# EXTERNAL EVALUATION

JULY 2014

# A real-time evaluation of ACF's response to cholera emergency in Juba, South Sudan

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Funded by ACF

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This report was commissioned by Action Against Hunger | ACF International. The comments contained herein reflect the opinions of the Evaluators only.

## Acknowledgement

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Lastly, I must specifically thank the ACF administrative staff for the smooth logistical arrangements that facilitated this evaluation process.

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# Acronyms

| | |
|---|---|
| ACF | Action Against Hunger |
| CDC | Centre for Disease Control |
| EMS | Emergency Management System |
| EP | Emergency Pool |
| EPRP | Emergency Preparedness and Response Plan |
| HQ | Headquarter |
| IDP | Internal Displaced People |
| KAP | Knowledge, Attitude and Practices |
| M&E-L | Monitoring, Evaluation and Learning |
| MoW | Ministry of Water |
| PDM | Post Distribution Monitoring |
| SOP | Standard Operating Procedures |
| SS-FELTP | Southern Sudan Field Epidemiology and Laboratory Training Program |
| TWiG | Technical Working Group |
| UNICEF | United Nations Children's Funds |
| WHO | World Health Organization |

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# Executive summary

On May 15th, the Ministry of Health, Republic of South Sudan formally declared cholera outbreak based on laboratory confirmation of stools samples done on the 6th of May. As of August 2nd, 5,536 cholera cases including 121 deaths (CFR 2.2%) have been reported throughout South Sudan, especially Central Equatoria, Eastern Equatoria and Upper Nile States. Currently, the epidemic is still ongoing in these locations despite WASH and medical partners' efforts. South Sudan already experienced previous epidemics in the past years (2006-2009) and as shown in the past, epidemic trends are likely to demonstrate an interpersonal transmission path (low practice of hand-washing, high proportion of open defecation, improper water conservation and treatment at household level, poor food conservation).

In that complex emergency context, ACF country team, supported by New York HQ, decided to request support from ACF international activating the Emergency Management System, with notably the deployment of ACF Spain Emergency Pool. Emergency specialists were deployed in country for 2 months in order to set up effective and timely response to cholera outbreak in Juba.

ACF South Sudan and New York were really appreciative of Madrid Emergency Pool's support. The collaboration was good, well balanced between autonomy and inclusiveness of South Sudan mission in decision making process and program orientations. ACF involvement in cholera response has been valuable and of importance to the overall response from WASH partners. ACF's work was much appreciated by beneficiaries, local authorities and Community Based Organizations, Donors, UNICEF and other NGOs. There was a clear recognition of ACF intervention, his key role as an emergency partner and it even significantly strengthened the overall response amongst WASH partners.

ACF intervention was fairly appropriate and effective but it could have been more flexible in the approach so as to increase coverage outside of Juba County such as in Torit where the attack rate of cholera was more than 3-fold higher than in Juba, and greater gaps in terms of partners' capacity. The program contributed to the overall containment of cholera epidemic in Juba that seriously slowed down (currently 5-6 cases a week compared to 50-60 cases when ACF began to intervene). Hence ACF intervention achieved its objectives even if it seemed that ACF program was built in a non robust way, as the strategy and activities implemented changed following the turnover of expatriates. By the time of the RTE, the program implemented was missing a crucial element for cholera outbreak response: daily precise epidemiological data collection in order to target and direct actions into where cholera outbreak is recorded and prioritizing high impact activities based on the specific transmission paths. In addition, the project was found without a proper Monitoring, Evaluation and Learning system that could provide qualitative information to feed the program and take corrective measures in the course of the operations.

Replacing in time the Emergency Pool specialist was a challenge; two important positions are still not filled which limits internal coordination and team cohesion, although, it has not yet seriously impacted the program implementation.

This overall response was a success for ACF South Sudan which benefitted from a greater visibility, and is seen as a key and strong partner in WASH sector to respond to emergencies. As such it strongly advised to ACF South Sudan to run through the process of elaborating its Emergency Preparedness and Response plan and to continue incorporating essential recommendations done through the RTE, especially regarding M&EL and reinforcing linkage between medical actors and ACF interventions.

# 1. South Sudan: background information

## a. General context

Violence broke out in Juba on December 15th, between Government –The Sudan People's Liberation Army (SPLA) – and opposition forces, and quickly spread to other locations in South Sudan (Jonglei, Upper Nile and Unity). There has been massive destruction of housing; men, women and children have been killed and injured, mainly targeted based on ethnicity or political affiliation. Medical facilities have been looted and in mainly places destroyed. As of July, 24th, around 1.1 million people have been internally displaced by violence and 435,000 people fled to neighboring countries, according OCHA[1]. Moreover, it is estimated[2] that over 3.9 million people will be in food security crisis or emergency by August 2014, and more than 90% of them are location in States that are the worst affected by the violence. The States with the highest levels of acute and emergency food insecurity are Jonglei (52% - 0.8m), Unity (71% - 0.76m) and Upper Nile (50% - 0.66m).

Due to the extent of the crisis, a UN L3 system wide emergency has been declared on February 11th, 2014 and recently has been extended for an additional six months period. The South Sudan crisis is far from being closer to a solution and the humanitarian situation is quickly deteriorating. Indeed, as South Sudan entered into the rainy season, community coping mechanisms are severely stretched. Family food stocks normally run out during the hunger gap (May-August), leaving households in market dependent States Jonglei, Unity and Upper Nile without food.

In that context, and knowing the poor sanitary conditions and WASH services[3] existing in communities and particularly in IDP camps, a cholera outbreak was unfortunately likely and dreadful. And on May 15th, the Ministry of Health, Republic of South Sudan formally declared cholera outbreak in Juba, Central Equatoria State.

## b. Epidemiological Context

### Past cholera epidemiological pattern

According WHO, South Sudan had suffered at least four cholera outbreaks since 2006 (table 1). The 2006 cholera outbreak started on 28 January 2006 in Yei Town but quickly spread to Juba, the regional capital, by the end of February 2006[4]. Overall, six out of the 10 states confirmed cholera cases and by the time the outbreak ended, a total of 19,277 cholera cases including 588 deaths (CFR 2.9%) had been reported. The second cholera outbreak occurred during January to June 2007 with 22,412 cases and 411 deaths (CFR 1.8%) being reported. And finally, cholera outbreaks were also reported in 2008 and 2009 with the later being the bigger outbreak with nearly 50,000 cases including 60 deaths being registered (table 1).

During April to June 2007, investigators from the Southern Sudan Field Epidemiology and Laboratory Training Program (SS-FELTP) and CDC investigated the cholera outbreak in the town of Juba, Southern Sudan. According to the report, the environmental investigation revealed **suboptimal hygiene practices and a lack of water and sanitation infrastructure** in Juba. A case-control study indicated that persons less likely to have cholera were **more likely to have consumed hot meals**

[1] OCHA sitrep 46: https://southsudan.humanitarianresponse.info/system/files/documents/files/SitRep46.pdf
[2] Revision of the Consolidated Appeal Process 2014-2016 for the Republic of South Sudan – June 2014
[3] Population having access to an improved water infrastructure: 57%; Population having access to an improved sanitation infrastructure: 9%; 77% of population practice open defecation; Source: JMP – WHO/UNICEF - 2012
[4] World Health Organization' Global Alert and Response. (2006). Cholera in South Sudan – updates 1-3. http://www.who.int/csr/don/archive/disease/cholera/en/

containing meat during the outbreak. Contaminated food or water was not identified as possible sources of the cholera outbreak in Juba. However, this might be attributed to limitations of the study, including small sample size. **Cholera can reach epidemic proportions if adequate control measures are not implemented early.** Mass media campaigns are important for current and new residents in Juba to understand the importance of proper food handling, chlorinated water, and optimal hygiene practices to prevent the spread of cholera.

Table 1: Comparison of AWD/Cholera cases & deaths in 2006 - 2014

| Year | Cholera/AWD | | CFR [%] |
|---|---|---|---|
| | Cases | Death | |
| 2006 | 19277 | 588 | 3.1% |
| 2007 | 22412 | 411 | 1.8% |
| 2008 | 27017 | 154 | 0.57% |
| 2009 | 48035 | 60 | 0.12% |
| 2010* | 100037 | 70 | 0.07% |
| 2011* | 198920 | 147 | 0.07% |
| 2012* | 291326 | 499 | 0.17% |
| 2013* | 418734 | 443 | 0.11% |
| 2014 (Jan-June) | 110014 | 95 | 0.086% |

***No confirmed cholera outbreak***

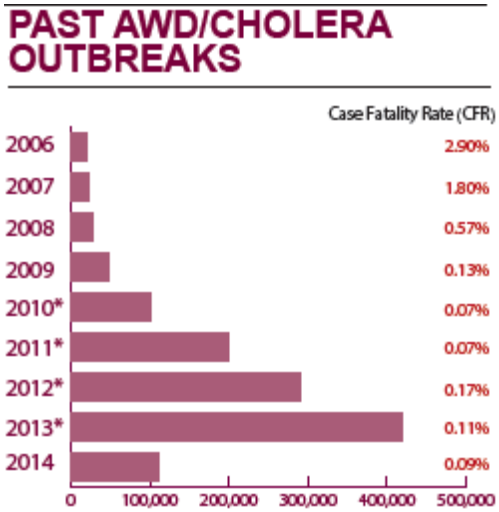



Figure 1: South Sudan past cholera and AWD epidemics (Source: Health cluster)

The graph on figure 1 emphasizes the fact that acute watery diseases are in constant and significant increase in South Sudan and pose a serious public health issue.

From WHO and MoH records, it looks like **past cholera epidemics in South Sudan usually ended with the beginning of the rainy season**. Indeed, it seems to be significantly slowed down during that particular moment, likely due to a **decrease of people's mobility,** and with sporadic cases that might continue throughout the year.

Recent and future urban population growth, especially in Juba, is of great concern and need to be considered seriously as it is a key factor favouring stronger and longer epidemic. For the past years, Juba has rapidly grown to over half a million inhabitants and without proper urban policy to support this growth. Housing in Juba for returning residents consisted of informal and formal settlements that included old brick homes, tent/iron sheet camps, and mud thatch houses. Each heavy rainfall goes with more or less significant destructions of housing leading people to re-settle wherever and with whatever they can. The major water sources are tanker trucks, pumping and distributing raw water from the Nile River, the Nile River itself, borehole well pumps[5], rarely shallow watering holes,

[5] Rarely repaired and/or maintained – as urban population, even with minimum financial means, prefers being delivered at home rather than walking up to the borehole and carrying heavy loads.

and treating water (bottle and tankers) for the richer ones. Latrines and indoor plumbing are often lacking; as a result, some residents practice open fields for defecation.

## Current epidemiological pattern

On April 29th 2014, the MSF clinic in Juba 3 UN House IDP camp notified WHO of a suspect cholera case involving a 28 year-old male who left his household in Juba 3 IDP camp on 28 April, 2013 to visit his relatives. He developed severe watery diarrhea and vomiting. On May 6th, stool samples from various suspected cases analyzed in Nairobi confirmed *Vibrio Cholerae*.

As shown in the figure 2, the epidemic then spread to several states, mainly Eastern Equatoria (mid June) and Upper Nile States. As of August, 2nd, a total of **5,536 cholera cases** including **121 deaths** (CFR 2.2%) had been reported throughout South Sudan and the epidemic is still ongoing. The current epidemic trends are likely to demonstrate an **interpersonal transmission path** (low practice of hand-washing, high proportion of open defecation, improper water conservation and treatment at household level, poor food conservation), so showed the past epidemics as aforementioned.

Recently, the reduction in the incidence rates has led to an important phasing out of several medical and WASH actors, especially in Juba County. Nonetheless, the longer the epidemic lasts, the higher risks of new epidemic alerts throughout the country, and thus the higher risk of overstretching current existing capacities.

