & Habila and Al Geneina Localities)	NPL (National Postcode Lottery)	Nov 2018 –Oct 2019
	Enhancing Communities Resilience to Climate Change in Sudan – Netherland RC Coordinator of the action	Kassala (Telkouk locality),	EU through Netherland RC lead consortium	June 2017 – May 2021
Spanish RC	Enhancing Communities Resilience to Climate Change in Sudan – Spanish RC technical support on assessment, training and livelihood.	River Nile, Kassala, Northern State	EU through Netherland RC lead consortium	June 2017 – May 2021
Swiss RC *last update Oct. 2018*	School Health Sennar (Health & WASH)	Sennar State (Dindir and Suki localities)		September 2017 – December 2020
German RC	WASH for IDPs	N-Darfur/Al Fasher	German MoFA	June 2017 – Dec. 2019 (3 months NCE considered)
	Food Security & Livelihood for refugees in closed camps and host communities	Gedaref/ Um Gulja and Um Rakuba	German Gov.: BMZ	Nov. 2017 – Dec. 2020
	School rehabilitation in 7 settlements	N-Darfur / Al Fasher	German RC own	2018 – Aug 2020
	Sanitation in schools	Kassala / Girba	Corporate: Sebapharma	2017 – June 2019
	Food Security & Livelihood for refugees and host communities	Kassala/Girba	German Gov.: BMZ	Nov 2018 – Dec. 2020
Qatar RC	Floods	Khartoum, White Nile & Red Sea	N/A	August-September 2019
Saudi RC	Floods	White Nile, Sinnar, Khartoum & Elgazira	N/A	August-September 2019
ICRC[8]	Cholera outbreak	Blue Nile	N/A	September 2019

In addition to the information in the table, below a specific overview of bilateral support provided by Movement Partner to the various ongoing emergencies in Sudan:

Danish RC: Coverage of running costs in White Nile State for the floods disaster in the framework of the ongoing programme on Protection and Forecast-based Financing (FbF);

Qatar RC: Implementation of activities in Khartoum, White Nile and Red Sea States in response to floods disaster in cooperation with the Government of Sudan including distribution though the SRCS of 733 tarpaulin, 733 blankets, 1466 plastic sheet and 1466 mosquito nets.

Saudi RC: Implementation of activities in White Nile, Sennar, Khartoum and Egazira States in response to floods disaster in cooperation with the Government of Sudan including distribution through the SRCS of 3900 Blankets, 73 tent, 880 food bag and 146 Health kits.

[8] Additional information on ICRC activities beyond DREF will be provided in the Operation Update.

ICRC: Implementation of activities in the Blue Nile State in response to the cholera outbreak including distribution through the SRCS of 200 Plastic Aprons; 400 Disposable overalls, ; 600 Disposable dust protecting masks; 200 Heavy duty rubber gloves; 200 Plastic goggles; 100 litres of Liquid Chorine; 5 Bladders with 750L capacity and contribution for volunteers' incentives (100 volunteers for 14 days).

SRCS will ensure a complementarity of the support provided by Movement Partners, both in terms of equipment and human resources, including volunteers. With regard to the latter, the SRCS will ensure an engagement of volunteers already involved in similar operations conducted by IFRC and/or Movement partners to build up on knowledge already acquired, , along with the involvement of new ones to create wider linkages with community members in the localities of intervention.

Movement Coordination

The SRCS, ICRC and Participating National Societies (PNSs) participate at National level in regular operation meetings, as well in emergency meetings in occasion of disasters. All issues, including SRCS plans drafted to prevent and/or respond to disasters, as well as potential bilateral and multilateral contributions are discussed during these meetings. Information sharing and coordination is also taking place at States level through the established mechanisms which ensure smooth cooperation. Although the IFRC does not currently have presence in country, information is shared regularly, and interactions are constant both with the NS and in-country Movements partners.

Overview of non-RCRC actors in country

The SRCS takes part in coordination meetings (Interagency, Cluster meetings, Emergency Response Committee meetings) organized both at National and Local level. As per the current cholera outbreak, WASH and Cluster meetings are those where Governmental plans and stakeholders' contributions are discussed. This ensures alignment in the response, as well as identification of gaps and no overlaps.

As per the OCHA Sudan Situation Report published on September 18th the following actions have been undertaken by non-RCRC actors to mitigate the cholera outbreak in the Blue Nile and Sinnar States:

- The FMoH and WHO are working together to strengthen disease surveillance, provide medical treatment for patients, distribute laboratory supplies, monitor water quality and chlorinate public water supplies, and promote health education and hygiene among affected as well as at-risk communities. Two cholera treatment centres are serving patients in Blue Nile, and a dedicated isolation centre has been established for cholera case management;

- The FMoH, WHO and UNICEF have already provided acute watery diarrhoea (AWD) kits—enough to treat 300 people—with three additional kits in the pipeline. In addition, IV fluids (Ringer lactate) and oral rehydration therapy supplies have already been provided for treatment of the patients. UNICEF is supporting eight Oral rehydration therapy points (ORP), to ensure the timely access of affected people to lifesaving rehydration at the community level.

- The State Ministry of Health (SMoH) in Blue Nile in partnership with UNICEF is supporting water chlorination activities and hygiene awareness in AWD-affected areas of Blue Nile at household levels. Additional rapid response activities include house-to-house visits by nearly 700 community mobilisers, providing families with information about how to protect themselves by cleaning and storing drinking water safely, good hygiene and hand washing practices, keeping food safe, and on how to handle a sick family member.

