

# HUMANITARIAN RESPONSE PLAN SUDAN

COVID-19 ADDENDUM

MARCH -  
DECEMBER  
2020



# About

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This document is consolidated by OCHA on behalf of the Humanitarian Country Team and its partners. It provides a shared understanding of the COVID-19 pandemic in Sudan, including its most immediate humanitarian consequences and the estimated number of people who need assistance. It represents a consolidated evidence base and helps inform joint strategic response planning. This addendum does not replace the current [Humanitarian Response Plan](#) but complements its strategy, response and budget.

*The designations employed and the presentation of material in the report do not imply the expression of any opinion whatsoever on the part of the Secretariat of the United Nations concerning the legal status of any country, territory, city or area or of its authorities, or concerning the delimitation of its frontiers or boundaries.*

## PHOTO ON COVER

*Using water and soap, a girl child washes her hands at Ban Jadid Primary School in the city of El-Fasher, the capital of the state of North Darfur, Sudan. Photo: UNICEF / Shehzad Noorani*

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OCHA coordinates humanitarian action to ensure crisis-affected people receive the assistance and protection they need. It works to overcome obstacles that impede humanitarian assistance from reaching people affected by crises, and provides leadership in mobilizing assistance and resources on behalf of the humanitarian system.

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## Humanitarian RESPONSE

Humanitarian Response aims to be the central website for Information Management tools and services, enabling information exchange between clusters and IASC members operating within a protracted or sudden onset crisis.

[www.humanitarianresponse.info/en/operations/sudan](http://www.humanitarianresponse.info/en/operations/sudan)



Humanitarian InSight supports decision-makers by giving them access to key humanitarian data. It provides the latest verified information on needs and delivery of the humanitarian response as well as financial contributions.

[www.hpc.tools/plan/870](http://www.hpc.tools/plan/870)



The Financial Tracking Service (FTS) is the primary provider of continuously updated data on global humanitarian funding, and is a major contributor to strategic decision making by highlighting gaps and priorities, thus contributing to effective, efficient and principled humanitarian assistance.

[fts.unocha.org](http://fts.unocha.org)

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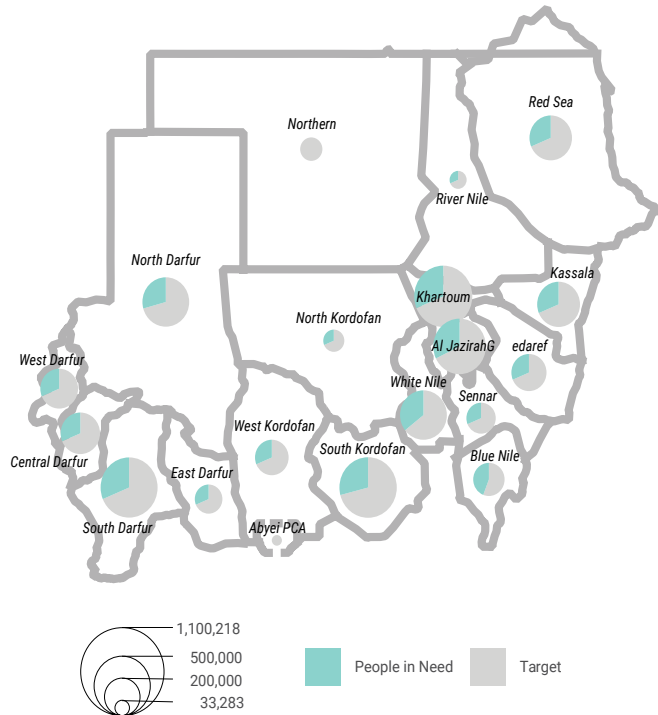
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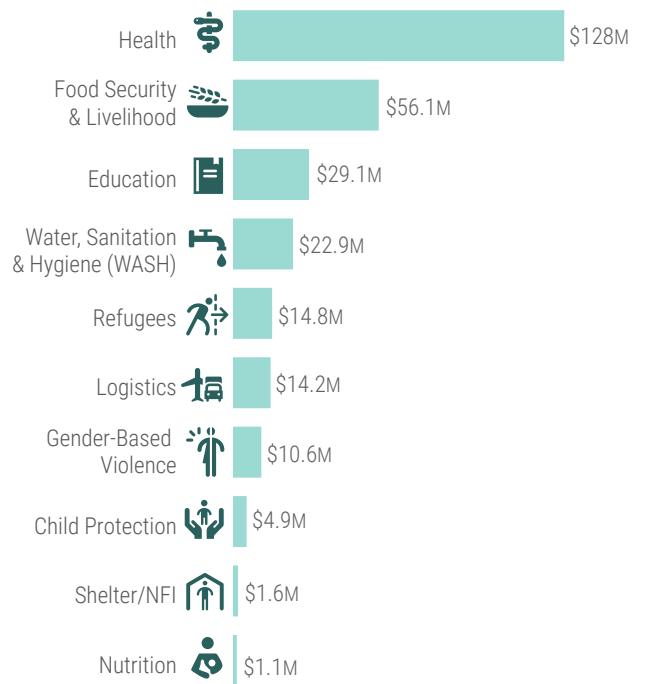
# COVID-19 Response at a Glance

PEOPLE IN NEED	PEOPLE TARGETED	REQUIREMENTS (US\$)	OPERATIONAL PARTNERS
9.8M	6.7M	\$283M	54

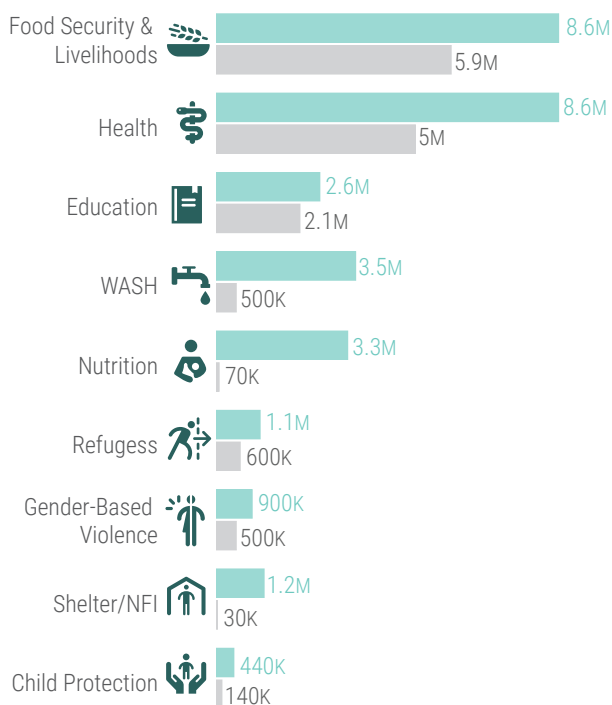
## People in Need and Targeted



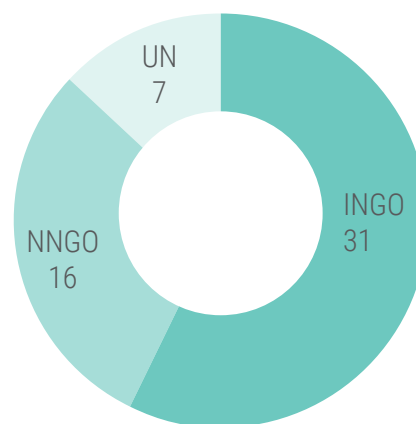
## Requirements by Sector\*



## People in Need and Targeted by Sector

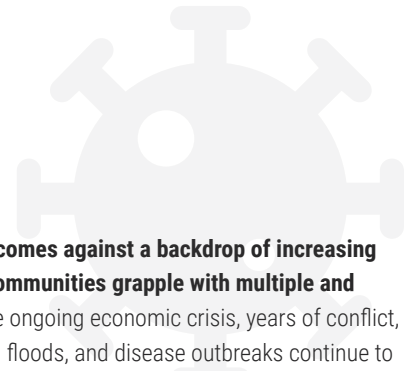


## Operational Partners by Type



\*The totals included here for the Health Response represent the requirements, people in need and targeted that are outlined in the [COVID-19 Country Preparedness and Response Plan CPRP](#) launched in May 2020.

# Context of the Crisis



Sudan recorded the first COVID-19 case on 13 March 2020 and, at the beginning of July, the Federal Ministry of Health had confirmed that nearly 10,000 people had contracted the virus, including over 600 who died from the disease across the country. Although more than 70 per cent of the confirmed cases are in the Khartoum area, COVID-19 has spread throughout the country, with the highest numbers recorded in the central and eastern states. With extremely low testing capacity – around 800 samples per day, the lowest in the region – the official figures of confirmed cases likely underestimate the extent of the pandemic and the actual situation is unknown.

