Care International Sudan

Comprehensive Multisector Need Assessment

South Darfur State

December 2021

Contents

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
RH	Reproductive health

Executive summary

- The need assessment was conducted by a team from CARE International Sudan, led by the MEAL coordinator. The assessment took place in South Darfur state covering Gereida locality, and East and South Jabal Mara areas in Kass locality. The objective is to assess the current situation, identify the gaps and needs of the targeted communities and recommend key interventions that meet the real needs of the targeted people. Different methods were used for data collection including individual interviews with household leaders, Focus Group Discussions with representative from different community groups, desk review of the existing information and Key Informant Interviews with the authorities in relevant ministries and institutions.
- Only 7.6 % of the people in the assessed area have easy access to adequate safe water for their family, the 92.4% are suffering either from difficulty in getting the water, poor quality of water or the insufficient amount for their households.
- Responsibility for fetching water lies primarily with women (55%) and girls (27%). This puts not only an uneven burden on women and girls with regards to the time and energy spend, but also exposes them to various types of violence (21.9% reported this), including sexual harassment (reported by 3.8%).
- There is lack of hygiene promotion within the assessed communities, as 97% of respondents indicated not having received any type of capacity building in WASH, this reflected in the way that communities dealing with environment and personal hygiene: Only half (50.9%) of the respondents regularly wash their hands with water and soap. With regards to sanitation, 45% of the populates practices open sanitation. Interestingly, while 51.5% of the population has a latrine in their household, 36.6% of the population uses a latrine in their household. Lack of hygiene and sanitation is associated with poor health outcomes, with open defecation contributing to the risk of (sexual) violence against women,
- The assessed areas are suffering from lack of health facilities, and the available facilities are poor in term of required services, only 36.4 % of the consulted people have health facilities in their villages, including health centers (31.3%), hospital (6.5%) and clinics (2.2%).
- Women and girls suffer from poor access to sexual and reproductive health services. Only 28.1% of deliveries are done in a health facility, with the assistance of a trained mid-wife (21.3%), nurse (3.4%) or doctor (3.4%). Home-based deliveries by a traditional mid-wife are the most common way to give birth (38.2%). The traditional mid-wives lack formal education and some of them also undertake harmful traditional practices such as Female genital mutilation.
- Malnutrition among children under 5 years is high (37.6%) as a result of; 1) lack of capacity among mothers on the importance of intensive breast feeding for infants and other best nutrition practices for other children, 2) the poverty and low level of livelihood among the targeted communities which affect their access to the food.
- Agriculture is the main source of income for 88.9% of the consulted households in the assessed area, 65% of them are women headed households, and within the consulted females 86.5% are depending on agriculture as the main source for income. 55.4% of people depending on their own agricultural production as main

source of food for their families. All farmers interviewed practice traditional rain fed agriculture

- House hold income is very low in the assessed area as 84.1% of the consulted people have an income of 5,000 SDG (12 USD) or less per month, 12.4% earn 5000 -10000 SDG/Month while only 3.5% of the people earn more than 10000 SDG per month. In the months prior to harvesting, food insecurity peaks. In September 93.3% if people suffer from lack of food. Figures are also particularly high in August (58.8%) and October (19.4%).

Background

CARE has been operational in Sudan since 1979, 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.

Since the beginning of the revolution in December 2019, Sudan has witnessed a lot of turmoil, fluctuations and political instability, which reflected in all life aspects. After the transitional government was formed by agreement between the civilians and military components, the situation began to move towards stability with a slight progress in the direction of economic growth, but soon this stability dissipated as a result of the incompatibility between the different components, and the situation get worsened after the coup on October 25th 2021, demonstrations started again rejecting the coup and demanding for civilian government. All initiatives to address the situation were failed, including the return of Prime Minister Abdullah Hamdok through an agreement with the military component on November 21st 2021, which was rejected by the protesters, forcing the Prime Minister to resign again. Situation get worsted with a complete constitutional vacuum represented in the absence of an executive government, and the continuation of demonstrations and protests, which negatively affected the situation and deteriorated the economy and services

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 prices[1].

[1] Sudan - Key Message Update_ Tue, 2021-11-30

South Darfur State:

South Darfur is one of the five states that compose the region of Darfur in western Sudan. Prior to the creation of two new states in the Darfur region in January 2012, South Darfur had an area of 127,300 square kilometers (49,200 sq. mi) and an estimated population of approximately 2,890,000.

The state is located in the western part of Sudan between longitudes 15-32 and 45-27 east and latitudes 30-8 and 13-13 north. It is bordered by North Darfur state from the north, Central Darfur state from the west, Central African Republic from the southwest, West and North states Bahr el Ghazal from the south and East Darfur state from the east.

South Darfur[2] are among the most food insecure states in Sudan, according to FAO 2020, while also being among the poorest, with a poverty rate of 67%, and hosting the largest number of internally displaced persons (IDPs). Acute food insecurity caused by currency devaluation, inflation, and local conflict is hitting both states particularly hard. According to IPC classification[3], 847,126 people in South Darfur are in IPC Phase 3 or higher and unable to meet their immediate needs. Kass and East Jebel Mara in South Darfur have the highest number of people experiencing acute food insecurity at 25% and 35% respectively. According to the WFP Strategic Plan for Sudan (2019-23), less than 2% of IDPs and refugees can adequately support themselves with food, and more than half of them are food insecure even with support. IDPs' livelihoods are highly dependent on rain-fed agriculture, which is highly vulnerable to climate shocks. For 77% of households in South and East Darfur, rained agriculture is their main source of income. 40% of farmers experienced disproportionately low yields due to farming practices and crop losses from flooding.