- Water chlorination activities are underway at eight water sources connected to the urban water network in both Ed Damazine and El Roseries towns (Blue Nile state). In addition, several open water sources have been chlorinated through volunteers who are working actively at the intake area and other open sources. The volunteers managed to chlorinate 1,340 donkey carts and 5,200 jerrycans at water sources[9]. New water sources have been installed to provide better water service to people in affected areas, with over 146,000 people now having improved access to safe water and sanitation in Blue Nile alone. To monitor and contain the outbreak, WHO has surged a team of public health experts to Blue Nile State; other international experts will soon follow.

[9] Chlorination of donkey cart: it is a way of getting water in urban setting where the water networking is not reaching people.

- Efforts to implement a communication strategy at the national level and in Blue Nile to empower the community are being ramped up. The health promotion department in SMoH and humanitarian partners are carrying out advocacy campaigns to raise awareness and promote prevention activities. UNICEF's Communication for Development C4D Section is training 1,400 volunteers in seven States. The training is focusing on the integrated strategy for water related diseases and long-term impact on behavioural change.

- In Blue Nile, UNICEF realized four mobile cinema shows reaching 370 people were staged, five theatre shows reaching 1,420 people and 16 health awareness messages were broadcast through radio. The total number of beneficiaries from radio messages represent 75 per cent of the State population (873,750). In addition, 22 public sessions were conducted reaching 465 people and informational materials were distributed to 51,135 people.

It is worth mentioning that although the same situation report highlights that according to the FMoH the States at highest risks of cholera outbreak are the White Nile, Gedaref, Sennar, Kassala and Khartoum, no information is available on preparedness measures implemented in these States. OCHA Situation reports, published on a regular base, provide in fact information only on response activities in Blue Nile and Sennar States, which are those affected by the outbreak.

In addition to the information provided by OCHA, below a specific overview of actors involved in chlorination activities as per Emergency Response Committee presentation dated 26th September:

Actors involved in chlorination activities in the Blue Nile state

Locality	Urban network system	Outside network	Comment
Damazin	SWC/UNICEF	SMOH/UNICEF	Ongoing
Roseires	SWC/UNICEF	SMOH/WHO	Ongoing
Wad Almahi	SWC/UNICEF	CORD/PA	In process
Al Tadamon	SWC/UNICEF	SMOH/UNICEF	In process
Bau	-	SRC/UNICEF	In process
Geissan	SWC/UNICEF	SRC/UNICEF	Ongoing
Kurmuk	-	Pan Care/W.V.I +Military	Ongoing

Actors involved in chlorination activities in the Sennar State.

Locality	urban network system	Outside network	Comment
Sinnar	SMOH & WES& UNICEF & WHO	SMOH & WES& UNICEF & WHO	WQ , chlorination

Singa	**SMOH & WES& UNICEF & WHO**	**SMOH & WES& UNICEF & WHO**	**WQ , chlorination**
Elsoki	**SMOH & WES& UNICEF & WHO**	**SMOH & WES& UNICEF & WHO**	**WQ , chlorination**
Eldindr	**SMOH & WES& UNICEF & WHO**	**SMOH & WES& UNICEF & WHO**	**WQ , chlorination**
Abuhggar	**SMOH & WES& UNICEF & WHO**	**SMOH & WES& UNICEF & WHO**	**WQ , chlorination**
East Sinnar	**SMOH & WES& UNICEF & WHO**	**SMOH & WES& UNICEF & WHO**	**WQ , chlorination**
Edali and Mazmom	**SMOH & WES& UNICEF & WHO**	**SMOH & WES& UNICEF & WHO**	**WQ , chlorination**

Needs analysis, beneficiary selection, risk assessment and scenario planning

Daily updates summaries provided by FMoH, SMoH and in WHO highlight the extent and trends in the outbreaks. Health Cluster Coordination meetings at National and States levels helped to outline gaps that required partners' attention for coordinating response and preparedness actions. These gaps are similar across all States, including those already affected by the cholera outbreaks and those at risk. Key among these gaps identified at the last Health Cluster meeting organized on September 18th are:

- Inadequate access to life-saving equipment and services in most communities, with the winding up of the Essential Package of Health Services (EPHS) which would prevent immediate response in case of an outbreak;
- Inadequate surveillance in place for early warning information to assist investigations and responses;
- Need to scale up WASH interventions to increase community access to safe water;
- Insufficient capacity of health staff in case management;
- Inadequate funding and logistics/supplies for rapid response to outbreaks;
- Inadequate coordination between the Health cluster and the FMoH.

The DREF operation will contribute to address some of these gaps, responding directly to the cholera outbreaks in the **Blue Nile** and **Sinnar States** and in implementing preventing measures to minimize the outbreak and risks in new cases in States considered at risk: **White Nile, Gedaref, Kassala and Khartoum**. The intervention will target 144,000 people, approximately 24,000 HH. To date the outbreak has been in pockets, however, the risk appears to be higher in communities characterized by a high concentration of people. Shared amenities and services generally in unsanitary conditions, coupled with inadequate use of unsafe water, increase the risk of infection.

Risk Assessment

As per the Sudanese Meteorological Authority the southern parts of Sudan, will continue to be subject to high levels of rain and rise in the River Nile water levels until the end of October. This will lead to a deterioration of the situation for people already affected by recent floods. In particular, there is a risk of further damages of infrastructures, including latrines and water points. This situation might lead to new outbreaks of cholera or other waterborne diseases, as well as vector borne diseases linked to contaminated and stagnated water.

