WASH CLUSTER 2012

WASH Cluster AWD/Cholera Preparedness and Response Plan

Objective:

The purpose of the cholera preparedness and response plan is to establish a minimum service provision for cholera and AWD outbreaks in order to control the extent and spread of AWD/Cholera outbreaks. It details which agency will coordinate response, in which locations and the protocols the responding agencies will follow. Agencies may go above and beyond the minimum level of service detailed here, but should not provide less.

Key Documents – on WASH Cluster website

- WASH/Health Cluster and Communications Responsibilities Matrix for AWD/Cholera Response
- InterCluster Hygiene Promotion Plan
- Somalia Specific Hygiene Promotion IEC material (flip chart, 3 piles sorting picture) and northern Kenya material
- AWD/Cholera Preparedness and Response Fact Sheets for use by Schools, OTPs, Health Centres, and for Burial
- Guide to WASH in Cholera Treatment Centres

Key Links

- WASH Cluster website: http://ochaonline.un.org/somalia/WASH
- WASH Cluster Somalia Hygiene Promotion and AWD/Cholera: Click the link on the WASH Cluster website, or go directly to: http://ochaonline.un.org/somalia/Clusters/WASH/HygienePromotion/tabid/7688/language/en-US/Default.aspx, for:
- Health Cluster website: http://healthsomalia.org
- SWALIM Flood Risk and Response Management Information System (daily update of current floods and river levels): http://www.faoswalim.org/subsites/frrmis/index.php

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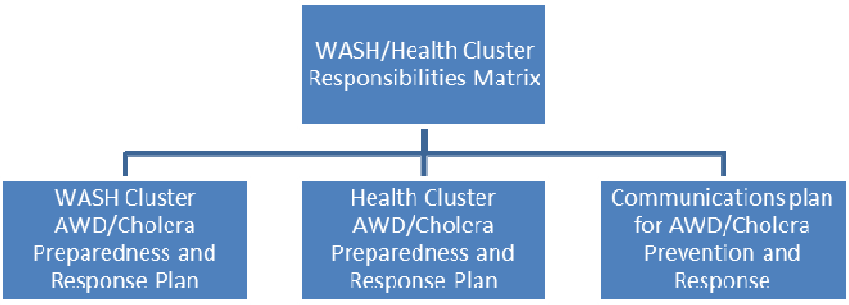
Preface

This is the key WASH Cluster plan, under the overarching WASH/Health Cluster and Communications Responsibilities Matrix for AWD/Cholera Prevention and Response, which is in Annex 1. The Health Cluster has an equivalent plan.



Minimum Service Provision

Overall response objectives

Control the extent of the outbreak and prevent the spread of AWD cholera, as per the WASH Cluster responsibility in the WASH/Health Cluster and Communications Responsibility Matrix for AWD/Cholera Prevention and Response in Annex 1.

Targets

100% of the population in high and medium risk areas with the following **minimum interventions** are covered[1]:

1. Ensuring access and use of Safe drinking water, via:
    a. Chlorination of unprotected sources
    b. Household water treatment and safe storage
2. Ensure hand washing with soap/ash (and safe hygienic practice)
3. Ensure safe excreta disposal in high risk areas:
    a. Cholera Treatment Centres (CTC's)
    b. Hospitals
    c. Wherever people report for treatment, e.g. Health Centre
    d. Areas of dense population (e.g. IDP settlements) as per Cluster standards (50 people (ideally 8 households) per latrine)
4. Ensure solid waste disposal in high risk areas
    a. Food handling areas, markets
    b. Areas of dense population (e.g. IDP settlements), with poor sanitation
    c. To clear drainage to prevent flooding in food handling areas, markets, CTC, Health Facility and Nutrition Centre

Total numbers

Populations at risk of cholera (as per Health Cluster Worst Case Scenario in the AWD/Cholera Preparedness and Response Plan Feb 2012):

- 5.6 million at risk of cholera

Timeframe

- Ongoing for areas with confirmed Cholera outbreak.
- Mid-October, and mid- March for preparedness / prevention
- The response will continue in high risk areas until the end of the rainy season or three weeks after the last confirmed case within the same district.

Indicators

Access to a temporary source of safe water – includes chlorination and vouchers
Access to a sustained source of safe water – includes boreholes, protected shallow wells
Number of people reached with participatory hygiene promotion

[1] WASH infrastructure in health Centres and CTC agreed primary responsibility of Health Cluster, with technical support from WASH Cluster as requested.

WASH Cluster Cholera Preparedness and Response Plan

Preparedness and Response Plan

No.	Target	Minimum Interventions	Minimum Activities	Standard Required	Further info
1.		Preparedness	• Preposition Chlorine and minimum WASH hygiene kit	• Minimum WASH Hygiene Kit (on WASH Cluster website) includes: - Jerry cans: one to be 20 liter, second can be 10 or 20 litre - Water treatment tablets: 1 tablet per 20 L container (ideally 67 mg/L NaDCC, ideally in strips for longer life). 100 tablets per household for three months supply – to provide 20 litres drinking water per HH per day - Soap (3 months supply = 2400 g per household)	Minimum WASH Hygiene Kit (available on website)
2.			• Coordination	• Regional Focal Point facilitate review of prevention measures, monitor response, and facilitate action to fill gaps • District Focal Point for AWD/Cholera and Flooding to establish local links with Health centres, for quick response and improved source investigation. Review preparedness and response, report gaps to Regional and National Cluster	ToR for Regional and District Focal Points – Annex 12
3.	Ensuring access and use of Safe drinking water	Chlorinate unsafe water sources	• Test all protected water sources to identify which are unsafe	• Test all protected water sources (boreholes, protected shallow wells) to confirm they are safe. To test use: a) H2S vial (for presence or absence of bacterial contamination) b) Sanitary Survey (to identify high, medium or low risk of bacterial contamination) Medium to longer term: Map water sources in SWIMS, marking protected or unprotected sources	Sanitary Survey (see WASH Cluster website)
4.			• Chlorinate unprotected wells and unsafe sources	• A positive free chlorine residual at all times of the day. To be measured for one week, at various times of the day, to confirm the dose is sufficient to achieve a positive chlorine residual at all times • If well chlorination is not able to provide safe water at all times of the day, options include: - Household water treatment with tablet (aquatabs, watermaker) - Bucket chlorination at the water point (the point of collection), to be done by a volunteer or NGO staff. Awareness is needed before starting this method. - Slow dissolving chlorine tablet (swimming pool chlorine) (UNICEF will check the feasibility) Medium/longer term: Protection of shallow wells + Establish spare parts	Chlorination – Annex 7 Effective Chlorination of shallow wells – Annex 8

No.	Target	Minimum Interventions	Minimum Activities	Standard Required	Further info
				mechanism to maintain hand pumps	
5.			• Chlorination of piped water systems	• Free Residual Chlorine should be maintained at 0.5 mg/l and verified twice a day	Effective Chlorination– Annex 8
6.		100% Household water treatment	• Household water treatments	• Household water treatment recommended to all households using private or protected sources of water (double barrier) - Water Treatment Tablets (eg aquatabs for clear water/low turbidy or Water maker/Pur (chlorfloc) for high turbidity - greater than 20 NTU) - Water filters for more sustainable approach • Detailed instructions in local language • Monitor use	
7.	Ensure handwashing with soap/ash, and hygienic practices	Behaviour change intervention Provision of soap	• Distribute minimum WASH Hygiene Kit • Hygiene promotion in: - IDP camps - Households - Nutrition Centres - Health Centres • Mass hygiene promotion campaign (e.g. radio, mosques etc.)	• Minimum WASH hygiene kit includes soap, jerry can and water treatment tablets • WASH Cluster Emergency Hygiene Promotion Package (3 day training, with trainers available across Somalia). This includes includes F-diagram, three pile sorting, and how to make ORS • Standards in InterCluster Hygiene Promotion Plan (available on WASH Cluster website), and recommended salaries/incentives - One Community mobiliser per 500 people - 40% of Community mobilisers should be women - One Hygiene Promoter per 15-20 Community Mobilisers - Hygiene promotion project should be at least 6 months - Recommended payments are: Community Mobiliser = incentive to $US30, Hygiene Promoter, for supervision = $US150-300, Field WASH/HP Coordinator (50%) = $US 300-1000 • Messages as per InterCluster Hygiene Promotion Plan (available on WASH Cluster website) • In an outbreak: - Disinfect affected households by patient relatives and caretakers - Provide relatives and or caretakers of patients with soap, disinfectant (or concentrated chlorine product) and hygiene education that will allow them to protect themselves and their relatives - Train relatives to disinfect their toilet cooking utilities and beddings etc	InterCluster Hygiene Promotion Plan (on WASH website) Key Hygiene promotion messages for Cholera – Annex 6
8.	Ensure Safe excreta	Where ever people report for treatment,	• Construction of communal latrines in high risk areas	• Provide toilets with hand washing facilities at Cholera Treatment Centres (CTCs), and health facilities where cholera patients might go. This is the responsibility of health cluster, but WASH Cluster can support	Guide for WASH in CTC's (on

