

Care International Sudan

Comprehensive Multisector Need Assessment

Gedarif State



December 2021

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Acronyms and Abbreviations

CIS	Care International S
SMoH	State Ministry of Health
SMoAAR	State Ministry of Agriculture and Animal Resources
CSOs	Community Social Organization
FGD	Focus Group Discussion
KII	Key Informant Interview
HH	Household
SRH	Sexual and Reproductive Health
CLTS	Community Led Total Sanitation
FSL	Food Security and Livelihood
WASH	Water Sanitation and Hygiene
NGO	Non-Governmental Organization
INGO	International non-Governmental Organization
IDP	Internal Displaced People
O&M	Operation and Maintenance
SWC	State Water Corporation
WES	Water and Environmental sanitation
GBV	Gender Based Violence
FNC	Focused Antenatal Care
ANC	Antenatal Care
HF	Health Facility
TBA	Tradition Birth Attendant

Executive summary

- To collect the required data on the needs of the targeted people in Gedarif State, CARE conducted a comprehensive need assessment, the assessment was conducted internally by team from CIS led by MEAL coordinator, it took place in Gedarif state covering three localities namely; Al-Galabat Shargia, Al-Mafaza and Al-Fashaga. The objective of the assessment is to assess the current situation, identify the gaps and needs of the targeted communities and recommend of key interventions that meet the real needs of them. Different methods were used for data collection including individual interviews with HH leaders, FGDs with representative from different community groups, Desk review of the existing information and KIIs with the authorities in relevant miseris and institutions.
- In total; 58,6% of the assessed people have access to easy safe and adequate water while 41.4% are suffering from difficult in collecting water, poor quality or the water they collect is not enough for their HH¹.
- Women have the main responsibility in fetching water from the sources comprising 33.2%, followed by boys and girls comprising 24%(12% each), and men have the lowest responsibility in fetching water (17.2%).
- lack of water sources closed to the housed is one of the main causes of Gender Based Violence (GBV), particularly women, girls and youth females who facing different types of violence during collecting water particularly those need to go far distances to collect water particularly during dry season. 21.8% confirmed that women and girls are facing problems during fetching water
- In general; less than third of the assessed people have latrines comprising 30.1% while the majority do not have latrines in their houses (69.9%). Situation in host communities is relatively better comparing to the refugees as 86.2% of the people have latrines comparing to only 13.8% of the refugees.
- Almost 25.8% of the people in the area practicing open defecation in different places, including, open spaces in/near their villages/camps (15.9%), in the stream bank (3.6%), in the push (3.4%) and 3% in other places including agriculture field.
- Waste management system only found in the refugee camps intruded by CARE international, the existing system covering only 28.8% of the refugees, and very few people in the host communities (0.4%) have containers outside houses for waste disposal.
- Half the consulted people did not receive any type of capacity building in hygiene (48.3%). However, there still gap in hygiene promotion within the refugees, but the situation is better than in the host communities, as only 29.1% of the host communities were received capacity building in hygiene comparing to 62.2% in refugee camps.
- However most of people have access to health facilities (91.7%), but many factors are affecting their access to the good health services. When they asked about the things affecting their access to health services; 58.2% is lack of medical supplies

¹ Households were directly asked on accessing, the three factors should exist: 1) easy collection, 2) good water quality and 3) enough water for HH.

such as medicines, 35.1% lack of medical personnel in the health facilities, 31.7% due to cost of the services, 23.8% lack of transportation, 18.4% lack of confidence in the health facilities services, 13% raised the issue of safety as they think the health facilities are not safe, 12.1% due to unavailability of female staff which contradicting with their culture, 9.9% is due to inaccessibility of the facilities for elderly and disabled people, 2.7% due to unsafety of the roads and 1.1% have cultural restrictions.

- From the consulted households; 65 (14.6%) have pregnant women during the last 12 months, most of them (76.9%) referred to midwives for ANC. 41.5% of them attended ANC two times or less, including 20% attended two times, 16.9% attended one time while 4.6% of the pregnant women have never attended ANC during pregnancy, 29.2% attended three times and 29.2% are the pregnant women attended ANC more than three times during pregnancy.
- There is a need for providing delivery support as 56.9% did not receive postnatal care after delivery, and 70.8% were not supported with the clean delivery kits.
- Most of the deliveries were assisted by midwives (76.9%), 41.5% of them delivered in their house assisted by trained midwives, 24.6% delivered in house assisted by traditional midwives, 12.35% assisted by nurse in health facility, 10.8% assisted by trained midwives in health facility, 4.6% assisted by doctors in their homes, 4.6% assisted by doctors in health facility while 1.5% delivered in home and assisted by TBA.

Background

CARE has been operational in Sudan since 2009, with humanitarian, early recovery and peace building interventions. Sectors involved include Peace building, WASH, Health & Nutrition, livelihood diversification and Economic Empowerment. Through UN agencies, ECHO, German MoFA OFDA, DCPSF, GAC, US AID and other donors funding, CARE has been supporting peace building and governance programs in South Darfur since 2013. The programs have been supporting community based resolution of conflict, inclusion of youth and women in community decision making and leadership and engagement in economic empowerment. CARE strongly supports and works with national NGOs, Community Based Organizations, government line ministries and universities.

The transitional government has taken bold steps to advance Sudan's economy, stability, and peace. However, these efforts will take time and humanitarian needs continue to grow. The 2021 Humanitarian Needs Overview (HNO) identifies 13.4 million people (29 per cent of the population) in need of assistance in 2021 – of which 7.6 million are women and girls, 2.5 million are IDPs, and 1.07 million are refugees from South Sudan, Central Africa Republic (CAR), Eritrea, and Ethiopia.

The country continues to face numerous challenges:

- (i) internal large-scale population displacement triggered by conflict,
- (ii) climatic and socio-cultural conditions leading to high levels of food insecurity and malnutrition, and
- (iii) the relatively large number of South Sudanese refugees within Sudan.
- (iv) The escalating economic crisis is central in intensifying the numbers of people in need.

Of the 13.4 million people in need, about 7.3 million need emergency assistance for life threatening needs related to critical physical and mental well-being. Meanwhile, 13.3 million people require life-sustaining support to meet minimum living standards. The Health sector has the highest number of people in need – 9.2 million, followed by WASH – 9 million, and the Food Security and Livelihoods sector – 8.2 million people in need.