Despite the Government, humanitarian partners and local organizations' efforts to increase awareness about the risks of COVID-19 and how to prevent transmissions, social/physical distancing and other practices have not been widely adhered to by the population. Stigma, denials, misinformation, and rumours have emerged as key challenges to the COVID-19 response, preventing positive health seeking behaviour in the affected populations.

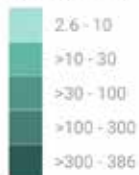
The COVID-19 pandemic comes against a backdrop of increasing humanitarian needs, as communities grapple with multiple and simultaneous shocks. The ongoing economic crisis, years of conflict, back-to-back droughts and floods, and disease outbreaks continue to lead to displacement, high levels of food insecurity and malnutrition that affect the lives and livelihoods of many Sudanese.

The necessary COVID-19 containment measures adopted by the Government will inadvertently exacerbate the economic crisis, while the high inflation continues to erode families' purchasing power. According to the IMF, the economy contracted by 2.5 per cent in 2019 and is projected to shrink by 8 per cent in 2020 as a consequence of the pandemic. Inflation is very high and rising—114 percent in May—, the Sudanese Pound continues to depreciate rapidly and there are chronic shortages of fuel, cooking gas and bread. The closure of borders also reduced internal movements for goods and people. In addition, the global economic slowdown during the pandemic has led to reduced remittances (estimated at about \$3

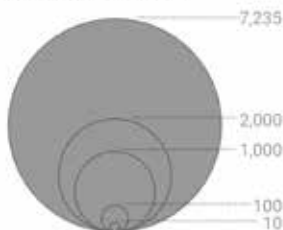
## Population Density and Confirmed Cases per State

(as of July 03, 2020 )

Population density (pop./km<sup>2</sup>)



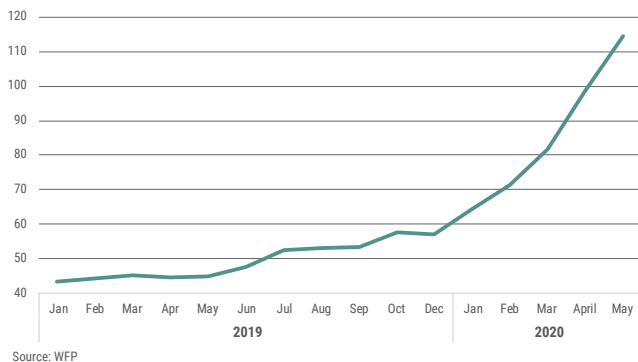
Number of cases



Map by the Sudanese Centre for Health and Demography, 2020

billion per year), which is likely to impact people’s wellbeing. The anticipated depreciation of the local currency and a reduction on exportations may lead to an increase in the cost of imported goods in local markets, including wheat and other essential commodities. Curfews and restrictions on movement will have a particularly high impact on the urban poor, many of whom rely on casual day labour to survive.

**Inflation Rate**



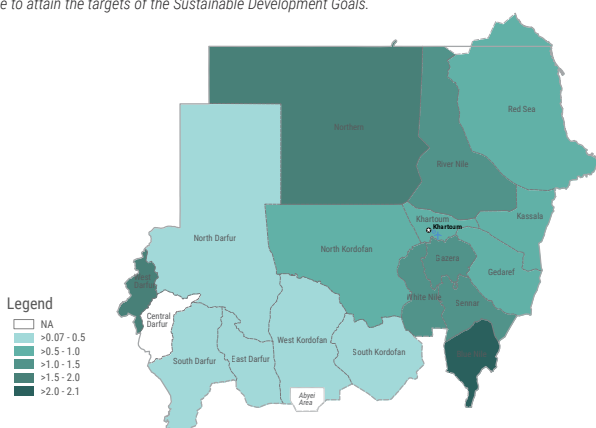
Source: WFP

**IMPACT ON SERVICES AND SYSTEMS**

Sudan’s health system was under extreme stress prior to the pandemic and has been further stretched in an effort to prevent, contain and treat COVID-19. The surveillance system does not cover the entire country, with long delays between alert and confirmation of an outbreak. Sudan lacks enough and adequately trained medical staff to support the increased demand, isolation units, intensive care units, infection control materials, medicines and medical supplies to address quickly spreading COVID-19 in all states across the country.

**Health Workforce Density by State**

This map illustrates the density of health workforce (doctors, nurses and midwives) per 1,000 population per state. According to WHO, 4.45 doctors, nurses and midwives per 1,000 population are an indicative minimum density of a workforce that is fit for purpose to attain the targets of the Sustainable Development Goals.



Since 2017, Sudan has struggled to sustain adequate supply of medicine and medical items as a result of economic crisis and hard currency shortages. In 2019, prior to this pandemic, medicine imports were 20 per cent less compared to 2017. This has resulted in lower availability of medicines in both Government and private facilities,

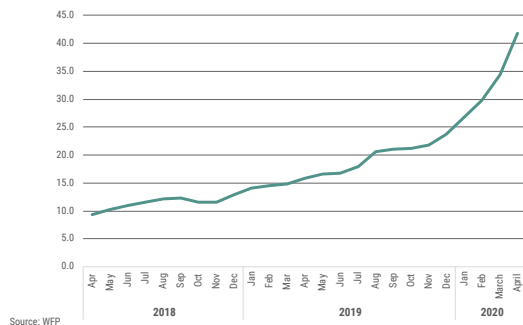
compared to previous years, according to the FMoH and the WHO.

Customs clearance procedures for medicines and medical supplies, including those related to COVID-19 response, normally take between three and four weeks if there are no interruptions. Currently, humanitarian agencies are facing challenges in clearing medical supplies, due to some Government entities working with limited staff (30 per cent), resulting in lower operating capacity available to clear items through customs. The shortage of fuel and movement restrictions is also impacting the transportation of supplies once cleared. As part of the measures to prevent the spread of COVID-19, ships docking Port Sudan, Sudan’s main port for the imports of strategic commodities, remain in quarantine for 14 days. There are concerns that this will delay delivery of any consignments, including vital medicines and medical supplies. Approximately 81 per cent of the population does not have access to a functional health centre within two hours of their home. These access gaps are a critical impediment to the fight against COVID-19, as well as people’s general well-being and survival from other threats. COVID-19 cases have led to closure of some health facilities to close to other patients due to isolation procedures. In Khartoum state, 70 per cent of the primary health clinics have been closed since May as a COVID-19 containment measure and in some facilities, stigma has resulted in patients not being admitted for treatment of other illnesses. Regular treatments for malnutrition or maternal care may have to be suspended.

FAO estimates that the COVID-19 in Sudan and related containment measures is adversely impacting all four dimensions of food security: availability, access, utilization and stability. Availability is affected due to labour shortage in the farms plus shortage [lack/increased cost] of transportation of items while access to food will be challenged as many micro-enterprises and petty/small informal businesses were restricted or curtailed, causing loss of income sources that enable vulnerable people to purchase basic commodities. With limited availability and access, vulnerable families will resort to low quality and quantity of food which will result in undernutrition. Sudan’s Food Security Technical Secretariat (FSTS) already projects that the consumption patterns will be shifted towards low quality and quantity and this will increase malnutrition. Restrictions and interruptions in the flow of goods and services that ensure safety nets and social protection of the vulnerable population is expected to have an impact on food stability.

More than 9.6 million Sudanese, almost a quarter of the entire population, are now severely food insecure. The figures, the highest ever recorded in the history of the IPC analysis in Sudan, represents an increase of 65 per cent if compared with the same period (June to September) last year. This includes about 2.2 million people facing emergency acute food insecurity (IPC Phase 4). The situation is especially concerning in some states like North Kordofan, with an increase of 335 per cent, or Gazera, with an increase of over 200 per cent. Conflict-related displacements, significant macroeconomic challenges, resulting in high inflation rates, exacerbated by COVID-19 prevention measures are the main causes of the increasing hunger in Sudan.

### National Average Price of Sorghum (SDG/1kg)



Staple food prices have continued to increase more rapidly than normal in May and reached record highs each month. National retail price of sorghum in May is 191 per cent higher than the previous year, and 477 per cent higher than the 5-year average (2015-2019). More than one-third of the households had to adopt food-based coping strategies e.g. eating less preferred foods, limiting portion sizes, reducing the number of meals per day to maintain minimum food consumption levels. Additionally, more than half of resident households had to resort to livelihood-based coping strategies including sale of productive assets or animals thus depleting their assets. According to WFP, majority of households already spend more than 65 per cent of their expenditure on food, limiting their ability to create or invest in livelihood assets. With the current COVID-19 pandemic and the onset of lean season, the food security situation is expected to worsen in the coming months at least until the next harvest season.