No.	Target	Minimum Interventions	Minimum Activities	Standard Required	Further info
	disposal in high risk areas	incl CTCs			website)
9.		Areas of dense population	• Latrines in IDP camps or settlements	• Cluster emergency standards are 50 people per latrine (ideally 8 households per latrine, to improve chance of latrine staying clean). • Promote keeping toilets clean – disinfecting if possible	WASH Cluster Strategic Operational Framework (on website)
10.			• Public Places like schools and markets	• Consider sanitary facilities including handwashing stations initially focussing on schools with feeding program	
11.	Ensure solid waste disposal in high risk areas	Food handling areas, markets, CTC's	• Clean up campaigns in high risk areas E.g. IDP settlements, with poor sanitation • Clear drainage to prevent flooding in high risk areas	• In general, solid waste disposal and the cleaning of drains will not be seen as an immediate priority, unless it can clearly prevent high risk areas from flooding (markets, high density population areas), or where waste is mixed with faecal matter • CTC's should not be built in areas that are prone to flooding. On request, the WASH cluster can assist the health cluster maintain drainage around CTC's and health facilities to further reduce those risks	
12.		Waste from CTCs		• Safe disposal of waste generated at the CTCs is the responsibility of Health cluster, but WASH Cluster can support	
13.	Schools and child friendly spaces			• Provide hand washing stations, sanitation, safe water & mobilize the students and teachers to understand cholera and how to prevent it • Provide hygiene kits to schools containing IEC material (WASH and education), water purification tablets, soap and preferably hand washing stands • Provide latrines at schools in affected areas with confirmed cholera cases, were the decision is taken to keep the school open.	Cholera Guides for teachers (on website)

Assumptions behind Prevention and Response Plan

- Provide a minimum quantity of 3 litres of chlorinated water per person per day for drinking water during AWD/Cholera response. (3 x 6 people = 18L per family per day)

Excreta disposal

- Increasing sanitation coverage nationwide is a long/medium term project, and although ensuring safe disposal of excreta should be key in the long-term cholera response, due to the scale and size of the areas affected or at risk for emergency response, the provision of toilets or safe excreta disposal at family level is of a lower priority, than the provision of safe water supply and hygiene education. It is unlikely that good sanitation coverage will be achieved in the short term with limited resources and time.

Solid waste

- General collection of waste is not seen as an emergency priority by the WASH cluster to control the cholera outbreak.

Annex 1: Responsibilities Matrix for WASH and Health Clusters for AWD Preparedness

(Last updated 25 February 2012)

Objective

This document details the responsibilities of WASH Cluster, Health Cluster and Communications for AWD/Cholera response, to reduce the number of outbreaks and minimise lives lost. The WASH Cluster, Health Cluster, and Communications have Cluster specific AWD/Cholera Preparedness and Response Plans which provide the technical detail to meet the responsibilities agreed in this matrix. These documents are available on the Cluster websites:

- WASH: http://ochaonline.un.org/somalia/WASH
- Health: http://healthsomalia.org

Note: ***Responsibility is ensuring the activity is done, not necessarily doing it***

Definitions:
CTC (Cholera treatment centres) = approx. 50 beds
CTU (Cholera treatment units) = approx. 5 beds
ORP (Oral rehydration point)
ORD (Oral rehydration depot)

RUMOURS OF ACUTE WATERY DIARRHOEA (AWD)
Please report all rumours of AWD outbreaks directly to Health Cluster, copying WASH Cluster. The Health Cluster will then work with partners to verify the information (target within 96 hours). If possible please include: What is the problem (with time frame), Where is the problem, Who is affected, Source of info with contact details. Please also state that the report or correspondence is currently "unconfirmed".

Please report rumours via email
TO Health Cluster team: cluster@nbo.emro.who.int, Angalukia@nbo.emro.who.int, sifumaj@nbo.emro.who.int, ayalo@un.org, saleho@nbo.emro.who.int

COPY WASH Cluster team and Zonal focal points: kharries@unicef.org, sokiomeri@unicef.org, fatali@unicef.org, dabuuru@unicef.org, skemoh@unicef.orgmailto:, aissack@unicef.org, mhasan20@gmail.com

If you need to follow-up, contact:
•Health Cluster Coordinator: Dr Kamran Mashhadi: +254 736 100 188
•Emergency Health Action (EHA-WHO): Dr Anthony Angaluki: +254 736 100 177

Health Cluster to copy all alert emails to the following:
kharries@unicef.org, sokiomeri@unicef.org, fatali@unicef.org, dabuuru@unicef.org, skemoh@unicef.orgmailto:, aissack@unicef.org, mhasan20@gmail.com, trteh@unicef.org, ssingh@unicef.org, mwarfa@unicef.org, jnikulin@unicef.org

Health/WASH/Communications – AWD/Cholera Responsibilities Matrix

Area	Specific Activity	Responsibility		
		WASH Cluster	Health Cluster	Communications
Coordination	Responsibilities	Review and disseminate WASH/Health AWD/Cholera Responsibilities Matrix	Review and disseminate WASH/Health AWD/Cholera Responsibilities Matrix	Review and update the communications responsibilities
	Central location for resources	Maintain WASH web site up to date, including Hygiene Promotion webpage	Maintain Health cluster web site up to date	Ensure communication and C4D material on websites are up to date. Provide guidance on updating web sites. (propose: WASH HP page for tools and guidance for partners, and Stamp Out Cholera page for donor/media information)
	Plan	Maintain and disseminate up to date WASH AWD Preparedness and Response plan – linking to overaching Responsibilities Matrix	Maintain and disseminate up to date Health AWD Preparedness and Response plan – linking to overaching Responsibilities Matrix. Maintain and disseminate high AWD risk areas and key dates of AWD outbreaks	Maintain and disseminate up to date communications plan for AWD Prevention and Response – linking to overarching responsibilities matrix
	Indicators	Establish indicators to track quality, timeliness and effectiveness of response. Include in plan	Establish indicators to track quality, timeliness and effectiveness of response. Include in plan	Establish indicators for the communication activities. Include in plan and share with Health and WASH
	Meeting	Participate in InterCluster Cholera Taskforce	Lead InterCluster Cholera taskforce in Nairobi and Mogadishu, and link	Participate in Intercluster Cholera Taskforce Convene a Communications technical working group, linked with the InterCluster Hygiene Promotion Group
	Focal Points	Assign District Lead Agencies for AWD/Cholera and Flooding. Establish link with local health/nutrition partners. Regular communication to share information on outbreaks.	Assign Regional Health focal agencies. Establish link with District Focal Point for AWD/Cholera	Maintain focal point list, with clear responsibilities – for use by WASH and Health Cluster Coordinators Liaise on a regular basis with the Focal Points for outbreak communication activities
	AWD/ Cholera tracking	Review format to ensure suitable for WASH Cluster	Establish regular information sharing mechanism in useful format	Receive regular updates

