RESIDENT/HUMANITARIAN COORDINATOR REPORT ON THE USE OF CERF FUNDS

19-RR-SDN-39315

REPUBLIC OF THE SUDAN

RAPID RESPONSE

CHOLERA

2019

RESIDENT/HUMANITARIAN COORDINATOR	**Selva Ramachandran**

REPORTING PROCESS AND CONSULTATION SUMMARY	
a. Please indicate when the After-Action Review (AAR) was conducted and who participated.	24 June 2020
An AAR was conducted on 24 June 2020. The review was conducted through an online discussion given Covid-19 containment measures. The discussion was recorded, and the outcomes of the discussion has been included in the AAR part of this report. There was participation from UNHCR, UNICEF and WHO as implementing partners. UNICEF ensured participation by its field office in Blue Nile state, where the first case of Cholera was registered. The WASH sector coordinator participated in the AAR, other sectors were focused on the Covid-19 response.	
b. Please confirm that the Resident Coordinator and/or Humanitarian Coordinator (RC/HC) Report on the use of CERF funds was discussed in the Humanitarian and/or UN Country Team.	Yes ☐ No ☒
CERF is discussed generally at the Humanitarian Country Team (HCT). However as the Covid-19 Covid-19 Pandemic created other competing priorities, this report was not discussed at the HCT.	
c. Was the final version of the RC/HC Report shared for review with in-country stakeholders (i.e. the CERF recipient agencies and their implementing partners, cluster/sector coordinators and members and relevant government counterparts)?	Yes ☒ No ☐
The report was shared with all implementing partners and relevant sectors' leads for fact checking and inputs before finalization.	

PART I

Strategic Statement by the Resident/Humanitarian Coordinator

Learning from the previous five years of Sudan Humanitarian Fund (SHF) responses to vector and water-borne diseases, the Humanitarian Country Team (HCT) has realized that timely and coordinated responses are critical to help mitigate the impact of floods. After the Federal Ministry of Health announced the outbreak of cholera in Blue Nile State, the Sudan Humanitarian Country Team was immediately mobilised. It released the Humanitarian Cholera Readiness and Response Plan. In accordance to the Plan, the SHF allocated $11 million to respond to the floods and cholera outbreak. However, significant gaps remained in the cholera outbreak response components particularly in high-risk states in the eastern part of Sudan with no presence of SHF partners, as well as refugee concentrated locations.

Focusing on Case Management and Infection Prevention and Control pillars of the Plan, CERF partners conducted massive community awareness campaign and training for health workers, fully equipped Cholera Treatment Centres were established, and robust water quality control measures were implemented, and integrated vector management strengthened. Partners also gave special attention to children who had severe acute malnourishment and were being treated in community based therapeutic centres and stabilization centres.

The CERF and SHF funds were allocated with complementarity and and allowed partners to successfully contain the cholera outbreak, which was contained with 346 cases and 11 death in four states (CFR 3.2 per cent) in Blue Nile, Sennar, Gezira and Khartoum states. This response contributed to reducing the number of cases and deaths. For example, the previous acute watery diarrhoea (AWD)/cholera outbreak that started in 2016 resulted in 36,000 cases with associated 823 deaths. This allocation has proven that coordinated and timely allocation of humanitarian funding saves lives.

1. OVERVIEW

TABLE 1: EMERGENCY ALLOCATION OVERVIEW (US$)	
a. TOTAL AMOUNT REQUIRED FOR THE HUMANITARIAN RESPONSE	**20,303,039**
FUNDING RECEIVED BY SOURCE	
CERF	2,999,889
Country-Based Pooled Fund (if applicable)	5,969,889
Other (bilateral/multilateral)	306,091
b. TOTAL FUNDING RECEIVED FOR THE HUMANITARIAN RESPONSE	**9,275,869**

TABLE 2: CERF EMERGENCY FUNDING BY PROJECT AND SECTOR (US$)			
Agency	**Project code**	**Cluster/Sector**	**Amount**
UNHCR	19-RR-HCR-035	Water Sanitation Hygiene - Water, Sanitation and Hygiene	399,883
UNICEF	19-RR-CEF-106	Water Sanitation Hygiene - Water, Sanitation and Hygiene	1,189,005
UNICEF	19-RR-CEF-106	Health - Health	217,501
UNICEF	19-RR-CEF-106	Protection - Child Protection	43,500

WHO	19-RR-WHO-051	Health - Health	644,000
WHO	19-RR-WHO-051	Water Sanitation Hygiene - Water, Sanitation and Hygiene	356,500
WHO	19-RR-WHO-051	Nutrition - Nutrition	149,500
TOTAL			**2,999,889**

TABLE 3: BREAKDOWN OF CERF FUNDS BY TYPE OF IMPLEMENTATION MODALITY (US$)	
Total funds implemented directly by UN agencies including procurement of relief goods	**$2,401,348**
Funds transferred to Government partners*	$579,086
Funds transferred to International NGOs partners*	$19,455
Funds transferred to National NGOs partners*	$0
Funds transferred to Red Cross/Red Crescent partners*	$0
Total funds transferred to implementing partners (IP)*	**$598,541**
TOTAL	**2,999,889**

** These figures should match with totals in Annex 1.*

2. HUMANITARIAN CONTEXT AND NEEDS

On 9 September 2019, the Federal Ministry of Health (FMoH) announced the outbreak of cholera in Blue Nile State. As of 2 October 2019, seven localities in Blue Nile and Sennar states had reported 215 suspected cholera cases, including eight deaths with case fatality rate (CFR) of 3.7 per cent, according to the FMoH and WHO. In Blue Nile State, the affected localities at that time were: El Roseries (90 cases), Damazine (47 cases), Wad Amahi (3 cases) and Bau (2 cases) while in Sennar State, the affected localities were: Abu Houjar (59 cases), Singa (4 cases) and El Souki (10 cases). The needs in Blue Nile were the highest as the index case was reported from El Roseries location. Samples from all reported 42 cases were collected and analysed at the National Public Health Laboratory (NPHL) in Khartoum, with 18 samples coming out positive for Vibrios Cholerae by culture test. The reported cases mostly fall within the age range of 5 to 45 years, with 61 per cent being female compared to 39 per cent male.

This cholera outbreak followed the same pattern as that in 2016 to 2018 where the first cases were reported in six localities of the Blue Nile state and the triggering factors for the outbreak remain the same as those in 2016 to 2018: poor access to safe drinking water and widespread open defecation, cross border movements from countries affected by cholera. This cholera outbreak took place against a similar backdrop of health needs that are characterised by over-stretched health services, poor WASH conditions and other vulnerabilities. Despite the prompt and initial control measures put in place by health and WASH partners under the leadership of the government, it was projected that the outbreak would spread to adjacent localities.

According to WHO, close to 23 million people are at risk in the eight states of Sennar, Blue Nile, Gadarif, Gezira, Kassala, Khartoum, White Nile and River Nile. An expert team from the WHO HQ that specializes on cholera forecasting visited Sudan during the week of 20 September 2019. Findings from the assessment projected between 5,000 and 13,200 cholera cases requiring case management in the next 6 months in the identified high- risk states. For the case management component, WHO developed two scenarios for the outbreak. In the best-case scenario, eight high-risk states - Blue Nile, Sennar, Gezira, Khartoum, Gadarif, White Nile, Kassala, and River Nile – were expected to experience between 20-30 percent of the cases experienced during 2016 to 2018 outbreak. In the worst-case scenario, it was projected that the outbreak will spread beyond the eight high-risk states (to Red Sea, and West Kordofan) and between 40-50 percent of the cases experienced in the last outbreak will occur where more than 13,000 people were projected to be affected in 10 states.

It is important to note that some of the potentially affected areas (Sennar, Gezira, Gadarif, River Nile, Red Sea and Khartoum) did not have large scale humanitarian programmes, although people in need in these states have been increasing particularly since the economic decline in early 2018. This CERF allocation had increased coverage to these high-risk areas which traditionally have not been targeted for humanitarian assistance and as a result, had not been supported for flood and cholera response under previous allocations. However, the recent floods that affected some of these high-risk states including Blue Nile, Gezira, River Nile and Gadarif, was an aggravating factor which increased the risk of cholera. This was further worsened by the underlying factors, which include large numbers and continuous influx and movements of refugees.

Sudan hosts a significant number of refugees from South Sudanese refugees in some of the affected locations, with an already strained economy, as well as the limited resources and services, the risk of the further spread of cholera was assumed to be high among the refugee communities. Most of the refugees cope with poor congested living conditions, lack of latrines, unavailability of soap for personal hygiene and the general absence of basic living. This is again was against a backdrop of lack of livelihood opportunities with many of the refugees being unable to access formal or sustained work to meet their basic needs. The White Nile was hosting populations beyond its initial capacity. The three refugee camps with highest refugee numbers are; Khor Al Waral camp (45,424), Umsangour (26,207) and Redais II (26,065). Crowded living settings and population movements in these locations among other poor WASH facilities and services make them more vulnerable to cholera outbreak.

The outbreak was spreading to neighbouring and adjacent localities and states despite the prompt and initial control measures put in place by health and WASH partners under the leadership of the government. Without timely and intensive scale up of control measures in high risk and adjacent states, the outbreak was prospectively to spread to other states.

3. CONSIDERATION OF FOUR PRIORITY AREAS[1]

This submission had a specific focus on school-going children, children in general and women. Of concern are the statistics which indicates the ages most affected (5 to 45 years) demonstrating that children were indeed also affected. UNICEF targeted five affected schools in the severely affected areas and provided gender-sensitive and disability-friendly WASH services combined with hygiene promotion interventions. WHO also noted the disproportionate number of women (61 per cent) affected by cholera compared to men (39 per cent) and highlighted the significant efforts to ensure that not only women to be prioritised in the response, but also ensure their empowerment through training of women community health care workers.

a. Women and girls, including gender-based violence, reproductive health and empowerment

In this cholera outbreak, more women (61 per cent) have been affected that men (39 per cent). Women have been identified as being at higher risk identified as they were the main caregivers of the sick, and therefore experienced higher exposure to contaminated surfaces without having awareness of the risks and prevention measures. Partners implemented the response plan ensured that Cholera Treatment Centres (CTCs) had gender-separate rooms for women and men. Health services were designed to ensure women were treated with dignity> For example the examination of female cholera cases was conducted in a private space. Activities were also designed to increase involvement of women and girls in the planning and management of WASH services to reach more female members of the communities. Additionally, and for the nutrition component, mothers played an important role in the completion of SAM inpatient treatment at the household level through Out-Patient Program (OTP), Infant and Young Child Feeding (IYCF), and Supplementary Feeding Program (SFP) until the child fully recovers. To promote adherence to treatment and addressability, partners ensured that at least 50 per cent of the staff of Stabilisation

[1] In January 2019, the Emergency Relief Coordinator identified four priority areas as often underfunded and lacking appropriate consideration and visibility when funding is allocated to humanitarian action. The ERC therefore recommended an increased focus on these four areas to ensure that they be given due consideration by RC/HCs and UNCTs/HCTs when prioritizing life-saving needs for inclusion in CERF requests. These areas are: (1) support for women and girls, including tackling gender-based violence, reproductive health and empowerment; (2) programmes targeting disabled people; (3) education in protracted crises; and (4) other aspects of protection. Please see the Questions and Answers on the ERC four priority areas here https://cerf.un.org/sites/default/files/resources/Priority_Areas_Q_A.pdf

Centres (SCs) were females.

b. Programmes targeting persons with disabilities

Interventions were planned to take into account the needs of children with disabilities and included measures to ensure that children with disabilities had facilitated access to the school WASH services. Additionally, provision of services and items facilities, while benefitting all members within a targeted household, prioritised inclusion of people living with disabilities.

c. Education in protracted crises

As there were some schools in the targeted locations for the interventions, activities were designed to ensure that school-going children have access to the school WASH services and hygiene promotion.

d. Other aspects of protection

The child protection section in UNCEF, in partnership and close collaboration with implementing partners and relevant sectors (health, nutrition and WASH) took the lead to raise the awareness about cholera. This was done in Child-Friendly Spaces and Temporary Learning Spaces, through play and role playing. The children continued to raise awareness within their families.