Humanitarian assistance needs remain high through November 2021, driven by political instability, above-average food prices, and reduced household purchasing power, along with the impact of increased conflict, tribal clashes, and protracted displacement in parts of Darfur, Kordofan, and Blue Nile state, along with Ethiopian and South Sudanese refugees. Crisis (IPC Phase 3) outcomes are likely among IDPs in SPLM-N controlled areas of South Kordofan, IDPs and conflict-affected households in Jebel Mara, households recently affected by tribal clashes in North Darfur, urban poor households, and the most vulnerable poor households in parts of North Darfur, North Kordofan, and Red Sea states affected by low food stocks and poor purchasing power due to limited access to income and high food and non-food prices².

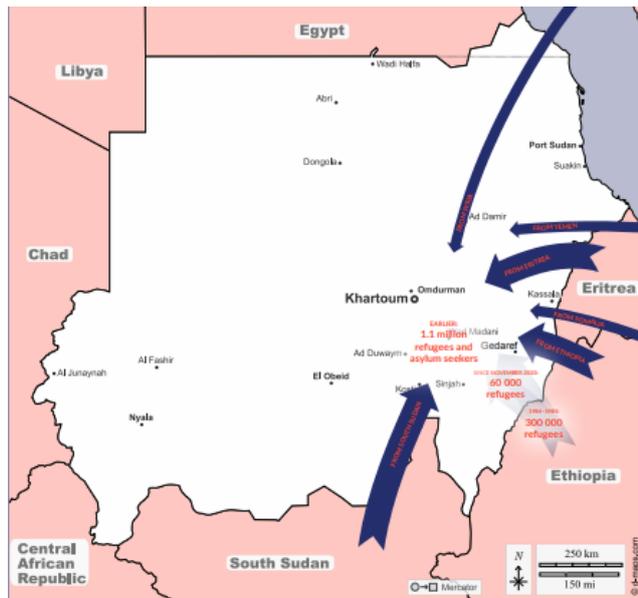
² Sudan - Key Message Update_ Tue, 2021-11-30

Gedari eastern states in Sudan, On November 4, 2020, conflict broke out in Tigray region,

Northern Ethiopia, between the Tigray People’s Liberation Front (TPLF) and the Ethiopian National Defense Forces (ENDF). One year later, the humanitarian situation remains extremely dire and continues to deteriorate, with severe impact on civilians leading to mass displacement and limiting the delivery of humanitarian assistance to those in need. The political dynamics across the region changed drastically on June 28 following the unilateral declaration of ceasefire by the Federal Government and the subsequent withdrawal of the ENDF from and the takeover of the Tigray region by the TPLF. Since July, the conflict spiraled into the neighboring regions of Afar and Amhara causing a large-scale upsurge in displacement and aggravating the humanitarian situation

Since early November 2020, communities in Eastern Sudan bordering Ethiopia have received up to 60,000 refugees fleeing from the ongoing conflict in Tigray in northern Ethiopia. Sudan is however not new to the role of hosting refugees. Prior to the conflict in Tigray, Sudan was hosting approximately 1.1 million refugees and asylum seekers from South Sudan, Eritrea, Ethiopia, Syria, Somalia and Yemen.

The new influx of Ethiopians into Eastern Sudan in 2020 is therefore happening in a context where the host communities are used to receiving refugees. This does not mean, however, that the host communities are in any way prepared for or have sufficient resources or a strong enough apparatus for receiving the refugees.³



The state is natural geographical area on the slopes of the Ethiopian plateau and descend towards the rivers, valleys and creeks loaded with water as well as enjoying the state with land of clay soil fertile and interspersed with some hills. It is characterized by vast land suitable for agriculture, and the largest projects for rain fed agriculture in Sudan, a mechanism that agriculture machine used in various stages of production such as tractors and combine harvesters rely on rainfall.

Gedari state has long boundaries with Ethiopia in the east part, and neighboring four of Sudan states; Kassala from the north, Gezira from northern east, Sinner in the west and Blue Nile state in the south.

The total area is 75263 km² and estimated population of about 1,369,300



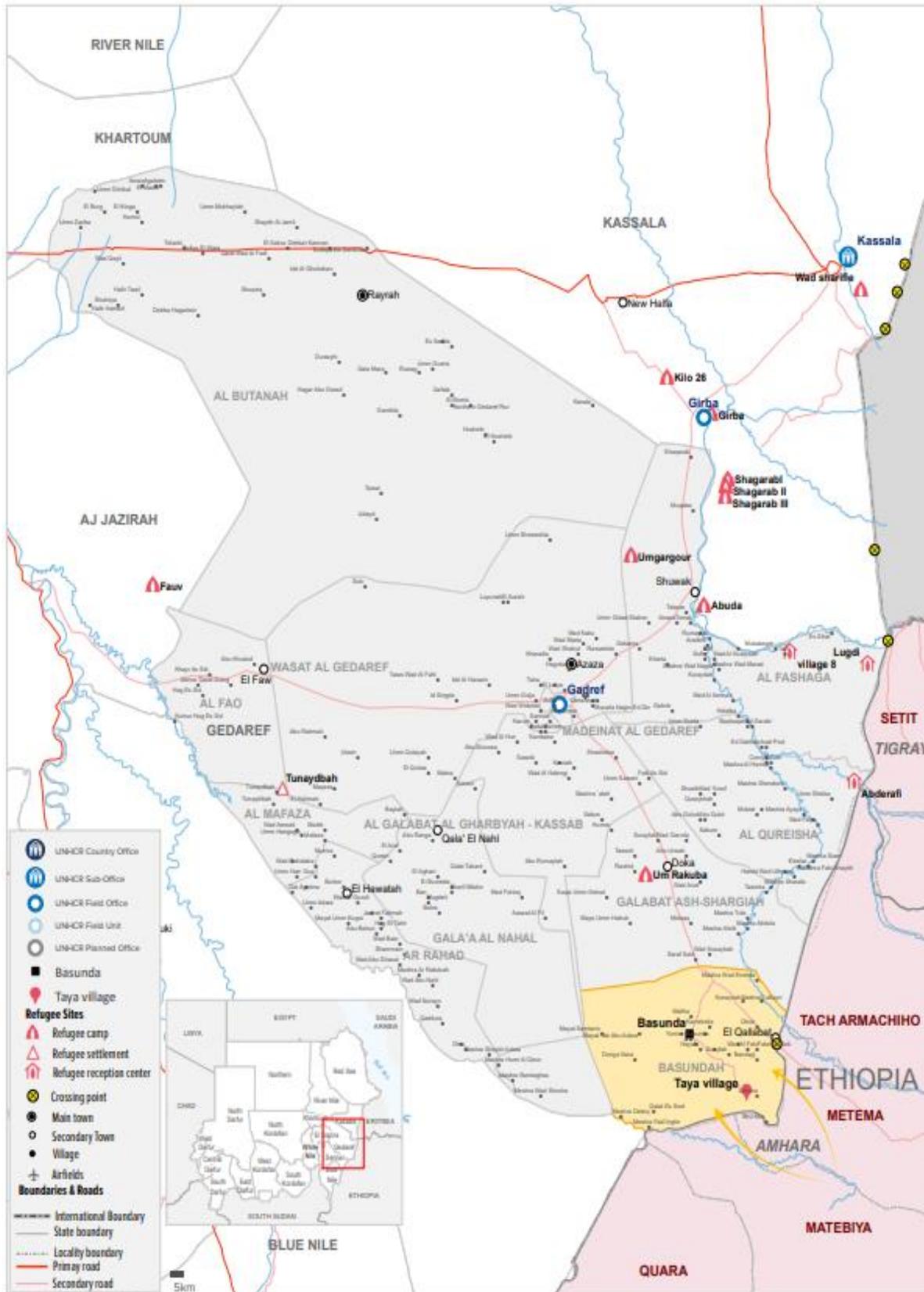
³ CMI. CHR MICHELSON INSTITUTE, SUDAN BRIEF, October 2021