Area	Specific Activity	Responsibility		
		WASH Cluster	Health Cluster	Communications
	matrix			
Coordination (cont)	Hygiene Promotion Material	Lead InterCluster Hygiene Promotion Working group to develop, review Somalia specific material	Participate in InterCluster Hygiene Promotion Working group	Participate in the meetings for agenda items linked to communication and for the review of the Somali materials Take the lead for field testing of the developed materials.
	InterCluster – Education, Nutrition	Share available AWD/Cholera material –such as HP material, and short guides for schools, feeding centres. Disseminate within cluster. Review possible additional collaboration with other Clusters, such as education and nutrition	Share available AWD/Cholera material with other Clusters –such as AWD/Cholera tracking matrix, guidelines and standards. Review possible additional collaboration with other Clusters, such as education and nutrition	Review and field test materials to ensure suitable for target group(s) and translate as required
Preparedness	WASH in Health Facilities, incl CTCs/CTUs/ORPs	Provide support to Health and Nutrition Clusters as requested, and as funding available	WASH Assessment in Health facilities. Provision and maintenance of safe water, sanitation facilities and hand washing stations in Health facilities	-
	Supplies		Estimate scale of possible outbreak, based on historic data and current situation, to support other Clusters to prepare.	-
		Preposition hygiene kits (water treatment tablets, jerry cans, soap), and chlorine in community. If possible, support Health Cluster by provision of Patient Hygiene kit	Ensure adequate supplies of ORS and chlorine in Health Facilities. Preposition drugs and medical supplies for Cholera Treatment, as per standard CTC, CTU supply requirements in Health Plan (including chlorine) Strategy and maximise ORS availability in communities	Review C4D material (eg for ORS and aquatabs) and ensure suitable for target group(s)
		Update available WASH emergency supplies on three monthly basis and share with Health	Update available health supplies on three monthly basis and share with WASH. Including what is available at community level and primary care level – eg ORS.	-
Preparedness (cont)		Share requests from Govt to reduce duplication	Share requests from Govt to reduce duplication	-
	Capacity	Support WASH partners to	Support health partners to	Training of media on

Area	Specific Activity	Responsibility		
		WASH Cluster	Health Cluster	Communications
	Development	achieve minimum standards in preparedness, prevention and response, for example effective chlorination and minimum distance between latrine and water source (30m)	achieve minimum standards in preparedness, prevention and case management	how to report on AWD prevention and response issues Support WASH and Health partners in job aids/teaching aids, including key messages
	Hygiene Promotion training	Provide TOT training to Nutrition, Health, Education as required for prevention and response - based on InterCluster Emergency HP package for diarrhoea prevention behaviour change Roll out for WASH Hygiene Promoter and Community Mobilisers	Roll-out HP Training on common HP package to ensure facility based health workers, as well as village health workers (during ICCM), can ensure hygiene promotion for family care givers especially AWD/Cholera patients.	Training of media personnel on hygiene promotion, including developing Resource Guide for media, in line with the InterCluster Hygiene promotion package
One month prior	Prevention activities	If funding available: Start prevention activities in high risk areas - Handwashing with soap/ash messages, chlorination of water sources, Household water treatment, safe food preparation, distribution of hygiene kits	Ensure all ready for functional surveillance, reporting and response as per Health Plan	Ensure and check that key messages and mass media products/programmes are ready
	Surveillance and early warning	Report all rumours directly to Health Cluster, copying WASH (contact details above) Information required • What is the problem (with time frame) • Where is the problem • Who is affected • Source of info with contact State "unconfirmed" in correspondence/report	Activate the Alert and Response Team in the identified high risk district within 96 hours Verify the rumour within 24 h Collect stool samples for verification /confirmation. Basic source investigation – including testing chlorine residual of water sources. Disseminate results. (Supplies not necessarily provided at this stage). Note: Health Authorities involved in Somaliland, Puntland, Galmaduud.	Handle all media inquiries on rumours
One month prior (cont)	Reporting Rumour, and outcome		Share email alert with key stakeholders – as listed on first page. Update weekly AWD Tracking matrix with outcome	Handle all media inquiries on rumours
Response (reduce mortality)	Prior to confirmation	District Focal Point for AWD/Cholera reviews preparedness measures (100% coverage of safe water) within district. Share	Regional Focal Points, with support from Cluster, review capacity of Health facilities in the concerned area for possible CTC, CTU set-up	-

Area	Specific Activity	Responsibility		
		WASH Cluster	Health Cluster	Communications
		information within region including neighbouring District Focal points. Region reviews for region. Strengthen preparedness measures if required		
	If AWD outbreak confirmed:	If confirmed by Health Cluster: WASH Cluster Zonal focal point, in conjunction with District Lead agency for AWD/Cholera and flooding, ensures a WASH agency is responding (either via UNICEF partners, or WASH Cluster partner using Emergency Reserve Funds)	Ensure response by Health Partner for Case Management and referral, including setting up CTC/ CTU and ORP according to need.	If confirmed outbreak, take lead on roll-out and distribution (to WASH and Health Partners) of communication materials targeting the affected areas.
	Lead response	Participate in local Outbreak response task force meeting, and respond as agreed	Lead response, including activating local outbreak response task force at the identified district hot spots (consisting of those that manage the sick, and those that prevent further spread) Taskforce led by (in order of priority): MoH /WHO /Health Cluster focal agency/OCHA)	Support local taskforce meetings, as requested
	Source Investigation	Use basic source investigation from Health partner, and additional surveillance as necessary (eg via discussion with Health Centres, water samples etc) to identify source.	Basic source identification of patients in health facilities, including tracking of where they come from, and likely source of epidemic. Inform WASH agency immediately	-
Response (reduce mortality) (cont)	Response	As per agreed WASH Cluster Preparedness and Response Plan: Provision of safe water, emergency latrines and hygiene promotion (in community, and selected MCH/ OTPs). Support Health Cluster with distribution of ORS with zinc, at community level, in conjunction with distribution of other WASH items, if available and individual trained.	As per agreed Health Cluster Preparedness and Response Plan: Establishment of Treatment Centres (CTC/CTU/ORPs). Ensure case management including ORS with zinc, IV fluid, etc, and referral to higher level of health care facility, if needed. Hygiene promotion in Health Centres, using agreed InterCluster Hygiene Promotion material.	Ensure referral messages (when and where to get health services) are in place and disseminated, in addition to prevention messages
	Supplies	Encourage Patient Hygiene kits to be provided in patient care to prevent re-admission and spread to family Distribute WASH Hygiene kit in high risk areas Replenish supplies as	Ensure supplies, according to the standard CTC/CTU/ORP supply requirements are replenished as required. This includes WASH items, such as Chlorine used in	Ensure leaflets/C4D materials are provided and included in the supplies

Area	Specific Activity	Responsibility		
		WASH Cluster	Health Cluster	Communications
		required	CTC/CTUs	
Monitoring	Each outbreak	Ensure positive free chlorine residual at household and water source, to ensure effective chlorination Monitor AWD rates at local Health posts/CTCs, and from WHO AWD tracking matrix, to assess impact of WASH intervention. Adjust intervention as required	Track AWD intervention and outcome. Provide summary of all AWD rumours and confirmed outbreaks – with response and status (increasing, reducing etc) to WASH and Nutrition Clusters	Take lead in dealing with media inquiries
	Monitoring against indicators	Cluster tracks progress against indicators set in planning phase. Reports in WASH Cluster meeting.	Cluster tracks progress against indicators set in planning phase. Reports in Health Cluster meeting.	Track progress against communications indicators
	Evaluation of outbreak and response	Review Health trend report against WASH interventions to understand impact, and improve AWD response plan accordingly	Review trends post season (July and December) and impact of prevention and response measures. Identify successes, areas of improvements, and update plan for improved response in following season.	Evaluation of communication activities per set of indicators, and recommendations for Health and WASH clusters
Reporting	Regular reporting	District Focal Point to submit weekly report to Cluster on preparedness and response for current outbreaks (if situation changes) Update Regional WASH Cluster during monthly meeting, adjust response as required	Health partner to submit weekly report on case load, including incidence and mortality rate to WHO. More frequently if major outbreak. Health partner to inform local WASH partner for quick response.	Be involved in reporting to make the information readable for various target audiences, especially donors, health partners and lay audience Provide input on communication activities for WASH and Health Cluster SitReps
	Monitoring reports	WASH Cluster collates and shares status of WASH AWD/Cholera response with Zonal Focal points, and Cluster agencies	WHO Surveillance to monitor incidence and mortality rate and recommend appropriate action. Disseminate weekly AWD/cholera tracking matrix.	-
Communications	Responding to media requests	Assist with and cross check technical information	Assist with and cross check technical information	Develop materials to increase awareness on the topic, including personal human interest stories, targeting local and international media Development of resource guide for media

