REQUEST RESPONSE

Saving Lives Through Learning: How Sudan's Education Sector Responded to Cholera

REQUEST SUBMISSION

In emergencies, education provides children with a safe and protective environment that supports their well-being, facilitates access to essential services, and enables referrals to specialised care. Lifesaving learning is increasingly recognised as a core component of quality Education in Emergencies (EiE), yet evidence on the lifesaving dimensions of education programming remains limited.

In 2025, amidst ongoing conflict, Sudan experienced a devastating cholera outbreak. Education partners contributed to the national cholera response through a range of key activities. While significant gaps and challenges persist, important lessons and emerging best practices have also been identified.

This rapid review draws on targeted primary and secondary data to document these learnings, highlight effective approaches, and identify gaps and challenges within the education sector's engagement in the integrated cholera response.

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EXECUTIVE SUMMARY: KEY FINDINGS AND RECOMMENDATIONS

This case study demonstrates the critical role of education actors in health and WASH emergency response during the 2025 cholera outbreak in Sudan. Schools served as trusted convening spaces, teachers acted as credible messengers, and education programming provided age- and context-appropriate platforms for lifesaving health and hygiene messaging.

Schools are essential platforms for lifesaving messaging in crises.

In drawing out key findings, learnings, and recommendations to evidence the value add of education in emergencies, this case study focuses on hygiene promotion and awareness-raising sessions delivered by education partners. These services are highlighted for their direct contribution to the dissemination of lifesaving skills to children and communities. The findings from the key informant interviews suggest that:

- Education Cluster partners responded swiftly to the cholera outbreak, guided by both the urgency of the crisis and community leadership, leveraging and adapting education programming to support and enhance ongoing health and WASH efforts, ranging from reactive interventions in outbreak hotspots to proactive outreach in at-risk communities.
- Education actors played a key role in delivering lifesaving skills and public health messaging to children and communities, contributing directly to the effectiveness of the cholera response.
- Schools and teachers, supported by Education Cluster partners, rapidly mobilised health, hygiene, and psychosocial support, leveraging their continued presence despite the conflict, well-established community trust, and existing social networks to scale the response.
- Education actors added value to the cholera response by adapting health information and hygiene promotion to ensure messages were culturally sensitive and age appropriate.
- The siloed nature of sector responses, with frequently distinct reporting indicators and separate reporting pathways, limited coordination between sectors, under-reporting and under-counting of education partner activities and impact.

Recommendations

While education contributes to prevention, preparedness, and response during health and WASH emergencies, this research focuses on the response phase, where rapid mobilisation, community networks, and capacity for continuous engagement make education actors critical partners. This research shows that education actors are uniquely positioned to target children and communities with culturally relevant and age-appropriate messaging, and recognising schools as part of the frontline response affirms that education contributes directly to saving lives and sustaining community trust during crises. In putting forward recommendations, this report emphasises integrated approaches that recognise the need for collective action to strengthen the humanitarian response rather than identifying actions for each group of stakeholders. Integration across education, health, and WASH sectors is essential; current siloed planning and separate indicators undervalue the role of education, limit impact, and undermine comprehensive coordination.

The research suggests the following actions would help to embed education within the humanitarian response architecture, enhancing the effectiveness and impact of health and WASH interventions by capitalising on the capacity and potential of education actors.

- **Leverage teachers' social capital.** Recognise and support teachers as key first responders in emergencies. Prioritise ensuring they have the information and materials required to enable

them to deliver health messaging effectively while maintaining their primary educational role.

- **Recognise education's role in contextualising and adapting information.** Draw on educational techniques to design and disseminate age-appropriate, locally relevant resources for health and hygiene education in and outside of schools. Ensure materials reflect local norms around water use, food sharing, and social practices to maximise relevance and uptake.

- **Empower children as change agents.** Promote peer-to-peer and interactive learning approaches that enable children to communicate accurate health information to their siblings, parents, and communities. This approach increases both access and efficiency, extending the capacity to engage households marginalised from formal health systems.

- **Institutionalise coordination.** Integrate education formally into inter-cluster preparedness and response frameworks related to lifesaving actions, alongside health and WASH. As part of this, formalise joint Education–Health–WASH task forces and shared planning mechanisms to reduce duplication, maximise limited resources, and extend outreach particularly in marginalised or remote areas where the primary school may be the only functioning community institution.

- **Measure what matters.** Develop and adopt indicators that capture both reach and behavioural change as well as indicators that track and therefore incentivise joint or integrated action by multiple sectors.

INTRODUCTION

In an era of shrinking international assistance and escalating humanitarian needs, the imperative for sectors to strategically coordinate and integrate their responses has never been more urgent. This case study presents compelling evidence of how education sector partners in Sudan contributed to a more effective and inclusive response to the 2025 cholera outbreak. It underscores the critical need for multisectoral collaboration, where education is not merely an adjunct but a core component of emergency preparedness and response.

Effective planning for future health and water, sanitation, and hygiene (WASH) emergencies requires clear recognition of how education partners can contribute not only to prevention and preparedness but also to emergency response itself. Schools and teachers represent a trusted, wide-reaching network for delivering information, supporting protective behaviours, and sustaining engagement at the community level. In contexts such as Sudan where conflict, displacement, and weak and overstretched health and WASH infrastructure exacerbate recurrent health crises, recognising this lifesaving potential of education can support the development of integrated, multisectoral responses that leverage the capabilities of all actors in the space.

The response by education sector partners to the 2025 cholera outbreak in Sudan illustrates how education actors can play a direct and complementary role in emergency response. Teachers, often the most educated and trusted figures in their communities, were able to mobilise rapidly, delivering age-appropriate and culturally sensitive health and hygiene messages. Where health and WASH responders faced access and resource constraints, education actors filled critical gaps communicating lifesaving information to learners, their families, and the wider community.

BACKGROUND

The crisis and cholera in Sudan

Sudan is currently experiencing one of the most severe and multifaceted crises in its history. The ongoing armed conflict, which escalated in April 2023, has triggered widespread displacement, economic collapse, and the breakdown of essential services. Political instability and targeted attacks on infrastructure—including schools, hospitals, and water systems—have left millions without access to basic services. In Khartoum alone, over 70 per cent of health facilities are non-functional as of July 2025 (OCHA, 2025), and insecurity continues to restrict humanitarian access across much of the country. The compounded effects of violence, governance failure, and economic deterioration have created a protracted poly-crisis, with devastating consequences for the civilian population and the systems meant to support them.