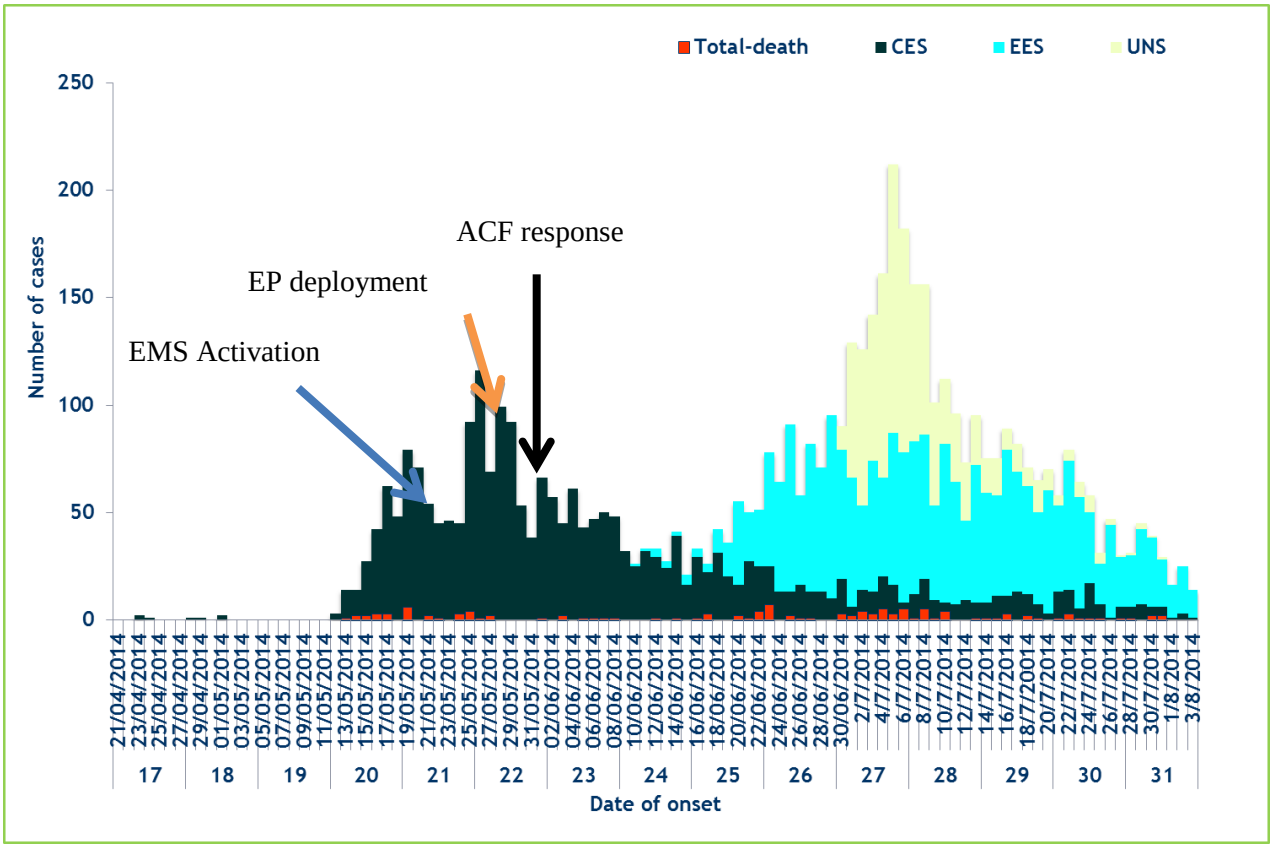



Figure 2: South Sudan cholera epidemic curve, 23 April to 27 July 2014 (Source: Sitrep #72 – Health cluster)

The table 2 below gathered the list of payams[6] affected by cholera, including the villages with higher caseload (as of the 2nd of August) – (in red, caseload over 101 cholera cases; in orange caseload between 51 to 100).

Table 2: Epidemic 2014 – List of payams affected in Juba County (including villages with higher caseload)

| County | Juba |
|---|---|

| Count of Case no | Column Labels | | | | | | |
|---|---|---|---|---|---|---|---|
| Villages | Female | | Female Total | Male | | Male Total | Grand Total |
| | <5yrs | ≥5yrs | | <5yrs | ≥5yrs | | |
| **Gondokoro** | **4** | **10** | **14** | **4** | **16** | **20** | **34** |
| **Juba Town** | **30** | **112** | **142** | **36** | **175** | **211** | **353** |
| Hai Tongping | 21 | 40 | 61 | 25 | 64 | 89 | 150 |
| **Kator** | **9** | **67** | **76** | **13** | **139** | **152** | **228** |
| Giada | 2 | 9 | 11 | 2 | 43 | 45 | 56 |
| **Lokiliri** | | **5** | **5** | **1** | **1** | **2** | **7** |
| **Mangala** | | **2** | **2** | | | | **2** |
| **Munuki** | **30** | **199** | **229** | **51** | **224** | **275** | **504** |
| Gudele 1 | 11 | 66 | 77 | 13 | 74 | 87 | 164 |
| Nyakuron | 3 | 16 | 19 | 7 | 26 | 33 | 52 |
| **Northern Bari** | **35** | **164** | **199** | **43** | **206** | **249** | **448** |
| Gudele 2 | 5 | 32 | 37 | 4 | 35 | 39 | 76 |
| Gurei | 11 | 48 | 59 | 22 | 46 | 68 | 127 |
| New Site | 7 | 32 | 39 | 2 | 49 | 51 | 90 |
| **Rejaf** | **62** | **197** | **259** | **79** | **197** | **276** | **535** |
| GUMBO | 36 | 138 | 174 | 49 | 128 | 177 | 351 |
| Juba 3 POC1 | 16 | 23 | 39 | 16 | 14 | 30 | 69 |
| **Unknown** | **1** | **12** | **13** | **2** | **13** | **15** | **28** |
| **Jebel Nyoka** | 1 | | 1 | | | | 1 |
| **Grand Total** | **172** | **768** | **940** | **229** | **971** | **1200** | **2140** |

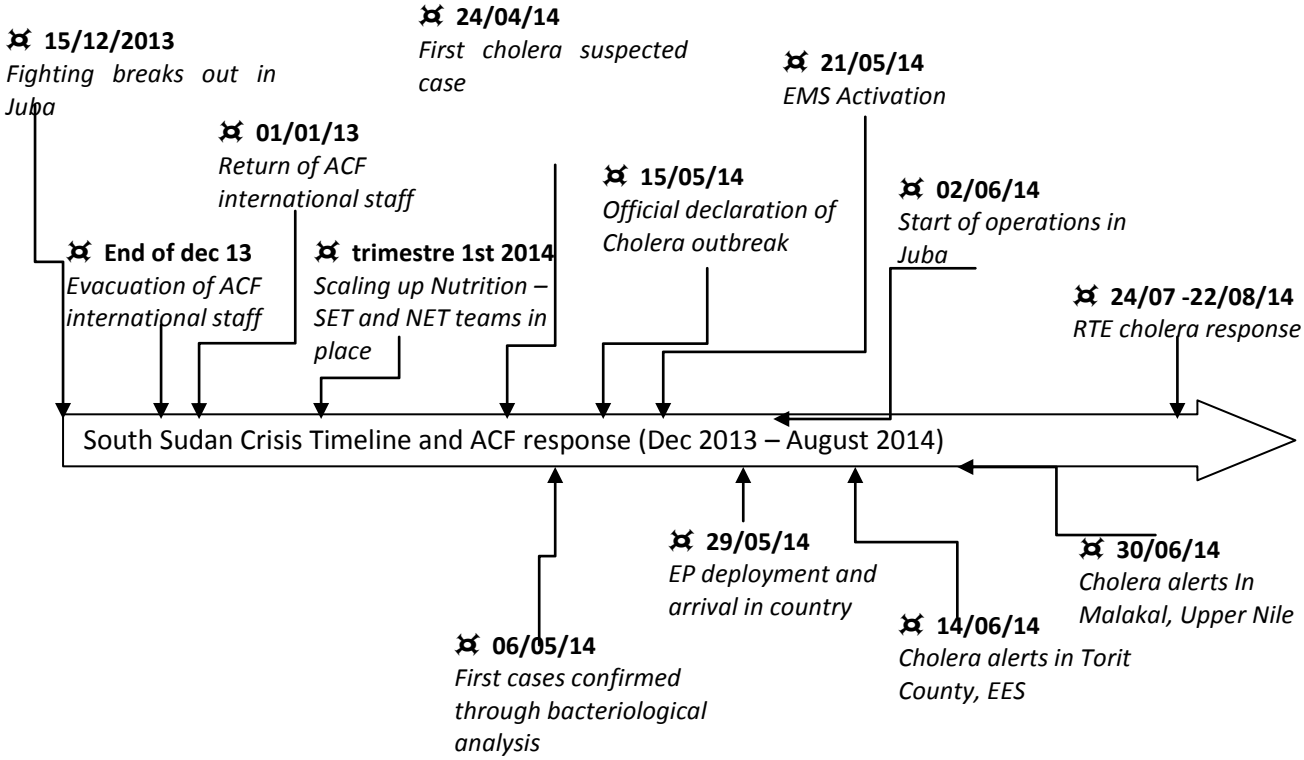
## c. Context of ACF mission and timeline for cholera response

The uprising of violence in Juba in December 2013 led to the evacuation of all international staff. On January 1st, 2014, the mission restarted with immediate priority to restore the ongoing life saving programs and respond immediately to the IDP needs in our operational areas, while continuing to explore the possibility of having a larger role in the emergency relief operations in other parts of the Country.

[6] Administrative distinction used in South Sudan

The team has also defined a three months emergency response strategy that has started to prove effective and is centered on strengthening our role as the main nutrition player in South Sudan (as to this days ACF South Sudan has the largest number of treatment cases in the country). Therefore, when cholera outbreaks in country end of April, the team was into scaling up its nutrition emergency response and thus did not have additional capacity to respond properly to a rapid deterioration in the crisis, in other sectors. ACF country team, supported by New York HQ, decided then to request support from ACF international triggering the EMS SOP. ACF Spain Emergency Pool was deployed in country, on May 29th to set up an operational base in Juba and lead first actions by June 2nd in response to the ongoing cholera outbreak.

South Sudan Crisis Timeline




## d. Review scope and methodology

The evaluation was undertaken by an independent external consultant, familiar with ACF operations incorporating a two weeks mission to South Sudan, including site visits in Juba to assess activities, as well as the operational support provided to enable such operations to effectively and efficiently function.

This evaluation aimed at:

1. Evaluating the effectiveness and efficiency of ACF operations in Juba County since the declaration of the epidemic (confirmed stool sample on the 6th May 2014[7]).
2. Evaluate the effectiveness and efficiency of the response related to the EMS activation.
3. Identify good practice, lessons and challenges that can be drawn from the response to date.
4. Provide practical and realistic short term recommendations to strengthen the on-going response to cholera in South Sudan.

[7] http://www.afro.who.int/en/ssd/news/item/6569-the-ministry-of-health-to-declare-cholera-outbreak-in-juba-south-sudan.html

The RTE was asked to cover 10 key areas relating to ACF's cholera response in the South Sudan. During the preparatory phase, the evaluator interviewing key staff decided to enlarge the scope adding the questions (in bold, below) to cover criteria such as effectiveness, coverage, impact and sustainability:

1. Has ACF response to the cholera epidemic in Juba been appropriate to the needs? Needs assessments and beneficiary involvement should be considered.
2. To what extent have ACF emergency response procedures been followed? Are these appropriate and have they facilitated a timely response?
3. Has the surge capacity provision (of the ACF network) been efficiently and effectively managed?
4. To what extent have the different ACF groups (ACF Spain ER Pool, ACF country team, ACF New York etc.) coordinated effectively?
5. Have ACF coordinated effectively with external stakeholders in the response?
6. To what extent have beneficiaries and local communities are involved in the design and implementation of the response?
7. Evaluate the appropriateness and effectiveness of ACF systems (HR, Logistics, and Finance etc.) to support the intended operations.
8. Evaluate the suitability of ACF monitoring systems in place.
9. To what extent is ACF sufficiently prepared for the on-going response to cholera in Juba and the rest of the country?
10. To what extent has learning from other comparable responses (EMS activations (such as Philippines) and cholera response) been drawn on in the response?
11. **To what extent ACF intervention objectives in Juba are on track to be achieved?**
12. **To what extent have all activities planned, their implementation methodology and timeframe contributed to achieve the objectives?**
13. **To what degree has ACF program raised community awareness about cholera prevention and cholera epidemic and realized activities to sustainably reduce cholera risks preventing future epidemics in Juba County?**
14. **Has ACF response achieved to contain and prevent the spread of cholera in the identified risk zones/areas?**

The evaluator used a mixture of data collection approaches in order to triangulate the data obtained.

- Key informant interviews: Structured and semi-structured interviews at Headquarter and country levels. Tailored interview guides and checklists based on identified relevance of stakeholder type to key evaluation questions. Interviews were conducted with more than 30 people; in-person where feasible and remotely by Skype (Appendix D – list of informants). Focus groups (or informal group meetings) were used at the country level for beneficiaries and local authority.
- Field visit and observations: Juba County, Tongping area of intervention where ACF cholera response was implemented.
- Formal document review: Review and analysis of operational report (Activity Progress Reporting, monitoring reports, donor reporting), work plans, handover notes, end of mission reports, situation reports, cluster reports, humanitarian situation reports, academic literature, financial and logistic records, and other evaluations RTE on ACF past emergencies, cholera response, etc. Data gathered were recorded in a central database organized by evaluation questions and indicators.