4. PRIORITIZATION PROCESS

OCHA developed a Concept Note which was shared with the respective sectors and agencies. The note was developed in line with the priorities defined in the three-month Cholera Readiness and Response Plan (October – December 2019) which focuses on three key sectors on Health, WASH and Nutrition against the seven global pillars. Priority activities included in the CERF application were extracted from the response plan based and guided by the CERF life-saving criteria with a strict focusing specifically on the current cholera response and in the eight high risk states.

Overall, partners targeted treatment of 13,000 case of cholera through case management strategy, reaching 1,016,006 people (including refugees in camps at risk) with provision of direct health services anddirectly targeting 2.5 million people to benefit from WASH interventions, 300,000 severely malnourished children and 546,000 mothers and caregivers to access infant and young child feeding counselling. Refugees living in camps in Kassala, Gadarif and White Nile states, and in Khartoum 'Open Areas' sites were also targeted through a multi-sector response. Activities also included activities to mitigate the underlying causes of high mortality like severe malnutrition in children under 5 years of age and targeting schools with WASH activities and hygiene campaigns.

Health: The health strategy in the Cholera Readiness and Response plan targeted 1,016,006 people in the eight states.[2] Health interventions focused on ensuring that the Ministry of Health both at the at national and state-levels, had the capacity and are prepared to treat any potential cholera cases by prepositioning the necessary medical supplies and kits at the state levels. Key interventions under the Case Management and Infection Prevention and Control (IPC) pillar included capacity development of health care workers, and community workers on AWD/ Cholera, standard case management training and supervision of staff both at the state and national level. The training contributed in improving access to treatment and ensured adherence to national and international protocols and guidelines contributing to reduction in CFR. As part of an overall integrated cholera response plan, partners supported MoH on surveillance of cases to monitor and control spread of the disease; maintained clean water, sanitation and nutrition; and raised awareness among at-risk communities. Additionally, the sector had established Oral Rehydration Therapy (ORTs) corners at health facilities, and community care centres for treatment of mild and moderate cholera cases. For specific case management, the strategy was to establish isolation centres including for refugees in camps which are in the locations considered to be very high risk. The health response also included procurement of cholera kits for in-patient care, equipment, medical supplies and infection prevention and control supplies for Cholera Treatment Centres (CTCs). Surge staff was deployed to support case management and infection prevention in CTCs in most affected states. The FMoH had requested over 3 million doses of the Oral Cholera Vaccine (OCV) to conduct a vaccination campaign to contain the outbreak and prevent the spread to adjacent areas.

[2] These 1,016,006 people are all direct benificiaries targted by Cholera Readiness and Response plan which is developed by the HCT to repsond to the Cholera outbreak.

WASH: The WASH component targeted a total of 2.5 million people including vulnerable refugee populations. The strategy's objective was to improve water, sanitation and hygiene promotion interventions with focus on the high- and medium risk localities. Key activities included; water safety supplies and equipment for the regular water quality monitoring, upgrading the water surveillance system, capacity building for the partners staff, emergency operational cost for the water samples collection and analysis, emergency operational support to the state's water quality laboratory (including deployment, capacity building and supplies), equipment and supplies for the integrated vector management with focus on the mosquito control for malaria, dengue fever and chikungunya.

Nutrition: Given the overall prevalence of malnutrition in the targeted states, nutrition response was aiming to decrease avoidable under five morbidity and mortality related to severe acute malnutrition and girls and boys affected by Cholera/AWD. This has been achieved through case management and improved access and quality of inpatient care in Stabilisation Centres (SCs) as well as Cholera Treatment Centres (CTCs). The proposed activities addressed clinical lifesaving needs in SCs and CTCs by applying the global treatment protocols for the case management of children with SAM and those who are cholera affected received cholera treatment in the CTCs. Specific project activities included capacity building of the health and nutrition staff of the SCs and CTCs providing the treatment of SAM with Cholera and AWD, provision of the WHO treatment guidelines and Job Aids to the participants of the targeted SCs. WHO procured and distributed medicines (SAM inpatient Kits – secondary level care) to SCs and CTCs for the treatment of SAM children with Cholera/AWD and other medication complications.

5. CERF RESULTS

CERF allocated US $2,999,889 to Sudan from its Rapid Response window in order to provide a timely and integrated multi-sector (health, Nutrition, protection and WASH) cholera response and control of community spread in eight states at high risk of cholera outbreak in Sudan. This CERF allocation allowed UN agencies and partners to contain the cholera outbreak within four months and reaching a total of 1,149,594 benificiaries. Whereas previous outbreaks counted for more than 10 000 cases with hundreds of deaths across the country, this outbreak was successfully contained with 346 cases and 11 death in 4 states (CFR 3.2 per cent) in Blue Nile, Sennar, Gezira and Khartoum states. The fundig enabled UN agencies to reach 160,262 people with health services; 45,140 children benifited from child protection services; 196 girls and boys received Cholera-related nutrition services and 738,923 people accessed water chlorination and a ppropriate sanitation and hygiene services. The funding reached 25,073 refugees with multi-sector refugee assistance. Cholera outbreak started and worsened in settled communites therefore; the bulk of reached popel are host communities of 727,583 people; IDPs 155,880 and the rest are refugees.Through this CERF funding, WHO provided effective leadership of the health sector, providing highly skilled technical experts and performing health data collection, analysis and management. WHO Prepositioned drugs, supplies and commodities in term of 25 cholera kits, distributed cholera treatment protocols to 210 Health facilities and establishment 26 CTCs. WHO directly supported re-training of 160 medical staff on cholera case management and 29 Rapid Response Teams (RRT). Furthermore, WHO conducted 60 integrated vector control campaigns and 85 water quality sampling missions and awareness campaigns. WHO adopted regional guideline for the treatment of Severe Acute Malnutrition (SAM) children with AWD/Cholera for Sudan.

UNICEF WASH interventions provided improved drinking water for 569,150 cholera-affected and at-risk population. Health and nutrition interventions focused on ensuring that the Ministry of Health had the capacity to treat any potential cholera cases by prepositioning the necessary medical supplies and kits to provide lifesaving treatment for 441 Severely Acutely Malnourished (SAM) children through the Out-patient Treatment Programme (OTP) services as well as supporting treatment of SAM children with the provision of nutritional supplies. Communication for Development (C4D) interventions reached more than one million cholera-affected and at-risk people through health promotion, while the child protection section worked in close partnership with implementing partners and in close collaboration will other sectors to raise awareness on cholera.

UNHCR and partners provided WASH support to 215,073 refugees. In addition, 22 communal hand washing facilities were set up in 2 health facilities and 2 common marketplaces and 350kgs of chlorine was procured to support increased chlorination dosage in 3 water treatment facilities providing water to three camps.

6. PEOPLE REACHED

Implementing partners have reached higher beneficiaries compared to the originally targeted populations. While the targeted people are 853,498, partners have reached 1,149,594 beneficiaries. This is mainly attributed to the over achievement of WASH and Communications for Development (C4D) interventions by UNICEF. As stated by UNICEF, for WASH interventions this achievement was due to blanket disinfection of water sources which allowed for a much wider reach of affected populations in Blue Nile state. The blanket disinfection approach is followed when Cholera outbreak hits big cities which requires chlorination of the central water sources as a preventive measure to stop the spread of the disease covering a wider reach of direct benifciaries. This blanket chlorination uses less amounts of chlorine compared to scattered specific water points chlorination. This blanket disinfection was not planned originally as the outbreak was scattered in different areas sourrounding Damazine town but quickly spreaded to other districts and blanket chlorination had to be applied to ensure the effectiveness of the interventions. An additional 1,178,000 people reached indirectly through social media with cholera-awareness messages through UNICEF.

Persons with disabilities were targeted by UNHCR interventions and the same targeted persons have been reached by multi-sector interventions.

The targets in table 4 of "Other affected populations" was mistakenly inserted in the submission documents where correctly they should be "Host communities". There was also a mistake in the targets in table 4a of WHO project where WASH and nutrition targets were swapped. The correct targeted people for nutrition is 183 while the WASH target is 170,000. This error has implication also in table 7a which needs to be corrected.[3]

TABLE 4: NUMBER OF PEOPLE DIRECTLY ASSISTED WITH CERF FUNDING BY CATEGORY[1]

Category	Number of people (Planned)	Number of people (Reached)
Host communities	622,558	727,583
Refugees	230,533	233,461
Returnees	0	0
Internally displaced persons	407	188,550
Other affected persons	0	0
Total	**853,498**	**1,149,594**

[1] *Best estimates of the number of people directly supported through CERF funding by category.*

TABLE 5: NUMBER OF PEOPLE DIRECTLY ASSISTED WITH CERF FUNDING BY SEX AND AGE[2]

	Men (≥18)	Women (≥18)	Boys (<18)	Girls (<18)	Total
Planned	178,865	202,649	240,021	240,570	**862,105**
Reached	217,528	242,429	336,519	353,118	**1,149,594**

[2] *Best estimates of the number of people directly supported through CERF funding by sex and age (totals in tables 4 and 5 should be the same).*

[3] To ensure that data is not incorrectly extracted, CERF has corrected these errors in the tables below. However, the CERF secretariat opted not to delete the paragraph highlighting the entry errors as it represents a record of a mistake that may have affected other documents related to this allocation (e.g. the application chapeau).

TABLE 6: NUMBER OF PEOPLE DIRECTLY ASSISTED WITH CERF FUNDING (PERSONS WITH DISABILITIES) [3]					
	Men (≥18)	**Women (≥18)**	**Boys (<18)**	**Girls (<18)**	**Total**
Planned (Out of the total targeted)	1,591	2,652	2,182	2,182	**8,607**
Reached (Out of the total reached)	1,591	2,652	2,182	2,182	**8,607**

[3] *Best estimates of the number of people with disabilities directly supported through CERF funding.*

TABLE 7a: NUMBER OF PEOPLE DIRECTLY ASSISTED WITH CERF FUNDING BY SECTOR (PLANNED)[4]					
By Cluster/Sector (Planned)	**Men (≥18)**	**Women (≥18)**	**Boys (<18)**	**Girls (<18)**	**Total**
Health - Health	35,169	34,134	41,327	39,811	**150,441**
Multi-Cluster - Multi-sector refugee assistance	33,415	55,696	65,835	65,835	**220,781**
Nutrition - Nutrition	0	0	90	93	**183**
Protection - Child Protection	10,350	10,350	0	0	**20,700**
Water Sanitation Hygiene - Water, Sanitation and Hygiene	110,281	112,819	122,509	124,574	**470,183**

TABLE 7b: NUMBER OF PEOPLE DIRECTLY ASSISTED WITH CERF FUNDING BY SECTOR (REACHED)[4]					
By Cluster/Sector (Reached)	**Men (≥18)**	**Women (≥18)**	**Boys (<18)**	**Girls (<18)**	**Total**
Health - Health	35,410	36,100	44,167	44,585	**160,262**
Multi-Cluster - Multi-sector refugee assistance	33,275	54,292	63,703	63,803	**215,073**
Nutrition - Nutrition	0	0	96	100	**196**
Protection - Child Protection	0	0	12,251	22,889	**35,140**
Water Sanitation Hygiene - Water, Sanitation and Hygiene	182,118	206,329	280,205	285,544	**954,196**

[4] *Best estimates of the number of people directly supported through CERF funding by sector.*

7. CERF'S ADDED VALUE

a) Did CERF funds lead to a fast delivery of assistance to people in need?