Safely managed water, sanitation, and hygiene services are an essential part of slowing the spread of COVID-19 in Sudan but this is being challenged by the limited access. According to the Joint Monitoring Programme for Water Supply, Sanitation and Hygiene, about 23 per cent of people in Sudan have regular access to basic hygiene services (soap and water). A third of the households have access to proper sanitation. About 68 per cent of households have access to improved drinking water sources, only a third have access to proper sanitation. All together a third of the households have access to both water and sanitation, with wide disparities between states as well as urban and rural populations.

With the closure of schools on 15 March, more than 8.1 million school children are out of school. This includes the 3.6 million children (aged between 5 and 13 years) who lack access to education across the country. At the time of closure, all classes had been completed in public schools. About 836,000 students have, however, been unable to complete the Grade 8 and Grade 11 school exams – attempts are being made to schedule the exams for July in six states (West Darfur, Khartoum, Kassala, Gedarif, White Nile, West Kordofan). Additionally, about 600,000 IDP children attending some form of learning in the camps and host communities are also affected. This follows various interruptions in 2019 due to the political crisis which impact the 2019 school calendar. At the same time, limited access to computers, internet and other connectivity options across Sudan means that teachers need to rely on TV, radio and paper-based alternatives to in-person education.

### IMPACT ON PEOPLE

COVID-19-related restrictions are having an adverse impact on food security and livelihoods of the most vulnerable households. This is especially worrying from June onwards when many parts of the country will be relying on seasonal rains to begin planting key cereal crops, such as millet and sorghum, with the harvest expected in November/December. Movement restrictions could impact farmers' access to markets for critical inputs and pastoralists' access to water and traditional grazing areas. Poor households in the pastoral areas are likely to continue facing difficulty meeting their minimum food needs as a result of very high staple food prices, reduced access to labour, lower than normal terms of trade and seasonally low access to animal products during the lean season. The vulnerable and poor whose income and livelihoods heavily depend on a daily wage, especially people living in urban and peri-urban areas, will be affected by containment measures and risk not being able to provide a daily meal for their family.

Increased numbers of people, including protracted IDPs in Darfur, Blue Nile and South Kordofan, and poor households in urban and rural areas most affected by COVID-19 control measures, are expected to face Crisis (IPC Phase 3) or worse food security outcomes through September 2020. Emergency (IPC Phase 4) outcomes are expected among IDPs in conflict-affected areas of Jebel Marra in Darfur and SPLM-N areas of South Kordofan as well as parts of Red Sea and Kassala during the peak of the lean season between June and September 2020, according to FEWSNET. According to WFP's analysis, there are currently 2 million people within marginally food secure group who rely on the informal sector as their main source of income and are most at risk of facing food insecurity as a result of COVID-19 related restrictions if no measures to mitigate this risk are taken.

Women and girls are more likely to experience a worsening of existing inequalities and disproportionate secondary impacts of restrictions compared to men and boys and even worse for other marginalized groups such as persons with disabilities and those in extreme poverty. The containment measures are limiting their work and economic opportunities. Projections indicate that the informal sector will be particularly impacted, and estimates show that women make up 50 per cent of this workforce; this will affect household income - an even longer-term impact on women. For example, by early June, the women cooperative union, had registered 12,000 women in small businesses including tea and food sellers in Khartoum who have been forced out of business without alternative means of livelihood or support.

Over 1.87 million IDPs and 1.1 million refugees are living in crowded settlements with inadequate water and sanitation services and already facing significant protection challenges in addition to loss of livelihoods and interruption in basic services. For refugees, it is particularly concerning as the health facilities in refugee camps and other refugee hosting locations are basic with inadequate supplies and poor infrastructure that do not meet infection control standards. While official border entry points with neighbouring countries have

closed, small numbers of refugees continue to arrive and are placed in a two-week quarantine, following the Government of Sudan's COVID-19 response protocols. Containment measures also prevent refugees from accessing sources of energy, such as charcoal or firewood, essential to cook and to provide energy to pump water to hand-washing facilities. This is compounded by a high inflation, fuel and bread shortages.

Measures to curb the spread of COVID-19 are compounding existing protection challenges, including gender-based violence, inter-communal conflict, human rights violations, harassment and there is heightened risk of exploitation such as trafficking, child labour or early marriage. The risk is higher in Khartoum and Gezira which have the highest number of children living and working on the streets and now require lifesaving protection support. Child protection partners reported 65,000 unaccompanied and separated children need to be reunited with their families after the closure of all childcare facilities and the release of children from reformatories, prisons and Khalwa schools, in mid-March.

The domestic and caregiving burdens that women and girls perform within the home exposes them to greater health risks. Trapped inside their homes for extended periods due to lockdown measures, the risks of gender-based violence increases and at the same time reduces their access to services such as psychosocial support, case management and legal assistance. Their reproductive healthcare needs - antenatal care, childbirth delivery and lactation - will be impacted. The initial suspension of provision of services such as antenatal care in Khartoum has been attributed to an observed increase in maternal deaths as there is limited capacity to detect high-risk pregnancies, limited access to public transportation, less number of functioning facilities, and fewer sexual and reproductive health (SRHR) services and supplies.

**IMPACT OF CONTAINMENT MEASURES ON HUMANITARIAN ACCESS**

On 18 April 2020, the Government effected a lockdown in Khartoum state (the epicentre of the outbreak in Sudan) to minimize the spread

of COVID-19. Following this decision, several states including North, Central West, South Darfur, White Nile, and Kassala put in place similar containment measures restricting movement. As of 16 March, all points of entry into Sudan have been closed for movement of people and non-essential cargo. Some entry points remain open for the movement of humanitarian supplies.

These containment measures have introduced additional challenges to delivery of effective and timely assistance to affected people and communities. Transportation of humanitarian supplies continues, but movement restrictions at the state and locality level – on top of existing fuel and cash shortages – have increased costs of transport and led to delays in delivery.

Movement of humanitarian workers has also been constrained with grounded or intermittent and unpredictable flights. As a result, sustaining or scaling up both COVID-19 response and other life-saving activities is difficult; as of 8 June, humanitarian personnel can come into the country. At state level, the Humanitarian Aid Commission (HAC) have allowed permits for only critical humanitarian staff to move including outside of curfew hours.

Movement of humanitarian supplies by road is facing delays due to fuel shortages and the time required to process permits. The fuel shortage is driving up operational costs. Furthermore, the reduced operating hours of banks or full closure in some areas is limiting partners' ability to withdraw cash to undertake activities or pay salaries/incentives to health workers responding to COVID-19.

Containment measures and the pandemic itself is also affecting people's ability to access assistance. Routine vaccination campaigns have been delayed or cancelled. The disease surveillance system is overwhelmed by response to COVID-19, and movement restrictions make it difficult for health workers to report to work in larger cities. Movement restrictions have slowed the distribution of critical medical supplies from capitals – and reportedly, only 15 per cent of the essential medicines and supplies are available on the open market.

The closure of schools and universities limit children and adolescents' access to education and child protection services including psycho-





social support, group counselling and detention monitoring, are paused, limiting access to services. Partners are resorting to remote management modalities – including contacting communities via phone – to ensure minimum provision of support and services while minimizing risk.

#### **POSSIBLE EVOLUTION OF SITUATION AND NEEDS UNTIL DECEMBER 2020**

Based on the information and data available, Khartoum is likely to remain the epicentre of COVID-19 transmission in Sudan. It is likely that COVID-19 will continue to spread with potential fluctuations depending on the effectiveness of the response and containment measures in place.

Lockdown restrictions due to COVID-19 will worsen the impact of June to September 2020 lean season when the food security situation of the most vulnerable households will be at its lowest. Food prices are expected to increase until the next harvest period in November/December 2020 exacerbated by limited food and commodity supply. The rising prices of commodities coupled with loss of income will substantially increase urban poverty and may result in population movements. In addition, limited access to agricultural inputs and shortage of labour will most likely affect area planted and the overall 2020 cereal production.

Meanwhile, the new school year is planned to start in September, however, the continued spread of COVID-19 could result in delayed opening of schools. With the limited access to alternative methods of learning there is a risk for children to miss out of critical learning periods.

The predicted above-average rainfall could induce flooding; with an over-stretched health system, vector and water-borne diseases that normally increase during the rain/flood season will likely spread further. The rain season will also provide conducive conditions for desert locust breeding whose infestation and spread is expected to escalate contributing to reduced 2020 food production.