According to Sudanese Coordination Office (COR) daily report. 26th September 2021, Gedarif state received 48337 refugees distributed in different camps as in table below:

Camps	Number	Ethicity
Village 8 Reception Centre	3093	Tigray
Basanda (Reception Centre)	1449	Kimant
Basunda	552	Kimant
Um Rakooba&Tenidba	41714	Tigray
Um Gargour	120	Tigray
Taya & Um Diblou	1409	Gumuz
Total	48337	

Host communities also express concern for the environment and the economy in and around the camps. They claim that the refugees' livestock have begun to feed on the agricultural crop of the Sudanese farms in the area. These rumors, true or not, have led to disputes between the refugees and Sudanese farmers. Refugees offering cheap wage labor is perceived to decrease the chances of employment for local people.⁴

⁴ CMI. CHR MICHELSON INSTITUTE, SUDAN BRIFIEF, October 2021



Sources: Geodata: UNHCR, OCHA. Author: UNHCR Sudan Feedback: Information Management Unit, SUDKIM@UNHCR.ORG

Objectives of need assessment:

The overall objective of need assessment is to assess the current situation, identify the gaps and needs of the targeted communities and recommend of key interventions that meet the real needs of the targeted people. The data was collected in four sectors:

- **WASH:** Hygiene promotion/awareness and hand washing practices, access to dignified, safe, clean and functional excreta disposal facilities, sufficient and safe water for domestic use, particularly in the targeted locations.
- **Health:** Situation and gaps in health services including public and maternity health.
- The assessment will give recommendation for improvement of different sectors.

1. Assessment methodology

1.1 Geographical coverage and scope:

The need assessment was carried in Gedarif State covering three localities namely Al-Galabat Shargia, Al-Mafaza and Al-Fashaga. The assessment covered host communities and Refugees camps in the three localities including Um Raquba, Tunedba and Village8.

1.2 Data Collection Methods and Tools:

The data gathered through checklists and detailed household constructive questionnaires. Check lists were used for gathering the qualitative data from groups through a Focused Groups discussions (FGDs), and individuals through Key Informant Interviews (KIIs). The household questionnaire designed to collect household information from the selected individual. A single visit technique was used to collect the information through the questionnaires.

Direct interviews:

Direct interviews were conducted with HH leaders using designed questioners, and simple random selection method. The survey used **Glenn. I., 2002 method** to determine the sample size with a confidence level of 95%, and a margin of error (5 %).

A sample frame of all homes was prepared and questionnaire forms collected at regular intervals say every 3 to 4 house interval with giving special consideration to the most venerable groups (poor, HH leded by women). A total of 445 HH leaders were interviewed, distributed 186 in Al-Galabat Shargia, 139 in Al-Mafaza and 120 in AL-Fashaga locality.

From the respondent 186 are females comprising 42% and 58% are males.

Focus Group discussions (FGDs):

Focus group discussion was conducted to collect qualitative data with different groups in the targeted communities. 4 FGDs were conducted with a group of about10 persons involving different groups in the communities including the leaders of the communities and representatives from other groups (women, men, youth males, youth females).

Key Informants Interviews:

Individual meetings conducted with the key informants from the relevant institutions including the Ministry of Health, Ministry of Agriculture, State Water Corporation, Water and Environmental Sanitation, and the managers of the camps.

Desk Review:

Literature and desk review was used for collecting the existing data including the different reports of the relevant institutions and the recently assessment conducted in the targeted areas, including inter agent assessments in which CARE participated.

Limitation:

The assessment witnessed some challenges includes;

- The long distances to the survey areas in addition to bad roads, specially Al-Fashaga locality
- The limited time for conducting the need assessment.

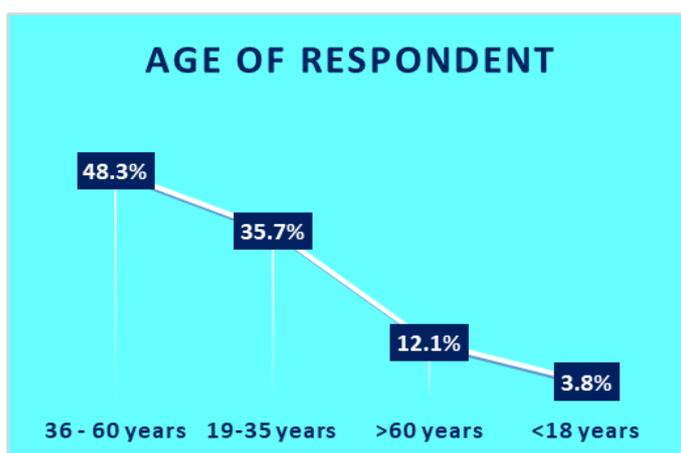
2. Findings:

2.1 Demography:

The assessed communities representing the local communities hosting the Ethiopian refugees in the three localities and the refugees from Ethiopia (Tigray region). From the 445 respondents, 304 are from the refugee camps comprising 68.3%, while 141 are from the host communities, comprising 31.7%.

Age of respondents:

Most of respondents are within the age 36-60 years (48.3%), followed by 19-35 (35.7%), 12.1% are elderly people more than 60 years and 3.8% are less than 18 years.



Sex of household head:

From the consulted households, 58.2 % are male and 41.8% are females.

There is different between Refugee camps and host communities regarding the HH sponsor, most of families in the camps are headed by women comprising 54.9% while in the host communities the most of HH are headed by males comprising 86.5%.