YES ☒ PARTIALLY ☐ NO ☐

This CERF allocation helped the fast delivery of assistance which led to the quick containment of Cholera and other diarrheal diseases in the Cholera affected states and helped delivering preventive services in neighbouring states. Also, the allocation facilitated UNHCR fast delivery services for refugees in Khartoum open area. Furthermore; WHO managed to develop nutritional guidelines for Cholera response which facilitated the fast delivery of nutritional services to children under five. The fast-track funding supported WHO and health partners to provide effective, timely and coherent delivery of cholera response interventions as first case of cholera reported in September, and CERF was allocated in October 2019. CERF funding contributed to a fast onset of the response and the delivery of assistance to people in need.

b) Did CERF funds help respond to time-critical needs?

YES ☒ PARTIALLY ☐ NO ☐

The golden rule is that outbreak response is time critical. UNHCR received timely which allowed them to deliver services in the right time. UNICEF usually starts implementation once agreement is signed using their own resources. Therefore; CERF commitments allowed responding to time critical needs for Cholera response based on that approach. CERF flexibility is one of the factors enabled UNICEF to disburse funds to government partners on time. Added to that, CERF fund allowed WHO to initiate and set up time critical operations to provide life-saving interventions and prevent further spreading of the outbreak. The timeliness of the multi-sectorial response is one of the essential factors which allowed to contain the outbreak and avoid human suffering.

c) Did CERF improve coordination amongst the humanitarian community?

YES ☒ PARTIALLY ☐ NO ☐

Cholera outbreak was a valuable opportunity for all relevant partners in Sennar and Blue Nile states to put their heads together. Coordination was one of the strongest tools used to control the outbreak at the field level. The CERF funds allowed WHO to support the coordination of the response through state level and local emergency operation coordination meetings to ensure that partners discussed gaps, needs and priorities and shared information regularly. Thus, overlapping and waste of limited resources could be avoided, and complementary actions ensured. Partners managed to bring state ministry of health and State ministry of water resources together which is not a usual practice for government bodies at the states. It was the first time for nutrition sector to be included in Cholera response funding. The benefit was maximized through coordination among the different sectors.

d) Did CERF funds help improve resource mobilization from other sources?

YES ☐ PARTIALLY ☒ NO ☐

UNHCR and UNICEF did not mobilize resource per se, however both organizations leveraged other internal resources to complement CERF funding. CERF fund was used for responding to cholera outbreak, that helped WHO cover the immediate needs. CERF funding did not immediately improved resource mobilisation from other resources, but the success story of the outbreak response was used as illustration in other resource mobilisation efforts.

e) If applicable, please highlight other ways in which CERF has added value to the humanitarian response

CERF funding played a role in building the capacity building of implementing partners that had previously not had experience responding to this type of emergency in Sennar and Gezira state. CERF fund for WASH, Nutrition and surveillance was complementary to WHO funded Oral Cholera vaccination (OCV) in Blue Nile and Sennar. CERF supported WASH, Health and nutrition activities as much as OCV campaigns are different components of one multi-sectorial response which resulted in controlling the cholera outbreak in short time with less spread to other states.

8. LESSONS LEARNED

TABLE 8: OBSERVATIONS FOR THE CERF SECRETARIAT	
Lessons learned	**Suggestion for follow-up/improvement**
N/A	N/A

TABLE 9: OBSERVATIONS FOR COUNTRY TEAMS		
Lessons learned	**Suggestion for follow-up/improvement**	**Responsible entity**
UNICEF has the flexibility to move supplies among states according to the required responses. Due to high cases in Blue Nile, UNICEF immediately moved supplies from other states to Blue Nile.	Other partners should also have a flexible stock movement/transfer, if they do not have yet.	All CERF partners
The outbreak happened during the time of the political instability. Resistance Committees composed of youth groups were established in each village and community during the revolution. These Resistance Committees were actively engaged in the outbreak response.	Partners to exploit such opportunities when implementing other humanitarian response.	All CERF partners

PART II

9. PROJECT REPORTS

9.1. Project Report 19-RR-HCR-035 - UNHCR

1. Project Information			
1. Agency:	UNHCR	**2. Country:**	Republic of the Sudan
3. Cluster/Sector:	Water Sanitation Hygiene - Water, Sanitation and Hygiene	**4. Project Code (CERF):**	19-RR-HCR-035
5. Project Title:	Cholera prevention through strengthening community health and hygiene practices in White Nile refugee camps and Khartoum Open areas		
6.a Original Start Date:	30/10/2019	**6.b Original End Date:**	29/04/2020
6.c No-cost Extension:	☒ No ☐ Yes	If yes, specify revised end date:	N/A
6.d Were all activities concluded by the end date? (including NCE date)		☐ No ☒ Yes (if not, please explain in section 3)	

7. Funding		
	a. Total requirement for agency's sector response to current emergency:	US$ 2,780,000
	b. Total funding received for agency's sector response to current emergency:	US$ 0
	c. Amount received from CERF:	US$ 399,883
	d. Total CERF funds forwarded to implementing partners	**US$ 23,297**
	of which to:	
	Government Partners	US$ 3,842
	International NGOs	US$ 19,455
	National NGOs	US$ 0
	Red Cross/Crescent	US$ 0

2. Project Results Summary/Overall Performance
UNHCR and partners provided WASH support to 215,073 beneficiaries: 187,177 in White Nile camps and 27,896 in Khartoum Open Areas. Out of the 215,073 beneficiaries, 33, 275 were men, 54,292 women, 63,703 boys and 63,803 girls. 902,864 pieces of soap were distributed: 145,156 pieces to Khartoum Open Areas and 757,708 in White Nile camps. 15,575 ibriks were distributed in Bantiu and Naivasha, reaching 23,629 beneficiaries. 4,224 pieces of soap were distributed to selected health facilities in While Nile and 4,776 pieces to similar health facilities in Khartoum Open Areas. In addition, 22 communal hand washing facilities were set up in 2 health facilities and 2 common marketplaces in Naivasha while 18 were set up across eight health facilities in White Nile. Through these interventions, beneficiaries were able to have consistent access to handwashing facilities which was critical in preventing the transmission of cholera. Moreover, 350 kgs of chlorine was procured to support increased chlorination dosage in three water treatment facilities providing water to three camps in White Nile State with the largest refugee populations: Khor Al Waral camp (45,424), Umsangour (26,207) and Redais II (26,065). This intervention benefitted approximately 12,450 people from the host communities and played an important role in promoting peaceful coexistence between the refugee and host communities.

3. Changes and Amendments

On 16 March 2020, the Government of Sudan announced a state of emergency and subsequently closed the country's borders in response to the Covid-19 pandemic. This was followed by the closure of schools and introduction of a curfew. As a result of this dynamic and unpredictable operational context, implementation was impacted on several fronts.

Due to restrictions on movement, partners' mobility was severely constrained and often resulted in delays in the distribution of ibriks and changes in partnership agreements for distribution. Hand washing facilities in Bantiu (Khartoum Open Areas) were set up by the Commissioner of Refugees (COR) - the Government agency mandated to coordinate refugee affairs in Sudan - instead of CIS as per the original proposal. During the country-wide lockdown, COR was granted a waiver to deliver lifesaving Covid-19 related assistance, including the distribution of ibriks in Bantiu. Distribution was also delayed in Naivasha although CIS was later granted a waiver to complete distribution. Despite UNHCR's efforts to remain agile, responsive and relevant, 800 ibriks were looted from the CIS warehouse in Naivasha during the lockdown. A police report was filed detailing this incident.

In an effort to protect persons of concern from Covid-19 , the distribution modality for ibriks changed. To ensure social distancing, community distributions were avoided and instead house to house distributions were carried out. This approach, however, took longer than the usual group distributions and continued beyond the anticipated project end date.

In White Nile, the target distribution of 11 communal hand washing facilities was exceeded following the distribution of 18 of these facilities. This was due to the fact that smaller 60 litre containers were chosen instead of the planned 100 litre containers so as to reach more people.

In UNHCR's initial proposal, the procurement and delivery of 9,000 pieces of soap for hand washing for 20 schools in White Nile and Khartoum Open Areas was also planned. Due to early closure of schools, however, these soap pieces were distributed at health facilities in line with Covid-19 preparedness and response. In addition, the original target to provide 11 handwashing facilities in schools was not met due to school closures following lockdown. As a result, this target to distribute these critical facilities was moved to health facilities inside the same camps which were still in operation.

Despite these modifications, the planned targets and beneficiaries remained the same in the camps. The goal to promote behaviour change through consistent hand washing with soap to prevent cholera outbreak was realised as the project's importance took on an even greater significance in light of the dynamic context as a result of the Covid-19 pandemic.

4.a Number of People Directly Assisted with CERF Funding (Planned)

Cluster/Sector	Water Sanitation Hygiene - Water, Sanitation and Hygiene				
Planned	**Men (≥18)**	**Women (≥18)**	**Boys (<18)**	**Girls (<18)**	**Total**
Host communities	0	0	0	0	**0**
Refugees	31,827	53,044	63,653	63,653	**212,177**
Returnees	0	0	0	0	**0**
Internally displaced persons	0	0	0	0	**0**
Other affected persons	0	0	0	0	**0**
Total	**31,827**	**53,044**	**63,653**	**63,653**	**212,177**
Planned	**Men (≥18)**	**Women (≥18)**	**Boys (<18)**	**Girls (<18)**	**Total**
Persons with Disabilities (Out of the total number of "people planned")	1,591	2,652	2,182	2,182	**8,607**

4.b Number of People Directly Assisted with CERF Funding (Reached)

Cluster/Sector	Water Sanitation Hygiene - Water, Sanitation and Hygiene				
Reached	**Men (≥18)**	**Women (≥18)**	**Boys (<18)**	**Girls (<18)**	**Total**
Host communities	0	0	0	0	**0**
Refugees	33,275	54,292	63,703	63,803	**215,073**
Returnees	0	0	0	0	**0**
Internally displaced persons	0	0	0	0	**0**
Other affected persons	0	0	0	0	**0**
Total	33,275	54,292	63,703	63,803	**215,073**
Reached	**Men (≥18)**	**Women (≥18)**	**Boys (<18)**	**Girls (<18)**	**Total**
Persons with Disabilities (Out of the total number of "people reached")	1,591	2,652	2,182	2,182	**8,607**

In case of significant discrepancy between figures under planned and reached people, either in the total numbers or the age, sex or category distribution, please describe reasons:	The achieved results are of multi-sectoral nature, but tables are swapped in targets.

4.c Persons Indirectly Targeted by the Project

Some 12,450 people from the host communities, living around and near Khor Al Waral Umsangour and Redais II camps benefitted from improved water quality as a result of additional provision of Calcium Hypochlorite for the three water treatment plants serving the three camps with the highest numbers of refugees.