Protection of civilians remains a major concern in the wider region; conflict and violence have resulted in massive displacement, both cross-border (with an estimated 3 million refugees and asylum seekers) and internal (with 4 million Internally Displaced Persons - IDPs). Displaced people continue to be completely dependent on external assistance for their survival. Unaccompanied minors and separated children are among the most vulnerable categories requiring specific attention and tailored assistance. Existing camps/settlements and hosting capacities in local communities are overstretched. Host populations often face the same risks and vulnerabilities as displaced persons and should therefore also be considered for humanitarian assistance depending on their needs and vulnerabilities. The growing economic difficulties, which particularly affect refugees and IDPs, could further feed tensions between the refugee populations and their host communities.[4]

[2] See appendix 5 and 6 for the exact location of the project area
[3] IPC May 2021: http://www.ipcinfo.org/ipc-country-analysis/details-map/en/c/1154879/
[4] HIP 2022

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:

- **Food Security and Livelihoods (FSL):** Covers the issues that related to, and affecting the livelihood of the targeted people, including the sources of income, capacity of people, opportunities, with giving special consideration to agriculture and animal resources as they are the main activities in the targeted areas.
- **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 and Nutrition:** Situation and gaps in health services including public and maternity health. Gap on children nutrition, malnutrition among children and mother's capacity.

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 South Darfur State covering two localities namely Gereida and Kass (East and South Jabal Mara). The assessment covered host communities and IDPs camps in the two localities including Graida and IDP camp in Graida locality and the villages of Sangora, Dogi hashaba, kalo, Hajar Baida, and Tori cluster (tori Nomi, Tori Simida, Tori Dali and Tori Kati) in Graida locality.

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 leaded by women). A total of 371 HH leaders were interviewed, distributed 207 in East and South Jabal Mara area in Kass locality and 164 in Graida locality.

HH questioner designed in Kobo toolbox and mobile were used for collecting the data in Graida locality while in Jabal Mara area data collected manually using papers as the armed group who controlling the area refused using of mobile.

Total of 371 individuals were interviewed, 207 are from Kass (East and South Jabal Mara) and 164 are from Graida locality, 75.7% of the respondent are female headed households.

Focus Group discussions (FGDs):

Focus group discussion was conducted to collect qualitative data with different groups in the targeted communities. 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:

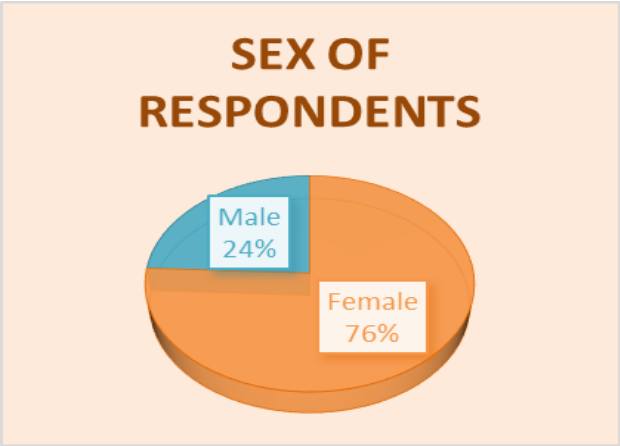
The assessment witnessed some challenges includes;

- The long distances to the survey areas in addition to bad roads, specially Jabal Mara area.
- Lack of communication in Jabal Mara area.
- The limited time for conducting the need assessment.
- The armed group who controlling the area of Jabal Mara refused the use of mobile for data collection which led to delay in order to redesign the questioner to be used manually and then inter it in Kobo.

2. Findings:

2.1 Demography:

From the 371 respondents, 169 are from the IDPs comprising 45.6% while 202 are from the host communities, comprising 54.4%.



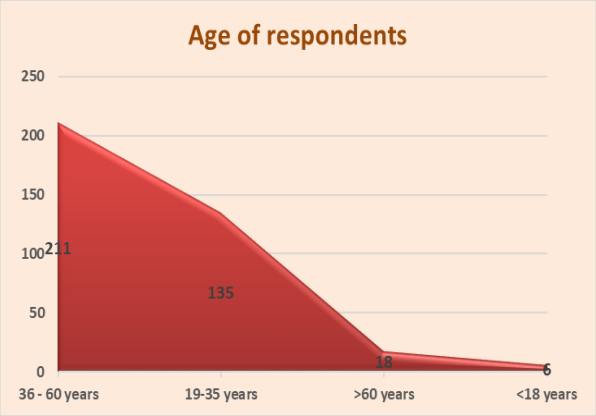
Most of the respondent are women headed households (75.5%), many families lost their sponsors due to the long period of conflicts in the area resulted in death of many people in addition to continue of involvement in armed action.

Jabal Mara area is under the control of the Sudan Liberation Army-Abdul Wahid (SLA-AW), government have no access to area which led to totally stop of development for long time.

No humanitarian organizations had been present for nearly ten years, has become accessible to humanitarian partners in November 2019 and CARE started providing limited health, nutrition, and WASH services in January 2020, and the need remains significant. For now; communities are resilience on the humanitarian interventions provided by international organizations.

Age of respondents:

Most of respondents are within the age 36-60 years (56.9%), followed by 19-35 (36.4%), 4.8% are elderly people more than 60 years and 1.6% are less than 18 years.