Amid this turmoil, Sudan is grappling with one of its worst cholera outbreaks in decades. Since July 2024, more than 83,000 suspected cases and over 2,100 deaths have been reported, with over 32,000 new cases emerging from January to July 2025 alone. The outbreak has spread to 16 of the country's 18 states, with Khartoum, Aj Jazirah, Gedaref, and White Nile accounting for the majority of cases. The destruction of water treatment plants, poor sanitation, and the collapse of public health infrastructure have severely undermined the country's ability to contain the disease. In Darfur and other conflict-affected regions, insecurity and flooding during the rainy season have further contaminated water sources and limited access to treatment. Despite efforts by humanitarian actors to scale up integrated health, WASH, and risk communication responses, the response remains critically underfunded, with only 16 per cent of the required USD 50 million secured, threatening to exacerbate an already dire public health emergency (OCHA, 2025).

The state of education in Sudan

The education system in Sudan has been profoundly disrupted by conflict, economic collapse, and political instability. The war that erupted in April 2023 has accelerated long-standing structural challenges in the education sector, including regional disparities, underfunding, and the breakdown of national education governance capabilities. With federal systems weakened and state and locality-level actors left to manage education delivery with minimal support, functionality varies widely across the country (Glade & Elbashir, 2025). In Rapid Support Forces (RSF)-controlled areas, education systems have largely collapsed, while in Sudanese Armed Forces (SAF)-controlled areas, a few states—such as River Nile and Red Sea—have managed to maintain relatively stable services. In the absence of consistent oversight and support, and a significant contraction in international funding for education in emergencies, many communities have been forced to rely on their own resources to sustain education.

Despite these challenges, Education Cluster partners, community-based organisations, local education authorities, and international humanitarian organisations have demonstrated remarkable resilience and adaptability. In the absence of consistent government support, these actors have mobilised to reopen schools, deliver psychosocial support, and provide alternative learning opportunities. Community-led initiatives such as Parent Teacher Associations (PTAs) and Emergency Response Rooms (ERRs) have played a critical role in sustaining education services, especially in areas where formal systems have collapsed. In some states, teachers continue to work without pay or rely on modest incentives from NGOs, highlighting both their commitment and the fragility of the current system. The education sector's reliance on international assistance has enabled some continued service delivery but also underscores the urgent need for sustainable, locally led solutions (Glade & Elbashir, 2025).

While 100 per cent of schools were forcibly closed at the outset of the war in April 2023, there has been a process of gradual reopening over the past 24 months, with 65 per cent of schools (serving approximately 44 per cent of the school age population) operational as of November 2025 serving approximately 7.5 million children, and non-formal programming offering some inclusion for children not able to access formal education. Trends in school reopening and the expansion of non-formal education (NFE) illustrate both the potential and limitations of the sector's reach. Notably, NFE coverage remains limited, reaching only 1–2 per cent of the out-of-school cohort and is unevenly distributed across Sudan due to access and funding challenges. Nevertheless, the presence of education actors on the ground, their embeddedness in communities, and their ability to deliver culturally relevant, age-appropriate content position them as uniquely capable of reaching some vulnerable populations and supporting integrated, life-saving responses in health and WASH emergencies.

METHODOLOGY

The case study used a rapid, qualitative approach to generate evidence on the role and value add of education in health emergencies. The research began with a literature review to identify and synthesise global evidence on education interventions in response to health emergencies. The study then incorporated targeted primary research through semi-structured key informant interviews (KIIs).

Participants included four global and country-level Education Cluster representatives, one representative from the national Health Cluster, and four representatives from global and country-level WASH Clusters, as well as education stakeholders from one INGO and six national Education Cluster partners actively involved in the Sudan cholera response.

The qualitative data collection explored the scope, nature, and impact of education partner support, coordination mechanisms, and lessons learned. Emergent thematic analysis was used to identify contributions, gaps, unintended consequences, and opportunities for strengthening education's role in health emergencies, with particular attention to monitoring and evaluation approaches, instruments, and indicators.

The research was guided by a set of core questions designed to understand:

- What existing global evidence there is around the role of education interventions in supporting response to health emergencies?
- What was the scope and nature of education partner support in the 2025 cholera response in Sudan?
- If and how education partners coordinated with others where there was an integrated response to cholera, and what factors enabled or constrained effective coordination?
- How were education-led cholera response activities monitored and evaluated?

This case study was designed to accommodate rapid research and is limited by time constraints and the availability of stakeholders. Although Education Cluster implementing partners operate across six states, researchers were able to engage with only seven organisations—six of the nine partners listed in cluster reporting and one additional implementing partner. Consequently, the key informant interviews (KIIs) reflect activities and insights from just five states: North Darfur, Central Darfur, White Nile, River Nile, and Sennar. This limited geographic and organisational coverage may not fully capture the diversity of education sector contributions across all operational contexts.

FINDINGS

In the complex humanitarian setting of Sudan, education actors mobilised rapidly, leveraging existing school networks, safe learning spaces (SLS), and community trust to deliver critical health and WASH messaging and services as part of the emergency response. Their activities and impact demonstrate the potential role of the education sector as a frontline partner in health emergencies. While not formally included within inter-cluster cholera frameworks, findings from this research indicate that education actors collectively extended the reach of health and WASH interventions.

The following sub-sections begin by examining existing evidence on the role of education in emergency response. They then draw on interviews and reports from Education Cluster implementing partners in six affected states in Sudan, demonstrating how education actors adapted their roles and the resources available, collaborating with others to respond to the outbreak. Additional insights from key informants across sectors represented within the cluster system confirm evidence from the implementing partners that while education actors demonstrated flexibility and commitment, sectoral silos and lack of integrated monitoring limited the overall effectiveness of the response.

Existing evidence on the role of education in health and WASH emergency responses

Although the evidence base remains relatively limited and unevenly reviewed, existing research indicates that education interventions play a vital role in health and WASH emergencies, including cholera outbreaks (see for example Taylor et al., 2015). Systematic reviews suggest that education can increase knowledge and influence behaviour, but that evidence on its contribution to response remains limited. While health and WASH collaborate on response planning and action in many contexts, there is limited evidence of integrated responses across health, WASH, and education.

The role of education in health and WASH emergencies

The literature identifies schools as effective platforms for both preparedness education and community behaviour change, with a comparatively stronger evidence base for preparedness than for emergency response. While schools have demonstrated potential during crises, most documented interventions focus on embedding health and hygiene education within curricula and preparedness planning, whereas evidence on schools' roles during outbreaks is drawn largely from guidance documents and stakeholder interviews. To strengthen future programming, it is important to distinguish where the evidence supports preparedness versus response, and to acknowledge the implications of these gaps for policy and practice.