5. CERF Result Framework

Project Objective	Improve health and hygiene practices of 212,177 South Sudanese refugees in White Nile camps and Khartoum open areas

Output 1	Soap and hand washing facilities distributed to promote personal hygiene for 212,177 South Sudanese refugees in White Nile State and Khartoum			
Sector	Water Sanitation Hygiene - Water, Sanitation and Hygiene			
Indicators	**Description**	**Target**	**Achieved**	**Source of Verification**
Indicator 1.1	Number of soaps distributed for personal hygiene (2 pieces/person/month)-3 months in Khartoum open areas and 2 months in White Nile)	898,708	902,864	• Beneficiary distribution lists • Pictures • Distribution Reports
Indicator 1.2	Number of Household Hand washing facilities (Ibrik) distributed – 2 per household	16,375	15,575	• Beneficiary distribution lists • Pictures Distribution Reports
Indicator 1.3	Number of Communal Hand washing facilities (drum with a tap) distributed to 15 schools	15	22	• Goods Received Forms

Indicator 1.4	Number of soaps distributed for hand Washing for 20 schools in White Nile and KOA	9,000	9,000	• Goods Received Forms
Explanation of output and indicators variance:		• 4,156 additional soap pieces were provided to an additional 10,258 South Sudanese Refugees in Khartoum Open Areas, bringing down the total soap pieces to 902,864 instead of the original figure in the proposal that is 898,708. The purchase of additional soap was made possible by fluctuations in the exchange rate, resulting in a saving, which was used to procure more soap pieces which reached an additional 10,258 South Sudanese refugees. • There was a shortfall of 800 ibrik pieces following a looting incident during lockdown. This is detailed in the partner incident report. • An additional 7 communal hand washing facilities were procured and distributed. UNHCR agreed with the implementing partner to increase the number of communal hand washing facilities in White Nile from the originally planned 11 to 18 pieces by reducing the size of these containers from 100 litre to 60 litres. This decision was made after the target was moved from schools to health facilities. There was a huge need of these facilities inside hospitals as part of Covid-19 preparedness and response.		

Activities	**Description**	**Implemented by**
Activity 1.1	Soap distribution in White Nile and Khartoum open areas	Catholic Agency for Overseas Development (CAFOD) (White Nile), CARE International Switzerland (CIS) (Khartoum Open Areas)
Activity 1.2	Ibrik distribution	CIS (Naivasha) and Commissioner for Refugees (COR) (Bantiu)
Activity 1.3	Communal Hand washing facilities (drum with a tap) distribution	CAFOD (White Nile), CIS (Khartoum Open Areas)
Activity 1.4	Soap for hand Washing for 20 schools students in White Nile and KOA distribution	CAFOD (White Nile), CIS (Khartoum Open Areas)

Output 2	Provision of additional chlorine to increase chlorine dosage and standard chlorine residual in White Nile State and Khartoum			
Sector	Water Sanitation Hygiene - Water, Sanitation and Hygiene			
Indicators	**Description**	**Target**	**Achieved**	**Source of Verification**
Indicator 2.1	Quantity of additional chlorine for White Nile (3 buckets of 50kgs each) procured and distributed	350 kgs	350 kgs	Partners' Procurement documentation
Indicator 2.2	Number of additional chlorine dosage at Water treatment facilities (three treatment facilities serving the biggest population)	7	7	Water Treatment Daily Log sheets
Explanation of output and indicators variance:		There was an oversight on the Item description of 'Indicator 2.1'-Quantity of additional chlorine for White Nile (3 buckets of 50kgs each) procured and distributed. It should read as '7 buckets of 50kgs each' instead of '3 buckets of 50kgs each'		

Activities	**Description**	**Implemented by**
Activity 2.1	Procurement of additional chlorine for White Nile	Water and Environmental Sanitation (WES)
Activity 2.2	Chlorination (Increase of chlorine dosage)	Water and Environmental Sanitation (WES)

6. Accountability to Affected People

6.a IASC AAP Commitment 2 – Participation and Partnership

How were crisis-affected people (including vulnerable and marginalized groups) involved in the design, implementation and monitoring of the project?

UNHCR and partners used the 2018 Participatory Assessment results as the entry point for discussions with persons of concern to see how best to address some of the needs and immediate concerns for refugees in all the camps for White Nile. For Khartoum Open Areas, the findings of an Inter-Agency Assessment conducted in 2017 were also used to ensure the project was responsive to the needs highlighted by participants.

Following this, UNHCR and partners met with community leaders and different community groups, including women and youth, in the targeted areas to inform them about the project and the donor and explain the reasons why their locations were being targeted as they were identified as one of the most at risk locations by the Ministry of Health. The project's objectives, activities and duration were also explained, and implementation modalities discussed to ensure maximum participation. It was during these consultations that locations for communal hand washing facilities were identified for installation. Together with WES and COR, discussions were also held to identify priority water treatment facilities in White Nile which could benefit from the procurement of more chlorine.

In addition, community representatives were selected to support in the distribution of soap and family ibriks. These were also used to monitor beneficiary registrations to ensure the intended beneficiaries received these hygiene items. In White Nile camps, selected beneficiaries also participated in a WASH Knowledge, Attitudes and Practices (KAP) survey carried out in all the 9 White Nile camps from December 1-11, 2019.

Were existing local and/or national mechanisms used to engage all parts of a community in the response? If the national/local mechanisms did not adequately capture the needs, voices and leadership of women, girls and marginalised groups, what alternative mechanisms have you used to reach these?

UNHCR and partners ensured the voices of women and youth groups were heard during the project's inception through separate focus group discussions for women, men and youth.

Moreover, this project also complimented UNHCR's winterization project from December 2019 and January 2020, where soap was concurrently distributed together with other winterization items such as jerry cans, shelter plastic sheets, blankets and kitchen set items to support refugees during the winter season. This involved sustained collaboration with both the Commissioner for Refugees and the Humanitarian Aid Commission and CARE International Switzerland (CIS) in Khartoum Open Areas.

Other activities such as the provision of soap and installation of communal hand washing facilities at health facilities and common marketplaces together with distribution of Ibriks were implemented during the Covid-19 response where the provision of soap and hand washing facilities was identified as one of the highest priorities in Covid-19 guidelines by the Ministry of Health and WHO.

6.b IASC AAP Commitment 3 – Information, Feedback and Action

How were affected people provided with relevant information about the organisation, the principles it adheres to, how it expects its staff to behave, and what programme it intends to deliver?

Project inception meetings were held across all project locations and were attended by UNHCR, implementing partner staff and government line ministries as well as government local leadership. These meetings provided the fora to share important information about the project's donor, objectives, activities and duration as well as the expectations regarding the communities' roles and responsibilities. Information about existing complaint mechanisms which were available to persons of concern in the camps in White Nile state were also highlighted. UNHCR and partner values as well as the roles and contacts for each organization were also shared as a way of promoting transparency and ensuring beneficiaries had access to this information.

Did you implement a complaint mechanism (e.g. complaint box, hotline, other)? Briefly describe some of the key measures you have taken to address the complaints. Yes ☒ No ☐

Partners raised attention of complaint mechanisms in White Nile was highlighted and beneficiaries were encouraged to make use of complaint boxes in the camps. In addition, the numbers for a UNHCR hotline were also shared during the inception meetings in both locations. Issues not related to the project raised by beneficiaries were shared with UNHCR's Protection unit for follow up. Other issues raised were also shared during the multi-sectoral Refugee Consultation Forum monthly meetings chaired by UNHCR and COR which draws strong participation from donors, UN and other humanitarian agencies.

Did you establish a mechanism specifically for reporting and handling Sexual Exploitation and Abuse (SEA)-related complaints? Briefly describe some of the key measures you have taken to address the SEA-related complaints. Yes ☒ No ☐

UNHCR held meetings with all implementing partners before project implementation on this important topic and number of key measures were taken to ensure all actors understood the significance of PSEA. CAFOD and CIS staff, including contractors and volunteers, for example were required to complete training or orientation in PSEA as part their commitment to working and abiding with their organization's values and the Humanitarian Accountability Framework. PSEA training is also mandatory for UNHCR staff, including affiliate workforce, who must complete an online course within the first week of recruitment. This online course is designed to raise awareness of UNHCR's zero tolerance of workplace harassment, sexual harassment and abuse of authority and is intended to strengthen understanding of the standards of conduct with a special focus on sexual exploitation and abuse.
It was also clearly explained during inception meetings that all the support to be provided was free of charge. Communities were also expected to participate voluntarily. Hotline numbers were also shared so that communities felt comfortable to express their views on anything they didn't feel was appropriate according to local societal norms and values.

Any other comments (optional):
N/A

7. Cash and Voucher Assistance (CVA)

Did the project include Cash and Voucher Assistance (CVA)?

Planned	Achieved
No	No

8. Evaluation: Has this project been evaluated or is an evaluation pending?

In White Nile camps, a WASH Knowledge, Attitudes and Practices (KAP) survey was carried out in all nine camps from 1 to 11 December 2019 to identify gaps in current facilities and hygiene practices so as to ensure interventions minimising harmful and risky practices will be prioritized for improvement. The other objective of this survey was to give an indication of the effectiveness of existing WASH interventions for future improvement. This survey was not specific to this CERF funded project but was part of UNHCR's year end evaluations of ongoing WASH interventions in all the 9 camps. Through this survey, it was discovered that 99.7 per cent households reported collecting drinking water from protected/treated sources, 39.2 per cent households reported having access to family latrine/toilet and 75.4 per cent households reported defecating in a toilet/latrine. In addition, 78.6 per cent per cent households reported having access to soap, which was a good indication considering the Emergency Standards is ≥ 70 per cent (report attached).

EVALUATION CARRIED OUT ☐

EVALUATION PENDING ☐

NO EVALUATION PLANNED ☒

9.2. Project Report 19-RR-CEF-106 - UNICEF

1. Project Information			
1. Agency:	UNICEF	**2. Country:**	Republic of the Sudan
3. Cluster/Sector:	Water Sanitation Hygiene - Water, Sanitation and Hygiene Health - Health Protection - Child Protection	**4. Project Code (CERF):**	19-RR-CEF-106
5. Project Title:	Integrated three-months response to the cholera epidemic		
6.a Original Start Date:	01/11/2019	**6.b Original End Date:**	30/04/2020
6.c No-cost Extension:	☒ No ☐ Yes	If yes, specify revised end date:	N/A
6.d Were all activities concluded by the end date? (including NCE date)		☐ No ☒ Yes (if not, please explain in section 3)	

7. Funding		
	a. Total requirement for agency's sector response to current emergency:	US$ 13,000,000
	b. Total funding received for agency's sector response to current emergency:	US$ 3,856,922
	c. Amount received from CERF:	US$ 1,450,006
	d. Total CERF funds forwarded to implementing partners	**US$ 575,244**
	of which to:	
	Government Partners	US$ 575,244
	International NGOs	US$ 0
	National NGOs	US$ 0
	Red Cross/Crescent	US$ 0

2. Project Results Summary/Overall Performance

A cholera outbreak, which started on 2 of September 2019 in Blue Nile state, quickly spread to other localities. Total cholera cases reported in Blue Nile were 202 cases and two deaths. On 17 September the disease imported to Sennar states which shares borders with Blue Nile in the south. A total of 132 cases and two deaths were reported in five localities. UNICEF's emergency response focused on the cholera-affected areas in the localities and communities most at risk.

The CERF-funded project supported integrated (WASH), health and nutrition, Communication for Development (C4D) and child protection interventions to respond to the cholera epidemic in Blue Nile, Sennar, Gezira, Khartoum, Gedaref, White Nile, Kassala, and River Nile states.

WASH interventions provided improved drinking water for 569,150 cholera-affected and at-risk population including Internal Displaced People. The interventions were combined with hygiene promotion interventions for 393,6000 people including the distribution of handwashing soap. Six schools (one more than the targeted five schools) in the severely affected areas were provided with gender-sensitive and disability-friendly WASH services combined with hygiene promotion interventions.

