

# Lebanon

## Cholera Outbreak Situation Report No 2

29 October 2022

### Epidemiological Overview

As of 28 October 2022, 3 weeks after the official declaration of a cholera outbreak by the Ministry of Public Health (MoPH) in Lebanon 1,225 confirmed and suspected cholera cases have been reported in the 9

governorates of Lebanon (Beirut, Akkar, North, Keserwan-Jbeil, Mt. Lebanon, Bekaa, Baalbek-Hermel, South, Nabatieh) according to the Lebanon Ministry of Public Health (MoPH). The cazas of Akkar, Minnieh-Dinnieh, Baalbek, Zahle and Keserwan are most heavily affected at present.

All cases (suspected and confirmed)		Confirmed Cases past 24 hours		Deaths (confirmed)	
New	Cumulative	New	Cumulative	New	Cumulative
130	1225	3	371	1	16

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A total of 16 associated deaths have also been reported with a case fatality ratio (CFR) of 1.37%. It is reported that 46% of cases are children under the age of 15, of which more than half are in children under 5 years old. Among all cases, 23% have required hospital admission.

Serotype *Vibrio Cholerae* O1 El-Tor Ogawa was identified as the currently circulating Cholera strain in Lebanon, similar to the one circulating in the region.

WHO has conducted a grading exercise of the current cholera outbreak in Lebanon and has assessed the overall risk to be very high at the national level due to:

- Initial outbreak arising in a higher risk area;
- Pre-existing compounded crises in Lebanon;
- Derelict health, water and sanitation services and systems;
- Scarcity and unaffordability of reliably safe water, triggering reliance on other unsafe water sources;
- Funding shortfalls for already on-going humanitarian programs;
- Limited knowledge, technical expertise and experience about cholera among the general population, health care providers and aid organizations in Lebanon due to nearly 20 years since the previous outbreak; and
- Continuous movements across the borders of Lebanon and Syria where outbreaks are occurring in both countries.

# Cholera Outbreak Response

## Multi-Sectoral Coordination and Leadership

The MoPH has developed the Lebanon Cholera Preparedness and Response Strategic Plan and Operational Plan with the support of the aid community under the overall coordinating and advising role of the WHO as lead in Health Emergency response. The overall response to the cholera outbreak is led by the MoPH on behalf of the Government of Lebanon. A national Task Force, chaired by the Minister of Public Health, convenes twice a week and gathers representatives from the different Ministries involved in the response, as well as the LCR, ICRC, and representatives from the UN agencies and NGO partners. A cross-ministerial group is also meeting on an *ad hoc* basis under the chairmanship of the Prime Minister, with the secretarial support of the Disaster Risk Management (DRM) unit in the office of the Prime Minister.

Representatives from WHO, UNHCR, UNICEF, IOM, UNRWA, Amel, LebRelief and OCHA are attending the national Task Force on behalf of the HCT and Health, WaSH and RCCE sectors and task force. Attendance has also been expanded to include representatives from donors, and NGOs.

On 22 and 23 October, the Minister of Health together with officials from WHO, UNICEF, UNHCR, IOM and UNRWA visited health facilities and water stations in Akkar, Tripoli, Minieh-Doniyeh, Baalbeck, Aarsal and other locations to monitor the cholera situation and response activities, while meeting with local officials and communities.

Under the leadership of the MoPH, WHO, as the overall coordinator of this health emergency, along with UNHCR and Amel Association (Amel) as co-lead and co-coordinator of the Health sector respectively, play a critical technical advisory role in the response planning. The Water, Sanitation and Hygiene (WaSH) sector, under the co-coordination of UNICEF and LebRelief (alongside MoEW for the LCRP), as well as the RCCE Task Force and other sectors are also supporting the development and implementation of the plan.

The Health and WaSH sectors have initiated a partner mapping across the country to assess level of readiness and identify gaps. At the same time, MoPH has initiated a registration of all health actors involved in the response with the coordinating support of the Disaster Risk Management (DRM) unit in the Office of the Prime Minister.

At the sub-national level, DRM committees within the offices of the Governors, are being activated to support coordination of the response. The regional Health and WaSH sector coordinators continue working closely with the sectors at national level as well as other sectors, including as part of regional Inter-Sector Working Groups, to ensure an efficient and coherent response from the aid community, in support of the Government plan.

Health, WaSH and RCCE sectors are supporting the rapid response capacity of the Government through integrated Cholera Rapid Response Teams (C-RRT) which intervene at the household

level, alongside MoPH officials, for case-area targeted interventions (CATI) and cross-sectoral support for patients' families and surroundings.