A 2025 literature review of health education interventions in low-income countries found that while 65 per cent of studies reported increased awareness of cholera symptoms, transmission, and prevention, only 35 per cent demonstrated corresponding improvements in hygiene practices—revealing a persistent "knowledge–practice gap" (Baluku et al., 2025). This gap reflects the disconnect between what communities learn through health actor-led education and what they do: increased knowledge rarely translates into consistent hand hygiene or other preventive behaviours. Notably, none of the reviewed studies directly addressed outbreak preparedness, highlighting a gap in both research and programming around the health sector's ability to translate awareness raising and information sessions into anticipatory action.

In contrast, the same review cites evidence from previous crises which speaks to the response phase, showing how education actors mobilised rapidly to deliver health messaging and psychosocial support. This suggests that while preparedness is under-researched, schools have proven effective in emergency response contexts. Moreover, studies like Yamamura et al. (2023) indicate that early and continuous investments in health literacy—even before an outbreak—can substitute for direct experience and build readiness for future emergencies.

Empirical evidence from Ghana (on malaria prevention) and Japan (handwashing and hygiene) confirms that when health messages are embedded in schooling, children become conduits for transferring lifesaving information to households and peers (Ayi, I. et al., 2010; Yamamura et al., 2023). A systematic review of WASH in schools found that school-based interventions protect against diarrhoeal disease and enhance hygiene knowledge and practice (McMichael, 2019), though the diversity of intervention designs and weak comparability across studies remain a limitation (Bick, 2025). Studies from China and Jordan further suggest that health education in classrooms not only strengthens literacy and prevention capacities but also supports psychosocial well-being and empowerment during emergencies.

The capacity to leverage existing and continuous education on health and WASH issues during response phases was highlighted in KIIs, not the literature. A global WASH sector stakeholder noted that schools and parent-teacher associations (PTAs) are viewed by other humanitarian actors as potential multipliers for behaviour change, but monitoring of their impact remains limited (KII, October 2025). UNICEF's Guidance for Safe School Operations during Cholera Outbreaks (2024) reinforces this perspective, directing actors to "ensure education is included in response planning from the outset" and emphasises that school-based education campaigns help children understand risks and model hygienic behaviours, while targeted advocacy and messaging for caregivers can strengthen community resilience. At the same time, WASH sector actors and reports point out that data on WASH access in schools is often outdated and incomplete and there is a need for dedicated WASH-in-schools surveys and better integration with education data systems (WASH KII, October 2025).

There is also evidence, primarily from guidance documents rather than empirical studies, that schools can provide safe spaces in emergencies and can serve as information dissemination hubs for

students and communities. The UNICEF ESARO Guidance Note for Safe School Operations during Cholera Outbreaks (2024) strongly cautions against school closures during cholera outbreaks, noting that closures are often not based on scientific evidence of increased risk in schools compared to the community. Instead, closures can have severe negative impacts on children's learning, mental health, protection, and access to essential services (meals, WASH, psychosocial support). The guidance note provides concrete examples from Zambia and Malawi, where millions of learners were affected by closures, and highlights that the most vulnerable children are disproportionately harmed.

Integrated responses and the inclusion of education

The existing evidence base is more robust for preparedness, through school-based health literacy and WASH education, than for emergency response which may be one of the reasons that integration across the education, health, and WASH sectors remains limited in emergencies. The literature review found that while education has demonstrated potential to prevent disease and sustain health behaviours during crises, its contribution remains undervalued in policy and coordination frameworks. The Global Education Cluster (GEC) analysis of the 2025 Humanitarian Needs Response Plan (HNRP) re-prioritisation process highlighted the reality that education is frequently neglected in humanitarian responses, reflecting the lack of consistent global consensus on the role of education as lifesaving.

The literature includes stronger and more documented integration of health into education programming—through school-based hygiene and preparedness curricula—than of education into health and WASH responses. Education actors have incorporated health promotion within national curricula and emergency preparedness plans, but health and WASH sectors have been slower to engage education in formal coordination and planning. The IASC's Inter-Cluster Cholera Response Framework (2015:46), for example, omits education as a recognised cluster partner. This reflects systemic challenges rather than actual resistance to collaboration. The barriers include weak mechanisms for tracking and measuring education's contribution to health outcomes, and limited participation of education actors in health-led coordination platforms. Where integration has occurred—such as standardised infection prevention messaging across schools in Syria—joint reporting has reduced duplication and improved community coherence (UNICEF WASH Cluster, 2023).

The Education Cluster system and its capacity to effectively engage in inter-cluster (sector) coordination

The Education Cluster, deriving its mandate from the 2005 Inter-Agency Standing Committee (IASC) Cluster approach, is the coordination mechanism utilised in humanitarian contexts to establish a shared understanding of needs, facilitate the development of response plans, and promote and monitor the education response (GEC Strategy 2022-2025). With recognition that people affected by crises typically require a range of basic services spanning multiple sectors, the Global Education Cluster (GEC) committed to broadening and deepening its operational partnerships, promoting education as 'the great connector' in humanitarian responses. The Education in Emergencies - Child Protection Collaboration Framework represents this commitment. Established as a key mechanism to strengthen collaboration across traditionally siloed humanitarian sector responses, joint and/or integrated child protection and education in emergencies programming has been demonstrated to result in more efficient, better targeted, and more effective programmes (INEE, 2020).

The nature and scope of Education Cluster partner response

The 2025 cholera outbreak in Sudan unfolded against a backdrop of protracted conflict, displacement, and widespread infrastructure destruction. In this context, teachers, schools, and Education Cluster partners played a vital role in the emergency response. Their contributions went beyond information

dissemination, leveraging trust, cultural sensitivity, and educational techniques to deliver relevant messaging and drive community mobilisation in response to the outbreak.

Education Cluster implementing partners responded to the cholera outbreak driven by both the urgency of the crisis and calls to action from community leaders at state and local levels. Their activities either leveraged existing education programming or augmented ongoing WASH and health efforts with education programming tailored to local needs. Education Cluster partners prioritised high-incidence areas in Darfur, utilised e-learning centres in North Darfur, launched new initiatives in River Nile and Sennar, and focused on child clubs in more accessible states—ranging from reactive responses in outbreak hotspots to proactive outreach in at-risk localities, often without additional funding.

Partners engaged through integrated programming where mandates spanned education, WASH, and health, and supported the expansion of WASH and health interventions (see Table 1 below for a summary of interventions across 6 states). Teachers and community volunteers led hygiene promotion in schools, markets, and mosques, using peer learning, drama, songs, and printed materials to engage children and families. Outreach was extended through mobile loudspeakers and social media. One partner adapted UNICEF guidance to deliver psychosocial support via teachers in Safe Learning Spaces (SLS) while others coordinated latrine rehabilitation and soap distribution alongside hygiene education in camps and communities.