HH composition:

The average HH size is 7. As shown in table ( ) below; there is a relatively convergence regarding the different age groups in the communities

locality	Sum of Number of HH members	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
Gereida	**1293**	160	163	162	161	159	164	163	161
Kass (S&E)GM	**1465**	166	194	194	181	166	195	186	183
Grand Total	**2758**	**326**	**357**	**356**	**342**	**325**	**359**	**349**	**344**
%		**12%**	**13%**	**13%**	**12%**	**12%**	**13%**	**13%**	**12%**

2.2 WASH sector:

Subsector water:

In South Darfur state; Most of the rural areas are depending on the ground water from boreholes, and the other parts are depending on the service water due to presence of the basement, where water collected in Hafirs in the rainy season for use in the dry season, in all Hafirs water is directly used without any type of treatment, people and animals share use of water from Hafirs. Hafirs became dry at the last Months of dry season (April-June) and it became very difficult for people to get water, they travel long distances for fetching water from nearest sources.

The State Water Corporation do not have capacity for development (as confirmed by SWC authorities) and they are now focusing only in the operation and maintenance. 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 to insure sustainability because it does not need fuel and have less breakdowns.

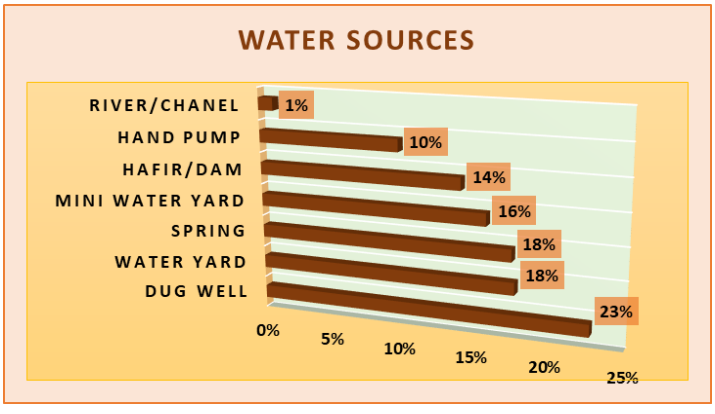
Use of the fuel as the main energy for operating the water sources is the main challenge that affecting the sustainability of the water supply due to continuous breakdown and high cost of operation and maintenance, in addition to problem of lack of fuel in most times during the year.

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:

Only 7.6 % of the people in the assessed area have easy access to and adequate safe water[5] for their family, the 92.4% are suffering either from difficulty in getting the water, poor quality of water or the insufficient amount for their households. People are in need of providing good quality water and use types of interventions that make it easy collection through networks or sufficient distribution points.

People in the targeted areas using different sources of water. Dependence on different sources varies during the year, as communities prefer to use service water during the rainy season due to easy collection such as ponds, Hafirs and springs. 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.



From the targeted communities; 23% are suing water from Dug wells, 18% from water yards, 18% from springs, 16% from mini water yards, 14% form Hafirs, 10% from hand pumps, 1% from

[5] Access to water assessed through direct question for the three factors; easy collection, good quality, and sufficient amount for HH

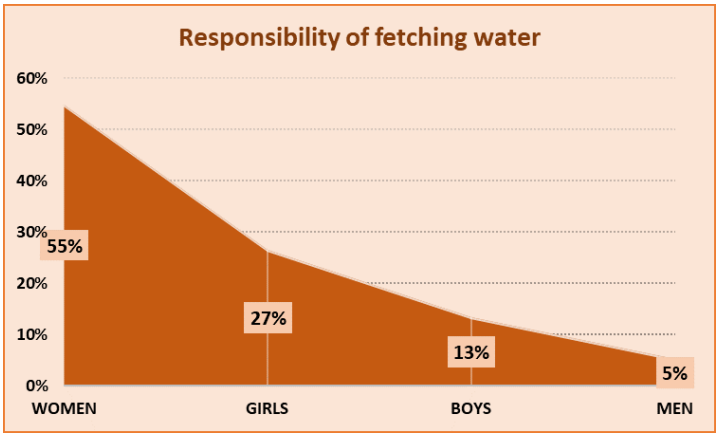
Families collecting the required amount of water regardless the quality and safety. 42.3% collecting more than 5 Jerri Cans (Jerri Can=18 litter) per day, 27.5% collect 4 Jerri cans, 20.2% collect 5 Jerri Cans, 5.1% collect 3 Jerri cans, 4.3% collect 2Jerri Cans, 0.3% collect 1 Jerri cans and 0.3% collect less than 1 Jerri cans.

Access to water is one of the difficulties that community facing, particularly in dry season as water sources became far from where they live and overcrowded. 53.1% of the families need more than 1 hour to fetch water from the sources, 23.5% need 30minutes-1hours, 16.2% need 15-30 minutes, and only 7.3 % can fetch the water in less than 15 minutes.

Due to limited sources, families spend time waiting in the sources (queuing) to have chance for water collection. 40.7% waiting 30 minutes – 1 hour in the queuing tell collect their water, 32.1% wait for more than 1 hour, 10.8% wait for 15-30 minutes, 4.3% less than 15 minutes while only 12.1% confirmed that they do not wait.

None of the assessed communities have water networks in homes, and all the families have to collect water from the sources. Different means are used in fetching water from the sources. Most of families collecting water by jerry Cans or metal buckets they put on their heads (46.6%), 44.7% use Khuruj (leather water container curried by donkey), 25.6% use donkey card, and 4.3% use other means.