## e. Evaluation challenges and limitations

The RTE took place end of July (9 weeks after operations), and not as recommended in EMS SOP (within 4 weeks). Thus, the evaluator could not meet in-person key informants that designed and implemented the project. Indeed, although these key informants manage to be available through

internet, the number of interviews and time for discussions were more limited than it could have been if the RTE took place before.

Also, there was a lack of consistent data in program Monitoring & Evaluation system. The evaluator identified rapidly that there was a clear gap in term of project M&E especially looking at qualitative information of the activities and results. Therefore, the evaluator supported the program manager and his deputies to set up some monitoring tools and test it on the field.

Despite the apparent 2-week of data collection, the evaluator could not perform a thorough analysis (3 boreholes visited out of 10, 2 distributions of hygiene kits, one quarter council met, 2 sites where latrines were constructed and one group of community volunteers met). The RTE evaluator arrived the day before 3 days-off (from 28th to 30th) and during the last days of handover for the cholera PM positions. Therefore the time was more limited than it appeared.

# 2. Findings

## a. The effectiveness, efficiency and appropriateness of ACF systems

*Sub-Questions of the evaluation:*

- *To what degree has the surge capacity provision facilitated a timely response?*
- *To what degree have ACF systems (HR, Logistics, and Finance, etc.) been appropriate to support the intended operations?*
- *To what extent have ACF emergency response procedures been followed?*

In May 2014, ACF South Sudan mission and its HQ decided to request the support of ACF network, especially the deployment of experienced and skilled personnel to set up an adequate response to cholera outbreak declared in Juba. The emergency was originally declared for an initial period of three months, as per ACF EMS protocol, and could be renewed if ACF-USA would assess that the magnitude of the emergency was still beyond their capacity to respond.

### A good effectiveness and efficiency to facilitate a timely response

The emergency pool of Madrid was hence deployed with the Emergency Pool coordinator, the WASH co, the Logistic co, the Admin co and an additional WASH Program Manager. All positions, except the WASH coordinator stayed for 2 months. According to all key members, this surge capacity was adequate and effective. The emergency specialists were **flexible** and **willing to collaborate** with the mission. **Collaboration** between mission and EP coordinators was **smooth** and **well-balanced** so as **not to overstretch the limited capacity of the mission** and at the same time, **keep the mission well informed** and **in all decisions taken** to ease hand-over further on. Hence, they manage to work in autonomy and set up a timely response in Juba – arrival date: May 29th, First actions: June 2nd – benefiting from a good support provided by the mission (bank account, logistic contract for transport, Juba base already identified, HR in process of recruitment prior to EP arrival in country).

Furthermore, prior to the deployment of the EP, ACF USA prepared a **specific document to rule the activation of EMS** in South Sudan. This document tailored the management plan, coordination and communication agreements, country director/desk/emergency pool coordinator's responsibilities,

and key elements for logistic, HR, finance and administration. It seems that having this document prepared and agreed upon prior to EP deployment considerably facilitated the EP's deployment in the field, and hence the overall perception of all stakeholders (Madrid EP, ACF USA, ACF South Sudan) is satisfactory.

### A greater visibility to donors

Moreover, the EP deployment led to a greater visibility of ACF mission at country level, especially towards donors. "*ACF was autonomous and had skilled-emergency personnel. They started up on private funds […] behavior that always encouraged donors to provide additional funding*" – Field Expert – ECHO South Sudan (31/8/2014). Indeed, **ACF NYC HQ released a US$150,000 envelope to kick off first interventions** and **this was strongly emphasized from donors' point of view as crucial to convince donors on the willingness and ability of the organization to perform**. Concretely, ACF South Sudan mission supported by Madrid EP rapidly signed €320,000 project for the first 3 months of intervention and additional funding[8] with ECHO and UNICEF should be secured to continue intervention up to the end of December 2014.

### Slow Emergency Pool Replacement:

Each deployment length usually varies between 4 to 8 weeks, based on the mission needs, the type of emergency and capacity of the mission to take over. In this case, all positions were planned on 2-month duration, which is an appropriate timeframe for HR officers to recruit international staff, especially for South Sudan mission. Thus, planning for EP replacement should have been a serious concern to be dealt with, straight from the beginning of the deployment. At the time of the RTE, the field co and Head of Base positions were still emptied and with no clear visibility on when these 2 will be filled (5 international positions including 4 emergency specialists down to 1 international position after 2 months).

**This really hindered the efficiency and appropriateness of ACF systems after each EP deployment**, knowing that the risk of gap is high if not worked on immediately and hence the risk of reducing the quality of the program implemented.

### Need for ACF Emergency procedures or supporting ACF mission to elaborate their Emergency Preparedness and Response Plan?

There is no ACF emergency procedure per se, other than the minimum ones agreed upon by all HQs, such as the Kit log. All other deviations in terms of process need to be tailored between mission, HQ and EP. It appeared in this response that the emergency logistic and admin coordinators encountered some challenges regarding the completion of ACF existing procedures. Indeed, there were existing constraints (longer time for recruitment due to South Sudanese regulations, shortage in core supply from UNICEF and delay to purchase, etc.). All these challenges were overcome with the support of respectively the HR, administrative and logistic coordinators by adapting their procedures in agreement with the HQ: i.e.: internal derogations for purchase, hiring daily workers while the recruitment process could be completed. It did not either decrease significantly the effectiveness and efficiency of the response but overloaded support department members for some time. . The evaluator found that this illustrates the need for any mission to be better prepared itself to emergency and how this would contribute greatly to increase the effectiveness and efficiency of the Emergency Pool deployment. **It is not necessary to create new emergency procedures**, rather

[8] ECHO proposal – €450,000 and UNICEF – US$474,892

than take dedicated time during the preparatory phase to coordinate, get a good understanding of the country specifications and requirements for each field (Log, HR, Admin, coordination and program).Support departments are vital to programs; they determine the efficiency and the timeliness in which a response can be implemented on the ground.

Therefore, the evaluator strongly recommends that **ACF International supports ACF HQs and missions to elaborate their Emergency Preparedness and Response Plan at mission level**. This process will allow the mission to take a logical approach to the management of risks, priorities and difficulties, in order to draw up a list of the actions to be completed for additional effectiveness and efficiency in its response to emergencies.

## b. Coordination

## External coordination

*Sub-questions:*

- *Has ACF coordinated effectively with external stakeholders in the response?*

### An active member to cluster coordination

While cholera outbreak was declared in Juba, the national WASH cluster coordinator asked WASH partners to increase their capacity to be able to respond to this new emergency. ACF as part of the Strategic Advisory Group and a key member to the WASH cluster decided to support this response, activating EMS. Thus**, ACF area of intervention was defined according to the 3W matrix** elaborated by the cluster in order to ensure no duplication amongst members. ACF was and is the only one to report on activities, according the national WASH cluster coordinator and the cholera taskforce coordinator, and because of his current position in the response, has been elected to be part of the TWiG on cholera guidelines and tools. Collaboration amongst partners seemed adequate in meetings but the **coordination was clearly lacking of harmonization:**

- Strategy of response – type of activity to prioritize,
- On hygiene kit composition (type of items – all stakeholders distributed different kits –, quantity, duration of the kit – some organizations gave for a 2-week duration, other for 4-week),
- Monitoring requirements and tools,
- And minimum criteria for needs assessment.

Only IEC materials were harmonized amongst all WASH partners, as messages needed to be agreed upon by the relevant national authorities and hence prepared in advance. That said, to the evaluator's point of view, ACF did the best it could have, timely providing the cluster with feedback and inputs regarding cholera guideline for South Sudan and with information on ACF ongoing activities. WASH and cholera cluster coordinators had supposedly a heavy workload due to the complexity of the crisis in South Sudan and did not manage to settle these important issues in a timely manner. As an example, the cholera guideline was finalized on August 1st.

Moreover, during the RTE, the evaluator observed that the coordination system in place was quite complex; multiple coordination structures existed (National cholera taskforce[9], WASH cholera taskforce, Social mobilisation group, Case management group, Surveillance meeting), and sometimes this may have duplicated coordination layers unnecessarily. Based on experience, a high number of

[9] A taskforce under the Ministry of Health of the Government of Southern Sudan, the Federal Ministry of Health, the World Health Organization and partners, was established to coordinate the public health response.

coordination groups toward coordinating one particular response is always a risk of decreasing the quality of coordination, especially if there is no structure to coordinate the whole. Due to the limited number of actors and their own limited resources, it is hardly possible for each partner to participate to all forums; and therefore, some key information are then lost in the process. Regarding ACF, the departure of the Madrid team clearly reduced ACF presence in the structures of coordination. Previously, ACF had one dedicated person (EP coordinator) to participate to each meeting, even ensuring the connection amongst these groups (except case management) as ACF was almost the only one to cover all 4. Later on, the WASH PM clearly had to allocate his time between coordination, field and office, and then limited his presence on the WASH cholera taskforce and social mobilization group. This made great sense, although ACF could have advocated to the cholera and WASH cluster coordinators that the social mobilization and WASH cholera taskforce be merged.

Finally, despite the high number of coordination groups, the evaluator found that all these coordination structures did not challenge partners on the quality of their implementation and accountability towards beneficiaries, their peers and donors. Coordination, not only been about collaboration but also been about working in partnerships, promoting coherence amongst actors, developing common tools and standards to raise the effectiveness of the overall response, is to be improved and in that regard, all key partners have the responsibility to actively enhance to this process. In that sense, ACF supported by the evaluator is currently taking the lead on promoting accountability to other partners and this was welcomed by the cluster coordinators, donors and cluster members.

### Perception of other WASH partners and donors

The perception of ACF work and external coordination is very good. Indeed, ACF worked hand-in-hand with Oxfam to recover their areas of intervention, and thus let Oxfam be ready for another emergency – Oxfam is one of the EPR members for ECHO.

From an external point of view, the arrival of Madrid EP was seen as the reinforcement of ACF South Sudan mission and not a separate entity. The **Madrid EP introduced themselves as ACF**, rather than coming from ACF Spain or going into the detail of the EMS which would be confusing unnecessarily. This clearly favours the smooth handover after the EP departure and strengthens ACF South Sudan in his role as a key emergency partner.

### Involvement of local authority structure

Since the beginning of the program, ACF designed its intervention in respect and good involvement of local authorities and Community Based Organisations. Indeed, ACF planned the reinforcement of these structures and involved them throughout the program such as in mass campaign, raising community awareness and disinfection activities.

Given the time allocated and the nature of the intervention, the reinforcement plan designed for local authority such as quarter council, local associations, and community volunteers was appropriate, notably as ACF contributed to raise their knowledge on cholera epidemic and means for prevention, and hence to modestly increase their resilience. Also, regarding water committees, ACF approach was acceptable at the time, but moving from an acute emergency response to a more "shield approach" as the program is extended up to the end of December, ACF needs to dedicate more time and focus supporting these committees created and/or reactivated "in haste" on the first three months. The "normal" approach to community mobilisation and involvement has been disrupted due to the emergency and thus ACF will have for these coming months to put a greater emphasis in order to ensure community ownership and capacity building.

## Internal coordination

*Sub-questions:*

- *To what extent have the different ACF groups (ACF Spain ER Pool, ACF country team, ACF New York etc.) coordinated effectively?*
- *Has the surge capacity provision (of the ACF network) been effectively managed?*

As aforementioned, the preparatory period prior to the deployment of Madrid EP in mission was perfectly used, tailoring the standard operating procedures of EMS to this specific case. This facilitated the incoming of EP from both sides and contributed to the overall good collaboration at mission and HQ level.

There was good collaboration between mission coordinators and their counterpart in EP, except for WASH as the WASH coordinator was new and it was agreed between HQ, mission and EP that his involvement would be minimum at that stage. The coordination remained mainly "in line", sector only and not inter-sectoral. Even if it did not hinder the implementation of activities on the ground, it is important in a matter of cohesion and common understanding that the mission coordinators and even the Emergency Pool coordinators meet regularly at capital level and amongst project managers at field level.

In the time of the RTE, there was no coordination meeting between logistic, finance, program managers at field level, supposedly due to the absence of Head of Base and Field Coordinator. This lack of formal coordination may lead to overstretch people ability and distract them from their main focus, responsibilities and objectives. Indeed, at some point, this led to problems and delays. For instance, it happened for 2 consecutive days that there was no fuel left in all 5 vehicles to go to the field and hence all the activities were stopped for several hours. Also, the continuity of ECHO proposal was worked on without a common work session between program and support departments to present the activities to be implemented, the areas of intervention, and results to achieve, so as to ensure consistence between needs and means.