Education-led interventions contributed to prevention and risk reduction through community-based awareness and behaviour change. Partner reporting into the Education Cluster mapped work across five different areas: chlorine distribution, school cleaning and disinfecting, hygiene kit distribution, hygiene promotion, and awareness sessions. Information dissemination (hygiene promotion and awareness sessions) made up most reported activities with just under half the reported activities classified as 'integrated'. The sessions were delivered by teachers, community volunteers, and health or WASH sector specialists depending on organisational mandates or partners, using schools, markets, and community spaces. The methods and approaches to these sessions ranged from peer-to-peer education and drama to mobile campaigns and market clean-ups.

The Education Cluster exercise to map cholera-related activities undertaken by its implementing partners asked partners to specify if the activities undertaken were led by their Education programme team or their WASH programme team or were an integrated effort. **'Integrated' in the context of the implementing partner work therefore represents combined activity across sector mandates within an organisation.**

The response was not without its challenges. Security risks and infrastructure damage, particularly in Darfur, restricted operations. Education implementing partners reported looting and attacks on facilities, as well as described how collapsed schools and lack of water infrastructure hindered the sustainability of education-led interventions. Underfunding was a recurrent challenge, with one organisation operating in North Darfur noting that limited resources led to unsustainable programming despite high community trust. For one partner, the loss of a facilitator to cholera during the response further underscored the vulnerability of frontline workers. Other partners discussed how funding and logistical constraints delayed their activation of education components, limiting the sector's early contribution to prevention and risk reduction.

When asked to estimate the impact of activities and to detail how the work was monitored and tracked, most partners relied on reported cases and community observations, highlighting the need for improved surveillance. The estimated reach described in KIIs varied depending on the approach to messaging, the focus of different partners and the access afforded groups by their existing programming. It is also difficult to make comparisons given the different metrics used to talk about impact. Most partners estimated their reach in terms of individuals or students in e-learning centres and SLS.

The education sector's response to Sudan's 2025 cholera outbreak illustrates its capacity to deliver lifesaving interventions through trusted community networks, child-friendly methods, and integration with WASH and health efforts. Despite operating constraints including insecurity, infrastructure damage, and limited funding, education partners were able to mobilise, creatively adapt materials, and reach vulnerable populations often overlooked by other sectors. Their contributions, unpacked in the following section, highlight the need for stronger recognition and integration of education within multi-sector emergency planning and coordination.

Table 1 – Education-led cholera response activities and their value-add to the work of other sectors

State	Health-Linked Activities	WASH-Linked Activities	Education Value-Add/ Adaptation
Central Darfur	- Health promotion & cholera awareness sessions - Community health messaging - Support to health centres with information and referrals	- Hygiene promotion (handwashing, safe water use) - Hygiene kit distribution - School cleaning/disinfection - Latrine rehabilitation	- Teachers and volunteers delivered sessions using drama, songs, and participatory methods - Peer-to-peer education by students - Sessions adapted for children and community - Schools as hubs for information and kit distribution
Central Darfur	- Awareness campaigns in IDP camps and host communities - Health messaging via banners, drama, and loudspeakers	- School cleaning/disinfection - Community cleaning campaigns - No direct chlorine distribution	- Focus on child-friendly methods and community mobilization - Use of school spaces for awareness and cleaning - Teachers as trusted messengers
North Darfur	- Awareness sessions in schools, mosques, markets - Health content developed by professionals - Isolation areas for cholera patients	- Sanitation campaigns (market/street cleaning) - Latrine construction/repair - Water source protection	- Use of local networks and volunteer labour - Social media and oral messaging for outreach - Schools and e-learning centres as focal points
North Darfur	- Training of hygiene promoters (using UNICEF materials) - Home visits for health messaging - Drama sessions for children	- Water supply upgrades - Hygiene kit distribution - Disinfection of homes and schools - Handwashing promotion	- Child-friendly drama and interactive methods - School-based cleaning and disinfection - Community engagement through schools and child-friendly spaces
White Nile	- Awareness sessions in schools/communities - Health messaging integrated into school routines	- Hygiene kit distribution - Establishment of handwashing facilities in schools	- Participatory learning (songs, drama) - Teachers and students as agents of change - Schools as platforms for outreach
River Nile & Sennar	- Awareness campaigns in schools - Health messaging integrated with school feeding programs	- Hygiene messaging as part of daily routines - Distribution of leaflets and banners	- Media team developed child-focused materials - Peer dissemination by students to families - Teachers cascaded messages to students
Crosscutting	- Peer-to-peer education (children as educators) - Community mobilization (*nafir*) - Coordination with health sector for messaging	- Community-led cleaning and minor infrastructure repairs - Handwashing and sanitation promotion	- Adaptation of materials for children - Use of drama, songs, and participatory learning - Schools as trusted, accessible community hubs

The value-add of education to the cholera response in Sudan

This section unpacks three core contributions of the education sector to Sudan's 2025 cholera response. Drawing on KIIs and partner reporting, it highlights how schools served as trusted convening spaces, teachers acted as credible messengers, and education programming provided age and context appropriate messaging and platforms for lifesaving health and hygiene messaging. These findings illustrate how education interventions not only supported immediate outbreak control but also fostered community engagement, psychosocial stability, and sustained behaviour change among children, one of the most vulnerable populations, reinforcing the sector's strategic value in integrated emergency response.

Schools as convening spaces

During the 2025 cholera outbreak, schools and temporary learning spaces functioned as trusted community hubs. Education partners worked with school management structures to share health and WASH messages with children, caregivers, and local leaders (KIIs, Implementing Partners). Learning spaces were used to distribute printed materials and conduct demonstrations on handwashing, safe water storage, and household cleaning. Their dual function as learning environments and multi-sectoral service delivery platforms highlights their potential as hubs for community resilience during crises.

Even when schools or safe learning spaces (SLS) in high-risk areas were temporarily closed to contain infection, they were then reopened as safe spaces for reinforcing health education. Partners reported that these pre-existing learning spaces enabled rapid mobilisation because they were already accepted as safe, neutral community venues (KIIs, 2025).

In areas where health facilities were inaccessible or overstretched, partners described how schools effectively substituted as delivery points for community health messaging. Their status as safe, familiar spaces enabled teachers and volunteers to coordinate with local authorities and, in some cases, UNICEF and Médecins Sans Frontières to support hygiene material distribution and chlorination campaigns. Local initiative and ownership reinforced the value of schools and their status as natural hubs for rapid action. Implementing partners talked about "*nafir*", a form of collective, community-driven mobilisation for responding to crises. This spirit of ownership is reflected in how communities self-organised and mobilised through schools to set up handwashing stations, cleaning campaigns, and even small isolation areas, often with minimal external support.

