SUDAN
CORONA VIRUS - COVID-19
COUNTRY PREPAREDNESS AND RESPONSE PLAN - CPRP

HCT/UNCT
JULY 2020

1. BACKGROUND

On January 30, 2020, the World Health Organization declared the 2019-nCoV outbreak a "Public Health Emergency of International Concern (PHEIC)". This decision was mainly to prevent spread of the virus in countries with weakest health systems so that all countries could be prepared for active surveillance, early detection, isolation and case management, contact tracing and mitigation of onward spread of COVID-19 infection. Coronaviruses (CoV) are of zoonotic origin, that are transmitted between animals and people.

The novel Coronavirus (COVID-19) is a new strain that has not been previously identified in humans. The index cases were detected in Wuhan City, Hubei Province, China on 31 December 2019. Early on, many of the patients in Wuhan, China had some link to a large seafood and live animal market, suggesting animal-to-person spread. Later, a growing number of patients reportedly did not have exposure to animal markets, indicating person-to-person spread. It was later reported in other countries that sustained person-to-person spread in the community is occurring.

2. SITUATION IN SUDAN

The first COVID-19 case in Sudan was confirmed on 13 March. As of 14 July 2020, 10,762 cases of COVID-19 have been confirmed in Sudan with 680 resulting fatalities; the total case fatality rate (CFR) is 6.3 per cent – geographical distribution below and 5,668 recoveries. The increase in number of reported cases and geographical distribution is indicative of community transmission but further analysis is being undertaken to confirm this.

State	Confirmed cases – 14 July
Khartoum	7734
Gezira	1038
River Nile	295
Gadaref	255
Red Sea	219
Sennar	196
North Kordofan	192
White Nile	165
Kassala	163
Northern	152
North Darfur	144
West Kordofan	68
South Darfur	38
West Darfur	33
Blue Nile	29
East Darfur	21
South Kordofan	14
Central Darfur	6

Currently all COVID-19 testing is done by the National Public Health Laboratory (NPHL) in Khartoum, the current capacity allows for the completion of 130 tests per day. Other labs in Red Sea, Gezira, and North Darfur have been identified to be part of the COVID national laboratory network; the aim is to increase testing capacity to at least 600 tests per day.

On 16 March 2020, Sudan's Transitional Government closed all airports, ports and land crossings and declared a public health emergency over fears of further spread of coronavirus. Only scheduled flights of goods and humanitarian supplies are permitted. Flights taking out passengers have been organised by member states on an ad hoc basis. As of 30 March 2020, inter-state public transportation has been halted and a country wide imposed curfew between 18:00 and 06:00; following this, on 18 April, authorities effected a lockdown in Khartoum and North Darfur. During the lockdown, people are allowed to purchase essentials goods between 06:00 and 13:00.

On 8 July, the Government started gradual lifting of the lockdown in some areas such as Khartoum with movement allowed between 05:00hrs and 18:00 hours and any movements outside those hours will require a permit. Government entities were also allowed to operate with between 30 to 50 per cent of the employees, to reduce congestion in the workplace with a requirement for all staff to wear masks. In addition, Sudan Civil Aviation Authority (SCAA) allowed the resumption of in-country flights as of 12 July with plans to have Khartoum airport gradually resume international flights.

3. EFFECTS ON PEOPLE, SERVICES, AND SYSTEMS

The effect of the COVID-19 pandemic will compound an already fragile situation characterised by an economic crisis, conflict, displacement, malnutrition, physical and food insecurity, lack of basic services, and natural disasters including floods.

The health system is marked by decades of limited to no investment, underfunding, and lack of qualified staff, infrastructure, equipment, medicines and supplies. The surveillance system does not cover the entire country and is structurally weak with long delays between alert and confirmation of an outbreak. 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 corona virus (COVID-19) in all states across the country. COVID-19 cases may force health facilities to close to other patients due to isolation procedures. Regular treatments for malnutrition or maternal care may have to be suspended. 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. To compound this, immunisation campaigns have been suspended, increasing the vulnerability of children and communities to communicable disease in a context where the capacity is already too fragile to respond to epidemics.