## Health

The aim of the multisectoral cholera prevention, preparedness and response plan is to reduce the potential of mortality and morbidity from cholera and acute watery diarrhea (AWD) amongst the affected population during the outbreak through preparedness, early detection and implementation of appropriate control and public health containment measures. The health sector strategy for controlling and eliminating cholera includes enhancing case management capacity for severe cholera cases; ensuring effective routine surveillance and referral networks together with laboratory capacity at peripheral levels to confirm suspected cases, inform the response and track progress towards elimination; strengthening healthcare system – through capacity building for staff, pre-positioning of resources and supplies for diagnosis, patient care and emergency WaSH interventions.

### Coordination:

On 27 October, the health sector facilitated a cholera coordination meeting with the MoPH and health partners. More than 80 persons attended from at least 47 agencies (health NGOs, UN agencies, Red Cross/Red Crescent affiliates, and donors) as well as the MoPH departments of Hospitals and Dispensaries, Epidemiological Surveillance Unit and Primary Health Care. In addition to the epidemiological overview, the meeting focused on the MoPH strategy for integrated Cholera Rapid Response Teams (C-RRTs) and case management within diarrhea treatment centers (DTCs) at hospitals and diarrhea treatment units (DTUs) and oral rehydration points (ORPs) at primary health care centers (PHCCs). Updates on the plan for introduction of oral cholera vaccine (OCV) were also shared. Finally, the MoPH reminded partners about the importance of coordinating plans and ensuring information is registered in the response dashboard operated by the Lebanese Red Cross (LRC) together with the DRM unit. So far, 30 health agencies have registered on the online dashboard of the DRM unit.

### Surveillance:

WHO supported and facilitated the ongoing field investigations of suspected cholera cases in high-risk areas, including testing kits, transportation and additional human resources. The agency also supported seven training sessions for cholera surveillance and case management at central and peripheral levels. Additional technical surge capacity is requested by WHO through the Global Outbreak Alert and Response Network (GOARN).

IOCC and Relief International (RI) are supporting MoPH Epidemiological Surveillance Unit (ESU) in collecting stool and water samples in North/Akkar and Bekaa/Baalbek respectively. Throughout normal operations at PHCCs and community level, IMC, IRC, PUI, and RI are ensuring they report suspected AWD/cholera cases to the ESU.

Following a meeting on 25 October chaired by the Health sector, ToRs and algorithm of coordination for the C-RRTs were finalized. The complete package will be shared with partners

and field coordination teams this week. The C-RRT model is embedded in a comprehensive alert-response strategy that includes multiple layers of engagement with households, communities, and referral to healthcare facilities, providing a wide range of complementary actions to support the control and prevention of cholera transmission. C-RRTs will support all population groups and nationalities, under the national cholera response plan.

The C-RRT will be led by the MoPH Emergency Operation Center at the national level and by the Qadaa Physicians' offices at sub-national level. The Qadaa Physicians will be responsible to initiate the preliminary control/containment measures needed to prevent further spread of the disease in coordination with the DRM, Prime Minister's Office and the National Cholera Task Force led by the Minister of Public Health, and municipalities. The C-RRT will coordinate with relevant ministries as needed, including the Ministry of Energy and Water (MoEW), Ministry of Environment (MoE), and Ministry of Interior and Municipalities (MoIM).

### Laboratory

Two referral laboratories are now operational: AUB-WHO collaborating center and RHUH reference microbiology laboratory, with support from WHO in terms of reagents and supplies.

A total of 1,000 rapid diagnostic tests (RDTs) were made available by WHO and distributed to 12 referral hospitals, as well as the ESU at the MoPH.

WHO completed the assessment of the eight water quality monitoring laboratories previously established at governmental hospitals in 2016 (1 laboratory per governorate). Five of these laboratories are ready for reactivation of testing; WHO is mobilizing rapid support to operationalize these laboratories.

### Case Management, and Infection, Prevention and Control (IPC)

WHO completed the rapid assessment of 10 out of the 12 Governmental hospitals, assessing mainly the IPC measures and their capacity to safely treat and manage cholera patients. Most of these hospitals need waste management capacity-building and IPC support, case management and supply kits, as well as training on case management and adequate care for severe cases. Under the leadership of the MoPH and its Emergency Operations Center, WHO is currently supporting medical teams to provide advanced training and coaching on case management and IPC practices to frontline health workers at referral hospitals.