Teachers' leadership and community trust gave credibility to the response, while shared action fostered a sense of collective responsibility and protection. In White Nile, the implementing partner described how "with the involvement of the parent teacher associations, we managed to convince societies, especially families, to bring their children to these newly established safe learning spaces." The use of PTAs illustrates one of the ways in which anchoring health interventions in schools built and reinforced trust in the wider humanitarian response efforts. This ability to leverage schools' stakeholders to establish schools and learning spaces as sites for community information dissemination and protection enhances their value in integrated response.

Teachers as trusted messengers

Teachers, known locally as *Ustaz*, are anecdotally understood to be respected and frequently among the most trusted and enduring figures in their communities. This trust enables them to deliver health and hygiene messages that are more likely to be accepted and acted upon by students and their families making them cultural intermediaries as well as deliverers of lifesaving skills.

In the interventions, teachers were deployed after receiving training from health and education professionals, and they played a vital role in transmitting this knowledge and frequently transforming it into learning activities for the students, and drama plays and campaigns for the broader community. In addition, teachers led awareness sessions, modelled safe hygiene behaviours, and convened parent–teacher meetings focused on cholera prevention.

Teachers supported by Education Cluster partners also acted as mobilisers and coordinators, bridging formal schooling and community action. In several states, education partners supported teachers who organised clean-up campaigns, oversaw the display of cholera-prevention posters, and used morning assemblies to reinforce key practices. As respected community members, they were able to engage elders and religious leaders who might otherwise have been sceptical of externally driven public-health messages. In Tawila locality, one partner's education network and community facilitators organised awareness-raising and hygiene-promotion activities across five major IDP camps, reaching nearly 21,000 children.

Education Cluster partners reported that many teachers took on additional responsibilities without extra remuneration or materials support. Organisations also collaborated "providing both pooled funds and volunteers" demonstrating commitment and the cost-effectiveness of leveraging existing staff (teachers) in the field but also revealing the challenges resulting from the low level of recognition of their frontline role (KII, Implementing Partner).

Education as a platform for lifesaving messaging

Teachers' training and experience positions them to translate technical health guidance into language and examples that resonate with parents and children alike. Education partner team members employed participatory and creative approaches to embed cholera prevention within school activities. Organisations described how they integrated songs, plays, storytelling, and peer-education clubs (child clubs) to promote handwashing, water treatment, and waste management. These methods had cultural resonance in regions like Blue Nile and Darfur and were likely more effective for children than generic health sector materials, which are rarely adapted for age or context (KII, Global Health Cluster).

Through repetition (in song) and performance (in plays), children took on board key health behaviours and were empowered to share information with their families and communities. Education partners talked about integrating hygiene messages into daily lessons in SLS, encouraging children to practice and promote preventive measures at home. Child-to-child learning thus created a multiplier effect for formal WASH and health initiatives. The value of such participatory approaches to Risk Communication and Community Engagement (RCCE) and Social and Behaviour Change (SBC) is recognised and taken on board by the WASH sector as well (KII, October 2025) and included in WASH guidance (see for example the UNICEF ESARO Guidance Note, 2024). The guidance note recommends participatory approaches like those used by education partners in Sudan, such as involving students as peer educators, integrating cholera prevention into curricula, and using school assemblies and community meetings for messaging.

Table 2 – Comparison of Health and Education Approaches to Messaging

	Health Approach	Education Approach	Added Value of Education Approach
Delivery Method	Generic pamphlets and posters (health); Context appropriate materials (WASH)	Interactive, age-adapted lessons, plays	Higher engagement, improved retention
Target Group	General public	Children, families, community	Wider audience, multiplier effect
Messengers	Health/WASH workers; community volunteers	Teachers and learners; PTAs connecting into the community	Trusted messengers; trusted connector into the community

Anecdotal evidence from implementing partners suggests that the education response fostered agency and psychosocial stability among children and communities. Students who learned about cholera transmission reported sharing chlorination and hand-washing techniques at home, prompting visible changes in household routines. Parents began storing water safely and involving children in cleaning tasks, a step towards bridging the "knowledge–practice gap" identified in the existing evidence (Baluku et al., 2025).

As an added advantage different to one-off public health or WASH information campaigns, education provides ongoing opportunities to reinforce lifesaving behaviours (e.g., handwashing, safe water use) through repeated lessons and lived experience in schools. This sustained engagement is critical for both immediate outbreak response and long-term community resilience.

Child-to-child learning in Blue Nile

In Blue Nile State, one education sector partner trained teachers and student clubs to script short plays and songs about cholera prevention. Performances were staged in school yards and marketplaces, drawing parents and traders who might not attend formal health sessions. Local officials later credited these dramas with improving household water-treatment practices and increasing community discussion of hygiene.

Challenges faced by implementing partners during the cholera response

Implementing partners in the education sector played a vital role in responding to the cholera outbreak, yet their efforts were shaped by a range of operational and structural challenges. The research revealed persistent barriers to cross-sector integration, uneven coordination mechanisms, and limited inclusion of education actors in strategic decision-making forums that are present both in the Sudan context as well as within global practice.

Education partners in Sudan navigated the complexities of local dynamics and cultural norms while adapting interventions to community needs in a conflict setting. Resource constraints, access limitations, and inconsistent terminology across sectors further complicated monitoring and reporting. These challenges underscore the need for institutionalised inter-cluster planning, harmonised indicators, and inclusive coordination frameworks that recognise and leverage the role of education in emergency response.

Integration and coordination

Key informant interviews with education sector implementing partners and cluster coordinators revealed that, despite the recognised value of education in emergency response, coordination across education, health, and WASH sectors during the cholera outbreak was limited. This siloed approach reduced the overall effectiveness of the response and constrained opportunities for alignment, scale-up, and joint planning. While some partners engaged in cross-sector coordination—particularly with WASH and Protection Clusters—others noted minimal integration at state and national levels, often due to resource constraints and the lack of multisectoral or inter-cluster coordination frameworks defining and structuring integrated action rather than willingness to engage with the response.

Education partners primarily coordinated through the Education Cluster at state level or national levels using mechanisms such as biweekly or monthly meetings, ad-hoc sessions, weekly reviews, and structured reporting to track activities and plan interventions. Tools like WhatsApp alerts enabled rapid information sharing and helped to align activities, reduce duplication, and improve coverage in affected areas.