Access to safe water and sanitation remains extremely limited; this as well as poor hygiene practices will further increase risk of transmission. At higher risk are 12 million people that lack access to improved water sources, 28 million people who lack access to improved sanitation, and 7.5 million people that lack access to hygiene services as well as the over 500,000 children suffering from severe acute malnutrition (SAM).

Measures to slow the spread of COVID-19 including closure of schools are affecting children's access to education and some may not be able to return to school. Following various interruptions in 2019, due to the political crisis, another prolonged closure of schools will impact learning. In some areas, children and their families benefit from school feeding programmes further affecting their nutrition.

The country is already facing an economic crisis, coupled with the closure of border crossings, reduced internal movements, reduced remittances (estimated at about $3 billion per year) due to global economic slowdown is likely to impact people's wellbeing. In 2019, Sudan imported 2.6 million MT of wheat and flour. A prolonged closure of the borders could limit availability of these supplies and interrupt services; available indicative analysis shows that production might be interrupted due to disruption in , transportation and supply of basic inputs for farmers, and lead to loss of income, further lowering household purchasing power – with the lean season coming up in May, this could lead to an increase in negative coping mechanisms.

With a huge debt burden and an IMF projection of GDP contraction by 7.2 per cent in 2020, the prevention and response measures, for example curfew, restricted transportation, physical distancing, and working from home to address the COVID-19, will significantly worsen an already struggling economy. The transportation sector, including transportation of goods, is likely to be reduced. The vulnerable and poor whose income and livelihoods heavily depends on a daily wage will be affected by curfew and, in the event of full lockdown, risk not to being able to provide a daily meal for their family.

The potential loss of household income earners can have a longer-term and widespread economic impact on women.

As the pandemic continues to take hold, various measures to curb it are likely to compound existing protection challenges including freedom of movement, exploitation, discrimination, and violations of basic human rights. Of concern are over 2 million IDPs and 1.1 million refugees many of whom 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 camps and other refugee hosting locations are basic with inadequate supplies and poor infrastructure that do not meet infection control standards. Lack of medical staff and high turnover are recurrent challenges. These facilities do not have the capacity for intensive care management and referral mechanisms are weak due to resource constraints. The situation can be aggravated by the remoteness of these locations that pose communications and logistics challenges.

Women and girls are more likely to experience a worsening of existing inequalities and disproportionate secondary impacts of restrictions to slow the pandemic as compared to men and boys. Curfews and lockdowns will limit their work and economic opportunities. 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. Their reproductive healthcare needs will likely suffer from curfews, lockdowns, funding diversion and scarcity of care services. Underlying gender biases of government policies that consider men as the main breadwinner could compound the risks of women falling into poverty as their significant presence in the informal work sectors and as heads of households is often overlooked. Women and girls also face a real risk sexual exploitation and abuse as they seek survival for themselves and their families during this pandemic. Further, the COVID-19 pandemic is likely to make discrimination of marginalized groups such as persons with disabilities and those in extreme poverty, worse.

4. OBJECTIVES

The main goal of this HCT/UNCT COVID-19 Country Preparedness and Response Plan (CPRP) is to support the Government of Sudan's efforts in preparing and responding to the pandemic and will be guided by two objectives:

i. Prevent and contain the spread of COVID-19 and minimise mortality and morbidity

ii. Enhance preparedness and response to lessen the impact of COVID-19 on vulnerable people

This CPRP outlines the measures to be taken at country level to contain the virus and will be updated with further guidance if the epidemiological situation changes. In line with the 2020 Sudan Humanitarian Response Plan and the Global Humanitarian Response Plan for COVID-19, through this plan, partners will respond to the pandemic focusing on high risk areas and population groups and adjust as needed.

The plan is built around the eight pillars focused on the major areas of the public health preparedness and response: (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, (ix) maintaining essential health services and systems

The plan is focused on preparedness and response to community transmission scenario which calls for adoption of test, trace and quarantine' (TTQ) strategy. In this regard, pillar interventions will be tailored for this scenario including:

- **National Coordination:** enhance whole-of-society coordination mechanisms including hospital and community preparedness plans; to support preparedness and response, including the health, transport, travel, trade, finance, security and other sectors.