On 25 October, MoPH launched a field hospital at Al-Iman Medical Center in Akkar with supplies provided by UNICEF. The hospital aims to relieve pressure from nearby Halba Governmental hospital and increase case management capacity to the overall response. The field hospital will operate 24/7 and is equipped with 20 beds as well as supplies sufficient to treat more than 500 patients. A paramedics team composed of LRC and NGOs is on standby for patient transport to DTC as needed.

MoPH released a memo on case management of cholera cases ([here](#)). It defines the IPC measures to be taken, including conducting an initial assessment of the suspected case, case-

management actions as well as identifying the 12 governmental hospitals designated as DTCs for cholera treatment.

MoPH has also finalized its strategy for case management at primary health care (PHC) level. All PHCCs will have the following 4 key roles

**1. RCCE:**

- All PHCCs to be mobilized for awareness and prevention campaigns (including outreach)
- Distribute brochures, chlorine products, hygiene kits.

**2. Entry point**

- Assess patients with AWD for dehydration.
- Refer to the appropriate cholera management facility according to case severity.
- Generate alerts, ensure linkages to surveillance.

**3. ORS**

- Distribute ORS, safe water and dispensers to prepare rehydration solutions.

**4. OCV**

- Serve as immunization centers for cholera (upon reception of vaccines)

Additionally, 20 selected PHCCs located in areas with limited access to affordable hospital services or absence of any other healthcare facility (secondary care) and with necessary infrastructure and staffing will be capacitated to become DTUs to stabilize patients. There is an urgency to establish DTUs in hotspot areas in Akkar, Tripoli and Bekaa. The cholera primary health care strategy suggests a phased process whereby selected PHCCs are activated for DTU services during normal business hours and later upgraded to 24/7 operations if needed.

A technical working group has been established by the MoPH with the aim of training, coaching and monitoring cholera case management practices at referral hospitals as well as establishing case management SOPs for the PHC level. The teams will be supported by WHO experts, and will include IPC practices.

UNRWA has established a fast-track procedure for symptomatic patients and referral for those in need of higher level care within its 27 supported PHCCs.

Regarding hospitalization costs, the MoPH updated the tariffication for emergency room care (ERC), intensive care unit (ICU) and regular care for cholera. The MoPH will be reimbursing the cost of hospitalization and ERC for Lebanese cholera patients, while UNHCR will be reimbursing cholera care for Syrian refugees, IOM for migrants and UNRWA for Palestinian refugees.

IMC has trained 220 staff on cholera awareness, prevention and first line case management according to MoPH protocols

Additionally, 95 community outreach workers have been trained on cholera awareness, prevention and key messages by IMC, IRC and PUI - with support of Balamand University - across Akkar, North, Beirut/Mount Lebanon, South and Nabatiyeh governorates.

IOCC, IMC, IRC and PUI have strengthened IPC, including cleaning and disinfection measures, at PHCCs they support: IRC is providing personal protective equipment (PPE) to three PHCCs in Akkar (Halba, Kouachra and Hrar).

### Oral Cholera Vaccines (OCV)

Due to the global vaccine shortage, OCV will be made available as one dose in countries that have outbreaks. With the support of WHO and UNICEF, the MoPH requested the International Coordinating Group for Vaccine Provision (ICG) 600,000 doses of cholera vaccine for the most vulnerable population groups, and the stock availability has been confirmed for use in Lebanon. WHO, UNICEF and UNHCR will work collaboratively to mobilize resources to procure and roll out the vaccine. WHO is also supporting the MoPH to seek further OCV doses given the challenging WASH situation in the country and the need to bolster the response and quickly combat the outbreak to prevent cholera from becoming endemic in Lebanon. MoPH has also been notified that it will receive a donation of 12,000 OCV doses from France (Sanofi) to be used in the prison population as part of those high-risk settings.

### Logistics, Kits and Supplies

With the support of WHO and UNICEF, 73 cholera kits (20 central, 13 periphery, 40 community) have been delivered in Lebanon sufficient to cover 2,200 severe cases and 5,180 moderate cases. An additional 175 kits (25 central, 20 periphery, 125 community) have been ordered. ORS sufficient for 150,000 people has been delivered, with additional supplies for 200,000 people in the pipeline. WHO supplied 1,000 rapid diagnostic tests (RDTs) while another 13,000 RDTs are expected to be delivered to the MoPH in the coming days. UNHCR also has 15,000 RDTs in the pipeline. Finally, WHO donated supplies to the reference laboratory to perform laboratory analysis (culture) for a large number of samples.