# c. The effectiveness and efficiency of ACF response

In order to contain cholera epidemic in Juba County, ACF response was declined into 2 main results:

a) The sources of infection in the targeted areas are limited by improving WASH conditions and increasing the population awareness;
b) The sources of dissemination in the target areas are limited.

The program was designed to have result 1 related to WASH interventions to tackle cholera outbreak and result 2 on cholera prevention: the "shield and sword strategy". One of the greatest limitations identified in ACF response in this particular context was about **targeting areas of interventions and beneficiaries.** ACF is promoting the shield and sword strategy, whereas, looking at the details of the program implementation, it appears that ACF fell into performing a "regular" WASH program as getting precise epidemiological data was missing to target interventions.
Indeed, regarding epidemiological data, at a cluster level, the link between medical and WASH actors was poor despite or because of the various forum of coordination as aforementioned. At the time of the presence of Madrid team, continuous coordination with other medical actors (mainly MSF and Medair) was ongoing and despite these efforts, ACF did not manage to receive significant information as medical actors had also a very basic way of collecting epidemiological information. Sometimes, epidemiological data was not even necessarily harmonized amongst all medical actors. Following the departure of Madrid team, this weak but existing linkage with medical actors vanished,

as ACF was not attending the various meeting of coordination and especially the surveillance meeting.

Thus, at the time of RTE, ACF did not receive any day-to-day information (number of cases newly recorded, precise location of new cases) in their areas of intervention although new cholera cases were recorded. By that time, ACF was not even looking for this either, but was targeting interventions, especially hygiene kit distribution, based on the identification of "areas at risk". Through a community approach, a mapping of the area was done, identifying water points, markets, public latrines, flooding area, overcrowded area, makeshift dwelling.

In case of cholera outbreak, receiving daily epidemiological data is crucial, like a pre-requisite to direct actions and hence ensuring the overall effectiveness of the program. This weakness in targeting immediate interventions where cholera cases are recorded was observed in every WASH partner involved in the response and this could explain why the epidemic in Juba County has been lasted for a long time, despite a net decrease since the first 4 weeks.

The evaluation reviewed each activity and the table below presents their level on achievement and observation/limitations.

*Sub-questions:*

- *To what extent ACF intervention objectives in Juba are on track to be achieved?*
- *To what extent have all activities planned, their implementation methodology and timeframe contributed to achieve the objectives?*

| Activity | Level of achievement | Observation/Limitation |
|---|---|---|
| Disinfection of households affected by cholera | **not on track** | • This activity was not undertaken as planned, as ACF was rarely able to collect patients' addresses and proceed to rapidly disinfect. Moreover during discussions at WASH Cluster level it was decided that actors should not focus on this activity, which has been considered not prioritized and which was supposedly done by medical actors. ACF decided therefore to target this activity by involving Quarter Council, training the volunteers on disinfection and providing the materials to conduct it<br>• Disinfections were done on specific days, based on the availability of the personnel and finally targeted places considered 'at risk' such as public and private latrines, markets, etc.<br><br><u>Activity effectiveness:</u><br>First of all, **this activity is not an activity of disinfection of household affected by cholera**. The title should be changed and ECHO advised accordingly. This activity is more related to improve the general cleanliness of the community by disinfecting hazardous places such as public latrines. In that sense, the evaluator would suggest to link it to "training and capacity building based of local authority and community based organizations".<br>Secondly, regarding the effectiveness of household disinfection, this activity should have been undertaken by ACF staff, as a full-time job, taking into consideration that this team would be based at the CTC/UTC level, and each time a suspected case was brought in, they would immediately go and spray homes of the patients and neighbours. They could have explained to the dwellers how to prepare a disinfection solution with products they can find in the local markets, what and at which frequency to disinfect and the precautions to take when the patients will come back at home. They could then connect with the hygiene promoters' team for further sensitization and hygiene kit distribution if relevant.<br>If disinfection is not immediately (few hours), the activity is considered as ineffective to protect the other dwellers to get contaminated at household. |
| Hygiene kit distribution (picture 1) | **not on track** | • This activity is based on the number of cases registered, which explains that it is not on track looking at the few cases recorded lately. The strategy on hygiene kit distribution changed during the program in order to increase the number of kits distributed. Before, only the affected household and its 4-5 neighbours received hygiene kits whereas the new strategy targets more beneficiaries: households living in an area qualified as 'at risk'. Unfortunately, distribution criteria amongst households are not clearly defined and thus not efficient looking at the WASH services context in Juba. Distribution criteria need to be clarified urgently, targeting the area where cholera cases are currently recorded **at village level**. Then a team should be sent and evaluate: |

| | | |
|---|---|---|
| | | ▪ the risks and the potential sources of contamination (water point – illustrated by a high number of cases (all gender and age) recorded on the same day having in common to use the **same water source for drinking and cooking purposes**, food restaurant – same as above taken into consideration that it would target more adults than children, or interpersonal contamination – at household, market, any social event),<br>▪ the knowledge, attitude and practice of the population (through a rapid focus group discussion and not a proper KAP survey that would require too much time),<br>▪ the capacity and ability of the population to protect themselves at household level;<br>And then decide to complete the distribution accordingly. Hygiene kit distribution is a crucial activity and effective activity to prevent cholera while an outbreak, although looking at the enormous need of the population and poor WASH services in Juba, clear and well-defined distribution criteria will guarantee higher efficiency.<br>• Moreover, **the distribution methodology is not efficient**; sites are not prepared and structured, sensitization and demonstration of PUR sachets are done on people whose names may not be on the list of beneficiaries; frustration from people who see the demonstration but are not on the list; low beneficiary attendance, ACF staff need to go back several times; etc.<br>• Hygiene kit composition varied, sometimes with buckets depending on UNICEF core pipeline capacities, and quantities do not follow Sphere standards especially for soap (800g rather 1500g – 250g per person/month). Water containers appeared to be a critical item based on field observations and PDM, and could be added to hygiene kit composition for further distribution. |
| Borehole rehabilitation | On track | • Activity of repair rather than rehabilitation;<br>• More than 80% of boreholes assessed by ACF were not functioning due to mainly a lack of maintenance. Some boreholes appear to have salty water and it is hard to define the proportion of people using it as drinking water sources.<br>• Activity useful to increase water availability in some locations, especially where water tankers cannot go. Each borehole visited was used by the population.<br>• A criterion on targeting borehole to repair was based on previous use or not by the population.<br>• **No water quality monitoring after borehole repairing** whereas some are pumping the water at very low depth (3-4m deep); It was supposed to be done at first in collaboration with the ministry of water. But due to issues about per diems, the partnership collapsed and ACF did not find a back-up solution such as doing water testing itself, especially as the budget already allowed this kind of expenditure.<br>• Some hardware works could be realized: access to boreholes in rainy season; borehole protection/fence; cleanliness of the area around the borehole – stagnant water. |

| | | |
|---|---|---|
| | | This activity could be more effective if combined with chlorination point or any other techniques to promote household water treatment and conservation, especially as the water quality is not tested and that ensuring good water quality at Point of Use (PoU) is always more effective than at Point of Distribution (PoD). Some corrective measures need to be taken immediately, especially regarding **water quality monitoring** |
| Support to community to construct HH latrines | NA (not in the proposal at first) | • Activity not in the initial proposal; ACF is providing technical advice (size, depth of the pit) to household willing to dig their pit and after the digging, ACF provides slabs and plastic sheeting to household.<br>• Fairly good willingness of the population - "more people are willing to dig their pit"<br>• **Serious concerns** regarding this activity as the beneficiaries are locating in slums and are digging in any available space: i.e.: construction of latrines in flooded risk area and/or where the water table is high (fig 4);<br>• No exit strategy - what about when the latrine will be full? Risk of faecal contamination of water sources?<br>Latrine construction is not an effective activity to tackle cholera outbreak, as it is time consuming to be able to ensure a suitable and sustainable sanitation service to the population and effective only if it is at scale. ACF should really develop a clear strategy about this activity, define the environmental and social criteria for implementation, appropriate timeframe and community mobilization methodology rather than just providing tools. Corrective actions have to be taken immediately regarding the fact that some constructions not at standard and can pose a public health issue. |
| Organization participating in the program | On track/ achieved | • Good involvement of community volunteers, and quarter councils, CBOs in the program<br>• Training of water committees after borehole repair on borehole management, accounting, hygiene and sanitation and simple maintenance. The training seems to be done fast and took place after the borehole repair. The methodology used may not be adequate to promote real sustainability of this infrastructure as the involvement of community, especially water users came after the process of repairing rather than initiated the process. No survey is done regarding the willingness of the water users to pay<br>• ACF needs as well to start close monitoring of these CBOs and their activities.<br>• ACF collaboration with the ministry of water is not sufficient. Obviously per diem issues hindered the monitoring, and stopped the collaboration between ACF and the Ministry of Water. Yet, their involvement with training and registering of water user committees should be sought further. |
| People trained and improved knowledge | On track | • No pre and post individual test undertaken to assess the level of knowledge and their improvement<br>• FGD with one group of community volunteers showed a good knowledge of people about cholera, prevention measures, and transmission paths. Unfortunately, the evaluation could not benefit from M&E data of the program, such as PDM which would indicate the level of knowledge and the quality of beneficiaries' sensitization. Based on the observations and beneficiaries interviewed, the evaluator will advocate for, bearing in mind that some of these recommendations do not rely only on ACF willingness but needs approval from relevant authorities in country: |

| | | |
|---|---|---|
| | | ▪ Providing community workers with pictures book (picture, no written indication) and not only on oral sensitization – UNICEF usually have this tool. If not, I can provide this so that ACF can submit to UNICEF South Sudan and all relevant authorities for approval;<br>▪ Change the message: "drink clean water" to "drink chlorinated water", and that hygiene promoters be provided with pool testers to test free residual chlorine.<br>▪ Add the following message "keep the latrine clean and covered to avoid flies",<br>▪ Develop stickers with the representation of PUR utilization or aquatab, so that it can be stick into water containers. |
| Mass campaign | Achieved | • Mass sensitization using megaphones in areas at risk and previously affected.<br>• Based on a small survey, inhabitants seem to have heard about cholera in Juba, and the recent epidemic either through radio, community leaders, etc. The information seems to have been effectively spread to the local population.<br>• Based on observations, the balance between public sensitization and house-to-house seems suitable, even if further surveys, such as KAP might refine this observation |

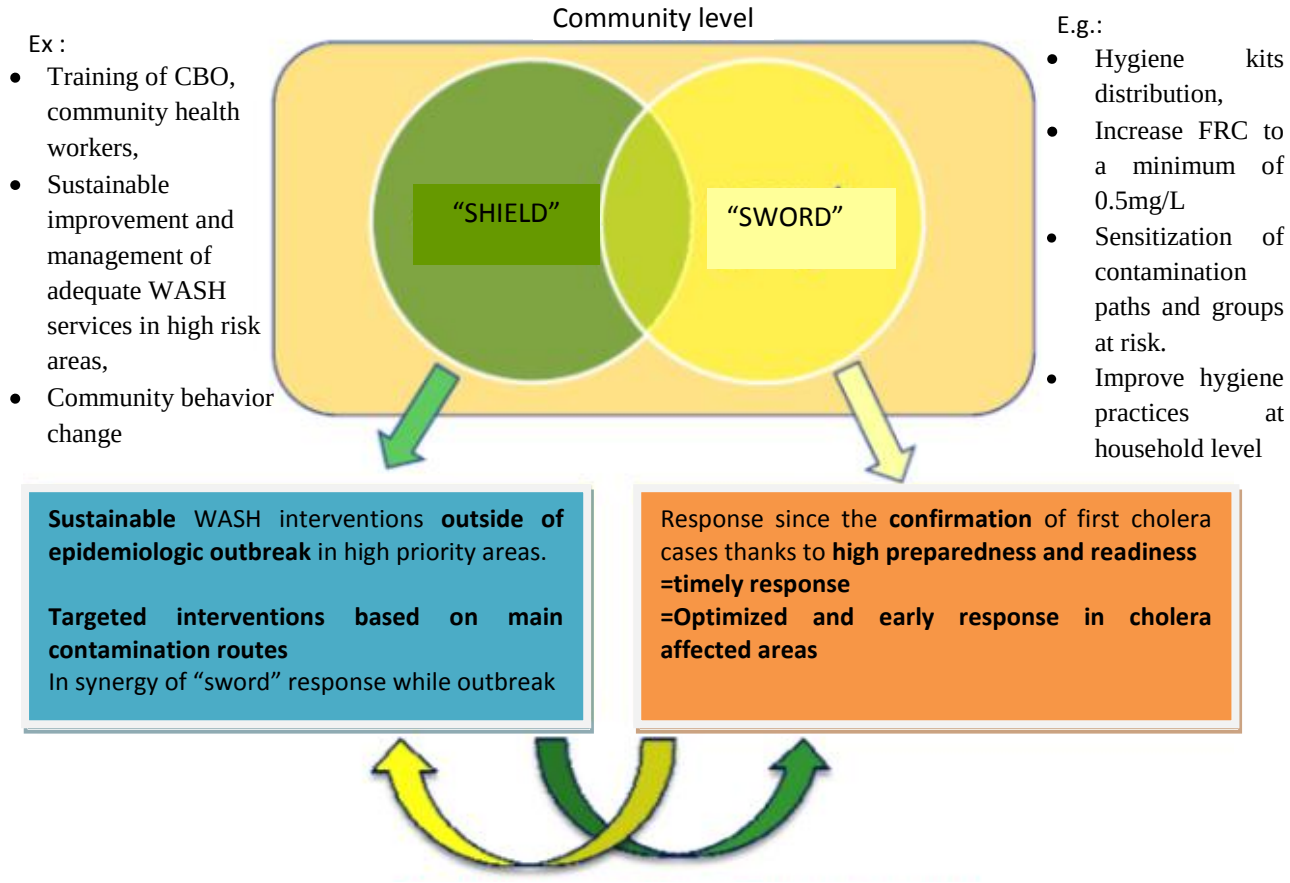
Figure 4: Latrine construction – high water table

*Sub-questions:*

- *To what extent have all activities planned, their implementation methodology and timeframe contributed to achieve the objectives?*

Following the definition of result 1, the activities implemented by ACF programs should match the epidemiological pattern and hence block the transmission paths of cholera outbreak. Based on epidemiological data, interpersonal transmission, especially **poor practices of hand-washing at critical times, no water chlorinated at household level, poor food conservation** seems to be the main routes of contamination.