Annex 2: Risk Level per District, with WASH Organisations and Regional/District Focal Points

Region/ Location	District	Village/Municipality/ Camp	Risk Level	WASH Organisations in Locality	WASH Cluster Regional Focal Point	WASH Cluster District AWD Lead Response Agency
Awdal	Borama					
Awdal	Baki					
Awdal	Zeylac					
Awdal	Lughaye					
Bakool	Rab Dhuure		M	Concern, JCC, UNICEF, GREDO, GRRN	GREDO – Ali Mohamed	
Bakool	Ceel Barde		L	IR, SYPD, UNICEF, GRRN	GREDO – Ali Mohamed	
Bakool	Waajid		L	ACF, BWDN, IR, UNICEF, GRRN	GREDO – Ali Mohamed	
Bakool	Xudur		M	Concern, IR, UNICEF, GREDO, GRRN	GREDO – Ali Mohamed	
Bakool	Tayeeglow		H	ADRO, AFREC, IR, UNICEF, GRRN	GREDO – Ali Mohamed	
Banadir	Mogadishu	Kax Shiiqal	H	?	SOPHPA – Ali Hussein Yusuf	SOPHPA
Banadir	Mogadishu	Deynile	H	SOPHPA, IR	SOPHPA – Ali Hussein Yusuf	No lead partner
Banadir	Mogadishu	Dharkeynley	H	ACF, DRC, GEELO, IR, NCA, NRC, Oxfam GB, Solidarites, SYPD, UNICEF, WARDI, DDRO, Baniadam, HIJRA, SADO, SCC, SOPHPA	SOPHPA – Ali Hussein Yusuf	HIJRA
Banadir	Mogadishu	Wadajir	H	ACF, Concern, DRC, FERO, IR, NRC, Oxfam GB, SYPD, UNICEF, Youthlink, WARDI, Baniadam, HIJRA, SOPHPA	SOPHPA – Ali Hussein Yusuf	HIJRA
Banadir	Mogadishu	Hodan	H	ACF, ACTED, NCA, NRC, Oxfam GB, SADO, Baniadam, HIJRA, CISP, Concern, DRC, FERO, IR, RAWA, UNICEF,	SOPHPA – Ali Hussein Yusuf	SCC
Banadir	Mogadishu	Waberi	H	SOPHPA, Lifeline Gedo, Youthlink, WARDI, GSA, SCC	SOPHPA – Ali Hussein Yusuf	SCC
Banadir	Mogadishu	Hamar Jabjab	H	DRC, WARDI, Oxfam GB, HIJRA, UNICEF, SCC, SOPHPA, ACF, NCA, Baniadam	SOPHPA – Ali Hussein Yusuf	WARDI

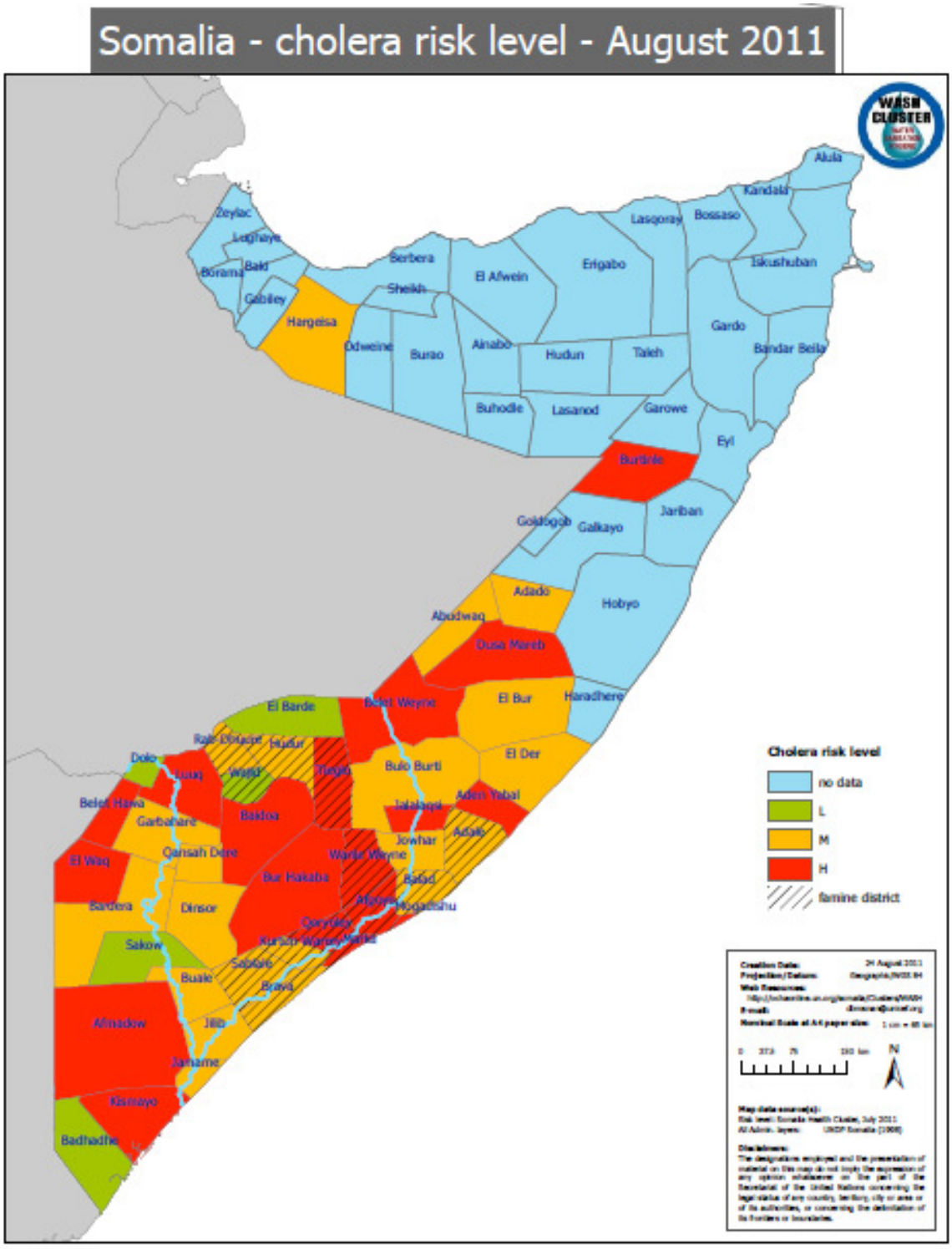
Region/ Location	District	Village/Municipality/ Camp	Risk Level	WASH Organisations in Locality	WASH Cluster Regional Focal Point	WASH Cluster District AWD Lead Response Agency
Banadir	Mogadishu	Hawlwadag	H	ACF, DRC, WARDI, UNICEF, SCC, SOPHPA	SOPHPA – Ali Hussein Yusuf	CPD
Banadir	Mogadishu	Wardhigley	H	ACF, IAS, UNICEF, SOPHPA	SOPHPA – Ali Hussein Yusuf	GREDO
Banadir	Mogadishu	Hamar Weyne	H	Oxfam GB, HIJRA, UNICEF, SOPHPA, ACF, NCA, Baniadam, SAVE UK	SOPHPA – Ali Hussein Yusuf	SOPHPA
Banadir	Mogadishu	Bondhere	H	ACF, CISP, MGV, MURDO, NRC, Oxfam GB, UNICEF, Baniadam, HIJRA, SOPHPA	SOPHPA – Ali Hussein Yusuf	SOPHPA
Banadir	Mogadishu	Shingani	H	ACF, Oxfam GB, NCA, Baniadam, UNICEF, SOPHPA	SOPHPA – Ali Hussein Yusuf	SOPHPA
Banadir	Mogadishu	Shibis	H	UNICEF, SOPHPA	SOPHPA – Ali Hussein Yusuf	SRC
Banadir	Mogadishu	Yaqshid	H	UNICEF, SOPHPA	SOPHPA – Ali Hussein Yusuf	ORDO
Banadir	Mogadishu	Aboul Aziz	H	SOPHPA	SOPHPA – Ali Hussein Yusuf	SRC
Banadir	Mogadishu	Karaan	H	ACF, UNICEF, SOPHPA	SOPHPA – Ali Hussein Yusuf	FARJANNO
Banadir		Heliwaa	H	UNICEF, SOPHPA	SOPHPA – Ali Hussein Yusuf	No lead partner
Bari	Bossaso		H	COOPI, NCA, NRC, Baniadam		
Bari	Caluula					
Bari	Qardho			IAS		
Bari	Iskushuban					
Bari	Qandala					
Bari	Bandarbeyla					
Bay	Baidoa		H	ACTED, ADRA, anon, Concern, IR, TGV, UNICEF, SADO, Gredo, BWB, DAYAH	GREDO – Ali Mohamed Ali	
Bay	Buur Hakaba		H	BARRDA, UNICEF, BTSC	GREDO – Ali Mohamed Ali	
Bay	Qansax Dheere		M	ACTED, COOPI, SDIO, SADO, IR	GREDO – Ali Mohamed Ali	
Bay	Diinsoor		M	ACTED, COOPI, SDIO, SADO	GREDO – Ali Mohamed Ali	
Galgaduud	Dhuusamarreeb		M	CPD, CISP, COOPI, UNICEF, Yme, GMC, IIDA, GREB, GSA, IR	GSA – Ilyaas Mohamed	GSA
Galgaduud	Cabudwaaq		H	COOPI, IRC, HOPEL, NCA, Solidarites, UNICEF, Yme, Baniadam, DFI, SADO, GREB, GSA, IR		
Galgaduud	Ceel Buur		M	Concern, HARDO	SRDO – Shurki Hillowle Addow	HARDO- Abdi Nur Ibrahim