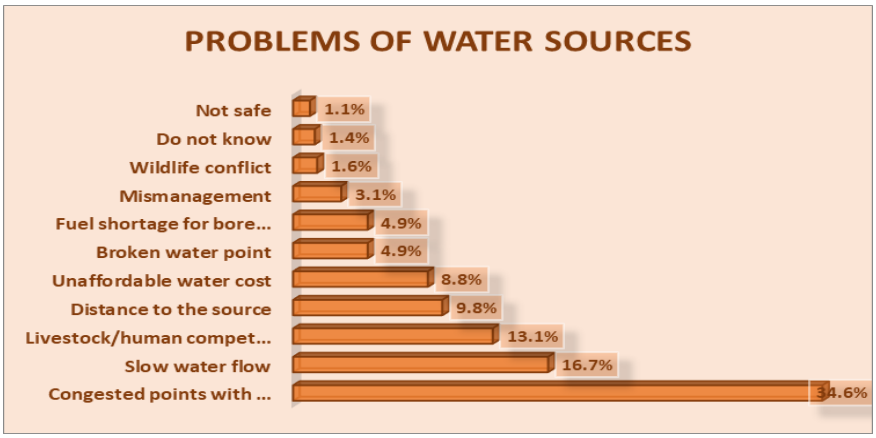
All family members participating in fetching water from sources, but the main responsibility is on women representing 55%, girls 27%, boys 13% and men are less participating in fetching water (5%).



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 girls and youth females who facing different types of violence during collecting water.

From the consulted individuals, 34% confirmed that women and girls are facing problems during fetching water, 23% reflect that it makes them tired and sick, 21.9 % confirmed they are subject to different types of violence, 4% get lost or kidnaped (0.5%)particularly among children when go far distances when the nearest sources stopped or get dry, 3.8% are facing sexual harassment, and 0.3 % reflect that girls are even subject to rape during fetching water.

Communities are facing Many problems affecting their easy access to safe and adequate water, particularly during dry season when natural sources get dry, the problems including; very crowded with long queues (34.6%), slow water flow (16.7%), livestock competition (13.1%), far distance to water sources (9.8%), unaffordable water cost (8.8%), broken water point (4.9%,), shortage of fuel (4.9%), mismanagement (3.1%), wildlife conflicts (1.6%), not safe (1.1%), and 1.4% do not know the problems.

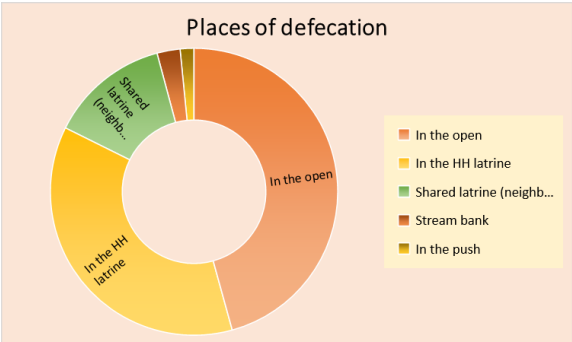


When they asked about the quality and safety of water they are use, 59% of the participants reflected that; the water they are use is not safe, and 41% they think it is safe. From those who confirmed water they use is not safe; 48.2% do not use any type of treatment in home to improve water quality while the remain are using different methods of treatment including silting (36.5%), filtering (6.8%), storing (5.4%), chlorination (1.4%), boiling (1.4%) while 0.5% are using local materials for water treatment.

Subsector Sanitation:

Latrines:

Most of families do not have latrines I their hoses (51.5%), 36.6% of them are using these latrines, the remain while the remaining 63.4% release themselves in different places, 13.5% are sharing latrines with their neighbors, and the remain are practicing open defecation in different place including open spaces (45.7%), streams (2.6%), and 1.6% in the bush.



Waste management:

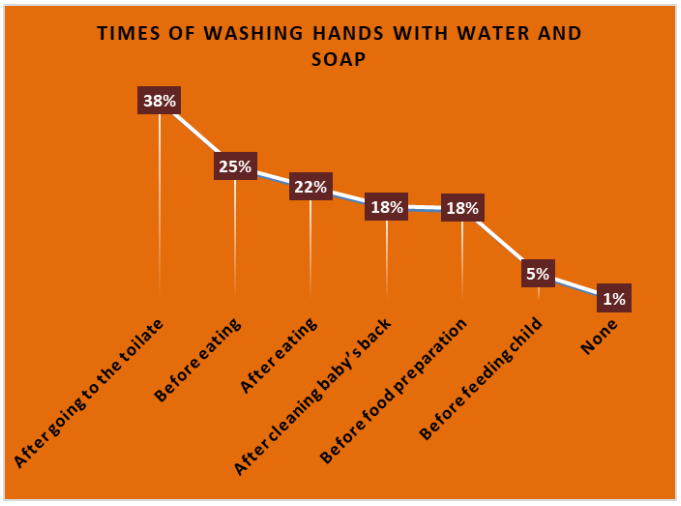
There is no certain type of management for waste disposal from households, and only 13% confirmed that they have containers outside their housed where can dispose their wastes, and the remain 87% have no clean and dignified place for waste disposal and they use different means, the majority of the people (58.4%) thrown their waste outside the yard, and 14.9% use open pits, 7.1% burn the wastes inside their houses while 6.6% throw it in the water streams.