HH composition:

The average HH size is 7. As shown in table below; 27% of the communities are within the age group 19-60 year (13.7 male, 13.2 female) followed by boys and girls within 6-18 years comprising 25.6% (12.9 bays, 12.7 girls), children under 5 comprising 24.4% (12.4% males, 12% females) while the elderly people above 60years are the less group in the community comprising 22.8% (11.6% males, 11.2% females).

locality	Count of Male over 60 year	Count of Adult Male 19 - 60 year	Count of Boys 6-18 year	Count of Male child 0 - 5 year	Count of Female over 60 year	Count of Adult Female 19 - 60 year	Count of Girls 6-18 year	Count of Female child 0 - 5 year	Total
Al-Fashaga	71	97	94	89	64	95	96	87	693
Al-Galabat Shargia	160	180	166	166	159	180	167	160	1338
Al-Mafaza	118	134	127	116	112	129	118	113	967
Grand Total	349	411	387	371	335	404	381	360	2998
%	11.6%	13.7%	12.9%	12.4%	11.2%	13.5%	12.7%	12.0%	100.0 %

2.2 WASH sector:

Subsector water:

In some parts of the rural area, people are depending on the service water from Hairs which collecting during rainy season to be used in dry season, most of this areas are using Hafir water directly without any type of treatment, peering in mind animals are sharing the same Hafirs as source for drinking in dry season. Most of the Hafirs get dry in the last Months of the dry season (April – June) and access to water became very difficult and people need to go far distances to fetch water. Most of the rural areas are depending on ground water in term of water yards, mini water yards and hand pumps.

The State Water Corporation is the government body responsible from providing and improving water supply in the state. During meeting with the Authority, they confirmed that; SWC now is running under very low capacity, they are not able to do any development and they are now focusing only in the operation and maintenance in which they also facing many problems. The current water tariff is low and not sufficient to cover the cost of O&M, the SWC in most cases depending on the international organization. Most of the existing water sources are old and it subject to continuous breakdown which result in deficit on water in most times during the years. There is a need to shift from using fuel to solar system particularly in rural areas to insure sustainability because it does not need fuel and have less breakdowns.

Use of the fuel as the main energy for operating the water sources is the main challenge that affecting the sustainability of the water supply due to continuous breakdown and high cost of operation and maintenance, in addition to problem of lack of fuel in most times during the year.

The SWC do not have the required staff with good capacities and experiences due to high turnover and continuous migration of staff seeking for better offers as it is very week in government.

Access to easy, safe and adequate water:

In total; 58,6% of the assessed people have access to easy safe and adequate water while 41,4% are suffering from difficult in collecting water, poor quality or the water they collect is not enough for their HH.

However, 34% of the people in the refugee camps do not have access to safe water, but the situation is better comparing to the host communities where 58% of the people do not have access to save water, this is due to more focusing of all the working organization on providing services to the refugee's camps due to their crises and critical situation, in addition to the very low capacity of the government authority (SWC) in improving water supply for rural people. In this regards, special consideration should be given to the host communities as they start complaining. Host communities during FGDs confirmed that; refugees are sharing with them the available resources in the area including natural resources, and the services in the refugee camps became better than in their

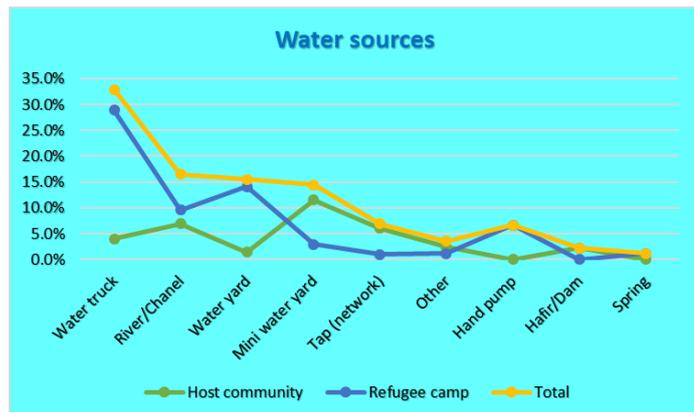


villages, and they are now start receiving some services from the refugee camps including water and health services.

Refugees camps more focusing should be on the water distribution to make collection easy for them, including networking and construction of distribution points.

The conflict is still continuing and more refugees are still coming, which indicate that, camps will remain for long times hosting those increasing refugees, in this regard, there in a need for thinking beyond emergency response to make services more sustainable for humanitarian assistance, including substitution of water trucking system with sustainable sources including more efforts in water distribution.

During the different seasons in the year; communities depending on different types of sources for collecting their water, difficulty of collecting water increase during dry season, however, use of service water during summer is easier, but the but the water have poor quality as people, particularly from host communities are using water service water without treatment. The dry season (March-June) is the most difficult time for accessing water, as people and animals –after service water get dry- depending on the limited available sources.



In general, most of consulted people are depending on truck as source of water (32.9%), most of them are from the refugee camps as 42.2% of the refugees are depending on truck to provide water for them in daily bases comparing to 12.8% from the host communities are depending on water from truck and in most cases thy bring it from the nearest camps.

16.5% from the consulted communities are using water from the rivers, 14.4% from mini water yards, only 7% have water network. Hand pumps were only found in the refugee’s camps comprising 6.7% from total respondents, using rain water from Hafir found only in the host communities comprising 2.3% from the total respondents.

Families collecting the required amount of water regardless the quality and safety. 58% collecting more than 5 Jerri Cans (Jerri Can=18 litter) per day, 13% collect 4 Jerri cans, 16.6% collect 5 Jerri Cans, 5.4% collect 3 Jerri cans, 3.6% collect 2Jerri Cans, 2.7% collect 1 Jerri cans and 0.7% collect less than 1 Jerri cans.

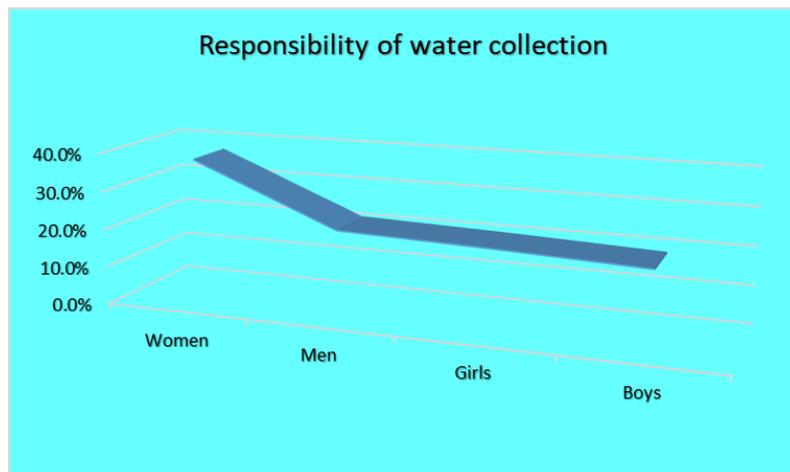
Access to water is one of the difficulties facing communities, particularly in dry season as water sources became far from where they live and overcrowded. From the total respondents; 38% need less than 15 minutes to collect water from the sources, 35.3% need 15-30minutes, 16.6% need 30-60 minutes while 10.1% spend more than 1 hour to collect water from the source. Water collection from the sources is easier in the camps comparing to host communities as 45.7% of the refugees can collect their water in less than 15 minutes comparing to 21.3% in the host communities and only 8.9% from refugees spend 30-60 minutes to collect water comparing to 33.3% in the host communities.