BEYOND, Ibad Al Rahman Association, IOM, Medair, MSF, UNHCR, UNRWA and WHO have initiated procurement of key cholera supplies and equipment including cholera kits, oral rehydration salts (ORS), personal protective equipment (PPEs), RDTs, intravenous (IV) and IV kits, medical supplies and medicines for hospitals. Caritas Lebanon maintains a small buffer stock of antibiotics and is procuring additional medications and ORS. IOCC has disbursed ORS to 310 individuals across 9 cadas in Akkar and 100 individuals across 3 cadas in the North.

### **Water Sanitation and Hygiene (WaSH)**

In order to ensure readiness and response capacity under the multi-sectoral plan, the WaSH sector will prioritize improving water safety, including through ensuring safe drinking and domestic water, adequate hygiene and awareness in the community and at schools; restoring and sustaining functionality of wastewater treatment systems; ensuring up-to-standard WaSH services in Informal Settlements; or sustainable improvements in water supply, sanitation, food safety and proper water quality monitoring as well as community awareness of preventive measures, particularly at identified AWD/cholera hotspots throughout the country.

## Support to Communities

The WaSH sector has mapped cholera risk alongside partners' capacity and available stocks across the country.

Preventive and preparedness interventions in all informal settlements supported by the WaSH sector partners are ongoing across the country. Partners ensure the services are delivered in line with the sector standards and according to agreed protocols, with water provision at the level of 35 l/c/d. Partners have enhanced water safety monitoring with the Free Residual Chlorine level of 0.5 mg/l at the point of delivery and desludging conducted with monitoring of the level of the wastewater cesspools/pits. Partners promote water tanks and jerry can cleaning campaigns and raise awareness on cholera prevention.

UNICEF with its partners AAH, DPNA, LebRelief, LOST, SCI, SI, and WVI has initiated the full-scale cholera WaSH response in over 50 informal settlements and a few collective shelters with suspected or confirmed cases (including water testing, water tanks cleaning, hygiene kits distribution and awareness raising, disinfection spraying, increasing the safety of water and wastewater disposal). UNICEF has supplied WaSH partners with a total of 4,934 Cholera family hygiene kits, while ICRC provided LRC with 700 kits. To date, 425 Cholera disinfection kits and 866 Cholera family hygiene kits have been distributed. In addition, 2,150 chlorine tablets (NaDCC) have been distributed through 4 partners in Bebnine and Aarsal.

### Prepositioning:

Sector partners have prepositioned various relief items across the country, including over 10,000 cholera disinfection kits, over 35,000 cholera family hygiene kits and 10,000 PPE disinfection kits for frontliners, 150,000 soap bars, 100 water tanks and limited household level water treatment tablets, and over 50,000 Aquatabs. In addition, UNICEF has prepositioned 30 tons of gas, liquid, and powder chlorine, that are ready to be dispatched to Water Establishments based on their requests/needs.

### WASH support to Water Establishments and Wastewater Systems:

UNICEF has continued to maintain and repair pumping stations and chlorination systems across Lebanon. Maintenance and repair of 13 chlorination systems in the North Lebanon Water Establishments has been completed in the following stations: Kwachra, Mashta Hassan, Mashta Hammoud, Qobayat station, Kfarhabo, Kadi spring, Jradeh, Chakdoun, Deir Amar, Markebta, Hekr el Koussa and Sir el Dinnieh village. Two main generators in Tripoli, Abouhalka and Al Manar, have been maintained. In addition ICRC is starting this week the rehabilitation of the solar system of Wadi Sweid pumping station (Aarsal), replacing the broken valves of Wadi Matlab pumping station (Aarsal) and rehabilitation of chlorination units in 3 pumping stations in Aarsal (Ain Chaab, Wadi Matlab and Wadi Sweid).

Fuel distribution has also been a priority with a total of 118,700 litres distributed by UNICEF, while ICRC provided 24,000 litres. To run the most critical water supply systems in affected areas the North Lebanon Water Establishments was supported with 64,000 litres, while Bekaa Water



Establishments were supported with 17,700 litres. Tripoli wastewater treatment plant has also received 37,000 litres of fuel to resume and maintain the operation and be able to receive desludging trucks from the North and Akkar. ICRC secured fuel to operate Ain Ali pumping station (Arsal) until the solarization of the station is completed.

The replenishment of all four Water Establishments' (WE) chlorine stock has been completed. In total 10.4 tonnes of chlorine liquid has been distributed.