- **Risk Communication and Community Engagement:** Use of wide scale and consistent mechanism to communicate about prevention and control measures and promoting culturally appropriate and empathetic community engagement to detect and rapidly respond to public perceptions and counter misinformation.
- **Surveillance and Risk and Severity Assessments: i**mplement national surveillance strategies to monitor and report disease trends, disease severity and impacts on health and other systems.
- **National Laboratories:** increase the number of specimens to be tested in the laboratory and ensure access to reagents
- **Infection Prevention and Control:** define patient referral pathways and a national plan for ensuring personal protective equipment (PPE) supply management and human resource surge capacity (numbers and competence), with focus on monitoring health personnel exposed to confirmed COVID-19 cases.
- **Case Management:** set up of surge triage, screening areas, treatment and critical care at health facilities and make guidance available for home care of patients with mild COVID-19 symptoms and recommend when referral to healthcare facilities is advised if symptoms worsen. Support comprehensive medical, nutritional and psycho-social care for people with COVID-19 and maintain routine and emergency health services for other people.
- **Operational Support and Logistics:** implement supply chain control, security, transport storage and distribution of COVID-19 Disease Commodity Package (DCP) and other essential supplies in country.
- **Maintaining essential health services and systems:** balance the demands of responding directly to COVID-19, while simultaneously ensuring the continuity of essential health service delivery in order to mitigate the risk of system collapse**.**

The scope of this CPRP is limited to public health measures taken in support of national preparedness and response and do not include the broader measures required to mitigate the social and economic consequences of COVID-19 which be covered separately or ensure business continuity of partner organizations.

5. KEY ACTIVITIES BY SECTOR TO SUPPORT PREPAREDNESS AND RESPONSE TO COVID-19

All the below activities are guided the pillars outlined in the CPRP. However, it is critical that all partners (UN and NGOs) through their regular programmes contribute and support community engagement through distribution of IEC material and hygiene promotions/awareness as they implement the regular programmes/activities. Beyond the direct implementation of the activities stipulated in the plan, all partners should have mitigation measures to ensure the continuity and prioritization of critical and life-saving activities particularly for programs targeting vulnerable and marginalized groups especially IDPs and refugees.

Sector Partners	Key Sectoral activities to support COVID-19 response
Education	• Risk communication and community engagement especially through schools and media • Psycho-social support for affected populations • Support engagement or re-purposing of teachers as agents for community awareness and risk communication
Emergency Shelter and Non-Food Items	• Support risk communication and community engagement. • Support infection, prevention and control through distribution of IEC material and community awareness • Support in identification of spaces and physical infrastructure to support other programmes and isolation. • Develop COVID-19 specific messages to mitigate exposure during emergency shelter and NFI distributions • Procurement, distribution and prepositioning of NFI kits especially for IDPS, refugees and other vulnerable groups affected by COVID-19 to reduce sharing of core relief items
Food Security and Livelihoods	• Monitor food and agricultural input prices including provision of guidance to framers • Support in securing essential food stocks to cover needs in the event of any market/farming disruptions • Support protection of livelihoods to minimise the impact • Incorporate risk communication components on COVID-19 in all FSL activities
Health	• Lead and coordinate overall response to COVID-19 including providing relevant guidance to partners on key response activities • Ensure the country has sufficient technical and operational capacities to detect, contain and treat COVID-19 • Support training on case management, infection, prevention and control • Engage with both development and humanitarian partners to support the strengthening of health system and response to the pandemic • Psycho-social support for affected populations
Logistics	• Operational support and logistics
Nutrition	• Support case management through providing nutritional requirements for patients • Continue regular nutrition activities including MUAC screening, treatment of severe and acute malnutrition • Support raising awareness and risk communication
Protection	• Support advocacy with partners and authorities to ensure containment measure lead to an increase in protection violations • Support awareness raising and risk communication in relation to COVID-19 especially through existing protection networks • Increase and sustain protection monitoring and reporting • Support individual protection assistance through provision of protection kits particularly for the most vulnerable groups • Provide and sustain psycho-social support
WASH	• Risk communication and community engagement. • Support the setup of WASH facilities and hygiene campaigns at Points of entry. Support to WASH interventions at treatment or health centers identified for referral/treatment. • Infection prevention and control through distribution of materials and hygiene campaigns • Provide WASH for vulnerable populations especially IDPs and refugees including provision of hand washing facilities in high risk areas