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:

There is lack of hygiene promotion within the assessed communities, most of them did not received any type of capacity building in WASH **97%**, this reflected in the way that communities dealing with environment and personal hygiene, lack of hygiene is one of the main causes of poor waste management and common practice of open defecation even from part of family members who have latrine in houses.

Only 50.9% of the consulted people are using water and soap for washing hands, the remain are using only water (43.9%), water and sand/soil (4.9%) and 0.3% are using ash for hand washing. The people who sue water and soap for hand washing, and when they asked about the time the usually washing their hand, 38% reflect after going to toilet, 25% before eating, 22% after eating, 18% after cleaning baby's back, 18% before food preparation, 5% before feeding children and 1% in none of the mentioned.



Recommended WASH intervention:

Water supply:

Provision of safe water:

- *Conduction of functionality assessment for all water sources in the targeted area to assess its need. This should be done in corporation with the SWC as the technical institution*

Construction or rehabilitation of water sources including;

- *Ground water source (water yards, hand pumps, mini water yards), or harvesting of rain water using Haffirs or small dams.*
- *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 massages.* • *Provision and distribution of hygiene materials/tools (Soap, hand washing facilities, etc.)*

2.3 Health and Nutrition sector

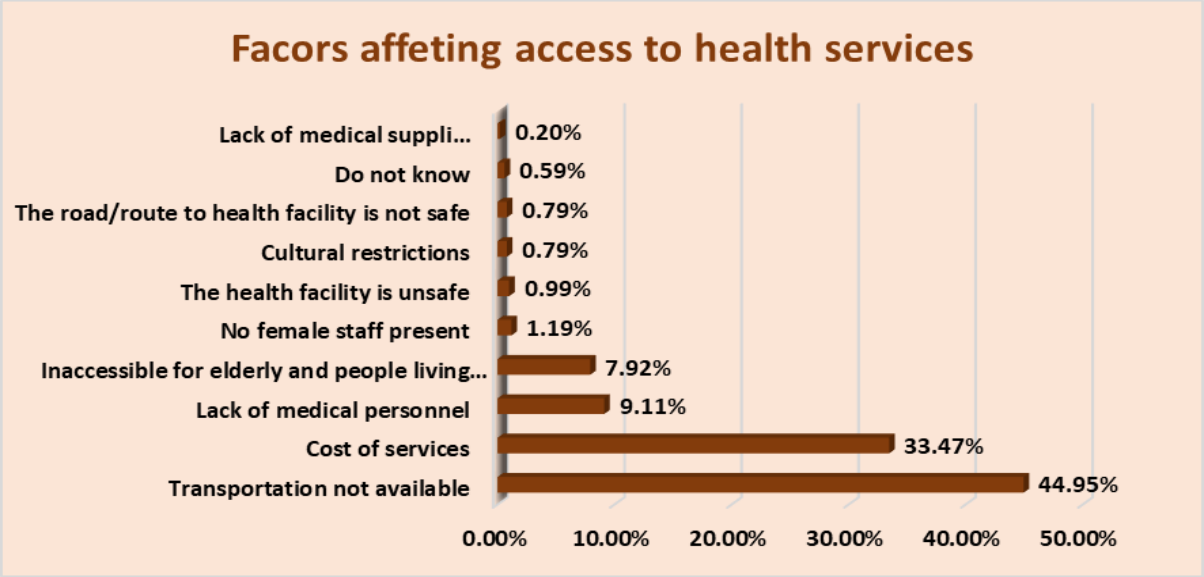
Sub sector Health – Public health:

The assessed areas are suffering from lack of health facilities, and the available facilities are poor in term of required services, only 36.4 % of the consulted people have health facilities in their villages, including health centers (31.3%), hospital (6.5%) and clinics (2.2%).

The remain people travel to nearest villages/towns seeking medical services, and most of them need more than hour to reach nearest health facility (47.7%) , 15.9% of people need 15-30 minutes, 15.1% need 2-3 hours, 9.2% spend 1 to 2 hours, 7.8% spend 30 -60 minutes and only 4.3 % can reach the health facility in less than 15 minutes.

Only 25% of the targeted communities refer to doctor for treatment, 44% refer to medical assistant while the remaining 25% are depending on traditional treatment including local medicine from wild and cultural and religious actors.

Communities are facing many challenges affecting their access to health services, in addition to lack of the services there is other factors, some of this factors are related to the households themselves which is in most cases caused by the high level of poverty. 45% cannot access health facilities because it is not available in their villages with lack of transportation to the health facilities in other villages/towns, 33.5% do not have the required money, as health services became costly, 9.1% due to lack of medical personal, as all the health facilities lack of codified staff, 7.9% is due to inaccessibility for the elderly people, 1.25 is due to lack of female staff in the facilities, 1% is due to lack of security in the health facility, 0.79% have cultural restrictions, unsafe road (0.79%), and 0.2% is due to lack of medical supply.



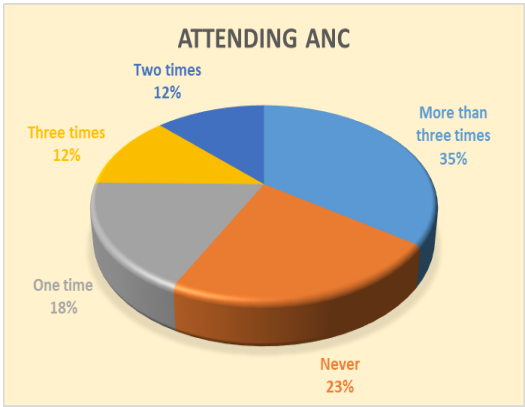
Sub sector Health – Maternity health:

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 midwifes.