*Photo: OCHA / Saviano Abreu*



# Response Strategy



This HRP addendum builds on the 2020 HRP and will address the risks and immediate humanitarian consequences of COVID-19 on the most vulnerable people. The overall response will be guided by the 2020 HRP three strategic objectives below:



**Provide timely multi-sectoral life-saving assistance to crisis affected people to reduce mortality and morbidity**



**Contribute to building resilience to recurrent shocks and improving vulnerable people's access to basic services**



**Enhance the prevention and mitigation of protection risks and respond to protection needs through quality and principled humanitarian action**

Response under the HRP addendum will focus on short-term and immediate new needs and pre-existing needs compounded by the pandemic. Partners have endeavoured to re-orient and prioritize life-saving activities within the existing HRP to compliment and contribute to COVID-19 response. In addition, humanitarian partners will undertake new or expand existing activities to minimise the impact of COVID-19 and related containment measures including providing take home rations to vulnerable families of enrolled children out of school that were previously benefiting from school feeding programmes; developing alternative distance learning programs; and supporting the government in development of guidance for safe re-opening of schools. New implementation approaches will be adopted for child protection services including psychosocial support, case management, support to UASCs and establishment of temporary/ interim care centres.

To protect the most vulnerable, partners will complement the Government's social protection activities, provide direct cash transfers and unconditional cash where market conditions allow. Efforts will also be made to upgrade and expand shelter for vulnerable households; provide additional NFIs; scale up WASH activities particularly increasing quantity of water to enable prevention measures and expand stations to facilitate physical distancing. Strengthening the integration of risk communication and community engagement to support prevention, risk reduction and building resilience while ensuring adequate accountability will be at the core of the response with emphasis on most at risk population groups.

Humanitarian partners continue to review delivery modalities and adopt mitigation measures to reduce exposure and transmission for both beneficiaries and frontline aid workers: this includes ensuring that the relevant personnel protective equipment is available; looking into ways to undertake remote monitoring and needs assessments; distribution of assistance to cover longer time periods.

Given the increased demand for operational support and logistics to

COVID-19 response and sustaining current operations, the Logistics Cluster was activated in May; this will enhance predictability, timeliness and efficiency of the logistics response to meet beneficiaries' needs.

This HRP addendum will be complimented by the HCT-UNCT COVID-19 Country Preparedness and Response Plan (CPRP) that is supporting the Government of Sudan's efforts in preparing and responding to the pandemic and is also aligned with the Global Humanitarian Response Plan (GHRP).

The CPRP will cover health-related response to the pandemic while additional activities in the addendum are to address non-health response. The CPRP covers the nine pillars: (i) Country-level coordination, (ii) Points of entry (iii) Surveillance, rapid-response teams, and case investigation (iv) National laboratories (v) Case management (vi) Risk communication and community engagement, (vii) Infection prevention and control IPC, (viii) Operational support and Logistics and (ix) Maintaining essential health services and systems.

Overall, the HRP will continue to be coordinated by the Humanitarian Country Team, in addition, a time-bound COVID-19 coordination mechanism has been set up to ensure timely and effective response to COVID-19. Under the overall guidance of WHO, the Strategic Coordination Group (SCG) - chaired by the RC/HC and comprised of WHO, UNICEF, OCHA, WFP, UNDP, UNHCR and UNFPA ensures the UN and the humanitarian community are aligned in supporting the government's preparedness and response efforts. The SCG interfaces with the Government's Higher-Level COVID -19 Committee to provide advisory services and actions as needed. This SCG is supported by the COVID-19 Working Group at operational and technical level. The COVID-19 Working group is composed of members of the Inter-Sector Coordination Group and Pillar Leads from Agencies and NGOs. In addition, COVID-19 IDP Camp Coordination Task Force led by UNHCR and IOM has been established to strengthen COVID-19 preparedness and response in IDP camps and settlements and reports to the COVID-19 Working Group.

# Sectoral Objectives & Response

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## BLUE NILE STATE

*A girl child stands outside the Gennis Health Centre in Roseires locality of Blue Nile State in Sudan.  
Photo: UNICEF / Shehzad Noorani*



# People in Need, Targeted & Requirements by Sector

 COVID-19 Addendum (this Plan)

 2020 Humanitarian Response Plan

Sector (in million)	People in Need (in million)	People Targeted (in million)	Requirements (US\$/million)	Projects	Partners
Common Services	-	-	-	-	-
	-	-	13.3	3	2
Education	2.62	2.1	29.1	10	10
	1.4	0.74	62.1	33	25
ES/NFI	1.2	0.3	1.6	2	2
	1.2	0.5	29	12	10
FSL	8.6	5.9	56.1	19	18
	6.2	4.7	339.6	54	43
Health	8.6	5	128	38	38
	8.6	5	110.7	32	25
Logistics			14.2	1	1
			25.9	2	2
Nutrition	3.3	0.74	1.1	4	4
	3.3	1.6	153	33	28
Protection	-	-	-	-	-
	1.7	0.6	17.5	12	13

Sector (in million)	People in Need (in million)	People Targeted (in million)	Requirements (US\$/million)	Projects	Partners
Child Protection	0.44	0.14	5	6	6
	1.84	0.74	15.6	15	15
GBV	0.93	0.5	10.6	8	8
	1.77	0.65	21.6	9	9
WASH	3.5	0.5	23	22	22
	7.6	3.2	71.6	49	40
Refugee Response	1.1	0.6	14.9	16	16
	1.1	0.9	476.8	33	34

# Education



## PEOPLE TARGETED

# 2.1M

## REQUIREMENTS (US\$)

# \$29.1M

### Needs Analysis

As part of the COVID-19 containment measures, schools were closed on 15 March 2020. The closure is expected to last up to six months and comes after extended interruptions to learning last year due to the political crisis. In addition to the 3.6 million children between 5 and 13 years who lacked access to education, often for economic reasons, the COVID-related school closures have now left more than 8.1 million primary and secondary level schoolchildren out of school including about 600,000 IDP children. The 2020 grade 8 and grade 11 exams have not yet been held, affecting 836,000 children's progression to the next level; attempts are being made to schedule the exams for July in six states (West Darfur, Khartoum, Kassala, Gedarif, White Nile, West Kordofan).

With the prolonged absence from school, children, and particularly vulnerable children including children with disabilities, are at a high-risk of dropping out of school and never finishing their primary or secondary education. When not attending school, children and youth are at a much higher risk of child labour, trafficking, early marriage, early pregnancy, and sexual exploitation and abuse. Additionally, many children rely on free school meals to meet their daily calorie or micro-nutrient requirements and schools provide a protective, supportive, and social environment which is critical to children's well-being.

### Response Strategy

The Education sector's response strategy will focus on distance learning programmes for out-of-school children, including community radio and TV programmes as well as paper-based at-home learning materials; conduct back-to-school multi-sectoral campaign to ensure that school management, teachers, administrators, parents and children are prepared for the safe re-opening of schools and that communities and families have been provided with clear information on minimizing the risk of COVID-19 transmission; and improve safety of learning environments by ensuring children, including children with disabilities, have access to clean, sex-segregated latrines and handwashing stations with soap, that girls are provided with menstrual hygiene materials, and personal protective equipment is available in-line with national recommendations;

Partners will also provide accelerated education programmes and catch-up classes to minimize learning inequalities that have become further exacerbated due to school closures; support the Ministry of Education in preparing for and facilitating grades 8 and 11 student exams with appropriate physical distancing measures in place; ensure children learning at home and later back at school have all required learning materials and school supplies; support teachers through peer networks, stress management training, professional development opportunities and providing financial incentives for volunteer teachers to return to work; undertake school feeding programmes to include take-home rations during school closures and on-site school feeding when children are able to attend school; and provide age-appropriate psychosocial support for children to help them process their feelings, reactions and challenges relating to COVID-19.



#### PORT SUDAN

"I love coming to school. I want to learn. I want to learn a lot and become like my teacher," Hawa Hamid, 10.

Photo: UNICEF / Shehzad Noorani

# Emergency Shelter/Non-Food Items



## PEOPLE TARGETED

30k

## REQUIREMENTS (US\$)

\$1.6M

### Needs Analysis

The needs of IDPs and other people affected by conflict have been exacerbated by COVID-19 and related containment measures. Many stay in congested camps and/or settlements with limited space to implement COVID-19 preventive measures; shelter remains a challenge with major gaps in several areas, and WASH and health services are limited. The most affected people will be the newly displaced especially in Jebel Marra in Central and South Darfur, protracted IDPs in Darfur, South Kordofan and Blue Nile. The situation is even more urgent due to the upcoming rain season which is projected to affect about 250,000 people across Sudan.

The socio-economic situation in the country is also contributing to shortages of fuel and cash liquidity which has been exacerbated by the containment measures. This has affected already vulnerable groups such as IDPs, returnees and host communities in already fragile situations. The Sector also considers the health high risks states such as Khartoum, Red Sea, East Darfur, Central Darfur, and Blue Nile.