ICRC has donated water monitoring and testing consumables and chemicals to the 3 labs of North Lebanon Water Establishment. Additional items were requested from abroad and are being imported. Support for the laboratories of the Beirut and Mount Lebanon WE and the South WE with water monitoring and testing consumables and chemicals is upcoming.

In 12 Palestinian camps, UNRWA continued bacteriological water testing of main water tanks (21 samples collected this week) and several end-user points for free residual chlorine and total chlorine tests (on a daily basis 6 samples in each camp are taken to ensure chlorination at the source is done at the appropriate level).

Collection of solid waste from camps to main municipalities' dumping areas in the five areas of operations continued.

### Places of Detentions

ICRC provided chlorine and test kits to Roumieh, Zahle and Qobbeh central prisons, and is awarding contract for supply consumables to all prisons and places of detention (powder chlorine, pool testers with accessories, DPD1 & Red phenol tablets) and training of the operators. On 24 October, emergency works on the water supply system started at Roumieh Central Prison started.

### **Risk Communication and Community Engagement (RCCE)**

In consultation with WHO and partners, UNICEF developed a preparedness and response RCCE strategic plan included in the integrated inter-sectoral National Cholera Prevention, Preparedness and Response Plan, led by the Ministry of Public Health. The RCCE plan aims to promote key identified behaviors, practices, and messages in scaled-up community engagement and social mobilization interventions with community-level, local, and national stakeholders.

RCCE partners have been mobilized and are conducting awareness raising and community engagement activities in all governorates, targeting all communities in country with specific efforts in hotspot areas, ensuring wide and extensive capillary reach, aiming to increase the public's knowledge on Cholera prevention and positive behaviours, in addition to the distribution of ORS to people suffering from diarrhea. UNICEF, as RCCE Task Force lead, is ensuring coordination with other sectors and actors on the ground to ensure an integrated response. Furthermore partners are gathering concerns and questions from communities to better inform collective interventions and messages.



To better inform outreach, community engagement and social mobilization interventions as well as contextualized awareness sessions were designed and are being conducted by UNICEF and Balamand University for partners and community-based organizations (CBOs) to increase knowledge on Cholera and AWD (Acute Water Diarrhea). The sessions include key messages on Cholera/AWD overview, transmission, symptoms, treatment, prevention, FAQs, and referral mechanisms. From 8 to 21 October, 24 training sessions were conducted, while additional sessions are currently being planned. So far, more than 5,000 participants from NGOs, CBOs, and sectors were trained which included UNICEF partners, UNHCR partners and outreach volunteers, technical and vocational education and training (TVET) teachers and nurses, WaSH/Health/Child Protection sector and partners, frontline workers, municipalities, and community volunteers.

UNICEF has facilitated the activation of crisis cells in several localities to raise awareness on prevention measures such as monitoring water trucking and mobilizing key stakeholders. Several local consultations are also being conducted including in the South and Mount Lebanon, in addition to engagement with municipalities in Bekaa and Baalbek-Hermel, and crisis cells in North and Akkar. Furthermore, key prevention measures were identified and are mainstreamed across all partners, who are encouraged to attend the sensitization sessions.

Enhanced coordination is being conducted with different sectors, UNHCR, WHO, UNRWA and different agencies and stakeholders to better inform and implement activities and interventions, and preparations for the sensitization sessions for public and private schools in coordination with MEHE are underway.

Cholera IEC materials have been designed, shared, and disseminated with partner organizations, key actors, and the media. This includes:

- A 2-pager flyer with information for the general public, community groups, caregivers, healthcare workers, and teachers. The flyer can be printed or shared digitally through platforms like WhatsApp.
- Posters disseminated in key public places in the affected areas like clinics, schools, and markets.
- Leaflets with more detailed information for sectors, partners, and frontline workers/volunteers are being shared in Arabic and English.
- Information shared via social media.
- An animation video for TV and social media has been disseminated
- Child friendly messages and materials are being designed to target schools, children and teachers, and materials translated in several languages with IOM to reach out migrant workers. Messages were also adapted for capacity building to engage people with disabilities, in collaboration with organizations of persons with disability (OPDs) .
- Cholera IEC materials (posters and flyers) have been printed and massively distributed to municipalities and communities with the Lebanese Red Cross through the MMUs under the immunization program, as well as through direct distribution to partners and other stakeholders from UNICEF. Several social media post and videos were also regularly shared on partners' and national social media and TV channels.