Engagement with other clusters including WASH, Health, and Protection occurred through inter-cluster forums and local authority-led coordination meetings. In some locations, education partners participated in planning sessions with Cholera Treatment Units (CTUs) and joined weekly or twice-weekly joint meetings to review activities. However, the consistency and depth of cross-sector integration varied. Coordination was often confined to locality-level discussions, and logistical or funding constraints occasionally delayed response efforts. Despite these challenges, partners acknowledged that joint meetings and shared information helped link education interventions with WASH and health activities where feasible.

Partners also worked with ministries, local authorities, and community representatives. Local authorities chaired cholera response meetings, coordinated site selection for learning spaces, and mobilised families, while communities played a central role in hygiene promotion and site maintenance. Access restrictions, security concerns, and the influx of displaced populations did complicate these types of interventions.

At national and inter-cluster levels, education's role in the cholera response was often underrepresented. Cholera task forces did not include education cluster coordinators or implementing partners, limiting the inclusion of community-level insights in strategic planning. This led to fragmented communication and missed opportunities for joint programming.

Coordination mechanisms at the state level—such as WhatsApp alerts and local task forces—varied in effectiveness. In North and Central Darfur, education partners joined local response committees chaired by authorities, enabling faster mobilisation and linking education with health and WASH efforts. However, these collaborations were often driven by individual initiative rather than formal frameworks with funding inflexibility and logistical barriers as persistent challenges.

Differences in terminology across sectors complicated monitoring and reporting. Health actors used terms like Risk Communication and Community Engagement (RCCE), while education and WASH partners referred to awareness sessions or life skills activities, encompassing diverse formats. This lack of standardisation made it difficult to compare contributions across sectors and often led to education-led activities being underrepresented in joint dashboards and situation reports.

Despite uneven integration, local successes reinforced the value of schools as convening spaces and the importance of institutionalising joint planning and monitoring. Teachers frequently acted as informal bridges between sectors, relaying health messages and mobilising students for community

campaigns. While impactful, these efforts were context-specific rather than systemic, highlighting the need for formalised inter-cluster frameworks that can capture and scale education's lifesaving contributions.

Measuring and monitoring education-led and integrated response activities

Monitoring of education-led cholera response activities in Sudan revealed both innovation and fragmentation, with partners using a mix of qualitative and quantitative methods. However, inconsistent definitions and limited integration of health and WASH indicators hindered systematic recognition of education's contribution.

Monitoring and evaluation occurred at both state and national levels through the Education Cluster. Impact was primarily assessed by reductions in cholera cases, while implementation was tracked via field staff observations, joint assessments, and cluster-specific reporting using the 5Ws (Education) and 3Ws (Health) frameworks. Despite these efforts, integration of health indicators into education monitoring tools remained limited, and definitions of activities—such as "awareness sessions"—varied widely, affecting consistency and comparability.

Education partners provided estimates of their reach based on local monitoring tools and observation-based reporting. These metrics varied significantly across partners and states, making aggregation and comparison difficult. Most estimates focused on simple counts of students, classrooms, Safe Learning Spaces (SLS), or schools and families reached. Examples included hygiene promotion and awareness sessions for nearly 21,000 children, child clubs in 40 schools, and engagement with over 6,000 individuals through integrated sessions, illustrating education's ability to reach marginalised populations.

Partners reported into the cluster using the 5Ws system, informing a dashboard mapping their inputs. While this captured valuable data, some organisations with broader coverage were not fully reflected, highlighting omissions or lags in reporting rather than errors. Monitoring in crisis settings is often constrained by lack of infrastructure and access, and the quality and consistency of interventions can be compromised (KII, Global Wash Stakeholder). Funding limitations also shape the extent of monitoring and reporting (KII, Hygiene Promotion Working Group). The absence of formalised, shared definitions continues to hamper consistent monitoring (KII, Education Cluster Coordinators).

To address these gaps, the Education Cluster has included health and hygiene categories in its lifesaving skills indicator for the 2026 Humanitarian Needs Response Plan (HNRP) and is exploring additional indicators to capture education-led health interventions. These include additional output measures (e.g., number of children receiving information sessions). However outcome-focused indicators (e.g., observed behaviour change and peer-to-peer knowledge transfer) while important, may prove more challenging to develop and adopt. There are also ongoing discussions around integrated indicators across sectors, recognising their potential to incentivise collaboration and provide a clearer picture of education's contribution.

Cluster Objective 1:
Children have access to lifesaving learning opportunities

The 2026 HNRP in Sudan will include an expanded Indicator 4– Number of teachers providing essential life-saving skills, information on GBV and other forms of violence, anti-trafficking, unexploded ordnance, diseases, nutrition, health, hygiene and psychosocial health.

The inclusion of 'diseases, nutrition, health and hygiene' will enable the sector to track its contribution to awareness raising and hygiene promotion as part of preparedness and response to health and WASH emergencies.

Informants from other sectors acknowledged that reporting is typically siloed, with limited integration into education or other sectors (KII, Hygiene Promotion Working Group). Without shared measurement frameworks, education's contribution to cholera response remains under-recognised. Cluster coordinators and implementing partners highlighted the absence of joint indicators as a critical gap in evidencing the sector's value-add. The lack of integrated metrics has weakened incentives for cross-sector collaboration and data sharing. For example, while health partners track cholera cases treated and WASH actors measure chlorine distribution, there is no unified metric linking these outcomes to education-led behaviour-change activities. Efforts are underway to develop standardised indicators for multi-sector humanitarian response plans, including WASH and education (KII, Global Wash Stakeholder).

Stakeholders emphasised the need for integrated indicators that measure outcomes such as the proportion of households practising safe water use after school-based awareness sessions, or communities reporting sustained handwashing practices. Such indicators would better reflect education's real impact and incentivise coordination across sectors. Joint metrics such as the number of hygiene awareness sessions delivered would also improve accountability and capture the effectiveness of collaborative interventions. Embedding these within inter-cluster monitoring systems would make education's lifesaving role more visible and evidence-based, strengthening its inclusion in future outbreak responses.

LESSONS AND IMPLICATIONS FOR PRACTICE

One of the Education Cluster coordinators in Sudan framed the response of the education sector to the cholera outbreak as an imperative. In emergencies, whether health, WASH, or conflict related, if a school or learning facility is operational in any form there is a commitment from national and international education actors to leverage the 'staff and space' of schools to contribute to addressing the emergency (see Paul Farmer's mantra for health crises). This research argues that these actions taken by education actors if systematically tracked and monitored will illustrate the importance of integrated approaches and the value-add of education to emergency response.