6. COORDINATION AND MONITORING

Under the overall guidance of WHO, the UN and partners have set up a time-bound COVID-19 coordination mechanism - the Strategic Coordination Group - chaired by the RC/HC comprised of WHO, UNICEF, OCHA, WFP, UNDP, UNHCR and UNFPA. This group ensures the UN and the humanitarian community are aligned in supporting the government's preparedness and response efforts and interfaces with the Higher-Level COVID -19Committee to provide advisory services and actions as needed. This strategic group is supported by the COVID-19 Working Group at operational and technical level.

No.	Pillar	Pillar lead	Supporting Agencies
1	Country Level Coordination, Planning & Monitoring	WHO	OCHA
2	Risk Communication & Community Engagement	UNICEF	UNFPA, UNHCR, UNDP
3	Surveillance, Rapid Response Teams & Case Investigation	WHO	UNHCR, UNICEF
4	Points of Entry	WHO	IOM
5	National Laboratories	WHO	
6	Infection Prevention & Control	UNICEF	WHO, UNFPA
7	Case Management	WHO	UNFPA, UNICEF
8	Operational Support & Logistics	WFP	UNICEF, UNDP

At state level, WHO will take the lead in states where they have presence and in states with limited WHO presence, another partner organization will take the lead. National pillar focal points will work closely with the state focal points, providing the necessary technical guidance. In the states where there is an Area Humanitarian Country Team (A-HCT) or an established humanitarian coordination architecture, Covid-19 focal points will work under these mechanisms. The aim is to work through existing coordination mechanisms to the extent possible.

No.	State	Lead	Co-lead
1	Al Gezira	-	-
2	Blue Nile	WHO	UNICEF
3	Central Darfur	WHO	OCHA
4	East Darfur	UNICEF	WHO
5	Gedaref	WHO	UNICEF
6	Kassala	WHO	UNICEF
7	Khartoum	WHO	OCHA
8	North Darfur	WHO	OCHA
9	North Kordofan	WFP	WHO
10	Northern	-	-
11	Red Sea	WHO	UNICEF
12	River Nile	UNDP	-
13	Sennar	-	-
14	South Darfur	WHO	OCHA
15	South Kordofan	OCHA	WHO, UNICEF
16	West Darfur	WHO	OCHA
17	West Kordofan	UNHCR	WHO
18	White Nile	UNHCR	Plan International
19	Abyei	OCHA	IOM

Monitoring: The COVID-19 CPRP monitoring and reporting will be led by the COVID-19 Working Group with the support of the Information Management Working Group (IMWG). Working together with partners, the COVID-19 Working Group has developed a 3W to collect and share data on the implementation of the activities in the plan. Data and information gathered as part of the monitoring process will be made available via the Humanitarian Response website to allow decision-makers at all levels (global, country-level strategic and operational) to easily access key information that provides an overall progress against activities outlined in the plan. The data will also be shared in the Humanitarian Data Exchange to promote transparency and allow partners to conduct independent analysis.