Early or childhood marriage is practiced especially in rural communities, increasing risks of maternal mortality and morbidity due to childhood pregnancy

Traditional/Village Midwives do not have formal education, they are only trained and certified by Government through basic training. They are found in villages and report into the PHC. TBAs do not have formal training, are not supervised by government structures, and still undertake harmful traditional practices like FGM/C[6].

Early or childhood marriage is practiced especially in rural communities, increasing risks of maternal mortality and morbidity due to childhood pregnancy, in this regard, there is a real need strong capacity building and awareness rising program, in addition, there is a need to introduce the approach of Community Health Workers (CHW) and provide them with the required capacity, as government does not have a governing CHW policy/strategy and doesn't usually recruit, retain or remunerate CHWs, these are primarily established by NGOs; Government is aware of NGO programs that establish CHWs (an MOU exists), however in some cases the States set different policies.



From the consulted households; 89 (24%) have pregnant women during the last 12 months, most of them (97%) referred to midwives for ANC. When they asked about the frequency of attending FNC during pregnancy, 52% of them attended AFC tow times or less, 12% attended two times,

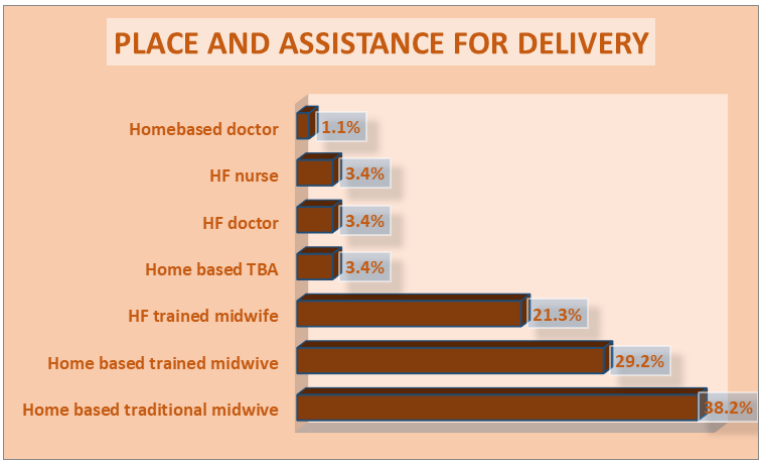
6 Improved Health Services and Systems in South Darfur and South Kordofan, Sudan Assessment (USAID, Momentum)

18% attended one time while 22% of the pregnant women have never attended ANC during pregnancy, 12% attended three times while 35% are the pregnant women attended FNC more than three times during pregnancy.

There are different reasons that affecting pregnant women access to FNC, 52% due to lack of service and far distance to the nearest health facility, 19% do not have the required money to do the required follow up (FNC), 14% they think no need for attending FNC, 10% because there is no female medical person and they do not prefer to go to male for check, while 5% have concern about the attitude of the medical person.

There is a need for providing delivery support as 57.3% did not received postnatal care after delivery, and 82% were not support with the clean delivery kits.

Most of the deliveries were assisted by midwives (89%), 38% of them delivered in their house assisted by traditional midwives, 29% delivered in house assisted by trained midwives, and 19% delivered in health facility assisted by trained midwives. 3% delivered in home and assisted by TBA. Only 4% of the delivered women were assisted by doctors (3% in the HF and 1% in home), while 3%assisted by nurse in the health facility.



Sub sector Health – Child nutrition:

Cultural practices exist that undermine nutrition well-being such as low rates of exclusive and continued breast feeding (almost 40% for both), limited dietary diversification due to lack of food variety or limited knowledge, intra-household food distribution with a priority to men, caregivers' knowledge on danger signs (e.g., convulsions, difficulty breathing, etc.) lower than national average.

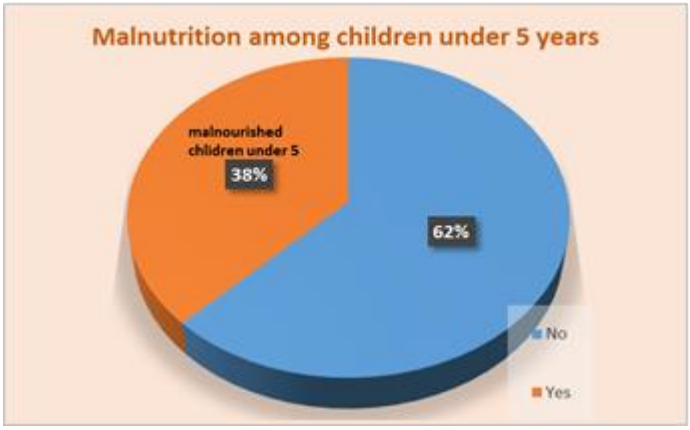
The communication program at the national and state levels is challenged, with non-routine/ad-hoc promotion and advocacy activities. 32% of women in the 15-49 age group have no education, which is higher among women with children at 43%

The demography of the consulted communities (see table 1) shown that, 24% population are children under 5 years. From the consulted households; 234 (63.1%) have children under 5. The average of meals they give to their children is three per day using the available food in houses.

From the children under 5, 37,6% experienced malnutrition. The reason of high rate of malnutrition among children under 5 have two dimensions: 1) is the lack of capacity among mothers on the importance of intensive breast feeding for infants and other best nutrition practices for other children, 2) the poverty and low level of livelihood among the targeted communities which affect their access to the food.