People also spend time queueing in the water sources for collecting water, from the total respondents; 42% spend few time (less than 15 minutes), 31% spend 15-30 minutes, 16%

spend 30-60 minutes, 55 spend more than 1 hour, while only 7% do not have queuing. When assessed separately; it is also clear that host communities have more difficulties in accessing water comparing to refugee camps as 24.8% from the people in host communities spending less than 15 minutes in queuing comparing to 24.8% of the refugees, and 2.7% from host communities wait for more than 1 hour comparing to 1.8% in refugee camps.

water networks only found in the host community where only 5% use networks in house for collecting water, the remain people have to collect water direct from the source using different means for transporting water to their houses. Most of the families currying water in their heads (58.1%) in Jerri Cans or metal bucket, 17.8% use donkey carts, 3.3% use khuruj (leather water container), 2.95 us bicycles/motorbikes, while 13% have other different means.

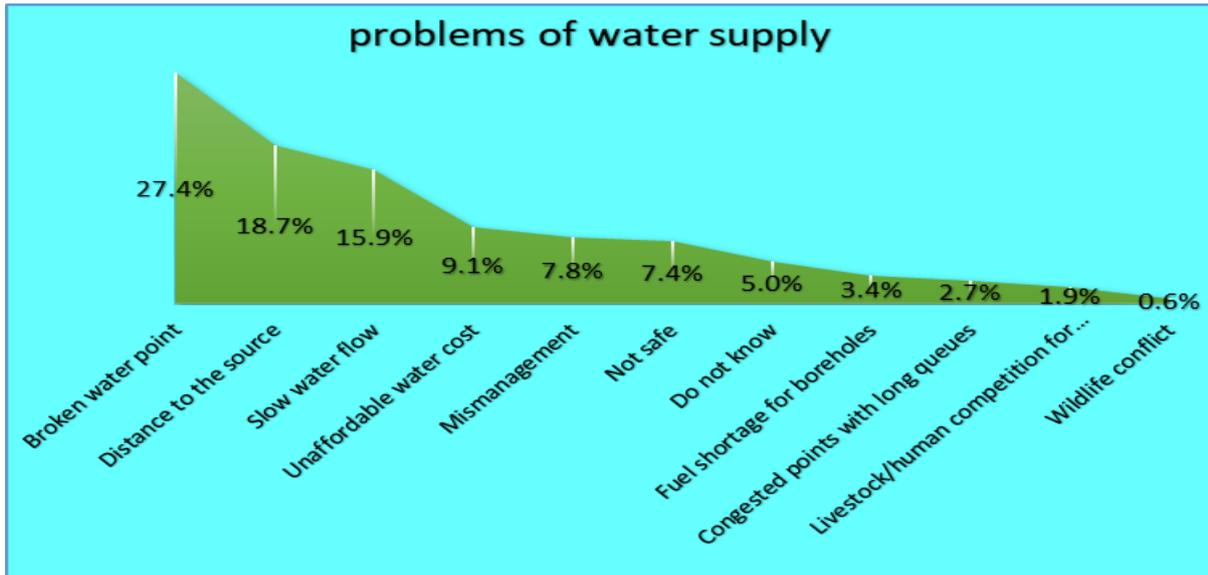
Fetching water from the sources is shared responsibility between family members, but women have the main responsibility in fetching water from the sources comprising 33.2%, followed by boys and girls comprising 24%(12% each), and men have the lowest responsibility in fetching water (17.2%).



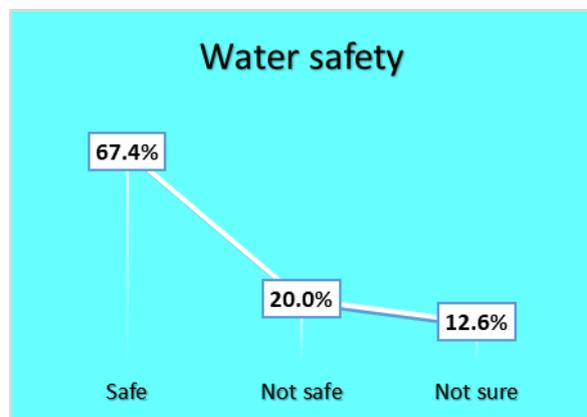
It worth to mention that; lack of water sources closed to the housed is one of the main causes of Gender Based Violence (GBV), particularly women, girls and youth females who facing different types of violence during collecting water particularly those need to go far distances to collect water particularly during dry season.

From the consulted individuals, 21.8% confirmed that women and girls are facing problems during fetching water, 16.6% confirmed they do not know as women and girls do not tell what happening to them during fetching water. When they asked about the types of problem facing women and girls, 19% is the lost among boys and girls when they go far distances searching for water particularly during dry season, 12.3% are facing the problem of violence and 11.7% facing sexual harassment. There is also cases of kidnaped reflected by 0.6%, and 6.1% have other different problems including; sink in river during fetching water, wild dogs attacking people in some cases, in addition to portion among pregnant as result from collecting water.

There are different types of problems affecting targeted people accessing easy safe and sufficient water Communities, they were asked about these problems and they reflect hat: continuous breakdown of the water facilities is the big problem affecting their access to safe water comprising 27.4%, far distance to water source (18.7%), slow water flow (15.9%), unaffordable cost (9.1%), mismanagement of water sources (7.8%), poor quality of water (7.4%), fuel shortage (3.4%), over crowd in the source (2.7%), competition with livestock (1.9%) and wildlife competition affecting 0.6%.