7. PREPAREDNESS AND RESPONSE PILLARS, KEY ACTIVITIES AND REQUIREMENTS – JULY UPDATE

Preparedness and Response Pillars	Total Requirements (US$)
1.Country-Level Coordination	
1.1 Establish Command and Control/IMS system	59,000
1.2 Establish and operate EOC at national and state level including deployment of WASH personnel to the EOC in states	320,500
1.4 Support emergency operations in high risk states	497,000
1.5 Support to national hotline	146,000
1.6 Support joint WHO/FMOH supervision to PoEs, EOCs and isolation centres	186,000
1.7 Multi-sectoral crisis coordination and Contingency at national and state level	75,000
Sub total	**1,283,500**
2.Risk communication and Community Engagement	
2.1 Disseminate IPC guidance for home and community care providers and Dissemination of messages and materials in local languages and adopt relevant Communication channels. Develop COVID implementation guidelines benefiting all the population including IDPs and refugees.	1,960,776
2.2 Engage with existing community-based networks, media, local NGOs, schools, local governments and other sectors such, education sector, business using a consistent mechanism of communication. Conduct focus training on COVID 19 prevention, preparedness and response for 20 community-based networks	6,097,705
2.3 GBV Risk mitigation: Media messaging an GBV risks and response	707,139
Subtotal	**8,765,620**
3.Surveillance, Rapid Response Teams and Case Investigation	
3.1 Production and distribution of guidelines, contact tracing, and case definition formats	111,501
3.2 Enhance existing surveillance system to enable monitoring and reporting of COVID-19 transmission.	1,881,221
3.3 Produce weekly epidemiological reports and disseminate to all levels and international partners.	2,000
3.4 Contact tracing through health promotion and rapid response teams and Training of surveillance officers on case definition and contact tracing	1,564,687
3.5 Support RRT through operational costs, subsidies, material and supplies and capacity building in order to strengthen surveillance, case detection and early action	2,928,700
3.6 Train and equip community protection works, social workers, community workers, health workers staff in prisons on identification and documentation of UASC's and referral mechanisms for PSS and alternative care	926,000
3.7 Production and distribution of guidelines, FTR, SOP's for case management, provision of PSS alternative care revised to incorporate the COVID response	105,550
Sub total	**7,519,659**
4.Points of Entry PoE	
4.1 Training for PoE staff on surveillance and case definition/ referral protocols	238,000
4.2 Establish/ rehabilitate Isolation room in selected PoEs and support with WASH supplies and access to water and sanitation	2,867,785
4.3 Provide PPEs and IPC supplies in PoEs and their attached isolation rooms staff	1,081,420
4.4 Provide/support running of Ambulances	662,000
4.5 Print and distribute IEC materials to travellers.	777,650
4.6 incentives for PoE medical staff	828,370
4.7 Conduct joint WHO/FMOH supervision to designated isolation unites to monitor adherence to treatment and IPC protocols	53,000
Sub total	**6,508,225**
5. National Laboratories	

5.1 Provide PPEs	665,000
5.2 Provide rapid testing kits and lab supplies, reagents, swabs, and transport medium	3,700,000
5.3 Build capacity for collection, storage and transportation of samples	20,000
5.4 Shipment of specimens to international reference laboratories	5,000
Subtotal	**4,390,000**
6.Infection Prevention and Control	
6.1 Prepare local messages and pre-test through a participatory process, specifically targeting key stakeholders and at-risk groups	179,900
6.2 Disseminate IPC guidance and messages for home and community care providers in local languages and adopt relevant communication channels	951,966
6.3 Carry out training to address any skills and performance deficits and Engage trained staff with technical expertise to implement IPC activities, prioritizing based on risk assessment and local care-seeking patterns	2,319,502
6.4 Support access to water and sanitation for health (WASH) services in public places and community spaces most at risk including handwashing facilities in high risk spaces focusing on isolation and treatment centres.	16,641,238
6.5 Improve WASH facilities in designated health facilities for COVID isolation centres	3,473,373
6.6 Provision of PPE to the health centre workers at state level	9,636,284
6.7. Prepare child friendly messages and pre-test through a participatory process, specifically targeting key stakeholders and at-risk groups	90,000
6.8 IPC in non-treatment health facilities including training, equipment and guidelines in PHC and rural health facilities	1,194,205
6.9 WASH NFIs like (soap, jerry cans, ibrigs, community and household water storage, spraying machines, disinfectants, MHM materials etc.)	298,140
6.10 Medical waste management	1,113,938
Subtotal	**35,898,546**
7.Case Management	
7.1 Identify Intensive Care Unit capacity in terms of equipment and supplies and renovation and support establishment	5,574,000
7.2 Ensure comprehensive medical, nutritional, and psycho-social care for those with COVID 19 including provision of dignity kits in isolation centres. Deploy rapid response teams in to support psycho-social care	1,646,306
7.3 Establish dedicated and equipped teams and ambulances to transport suspected and confirmed cases, and referral mechanisms for severe cases with co morbidity.	391,492
7.4 Use innovation and technology (app-based learning) to build capacity of health care providers on case management of patients	300,000
7.5 Incentive for medical staff at isolation centres	2,519,936
7.6 Training of health workers on case management, IPC protocols and case definition and IPC training for ambulance and triage	958,427
7.7 Printing and distribution of guidelines and protocols	56,889
7.8 Essential medicines, IPC supplies and consumables for health facilities and Support rehabilitation of isolation centres to function as appropriate	8,181,978
7.9 Provide/rehabilitate WASH facilities in health facilities and isolation centres including waste management	3,173,931
7.10 PPE for medical staff	3,298,558
7.11 Identify and equip medicalized and non-medicalized isolation centers including intermediate and ICU units	2,000,000
7.12 FTR for Children in the Khalwas and Reformatories as well PPE for children in detention	71,400
Subtotal	**28,172,917**
8. Operational support and Logistics	
8.1 Review supply chain control and management system (stockpiling, storage, security, transportation and distribution arrangements) for medical and other essential supplies, including COVID-19 DCP and patient kit reserve in-country	2,211,000
8.2 Review procurement processes (including importation and customs) for medical and other essential supplies, and encourage local sourcing to ensure sustainability	450,000
8.3 Support to MoH - equipment and consumables (including ICT material, medical and non-medical supplies; support to PMO - BCP	1,855,994