Health and nutrition interventions focused on ensuring that the Ministry of Health (at national and state-level) had the capacity to treat any potential cholera cases by prepositioning the necessary medical supplies and kits at the state levels; building the technical capacity of 70 health workers and supporting supervision of the interventions from the national and states levels.

Nutrition supplies were secured to provide lifesaving treatment for 441 Severely Acutely Malnourished (SAM) children through the Out-patient Treatment Programme (OTP) services as well as supporting treatment of SAM children with complications through the provision

of Ready-to-Use Therapeutic Food (RUTF), therapeutic milk and ReSomal. This included the procurement and distribution of a 20 per cent buffer stock which helped to ensure that no facilities experience stock-out throughout the duration of the project. During the project period zero per cent stock-out of Oral Rehydration Solution (ORS) was reported and only one per cent of health and nutrition facilities in the targeted states reported stock-out of RUTF.

Communication for Development interventions reached more than one million cholera-affected and at-risk people through health promotion. Due to Covid-19 pandemic, the community theatre sessions were changed to community awareness campaigns using public announcement, radio, social media, wall drawings and distribution of information, education and communication (IEC) materials taking in consideration the precautionary measures. Therefore, the number of beneficiaries has significantly exceeded target of 300,000 people reached.The child protection section worked in close partnership with implementing partners and in close collaboration will other sectors (health and nutrition, WASH and C4D) to raise awareness on cholera. This was done in Child-Friendly Spaces and Temporary Learning Spaces, through play and role playing. The children continued to raise awareness within their families and communities. In addition, the child protection section trained/involved adolescents in peer-to-peer education and information dissemination A total of 39,140 children were reached in Blue Nile and Sennar states (which is almost double the target).

3. Changes and Amendments

No changes.

4.a Number of People Directly Assisted with CERF Funding (Planned)

Cluster/Sector	Health - Health				
Planned	**Men (≥18)**	**Women (≥18)**	**Boys (<18)**	**Girls (<18)**	**Total**
Host communities	0	0	0	0	**0**
Refugees	0	0	0	0	**0**
Returnees	0	0	0	0	**0**
Internally displaced persons	107	160	63	77	**407**
Other affected persons	533	800	313	388	**2,034**
Total	**640**	**960**	**376**	**465**	**2,441**
Planned	**Men (≥18)**	**Women (≥18)**	**Boys (<18)**	**Girls (<18)**	**Total**
Persons with Disabilities (Out of the total number of "people planned")	0	0	0	0	**0**

4.b Number of People Directly Assisted with CERF Funding (Reached)

Cluster/Sector	Health - Health				
Reached	**Men (≥18)**	**Women (≥18)**	**Boys (<18)**	**Girls (<18)**	**Total**
Host communities	2,719	2,717	2,937	2,828	11,201
Refugees	0	0	0	0	-
Returnees	0	0	0	0	-
Internally displaced persons	137	211	114	137	599
Other affected persons	0	0	0	0	-
Total	**2,856**	**2,928**	**3,051**	**2,965**	**11,800**
Reached	**Men (≥18)**	**Women (≥18)**	**Boys (<18)**	**Girls (<18)**	**Total**

Persons with Disabilities (Out of the total number of "people reached")	0	0	0	0	**0**

4.a Number of People Directly Assisted with CERF Funding (Planned)					
Cluster/Sector	Water Sanitation Hygiene - Water, Sanitation and Hygiene				
Planned	**Men (≥18)**	**Women (≥18)**	**Boys (<18)**	**Girls (<18)**	**Total**
Host communities	0	0	0	0	**0**
Refugees	0	0	0	0	**0**
Returnees	0	0	0	0	**0**
Internally displaced persons	0	0	0	0	**0**
Other affected persons	73,000	77,000	73,000	77,000	**300,000**
Total	**73,000**	**77,000**	**73,000**	**77,000**	**300,000**
Planned	**Men (≥18)**	**Women (≥18)**	**Boys (<18)**	**Girls (<18)**	**Total**
Persons with Disabilities (Out of the total number of "people planned")	0	0	0	0	**0**

4.b Number of People Directly Assisted with CERF Funding (Reached)					
Cluster/Sector	Water Sanitation Hygiene - Water, Sanitation and Hygiene				
Reached	**Men (≥18)**	**Women (≥18)**	**Boys (<18)**	**Girls (<18)**	**Total**
Host communities	79,213	82,447	118,820	123,670	**404,150**
Refugees	0	0	0	0	**0**
Returnees	0	0	0	0	**0**
Internally displaced persons	32,340	33,660	48,510	50,490	**165,000**
Other affected persons	0	0	0	0	**0**
Total	**111,553**	**116,107**	**167,330**	**174,160**	**569,150**
Reached	**Men (≥18)**	**Women (≥18)**	**Boys (<18)**	**Girls (<18)**	**Total**
Persons with Disabilities (Out of the total number of "people reached")	0	0	0	0	**0**

4.a Number of People Directly Assisted with CERF Funding (Planned)					
Cluster/Sector	Protection - Child Protection				
Planned	**Men (≥18)**	**Women (≥18)**	**Boys (<18)**	**Girls (<18)**	**Total**
Host communities	0	0	0	0	**0**
Refugees	0	0	0	0	**0**
Returnees	0	0	0	0	**0**
Internally displaced persons	0	0	0	0	**0**

Other affected persons	0	0	10,350	10,350	**20,700**
Total	**0**	**0**	**10,350**	**10,350**	**20,700**
Planned	**Men (≥18)**	**Women (≥18)**	**Boys (<18)**	**Girls (<18)**	**Total**
Persons with Disabilities (Out of the total number of "people planned")	0	0	0	0	**0**

4.b Number of People Directly Assisted with CERF Funding (Reached)					
Cluster/Sector	Protection - Child Protection				
Reached	**Men (≥18)**	**Women (≥18)**	**Boys (<18)**	**Girls (<18)**	**Total**
Host communities	0	0	1,800	10,389	**12,189**
Refugees	0	0	0	0	**0**
Returnees	0	0	0	0	**0**
Internally displaced persons	0	0	10,451	12,500	**22,951**
Other affected persons	0	0	0	0	**0**
Total	**0**	**0**	**12,251**	**22,889**	**35,140**
Reached	**Men (≥18)**	**Women (≥18)**	**Boys (<18)**	**Girls (<18)**	**Total**
Persons with Disabilities (Out of the total number of "people reached")	0	0	0	0	**0**

In case of significant discrepancy between figures under planned and reached people, either in the total numbers or the age, sex or category distribution, please describe reasons:	For WASH interventions, this overachievement was due to blanket disinfection of water sources which allowed for a much wider reach of “Host communities” in Blue Nile state.

4.c Persons Indirectly Targeted by the Project
1,178,000 people were reached through social media with cholera-awareness messages.

5. CERF Result Framework	
Project Objective	Increase access to integrated lifesaving services for 300,000 cholera-affected and at-risk population

Output 1	Access to improved gender sensitive WASH services increased for 300,000 cholera affected/at risk population with focus on the currently affected states			
Sector	Water Sanitation Hygiene - Water, Sanitation and Hygiene			
Indicators	**Description**	**Target**	**Achieved**	**Source of Verification**
Indicator 1.1	Number of people have access improved water sources through drinking water disinfection interventions	300,000	569,150	Field monitoring visits, reports

Indicator 1.2	Number of people outreached with cholera related hygiene promotion interventions.	300,000	393,600	Field monitoring visits, reports
Indicator 1.3	Number of schools provided with gender sensitive and disability-friendly WASH facilities and cholera related hygiene promotion.	5	6	Field monitoring visits, reports
Indicator 1.4	Number of people who have access to 12 new/rehabilitated improved water sources	55,000	206,884	Field monitoring visits, reports
Explanation of output and indicators variance:		More people were reached with improved water through blanket disinfection of water sources, which was cost-effective and allowed a larger number of people to be reached. There is no re-programming but changing the modality of chlorination where the original plan to target specific water sources but the outbreak moved to the towns in Blue Nile state and UNICEF had to chlorinate the central water resources in using blanket chlorination strategy. This strategy allows preventive services for more people with less amount of chlorine.		

Activities	**Description**	**Implemented by**
Activity 1.1	Flocculate and disinfect affected population water supply for three months.	WES/SWC and State Ministry of Health in both Blue Nile and Sennar states
Activity 1.2	Construct/rehabilitate 12 improved water sources for 55,000 severely affected population (UNICEF will focus on the rehabilitation of existing systems and construction of rapid response emergency water supply systems such as OXFAM tank-based emergency water treatment plants.).	WES Blue Nile and Sennar states
Activity 1.3	Outreach 300,000 cholera affected population with hygiene promotion interventions	State Ministry of Health in Blue Nile and Sennar states
Activity 1.4	Provide 6 schools in the cholera affected areas with improved water, sanitation and hygiene promotion	State Ministry of Health in Blue Nile and Sennar states

Output 2	Government at national and subnational levels have strengthened capacities to respond, treat and prevent AWD/cholera			
Sector	Health – Health			
Indicators	**Description**	**Target**	**Achieved**	**Source of Verification**
Indicator 2.1	Number of Health Workers trained	70	70	Training reports
Indicator 2.2	Percentage of health facility report Oral Rehydration Solution (ORS) stock-out in the affected localities	0 per cent	0	State ministry records and facility stock report
Indicator 2.3	Percentage of OTPs & Stabilization Centres (SCs) with zero stock out of RUTF & therapeutic milk respectively	More than 95 per cent	99 per cent	CMAM database
Explanation of output and indicators variance:		NA		

Activities	**Description**	**Implemented by**
Activity 2.1	Training of 70 community volunteers on AWD/ Cholera prevention and community base referral	Ministry of Health
Activity 2.2	Procurement and distribution of different AWD kits	UNICEF
Activity 2.3	Conduct supportive supervision	UNICEF and Ministry of Health

Activity 2.4	Support operation cost for two mobile clinics to provide integrated primary healthcare (PHC) services to hard-to-reach communities	Ministry of Health
Activity 2.5	Support the procurement and distribution of 441 cartons of RUTF & 52 cartons of therapeutic milk.	UNICEF, State Ministry of Health, and NGO partners
Activity 2.6	Ensuring intact nutrition supplies pipeline for nutrition interventions in the targeted localities	UNICEF, State Ministry of Health, and NGO partners

Output 3	20,700 girls and boys have access to psychosocial distress services and prevention from separation from caregivers in the cholera affected areas in Blue Nile state.			
Sector	Protection - Child Protection			
Indicators	**Description**	**Target**	**Achieved**	**Source of Verification**
Indicator 3.1	Number of girls and boys reached with prevention and response of separation from caregivers	20,700	22,700	Partners report, State Council for Child Welfare (SCCW) desk review, member of sub-sector monitoring report in addition to paralegal association repots
Indicator 3.2	Number of girls and boys who benefited from psychosocial distress response services	2,070	9,346	Partners report, State Council for Child Welfare (SCCW) desk review, member of sub-sector monitoring report in addition to paralegal association repots
Explanation of output and indicators variance:		Because UNICEF added additional intervention areas such as Quranic (Khalwa) schools and Mosques, where interventions were through all mosques in the state. UNICEF responded to the unexpected release (due to COVID-19) of boys and girls from Quranic (Khalwa) schools . The children were released due to the COVID-19 lockdown and benefitted from family tracing and reunification as well as psychosocial support.		