The Sudan case offers transferable lessons for other protracted crises on the role for and value of education in emergency response including:

Education institutions and actors represent an existing, trusted infrastructure for communicating lifesaving skills. Implementing partners interviewed for the study describe how they increasingly view education as a platform for integrated service delivery. This is in part informed by the recognition of education spaces and actors as trusted community hubs and their use as partners in activating community engagement as well as delivering lifesaving messages. The conclusion is also supported by the experience of how they were able to bridge critical gaps between hygiene promotion, health awareness, and community resilience.

Value-Add of Education
Trusted status of teachers enables effective behaviour change
Schools as accessible, familiar community hubs
Culturally relevant, interactive methods (drama, songs, peer-to-peer)
Rapid mobilisation through existing education networks and community mechanisms
Ongoing, repeated engagement allows for sustained behaviour change
Empowerment of children as agents of change in their families and communities
Community ownership facilitated through PTAs and strengthened by mechanisms like '*nafir*'
Pre-existing safe learning spaces facilitate rapid response

Education provides a multiplier effect in emergencies as demonstrated through its capacity to increase reach and improve the uptake of health messaging. In the Sudan case, teachers and schools were cost-effective delivery platforms. In addition, the education-led work undertaken by implementing partners illustrates the potentially significant value-add of participatory, child-centred approaches for behaviour change and the importance of ensuring context-specific and culturally relevant engagement with communities. These lessons are not necessarily new–WASH actors spoke to their learning that while global standards and templates provide a useful starting point to engagement, local adaptation and 'context appropriate' approaches are essential (KII 28 Oct; WASH HP Resources).

Education was able to unlock greater impact within the response where action was integrated, planning was collaborative, and coordination mechanisms maintained open communication. In the resource-constrained, protracted, poly-crisis context of Sudan, the research demonstrates how integrated planning across sectors increases the scope, efficiency and efficacy of emergency response. One example was the integrated approach adopted by Cholera Treatment Units (CTUs) which led to improved understanding of community needs and more accurate planning to deliver critical interventions. At the same time, the Sudan case study illustrates the challenge—shared by other sectors—that global standards might ask for integrated response but in crisis response such standards can be applied in ad hoc rather than systematic ways depending on the context and actors in place (see WASH Guidelines for Hygiene Promotion in Emergency Operations, KII, HP Working Group; or the integrated planning and response architecture in the GADRRRES Comprehensive School Safety Framework 2022-2030). The adaptations and unique contributions by education actors, such as child-friendly methods, leveraging trust in teachers, and using schools as platforms for both health and WASH interventions. (WASH sector focus on 'context appropriate', KII 28 Oct; WASH HP Resources) demonstrate that investing in integrated, context-sensitive education responses is essential—not only for maximizing the reach and effectiveness of emergency response, but also for building community trust and resilience in the face of complex, resource-constrained crises.

Education's role matters when it is measured. The research used the Education Cluster mapping of the work of their partners in response to the cholera outbreak as the starting point for the study. However, sector clusters in the humanitarian response system monitor and report on what is in their framework within the HNRP. Currently, education activity in support of Health or WASH emergencies is not covered and joint activities are not well defined in the HNRP. The Education Cluster will start to measure health/WASH interventions by teachers but there is a need for more systematic and combined impact indicators to demonstrate the value of integrated interventions (KII, Hygiene Promotion Working Group).

> "We need to find ways to not have siloed indicators. Our approach to success needs to include combined impact indicators because if we measure our impact as minimising outbreaks, that is not something that can be delivered by one sector alone. Yet that is how we currently set it up, in silos. If we were combining forces a little bit more maybe we could do more within the restricted funding envelopes currently supporting humanitarian response."

KII, Hygiene Promotion Working Group Stakeholder

Implications for Practice

In seeking to drive change in the way things are done it is important to formalise approaches and mechanisms in shared frameworks for operation, which are accessible to all actors and established as the standard to which sectors will be held to account. If the humanitarian sector is held accountable for the extent to which it engages in integrated action, then each sector will be incentivised to leverage the value and contribution of others in the achievement of combined goals through cost effective, efficient, and high impact modalities.

This case study provides evidence that education represents an existing, trusted infrastructure for health communication, but its potential as a lifesaving, cross-sectoral tool is constrained by institutional silos and the lack of evidence frameworks that capture its full contribution. To capitalise on the broad recognition of schools as part of the frontline response, the humanitarian sector needs to recognise education as lifesaving by:

Prioritise integration. Integrating education into health and WASH planning from preparedness through response will unlock a cost-effective, community-anchored delivery channel for prevention, early detection, risk communication, and response. Strengthening shared monitoring indicators, embedding education actors in inter-cluster coordination, and documenting outcomes systematically would help incentivise integration and bridge the current evidence and accountability gaps. An organisation like UNICEF, which leads multiple sector clusters in crisis contexts and has programming across the three sectors, is in a strong position to drive approaches that reduce siloes and maximise effectiveness, efficiency, and impact.

Institutionalise coordination. Several key informants confirmed that education is often overlooked in emergency planning, despite its potential to amplify health and WASH outcomes, and that is it a "missing piece" in multi-hazard preparedness and response, not yet systematically included in health or WASH strategies (KII, WASH coordinator). The education sector needs to be included in response forums from planning through implementation to after action reviews related to lifesaving actions. A first step could be the formalised inclusion of education representation in cholera task forces at national and local levels.

Acknowledge the complexities of context. Effective responses are not one-size-fits-all but must be tailored to local needs and resources. Education houses unique capacity to develop, customise, and share age-appropriate, culturally relevant materials for health messaging in schools. The humanitarian sector needs to:

- Leverage teachers' social capital. Recognise and support teachers as key agents in emergency response, including through training and incentives.
- Empower children. Use peer-to-peer and interactive methods to enable children to act as change agents in their communities.
- Enhance community engagement. Recognise the potential of education actors to mobilise community action to maximise the lifesaving humanitarian emergency response during time of crisis and outbreak.

Monitor what matters. Actors prioritise what is monitored, and what is monitored gets supported (with financial and human resources). While recognising that measuring the value of "lifesaving learning" is challenging in emergencies (KII, Global Health Stakeholder), there is scope to make education's lifesaving contribution more visible by:

- **Continuing to work to embed child-focused health indicators in humanitarian response plans.** The inclusion of the provision of disease, health, nutrition, and hygiene lifesaving skills in the 2026 HNRP is a critical first step in using monitoring and evaluation to evidence the role of the education sector in emergency response. Current monitoring emphasises outputs by measuring activity counts (sessions, materials, attendance) rather than meaningful behavioural or community-level change (outcomes).
- **Monitoring integrated responses to demonstrate the multiplier effect.** Developing shared language for activities, common frameworks for monitoring and joint indicators would improve coherence and visibility across sectors. Developing joint education–health–WASH indicators would better capture behaviour change, strengthen incentives for coordination, and make education's lifesaving impact visible in future emergency responses.