The measures to curb COVID-19 also had an impact on ES/NFI activities including monitoring, reporting, verification, and transportation of lifesaving NFIs and shelter material across the country.

### Response Strategy

The S/NFI sector response to mitigate the impact of COVID-19 and related containment measures includes distribution of additional life-saving NFI and shelter material as a measure to minimize the spread of the disease – as this will contribute to reduce sharing of household items; upgrading and expanding shelters of vulnerable households, to reduce overcrowding in light of limited quarantine and isolation centers; and decongesting shelter in IDP settlements – if possible - to support social distancing. Distributions (in-kind or cash) will ensure requisite safety measures are in place, including physical distancing, hand-washing facilities, taking temperature, and distribution which allow for space among beneficiaries.

In coordination with Health and WASH sectors, S/NFI partners will complement the inter-sectoral response through the rehabilitation, expansion or upgrade of existing facilities, such as community centers, or setting up rub halls/prefab structures. Further response will consider alternative shelter solutions (such as repurposing) for temporary medical facilities, these facilities will be equipped with NFIs from the core pipeline such as blankets, mosquito nets, kitchen sets and any additional items required to support activities. In urban settings, such as Khartoum and other main cities, sector partners will support isolation centers with NFI materials. Partners will continue to support risk communication on infection prevention and control, as well as distribution of IEC materials and community awareness/engagement during regular activities and distributions done by partners.

Due to the lack of protective equipment and containment measures, sector partners anticipate some challenges in the response including physical access to people, on site data collection, and verification. Also, fuel shortages, disruptions of supply chains, and closure of markets will likely pose challenges to partners, including reduced availability of items in the local and international markets, delays and increased prices on transportation to and inside Sudan. If required to undertake decongestion of camps, this will probably remain a challenged due to house, land and property rights especially for IDPs in more established camps. For this, the S/NFI sector may need to explore upgrading shelters with more durable solutions.

# Food Security & Livelihoods



## PEOPLE TARGETED

5.9M

## REQUIREMENTS (US\$)

\$56.1M

### Needs analysis

The food security situation of vulnerable people is likely to worsen especially between June and December 2020 due to the direct and indirect impacts of the COVID-19 pandemic. The vulnerable and poor households whose income and livelihoods depend mainly on informal economic activities and daily wage are already struggling to provide a meal for their families.

Domestic trade disruptions are expected to create unstable food market prices as already witnessed by the increase in prices of basic goods in major urban centers; in April, the national average cost of a local food basket increased by 11.6 percent compared to March; the average price of sorghum has increased 17 percent over the same period, and is 136 per cent higher compared to a year before.

The agriculture sector will be negatively impacted; fuel scarcity and increased transportation costs exacerbated by containment measures have also led to an increase in the price of food and agricultural inputs. Transportation blockages or interruptions will disrupt the distribution of inputs like animal feed, some farmers may encounter shortages in labour and farming inputs and may experience difficulties in deliveries which could also affect domestic and regional supply chains.

A decline on income in daily workers caused by the COVID-19 containment will have a negative impact on the local economy, leading to delays in planting and cultivation and in turn affect income and livelihoods. If further restrictions of movement are put in place, access to markets may become even more difficult, and farmers may face shortages of crops and livestock inputs, especially seeds, fertilizers, veterinary supplies and medicines, vaccines, and minerals.

The most at-risk population groups are female/elderly/child-headed households, households with many elderly and children, disabled, informal sector workers. However, additional attention is also required for people living in high-concentration areas, such as IDPs, refugees, returnees, migrants and children. Women and girls are also particularly at risk. These population groups may adopt negative coping mechanisms such as reducing food consumption, selling assets and livestock, incur in debt or forced marriage.

### Response Strategy

To minimize exposure of beneficiaries and aid workers, FSL partners will advance rations of food distributions to IDPs to cover three months, this will also ensure food consumption is maintained. Food distributions will be phased to limit exposure of beneficiaries when they receive food packages. FSL sector partners will also work with the Government to provide food assistance to households most affected by the containment measure.

Sector partners will provide time-critical agriculture inputs seeds and tools to farmers to mitigate the impact of COVID-19 containment measures on supply chains, and support livelihood diversification and home-based food production. Partners will also prioritize animal treatments, feed and supplements, specifically targeting herders whose movements are restricted, and support livelihood diversification (e.g. distribution of small stock).

To support the Government's social protection efforts, partners will implement direct cash transfers, cash schemes, and provide unconditional cash where the existence of markets and availability of goods allows. The FSL sector will also expand real-time remote monitoring systems to collect and assess the impact of COVID-19 on food insecurity at national, state and locality levels, and monitor market and health related indicators to support coordinated analysis and informed decision making for both government and partners.

Activities that require gathering or physical contact with beneficiaries, including distributions of inputs, cash, or vouchers, will include precautions to minimize exposure; (i) providing information to beneficiaries and staff about COVID-19, (ii) implementing physical distancing and (iii) taking precautions with high-risk populations. Distribution sites will be clearly marked, and flexibility will be allowed for populations at risk to designate people to collect assistance on their behalf. When not possible, adequate areas for the elderly, pregnant and lactating women and people with disabilities will be allocated in order to prioritize distribution and minimize exposure.



# Health



## PEOPLE TARGETED

5M

## REQUIREMENTS (US\$)

\$128M

### Needs Analysis

Sudan's health system was under extreme stress prior to the pandemic and has been further stretched to prevent, contain and treat COVID-19. Decades of limited to no investment, underfunding, and lack of qualified staff, infrastructure, equipment, medicines and supplies left Sudan with an extremely low capacity to respond to any outbreak and maintain the normal health services. The surveillance system does not cover the entire country and is structurally weak with long delays between alert and confirmation of an outbreak. Approximately 81 per cent of the population do not have access to a functional health centre within two hours of their home and the situation is getting worse, as many clinics are closing during the pandemic.

Sudan lacks sufficient and adequately trained medical staff to support increased demand, isolation units, intensive care units, infection control materials, medicines and medical supplies to address quickly spreading outbreaks, including the COVID-19, in all states across the country. COVID-19 cases may force health facilities to close to other patients due to isolation procedures. In Khartoum State alone, nearly half of the health centres closed during the pandemic, and Darfur had already closed a quarter of their facilities in 2018 due to lack of funds and staff. Regular treatments for malnutrition or maternal care may have to be suspended.

Increasing demand for care of people with COVID-19, compounded by fear, stigma, misinformation and limitations on movement are also contributing to disruption of health services. Women and children have been especially affected. Maternal health clinics have closed, reproductive health services have been interrupted and over 110,000 children are missing out essential vaccines. Suspension of immunization campaigns lead to increasing vulnerability of children and communities to communicable disease in a context where the capacity is already too fragile to respond to epidemics.

The points of entry (PoE) in the country – although closed for the moment but there are porous points - are only rudimentarily equipped and insufficiently staffed. In addition, the country remains prone to other disease outbreaks, including cholera, chikungunya, dengue, malaria, measles and Rift Valley.

### Response Strategy

Overall health response to COVID-19 will be guided by the HCT/UNCT COVID-19 Country Preparedness and Response Plan (CPRP), which outlines the measures to be taken at country level to contain the pandemic.

In addition to preventing and containing COVID-19 transmissions, health partners will also ensure the continuity of health services. The health sector and partners will adapt key health system functions to accommodate the increased demand on health services. This will include to strengthen the disease surveillance and reporting system for early detection of disease outbreaks; monitor vaccine-preventable diseases such as measles, polio, with focus on community-based surveillance; enhance the procurement supply chain to provide health facilities and actors with the required essential medical supplies and mitigate the effect of global shortages of drugs and disruptions in logistics; ensure adequate preparedness and response to forecasted emergencies such as seasonal floods and disease outbreaks through need-based planning and prepositioning of medical supplies across the country; continue outreach vaccination activities, malaria and other vector-borne disease prevention programs; prioritize reproductive, maternal, newborn, child, adolescent health services; improve the capacity of available health staff through training programs to address the existing knowledge gaps; and expand the number and reach of rapid response teams and referral capacity across all levels of the response.

# Logistics



## REQUIREMENTS (US\$)

# \$14.2M

### Needs Analysis

As part of the efforts to respond to COVID-19 – now a humanitarian system-wide scale-up by the IASC - there has been an increase in demand for operational support and logistics to streamline delivery of COVID-19 supplies, in addition to sustaining current humanitarian operations in Sudan. To adequately respond to the emerging needs of COVID-19, Logistics Cluster will support humanitarian community and the government of Sudan to deliver supplies and required medical and non-medical supplies to affected states across the country.