8.4 Air freight - regional hub to Khartoum	172,000
Subtotal	**4,688,994**
9. Maintaining essential health services and systems	
9.1 Support access to WASH services at the health centres, schools, including in high risk communities, camp and camp-like settings.	5,500,000
9.2 Procurement of life saving and life sustaining medicines and medical supplies	10,250,000
9.3 Early action on water-borne and Vector borne diseases through applying preventive and curative measures, and supporting designated treatment facilities, rapid response teams, and community-based surveillance	6,000,000
9.4 Increasing access to childhood and maternity health care, and referral systems (light rehabilitation, staff incentives, supporting ambulance teams)	6,000,000
9.5 Supporting nutrition stabilization centers and procurement of SAM treatment kits	3,000,000
Subtotal	**30,750,000**
Grand Total	**127,977,461**

7.1 FINANCIALREQUIREMENTS BY PILLAR

Pillar	Requirements (US$)
1.Country-Level Coordination	1,283,500
2.Risk communication and Community Engagement	8,765,620
3.Surveillance, Rapid Response Teams and Case Investigation	7,519,659
4.Points of Entry PoE	4,390,000
5. National Laboratories	6,508,225
6.Infection Prevention and Control	35,898,546
7.Case Management	28,172,917
8. Operational support and Logistics	4,688,994
9. Maintaining essential health services and systems	30,750,000
Grand Total	**127,977,461**

7.2 FINANCIALREQUIREMENTS BY ORGANIZATION

Agency/Partner	Requirements
WHO	38,211,500
UNICEF	37,535,000
UNHCR	14,521,255
SCI	3,804,050
IOM	5,725,000
UNFPA	7,936,561
UNDP	3,491,700
MC	1,623,500
CARE	1,551,500
WFP	1,460,963
GOAL	1,413,443
SHPDO	1,210,000
COOPI	965,627
ADRA	911,600
AOSCD	811,000
ARC	810,000
PLAN	747,174
WHH	670,000
NRC	580,000
WVI	505,000
HDPO	454,000
OUS	435,000
ISLAMIC RELIEF	350,000
IAS	317,500
EMERGENCY	300,640
SAO	280,000
RCDO	268,000
NADA	223,150
HOPE	150,000
ZOA	131,000
CRS	125,630
APDO	117,140
ECDO	104,000
DRC	100,000
CAFOD	48,000
TGH	38,000
JMCO	25,999
RI	24,529
GRAND TOTAL	**127,977,461**