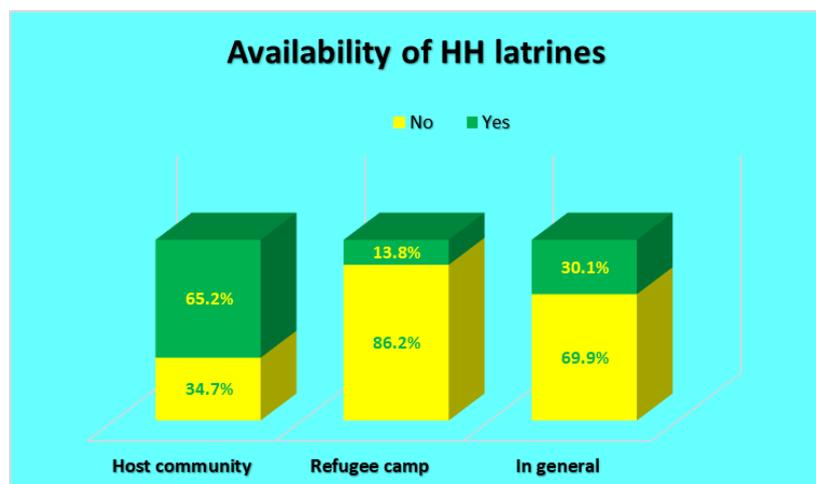
When they asked about the quality and safety of water they are use, 20% of the participants reflected that; the water they are use is not safe, and 67.4% they think it is safe while 12.6% are not sure about the safety of water. From those who confirmed water they use is not safe or they not sure; 12.1% do not use any type of treatment in home to improve water quality while the remain are using different methods of treatment including boiling (26.2%), chlorination (21.5%), filtering (14.8%), storing (12.1%), use local materials (11.4%), while 2% use silting.



Subsector Sanitation:

Latrines:

In general; less than third of the assessed people have latrines comprising 30.1% while the majority do not have latrines in their houses (69.9%). Situation in host communities is relatively better comparing to the refugees as 86.2% of the people have latrines comparing to only 13.8% of the refugees who have latrines in their houses, this is due to concentration of

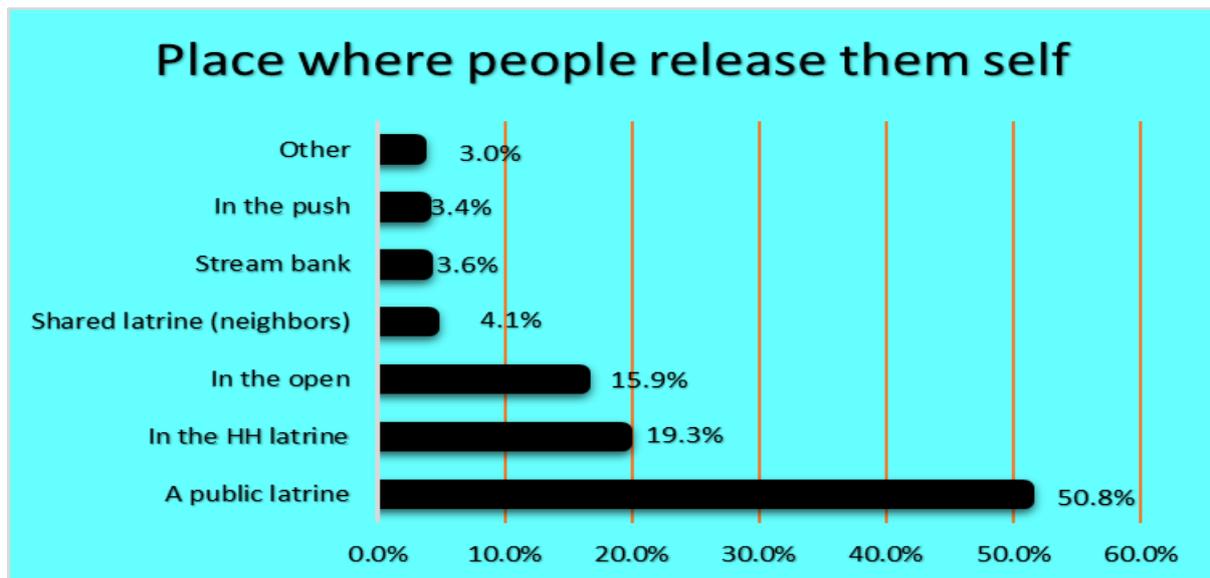


service providers in refugee communities in providing communal latrines rather than HH latrines, in this regard, the communal latrines observed not sustainable, even for its lifetime

as people continuously stall the super structure materials to use it for housing, particularly during rainy season when their houses damaged and they prioritize housing for their families. Shared latrines can be option as it will be under responsibility of about two families, on other hand, discussion should be held with other service provider, particularly actors working in shelters.

Almost 25.8% of the people in the area practicing open defecation in different places, including, open spaces in/near their villages/camps (15.9%), in the stream bank (3.6%), in the push (3.4%) and 3% in other places including agriculture field.

50.8% are using public latrines, all of them are from the refugees, HH latrines found and used in the host communities (19.3%), while 4.1% are sharing latrines of their neighbors.



From the people who have access to latrines, 64.5% confirmed that it is not accessible to elderly and people with disabilities, it worth to mentioned here, there other factors regarding use of latrines, as some of community members need capacity building and awareness in importance of using latrines and the best way of using latrines to keep it cleans as most of latrines observed not clean and it became good environment for flies.

Waste management:

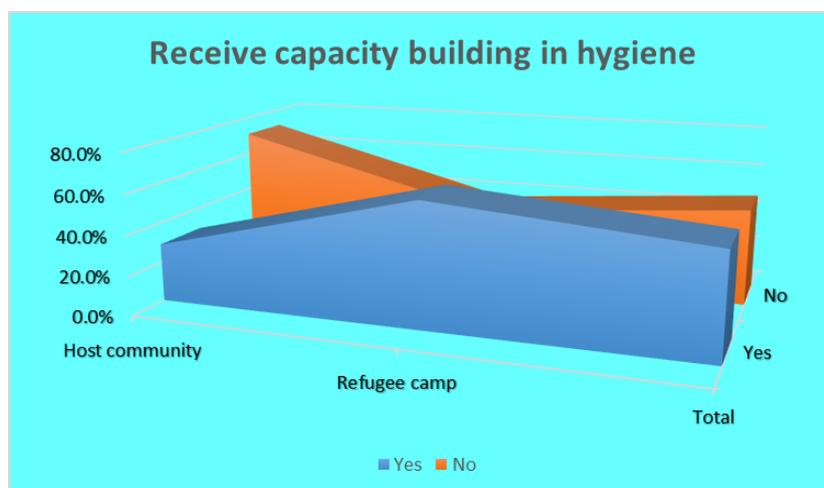
Waste management system only found in the refugee camps intruded by CARE international, the existing system covering only 28.8% of the refugees, very few people in the host communities (0.4%) have containers outside houses for waste disposal. The remain 71.3% of the people in both refugee camps and host communities do not have waste management system and they have different ways to dispose their wastes including; 24.8% are throwing their waste outside the yard, 22.4% use open bits, 12.75 burn wastes inside houses, 7.5% thrown into latrine, 3.65 thrown in the water streams while 0.4% do not dispose of their wastes. It observed that; there is a poor management of waste in the targeted communities, it is spread everywhere including roads between houses. Some people throw it in the water streams which became water sources in the rainy season and it is the same streams take rain water to the service water sources (Haffirs).