### Response Strategy

The Logistics Cluster will strengthen the pre-existent Logistics Working Group, and other logistics capacities of other organizations including local authorities; it will also provide a platform for exchanging information and decision making to improve strategic coordination. The cluster will develop and maintain common logistics operational plans together with the humanitarian actors and other sectors to ensure efficient logistics operations and timely delivery of humanitarian cargo and personnel across the country. The Logistics cluster will also identify and address gaps, bottlenecks or duplications in operations; will provide advice and troubleshoot assistance to its partners.

The Logistics cluster will facilitate the delivery of timely response to COVID-19 needs within the country. Key priorities of the sector include the provision of common logistics services, including transportation and freight of COVID-19 supplies by air, and storage and warehousing of health and WASH supplies. Approximately 10,000MT of supplies will be transported by road – from Khartoum and Port Sudan to states, or across states - or stored across different facilities in the next 3 months. COVID-19 supplies will be airlifted to areas where road transport may not be possible. The Logistics cluster will establish cargo consolidation hubs in both Port Sudan and Khartoum for onward dispatches to the states as per the Ministry of Health (MoH) and WHO distribution plans.

Under the Logistics Cluster, WFP will continue to import fuel to support partners, including storage and distribution. WFP will provide humanitarian partners with access to fuel for light vehicles and generators through service provision on full cost recovery.

# Nutrition



## PEOPLE TARGETED

74K

## REQUIREMENTS (US\$)

\$1.1M

### Needs Analysis

In 2020, approximately 2.7 million children will suffer from an episode of wasting and it is anticipated that current malnutrition levels will be further exacerbated by COVID-19. The virus puts malnourished children at a higher risk of mortality as they are more susceptible to infections due to their impaired immune system.

The spread of the virus will likely have an impact on vulnerable people, particularly on women and children. Containment measures established by the government such as movement restrictions will likely result in loss of household income and reduced access to essential health services thereby reducing peoples' ability to meet dietary, health and pharmaceutical needs. Furthermore, WFP projects an increase in the number of food insecure people in Sudan. Food insecurity coupled with an overburdened health system will put people at higher risk of malnutrition. The Nutrition Sector anticipates higher needs between May and December 2020, complicated by an overall reduction in service uptake due to physical distancing and lockdown related measures; anecdotal initial information indicates a reduced uptake of both treatment (CMAM) and prevention (IYCF) services.

The Sector foresees additional requirements to what was planned in states that were not initially anticipated in the 2020 HRP such as Khartoum, Al Gezira and North Kordofan as well as increased operating costs due to implementation of infection control and prevention (IPC) measures and enhanced outreach activities.

### Response Strategy

Sector partners will support State Ministries of Health (SMoH) in ensuring continuity of life-saving nutrition interventions through existing structures (health systems and fixed nutrition sites) and expand outreach of services to mitigate reduced service uptake due to lockdown measures.

Through appropriate training, nutrition services will be adapted in line with COVID-19 prevention measures to minimize the spread of the virus and ensure the safety of the nutrition workers and communities. These will include provision of PPE, hygiene and sanitation supplies, physical distancing, crowd control measures and more frequent distributions.

Awareness raising campaigns will be implemented at facility and community level including provision of IEC materials on COVID-19, and community outreach through community nutrition volunteers (CNVs) and leaders.

PLWs and caregivers of children suffering from acute malnutrition will be targeted for infant and young child nutrition (IYCN) counselling through mother support groups at community level and nutrition staff at the facility level. Counselling will promote a healthy and diverse diet and educate breastfeeding mothers on best practices on infection prevention and control measures.

Sector partners will continue adopting integrated nutrition-specific approaches addressing chronic food and nutrition insecurity. Households with acutely malnourished children and PLW will be prioritized for essential food assistance to ensure access to nutritious foods. The sector will promote multi-sectoral approach through integration with the WASH sector for the provision of WASH services at nutrition facilities, to ensure proper handwashing for the caregivers, lactating mothers and staff. Nutrition partners have provided guidance on how to continue nutrition services in the context of COVID-19 and additional guidance is being developed as the situation evolves.



#### PORT SUDAN

"I love coming to school. I want to learn. I want to learn a lot and become like my teacher," Hawa Hamid, 10.

Photo: UNICEF / Shehzad Noorani

# Protection - Child Protection



## PEOPLE TARGETED

141k

## REQUIREMENTS (US\$)

\$5M

### Needs Analysis

The COVID-19 pandemic and related containment measures will likely increase the risk for children to suffer violence, exploitation and abuse, and negatively impact their well-being as well as that of their caregivers. Children on the street, and in state institutions are at an even higher risk and more exposed, not least because of their limited access to basic health services and sanitary facilities. The risk is particularly high in Khartoum and Gezira which have the highest number of children living and working on the streets.

In March, following the closure of all childcare facilities and release of children from reformatories, prisons and khalwa schools, partners reported an increase in the number of unaccompanied and separated children (UASC) - from 15,000 to 65,000 in Khartoum and Gezira alone. These two states have also recorded the highest number of COVID-19 confirmed cases, further exposing children living on the streets, most of which have no possibility to practice preventive measures and have no or limited access to health facilities. Loss of livelihoods will expose children to abuse, exploitation, neglect and violence including child labour, sexual violence and child marriages. In addition to the possible loss of livelihoods, caregivers will also be exposed to increased stress which will result in anxiety and indirectly impact children's wellbeing.

All facility-based activities have been suspended leading to the disruption of peer and social support networks for children/ caregivers, psychosocial community and social support services. Partners have reported an increased demand to support and mentor child protection workers and community volunteers. Additionally, there are significant knowledge and capacity gaps within the health systems on the provision of specific protection services for children – which could affect 50,000 children - including prevention from separation as well as mental health and psychosocial support services.

### Response Strategy

To cope with the crisis, child protection partners need to adopt new implementation approaches, which require additional human and financial resources. Partners will scale up case management, support to UASC's (FTR and alternative care) in locations with high numbers of children without parental care, establish temporary/ interim care centres for not more than six months as they facilitate the family reintegration process; the centres will also be used for children from families that have been separated due to COVID.

Child Protection partners will coordinate with the health and WASH sectors to streamline standard operating procedures and referrals in case of any separation, and to make services accessible to vulnerable children; strengthen community-based child protection; provide psychosocial support services (PSS) and psychological first aid (PFA) through the health service delivery mechanisms by deploying CP workers in quarantine and treatment centres and family-based programs; and develop child friendly messages for different age groups. As part of the education response, CP partners will integrate PSS activities into the remote learning programs and risk communication and community engagement activities.

Partners will undertake trainings and deploy community-based child protection teams to support children within their homes, provide parents with PSS materials and phone-based counselling services for children that need specialized counselling. Alternative remote managed programs will be implemented to minimize exposure for both partners and beneficiaries. Family tracing and reunification services will be scaled up and partners will set up systems to provide shelter and support to children living and working on the streets including access to a daily meal.

The Child Protection sub-sector will develop guidelines and update referral pathways to enable faster referrals; trainings will be undertaken to increase the coverage of the children helpline from 12 to 24 hours; and partners will establish a hotline to support staff on child-friendly psychological first aid, child safeguarding and safe referral strategies.

# Protection - Gender-Based Violence



## PEOPLE TARGETED

**500K**

## REQUIREMENTS (US\$)

**\$10.6M**

### Needs Analysis

The COVID-19 pandemic will compound gender inequalities and gender-based violence (GBV) risks for adolescent girls, and women. Anecdotal reports already suggest an increase in intimate partner violence (IPV), domestic violence and exploitation as well as other forms of GBV in Sudan. Further, women and girls tend to be the primary caregivers for children, elderly and sick household members which puts them at higher risk of contracting the virus.

Mobility restrictions, limited access to health care- requiring the authorization from a male family member to seek healthcare, and limited access to protective networks, and GBV services is exacerbating the risks. Limited movement is also impacting livelihoods of low-income families, especially female-headed households, as many have lost their income sources; projections indicate that the informal sector such as tea and vegetable or firewood sellers - of which about 50 per cent are women - will be impacted by the containment measures. The loss of income is also impacting women and girls' access to needed family planning and hygiene items and consequently, they could end up adopting negative coping strategies including survival sex; in Khartoum, partners are reporting an increase in commercial sexual exploitation of children. Female-headed households and households with many dependents are also among the most vulnerable, now facing additional burdens in case a family member falls ill.

The COVID-19 pandemic has overburdened the service delivery system, diverting attention and resources away from GBV and reproductive needs. This may exacerbate maternal mortality and morbidity, increased rates of unplanned pregnancies, HIV and sexually transmitted diseases, as well as unsafe abortions considering the unavailability of emergency contraceptives in the country. This is in addition to already limited GBV and reproductive services including police gender desks, legal aid services, and GBV service entry points.