Activities	**Description**	**Implemented by**
Activity 3.1	Raise awareness of children and parents on the risks of separation due to cholera outbreak at Child friendly Spaces, Temporary Learning Spaces, schools, and communities.	State Ministry of Health and Social Development and Paralegals Assassination with support of Future Generation Association.
Activity 3.2	Train the Health and Social workers at the TC's on child protection risk mitigation and provision of Psychosocial Support (PSS) including Psychological First Aid (PFA)	State Ministry of Health and Social Development and Paralegals Assassination with support of Future Generation Association.
Activity 3.3	Provide psychosocial first aid (PFA) and Psychosocial Support (PSS) to at least 2,070 girls and boys	State Ministry of Health and Social Development and Paralegals Assassination with support of Future Generation Association.

Output 4	300,000 cholera affected population reached with C4D/DRR cholera prevention interventions with focus on the currently affected states (Blue Nile and Sennar).			
Sector	Health – Health			
Indicators	**Description**	**Target**	**Achieved**	**Source of Verification**

Indicator 4.1	Number of people who attended the community theatre sessions	300,000	240,000	Field visit reports
Indicator 4.2	Number of community groups and government and NGOs trained of on the Interpersonal Communication (IPC) and community engagement approaches	50	55	Field visit reports
Indicator 4.3	Number of social mobilisation activities organised to engage adolescents, media and drama group	25	35	Field visit reports
Explanation of output and indicators variance:		UNICEF trained fourteen health promotion staff in each of the targeted three states BN, SN and WN. The total number of the trainees was 42 staff, they have been trained on social media usage and management. They shared the cholera prevention message through WhatsApp and Facebook and coordinated with resistance committee members in the three state, they volunteered to share the cholera prevention messages through their informational platforms in Facebook and WhatsApp.As the situation allowed, UNICEF tried to reach additional community groups and organise additional social mobilisation activities.		

Activities	**Description**	**Implemented by**
Activity 4.1	Coordinate with the MoH/Health Promotion department on social mobilisation activities and facilitate the C4D/DRR Task Force meetings for advocacy and community engagement activities to increase utilisation of all WASH and H&N services	State Ministry of Health in Sennar and White Nile states (health promotion department)
Activity 4.2	Train community groups, government and NGOs on the IPC and community engagement approaches to support prevention and responses activities	State Ministry of Health in Sennar and White Nile states (health promotion department)
Activity 4.3	Organise social mobilisation activities by engaging adolescents, media and drama group to raise the awareness at a community level	State Ministry of Health in Sennar and White Nile states (health promotion department)
Activity 4.4	Organise Community Theatre activities in public areas in the target states to enhance public adoption of good health practices to prevent/ end the cholera outbreak.	State Ministry of Health in Sennar and White Nile states (health promotion department)

6. Accountability to Affected People

6.a IASC AAP Commitment 2 – Participation and Partnership

How were crisis-affected people (including vulnerable and marginalized groups) involved in the design, implementation and monitoring of the project?

Targeted cholera-affected populations will participate in the design and planning, implementation and monitoring of the project. They will actively participate in the following activities - with a special focus on the inclusion of children, young people and women:

Project Design and Planning:
Affected populations were consulted at the project design and planning phase in order to determine the best location of the provided services to the extent possible to ensure convenient and safe location for the beneficiaries. For hygiene/health promotion and C4D interventions, implementation partners considered the local culture and language when implementing hygiene sessions.

Project Implementation:
The targeted population supported the project implementation in term of:
- household water treatment;
- hygiene promotion campaigns;

- Household hygiene visits;
- Distribution of hand washing soap;
- Provision of labour work required for the implementation of the project activities.

Monitoring and evaluation
The targeted affected population monitored the performance, operational status and utilisation of health and nutrition facilities and water/sanitation services, mainly through community committees

Where existing local and/or national mechanisms used to engage all parts of a community in the response? If the national/local mechanisms did not adequately capture the needs, voices and leadership of women, girls and marginalised groups, what alternative mechanisms have you used to reach these?

UNICEF normally engage communities in the response through community-based approach and regular advocacy meetings with key community leaders, women, youth, teachers and any other groups who have influential roles within the community. These community members were provided with all the required trainings that help them in managing the services provided to them. UNICEF also ensured the representation of women and girls.

6.b IASC AAP Commitment 3 – Information, Feedback and Action

How were affected people provided with relevant information about the organisation, the principles it adheres to, how it expects its staff to behave, and what programme it intends to deliver?

During the advocacy meetings and in any interaction with key leaders of the community and during the implementation, UNICEF staff are requested to adhere to UNICEF rules and regulations and to act in way that 'do no harm'. UNICEF staff received training on issues related to harassment and gender sensitivity and how to respect the different cultures of the community.

Did you implement a complaint mechanism (e.g. complaint box, hotline, other)? Briefly describe some of the key measures you have taken to address the complaints. Yes ☒ No ☐

The complaints mechanism with feedback loop was implemented.

Did you establish a mechanism specifically for reporting and handling Sexual Exploitation and Abuse (SEA)-related complaints? Briefly describe some of the key measures you have taken to address the SEA-related complaints. Yes ☒ No ☐

Yes, all UNICEF staff is trained on sexual harassment and in each office, there is a focal person for handling PSEA-related issues and the complaint box is placed in all offices for addressing these issues.

Any other comments (optional):
NA

7. Cash and Voucher Assistance (CVA)

Did the project include Cash and Voucher Assistance (CVA)?

Planned	Achieved
No	No

8. Evaluation: Has this project been evaluated or is an evaluation pending?

No specific (end of action) evaluation is planned, but monitoring was done regularly through field visits.	EVALUATION CARRIED OUT ☐
	EVALUATION PENDING ☐
	NO EVALUATION PLANNED ☒

9.3. Project Report 19-RR-WHO-051 - WHO

1. Project Information			
1. Agency:	WHO	**2. Country:**	Republic of the Sudan
3. Cluster/Sector:	Health - Health Water Sanitation Hygiene - Water, Sanitation and Hygiene Nutrition - Nutrition	**4. Project Code (CERF):**	19-RR-WHO-051
5. Project Title:	Integrated response to cholera outbreak in the Republic of Sudan		
6.a Original Start Date:	18/09/2019	**6.b Original End Date:**	17/03/2020
6.c No-cost Extension:	☒ No ☐ Yes	If yes, specify revised end date:	NA
6.d Were all activities concluded by the end date? (including NCE date)		☐ No ☒ Yes (if not, please explain in section 3)	

7. Funding		
	a. Total requirement for agency's sector response to current emergency:	US$ 7,936,233
	b. Total funding received for agency's sector response to current emergency:	US$ 290,000
	c. Amount received from CERF:	US$ 1,150,000
	d. Total CERF funds forwarded to implementing partners	**US$ 0**
	of which to:	
	Government Partners	US$ 0
	International NGOs	US$ 0
	National NGOs	US$ 0
	Red Cross/Crescent	US$ 0

2. Project Results Summary/Overall Performance

WHO prepositioned drugs, supplies and commodities in term of 25 cholera kits, 18 IEHK enough to treat 5,000 cases covering more than 100,000 people at risk of cholera in five states (Sennar, Gezira, Blue Nile, White Nile, Khartoum), cholera treatment protocols were distributed to 210 Health facilities,

A total of 346 cholera cases were reported, with 11 related deaths (CFR 3.1 per cent). WHO supported establishment and implementation of 26 CTCs out of 31 centres in five states (Sennar, Gezira, Blue Nile, White Nile, Khartoum), the CTCs were fully equipped with infection prevention tools and supplies.

WHO directly supported training and re-training of 520 medical staff (160 of them through CERF fund) on cholera case management and 29 Rapid Response Teams, in addition to: 714 medical staff who work in hospitals attended orientation sessions on cholera case management. The RRT teams supported with investigation tools, reagents/RDTs and transportation for quick response, up to 1,079 community health workers trained and supported to disseminate messages on cholera prevention and promote the health. More than 117,000 copies of different IEC materials on cholera prevention and best practice were produced and distributed.

Technical, operational and logistic support for maintaining and strengthening of EWARN system to cover all targeted communities and immediate expansion capacity to cover potential cholera at risk areas (staff training, provision of tools for recording and reporting, centralization and analysis of health data and dissemination of reports.) – Up to 550 alerts of cholera investigated, 63 per cent of them confirmed in Gezaira, Sennar and Blue Nile.

WHO co -ed the WASH response by providing the directions and technical guidance on appropriate interventions. The procurement of water testing supplies (80 starter packs for 16,000 bacteriological samples), 25 mini water testing kits and 15 fogging machines and 45 Hudson sprayers has helped WHO, MoH and other supply agencies and partners to ensure the quality of water provided through regular monitoring and timely control of house flies beside Solid Waste management programs.

With the CERF Rapid Response fund; WHO managed to train 245 environmental health Officers and community volunteers on different environmental health topics including water quality monitoring system, sanitary inspection and health promotion, the trained staff were utilized during the log phase of the outbreak by different agencies in different activities including water quality monitoring, sanitary inspection and improvement of hand pumps, distribution of chlorine tabs for households where people drinks from unprotected sources in addition to the huge involvement in health promotion campaigns supported by UNICEF.
The trained community volunteers also participated in general cleaning campaigns which followed by 60 integrated vector control campaigns targeting flies which are vectors fo diarrheal diseases via a faeces-food pathway. Control of the flies as potential vector for diarrheal diseases is part of the strategy of outbreak control. These campaigns were conducted in high risk areas and included dusting of breeding sites in waste collection points and adult knock down in Wad Alnayal, Singa, EL Roseries, Ed Damazine, and Elsouky. WHO conducted 85 water quality sampling missions and awareness campaigns, in the affected areas in Abu Hujar (Wad Alnayal), Singa, and Elsouky, Sinnar and Aldindir, a total of 3,910 samples were collected, 3,150 houses visited. During the first stage of the chloera response; chlorination coverage was found very low (4 percent) and in order to interrupt the potential transmission of Cholera through drinking water, corrective measures were taken. The water quality monitoring teams distributed chlorine taps to vulenrable households, followed by random water quality check at household level to ensure the utilization of the distributed taps and identify needs for new distribution round. Furthermore, the results of the water quality monitoring were shared with WASH partners and chlorination was scaled up. In the following weeks, 30 per cent of tested water quality samples in the network were found with an acceptable residual chlorine level, while at house hold level the chlorination coverage increased up to 65 per cent in the affected areas following the mass distribution of chlorine taps. WHO conducted a series of feedback meetings and follow up visits to the main water treatment plants in Singa, Wad Alnayal, Al Roseries and Ed Damazine for improvement, of which the gap identified by the monitoring team were addressed by the States Water Corporation with support from UNICEF.

Through this CERF Rapid Response WHO and its partners provided treatment for 2,439 (1,244 girls and 1,195 boys) <5 children suffering from severe acute malnutrition with medical complications in the 10 targeted stabilization centres; out of these admitted children 196 children were suffering from the diarrhoea .The total number of nutrition staff trained on SAM inpatient care were 170 from the 8 targeted states.

In addition to conducting these activities, WHO adopted regional guideline for the treatment of Severe Acute Malnutrition (SAM) children with AWD/Cholera for Sudan. The federal ministry of health, chair of the CMAM Working group and other paediatricians were part of the document reviewing. As result, the guideline was disseminated to the partners and WHO field offices to be used for the treatment of the SAM children with AWD/Cholera.

3. Changes and Amendments

No change in the project has been made, however, due to the successful outbreak response, fewer cases than expected were received. WHO requested to reprogramme funds remaining from the CERF RR allocation for the cholera response to to the Covid-19 response. in February 2020. However, this was not granted; as a result WHO will reimburse CERF with the $600,000 which remained at the end of the project.