Moreover, the floods disaster, coupled with an escalation of the cholera outbreaks, might result in displacement of affected communities adding on to the existing large number of refugees and displaced persons in Sudan. The likely rise in population density in less-affected areas and temporary housing facilities, especially in larger villages and towns, may result in further contamination of water sources and an increase in vector borne diseases such as malaria.

The political and socio-economic situations in Sudan remain volatile, making the country, population and RCRC personnel vulnerable to security risks. To reduce the risk of RCRC personnel falling victim to crime or violence, active risk mitigation measures should be adopted. This includes situation monitoring and implementation of minimum-security standards. All RCRC personnel actively involved in the operations should have completed the respective IFRC security e-learning courses (i.e. Stay Safe Personal Security, Security Management, or Volunteer Security). Road travel also presents a considerable risk, which ought to be addressed appropriately. Contingency plans should be in place to manage security and safety related emergencies sufficiently.

Furthermore, a visit conducted by the EA Head of Cluster in Sudan in September had among other objectives the one to engage with ICRC on context analysis, scenario planning and security. On the latest ICRC delegation in Khartoum, has offered to IFRC all support need for its re-engagement in Sudan, including the use of any logistical means and for security operettas.

Considering the complexity of the contest and situation, and the fact that the IFRC does not have yet a permanent presence in country, a close coordination with the ICRC will be created and maintained for the conduction of risk assessments and adoption of security measures.

Scenario Planning

Best case scenario	Most likely scenario	Worst case scenario
The cholera outbreak is contained with no further spreads being reported in new States. This will be based on the FMoH, WHO, UN agencies and SRCS actions including case management, social mobilisation and provision of water purification chemicals and cholera kits. The security situation remains calm and enable access to affected communities	New cases will be reported in States identified as at risk of cholera outbreaks; however, the situation will be contained through the already established CTCs and Isolation Centre in the Blue Nile State and/or new ones, the set-up of Oral Rehydration Points (ORP) as well as scaling up of sanitation and hygiene promotion activities.	The outbreak spreads across the country, affecting more States thus overwhelming the capacity of the Government and humanitarian actors to contain it. The security situation deteriorates, including internal movement of population, impacting the ability of implementation of response efforts.
SRCS Action		
SRCS will continue implementing Health and WASH activities, including identification and referral , awareness raising, water control and water purification through the use of chemicals.	SRCS will start conducting case management, in addition to identification and referral, in States previously considered at risk. This will be done at community level through the management of ORPs and in coordination with the Government.	SRCS revises the response plan to ensure the outbreak is contained, requesting surge support as well.

As per the latest OCHA Situation report dated 26th September, forecasts estimate up to:

- 5,013 cholera cases in the next 6 months in high risk states of Sudan as best-case scenario;
- 13,247 cholera cases in the next six months in high risk States of Sudan as worst-case scenario.

Beneficiary selection

The total number of beneficiaries of this DREF is **144,000 persons (24,000 HH)**, out of 7,407,925 people living in the **Blue Nile, Sennar, White Nile, Gedaref, Kassala and Khartoum States**. As such, this DREF operation will not cover all population and localities of the six above mentioned States, but only those already affected by the cholera outbreak and those considered at risk. The specific localities of intervention in each State, as well as the exact number of beneficiaries per localities of intervention will be defined by the SRCS at the beginning of the operation in coordination of WHO and MoH and on the base of beneficiaries' selection assessments.
In the identification of the localities of intervention, among those affected/at risk, priority will be given to those where the SRCS has already a presence through its Branches and trained volunteers. The selection of beneficiaries within these localities will be realized through an assessment that the SRCS will undertake adopting criteria agreed at Cluster level among partners. This will ensure uniformity of actions between stakeholders.

Beneficiary selection will also include communities that have reported recent outbreaks such as El Roseires, Damazin, Geissan and Wad Elmahi in Blue Nile State and in Abu Hajjar, Sokey and Senja in the Sinnar State. These communities will be supported by enhancing their capacity to obtain and transmit timely outbreak information for the necessary responses.
In the selection of localities and identification of beneficiaries, the SRCS will collaborate the SMoHs and UN agencies, as well any other stakeholders which might join the repose and preparedness efforts. So far, no actor is present in the White Nile, Gedaref, Kassala and Khartoum States.

Table 2: Total number of people living in the 6 targeted States

No.	State	Locality	People
1	Blue Nile	Al Damazin	293,358
		Al Roseires	297,681
		Wad Almahi	102,273
		Gissan	121,388
		Bao	175,495
		Al Kurmuk	152,828
		Al Tadamon	107,115
2	Sennar	Sinnar	510,844
		Sinnar East	399,790
		Al Soki	377,580
		Senja	222,106
		Al Dali Wa Al Mazmom	133,263
		Al Dinder	399,790
		Abo Hajar	177,688
3	White Nile	Rabak	278,040
		Al Jabalain	177,414
		Al Salam	140,787
		Goli	415,593
		Kosti	459,991
		Umm Rimta	118,919
4	Gedaref	Gala`a Al Nahal	93,978
		Elgadref	542,004
5	Kassala	Rafi Kassala	156,000
		Kassala	170,000
6	Khartoum	Jabel Awelia	200,000
		Bahri	1,184,000
		Total	**7,407,925**

B. Operational strategy and plan Overall objective

Overall Operational objective

The overall objective of this DREF operation is to contribute to containing the ongoing cholera outbreak by reducing the case fatality and breaking transmissions routes through the implementation of **Health and WASH** interventions in favour of **24,000 Households** (144,000 people) affected or at risk of communicable diseases in Blue Nile, Sennar, White Nile, Gedaref, Kassala and Khartoum States.