RCCE health partners such as Amel, ANERA, Hariri Foundation, Humedica, IMC, IOCC, IRC, Medair, MSF, PUI and RI are also conducting awareness sessions and distributing IEC materials within their supported PHCs and MMUs. Mobile midwifery teams have also integrated cholera awareness within their outreach activities. Since the beginning of October IOM have mobilized 43 hygiene and health community workers in North, Bekaa, Beirut/Mount Lebanon, and South to raise awareness on cholera prevention, symptoms, treatment and referral pathway reaching around 15,000 individuals in cholera hotspots.

### Challenges/Gaps

- Due to the ongoing economic crisis in Lebanon and related migration of professionals out of the country, there is an insufficient number of health care workers operating across the country while at the same time there is a shortage of health partners to support at the secondary level. Similarly, there is a significant 'brain drain' of technical and managerial staff of Water Establishments, disabling proper functionality of the water and sanitation systems.
- The crisis also has impacted health and surveillance systems which have very limited capacity.
- Some of the designated referral hospitals lack adequate space to manage cholera patients.
- Available medical and non-medical cholera supplies are insufficient for the required response. There are also global shortages of critical cholera supplies such as RDTs and vaccines.
- Ongoing electricity blackouts and heavy reliance on generators in Lebanon have a devastating impact on the ability of water and wastewater systems to properly function, as well as operational impact across all actors and partners involved in the response. The current water tariffs are inadequate to the context. Collection and subscription rates are chronically insufficient, contributing to a huge gap between expenses and revenues, resulting in the inability of Water Establishments to cover operation and maintenance costs.
- Prevention requires substantial investment in systems – particularly water supply, wastewater treatment and their connections to functioning electrical service lines.
- Failure to mobilize a rapid, comprehensive response could result in cholera becoming endemic in Lebanon.

### Key Priorities

- The outbreak is rapidly spreading and Government leadership, as well as the involvement and coordination of all relevant Government institutions and partners is critical.
- Both prevention/preparedness and response activities, including fuel to operate water supply and wastewater treatment systems, are priority to ensure swift and efficient curbing of the outbreak. Ensuring sustained electricity supply over the longer term remains critical to avoid a long-lasting and wide outbreak.
- Response activities should aim to prioritize the needs of high-risk and vulnerable groups and settings, including securing adequate WaSH service provision in informal settlements

and ensuring a focus on individuals living in overcrowded conditions such as in collective shelters and institutions.

- Response activities for cholera are mostly repurposing of planned activities within existing response plans - with the addition of some cholera specific response activities. Swift disbursing of extra funding is required to ensure that critical and time sensitive new and previously planned activities can be implemented in a timeline manner.
- Further, donors should:
  - Prioritize funding for activities identified as critical and in line with the coordinated response strategies developed by the WASH, Health and RCCE sectors and task force.
  - Continuing flexible funding for the UN agencies, in particular UNICEF, WHO and UNHCR as sector lead agencies, to allow for greater responsiveness to rapidly evolving priorities across the whole country.
  - Allow flexibility in on-going grants and continue direct funding to international and national NGOs, noting that NGOs coordinate via the sectors and are often the closest entities to communities and affected people, especially those with special needs.
  - Fund the Lebanon Humanitarian Fund: LHF is particularly efficient and effective to support NGOs to respond.

## Funding

### Priority Funding Needs Health, WASH & RCCE

#	Pillar	Six-Month Budget (USD)	Immediate Needs (3 months)	
			Preparedness	Response
1	Leadership & Coordination	285,000	100,000	15,000
2	Surveillance	833,400	110,000	560,100
3	Laboratory	1,131,650	294,850	551,000
4	Case Management and IPC	8,148,650	0	6,865,325
5	Oral Cholera Vaccine*	4,560,000	0	4,560,000
6a	WASH: critical O&M support to systems, incl. fuel and subsidies	20,000,000	9,285,000	1,500,00
6b	WASH: prevention, preparedness and response	21,100,000	5,700,000	3,750,000
7	RCCE, Hygiene promotion	1,185,000	75,000	475,000
8	Logistics, Equipment & Supplies	6,916,000	2,108,000	3,750,000
	Sub-total	64,159,700	18,212,850	22,026,425
	7% PSC	4,491,179	1,274,900	1,541,850
	<b>TOTAL</b>	<b>68,650,879</b>	<b>19,487,750</b>	<b>23,568,275</b>
<b>GRAND TOTAL IMMEDIATE NEEDS (USD)</b>			<b>43,056,024</b>	

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