4.a Number of People Directly Assisted with CERF Funding (Planned)

Cluster/Sector	Health - Health				
Planned	**Men (≥18)**	**Women (≥18)**	**Boys (<18)**	**Girls (<18)**	**Total**
Host communities	32,744	31,459	38,585	37,072	**139,860**
Refugees	1,785	1,715	2,366	2,274	**8,140**
Returnees	0	0	0	0	**0**

Internally displaced persons	0	0	0	0	**0**
Other affected persons	0	0	0	0	**0**
Total	**34,529**	**33,174**	**40,951**	**39,346**	**148,000**
Planned	**Men (≥18)**	**Women (≥18)**	**Boys (<18)**	**Girls (<18)**	**Total**
Persons with Disabilities (Out of the total number of "people planned")	0	0	0	0	**0**

4.b Number of People Directly Assisted with CERF Funding (Reached)					
Cluster/Sector	Health - Health				
Reached	**Men (≥18)**	**Women (≥18)**	**Boys (<18)**	**Girls (<18)**	**Total**
Host communities	31,104	31,452	38,645	39,060	**140,261**
Refugees	1,450	1,720	2,471	2,560	**8,201**
Returnees	0	0	0	0	**0**
Internally displaced persons	0	0	0	0	**0**
Other affected persons	0	0	0	0	**0**
Total	**32,554**	**33,172**	**41,116**	**41,620**	**148,462**
Reached	**Men (≥18)**	**Women (≥18)**	**Boys (<18)**	**Girls (<18)**	**Total**
Persons with Disabilities (Out of the total number of "people reached")	0	0	0	0	**0**

4.a Number of People Directly Assisted with CERF Funding (Planned)					
Cluster/Sector	Nutrition - Nutrition				
Planned	**Men (≥18)**	**Women (≥18)**	**Boys (<18)**	**Girls (<18)**	**Total**
Host communities	0	0	81	83	**164**
Refugees	0	0	9	10	**19**
Returnees	0	0	0	0	**0**
Internally displaced persons	0	0	0	0	**0**
Other affected persons	0	0	0	0	**0**
Total	**0**	**0**	**90**	**93**	**183**
Planned	**Men (≥18)**	**Women (≥18)**	**Boys (<18)**	**Girls (<18)**	**Total**
Persons with Disabilities (Out of the total number of "people planned")	0	0	0	0	**0**

4.b Number of People Directly Assisted with CERF Funding (Reached)					
Cluster/Sector	Nutrition - Nutrition				
Reached	**Men (≥18)**	**Women (≥18)**	**Boys (<18)**	**Girls (<18)**	**Total**

Host communities	0	0	86	90	**176**
Refugees	0	0	10	10	**20**
Returnees	0	0	0	0	**0**
Internally displaced persons	0	0	0	0	**0**
Other affected persons	0	0	0	0	**0**
Total	**0**	**0**	**96**	**100**	**196**
Reached	**Men (≥18)**	**Women (≥18)**	**Boys (<18)**	**Girls (<18)**	**Total**
Persons with Disabilities (Out of the total number of "people reached")	0	0	0	0	**0**

4.a Number of People Directly Assisted with CERF Funding (Planned)					
Cluster/Sector	Water Sanitation Hygiene - Water, Sanitation and Hygiene				
Planned	**Men (≥18)**	**Women (≥18)**	**Boys (<18)**	**Girls (<18)**	**Total**
Host communities	35,044	33,670	46,454	44,632	**159,800**
Refugees	2,237	2,149	2,965	2,849	**10,200**
Returnees	0	0	0	0	**0**
Internally displaced persons	0	0	0	0	**0**
Other affected persons	0	0	0	0	**0**
Total	**37,281**	**35,819**	**49,419**	**47,481**	**170,000**
Planned	**Men (≥18)**	**Women (≥18)**	**Boys (<18)**	**Girls (<18)**	**Total**
Persons with Disabilities (Out of the total number of "people planned")	0	0	0	0	**0**

4.b Number of People Directly Assisted with CERF Funding (Reached)					
Cluster/Sector	Water Sanitation Hygiene - Water, Sanitation and Hygiene				
Reached	**Men (≥18)**	**Women (≥18)**	**Boys (<18)**	**Girls (<18)**	**Total**
Host communities	35,121	33,816	46,012	44,657	**159,606**
Refugees	2,169	2,114	2,960	2,924	**10,167**
Returnees	0	0	0	0	**0**
Internally displaced persons	0	0	0	0	**0**
Other affected persons	0	0	0	0	**0**
Total	**37,290**	**35,930**	**48,972**	**47,581**	**169,773**
Reached	**Men (≥18)**	**Women (≥18)**	**Boys (<18)**	**Girls (<18)**	**Total**
Persons with Disabilities (Out of the total number of "people reached")	0	0	0	0	**0**

In case of significant discrepancy between figures under planned and	N/A

reached people, either in the total numbers or the age, sex or category distribution, please describe reasons:	

4.c Persons Indirectly Targeted by the Project

More than 1 million people living in the prioritized localities are the indirectly benefiting having access when/if needed to CTCs, being also covered by an activated EWARS and rapid response mechanism. An efficient control of community spread of cholera through public health interventions such as water quality surveillance as the base of corrective measures and campaigns for community awareness and education had a protective effect on all communities living in the targeted localities

5. CERF Result Framework

Project Objective	To provide a timely and integrated multi-sector cholera response and control of community spread in 8 states at very high risk in Sudan.

Output 1	To improve the access to quality treatment for the cholera patients aiming to decrease the case fatality rate to internationally acceptable level in Blue Nile and Sennar states			
Sector	Health – Health			
Indicators	**Description**	**Target**	**Achieved**	**Source of Verification**
Indicator 1.1	Case fatality rate for cholera for the project period.	1 per cent	3.1 per cent	2019 Cholera outbreak report, FMOH/WHO
Indicator 1.2	Number of CTCs with trained staff	18	26	WHO/FMOH report
Explanation of output and indicators variance:		The CFR is 3.1 per cent is higher than the standard rate, but the attack rate is below the emergency level as only 346 cases reported and responded to in all states. 26 CTCs were established and made ready but only 15 were received cases.		

Activities	**Description**	**Implemented by**
Activity 1.1	Procurement and distribution of 20 Cholera (re-assembled) kits that includes medicines, and renewable for the treatment of 2,000 cholera inpatient (1 kit covers the treatment of 100 severe dehydration cases). This will cover around 15,6 per cent of the projection of cases over the next 6 months, filling in the immediate gaps as CERF RR is the fastest funding mechanism for response to acute crisis. The SHF, CERF UF and WHO Central Fund for Emergencies will complement. The quantities will be distributed as per identified needs, complementing the response already initiated in Sennar and Blue Nile, increasing the rapidly evolving stock in White Nile where the risk due the significant trans-borders movement is very high, and also providing essential surge stock for the other targeted 5 states that are not included into the Sudan HRP (details in the table of activities – Summary heading). The quantities and locations could be changed depending on situation development. The kits to be procured from WHO Dubai stock for shorter delivery time.	WHO through international procurement
Activity 1.2	Distribution of Medical equipment and furbishing for Cholera Treatment Centres (CTC) focusing on the availability of infection prevention tools and materials. The distribution focus on the existing CTCs in Blue Nile (3 CTCs) and Sennar (3 CTCs) identified as in needs. Essential, minimal surge stock for	WHO

	immediate response will be established in all other states tailored on the risk (table of activities in summary). The quantities/location could be changed depending on situation development.	
Activity 1.3	Procurement of Personal Protection equipment (PPE) for the staff working in CTCs (sufficient for 15 CTCs for 3 month). Distribution would be determined by the situation development	WHO
Activity 1.4	Procurement and distribution of Infection prevention materials for the disinfection of surfaces, skin and instruments.	WHO
Activity 1.5	Training of the medical and auxiliary staff (cleaners, sprayers) for optimal quality of care in 18 CTC in Gezira, Gedaref, Kassala and River Nile states: at least 30 per cent of trainees to be female staff. These states have almost no humanitarian programs, although people's needs have been increasing since the economic crisis (2018) and the risk for rapid spread of cholera is very high. The allocations from SHF are small, and they are not covered by CERF UF.	WHO and MOH
Activity 1.6	Transfer to SMOH for the operational costs for 5 CTCs – In Blue Nile 2 CTCs in Wad el Mahdi and Bau localities, and in Sennar states three CTCs in Sinja, Dali & Mazoum, and Suki localities. WHO had initiated the support of the MOH to run these five CTCs and there is need for continuous support as outbreak is still ongoing. This includes incentives for the staff to ensure 24 hours, seven days a week functioning. Support through Save the Children (SC) of 2 CTCs in Dani & Mazoum and Sennar (Sennar state) for improvement of the quality of provided services bringing additional competencies and partnership in Sennar Save the Children (SC) will also implement WASH component at community level. All CTC will have at least 30 per cent female staff to promote acceptance (local social norms) as more than 60 per cent of the patients are female.	WHO, MOH and Save the children
Activity 1.7	Supportive monitoring and supervision to include on-the –job coaching essential for following up the impact of training and correction of the implementation of protocols.	WHO and MOH

Output 2	Timely identification, confirmation, and initiation of response for the control and prevention of community transmission of cholera outbreak tailored on effective collection, analyses and dissemination of critical health data in 8 high risk states of Sudan			
Sector	Health - Health			
Indicators	**Description**	**Target**	**Achieved**	**Source of Verification**
Indicator 2.1	Percentage of alerts investigated within 28 hours from notification	98 per cent	97 per cent	Outbreak report
Indicator 2.2	Percentage of Health facilities reporting to EWARS/daily zero reporting in targeted states	98 per cent	98 per cent	Surveillance reports
Explanation of output and indicators variance:		N/A		
Activities	**Description**		**Implemented by**	

Activity 2.1	Training of Rapid Response Teams (RRTs with at least 30 per cent female participants) from 18 localities at high risk in Gezira Gazira (Shark al Gezira, Ganub Al Gezira, El kameleen, Hassahisa, Wad Madani), Gedaref (Gedaref, Al Fashanga, El Faw, Basanda, El Mofanza), Kassala (Shamal Il Delta,Gharbi, Halfa, Wad el Hellew), and River Nile (Al Buhaira, al Mattana, Shandi, Al Damir). The RRTs are vital for ensuring that any alerts are immediately investigated, samples taken for confirmation, active case-finding, potential source/s of infection and ways of transmission identified, and immediate community awareness and education initiated. To ensure acceptability at least 30 per cent of the RRTs staff will be female. WHO already trained more than 2,000 Community volunteers for community-based surveillance who will be activated to support immediate reporting from communities of alerts. The SHF funding and CERF UF (for Blue Nile) will complement to implement in all high-risk localities and states.	WHO and MOH
Activity 2.2	Alert investigation missions by the RRTs (SMOH and WHO jointly) operational costs. The RRTs will be provided with sampling materials, RDT, protocols and guidelines for closest Health Facilities (HFs)s, and health promotion materials to initiate health education campaigns in affected areas (schools, mosques, community groups) it is expected that between 4000-6000 people will benefit from each alert investigation mission.	WHO, MOH, Save the children and WASH partners
Activity 2.3	Procurement of laboratory materials for immediate confirmation and quality check, including RDT, sampling material and lab confirmation kits (including zero-typing and antibiogram) for 1200 cases.	WHO through international procurement
Activity 2.4	Activation of EWARS/daily reporting in targeted localities through printing and distribution of case definition to be distributed by the locality health authorities and coaching and monitoring during the supervisions and alert investigation missions.	WHO and MOH