Proposed Strategy

Heavy rains and flash floods started between July and August have been the main cause of the cholera outbreak declared by the FMoH in accordance with the International Health Regulations on 9th September. .

Through this DREF, SRCS aims to contribute to the containment of the current cholera outbreaks in the Blue Nile and Sennar States and its possible spreading in the White Nile, Gedaref, Kassala and Khartoum States though a strategy focused on 2 components, to which are related specific objectives. Activities reflect needs on the ground as well as guidance provided by the FMoH and SMoHs.

30 volunteers/state, for a total of 180 volunteers over the 6 targeted states will be mobilizes 3 days/week for three (3) months to contribute to the action.

Health and Care:
To reduce the case fatality rate of the Cholera outbreak though timely access to Oral Rehydration Therapy (ORT) set up in one of the two established CTC. To reach this objective the following activities will be implemented:

1) Realize **1 beneficiary selection assessment / states** and **2 subsequent reviews** for updating beneficiaries list. Total assessments: 18.

2) Conduct a 4-day **training / refresher training on Cholera case management**, including:
- identification and reporting of cases/suspected cases;
- use and set up of ORPs.

Participants of the training will be: 1 Health Branch Officer/Branch and 10 volunteers/State per 6 targeted States, for a total number of 6 Health Branch Officers and 60 volunteers;

3) Conduct, by the 60 volunteers trained in Cholera case management, **identification and reporting of cases/suspected cases** to health facilities. The SRCS will not create any additional or parallel structure for reporting of cases, but will utilize existing channels, including communication ones. Due to the limited timeframe of the operation, no Community Based System (CBS) will be put in place. Cases / suspected cased identified by volunteers will be reported to Branch Health Officers who will be in contact with SMoH' Health Officers. While conducting sensitization activities, SRCS' volunteers will transfer information to community members on how identify and refer cases.

4) **Procure 18 ORPs kits** (3 ORPs/State);

5) **Set up and manage ORPs** by the 60 volunteers trained on Cholera case management in case of further spreading of the cholera outbreak in States considered at risk;

6) **Duplicate and disseminate IEC materials** (30.000 posters, 8 drawings) which design was developed in collaboration with the FMoH;

7) **Conduct health education sessions and community engagement activities** along with the distribution of IEC materials by the 60 volunteers trained on Cholera case management. In the realization of the activity, the SRCS will pay attention not to organize gatherings in localities characterized by an ongoing outbreak. However, as these areas are those most at risk, door to door visits will be realized to ensure the transfer of information and messages.

As per the latest Health Cluster meeting, on the base of the current situation and on the base of capacities the FMoH identified as under its own responsibility the safe referral of cases/suspected cases to health facility and the treatment at community level of cases / suspected cases. This left to the SRCS the responsibility of creating

awareness at community level, including the identification and reporting of cases / suspected cases directly by community-based volunteers and/or by community members through established reporting mechanisms.

Nevertheless, as defined in the Scenario planning/Most likely scenario in case of a spreading of the outbreak in states considered at risk, the SRCS should be able to provide first level of treatment of cholera, improving access to Oral Rehydration Solutions (ORS) at community level through the set up and management of ORPs. The activity will be coordinated with the MoH and implemented upon a specific request of support firm the same institution.

The 60 volunteers involved in the three (3) main Health activities (i) Identification and reporting of cases; ii) set-up and manage ORPs and iii) conduct health education sessions and community engagement activities) will be organized on a rotational base, so as each volunteer could contribute to the success of the entire action and could maintain a good level of knowledge on the different actions. The volunteers will be mobilized 3 days/week for 3 months.

On 19th September, the FMhoH in Sudan requested the Oral Cholera Vaccine (OCV) from the International Coordinating Group. At the moment there is no involvement of the SRCS in the discussions, However, the SRCS is committed to provide support whereas requested by the FMoH.[10]

WASH
To break transmission routes and contain the outbreak trough provision of safe water though chlorination of at sources monitored by volunteers, distribution of chemicals at HH level and conduction of hygiene and sanitation awareness sessions and campaigns. To reach this objective the following activities will be implemented:

1) Participate in **coordination meetings** on AWD/Cholera with relevant departments within SRCS, FMoH and Inter-Agency teams both at National and State levels (1 meeting/week * 3 months * 6 states)

2) Conduct a 2-day **training / refresher training on Sanitation, Hygiene and Safe water promotion** (ex. Food safety and F diagram) targeting epidemiologically hotspot. Participants of the training will be: 1 Health Branch Officer/Branch and 10 volunteers/State per 6 targeted States, for a total number of 6 Health Branch Officers and 60 volunteers);

3) **Conduct hygiene and safe water promotion sessions** through community meetings and door-to-door visits by the 60 volunteers trained on sanitation hygiene and safe water promotion. In the realization of the activity, the SRCS will pay attention not to organize gatherings in localities characterized by an ongoing outbreak. However, as these areas are those most at risk, door to door visits will be realized to ensure the transfer of information and messages. Hygiene and safe water promotion sessions conducted at HH level will be as well the occasion for volunteers to monitor treatment and storage of water, as well as performing water tests.

4) **Train population** of targeted communities **on safe water storage and on safe use of water treatment products.**

5) **Monitor treatment and storage of water through** household surveys and household water quality tests.

6) **Conduct sanitation campaigns** as a measure to prevent outbreaks. The activity will be conducted by the 60 volunteers trained on sanitation, hygiene and safe water promotion, together with community members. In the realization of the activity, the SRCS will pay attention not to organize gatherings in localities characterized by an ongoing outbreak, but to focus in those particularly at risk as preventive measure.