Subsector Hygiene:

Hygiene promotion is need to be integrated with all WASH intervention as some services need good effort to improve community knowledge and improve their attitude and practice to avoid its negative impact on their health, including use of latrines, keep water safe in source, during transporting and storage in home, good practices for environmental sanitation through cleaning houses and roads and best way for disposing the wastes, in addition to personal hygiene. Hygiene promotion can be also used for community mobilization for good participation in improving environmental health.

Half the consulted people did not receive any type of capacity building in hygiene (48.3%). However, there still gap in hygiene promotion within the refugees, but the situation is better than in the host communities, as only 29.1% of the host communities were received capacity building in hygiene comparing to 62.2% in refugee camps.



This was reflected in the hygiene practices, as 20% of the people do not use water and soap for washing hands at any time, they only wash their hands when it gets dirty using only water (14%), 4% are using water and sand/soil and 1% use ash.

The 80% who confirm using water and soap for hand washing and when they asked about the times they usually use water and soap for hand washing, it found that; 71.2% of people wash their hands with water and soap before eating, 70.3% after going to the toilet, 70.1% before food preparation, 69.2% after eating, 60.2% after cleaning baby's back, 55.5% before feeding children and 5.4% in none of the mentioned times.

Recommended WASH intervention:

Water supply:

Provision of safe water:

- *Improve the water distribution systems (networks and distribution points) to reduce over crowd in the water sources.*
- *Ground water source (water yards, hand pumps, mini water yards) preferred in places have good ground water aquiver.*
- *Harvesting of rain water using Haffirs can be option for places where there is no ground water, or it can be constructed for livestock consumption due to low operation cost and to reduces the stress on other water sources.*
- *Rain water harvesting should be treated for human use as it is subject to pollution, or use it only for animal use to reduce stress on other sources.*

Water distribution: *Through construction:*

- *Networks for distribution water to houses*
- *or to sufficient water point.*

Water quality:

- *Continuous monitoring system for water sources including frequent water testing.*
- *Water treatment particularly when using service water or trucking.*
- *Capacity building for people on best and safe practices for water collection and storage*

Sustainability:

- *Involvement of communities in the management, O&M of water sources, by forming and train of Water Users Associations.*
- *Introduce water tariff to communities who do not have and support the poor people through water vouchers.*
- *Build the capacity of the communities on the best way of using sources.*
- *Provide the required protection as part of construction/rehabilitation design.*
- *Introducing of solar system instead of using fuel.*

Sanitation:

Stop open defecation:

- *Improve access to latrines through construction of HH and communal latrines. And construction of latrines in the public facilities specially in schools.*
- *Introducing of Community Led Total Sanitation (CLTS) approach.*

Environmental health:

- *Introducing of a good system for solid waste management.*
- *Conducting of cleaning campaigns.*
- *Build the capacities of people in safe disposal of solid wastes.*

Hygiene promotion:

- *Conducting of capacity building programs in best hygiene practices (hand washing, use of latrine, waste disposal etc.)*
- *Forming and train of Community Health Works (CHWs) groups to lead hygiene work in the communities including conducting of regular HH visits.*
- *Produce and distribute of signboard/leaflets in hygiene messages.*
- *Provision and distribution of hygiene materials/tools (Soap, hand washing facilities, etc.)*

2.3 Health and Nutrition sector

Sub sector Health – Public health:

During meeting with them, authorities in the ministry of health confirmed that; The capacity of the ministry is very weak, it depends on the working International organization on providing both preventive and curing services. The department of primary health care in the ministry include nine administrations one of them is the mothers and children health care unit, which is responsible from child nutrition, vaccination, reproductive health, child health.

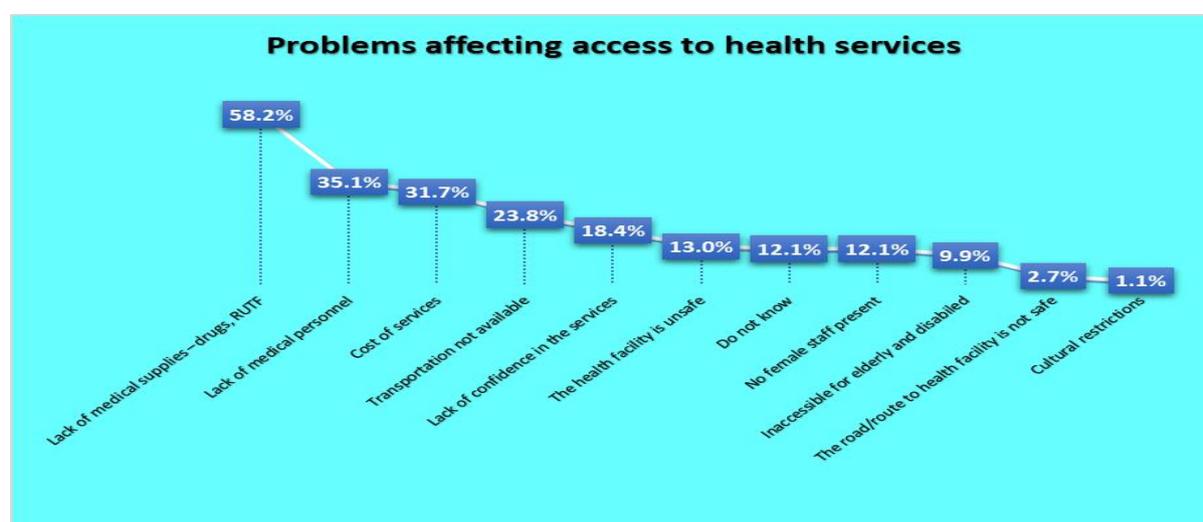
Child nutrition unit receiving some support from Unicef, WHO and WFP. The unit well established but it lacks of staff with good capacity as the ministry suffering from the high turnover among staff due to very low offer. Lack of required logistic hindering the spread of workers in different area in the state to provide the required support in mothers and children health, which resulted in high cases of malnutrition among children and week services in sexual and reproductive health, and there is high need for training for the available staff.

Most of the assessed people do not have problem in accessing health facilities (91.7%) and the coverage seems good, the available facilities are health centers serving 54.9%, clinics serving 30% and hospitals serving 15.1% of the assessed people.