Region/ Location	District	Village/Municipality/ Camp	Risk Level	WASH Organisations in Locality	WASH Cluster Regional Focal Point	WASH Cluster District AWD Lead Response Agency
Galgaduud	Cadaado		M	Anon, CED, CPD, Concern, COOPI, Solidarites, UNICEF, Yme, SADO, GREB, GSA, IR	GSA – Ilyaas mohamed	GSA
Galgaduud	Ceel Dheer		M	SRDO, SRC, CISP	SRDO – Shurki Hillowle Addow	CISP- Mahamud Muhidhin
Gedo	Luuq		H	Baniadam, BARRDA, COOPI, UNICEF, SHRA	NAPAD – Hassan Shirwa	SHRA -Mohamed
Gedo	Garbahaarey		M	COOPI, NCA, UNICEF, Baniadam	NAPAD – Hassan Shirwa	NEPAD- Abdi Ali
Gedo	Doolow		L	COOPI, NCA, UNICEF, Baniadam	NAPAD – Hassan Shirwa	PAH –Ahmed Abdi
Gedo	Belet Xaawo		H	Concern, COOPI, NCA, UNICEF, Lifeline Gedo, Baniadam	NAPAD – Hassan Shirwa	COSDA – Yacoub Sheikh Ali
Gedo	Ceel Waaq		H	Concern, NCA, Solidarites, Lifeline Gedo, Baniadam, SADO	NAPAD – Hassan Shirwa	SOM –Action – Ali Abdi
Gedo	Baardheere		M	Baniadam, NCA, Solidarites, SADO, SDRO, WDC	NAPAD – Hassan Shirwa	SADO – Abdirizak Gerio
Hiraan	Bulo Burto		M	DRC, HWS&CDO, RAWA, SYPD, Technoplan, UNICEF, Yme, WARDI, GSA	HWS&CDO – Abdinasir Haggi Shirwa	TECHNOPLAN – Omar Sheikh Hassan
Hiraan	Jalalaqsi		H	Solidarites, SYPD, TGV, UNICEF, WARDI	HWS&CDO – Abdinasir Haggi Shirwa	TECHNOPLAN- Omar Sheikh hassan
Hiraan	Belet Weyne		H	COOPI, DRC, FO-AID, HWS&CDO, UNICEF, Yme, WARDI, GSA	HWS&CDO – Abdinasir Haggi Shirwa	HWS &CDO – Abdinasir Haggi Shirwa
Middle Juba	Jilib		M	Oxfam GB, HIJRA, WASDA, TGV, UNICEF, AFREC, GREDO, Juba Shine	AFREC- Abdi Aziz Duwa	AFREC – Aden salah Buthul
Middle Juba	Bu'aale		M	Anon, IRC, JCC, UNICEF	AFREC- Abdi Aziz Duwa	JCC- Omar hassan dahir
Middle Juba	Saakow		L	ACTED, SADO, anon, DRC, WARDI, EREDO, Save UK, SDIO, UNICEF, GREDO, JCC	AFREC- Abdi Aziz Duwa	JCC – Abdi Sirad Khalif
Lower Juba	Badhaadhe		L	AFREC, DHO, DIAL	AFREC- Abdi Aziz Duwa	AFREC- Abdi Mohamed Ali

Region/ Location	District	Village/Municipality/ Camp	Risk Level	WASH Organisations in Locality	WASH Cluster Regional Focal Point	WASH Cluster District AWD Lead Response Agency
Lower Juba	Kismaayo	Yontoy,Warkoy,Bulagudud,KhamKham,Fagaan,Kooban	H	ACF, DIAL, Oxfam GB, WASDA, AFREC	AFREC- Abdi Aziz Duwa	Muslim Aid- Ibrahim Abdi Mohamed
Lower Juba	Afmadow		H	ACF, Oxfam GB, HIJRA, WASDA, SDIO, Solidarites, UNICEF, AFREC	AFREC- Abdi Aziz Duwa	AFREC – Mustaf Abshir Ahmed
Lower Juba	Jamaame		M	UNICEF, Juba Shine, AFREC, Oxfam GB	AFREC- Abdi Aziz Duwa	Juba Shine
Middle Shabelle	Jowhar		M	UNICEF, AFREC, SDRO, WOCCA	WOCCA – Abukar Tifow	WOCCA – Abukar Tifow
Middle Shabelle	Cadale		M	?	WOCCA – Abukar Tifow	WOCCA – Abukar Tifow
Middle Shabelle	Adan Yabaal		H	UNICEF, GRRN, WOCCA	WOCCA – Abukar Tifow	WOCCA – Abukar Tifow
Middle Shabelle	Balcad		M	SWRDA, UNICEF, WOCCA	WOCCA – Abukar Tifow	WOCCA – Abukar Tifow
Lower Shabelle	Afgooye Corridor		H	Bani'Adam, GEELO, IAS, IR, NCA, NRC, VARDO, Oxfam GB, HAVOYOCO, HIJRA, SYPD, UNICEF, AFREC, GSA, SDRO, SOPHPA, WARDI	SOPHPA – Ali Hussein Yusuf	Islamic relief
Lower Shabelle	Wanla Weyn		H	ADRO, UNICEF, WARDI	SOPHPA – Ali Hussein Yusuf	Wardi
Lower Shabelle	Baraawe		M	?	SOPHPA – Ali Hussein Yusuf	COSV
Lower Shabelle	Sablaale		M	?	SOPHPA – Ali Hussein Yusuf	COSV
Lower Shabelle	Marka		H	Baniadam, UNICEF, SAREDO	SOPHPA – Ali Hussein Yusuf	COSV
Lower Shabelle	Qoryooley		H	?	SOPHPA – Ali Hussein Yusuf	Islamic Relief
Lower Shabelle	Kurtunwaarey		M	IR	SOPHPA – Ali Hussein Yusuf	Ayub/COSV
Mudug	Jariiban			IR	GSA – Ilyaas Mohamed	GSA – Ilyaas Mohamed