7) **Procure 50 sanitation toolkits/State**, for a total of 300 sanitation toolkits, including wheelbarrows, spades, rakes, pickaxes, heavy duty gloves, face masks to conduct sanitation campaigns.

8) Conduct a 1-day training / refresher training on **Chlorination of water supply, pool testing and Infection Prevention and Control (IPC)**. Participants of the training will be: 1 Health Branch Officer/Branch and 10 volunteers/State per 6 targeted States, for a total number of 6 Health Branch Officers and 60 volunteers);

[10] As per OCHA report, 26th September: On 19 September, the Federal Ministry of Health in Sudan requested the Oral Cholera Vaccine (OCV) from the International Coordinating Group, which manages the global stockpile of oral cholera vaccines, for a vaccination campaign targeting 1.6 million people in high risk communities in Blue Nile and Sennar states. The aim of the campaign is to contain the outbreak and prevent its spread to neighbouring states.

9) **Procure pool testing and conduct pool testing at water points and at HH level** by the 60 volunteers trained on Chlorination of water supply, Pool testing and IPC. The frequency of the activity will be defined by the outbreak and with guidance form epidemiologists.

10) Procure **600 litres of liquid chlorine** to be used at water points level;

11) Procure **60,000 Aqua tabs** to be distributed at HH level on the base of assessments[11];

12) Procure **70 pairs of rubber gloves and masks** to be used by Health branch officers and volunteers involved in chlorination activities.

The 120 volunteers involved in the WASH activities will be divided between:
- 60 volunteers (10 volunteers/state) engaged in sanitation, hygiene and water promotion activities;
- 60 volunteers (10 volunteers/state) engaged in chlorination activities.

The volunteers will be mobilized 3 days/week for 3 months.

This DREF operation will support the replenishment of stock which can be distributed directly from the SRCS warehouses as well as procurement of budgeted items not available in the current stock.

The SRCS visibility is maintained through procurement of operational items and visibility materials (branded jacket) to be used by volunteers. Continued assessments and monitoring are also integrated in the operation to ensure that it is in line with the evolving situation on the ground. In particular 3 days mission/month will be conducted by SRCS Head Quarter (HQ) staff involved in the operation, in addition to 5 days mission/month conducted by the Branch Health Officers to provide technical support to volunteers.

Two monitoring missions will be conducted by the EACCTS to provide support in the realization of the action, ensuring timely implementation of activities.

A lesson learnt workshop will be conducted to review the implementation and a report will be produced for learning and improving future operations.

A DREF review for this operation will be conducted with a focus on understanding triggers in the context, timeliness and implementation capacity of the SRCS.

Support Services

Human Resources

The DREF request will cover a period of three (3) months and will require the mobilization of the below human resources:
- One Operations Manager with a Public Health background to be seconded to ensure effective implementation of activities planned, including monitoring, supervision and reporting. He/she will work in collaboration with the FMoH and the SMoH, as well as with WHO and other stakeholders. He/she will report to the SRCS Health Coordinator based at HQ level;
- 6 Health Branch Officer in charge of technical supervision of volunteers, reporting and collaboration with SMoH and stakeholders at state level;
- 180 volunteers (30/state in the 6 targeted States) involved in Health and WASH activities, mobilized 3 days/week for 3 months and divided as per follow:
- a) 10 volunteers/State for a total of 60 volunteers engaged in Health activities;
- b) 10 volunteers/State for a total of 60 volunteers engaged in sanitation, hygiene and water promotion activities;
- c) 10 volunteers/State for a total of 60 volunteers engaged in chlorination activities.

The SRCS requests for the timely implementation of activities the recruitment of an Operations Manager dedicated 100% to the action.

[11] 2/3 Aqua tab per HH. However, the number of HH to reach is not specified because it depends on the situation. It is possible that a lower number of HH will receive a higher number of aqua tabs and vice versa.

With regards to volunteers, as the number of beneficiaries per State will be computed following the initial beneficiary assessment exercise, it is possible that in areas more at risk the number of volunteers increase. However, SRCS will maintain as much as possible the defined numbers, in order to guarantee adequate coverage in all target States,

Logistics and supply chain
Logistic responsibilities will include sourcing the relevant relief items as per DREF document, delivered and distributed to beneficiaries selected, in a timely, transparent and cost-efficient manner. For the initial response, available prepositioned SRCS stocks will be utilized and replenished through the DREF. Technical support will be provided through the IFRC Regional Logistic Unit in Nairobi.

Procurement
All items to be procured with this DREF (liquid chlorine, chlorine tabs, ORPs content kits and sanitary toolkits) will be procured locally as available in the local market. However, as part of these items are medical ones, specific thresholds will be defined between IFRC and SRCS to guarantee fully adherence of IFRC standard procurement procedures.

Warehousing
Each of the targeted Branches has a secured warehouse that will be used for the storage and distribution of all supplies procured. Inventory will be taken of all procured items and existing stores procedures will be followed in the management of the stores.

Transport and fleet needs
Bulk distribution of the supplies procured will be made with SRCS vehicles. Dedicated funds for the transportation of the ORT procured from Port Sudan to Khartoum and then to the field will be allocated in the budget.

Communications
Branch level Information Communication and Technology (ICT) equipment will be used within the DREF operation. The Branch communication units will be supported by the SRCS HQ. Communications Unit to package messages to communicate about progresses in the operation and on the general situation. This will include raising-awareness on activities implemented, as well as on the preparation of case studies/photographs for use on the IFRC websites, and social media platforms.

Publications will be shared both locally and internationally on different platforms including *Facebook* and *Twitter*. Information will be continuously shared with the IFRC EACCST for further dissemination with partners and donors.