Thus, based on the technical review of ACF activities, there are some improvements to be made so that the program would become more effective. Firstly, ACF should work on prioritizing **the activities based on their effectiveness on cholera and use a targeting based on cholera cases** ("sword") and in completion, continue primary prevention measures ("shield"), taking into account the appropriate timeframe for community involvement so as to ensure ownership and hence sustainability. Indeed, as an example, water committees are revitalized after borehole repairing, whereas a better ownership could be reached by firstly ensuring community willingness to use and pay for water in the coming future, secondly constituting and/or revitalizing the water users committees, and finally performing borehole rehabilitation/repair.




Complementary: i.e.: optimization of response

ACF South Sudan managed to secure additional funding from ECHO and very likely from UNICEF, this should help ACF strengthening their activities on the ground, taking the corrective measures

necessary, developing a better understanding of population needs, thanks to better M&E and KAP surveys and then designing further steps for ACF program in Juba.

### Low budget consumption and cost efficiency of the program

| | Result 1 | Result 2 |
|---|---|---|
| Number of beneficiaries[10] | 32,500 | 30,150 |
| Budget € | 114,993 | 205,007 |
| Cost per beneficiaries | 3,54€/p | 6,80€/p |

The cost per beneficiary is low for usual emergency response, especially for result 1 which accounts for hardware and hygiene kit distribution. But it is emphasized that this cost does not account for in-kind donation from UNICEF. This information is not registered at the mission level. The evaluator did not know whether this will be adjusted in the next PCA to track goods and uses.

Based on the last BFU of July 2014, the overall balance vs budget accounts for only 20%. This is mainly due to a lower consumption regarding HR, especially international staff. That said, the WASH PM, supported by the WASH Co and WASH Advisor could already look into the details of operations and re-allocate funds to complete works such as borehole repairing as aforementioned, purchasing water quality tests, pool tests, supplement hygiene kits with water containers as based on field observation, this item seems to be needed.

*Sub-question:*

- *To what degree is ACF sufficiently prepared and designed for the on-going response to cholera in Juba and the rest of the country?*

### Always prefer overstaffing, especially for support departments

The activities ran efficiently despite the limited number of staff in support departments especially in logistic. This program tended to overstretch support capacities, due to a undersized logistic team, notably at the base level and also due to the low level of knowledge from staff. Most of the staffs have a very good potential but need to be accompanied to build capacity. Unfortunately, staffing plan at the beginning was limited in terms of number and took too much time to be validated. Then, the training period with the Madrid EP was limited to ensure good capacity building and the fact that the field co and head of base positions are still emptied did not ease maintaining a good efficiency after 2 months.

As far as the RTE went, it did not seem to have seriously impacted the program in the field. However, for the continuity of program, it is strongly advised to fill these positions as soon as possible in order to build staff capacity and coordinate program and support departments more efficiently.

### Building a team spirit

As the team is not yet complete, building a team spirit is a bit hard. However, during the RTE, it was found that the level of communication and information amongst the staff was low. In addition, transition period such as now, with the supposedly end of the project, is always challenging and requires to be handled carefully in order to maintain the team members trained by ACF in the first phase into the following projects. Indeed, national colleagues are often wondering whether the program will continue or whether their contract will end in 3 weeks. Unfortunately, there has not

[10] Based on the LFA for ECHO, 32,500 beneficiaries for result 1 detailed as such: 30,000 people benefitting from hygiene kits and 2,500 people (based on international norm regarding hand-pumps – 250 users per borehole), and 30,150 beneficiaries for result 2: 30,000 people sensitized, 150 people trained in CBOs.

been any clear and official communication from coordination office on that and this could lead to further challenges later on.

### Readiness and preparedness to response to cholera outbreak

The proposal to ECHO stated a response in Juba and other locations where ACF traditionally operates such as Northern Bahr El Ghazal, and Warrap states. Based on tha Wash Coordinator interview, no training to staff in these locations was realized in order to concretely build readiness and preparedness to respond to cholera outbreak in these areas. Hopefully for ACF, the epidemic concentrated mainly on the southern part of the country and Upper Nile state.

Furthermore, based on the field visit done by the log coordinator and the log advisor in some of these locations, it appears that inventory and tracking system is not appropriate. The evaluator does not have the knowledge of the quantity of stocks remaining but this should be looked at in order to ensure sufficient contingency stock for the coming weeks.

Therefore, based on the evaluation, ACF mission did not seem to have a greater readiness and preparedness to respond to cholera outbreak, also taking into account the protection of national and international staffs working in cholera affected areas. No protective measure is in place or applied (2 bathrooms are available but no one is practising hand-washing after being in the field, disinfection products available, first aid kit in each car with ORS sachets and clean bottle water to prepare solutions if needed, etc.). The appropriateness and coverage

*Sub-question:*

- *Has ACF response to cholera epidemic in the areas of intervention been appropriate to the local needs and to this specific epidemiological pattern?*

Activities realized by ACF, except latrine construction and household disinfection – bearing in mind that ACF has not actually completed this activity per se, appeared to be relevant; the main proxy indicator to illustrate this is the good perception of beneficiaries, their active involvement and their positive feedback collected though post-monitoring.

The evaluator considered developing other activities such as:

- ORS distribution – not appropriate as medical actors had a really good coverage especially regarding ORPs. Another proxy indicator is the case Fatality Ratio that in that particular case was low and hence did not indicate strong dehydration.
- Surface water treatment: not appropriate in sword approach as it is unlikely that water from the Nile was source of contamination. That said, **this is highly appropriate in a shield approach**, as this is an urban context. However, issues of running cost and partnerships to operate in the short and mid-term needs to be dealt prior any investment.
- Bucket chlorination: not appropriate looking at the behavior and habits of water users in Juba;
- Chlorination of tankers: performed by UNICEF and totally ineffective as the water is turbid and chlorination inappropriate without a proper flocculation;
- Blanket distribution of water treatment products: appropriate but poorly cost efficient, if the idea was to target all areas at risk. However this would be cost efficient within a shorter range of household, tracking current cholera cases, at village level and based on criteria defined on sanitary and living conditions

As aforementioned, the findings highlight the fact that it is more about the strategy and the planning of activities that could hinder the level of effectiveness and the appropriateness of the program. Throughout the program, the strategy evolved, and so did the targeting of beneficiaries and areas of intervention following the turnover of international staff. At a certain point, the program was holding

up by a WASH PM, first mission lacking support and regular follow up from the coordination. The evaluator thinks as well that the strategy in response to cholera was not detailed and clear enough in ECHO proposal to be self-guiding and to a certain extent, achieving output goals began dictating ACF intervention. ECHO proposal do not have proper indicator for results. The table below illustrates some examples of indicators extracted from ECHO LFA and which are indicators of activity:

| **Example of indicators for result in ECHO proposal** | **Corrective indicator suggested** |
|---|---|
| Number of persons (HH) affected by cholera and their neighbours benefit from the targeted distribution of hygiene kits and from HH level hygiene promotion and cholera awareness | number of household receiving a hygiene kit, it is preferred to monitor the percentage of HH drinking chlorinated water (FRC>=0.5mg/l)<br>Number of household practicing hand-washing with soap at regular times and especially at critical time<br>Number of cholera case contaminated following the return of a patient at home |
| Number of boreholes equipped with hand-pumps are rehabilitated | Number of household having access to an improved water source in high risk areas |
| Number of households affected by cholera are disinfected | Number of household **with cholera case** disinfected in the first 12 hours |
| Number of institutions and organizations participate in the program | Number of institutions and organizations with trained personnel,<br>Number of trained personnel able to describe cholera symptoms and means for protection |

By the time of the RTE, the "sword and shield" strategy was mixed up; all activities were done in the same process and methodology, and with the same degree of relative importance. Shield activities such as increase water availability through infrastructures at village level, and sanitation services at household level underestimated the time and the right process required for community involvement. Likewise, sword activity such as hygiene kits distribution was not target current cholera cases locations but all areas estimated at risk to increase the number of kits distributed.

*Sub-question:*

- *To what extent has ACF response covered local needs due to the cholera epidemic?*

### To improve coverage ACF interventions could have been expanded to Torit County

Within Juba County, ACF covered at first the gap as agreed in cluster and recently took over the areas covered by Oxfam program. Nowadays, ACF is currently covering one of the biggest areas of intervention in Juba town. Hence, the coverage is appropriate to the needs in Juba County and regarding ACF capacity. However looking at cholera outbreak throughout the country, there were higher needs outside of Juba County (figure 3 below). Indeed, it would have been relevant in terms of coverage of humanitarian needs for ACF to consider supporting intervention in Torit County, especially as needs were higher than in Juba County, bearing in mind that this might have required additional resources and overstretching existing capacities. Without setting up an additional operation base, mobile teams could have been planned in the proposal, with sufficient logistic and administrative means or added further on in accordance with the donor and cluster partners as the outbreak spread in Torit later on in June. Nowadays, very few WASH (IOM, PAH) partners are working in this location. ACF should have advocated earlier into having mobile teams likewise they are planning on doing now.

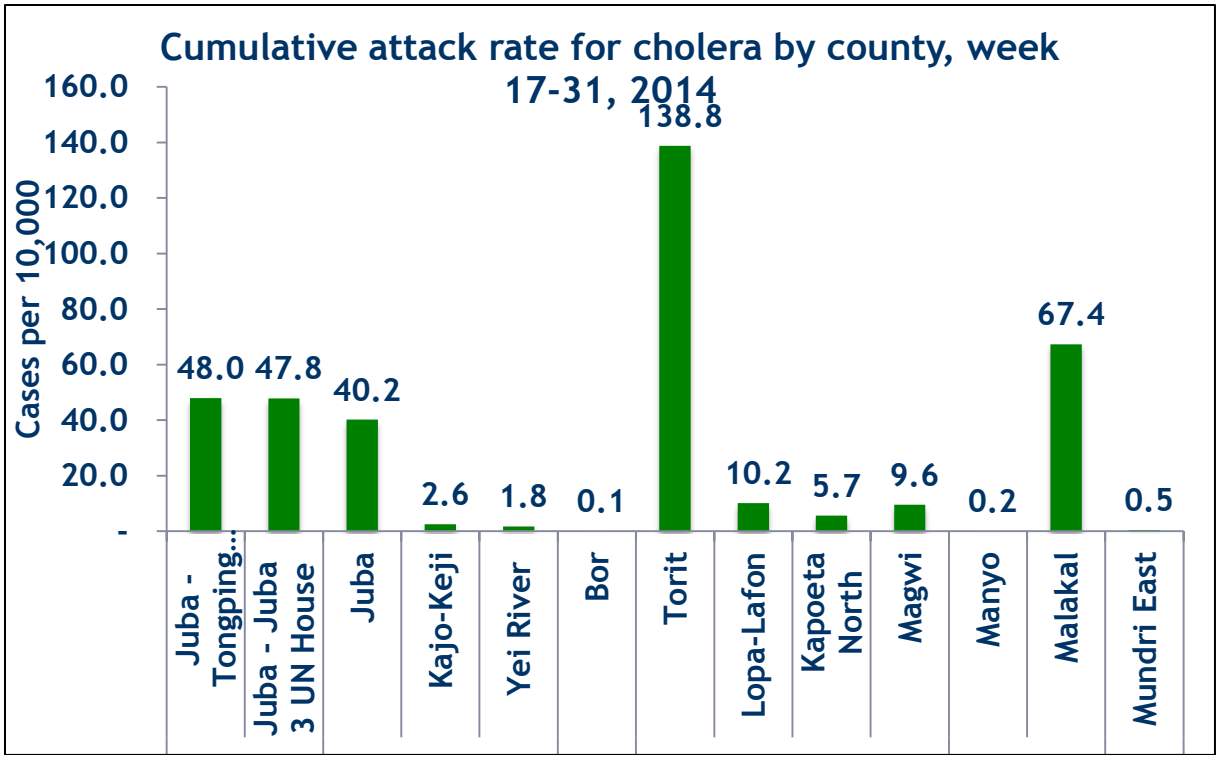



Figure 3: Cumulative attack rate for cholera by County since the beginning of the outbreak 2014 (WHO/MoH)