### Response Strategy

The GBV sub-sector will monitor the effects of the containment measures on women and girls especially disruption of livelihoods, negative coping mechanisms, increase in violence/harassment etc. and scale up interventions and advocacy.

A national GBV hotline and GBV hotlines in seven states have been established to provide tele-counselling and reporting of GBV cases. Partners are working closely with the protection and health sectors to ensure continued availability of GBV case management, psychosocial support (PSS), and integrated services including sexual reproductive health (SRH), and clinical management of rape (CMR) services.

GBV referral pathways have been modified after a comprehensive mapping exercise to include temporary COVID-19 isolation units, treatment facilities, and midwifery services. Program delivery will be adapted to meet COVID-19 safety requirements, such as using remote/mobile services. Dignity kits will be pre-positioned and distributed in isolation and quarantine centers to support specific needs of women, including health workers.

Sector partners are already implementing awareness sessions on GBV and protection of women and girls for law enforcement officers, and partners will work to integrate GBV prevention, mitigation, and response across sectors and government COVID-19 interventions. While GBV confidential corners and women centers continue, social workers and caseworkers in these facilities need PPEs and other safety equipment. Sub-sector partners will scale up programs on community engagement with key community members and religious leaders, undertake GBV awareness programs on local radios and provide online capacity-building for caseworkers, social workers, counsellors, and health staff to support GBV survivors. When feasible, partners will also provide in-kind and cash distributions to women and girls in the most vulnerable households to mitigate harmful coping mechanisms.

The GoS CVAW unit is leading advocacy on change in laws to protect domestic violence survivors and the police, including the FCPU has had their mandate strengthened to deal with GBV. There has been advocacy within law enforcement at state level to allow the service providers movement after curfew time to enable response to emergency GBV cases. Ten gender desks in Darfur states have been supported with mobile phones and airtime as part of response.

# Water, Sanitation & Hygiene



## PEOPLE TARGETED

500k

## REQUIREMENTS (US\$)

\$23M

### Needs Analysis

About 74 percent of Sudan's population have access to drinking water, 39 percent have access to limited sanitation services, and only 13.4 percent have access to basic handwashing facilities (S3MII). Due to the compounding effects of COVID-19, a deteriorating economy and poverty, and lack of investment in public health systems, highly populated states like Khartoum and Al Gezira are facing additional challenges in prevention and response to COVID-19.

In Khartoum, only 42 percent of people have access to basic handwashing facilities – critical to COVID-19 prevention, however, this percentage is much less in states such as Sennar (10.1percent), River Nile (31.4per cent), or Blue Nile state, where access is estimated only at 2 percent (S3MII).

Needs in the east of Sudan are increasing, and lack of humanitarian partners in these areas poses additional challenges to respond in a timely manner. Only 11 per cent of the population in Al Gezira have access to basic handwashing facilities, 8.7 per cent in Kassala, and 4.5 per cent in Gedaref. Promoting handwashing practices, including provision of additional handwashing stations and handwashing campaigns, together with equipping the isolation centers, health facilities, points of entries, and other quarantine facilities with adequate WASH is urgently required.

### Response Strategy

The sector partners will target an additional 500,000 people; the revised HRP target after this addition will be 3.7 million from 3.21 million people. The WASH sector will aim to provide access to minimum WASH package in health centres

The WASH sector strategy will be twofold: Partners will prioritize adequately equipping isolation centers health facilities, point of entries, and other quarantine facilities with water supply, sanitation and IPC supplies for disinfection. Partners will also prioritize risk messaging on COVID-19 and assist with trainings on infection prevention and control (IPC) on WASH response; secondly, partners will increase the quantity of water supply and household storage capacity to enable frequent hand washing with soap, increase the number of tap-stands and latrines (if required) to maintain social distancing in crowded places.

Partners will also prioritize risk communication messages using radio, TV and other local media in coordination with the Risk Communication pillar lead - UNICEF. WASH sector partners will explore best practices for the delivery of WASH services and innovate measures to ensure physical distancing while undertaking the response. WASH supplies like soap and jerry cans will be distributed in areas at high risk and partners will undertake capacity building to support water committees and WASH and health frontline workers.

# Refugees



## PEOPLE TARGETED

**629K**

## REQUIREMENTS (US\$)

**\$14.9M**

### Needs Analysis

While official border entry points with neighbouring countries have been closed, small numbers of refugees continue to arrive and are placed in a two-week quarantine. Refugees in Sudan are highly vulnerable to COVID-19 due to overcrowding in camps and settlements. There has been no major COVID-19 outbreak among the over one million refugees so far in Sudan, however, in June, a limited number of individual positive cases were reported in Khartoum in May and East Darfur. Contacts were traced and advised to isolate.

Consequences of COVID-19 go beyond health, especially in urban and dispersed settings, but also in camps. Due to lockdowns and additional movement restrictions, refugees' already limited livelihoods opportunities have been further reduced, negatively affecting their self-reliance to provide for their basic needs. This is leaving refugees in a more vulnerable situation and at further risk of protection concerns such as sexual and gender-based violence (SGBV), which may also lead to negative coping mechanisms. The restrictions also prevent refugees from accessing sources of energy, such as charcoal or firewood, essential to cook, and has also affected the ability to provide fuel to pump water to hand-washing facilities. This is compounded by a high inflation, fuel and bread shortages.

Moreover, access to water and hygiene preventive measures for COVID-19 is challenging for refugees, due to their limited access to non-food-items (NFIs) such as jerry cans. Also, the poor shelter conditions many refugees live in makes physical distancing and self-confinement extremely challenging. Overcrowding in camps and settlements remains a major challenge, particularly in White Nile and East Darfur States.

All schools have been closed since 15 March as a preventative measure, this negatively affects refugee children and youth, including interrupted learning and behavioral development. The disruption of education can increase school dropouts, particularly for girls, and increase the risk of child labour and early marriage.

### Response Strategy

The RCF developed an inter-agency COVID-19 Contingency and Preparedness Action Plan looking at several scenarios, including camps and settlements lockdowns and rapid spread of the virus. Also, localized plans have been developed in the field to ensure the continuation of life-saving interventions. Given that the health

facilities in the refugee camps and settlements have limited capacity to treat severe cases of COVID-19, RCF advocates for refugees to have equal access to services provided at the Ministry of Health (MOH) designated isolation and treatment facilities supported by partners.

Refugee response partners have activated COVID-19 prevention and response measures including the set-up of surveillance systems in all refugee camps, strengthening personal hygiene promotion and access through installation of additional handwashing stations and water tanks, soap distribution, and communication with communities. However, additional multi-sectoral interventions are needed to address the humanitarian needs described above. Multi-purpose cash-based interventions for the most vulnerable refugees are essential as their livelihood opportunities have been disrupted and they find themselves further exposed to protection risks, especially in urban and dispersed settings across the country. This cash modality will ensure refugees can cover their most critical needs, will reduce their food insecurity and reduce being at risk of exploitation and abuse. In addition, this modality can also be used to upgrade the shelters of vulnerable households to reduce overcrowding.

To improve access to energy, the provision of reliable power sources to provide power to health centres, pump sufficient water to handwashing facilities and to provide cooking fuel for refugees is needed. The provision of non-food-items, such as jerry cans, will facilitate water storage for refugees. The provision of NFIs and hot meals in isolation centers will be included in the response, to support their services and ensure basic conditions are met. Shelter upgrades to use existing facilities as isolation centres in camps and settlements will be needed to contain the spread of the virus.

Payment of incentives to refugee teachers in primary and secondary education in camps and urban areas will be prioritized to support refugee students in preparing for their exams and prevent dropouts; additionally, protection monitoring and assistance and SGBV and sexual exploitation and abuse (SEA) risk mitigation measures will be strengthened, including strengthening the complaints' feedback mechanisms and referral pathways.