Communications funds budgeted will be used as well by field staff for the reporting of cases/suspected cases according to the established communication channels.

Security
SRCS will work closely and coordinate with Humanitarian Aid Commission (HAC), local authorities, and other partners to ensure access of the intervention areas by the SRCS volunteers and staff. The SRCS staff and volunteers will strictly follow SRCS security guidelines. The Security focal point for SRCS will make sure to participate in Security forum and/or be part in other communication channels to triangulate information.
All volunteers mobilized will be insured as per the IFRC Global Insurance policy.
Due to the typology of the intervention, protective equipment (gloves and face masks) will be procured only for volunteers involved in chlorination activities. Identification jacket will be procured for all volunteers to ensure their visibility in the field. The distinctive emblem will ensure in the same time their identification and protection. Due to the rainy season, gumboots and rain jacket will be procured for all volunteers to facilitate their work in the field.

Planning, monitoring, evaluation, & reporting (PMER)
IFRC EACCST will provide SRCS with necessary PMER support, especially with regards to monitoring and reporting of this DREF operation. Regular field visits by SRCS teams will ensure daily/weekly supervision of activities, respect of international humanitarian standards and correct management of resources available. Continuous needs and situation assessments, in collaboration with WHO and other stakeholders, will be carried out during the DREF implementation to inform decision-making.

The Operations Manager will compile daily/weekly reports received by Branch Health Officers and he/she will present them to SRCS Health department staff at HQ involved in the operation for further dissemination. SRCS will be responsible for providing an operational and financial report (2 months after the end of the operation). This way, the IFRC EACCST can consolidate and ensure publishing within 3 months from the end of operation.

At the end of the operation, a lesson learnt workshop will be organized by SRCS with IFRC and other stakeholders, to reflect on implementation. This workshop will allow for informed planning in future operations planned and implemented by SRCS, but also will allow the NS to reflect on its disaster readiness status, given that it is prone to cholera outbreaks.

Community Engagement and Accountability (CEA)
CEA will be mainstreamed throughout the intervention to guarantee maximum and meaningful participation of the affected communities. A feedback and complaint desk will be put in place for ensuring the possibility of community members to provide feedbacks on the activities implemented by SRCS and other stakeholders. SRCS will share these feedbacks in occasion of coordination meetings both and National and State level and will collaborate with stakeholders to properly address them. For the purpose of clarity and for a good flow of information, clear roles and responsibilities will be agreed with representatives, community leaders and committees. The beneficiary selection process will be clearly communicated to all affected.

Protection, Gender and Inclusion (PGI)
Acknowledging that women, girls, men and boys with diverse ages, disabilities and backgrounds have very different needs, risk and coping strategies, the operation will pay particular attention to protection and inclusion of vulnerable groups base and on gender and diversity analysis. Gender roles will be considered when setting up distribution time and dates as well as in health promotion activities

Administration and Finance
A Project Grant Agreement will be signed between the SRCS and IFRC articulating roles and responsibilities of each party in the implementation of this DREF operation. The management of the DREF allocation will be carried out in accordance with the existing IFRC and SRCS procedures.

SRCS administration and finance unit will be closely involved to support the operation. IFRC EACCST will provide support through the realization of one mission to ensure a timely and quality implementation of DREF activities.

C. Detailed Operational Plan

Health

People targeted: 144,000

Male: 70,560

Female: 73,440

Requirements (CHF): 69,119

Needs analysis: Through this DREF, the SRCS aims at contributing to address gaps identified by the Health Cluster and in particular the: i) Inadequate access to life-saving equipment and services in most communities; ii) Inadequate surveillance in place for early warning information to assist investigations and responses.

Population to be assisted: 144,000 people across the 6 states targeted will be benefit from identification and reporting by SRCS' volunteers of cases/suspected cases through established referral mechanisms. Moreover, the procurement or 18 ORPs will allow immediate response in case of an outbreak.

Programme standards/benchmarks: The activities implemented under this section will seek to meet Sphere standards or WHO standards.

P&B Output Code	**Health Outcome 1: The immediate risks to the health of affected populations are reduced**							***# of people reached weekly/State by health education sessions and community engagement activities though the distribution of IEC materials. Target: 2,000***					
	Health Output 1.1: The health situation and immediate risks are assessed using agreed guidelines							***# of SRCS staff and volunteers trained on Cholera case management. Target: 66 people***					
	Activities planned Week	1	2	3	4	5	6	7	8	9	10	11	12
	Realize beneficiary selection assessment and review												
AP21	Conduct a 4-day training / refresher training on Cholera case management, including: i) identification and reporting of cases/suspected cases and ii) use and set up of ORPs. Participants of the training will be: 1 Health Branch Officer/Branch and 10 volunteers/State per 6 targeted States, for a total number of 6 Health Branch Officers and 60 volunteers.												
P&B Output Code	**Health Output 1.3: Community-based disease prevention and health promotion is provided to the target population**							***# of HH visited/State and sensitized on health through education sessions. Target: 334***					
	Activities planned Week	1	2	3	4	5	6	7	8	9	10	11	12
AP011	Conduct, by the 60 volunteers trained in Cholera case management, identification and reporting of cases/suspected cases to health facilities.												