## d. The impact

*Sub-question:*

- *Has ACF response achieved to contain and prevent the spread of cholera in the identified risk zones/areas?*

In this kind of intervention, it is always difficult to clearly gauge the impact, but it seems fair to state that ACF response **contributed to achieve the overall objective so as to contain and prevent the spread of the epidemic in Juba County**. The weekly attack rate has been decreasing since and even prior to ACF interventions in Juba. However, as aforementioned, the weakness in targeting immediate interventions where and when cholera cases were recorded certainly diminished the impact of ACF response to contain and prevent the spread of cholera

Furthermore, the RTE highlighted that the indicators in the LFA are more indicators of activities rather than indicators of results which could have supported the RTE in evaluating the impact. Also, the lack of internal monitoring and evaluation systems could not help either to get qualitative data about practices. However, based on the field visits and beneficiaries encountered, it seems that the knowledge on cholera, transmission paths and ways to protect them were understood. Hygiene items seems to have been used rapidly due to a high number of people within a family (above the average of 6 people) and putting in practice messages promoting by ACF, especially hand washing, seems to be an issue.

## e. The sustainability

*Sub-questions:*

- *To what degree has this cholera response activity created an opportunity for ACF?*

- *To what degree has ACF program raised community awareness about cholera prevention and cholera epidemic and realized activities to sustainably reduce cholera risks preventing future epidemics in Juba County?*

Linking impact and sustainability, it is clear that this type of program and its short duration cannot overcome blockages, traditional beliefs and reach behaviour change in such a constraint timeframe. Indeed, even if knowledge seems to be relatively good from beneficiaries' point of view, attitude and practices do not seem to be consistent with the level of knowledge. For instance, hygiene promoters sensitizing the population on the importance of hand-washing to prevent cholera transmission do not put in practice for themselves these measures when they come back to the office from the areas of intervention. Likewise, beneficiaries after using the items of the hygiene kit do not purchase them again to continue promoting good health and hygiene at household level, whereas they have the financial means to do so.

ACF understands the need for a next phase to develop a consistent "shield" approach in which WASH services needs to be significantly improved, targeting the previously cholera affected areas, and through a long-term approach to reach behaviour changes through community involvement. Such a strategy and programs need to be established and ACF should be working on developing it in the meantime of this project implementation.

Furthermore, ACF is now sensitized on the need to include cholera risk into the country strategy (ongoing exercise at mission level).

## f. Monitoring

*Sub-question:*

- *Is ACF monitoring system for cholera response suitable to provide qualitative and quantitative data in order to ensure accountability towards beneficiaries, other stakeholders (local and national authority, NGOs, UNs) and donors?*

Although some tools existed such as daily management plan and activities follow up matrix "ACF Internal Monitoring Activity", no quality monitoring system was in place, such as Post Distribution Monitoring, water quality monitoring, follow up of water users from borehole repaired, initial and final KAP studies, etc.

In addition, no beneficiary complaint mechanism is in place and no system to document and learn from the implementation of activities, such as an intern evaluation system.

The evaluator supported the mission to establish and test some of these key documents urgently (PDM, database of analysis, purchase order for bacteriological tests to monitor water quality at borehole level and pools testers at household level). Also, the evaluator recommended for the next program to set up a dedicate team of national staffs that would elaborate tools and run frequent monitoring to promote internal Monitoring, Evaluation and Learning.

## g. Cross-Cutting issues

ACF program managed well cross-cutting issues related to gender, age and community involvement. ACF took into consideration the profile of people affected by cholera in their need assessment, noticing the fact that many children were affected and thus providing sensitization at school level for cholera awareness and hygiene education.

Also, ACF teams seem to be relatively balanced between men and female staffs and community volunteers.

In completion to the actual program, the evaluation suggested ways for improvement:

- Community involvement needs to be seek prior to the action,
- Age: importance to develop different approaches depending on the age of the targeting population: i.e.: for school children, design games to let the children play around hygiene promotion; advocate at the cluster level to develop graphic tools for sensitization to be able to be used throughout the country no matter the level of literacy of the population;
- Integrate principles of Human Right for Water and Sanitation in emergency into WASH country strategy, and advocate towards donors to increase funds available in Juba for instance.

# 3. Conclusions

In general, ACF response to cholera outbreak has been valuable and of importance to the overall response from WASH partners. ACF's work was much appreciated by beneficiaries, local authorities and Community Based Organizations, Donors, UNICEF and other NGOs. There was a clear recognition of ACF intervention and it strengthened the overall response and cohesion amongst WASH partners.

The intervention itself was appropriate in terms of overall improvement of WASH services to the needy population although some technical corrective measures have to be urgently made and the targeting and timeframe of activities revised and prioritized. In addition, the question remains whether or not ACF could have developed a more flexible approach at the beginning, so as to be able to respond to cholera outbreak outside of Juba town, for instance Torit, where gaps were important and needs even higher than in Juba. That being said, ACF has now increased its coverage, having a bigger area of intervention than in the first months. Thus ACF will have to refine criteria for targeting and activities to implement; especially linking the routes of contamination with prioritizing high impact and efficient activities accordingly. With these improvements, the program will gain in efficiency and effectiveness to contain cholera epidemic, especially as many WASH and medical partners are currently phasing down.

Furthermore, ACF program should be urged to set up an appropriate and robust monitoring, evaluation and learning system, and beneficiary's complaint mechanisms in order to provide relevant qualitative information that will feed the program and define corrective measures in terms of methodology. ACF has not been recently working in Juba and hence needs to develop a good understanding of population's capacities, abilities, and willingness for behaviour changes. This cholera epidemic may not last for long but the risk of having another cholera epidemic in the coming months/year remains high. Thus, ACF needs to put effort to ensure operational and institutional knowledge based on this experience.

The support provided by ACF network, especially the deployment of Madrid Emergency Pool was very valuable to ACF South Sudan mission. Indeed, highly skilled and experienced personnel were deployed in country and working in good collaboration with the mission, they managed to help the mission growing smoothly and strongly. By being autonomous and quick learners, they immediately relieved the pressure of the mission by not overstretching them, and by being inclusive, they gain in efficiency overall. Indeed, keeping the mission in the loop, especially for decision making, favours smooth handover to the mission but also they could benefit from the mission support as well. The collaboration between the Emergency Pool and mission coordinators was very efficient and effective, and led ACF to provide a timely response to cholera.

Also, « ACF was autonomous and started up on private funds […] behaviour that always encouraged donors to liberate additional funding » - ECHO South Sudan Field Expert. ACF emergency response to

cholera increased ACF visibility in country and this help ACF to secure additional significant funding to operate in Juba up to the end of 2014.

However, as experienced before in other emergencies, the replacement of Emergency Pool personnel is often challenging and leads, if not finely handled, to a fragile transition. In this mission, the number of skilled staff went from 5 to 1 in the first 6-8 weeks. Two key positions (HoB and Field Co) to support proper project implementation are still not filled, which hinders cohesion between team members in Juba base and increases the risk for poor project implementation and overstretching existing capacities. Therefore, in the same spirit as for activation of EMS, ACF network should continue following up with the mission on the phasing out of EMS, and especially on the replacement of the emergency team.

Also, as highlighted in the RTE of ACF Haiyan response, institutional learning within ACF does not seem to improve from one intervention to another. In this response, strategy changed accordingly to the turnover of international staff and their individual knowledge and past experienced. How lessons learnt from this operation will be drawn out from the program and taken forward is unclear. As an organisation, there needs to be a greater focus on how individual learning can be passed on institutionally.

# 4. Recommendations

This essence of a real time evaluation is to provide practical recommendations that can improve ongoing operations in the short term and as such increase programmatic quality and beneficiary support. The immediate recommendations are as follows:

1) Develop a Monitoring, evaluation and learning unit:
    - Dedicated staff, reporting directly to program manager.
    - Set up monitoring and evaluation tools, database for analyses, Lab for water quality monitoring.
2) Prepare information sessions to sensitize all ACF staff in country, Juba capital at first on cholera prevention, risk and treatment;
3) Strongly advocate on merging cholera coordination structures, especially social mobilization and WASH cholera taskforce and that WHO presents data at village level rather than payam in order to get more precise epidemiological data to target intervention;
4) Regarding the activity of latrine construction, the activity as done should be stopped and corrective measures be taken.
    a. Firstly, all latrines sponsored by ACF should be visited again to see their evolution in time (cleanliness, sign of recent flooding and/or increase of water table, quality of superstructure). For latrines with a high water table, disinfection should be realized and new protected pit (drums, raised latrines, etc.) should be constructed instead, with the support of the family.
    b. Secondly, develop a clear longer term approach about this activity, define the environmental and social criteria for implementation, appropriate timeframe and community mobilization methodology.
5) Collaboration with the Ministry of Water: ACF should strengthen its partnership with the MoW regarding water users committee training and registering. ACF could even seek advice through UNICEF so that the latter supports facilitation around per diem issues. For all activities related to improvement of WASH services, the collaboration with relevant authorities should be compulsory and sought using different approaches.
6) Increase preparedness and readiness of ACF mission by:
    a. Updating inventory in warehouse in Warrap, NBG states and Juba,
    b. Organizing a short training of WASH staff from other bases on cholera response,

c. Design and test a process with medical actors in these areas so that ACF would be informed if a suspected case was recorded and to track the locations of new cases.

7) Take protective measures in each field where cholera outbreak is recorded: hand-washing with soap for and disinfection at entrance of compounds and offices, ORS sachets and clean bottle water to prepare the ORS solution in case of one ACF staff develops symptoms, updated contact list of CTC and medical actors in the areas of intervention. Taking appropriate protective measures will be essential especially for the mobile teams.
8) Formalize an official relationship between ACF cholera team focal point and medical actors in the areas of intervention, going to CTCs, explaining the role of ACF program, areas of intervention and the need for ACF to be informed immediately of new cases and their location, at village level at least. If the data is still not coming up after this, task one ACF staff to go on a daily basis to CTCs to get information on cases and origin – for Juba, continue collecting on a daily basis information from JTH.
9) Revise the kit composition to respect Sphere standards and South Sudan cholera guidelines;
10) Clarify the criteria for hygiene kits distribution, based on location of new cholera cases, risk area in this location, household capacity (financial, behavioural) to prevent cholera, water sources used;
11) Decommission latrines, realized with ACF support and which pose a public health threat and provide replacement solutions;
12) Establish the list of actions to complete each borehole repair up to ACF standards with the involvement and financial participation when possible of water committees (to ensure ownership);
13) Revise hygiene distribution methodology to increase efficiency:
    a. Distribution of token with date and time of distribution and which help identifying beneficiaries,
    b. With the participation of quarter council, and local association, define a place for distribution and sensitization of hygiene item,
    c. Take protective measures at the distribution sites (hand washing stations with soap, disinfection of hands with chlorine solutions),
    d. In the specific area of intervention, prior to distribution, confirm through a rapid test that the free residual chlorine after using PUR is adequate – to confirm if the dosage of PUR and time of contact is adequate testing the main source of water supply the population uses in order to adapt messages ultimately;
    e. Perform random and statistically verifiable Post Distribution Monitoring.
14) Staff should be requested to log best practices and lessons learnt during the course of their mission so as to facilitate institutional learning/contribute to end of mission reports.
15) Putting a great emphasis on filling the Field co and HoB positions as soon as possible, and in the meantime, dedicated time at coordination level to support coordinating Juba base operations.