Output 3	Provision of lifesaving SAM inpatient services to the under-five SAM children suffering from Cholera/AWD in the 8 targeted states of Blue Nile, Sennar, El Gezira, Gedarif, Kassala, Khartoum, Red Sea and River Nile.			
Sector	Nutrition - Nutrition			
Indicators	**Description**	**Target**	**Achieved**	**Source of Verification**
Indicator 3.1	Number and coverage of children suffering of SAM Cholera/AWD treated in supported SCs/CTCs	100 per cent (183: 93 girls, 90 boys)	196 (100 girls, 96 boys)	Registers of SCs
Indicator 3.2	Number of health staff trained on case management of SAM <5 children with Cholera/AWD	160 (80 males, 80 female)	170 (82 male, 88 Female	Supervision Reports
Explanation of output and indicators variance:		N/A		

Activities	**Description**	**Implemented by**
Activity 3.1	Procurement and distribution of SAM inpatient Kits including fluids for the 10 SCs in targeted eight states and the 11 CTCs (in affected states Sennar and Blue Nile)	WHO

Activity 3.2	Capacity Building of the targeted CTCs (Blue Nile and Sennar) and SCs (all 8 targeted states) Staff 160 on WHO standard treatment protocol for the SAM children suffering from Cholera/AWD.	WHO
Activity 3.3	Supervision of the CTCs and SCs staff in the target 8 states	WHO and MoH
Activity 3.4	Printing and dissemination of IEC materials and treatment protocols to the targeted 10 SCs and 11 CTCs	WHO

Output 4	Water quality monitoring established and functioning in the 8 states and supporting the identification and control of water borne diseases outbreaks			
Sector	Water Sanitation Hygiene - Water, Sanitation and Hygiene			
Indicators	**Description**	**Target**	**Achieved**	**Source of Verification**
Indicator 4.1	Functioning and monthly reporting water quality monitoring systems	8 states	8 states	Reports from MOH data base and WHO field report
Indicator 4.2	Water sampling and testing missions with finding reported and disseminated to partners	50 Mission	85 missions	Daily MoH and WHO Field reports
Explanation of output and indicators variance:		The number of water quality missions was increased because the chlorination levels were extremely low. Therefore a scale up of chlorination was quickly required which resulted in an initiative of chlorine tablet distributions with following quality visits to the households. The effects of the chlorination were monitored very closely on household level as much as on community level.		

Activities	**Description**	**Implemented by**
Activity 4.1	Water quality testing supplies (H2S bottles and DPD tabs) for the state water quality laboratories in Sennar, Blue Nile, Gaderef, El Gezira, Kassala, Khartoum, White Nile, and River Nile to conduct testing in all affected and high-risk areas. Local procurement for rapid delivery	WHO
Activity 4.2	20 mini water testing kits: each Kit covers 1000 Samples (5,000 Population) testing for PH, Fecal Contamination, Turbidity and Free Residual Chlorine (FRC) Kits will be distributed to gap areas to complement the procurement from previous Pooled emergency funds and bilateral WH funding. Sennar and Blue Nile 3 kits each as outbreak is ongoing, and 2 kits/each for White Nile, River Nile, Kassala, Khartoum, Gezira and Gedaref.	WHO
Activity 4.3	Support the infection prevention and control in CTCs to prevent the hospital acquired infections, and cholera transmission through the CTCs. this will be 18 CTCs as follow: Blue Nile 3 out of 6 functioning CTCs (3 supported by MSF Spain), Sennar: 4 CTCs out of 5 functioning (1 supported by MSF Swiss), 2 in Khartoum (Bashair and Un Durman), River Nile 1 CTCs, Kassala 1 CTC, White Nile 2 CTCs , 2 CTCs in Gazera and 2 CTCs in Gadaref State – See annex for details of the items included. The quantities and locations would be adapted to the situation developments.	WHO
Activity 4.4	Printing of the water surveillance format and demonstration materials for the household water treatment and storage	WHO and SMoH

Activity 4.5	Training of 280 Environmental Health officers, workers and volunteers on water safety planning, water sampling and testing, household water treatment and storage and water sources risk assessment.	WHO and SMoH
Activity 4.6	Water sampling and testing missions in the targeted locations & localities	WHO and SMoH

6. Accountability to Affected People

6.a IASC AAP Commitment 2 – Participation and Partnership

How were crisis-affected people (including vulnerable and marginalized groups) involved in the design, implementation and monitoring of the project?

Cholera outbreak was declared during a critical time of civil unrest and nationwide lack of medicine. The project was designed based on results of risk assessments and integrated response plan developed with involvement of partners, affected communities including the refugees and displaced populations were consulted and involved in implementation of the earmarked response activities such as community mobilization and monitoring of water sources. Community volunteers for hygiene promotion and vector control were selected and trained from the respective communities. WHO made use of its team existing prior to the outbreak for flood response. Preparedness and response for the outbreak were done smoothly and all community components were actively engaged in addition to the strong participation in the daily taskforce meeting as important member.

Nutrition field teams had consultations with the stakeholder at the state level including SMOH and affected communities about their perceived needs and gaps. The information from the stakeholders were considered during the project design in order to be responsive to all crisis-affected children without any distinction. The project supported all people in the catchment area of the 10 targeted stabilization centres in the without any discrimination with the basics of leaving no one behind.

Were existing local and/or national mechanisms used to engage all parts of a community in the response? If the national/local mechanisms did not adequately capture the needs, voices and leadership of women, girls and marginalised groups, what alternative mechanisms have you used to reach these?

Consultations with the WHO field response teams, the MOH (national and state level, community leaders and NGOs. community based surveillance has been established where the community members trained and equipped and continue reporting on outbreak events and identification of needs.

6.b IASC AAP Commitment 3 – Information, Feedback and Action

How were affected people provided with relevant information about the organisation, the principles it adheres to, how it expects its staff to behave, and what programme it intends to deliver?

WHO having field offices in these states, the affected community are engaged in many health programmes and aware about WHO principles. The community health promoters were select from the same affected communities, undergone trainings on risk communication and community best practise messages, the community volunteers delivered messages to their communities on role of WHO, SMOH and international community roles and responsibilities, messages on cholera prevention and best practise is disseminated.

Did you implement a complaint mechanism (e.g. complaint box, hotline, other)? Briefly describe some of the key measures you have taken to address the complaints. Yes ☐ No ☒

No separate complaint mechanism being established; hence the community-based surveillance system serves as complaint mechanism. Community health workers also are selected from the respective communities, trained and established to deliver messages on best practice. During their home's visits and group sessions the CHWs records the health needs and complaints raised by the communities. WHO monitoring visits to the clinics also check the availability of medicines and tools in addition to issues raised by medical staff. Meetings with community health promoters and community leaders also serves as complaint mechanism and reporting tool.

Did you establish a mechanism specifically for reporting and handling Sexual Exploitation and Abuse (SEA)-related complaints? Briefly describe some of the key measures you have taken to address the SEA-related complaints.	Yes ☒ No ☐
WHO is a signatory of the PSEA framework with the humanitarian country team, trained the staff and established the complaint mechanism at the country office	
Any other comments (optional): N/A	

7. Cash and Voucher Assistance (CVA)	
Did the project include Cash and Voucher Assistance (CVA)?	
Planned	**Achieved**
No	No

8. Evaluation: Has this project been evaluated or is an evaluation pending?	
WHO usually doesn't evaluate standalone project, instead; WHO conducts produces annual report and continuous assessments	EVALUATION CARRIED OUT ☐
	EVALUATION PENDING ☐
	NO EVALUATION PLANNED ☒

ANNEX 1: CERF FUNDS DISBURSED TO IMPLEMENTING PARTNERS

CERF Project Code	CERF Sector	Agency	Implementing Partner Type	Total CERF Funds Transferred to Partner US$
19-RR-CEF-106	Water, Sanitation and Hygiene	UNICEF	GOV	$10,000
19-RR-CEF-106	Water, Sanitation and Hygiene	UNICEF	GOV	$81,494
19-RR-CEF-106	Water, Sanitation and Hygiene	UNICEF	GOV	$40,587
19-RR-CEF-106	Water, Sanitation and Hygiene	UNICEF	GOV	$8,182
19-RR-CEF-106	Water, Sanitation and Hygiene	UNICEF	GOV	$58,693
19-RR-CEF-106	Water, Sanitation and Hygiene	UNICEF	GOV	$33,110
19-RR-CEF-106	Water, Sanitation and Hygiene	UNICEF	GOV	$160,977
19-RR-CEF-106	Water, Sanitation and Hygiene	UNICEF	GOV	$101,648
19-RR-CEF-106	Health	UNICEF	GOV	$8,978
19-RR-CEF-106	Health	UNICEF	GOV	$8,978
19-RR-CEF-106	Health	UNICEF	GOV	$14,000
19-RR-CEF-106	Health	UNICEF	GOV	$6,328
19-RR-CEF-106	Health	UNICEF	GOV	$12,269
19-RR-CEF-106	Child Protection	UNICEF	GOV	$30,000
19-RR-HCR-035	Water, Sanitation and Hygiene	UNHCR	INGO	$16,399
19-RR-HCR-035	Water, Sanitation and Hygiene	UNHCR	GOV	$1,000
19-RR-HCR-035	Water, Sanitation and Hygiene	UNHCR	INGO	$3,056
19-RR-HCR-035	Water, Sanitation and Hygiene	UNHCR	GOV	$2,842

ANNEX 2: ACRONYMS AND ABBREVIATIONS (Alphabetical)

AAP	Accountability to Affected Populations
ANC	Ante Natal Care
AWD	Acute Watery Diarrhoea
C4D	Communication for Development
CFM	Complaint and Feedback Mechanism
CFR	Case Fatality Rate
CFSs	Child Friendly Spaces
CHAST	Child Hygiene and Sanitation Training
CHW	Community Health Workers
CLTS	Community-led Total Sanitation
CMAM	Community Management of Acute Malnutrition
CSOs	Civil Society Organizations
CTCs	Cholera Treatment Centres
ES/NFIs	Emergency Shelter/Not Food Items
EWARS	Early Warning and Alert Reporting System
FMOH	Federal Ministry of Health
FP	Family Planning
HAC	Humanitarian Aid Commission
HCT	Humanitarian Country Team
IDP	Internally Displaced Person
IPC	Infection Prevention and Control
IMCI	Integrated Management of Childhood Illness
IYCF	Infant and Young Child Feeding
MAM	Moderate Acute Malnutrition
MoE	Ministry of Education
MoH	Ministry of Health
NGO	Non-Governmental Organization
NGOs	Non-Governmental Organizations
NPHL	National Public Health Laboratory
OCHA	Organization for the Coordination of Humanitarian Affairs
OPT	Outpatient Treatment Center
ORT	Oral Rehydration Therapy
PHC	Primary Health Care
PLW	Pregnant and Lactating Women
RH	Reproductive Health
RRT	Rapid Response Team
RRK	Rapid Response Kits
RUSF	Ready to Use Supplementary Food
RUTF	Ready to Use Therapeutic Food
SAM	Severe Acute Malnutrition
SC	Stabilization Centre
SFP	Supplementary Feeding Program
SHF	Sudan Humanitarian Fund
SMoE	State Ministry of Education
SMoH	State Ministry of Health
SRCS	Sudanese Red Crescent Society

SRH	Sexual and Reproductive Health
SSR	South Sudanese Refugees
UNHCR	United Nations High Commission for Refugees
UNICEF	United Nations" Children Fund
WASH	Water, Sanitation and Hygiene
WES	Department for Water and Sanitation (Ministry of Health)
WFP	World Food Programme
WHO	World Health Organization