Starting to shape additional lifesaving learning indicators

There are additional or alternative indicators that could be considered for inclusion in the HNRP in future iterations. In the table below, the first set reflect different approaches to quantitative measurement of lifesaving skills (lifesaving learning). The variations captured include options that capture institutional capacity, behaviour change potential, and improved cross-sector comparability. The second group represent options for stronger recording and recognition of integrated response initiatives including systemic rather than once-off coordination and joint planning and more inclusive framing of inter cross-sectoral approaches.

	Proposed Indicator	Framing Rationale
Lifesaving Learning		
	Number of children (M/F) receiving essential life-saving skills and information on health and WASH in temporary learning spaces (TLS) and schools	Builds on existing HNRP indicator, shifts focus from protection to health/WASH; the focus on children emphasises the lifesaving element
	Number of Temporary Learning Spaces (TLS)/schools with ongoing health and hygiene awareness activities	Institutional alignment with WASH indicator structure; captures institutional capacity for preparedness as well as response
	Number of children reached with hygiene or health promotion sessions	Starts to track behavioural change, connects to WASH's "individuals reached" metric
Integrated Response		
	Number of systems established to monitor essential services at education delivery points	Derived from Health indicator, see also ECHO framing of an indicator on service/ specialist referrals
	Number of integrated plans and M&E frameworks including education in multisector responses	Captures collaboration and accountability through integrated planning
	Number of donor briefings and coordination meetings including education updates	Tracks advocacy and visibility, elevates Education in humanitarian dialogue

ANNEX 1. SEMI-STRUCTURED INTERVIEW GUIDE: EDUCATION IMPLEMENTING PARTNERS

Introduction

This research has been designed to highlight the recent work of Education Cluster members in the cholera response in Sudan. The work of education members provides an opportune moment to establish stronger empirical evidence on the potential contributions of education partners in a major health and WASH emergency context characterised by concurrent crises. Particularly in this moment of decreasing funding for education in emergencies, we are hopeful that this scope of work can help gather evidence to demonstrate the unique value education can bring to outbreak response and wider humanitarian efforts.

Consent

Before we proceed, can you confirm that you consent to participation in this research?

With your permission, I would like to record this interview for accuracy and reference. Do I have your consent to record?

Part I - Scope of Support (What)

1. Can you describe your organisation?
    a. Sectors that you deliver in (i.e. education, health, WASH, etc)
    b. Target locations
    c. Beneficiaries (students, education personnel, communities)
    d. Key partners that you work with - non-government, government, international
2. Can you explain the specific activities your organisation implemented in response to the Cholera outbreak?
    a. Awareness session, probing questions: can you explain the profile of attendees/target beneficiaries? **Length and frequency of sessions**? What content was covered/objectives? How was this content identified and developed? If delivered to students or teachers, does it align with the national curriculum or ALP? **Will it be mainstreamed into programming delivered by your organisation or remain an add-on**? Who was responsible for delivery—did they receive additional support or training?
    b. Hygiene promotion, probing question: What specific activities were undertaken? If training, what was the length and frequency? What was the profile of beneficiaries? Where did the content come from? What was the content/specific objectives? Who was responsible for delivery?
    c. Hygiene kit distribution, probing questions: What materials were provided? Who determined what materials to provide? Who were the recipients?
    d. School cleaning/disinfection, probing questions: who was responsible for delivery? What materials were used?
    e. Chlorine distribution probing questions: Who was responsible for delivery? Who were the beneficiaries (i.e. schools?)
    f. Other
3. For the activities implemented, how did your organisation decide which to undertake or which to prioritise? Were you undertaking similar activities already? Did other areas of your

work facilitate your capacity to deliver these interventions? (Probe: integrated with WASH/health work you were already doing, other organisations were doing in your area? Try to establish if they expanded what they were delivering in education to include health OR if they expanded what they were doing in Health/WASH to include education spaces.)

4. When did you start the education response activities? What was the catalyst for the decision (to act or not to act—funding, technical; acute nature of the outbreak)? Was there a time where activities had to pause? Are the activities ongoing?
5. How were target beneficiaries identified? (Probe: was there capacity to prioritise high risk location or was it a matter of where people or resources were prepositioned or most able to access? Was there collaboration with implementing partners in the WASH or Health sector?)
6. Has your organisation undertaken similar activities in prior cholera outbreaks?
7. Were there any unintended consequences of programming these activities, good or bad?

Part II - Measurement

8. Can you talk me through how each of the different interventions you delivered contributed to the cholera response? (Probe: was it about preventing the spread, detecting new outbreaks, communicating risk?)
9. Can you talk me through how results were monitored and measured for each of the different interventions delivered (Probe: **specific indicators, tools and processes**. Request that the interviewee share any tools utilised: possible probe; what might be indicators that used to measure lifesaving interventions by education?)
10. How were these results communicated, and to who?

Part III - Coordination

11. What was the role of the education cluster in the cholera response? How did your organisation engage with them?
12. Did you or your colleagues engage with other clusters in the planning or implementation of these interventions? If yes, how? If no, why do you think that communication did not happen?
13. Did you or your colleagues engage with other organisations in your state (whether education related or health or WASH) in the planning or implementation of these interventions? If yes, how? If no, why do you think that communication did not happen?

Part IV – Reflection

14. Can you share any learning from the delivery of these interventions? What do you feel went particularly well? What could be improved in the future?
15. If you thought about looking forward, are there things you think the education sector could do/spaces for education interventions that the sector isn't doing now? Where is there potential for the education sector to add value in response to health emergencies?

Is there anything I have not asked that you feel is relevant?

ANNEX 2. LIST OF KEY INFORMANT INTERVIEWS AND DISCUSSIONS

Global Humanitarian Actors

- Representatives from the Global Education Cluster
- Representatives from the Global Health Cluster
- Representatives from the Global WASH Cluster
- Representatives from the Hygiene Promotion Working Group

National Cluster Stakeholders

- Education Cluster Coordinators
- WASH Cluster Coordinators

Education Sector Implementing Partner Stakeholders

- Auttash
- Child Development Foundation (CDF)
- Depth Action Organisation (DAO)
- NORD
- Trust, Rehabilitation and Development Organisation (TDO)
- Triangle
- Save the Children (SCI)

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