From the households who have malnourished children, 27.3% did not received any type of support for treatment while the remain received some supports, mostly from the INGOs working in the area.

94% of the consulted households confirmed hat; they never received capacity building in children nutrition, which indicated the lack of capacity building program in this area.



Recommended health and nutrition intervention:

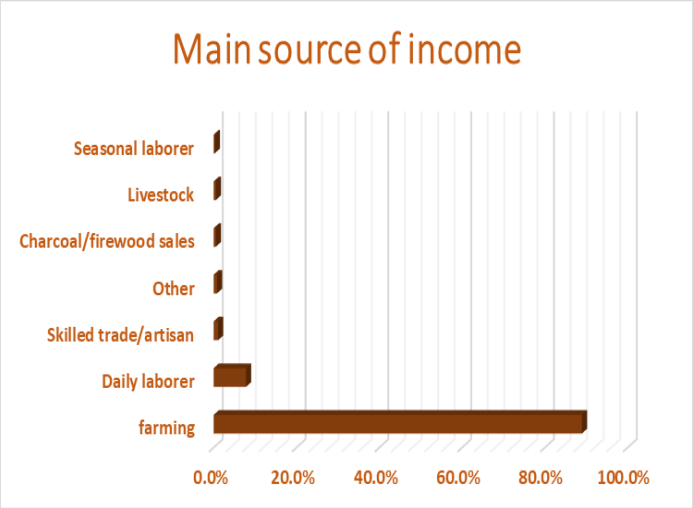
Public health:
Support of the existing health facilities:
• *Provision of required equipment and tools.* • *Provide the required Capacity building for HF staff.* • *Provision of water and sanitation services.* • *Medical supply: including provision of medicines and required and required testing materials.*
Sexual and Reproductive Health (SRH):
• *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.*
Nutrition
• *Build the capacities of mothers and care givers on best nutrition practices including preparation of available local food.* • *Support poor families to improve their livelihood particularly in agriculture.* • *Support existing health facilities with required capacities to response to malnutrition cases for good treatment and reduce mortality rat.*

2.4 Livelihood and food security:

The political turmoil and the existence of a constitutional vacuum have resulted in bad economic conditions, majority of the people were affected particularly the vulnerable in IDP camps and host communities. The deterioration in the economy, which accelerated after the last coup and the absence of the executive government, halted development processes, and government institutions became unable to provide support in various areas of production, in particular the agricultural sector, which is main source of income and food security for the majority of the Sudanese people.

Agriculture is the main source of income for 88.9% of the consulted households in the assessed area, 65% of them are women headed households, and within the consulted females 86.5% are depending on agriculture as the main source for income. it is also the main source of food security as many people depending on their own product for food and selling part to the local communities.

All the consulted people are practicing traditional rain fed agriculture. Lack of agriculture land is one of the challenges in practicing agriculture, 60% do not have agricultural land most of them are from the IDPs who were forced to left their lands, as they do not practice other jobs,55% are renting small lands, 4% using lands donated by others fore last season and 1% are practicing agriculture in communal lands.



The main source of income for 7.8% is working as daily labors most of them are also in agriculture activities in the farms owned by other people. The remain few people have different practices as the main income including trading, collection of forest products, livestock and seasonal labors.

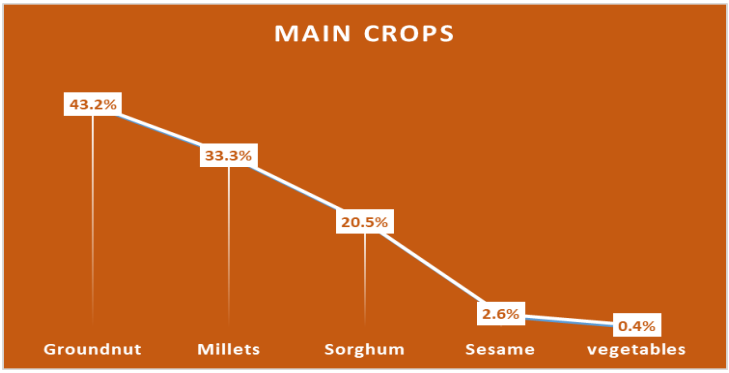
As agriculture is a seasonal practice during rainy season, people practicing other activities as secondary source of income during dry season including daily laborer (22%), charcoal/fire wood sale (19%), seasonal laborer (4%), trading (2%) and livestock (1%).

Groundnut is the main crop produced by most of farmers comprising 43.2% followed by cereals including millets (33.3%), sorghum (20.5%) sesame (2.6%) while only 0.4 % cultivating different types of vegetables.

Traditional rain fed Agriculture

It is a type of agriculture practiced during rainy season, it is totally depending on rain water. People using very traditional tools for agriculture practices (seeding, weeding and harvesting). No use for machineries, and no practicing of any technologies.

House hold income is very low in the assessed area as 84.1% of the consulted people have an income of 5,000 SDG (12 USD) or less per month, 12.4% earn 5000 -10000 SDG/Month while only 3.5% of the people earn more than 10000 SDG per month. This is understood as the lack of knowledge and required skills among people that enable them to practice works that needs technical experiences in addition to the high rate of illiteracy in addition to the challenges facing agriculture as main source of income and affecting improvement of production and productivity.