Region/ Location	District	Village/Municipality/ Camp	Risk Level	WASH Organisations in Locality	WASH Cluster Regional Focal Point	WASH Cluster District AWD Lead Response Agency
Mudug	Gaalkacyo			anon, COOPI, DRC, GEELO, IAS, NUWA, IRC, IR, NRC, Baniadam, Oxfam GB, HIJRA, WASDA, SDRO, Yme, GSA	Relief International – Abdullahi Musse	No lead partner
Mudug	Galdogob			IAS, IRC, IR	GSA – Ilyaas Mohamed	GSA – Ilyaas Mohamed
Mudug	Xarardheere			CISP, ADAMI	SRDO – Shurki Hillowle Addow	CISP –Hassan Shaddor
Mudug	Hobyo			CPD, CISP, GMC, COOPI, IAS, NCA, Baniadam, SDRO, Yme, GSA, IR	GSA – Ilyaas Mohamed	GSA – Ilyaas Mohamed
Nugaal	Garoowe			IR, NRC, Baniadam		
Nugaal	Burtinle		H			
Nugaal	Eyl			NCA, Baniadam		
Sanaag	Laasqoray			NCA		
Sanaag	Ceerigaabo			ADRA, NCA		
Sanaag	Ceel Afweyn			DRC		
Sool	Xudun			?		
Sool	Laas Caanood			ADRA, DRC, UNICEF, GRRN, Oxfam GB, HAVOYOCO		
Sool	Caynabo			DRC, Oxfam GB, HAVOYOCO		
Sool	Taleex					
Togdheer	Sheikh			ADRA		
Togdheer	Owdweyne			DRC, Oxfam GB, HAVOYOCO		
Togdheer	Burco			ADRA, DRC, Oxfam GB, HAVOYOCO		
Togdheer	Buuhoodle			Oxfam GB, HAVOYOCO		
Woqooyi Galbeed	Gebiley			?		
Woqooyi Galbeed	Hargeysa		M	ADRA, DRC, NRC, Baniadam, Oxfam GB, HAVOYOCO		
Woqooyi Galbeed	Berbera			ADRA		

Annex 3: Map of Cholera Risk Levels per district



Source: Health Cluster

Annex 4: AWD/Cholera Emergency Assessment

Date of Visit:	Compiled by:	GPS coordinates:
Name of Location:	Urban / Rural (circle one)	District:

1. What is the population of this village/location?

2. Are there any organizations providing assistance?
    a. If yes, what are they providing?
    b. How many villages have they covered?

3. Are there any organizations providing assistance to the AWD/Cholera outbreak?
    c. If yes, what are they providing?
    d. How many villages have they covered?

Health:

4. What percentage/number of the population over 5 years of age has had suspected AWD/Cholera in the last 2 weeks? This question is very difficult to answer because the real catchment population is usually unknown

5. What percentage/number of children under 5 have had suspected AWD/Cholera in the last 2 weeks? To be more specific e.g. children visiting a health facility rather than population based

Water Supply:

6. How much water can each family collect per day?

7. What water sources are available in this location – see table on next page:

Water source	No. of sources	% of population using source(s) for drinking	No. of functioning sources	Water treatment options used at source (Well or chlorination, bucket etc.)	Condition – broken, dry, polluted, collapsed, silted, low yield, reduced storage capacity	Average distance between source(s) and users' homes (km)	How many months a year does this source provide water?
Lake, river, stream							
Protected spring							
Unprotected spring							
Unprotected Shallow well							
Shallow Well with handpump							
Borehole							
Water Pant							
Berkhad							
Other, specify:							

8. Are people doing anything to improve the quality of their drinking water? *Yes* *No*

9. If yes, which treatment method(s) are used? *select all that apply*
   Chlorination
   Sedimentation Simple sand filtration Cloth filtration Boiling Sun exposure

10. Do people have soap or other cleaning materials? *Yes* *No*
    a. If no, why not?
    b. If yes, when do they use soap or other cleaning materials?

11. What percentage of households knows how to prepare ORS and when to use it?

12. What percentage of the population washes their hands with soap, ash, sand or other cleaning materials after defecating?

Annex 5: What is Cholera?

Cholera information for the public

1. **What is cholera**?
It is a human disease starting with a sudden onset of numerous watery stools, often combined with vomiting. It leads to dehydration and death if not treated quickly.

2. **What do you have to know about cholera?**
It's a very contagious disease, but can be treated easily and quickly.
Of those who develop the disease, 90% will have a mild or moderately severe illness with diarrhoea, which can be treated with ORS. Of the people who develop typical cholera normally less than 10% will suffer from moderate to severe dehydration. These cases should be taken to a health facility …or an isolation centre **EARLY. EARLY TREATMENT IS ESSENTIAL.**

3. **When do you suspect cholera?**
As soon as you have sudden diarrhoea, watery stools and vomiting.

4. **How can you get cholera?**
By drinking water from unsafe sources – rivers, open wells, water pans, berkads - that has not been chlorinated or boiled. By drinking water that has become contaminated because of the way, it was transported or stored.
By eating food contaminated during or after preparation.
By eating fruits that have not been peeled and washed.

5. **How is cholera transmitted?**
The main mode of transmission is through contaminated food or drinking water. Faeces and vomit are infectious. Cholera is rarely transmitted directly from person to person but this is possible in areas of dense populations and poor sanitation and hygiene, such as poor urban areas and IDP camps. Persons with asymptomatic infections play an important role in the transmission of the infection.

7. What to do in case of suspected cholera?

- Give the person extra fluids preferably ORS or SSS and,
- Take the patient immediately to a treatment centre.
- Inform the community of the suspected outbreak
- Raise awareness and disseminate key messages on cholera transmission and prevention
- Check people regularly who are in contact with cholera cases and sensitize on mode of spread. k and collect data on diarrhoea cases within the community to monitor trends
- Monitor hygiene practises such as latrine use, hand washing, water handling practices and general environmental sanitation.

Cholera information – more technical

What is cholera?

Cholera is one type of diarrheal disease caused by infection of the intestine with the bacterium *Vibrio Cholera* present in faecally contaminated water or food. Cholera is primarily linked to insufficient access to safe water and proper sanitation.

Children as well as adults can get infected. Patients develop very severe watery diarrhoea and vomiting from 6 hours to 5 days after exposure to the bacterium. In these cases, the loss of large amounts of fluids can rapidly lead to severe dehydration. In the absence of adequate treatment, death can occur within hours. People with low immunity – such as malnourished children or people living with HIV – are at a greater risk of death if infected.

Diarrhoea is usually a symptom of an infection in the intestinal tract, which can be caused by a variety of bacterial, viral and parasitic organisms. Infection is spread primarily through contaminated food or drinking-water, and less frequently from person-to-person as a result of poor hygiene. The short incubation period of 2 hours to five days, enhances the potentially explosive pattern of outbreaks.

There are three clinical types of diarrhoea caused by a number of different organisms:

- acute watery diarrhoea – lasts several hours or days, and includes cholera;
- acute bloody diarrhoea – also called dysentery; and
- chronic diarrhoea – lasts longer than a month

What is the difference between acute watery diarrhoea (AWD) and cholera?

Cholera is a type of acute watery diarrhoea – AWD is a symptom of cholera which can be isolated through laboratory testing. Based on a clinical definition (3 watery stools in 24 hours) confirmation of an outbreak of cholera is done through laboratory testing of the stools of an infected person.

Surveillance systems should be able to rapidly detect an increase in reported cases of acute watery diarrhoea. Such an increase should trigger efforts to determine the source of transmission and ensure implementation of control measures in the affected area. If laboratory testing confirms the presence of cholera in an area, it is assumed that there is an outbreak.