Future recommendations:

16) Develop ACF cholera response and preparedness plan for South Sudan – Tailoring the Shield and Sword strategy:
    a. Sword: Community awareness using different techniques (door-to-door, FGD, games on hygiene for school children, etc.), hygiene kit distribution, bucket chlorination at point of distribution level, M&E to monitor behaviours at risk at household level, PDMs and random water quality monitoring tests at PoD and PoU in cholera affected areas,
    b. Shield: In previously cholera affected areas, starting first with community mobilization and involvement to define tailored and innovative sanitation and water

services solutions, provide technical guidance and support to CBOs, hand-over infrastructures to community as planned.

17) Elaborate an Emergency Preparedness and Response Plan for South Sudan – at least Risk mapping, and workshop among coordinators at capital and field level;
18) Develop a LRRD strategy, integrated all ACF sectors based on population's needs in Juba County, moving from an opportunist approach to a coherent and structured logical framework.

**Toward ACF network for future EMS activation:**

19) Include in Coordinators training information on EMS SOP, capacities of ACF networks (stocks, HR, EP, funds, etc.)
20) Prior to EP deployment, tailor the EMS SOP to clarify roles and responsibilities, lines of communication, key elements for all sectors so that it facilitate coordination and collaboration in mission (Best practice – see appendix B)

# Appendix A: Terms of Reference

**A Real-time Evaluation of ACF-USA's Response to Cholera Emergency In Juba**

**Terms of Reference (ToR)**

**18th July 2014**

## 1. INTRODUCTION

On 15 May 2014, the Ministry of Health declared an outbreak of cholera in Juba. Since 23rd April 2014 when the first case of cholera was detected, a total of 3,403 cases of cholera have been recorded to date (13th July[11]). Partners in all states have stepped up preparedness for cholera. In areas with displaced populations like Bentiu, Bor, Mingkaman and Malakal, cholera treatment centres have been constructed and social mobilization and community sensitizations stepped up. The ongoing outbreak of cholera in Juba and other parts of South Sudan like, Yei, Kajo-keji, and potential to spread remains a public health concern for health partners. Since the start of the outbreak, 28 alerts for suspected cholera cases have reported from from Lanyi, Mundri East, Western Equatoria, Bor County, Jonglei State, Magwi and Torit counties in Eastern Equatoria States. WHO in collaboration with Ministry of Health continue to investigate and verify all alerts.

## 2. PURPOSE

*The purpose of the real-time evaluation is to capture learning from the response to the recent cholera epidemic and to strengthen the on-going response. Although not a primary focus, ultimately this evaluation will also inform future rapid-onset emergency responses.*

## 3. OBJECTIVES

1.1. Evaluate the effectiveness of ACF operations in Juba County since the declaration of the epidemic (6th May 2014[12]).
1.2. Evaluate the effectiveness of the response related to the EMS activation.
1.3. Identify good practice, lessons and challenges that can be drawn from the response to date.
1.4. Provide practical and realistic short term recommendations to strengthen the on-going response to cholera in South Sudan.

## 4. TARGET USERS:

- South Sudan Country Director
- ACF Coordinator/s in South Sudan (WaSH & others)
- ACF-Spain and ACF-France Emergency Pools
- ACF-USA Head of Programs (East Africa)
- ACF Operations Directors (ACF-Spain, ACF-France, ACF-UK, ACF-Canada and ACF-USA)

## 5. SCOPE

The RTE will cover 10 key areas relating to ACF's cholera response in the South Sudan. These 10 areas will be supplemented and unpacked during the preparatory phase. The evaluator will ask key staff what it is they would like this evaluation to tell them, and where possible, incorporate those into the evaluation. The evaluator will use his/her judgment (and guidance from the ELA Unit) to ensure they do not go beyond the scope of the evaluation.

[11] Health Cluster
[12] http://www.afro.who.int/en/ssd/news/item/6569-the-ministry-of-health-to-declare-cholera-outbreak-in-juba-south-sudan.html

15. Has ACF response to the cholera epidemic in Juba been appropriate to the needs? Needs assessments and beneficiary involvement should be considered.
16. To what extent have ACF emergency response procedures been followed? Are these appropriate and have they facilitated a timely response?
17. Has the surge capacity provision (of the ACF network) been efficiently and effectively managed?
18. To what extent have the different ACF groups (ACF Spain ER Pool, ACF country team, ACF New York etc.) coordinated effectively?
19. Have ACF coordinated effectively with external stakeholders in the response?
20. To what extent have beneficiaries and local communities are involved in the design and implementation of the response?
21. Evaluate the appropriateness and effectiveness of ACF systems (HR, Logistics, and Finance etc.) to support the intended operations.
22. Evaluate the suitability of ACF monitoring systems in place.
23. To what extent is ACF sufficiently prepared for the on-going response to cholera in Juba and the rest of the country?
24. To what extent has learning from other comparable responses (EMS activations (such as Philippines) and cholera response) been drawn on in the response?

## *6. METHODOLOGY OF THE REVIEW*

A full methodology including approach, stakeholder analysis, evaluation matrix, FGD and KII questionnaires, a detailed work plan and interview list will be provided in an Inception Report to the Evaluation Team and Target Users during the preparatory stage. The Inception Report will outline country specific and regional related challenges and issues. Where possible, learning from passed ACF emergency responses (specifically evaluations of responses such as Haiti, Horn of Africa, Ivory Coast, South Sudan and Sahel) will be drawn upon to guide the RTE

### Briefing

Prior to the RTE taking place, a briefing will be conducted over phone with ACF-USA HQ in New York. Briefings will happen at field level and via Skype prior to departure.

### Data Collection

The team will use a mixture of data collection approaches in order to triangulate the data obtained. The following methods will be used:

- Interviews with ACF staff: ACF Technical and Operations staff in New Tork, Emergency Pool and Support staff in both Paris and Madrid where important, ACF-USA support staff in New York and Nairobi, in person interviews with ACF mission staff in South Sudan.
- Stakeholder Interviews: Interviews with beneficiaries and local representatives, meeting with local authorities, groups of beneficiaries, humanitarian agencies, donors, UN agencies and other stakeholders. For indirect data collection, standard and participatory evaluation methods are expected to be used (HH interviews and FGDs with beneficiaries, non-beneficiaries, key informants – health workers, teachers and leaders).
- Secondary information analysis: Analysis of project monitoring data (Activity Progress Reporting, donor reporting and other data) or of any other relevant statistical data. Review of project documentation including monitoring reports, regional and national sitreps, donor reports, Log-frame Analyses, proposals, internal evaluations etc.

## 7. DELIVERABLES

### In Field Debriefing

The evaluator should provide a debriefing before leaving with the following objectives:

- To present the draft findings of the Review to the Country Director and coordination team.
- To gather feedback on the findings and build consensus on recommendations.
- To develop action-oriented workshop statements on lessons learned and proposed next steps. The evaluator will be responsible for facilitating this process, but the Country Director will be accountable for ensuring the recommendations from the RTE are acted upon. The ELA Unit will lend support in terms of tools and advice in this.

### HQ Debriefing

The evaluator should provide a debriefing (via Skype) to the ACF-USA HQ on the main findings, conclusions and recommendations of the RTE.

### Report

- The RTE report shall have a maximum length of 25 pages including the Executive Summary at the beginning of the document, Findings, Conclusions and Recommendations.
- The report will be presented in draft form for comment, before the final report is completed.
- Relevant comments from the Learning Workshop and Debriefing should be incorporated in the final report.

## 8. KEY CONSIDERATIONS AND GENERAL TERMS

The following considerations will need to be taken in planning the evaluation. The Inception Report will outline mitigation strategies.

- Quality and triangulation of data.
- Availability and work load of staff.
- Recommendations will be directed, precise and immediately actionable.

The RTE aims to be light with limited burden on the field teams but rigorous enough to enable a clear understanding of the key issues and challenges of the response through evidence based analysis, and to provide credible conclusions and recommendations. The RTE will provide the evidence base on which Country and HQ teams (See Target Users) can make strategic and technical decisions to improve the quality and scale of the response.

## 9. TIME OF THE RTE

The RTE field work will take place between 25th July & 30th August with document review, briefings and preparation beforehand, and report writing and HQ debriefing afterwards. See attached for a provisional work plan. The assignment will consist of approximately 20 days paid work.

## 10. TEAM

The RTE will be managed by the ELA unit, in close collaboration with target users, and conducted by an external consultant with experience in RTEs, cholera and/or humanitarian work in the South Sudan/East Africa region.

## *11. Best Practice*

The evaluation is expected to provide one key example of Best Practice from the response. This example should relate to the technical area of intervention, either in terms of processes or systems, and should be potentially applicable to other contexts where ACF operates. This example of Best Practice should be presented as an Annex to the report as per the following template. The typically the whole table would be between 200-500 words:

| **Title of Best Practice** |
| --- |
| |
| **Innovative Features & Key Characteristics** |
| |
| **Practical/Specific Recommendations for Roll Out** |
| |

## Appendix B: Best Practice Reporting table

| **Title of Best Practice:** |
| --- |
| Tailoring EMS SOP to ACF mission prior to EP deployment in country |
| **Innovative Features & Key Characteristics** |
| ACF EMS SOP already delineates the support, role and responsibilities from each HQ toward the requesting HQ. It defines the process in general way and highlight key features.<br><br>ACF US decided to tailor this SOP to this particular case, not because South Sudan mission has anything special, but rather ensuring a proper understanding and involvement of all stakeholders throughout the process. ACF US used the time prior to EP deployment by:<br>• promoting thorough communication and coordination between HQs (Paris, NY and Madrid),<br>• and elaborating papers such as management plan and operational guidelines reviewing key issues for all departments and the way it could be efficiently overcome (i.e.: Logistic advisor of ACF US coordinated with ACF Spain, and France and reviewed all key aspects for logistic – proposal, log needs, security, procurement/customs clearance, supply, ICT, Communication, international ACF warehouse, etc.)<br><br>This preparatory work managed firstly to widely inform and prepare each level, and not only DirOps Emergency Pool coordinators and Desks, then by being inclusive to efficiently coordinate means and knowledge, notably institutional experience which is a repeated weakness of ACF in emergency – not to be able to sufficiently access and mobilize institutional experiences in the field –, and finally for ACF mission and the EP members to get familiar and personal even before being in the field. |
| **Practical/Specific Recommendations for Roll Out** |
| • This process has to be inclusive amongst all HQs and not only the requesting HQ and the EP to be deployed and *ad hoc* departments (HR, Admin/Fin, Communication, Logistic, Coordination and the appropriate technical departments);<br>• Remind that the process matters more than the documents produced;<br>• Requesting HQ: leading HQ for this process;<br>• This work will be complementary of mission EPRP. |

## Appendix C: Itinerary and meetings

| Date | Activity | Location |
|---|---|---|
| | Phase 1: Set up and inception | |
| 21/07 | Briefing with HQ | France |
| 28/07 | Document review to be selected | South Sudan |
| 28/07 | General and Epidemiological context analysis | South Sudan |
| 30/07 | Draft and submit the inception report | South Sudan |
| 29-31/07 | Briefing with Key informants from the EP Madrid | South Sudan |
| | Phase 2: Data collection and analysis | |
| 31/07 | Finalize Data collection instruments | South Sudan |
| 03/07 | Review of inception report | South Sudan |
| 04/08 | Refine interview tools | South Sudan |
| 05/08 | Formal document review | South Sudan |
| 05/08 | Key informant interviews | South Sudan |
| 05/08 | Focus group discussions | South Sudan |
| 06/08 | Consolidate data in analysis framework | South Sudan |
| 06/08 | Conduct initial triangulation analysis | South Sudan |
| 06/08 | Draft preliminary findings | South Sudan |
| 07/08 | Prepare preliminary analysis presentation and discussion questions | South Sudan |
| | Phase 3: Reporting | |
| 10/08 | Conduct further analysis on key questions | France |
| 12/08 | Draft final report | France |
| 13/08 | Submission of draft report | France |
| 17/08 | Review of draft report | France |
| 18/08 | Debriefing HQ on RTE recommendations and draft report | France |
| 21/08 | Finalize report incorporating comments | France |
| 22/08 | Submission of final report | France |

**Persons interviewed:**

| | ORGANISATION | Position | Name |
|---|---|---|---|
| 1 | ACF - South Sudan | Cholera WASH PM | Iván Álvarez |
| 2 | ACF - South Sudan | Cholera WASH PM | Murindi Taru |
| 3 | ACF - South Sudan | deputy WASH PM | Kumi Anthony Tobiolas |
| 4 | ACF - South Sudan | deputy WASH PM | Henry Acidri |
| 5 | ACF - South Sudan | HP Supervisor | Robert Mori Patrick Dikwat |
| 6 | ACF Spain- Emergency Pool | Wash Coordinator | Roberto Arranz |
| 7 | ACF Spain- Emergency Pool | Emergency Coordinator | Chiara *Saccardi* |
| 8 | ACF Spain- Emergency Pool | Logistic Coordinator | Cristina Sainz de Vicuña |
| 9 | ACF Spain- Emergency Pool | Admin/Fin Coordinator | Romina *Rojek* |