Among women headed households, 88% have income 5000 SDG or less (about 11 USD), 20% of them have income of 0-500 SDG while only 1% have income of more than 10000 SDG,

Almost 99.2% of the targeted people confirmed that; they have never received any type of vocational training and only 2 persons (0.5%) were received vocational training provided by INGO.

When they asked about the main constrains affecting their livelihood improvement; 25% confirmed that it is the high market prices, 22% security concerns, 155 lack of productive assets, 15% access to the markets, 15% lack of agriculture inputs and 9% due to lack of capital.

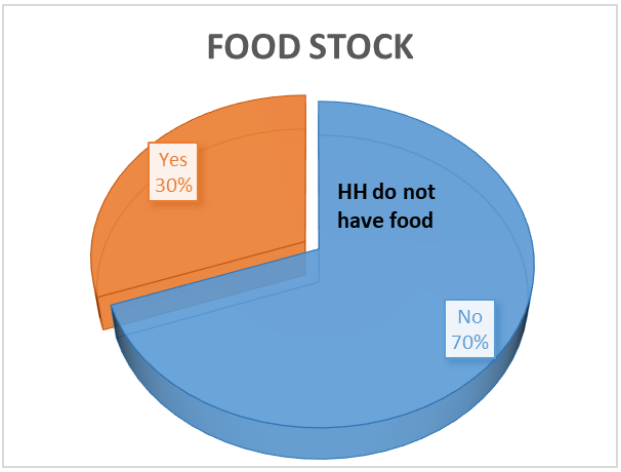
Food security:

Latest data shows that an estimated 7.3 million people in Sudan (16% of the population analyzed) are in high levels of acute food insecurity (IPC Phase 3 or above) between April and May (current period) and require urgent action. Of these, around 5.5 million people are classified in Crisis (IPC Phase 3) while around 1.8 million are critically food insecure classified in Emergency (IPC Phase 4)

In some remote areas in eastern and western Sudan, the availability of food commodities in the markets was below average. The food supply chains have been negatively impacted by a scarcity of fuel and high transportation costs. Following fuel subsidy reforms, the price of petrol and diesel prices is part of a series of economic measures[7].

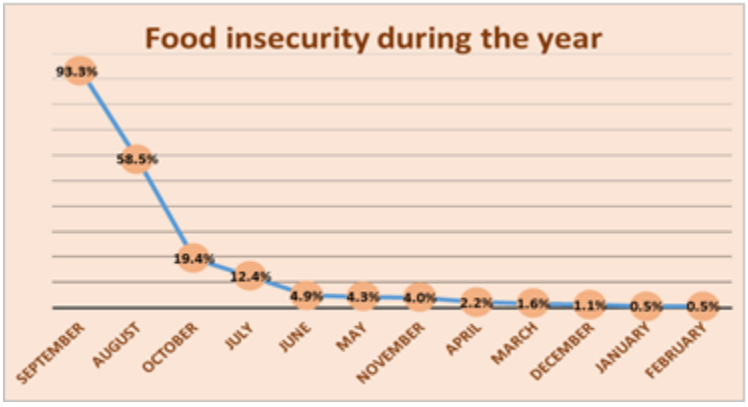
The people facing high acute food insecurity are the new and existing internally displaced people (IDPs), returnees, those stranded in conflict areas, refugees from South Sudan and other neighboring countries. Very poor and poor households are especially vulnerable to an increase in staple food prices because they are heavily dependent on the market for food and their relatively limited purchasing power.

From the consulted households, 69.5% do not have food stock in their houses, the remain 39.5 % (21.3% are female headed households) have some stocks including cereals (sorghum, millet) and very few of them have meet and vegetable.



Most of the households are depending on their own agriculture products as source of food for their families (55.4%), 26.8% are purchasing food from the local market, 17.3% are depending on the relief and food distribution. Barter trading and livestock keeping provide food to 0.4% (2% each).

Access to food vary from month to other during the year, this found related to agriculture season in particular the harvesting period, September is the Month in which most of the people (93.3%) suffering from lack of food as it is the month before starting the harvest of crops with no stocks from previous season, followed by August (58.5%) (two months before harvest). Pproblem of food shortage start declining with the starting of the harvest during the October (19.4%) as farmers use their product as well as selling for



[7] IPC_Sudan_AcuteFoodInsecurity_2021Apr2022Feb_report

others. The best period for accessing food is the Months come after the harvesting period (November – June).

Food security is directly linked to the agricultural production, as most of the household practice agriculture and depend on it as a main source of food. Therefore, there is an urgent need to support agricultural production to improve the food security.

3. Recommendations:

- Special consideration should be given to the women headed households, as the targeted areas witnessed a long period of armed conflicts which resulted in continuous absence of family sponsors due to death or involvement in the armed action.
- 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.
- There is a need for introducing a good system for waste management, only 13% have existing containers outside for waste disposal, the remain dispose it everywhere including roads between houses and water sources, this has a negative impact on people health and act as source of diseases.
- 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.
- To address the high rate of malnutrition among children under 5, livelihood should be considered as it is one of the main causes beside the low capacity among the mothers and children care givers, as most of the targeted household are under poverty line and have limited access to food.
- There is a need for capacity building particularly for mother and care givers in intensive breast feeding and nutrition practices and referral to doctors to reduce malnutrition and mortality rate among children under 5 Year.
- Food security is directly linked to the agricultural production, as most of the household practice agriculture and depend on it as a main source of food. Therefore, there is an urgent need to support agricultural production to improve the food security.
- There is a need to support food security and provide emergency cash or food distributions during the months August – October as they are the months of acute food insecurity.