The Refugee Response analysis and strategy reflected here are aligned with the COVID-19 updates of the Sudan Country Refugee Response Plan (CRP) and the South Sudan Regional Refugee Response Plan

# Annexes

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## KASSALA STATE

*A man waits to receive medical attention at the health centre funded by the Sudan Humanitarian Fund in Daresta.*

*Photo: OCHA / Saviano Abreu*





# Participating Organizations



ORGANIZATIONS	TARGET BENEFICIARY	BUDGET (US\$)
Action Against Hunger	13,399	627,659
Addition for Disaster assistance and Development	5,000	43,316
Adventist Development and Relief Agency	135,952	3,348,170
Almasheesh for Peace and Development Organization	36,250	837,140
Almassar Charity organization for Nomad's Development and Environmental Conservation	30,000	1,600,000
Alsalam Organization for Rehabilitation and Development	29,670	1,474,000
Alshrooq Organisation for Social and Cultural Development	14,500	1,211,000
American Refugee Committee (Alight)	507,405	10,651,530
Business and Professional Women Organization	2,750	205,000
CARE International Switzerland in Sudan	1,250	1,601,500
Catholic Agency for Overseas Development	35,617	1,492,691
Catholic Relief Services	37,201	1,613,654
Concern Worldwide	4,605	231,525
Cooperazione Internazionale - COOPI	8,750	1,315,627
Danish Refugee Council	160,000	2,800,000
Deutsche Welthungerhilfe e.V. (German Agro Action)	45,513	2,041,999
Elemar Charitable Development Organization		104,000
EMERGENCY - Life Support for Civilian War Victims ONG Onlus		300,640
Food & Agriculture Organization of the United Nations	984,616	11,640,000
Global Aid Hand	86,625	1,355,000
GOAL	99,502	2,927,600
Hope and Friendship for Development Organization	6,250	400,000
Human Appeal-UK	3,750	150,000

<b>ORGANIZATIONS</b>	<b>TARGET BENEFICIARY</b>	<b>BUDGET (US\$)</b>
Humanity for Development and Prosperity Organization		454,000
International Aid Services	20,500	1,243,860
International Organization for Migration	73,056	11,676,830
Islamic Relief Worldwide	47,495	2,550,000
Jabal Marra Charity Organization for Rural Development		25,999
JASMAR Human Security Organization	15,000	390,000
Medair	2,000	350,000
Mercy Corps Scotland		1,623,500
Nada Elazhar for Disaster Prevention and Sustainable Development	212,250	622,040
Near East Foundation	28,370	244,139
NRC	27,925	1,030,000
OUS		435,000
OXFAM America	90,468	851,540
Plan International	189,761	3,878,109
Relief International	16,397	680,404
Rural Community Development Organization - Sudan		268,000
Samaritan Aid Organization		280,000
Save the Children	47,807	6,023,550
Sudanese Hilef for Peace and Development Organization (SHPDO)	100,200	3,860,000
Sudanese Organization for Relief and Recovery (formerly Sudanese Organization for Rehabilitation and Construction)	23,000	350,000
Triangle Génération Humanitaire	20,380	1,781,371
United Nations Children's Fund	368,929	57,061,416
United Nations Development Programme		3,491,700
United Nations High Commissioner for Refugees	201,430	17,375,236
United Nations Population Fund	154,000	13,266,561
Vétérinaires sans Frontières (Germany)	102,500	2,122,000
World Food Programme	7,341,375	61,206,521
World Health Organization	17,160	39,311,500
World Relief	7,500	300,000
World Vision International	73,998	2,690,000
ZOA		131,000
<b>Grand Total</b>		<b>283,546,327</b>

# Acronyms

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<b>AAP</b>	Accountability to Affected Populations	<b>LET</b>	Logistics and Emergency Telecommunications
<b>AoR</b>	Area of Responsibility	<b>MAM</b>	Moderate Acute Malnutrition
<b>AWD</b>	Acute Watery Diarrhoea	<b>MEB</b>	Minimum Expenditure Basket
<b>CERF</b>	Central Emergency Response Fund	<b>MHM</b>	Menstrual Health Management
<b>CMR</b>	Clinical Management of Rape	<b>MISP</b>	Minimum Initial Service Package
<b>COR</b>	Commission for Refugees	<b>MoE</b>	Ministry of Education
<b>CP</b>	Child Protection	<b>MSSD</b>	Ministry of Security and Social Development
<b>CPAoR</b>	Child Protection Area of Responsibility	<b>NFI</b>	Non-Food Items
<b>CPMS</b>	Minimum Standards of Child Protection in Humanitarian Action	<b>NMAC</b>	National Mine Action Centre
<b>CWC</b>	Communication with communities	<b>NSAGs</b>	Non-State Armed Groups
<b>EMIS</b>	Education Management Information System	<b>PiN</b>	People in Need
<b>EPI</b>	Expanded Program of Immunization	<b>PLW</b>	Pregnant and Lactating Women
<b>FCPU</b>	Family and Child Protection Unit	<b>PSEA</b>	Prevention of Sexual Exploitation and Abuse
<b>FGM</b>	Female Genital Mutilation	<b>R-ARCSS</b>	Revitalized Agreement on the Resolution of the Conflict in South Sudan
<b>FMoH</b>	Federal Ministry of Health	<b>RCF</b>	Refugee Consultation Forum
<b>GAM</b>	Gender and Age Marker	<b>RPM</b>	Response Planning Module
<b>GAM</b>	Global Acute Malnutrition	<b>RRT</b>	Rapid Response Team
<b>GBV</b>	Gender-Based Violence	<b>RVF</b>	Rift Valley Fever
<b>HCT</b>	Humanitarian Country Team	<b>S3M</b>	Simple, Spatial, Survey Method
<b>HNO</b>	Humanitarian Needs Overview	<b>SAM</b>	Severe Acute Malnutrition
<b>HPC</b>	Humanitarian Programme Cycle	<b>SDGs</b>	Sustainable Development Goals
<b>HRP</b>	Humanitarian Response Plan	<b>SENS</b>	Standardized Expanded Nutrition Survey
<b>IASC</b>	Inter-Agency Standing Committee	<b>SGBV</b>	Sexual and Gender-Based Violence
<b>IDPs</b>	Internally Displaced Persons	<b>SHF</b>	Sudan Humanitarian Fund
<b>IMF</b>	International Monetary Fund	<b>SLF</b>	State Liaison Function
<b>IMWG</b>	Information Management Working Group	<b>TMC</b>	Transitional Military Council
<b>IPC</b>	Integrated Food Security Phase Classification	<b>UNAMID</b>	United Nations - African Union Mission in Darfur
<b>ISCG</b>	Inter-Sector Coordination Group	<b>UNDAF</b>	United Nations Development Assistance Framework
<b>IYCN</b>	Infant and Young Child Nutrition	<b>VIP</b>	Ventilated Improved Pit
<b>KAP</b>	Knowledge, Attitudes and Practices	<b>WASH</b>	Water, Sanitation and Hygiene

# How to Contribute

## CONTRIBUTING TO THE HUMANITARIAN RESPONSE PLAN (HRP)



To see Sudan's Humanitarian Needs Overview, Humanitarian Response Plan and monitoring reports, and donate directly to organizations participating to the plan, please visit:

[www.humanitarianresponse.info/en/operations/sudan](http://www.humanitarianresponse.info/en/operations/sudan)

## DONATING THROUGH THE CENTRAL EMERGENCY RESPONSE FUND (CERF)



CERF provides rapid initial funding for life-saving actions at the onset of emergencies and for poorly funded, essential humanitarian operations in protracted crises. The OCHA-managed CERF receives contributions from various donors – mainly governments, but also private companies, foundations, charities and individuals – which are combined into a single fund. This is used for crises anywhere in the world. Find out more about CERF and how to donate by visiting the CERF website:

[www.unocha.org/cerf/our-donors/how-donate](http://www.unocha.org/cerf/our-donors/how-donate)

## DONATING THROUGH THE SUDAN HUMANITARIAN FUND



The Sudan Humanitarian Fund (SHF) is a country-based pooled fund (CBPF). CBPFs are multi-donor humanitarian financing instruments established by the Emergency Relief Coordinator (ERC) and managed by OCHA at the country level under the leadership of the Humanitarian Coordinator (HC). Find out more about the CBPF by visiting the CBPF website:

[www.unocha.org/what-we-do/humanitarian-financing/country-based-pooled-funds](http://www.unocha.org/what-we-do/humanitarian-financing/country-based-pooled-funds)

For information on how to make a contribution, please contact:

[chfsudan@un.org](mailto:chfsudan@un.org)

## IN-KIND RELIEF AID

The United Nations urges donors to make cash rather than in-kind donations, for maximum speed and flexibility, and to ensure that the aid materials which are most needed are the ones delivered. If you can make only in-kind contributions in response to disasters and emergencies, please contact:

[logik@un.org](mailto:logik@un.org)



## REGISTERING AND RECOGNIZING YOUR CONTRIBUTIONS

OCHA manages the Financial Tracking Service (FTS), which records all reported humanitarian contributions (cash, in-kind, multilateral and bilateral) to emergencies. Its purpose is to give credit and visibility to donors for their generosity and to show the total amount of funding and expose gaps in humanitarian plans. Please report yours to FTS, either by email to [fts@un.org](mailto:fts@un.org) or through the online contribution report form at <http://fts.unocha.org>