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|---|---|---|---|
| 10 | ACF - South Sudan | Country Director | Aleksandra *Todorovic* |
| 11 | ACF - South Sudan | Wash Coordinator | Jack |
| 12 | ACF - South Sudan | Admin/Fin Coordinator | Charles *Mwakera* |
| 13 | ACF - South Sudan | HR Coordinator | Joy *Magadju* |
| 14 | ACF - South Sudan | Logistic Coordinator | Guillaume Mathieu |
| 15 | ACF NY | Desk | Nipin Gangadharan |
| 16 | ACF NY | WASH advisor | Nick Radin |
| 17 | ECHO | Field Expert | Laetitia Beuscher |
| 18 | UNICEF | WASH Director | Lililan Okwirry |
| 19 | UNICEF | Wash specialist | Robert Odong P'Duny |
| 20 | WASH Cluster | Coordinator | Jesse Pleger |
| 21 | WASH Cluster | Cholera Coord | Silvia Ramos |
| 22 | WHO | WHO Surge | Joseph Wamala |
| 23 | MSF-Epicentre | | |
| 24 | Quarter council | Juba Na Bari | |
| 25 | Community volunteers | Mouna | |
| 27 | OXFAM | Wash Coordinator | Paco del Pozo |
| 28 | OXFAM | Public Health Coord | Jeffrey Silverman |

## Appendix D: Evaluation matrix

| Objective 1: | | Evaluate the effectiveness and efficiency of ACF operations in Juba County since the declaration of the epidemic (6th May 2014[13]). | | | | | |
|---|---|---|---|---|---|---|---|
| # | Criteria | # | Sub-Questions | Measure/indicator | Source type | Data collection method | Main position to be consulted |
| 1 | Effectiveness | 1 | To what extent ACF intervention objectives in Juba are on track to be achieved? | Evidence within activities progress reports that show the degree of completion of all activities | Quantitative | Document review | |
| | | | | Evidence based on project planning and monitoring | Quantitative and qualitative | Document review | |
| | | | | Epidemiological data in the areas of intervention | Quantitative | Document review and interviews | WASH PM, WASH Co, medical actors, WASH cluster |
| | | | | Evidence on the field of activities realized | Quantitative and qualitative | Field visit, Interviews | ACF Juba Wash team, Quarter Councils |

[13] http://www.afro.who.int/en/ssd/news/item/6569-the-ministry-of-health-to-declare-cholera-outbreak-in-juba-south-sudan.html

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|---|---|---|---|---|---|---|---|
| | | 2 | To what extent have all activities planned, their implementation methodology and timeframe contributed to achieve the objectives? | Consistency between activities planned and realized, and potential epidemiological routes of transmission in Juba town and existing conditions of WASH services in Juba | Qualitative | Document review and interviews | WASH PM, WASH Co, Cholera Taskforce coordinator |
| | | | | Evidence based on activities realized, their potential importance and limitations | Qualitative | Document review and interviews | WASH PM, WASH Co, Cholera Taskforce coordinator |
| 2 | Efficiency | 1 | To what degree is ACF sufficiently prepared and designed for the on-going response to cholera in Juba and the rest of the country? | Budget forecast and follow-up<br><br>Overall expenses | Quantitative | Document review and interviews | WASH Co &PM, Admin officer & Co, |
| | | | | Evidence on Contingency stock and supply capacity | Quantitative and qualitative | Document review and interviews | WASH Co &PM, Log officer & Co, |
| | | | | Active cholera surveillance and monitoring in the areas of intervention | Quantitative and qualitative | Document review and interviews | Field Co, WASH Co |
| | | | | Human Resources capacity and training (programs and support) | Quantitative and qualitative | Document review and interviews | WASH Co &PM, HR officer & Co, |
| | | | | Capacity for ACF to raise extra funding | Qualitative | Document review and interviews | CD, DCD, WASH Co |

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| | | | | Evidence on how ACF integrated security constraints in the implementation of their activities | Qualitative | Document review and interviews | CD, WASH Co, Log Co, |
| | | | | General evidence on how ACF improved their readiness and capacity of respond to cholera in areas of focus | Qualitative | Document review and interviews | CD/DCD, Wash Co, Field Co |
| 3 | Relevance / appropriateness | 1 | Has ACF response to cholera epidemic in the areas of intervention been appropriate to the local needs and to this specific epidemiological pattern? | Evidence that this epidemiological pattern led to risk analyses and field assessments in order to define the prioritization of areas of intervention and activities for a rapid and effective response | Quantitative and qualitative | Document review and interviews | Epidemiologists, WASH PM, Cholera taskforce, WASH cluster, WASH EP Madrid |
| | | | | Evidence on the integration and respect of local context, community organization structures, traditions, beliefs into the implementation strategy | Qualitative | Document review and interviews | WASH PM, Deputy WASH PM, Beneficiaries, WASH EP Madrid |
| | | | | Evidence on how ACF response strategy was elaborated taking into account activities to implement, fields constraints and their particular timeframe | Qualitative | Document review and interviews | WASH Co, WASH PM, WASH EP Madrid |
| | | | | Perception of ACF works by | Qualitative | Interviews | Beneficiaries, |

| | | | | | | | |
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| | | | | local community, local authority, cluster and other NGOs, national authority, technical directorates, donors | | | WASH cluster, ECHO, UNICEF, Ministry of Health, Ministry of Water |
| | | | | Contingency measures taken by ACF to overcome any risks and/or blockages previously identified | Qualitative | Document review and interviews | WASH Co, WASH PM, WASH EP Madrid, Log Co, Admin Co |
| | | | | Evidence that ACF cholera response plan took into consideration exit strategy and/or was defined considering the next steps (from cholera outbreak to cholera primarily prevention) | Qualitative | Document review and interviews | WASH Co, WASH PM, WASH EP Madrid |
| 4 | Coverage | 1 | To what extent has ACF response covered local needs due to the cholera epidemic? | Evidence within cholera taskforce situation reports, (needs assessment, gaps, 3W matrix) | Qualitative | Document review and interviews | WASH Co, WASH PM, WASH EP Madrid |
| | | | | Number of beneficiaries reached | Quantitative | Document review | |
| | | | | ACF Needs assessments – methodology used | Qualitative | Document review | WASH EP |

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|---|---|---|---|---|---|---|---|
| 5 | Coherence | 1 | Has ACF coordinated effectively with external stakeholders in the response? | Perception of local authorities | Qualitative | Interviews | Local authorities |
| | | | | Perception of other WASH partners | Qualitative | Interviews | Oxfam, Medair, PIN, PAH, UNICEF, CRS |
| | | | | Evidence on their role and active participation in clusters and ad hoc coordination meetings | Qualitative | Interviews and document review | UNICEF, Medair as WASH Cluster Lead, WHO, Health cluster lead |
| | | | | Coherence with WASH local/national policies and national cholera response plan | Qualitative | Interviews and document review | Ministry of water, Ministry of Health and technical directorates |
| | | | | Coherence with donor policies | Qualitative | Interviews and document review | ECHO, UNICEF |
| 6 | sustainability | 1 | To what degree has this cholera response activity created an opportunity for ACF? | Willingness of ACF to be positioned in Juba base and developed WASH programs, especially in high cholera risk areas | Qualitative | Interview | CD, DCD, WASH Co |

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| | | | | Evidence on how ACF South Sudan integrated cholera epidemic risks into its country strategy | Qualitative | Interview and document review | CD, DCD, WASH Co |
| | | | | ACF strategy Linking Relief, Rehabilitation and Development | Qualitative | Interview and document review | CD, DCD, WASH Co |
| | | 2 | To what degree has ACF program raised community awareness about cholera prevention and cholera epidemic and realized activities to sustainably reduce cholera risks preventing future epidemics in Juba County. | Knowledge on cholera of the local population in the area of intervention, post intervention | Qualitative | Interviews | Beneficiaries, local authority, community volunteers |
| | | | | Evidence to sustain behavior changes within the targeted population | Qualitative | Interviews | Beneficiaries, local authority, community volunteers |
| | | | | Evidence on reduction of risk factor for cholera outbreak within the area of intervention | Quantitative and qualitative | Document review and Interviews | Beneficiaries, local authority, community volunteers |
| 7 | Impact | 1 | Has ACF response achieved to contain and prevent the spread of cholera in the identified risk zones/areas? | Weekly attack rate in the areas of intervention | Quantitative | Document review | |
| | | | | Consistency between epidemiological pattern and ACF activities and timing in the | Quantitative and qualitative | Interviews and document review | Epidemiologists, MSF |

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| | | | | field | | | |
| 8 | Monitoring | 1 | Is ACF monitoring system for cholera response suitable to provide qualitative and quantitative data in order to ensure accountability towards beneficiaries, other stakeholders (local and national authority, NGOs, UNs) and donors? | Evidence on how M&E system is effective and feeds into the program | Qualitative | Interview and document review | Wash Co&PM, Deputy WASH PM, |
| | | | | Existing Tools (Post Distribution Monitoring, KAP surveys, borehole rehabilitation completion forms, etc.) | Qualitative | document review | |
| | | | | Existing beneficiary complaint mechanisms | Qualitative | Interview and document review | Wash Co&PM, Deputy WASH PM, beneficiaries |
| | | | | Lessons learnt from the implementation of the emergency cholera response | Qualitative | Interview and document review | Wash Co&PM, Deputy WASH PM |
| 9 | Cross-cutting issues | 1 | To what extent has ACF cholera response taken into consideration cross-cutting issues? | Evidence showing cross-cutting issues were integrating to the PCM | Qualitative | Interview and document review | Wash Co&PM, Deputy WASH PM |
| | | | | Cross-cutting elements taken into consideration at the mission level (community involvement in the design and implementation to ensure better ownership, right to water | Qualitative | Interview and document review | Wash Co&PM, Deputy WASH PM |

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| | | | | in emergency, environmental impact of ACF response, etc.) | | | |
| Objective 2: | | Evaluate the effectiveness, efficiency and appropriateness of the response related to the EMS activation. | | | | | |
| 1 | Relevance/appropriateness | 1 | To what degree have ACF systems (HR, Logistics, and Finance, etc.) been appropriate to support the intended operations? | Consistency between EMS SOP and Spanish EP deployment in South Sudan | Qualitative | Document review and interviews | ACF HQ, Spain EP |
| | | | | Evidence on the timeline for activities implementation | Qualitative | Document review and interviews | Spain EP |
| | | | | Perception of Spanish EP, HQ and ACF country mission | Qualitative | Document review and interviews | ACF HQ, EP, ACF country team |
| | | | | Evidence on the constraints identified and that hindered the response | Qualitative | Document review and interviews | Spain EP |
| 2 | Efficiency | 1 | To what extent have ACF emergency response procedures been followed? | Evidence on how ACF Emergency response procedures were followed | Qualitative | Document review | |
| | | | | Perception of Spanish EP, HQ and ACF country mission | Qualitative | Interviews | Madrid Log & Admin EP, Log Co, Admin Co |
| | | 2 | To what degree has the surge capacity provision facilitated a timely response? | Timeframe for implementation of activities | Qualitative | Document review | |
| | | | | Perception of Spanish EP, HQ | Qualitative | Interviews | Madrid Log |

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|---|---|---|---|---|---|---|---|
| | | | | and ACF country mission | | | & Admin EP, Log Co, Admin Co |
| | | | | Perception from other cholera response stakeholders | Qualitative | Interviews | Medair, UNICEF, ECHO, Oxfam |
| 3 | Effectiveness | 1 | Has the surge capacity provision (of the ACF network) been effectively managed? | Evidence based on activities realized and timeframe | Quantitative Qualitative | Document review | |
| | | | | Consistency between EMS Request for Declaration and activities completed in mission | Quantitative Qualitative | Document review | |
| | | | | Perception of ACF country team and Madrid EP | Qualitative | Interviews | ACF country team and Spain EP |
| 4 | Coherence | 1 | To what extent have the different ACF groups (ACF Spain ER Pool, ACF country team, ACF New York etc.) coordinated effectively? | Perception of each team members | Qualitative | Interviews | ACF HQ, EP, ACF country team |
| | | | | Perception from cholera response stakeholders | Qualitative | Interviews | Cholera cluster, WASH cluster |
| | | | | Evidence on how easily ACF country mission is taking over ACF Spain EP | Qualitative | Interviews | ACF country team |