Potential locations for outbreaks include:

1. Locations of previous outbreaks (hot spots)
2. Area where sanitation facilities are located within 20 m of water sources
3. An environment with poor personal hygiene (poor availability of water and poor food handling practices)
4. Inadequate sanitation
5. A population living in crowded conditions
6. Where people use drinking water of poor quality
7. High poverty and malnutrition
8. Areas of ecological disturbances and seasonal variations in temperature and after flooding (in endemic areas)
9. Coastal areas, areas around water bodies and around transport links.

Annex 6: Key Hygiene Promotion Messages for Cholera

Cholera - Key messages for health education

1. Cholera is a disease that causes watery diarrhoea. It causes rapid loss of water and salts from the body (dehydration) which can lead to death within hours if **not** treated.

2. If you or a family member have watery diarrhoea and vomiting, go to the health care facility immediately.

3. Start drinking ORS or treated water at home and during travel to the health care facility.

4. Cholera spreads quickly. Protect yourself from cholera germs; Wash your hands with running water and soap or ash before eating, after wiping a child's bottom and after using the toilet/ defecating.

5. Continue breast feeding a sick child and encourage the child to eat regularly.

6. Food: COOK IT – PEEL IT – OR LEAVE IT

7. Drink safe water. Safe water is chlorinated, bottled, boiled or filtered water.

8. Use latrines: If you have no latrine, bury faeces 30 meters from any body of water

9. Thoroughly wash your hands with soap and water after taking care of people with cholera, touching them, their stools, vomit, or clothes.

Annex 7: How to chlorinate water for drinking

The first step in the chlorination process is to make a stock solution.

To make a stock solution you need to use 1 level tablespoon to every litre of water.

The stock solution is what you will use to chlorinate water. Do not keep the stock solution for more than 1 week. Do not store chlorine or stock solutions in metal containers, or in direct sunlight.

How much stock solution is required?

When you add chlorine to water, the chlorine starts to kill off bacteria. If the water is clean, no chlorine is used. If the water is very contaminated all of the chlorine may be used up, and there still may be more bacteria left, because the amount of chlorine used was insufficient.
When chlorinating drinking water it is important to know how much chlorine is needed to kill all the bacteria, because we want to leave extra to protect the water from further contamination. This extra is called the Free Residual Chlorine (FRC), and in cholera outbreaks, we want this to be 0.5mg/l – that is 0.5 milligrams of chlorine remaining for each litre of water. Residual chlorine levels can be measured with a pool tester/comparator.

The method of determining how much chlorine is required is called the jar test.

Jar Test

The main method of determining the chlorine demand of the water is as follows:

1. Prepare a 1% Stock Solution of chlorine (1 level table spoon of HTH in 1 ltr of water)
2. Fill 4 non-metal buckets with 20L each of water to be treated
3. Add an increasing volume of 1% stock solution of chlorine to each bucket using a syringe e.g.

   1st Bucket: 1ml of 1% Stock solution
   2nd Bucket: 1.5ml of 1% Stock solution
   3rd Bucket: 2ml of 1% Stock solution
   4th Bucket: 2.5ml of 1% Stock solution

4. Stir each bucket for 30seconds to ensure the chlorine solution is properly mixed
5. Wait a minimum of 30 minutes contact time – **VERY IMPORTANT**
6. Measure the levels of Free Residual Chlorine in each bucket
7. Choose the bucket, which gives approximately 0.5mg/L FRC.
8. Always recheck the chlorine demand periodically, especially when the water source is changed or known to vary or when new batch of HTH is used. This will ensure that the FRC level is maintained. (note that the strength of HTH will reduce over time when stored at high temperatures.
9. It may be necessary to repeat the test if the water has high chlorine demand. In this case, you would put 3ml of 1% Stock solution in the first bucket, 3.5ml in the second, 4ml until a FRC of 0.5mg/l is obtained). You may need to repeat this process a third time if necessary.

Use this result to calculate the amount of 1% stock solution to add to the total volume of water in the individual water containers.

Worked example of chlorine demand of water

This example is for the chlorination of a 5l jerry can filled with water at the well.

Follow steps 1-5 outlined above.
The FRC levels of the water in the individual buckets after 30 minutes contact time were as follows:

1st Bucket: 1ml of 1% Stock solution = 0mg/L
2nd Bucket: 1.5ml of 1% Stock solution = 0.3 mg/L
3rd Bucket: 2ml of 1% Stock solution = 0.5 mg/L
4th Bucket: 2.5ml of 1% Stock solution = 0.8 mg/L

The desired FRC level therefore will be that for bucket 3 (2.0ml of 1% Stock solution in 20L= 0.5 mg/L).
So if 2ml of 1% stock solution added to 20L of water gives 0.5mg/L FRC then you need a quarter (1/4) the amount of stock solution to correctly dose the a 5L water container e.g. 0.5ml of a 1% solution.

Annex 8: How to ensure chlorinated water safe for drinking

This was agreed in the WASH Cluster Technical Meeting held in Mogadishu on 22 November 2011, to ensure effective chlorination of shallow wells.

Background

The aim of WASH Cluster is to protect the population from AWD/cholera which includes access to safe drinking water. So when shallow wells are chlorinated, it is important to ensure they provide safe drinking water.

"Residual Chlorine" is a measure to ensure effective chlorination. Residual Chlorine can be measured in many ways. The easiest is with a "Test Strip", which changes colour to show the level of Residual Chlorine present in the water sample.

Standard

- There must always be a positive "Residual Chlorine" in shallow wells receiving chlorination.

Agreed method to confirm effective chlorination

- All wells receiving chlorination must be tested for one week, a few times a day, to confirm there is positive residual chlorine at all times of the day. If the Residual Chlorine is:
  - Positive at all times of the day – the level of chlorination can remain the same
  - Not measurable at any time throughout the day – the amount or frequency of chlorination should increase, and the well re-tested.
- If the level of chlorination cannot be increased, and there is not a positive residual chlorine at all times of the day, an alternative method should be promoted.

- Alternatives methods include:
  - Household water treatment with tablet (aquatabs, watermaker)
  - Bucket chlorination at the water point (the point of collection), to be done by a volunteer or NGO staff. Providing a specific amount of chlorine directly into each bucket after it has been filled from the unsafe source. Awareness is needed before starting this method.
  - Slow dissolving chlorine tablet (swimming pool chlorine)

Annex 9: How to make Chlorine solution for cleaning hands and floors

When to use 0.05% Chlorine	When to use 0.2% Chlorine
Disinfect utensils used by cholera patients like; plates, dishes, spoons etc	Disinfect latrines that have been used by cholera patients.
Washing hands after using the toilet, handling a cholera patient, before preparing food. (If 0.05% chlorine is used, soap is not required)	Disinfect place where cholera patients have vomited or had diarrhea.
How to make Chlorine Solution	
0.05 %	**0.2%**
With HTH 70%: · **1 tablespoon in 20 litres of water**	With Chlorine HTH 70%: · **1 tablespoon in 5 litres of water**
With Bleach 5 % (Sodium hypochlorite solution): · **14 tablespoons in 20 litres of water** · **¼ of cup in 20 litres of water**	With Bleach 5 % (Sodium hypochlorite solution): · **20 tablespoons in 5 litres of water**
Note: 1 table spoon = 10 mL, 1 cup = 200 mL	

Annex 10: How to request Chlorine from UNICEF

Below are the procedures that should be followed when requesting chlorine from UNICEF. Given the AS ban, supplies can only be requested from UNICEF in areas not in Al Shabaab control.