P&B Output Code	Activities planned Week	1	2	3	4	5	6	7	8	9	10	11	12
AP011	Duplicate and disseminate IEC materials (30.000 posters, 8 drawings) which design was developed in collaboration with the FMoH												
AP011	Conduct health education sessions and community engagement activities along with the distribution of IEC materials by the 60 volunteers trained on Cholera case management[12].												
P&B Output Code	**Health Output 1.4: Epidemic prevention and control measures carried out.**							***- # of ORP kits procured. Target: 18 - # of people benefitting from ORP: 1,800 (1 OPR * 100 people)***					
	Activities planned Week	1	2	3	4	5	6	7	8	9	10	11	12
AP021	Procure 18 ORP kits (3 ORP/State)												
AP021	Set up and manage ORPs by the 60 volunteers trained on Cholera case management in case of further spreading of the cholera outbreak in States considered at risk[13]												

Water, sanitation and hygiene

People targeted: 144,000
Male: 70,560
Female: 73,440
Requirements (CHF): 128,056

Needs analysis:. Through this DREF, the SRCS aims at contributing to address gaps identified by the Health Cluster and in particular the need to scale up WASH interventions to increase community access to safe water.

Population to be assisted: 144,000 people will be sensitized on sanitation, hygiene and safe water, including water chain safety, food safety, F-diagram in occasion of door to door visits, as well as community awareness campaign conducted in marketplaces, churches, schools, distributions points and water collection points, where pool testing will be conducted by volunteers. Chemicals to be used at HH and water collection points levels will be used and distributed on the base of pool testing.

Programme standards/benchmarks: The activities implemented under this section will seek to meet Sphere standards.

[12] List of topics for sensitization session to be defined taking into consideration the situation on the ground, which might differ from one State to another.
[13] As per Risk Analysis, OPRs will be set up only in case of a worsening of the situation. Included in the DREF as contingency measure.

P&B Output Code	WASH Outcome1: Immediate reduction in risk of waterborne and water related diseases in targeted communities						*% of reduction of cholera cases in the target areas. Target: 0 case*					
	WASH Output 1.1: Continuous assessment of water, sanitation, and hygiene situation is carried out in targeted communities						***# of SRCS staff and volunteers trained on Sanitation, Hygiene and Safe water promotion. Target: 66 people***					
	Activities planned Week	1	2	3	4	5	6	7	8	9	10	11	12
AP026	Coordinate with other WatSan actors on target group needs and appropriate response.												
AP026	Conduct a 2-day training / refresher training on Sanitation, Hygiene and Safe water promotion (ex. Food safety and F diagram) targeting epidemiologically hotspot. Participants of the training will be: 1 Health Branch Officer/Branch and 10 volunteers/State per 6 targeted States, for a total number of 6 Health Branch Officers and 60 volunteers)												
P&B Output Code	**WASH Output 1.2: Daily access to safe water which meets Sphere and WHO standards in terms of quantity and quality is provided to target population**						***- # of volunteers mobilized to conduct chlorination activity. Target: 60 people. - # of water purified with 600 litres of liquid chlorine at water points. Target: 60.000 litres - # of chlorine tabs distributed at HH level. Target: 60.000***					
	Activities planned Week	1	2	3	4	5	6	7	8	9	10	11	12
AP026	Conduct a 1-day training / refresher training on Chlorination of water supply, pool testing and Infection Prevention and Control (IPC). Participants of the training will be: 1 Health Branch Officer/Branch and 10 volunteers/State per 6 targeted States, for a total number of 6 Health Branch Officers and 60 volunteers);												
AP026	Conduct pool testing at water points and at HH level by the 60 volunteers trained on Chlorination of water supply, Pool testing and IPC.												
AP026	Train population of targeted communities on safe water storage and on safe use of water treatment products												
AP026	Monitor treatment and storage of water through household surveys and household water quality tests.												
AP026	Procure pool testers												
AP026	Procure 600 liters of liquid chlorine to be used at water points level;												

AP026	Utilize 600 liters of liquid chlorine at water points level (1ml chlorine * 1000 liters water)												
AP026	Procure 60,000 Aqua tabs to be distributed at HH level on the base of assessments												
AP026	Distribute 60,000 Aqua tabs at HH level on the base of assessments												
AP026	Procure 70 rubber gloves and masks to be used by Health branch officers and volunteers involved in chlorination activities												

P&B Output Code	**WASH Output 1.4: Hygiene promotion activities which meet Sphere standards in terms of the identification and use of hygiene items provided to target population**												- *# of people reached weekly/State by hygiene and safe water promotion sessions. Target: 2,000* - *# of volunteers mobilized to conduct hygiene and safe water promotion sessions. Target: 60 people.* - *# of sanitation campaigns conducted. Target: 36* - *# of people reached by sanitation campaigns. Target: 6,000*
	Activities planned Week	1	2	3	4	5	6	7	8	9	10	11	12
AP030	Conduct hygiene and safe water promotion sessions through community meetings and door-to-door visits by the 60 volunteers trained on sanitation hygiene and safe water promotion												
AP30	Conduct sanitation campaigns as a measure to prevent outbreaks. The activity will be conducted by the 60 volunteers trained on sanitation, hygiene and safe water promotion, together with community members.												
AP30	Procure 50 sanitation toolkits/State, for a total of 300 sanitation toolkits, including wheelbarrows, spades, rakes, pickaxes, heavy duty gloves, face masks to conduct sanitation campaigns												

Strategies for Implementation

Requirements (CHF): 59,230

P&B Output Code	**S1.1: National Society capacity building and organizational development objectives are facilitated to ensure that National Societies have the necessary legal, ethical and financial foundations, systems and structures, competences and capacities to plan and perform** **Output S1.1.4: National Societies have effective and motivated volunteers who are protected**												*# of volunteers ensured: Target: 180*
	Activities planned Week	1	2	3	4	5	6	7	8	9	10	11	12