From the consulted people, 34.8% always have access and go to doctors for treatment, 54.9% go to medical assistant while the remaining either used traditional treatment (8.6%) or do nothing when a family member get sick (0.3%)

Most of people (60.8%) need 30 minutes or less to reach the health facility, 20.9% need less than 15 minutes. 16.4% need 30-60 minutes, 9.75 need 1-2 hours, 8.3% need more than one hour while 4.7% need 2-3 hours to reach the health facility.

However most of people have access to health facilities, but many factors are affecting their access to the good services. When they asked about the things affecting their access to health services; 58.2% is lack of medical supplies such as medicines, 35.1% lack of medical personnel in the health facilities, 31.7% due to cost of the services, 23.8% lack of transportation, 18.4% lack of confidence in the health facilities services, 13% raised the issue of safety as they think the health facilities are not safe, 12.1% due to unavailability of female staff which contradicting with their culture, 9.9% is due to inaccessibility of the facilities for elderly and disabled people, 2.7% due to unsafety of the roads and 1.1% have cultural restrictions.



Sub sector Health – Maternity health:

Lack of good health services is also reflected on weak maternity health among the targeted communities, there no specialized doctors in this sectors and all communities depending on the trained/traditional midwives.

There are some practices related to cultures and tradition have negative impacts on the sexual and reproductive health including FGM and early child marriage particularly in the rural communities.

As confirmed by the authorities, most of people in the rural areas are depending on midwives for providing sexual and reproductive health services. However, the number and of available midwives is good covering all the villages, but they did not receive the required training and capacity building, in addition they lack of the required tools that support them to do their work effectively.

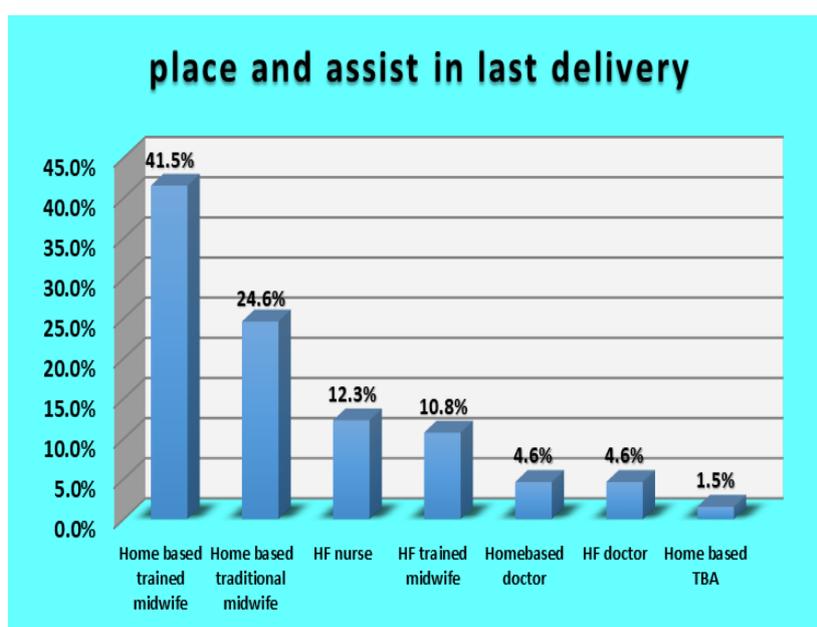
From the consulted households; 65 (14.6%) have pregnant women during the last 12 months, most of them (76.9%) referred to midwives for ANC. When they asked about the frequency of attending FNC during pregnancy, 41.5% of them attended AFC tow times or less, including 20% attended two times, 16.9% attended one time while 4.6% of the pregnant women have never attended ANC during pregnancy, 29.2% attended three times and 29.2% are the pregnant women attended FNC more than three times during pregnancy.

For those who never attended ANC, 33.4% of them did not attend because they do not like the attitude of the medical workers, all from refugees, the remain 66.6% are all from host communities and they did never attend ANC due lack of female medical care person (33.3%) and 33.3% they think there is no need to attend ANC during pregnancy.

And those who attended ANC only one time relate this to; lack of money (52.9%), unavailability of female medical care person (23.5%), 11.8% due to far distance to health facility (all from refugees), while 11.8% they think one check is enough and no need to go for the second time (all from host communities).

There is a need for providing delivery support as 56.9% did not received postnatal care after delivery, and 70.8% were not support with the clean delivery kits.

Most of the deliveries were assisted by midwives (76.9%), 41.5% of them delivered in their house assisted by trained midwives, 24.6% delivered in house assisted by traditional midwives, 12.35 assisted by nurse in health facility, 10.8% assisted by trained midwives in health facility, 4.6% assisted by doctors in their homes, 4.6% assisted be doctors in health facility while 1.5% delivered in home an assisted by TBA.



Recommended health and nutrition intervention:

Public health:
Support of the existing health facilities: <ul style="list-style-type: none">• Provision of required equipment and tools.• Provide the required Capacity building for HF staff.• Provision of water and sanitation services.• Medical supply: including provision of medicines and required testing materials.
Sexual and Reproductive Health (SRH): <ul style="list-style-type: none">• Advocacy and capacity building for authorities and community members to stop harm practices such as Female Genital Mutilation (FGM) and early child marriage.• Conduction of capacity building program for women and girls on SRH.• Provision of extensive and advanced training for the existing midwives.• Provision of the required tools for the trained midwives.• Construction of special rooms for SRH in the existing health facilities.• Provision and distribution of save delivery kits.

3. Recommendations:

- Host community should be considered in developing the proposal and intervention as they have many problems in accessing services, in addition to reduce tension between host communities and refugees.
- Need of strong corporation with the State Water Corporation and it is related department like water and Environmental Sanitation (WES) project to identify the needs and types of required interventions.
- Introduction of Solar system is very essential to insure sustainability in addition to environmental consideration, this can include upgrading of the existing sources and to be part of designs for new construction of water sources.
- There is a need for providing latrines and hygiene promotion to stop the existing practice of open defecation and reduce the spread of related diseases.
- Suitability should be considered in designing and allocation of latrines, as people are always use taking the superstructure material to use it for housing.
- There is a need for introducing a good system for waste management, particularly in the host communities and improve the existing system in the refugee camps.
- There is a need for providing support to SMOH to improve coordination of community health program at state and locality levels, through capacity strengthening of state and locality focal points of the community health and health promotion programs.
- There is a need for intensive work in awareness, capacity building and advocacy to reduce the harm practices affecting girls and SRH, particularly practicing of FGM and early child marriage.