Project detailed information

Detail assessment of all the water sources to be chlorinated, the following information is needed:

1. Name of Region, District and Village where the waters sources /well is situated
2. Name of village, GPS coordinates, or well ID-region/district/village
3. Estimated target population to be served.
4. Type of water supply source: un-protected waters source (hand dug/drilled well, water catchments/pan/pond/dam and bekard/ household). Protected water sources (hand dug/drilled wells and water tank/truck)
5. Method of abstraction (hand pump/motorized/solar powered)
6. Daily abstraction rates (M3/day)
7. Daily chlorine requirements based on the number of water sources to be chlorinated (Should include names of well owners or names of villages where the wells are located, frequency of chlorination)

NB: These can be presented in a simple table

Issuance of chlorine from UNICEF warehouse

The following documents should be in place before partners can be issued with chlorine from UNICEF warehouse

1. Duly signed agreement (PCA/SSFA) with UNICEF
2. Duly completed Request for Supplies form (on UNICEF standard format).
3. Supplies release order prepared by UNICEF WASH section.
4. WASH Officer to update the chlorine monitoring excel sheet based on all partners requests and monitor the remaining stocks.
5. WASH Officer to review overall chlorination progress every 3 months.

Annex 11: How to request UNICEF emergency WASH supplies

Below are the procedures that should be followed when requesting WASH supplies from UNICEF for rapid repair of strategic water supplies. Given the AS ban, supplies can only be requested from UNICEF in areas not in Al Shabaab control.

Project detailed information

Brief assessment of the water source(s) to be repaired, the following information is needed:

Name of Region, District and Village where the water supply is situated

1. Name of village, GPS coordinates,
2. Estimated target population currently relying on supply, including estimated livestock numbers.
3. Type of water supply (water yard, borehole, hand dug/drilled wells)
4. Details of extraction equipment (pump – make and model, generator – make & model/power rating). Standby generator – make/model/power rating
5. Daily abstraction rates (M3/day)
6. Nature of breakdown. When did breakdown occur? What part of the system is not working? What action has been taken so far?

NB: These can be presented in a simple table and/or sent on an email.

Issuance of supplies from UNICEF warehouse

Note: UNICEF will only issue supplies to its partners and only after the above information has been received.
The following documents should be in place before partners can be issued with supplies from UNICEF warehouse:

1. Duly signed agreement (PCA/SSFA) with UNICEF
2. Duly completed Request for Supplies form (on UNICEF standard format).
3. Supplies release order prepared by UNICEF WASH section.
4. Partner to report on action taken using supplies
5. WASH Officer to inform WASH Cluster Coordinator when supply is functioning.

Under exceptional circumstances UNICEF can loan supplies to NGOs/communities to repair catastrophic breakdown but only after verification of the needs by a reliable third party.

Annex 12: Terms of Reference for Regional Focal Point and District Focal Point for AWD/Cholera and Flooding

The Regional and Deputy regional focal points are the Cluster points of contact who undertake facilitation of cluster activities at the field level, share information and response planning with the overall objective of identifying gaps, preventing duplication and ensuring an effective response. This document summarises the roles and responsibilities of WASH Cluster Regional, Deputy and District AWD/Flooding Focal Points.

Focal Point	Role and Responsibility
Regional	• Identify partners in the region, where they are working, and identify any gaps and overlaps in the districts. Inform WASH Cluster Team to update the 4W matrix if required • Facilitate field coordination meetings to share information, identify common problems. If problems can't be addressed at regional level, request support from Zonal focal point or WASH Cluster team • Facilitate joint needs assessments and monitoring missions to prioritise needs in the region, as required or requested – in coordination with OCHA field officer • Facilitate implementation of standards and guidelines, • Ensure appropriate information exchange between the cluster members in the field and Nairobi based Cluster team • Ensure the Cluster coordinator and OCHA field officers are informed of cluster specific developments in the region • Disseminate key WASH documents to members • Jointly with the Zonal focal point, coordinate AWD/Flood Preparedness and Response for the WASH Cluster at District level. • Establish strong working relationships with all the cluster members in order to facilitate effective collaboration and communication
Deputy Regional	• Support Regional Focal point to follow up with the WASH cluster team to update the 4W matrix and guide members who have a problem filling out the 4W matrix • Chair the regional meetings in case the regional focal point is absent and write meeting minutes • Proactively share information with the cluster members
District AWD/ Flooding	• Collect information on existing AWD outbreaks and floods and share with Nairobi WASH cluster, SWALIM and the regional Focal point for onward response • Identify gaps during AWD/Flooding, who is responding, supplies needed and share information during the regional cluster meetings • Monitor river levels through observation and through SWALIM websites and share the information during the regional cluster meetings • Support establishment of a multidisciplinary taskforce for AWD/Cholera for each region, including community members, ideally led by local health facility • Establish coordination with other WASH agencies working in district
WASH Cluster Agency	• Share information with District Focal Point • Update 4W matrix to avoid overlaps and gaps • Attend Regional WASH Cluster meeting

Annex 13: District Reporting for AWD/Cholera and Flooding prevention and response

WEEKLY REPORT for WASH Cluster District Lead Agency for AWD/Cholera and Flooding
Due date: End of each week – if there are changes to report
Send to: WASH Cluster Coordination team, Zonal and Regional focal points (kharries@unicef.org, fatali@unicef.org, sokiomeri@unicef.org, dabuuru@unicef.org, mhibrahim@unicef.org, mhasan20@gmail.com, skemoh@unicef.org aissack.unicefsomalia@gmail.com and your Regional Focal Point)

Region / District: ……
WASH Cluster District Lead Agency for AWD/Cholera and Flooding: ……
Contact (name, email, phone number):……
Date submitted: ……..

PREPAREDNESS for Outbreaks and Flooding *(please update only if there are changes)*

Location	Prevention			Response	Gaps
In the past three years, where are the most likely locations in your district for AWD/cholera outbreaks?	Are key unprotected wells being chlorinated? (Y/N) Please list organisations doing the chlorination	Are organisations distributing WASH items (for example: jerry cans, soap, aquatabs)? (Y/N) Please list the organisations doing this	Is Hygiene Promotion taking place? (Y/N) and is it as per the WASH Cluster Hygiene Promotion Package Please list organisations	Is an agency ready to respond to an outbreak – with capacity and supplies? Please list the organisation	What are the remaining gaps? Report these to Regional Cluster meeting for action
•					
•					
•					
•					
•					

Preparedness activities in place in the district?	
• Are WASH preparedness supplies (chlorine, aquatabs, soap, jerry cans) available? (Y/N) If so, with which agencies, and are they at Regional or District level	
• Do Health centres/clinics have supplies of chlorine and soap? (Y/N) (It is Health's responsibility, but WASH can support)	
• Have organisations who are doing AWD/Cholera preparedness or response submitted a 4W matrix (Y/N). *(Contact Shem Okiomeri, sokiomeri@unicef.org, WASH Cluster Information Management Specialist, if you need support for 4W)*	

WASH ***(Water, Sanitation, Hygiene)***
CLUSTER **DISTRICT REPORTING for AWD/CHOLERA and FLOODING Prevention and Response**
Somalia

Who is responding to current AWD/Cholera outbreaks and flooding in the District for WASH?

(Please report weekly, if new outbreaks or rumours occur)

- AWD/Cholera

Where are the current AWD/CHOLERA Outbreaks? *(please use information from local hospitals, MCHs and OTPs)*			**Is there a WASH organisation responding?** *(Y/N)*	**Which WASH organisation is responding?**				**Is extra support required (Y/N)** If *Yes, provide detail below*
Region	**District**	**Village**		**Agency**	**Contact name**	**Email**	**Phone number**	

Additional information:….

- Flooding

Current FLOODING			**Is there a WASH organisation responding** *(Y/N)*	**Agency Responding**				**Is extra support required (Y/N)** If *Yes, provide detail below*
Region	**District**	**Village**		**Agency**	**Contact name**	**Email**	**Phone number**	

Additional information:….

If there are any rumours of AWD/Cholera please report directly to Health Cluster, copying WASH Cluster (as per email addresses below), and coordinate scale-up of prevention activities in this area

Please report to Health Cluster: cluster@nbo.emro.who.int, Angalukia@nbo.emro.who.int, sifumaj@nbo.emro.who.int, ayalo@un.org
Copy WASH Cluster: kharries@unicef.org, sokiomeri@unicef.org, fatali@unicef.org, dabuuru@unicef.org, skemoh@unicef.org, aissack@unicef.org, mhasan20@gmail.com