AP040	Ensure that volunteers are insured												
AP040	Provide complete briefings on volunteers' roles and the risks they face												
AP040	Ensure volunteers are aware of their rights and responsibilities												
AP040	Ensure volunteers' safety and wellbeing												
AP040	Ensure volunteers are properly trained												
P&B Output Code	**Outcome S3.1: The IFRC secretariat, together with National Societies uses their unique position to influence decisions at local, national and international levels that affect the most vulnerable.**	- ***# of IFRC monitoring missions conducted. Target: 2*** - ***# of lessons learnt workshops conducted. Target: 1*** - ***# of feedback mechanism established: Target 2***											
	Output S3.1.2: IFRC produces high-quality research and evaluation that informs advocacy, resource mobilization and programming.												
	Activities planned Week	1	2	3	4	5	6	7	8	9	10	11	12
AP084	Establish feedback mechanism												
AP055	Conduct monitoring mission from IFRC												
AP055	Conduct lessons learnt workshop												
AP055	Conduct DREF review												

D. Budget

The overall budget for this DREF operation is CHF 256,404 as detailed in attached budget.

DREF OPERATION

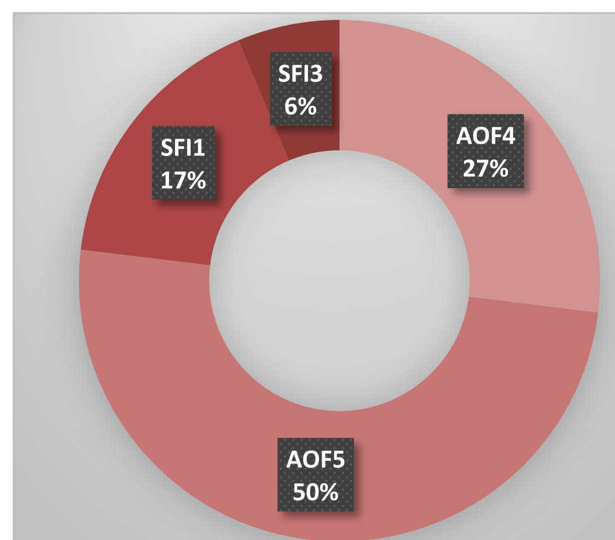
MDRSD027 - SUDAN - CHOLERA OUTBREAK 30/09/2019

Budget by Resource

Budget Group	Budget
Water, Sanitation & Hygiene	52,780
Relief items, Construction, Supplies	**52,780**
Storage	2,700
Transport & Vehicles Costs	13,920
Logistics, Transport & Storage	**16,620**
National Staff	34,200
National Society Staff	3,525
Personnel	**102,795**
Workshops & Training	24,660
Workshops & Training	**24,660**
Information & Public Relations	28,200
Office Costs	2,400
Communications	2,400
Financial Charges	900
General Expenditure	**43,900**
DIRECT COSTS	240,755
INDIRECT COSTS	15,649
TOTAL BUDGET	**256,404**

Budget by Area of Intervention

AOF4	Health	69,119
AOF5	Water, Sanitation and Hygiene	128,056
SFI1	Strengthen National Societies	42,967
SFI3	Influence others as leading strategic partners	16,263
	TOTAL	**256,404**



Contact information

Reference documents

Click here for:
- Operation update
- Emergency Plan of Action (EPoA)

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

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- IFRC Africa Regional Office for resource Mobilization and Pledge: Franciscah Cherotich Kilel, Senior Officer, Partnership and Resource Development, Nairobi, email: franciscah.kilel@ifrc.org, phone: +254 202 835 155

For In-Kind donations and Mobilization table support:
- IFRC Africa Regional Office for Logistics Unit: Rishi Ramrakha, Head of Africa Regional Logistics Unit, email: rishi.ramrakha@ifrc.org; phone: +254 733 888 022

For Performance and Accountability support (planning, monitoring, evaluation and reporting enquiries)
- **IFRC Africa Regional Office:** Illah Ouma, Acting PMER Coordinator, email: illah.ouma@ifrc.org

How we work

All IFRC assistance seeks to adhere to the **Code of Conduct** for the International Red Cross and Red Crescent Movement and Non-Governmental Organizations (NGO's) in Disaster Relief and the **Humanitarian Charter and Minimum Standards in Humanitarian Response (Sphere**) in delivering assistance to the most vulnerable. The IFRC's vision is to inspire**, encourage, facilitate and promote at all times all forms of humanitarian activities** by National Societies, with a view to **preventing and alleviating human suffering**, and thereby contributing to the maintenance and promotion of human dignity and peace in the world.

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

Save lives, protect livelihoods, and strengthen recovery from disaster and crises.

Enable healthy and safe living.

Promote social inclusion and a culture of non-violence and peace.

جمعية الهلال الأحمر السوداني
Sudanese Red Crescent Society

International Federation
of Red Cross and Red Crescent Societies

26 September 2019
EP-2019-000113-SDN

Sudan Cholera Outbreak
Disaster Relief Emergency Fund

LIBYA
EGYPT
CHAD
SUDAN
ERITREA
ETHIOPIA
SOUTH SUDAN
KHARTOUM
ASMARA
Khartoum
Kassala
Al Qadarif
White Nile
Sennar
Blue Nile

Legend

Targeted areas
- Affected areas
- At risk areas
- Country capital

0 100 200 300 400 km

The maps used do not imply the expression of any opinion on the part of the International Federation of Red Cross and Red Crescent Societies or National Societies concerning the legal status of a territory or of its authorities. Sources: GADM, IFRC, Sudanese Red Crescent.