NEEDS ASSESSMENT, EAST DARFUR, ANALYSIS AND REPORT: Annex 3b

Multi-sectoral and integrated humanitarian assistance for the conflict displaced and most vulnerable populations in East and South Darfur - Sudan

Assessment Questions:

- What evidence can be drawn for establishing project base values that demonstrate current social status, vulnerabilities, and level of access to lifesaving services as well as needs of the households and communities (IDPs, Refugees, Returnees and Host communities) in line with the project logical framework?
- What are key recommendations from target households and communities for quality project implementation in the project areas?
- What are gendered-related rights denials in the context of a humanitarian response? How do unequal gender relations, gendered discrimination, subordination and exclusion influence rights denials? How do these impact the effectiveness of the humanitarian response?

Assessment Methods used and Limitations:

The needs assessment has been conducted internally by CARE staff led by the MEAL coordinator at national level, MEAL team and program staff at field level. The survey took place in East Darfur state during the period 25th February to 20th March 2022. The primary data in the field collected during the period 6th -11th March 2022.

In general, the need assessment focused on the different sectors will be targeted by the project including:

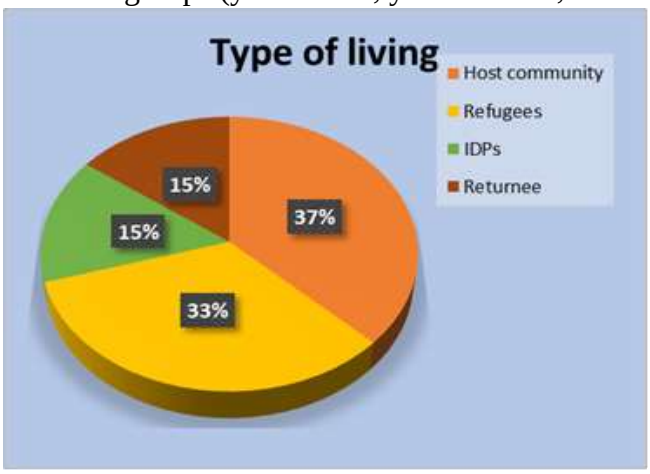
WASH: the assessment collected data on the different sub sectors of WASH including:

- ***Water supply:*** Assess the availability of and ease of access to safe water by the targeted communities, water consumption and gaps, contribution of the official authorities, the main factors affecting communities' access to safe, easy and adequate water.
- ***Environmental sanitation:*** Focus on collecting information on communities' access to sanitation, including availability and need of household latrines, need of solid and waste disposal system.
- ***Hygiene promotion:*** Assess the level of community knowledge and gaps and types of capacity needed to improve health and hygiene.

Health and nutrition: Assess the gaps and needs in general health in term of gaps and availability of health services, including maternity health, in addition to assess the gaps in nutrition including both knowledge and availability of support and gaps.

In line with the Sphere assessment standards and guidance from the Good Enough Guide – Humanitarian Needs Assessment, CARE reviewed existing data and reports related to the different sectors before deciding whether to collect new data. Sex-disaggregated data was collected to understand the different effects of the crisis on different groups.

The strategy of the survey was built in collecting qualitative and qualitative data through different approaches, including HH direct interviews, through using designed questionaires to collect quantitative data, taking into consideration the participation of vulnerable groups in the target communities, especially women headed households, elderly and youth groups, in addition to rapid appraisal approach with different groups (youth male, youth female, adolescent male and adolescent female) in the communities using check lists for collecting qualitative data.



Direct interviews: Direct interviews were conducted with heads of households. Total of 704 HH leaders were interviewed, distributed 180 Abu Karinka, 180 in Yassin, 178 in Al-Deain and 166 samples in Assalaya locality. Different groups in the communities were involved in the survey, 40% of the assessed people are women headed household, 19.5% of them are youth females (19-35 years), 2.4% are elderly women over 60, and the 17.5% are adult women headed households (19-35 years).

Status was considered in selecting the participant in this assessment, as 37% representing people from host communities (14.8% of them are females), 33.1 % are from refugees (15.5% are females), 14.9% are IDPs (5% females) while 14.8% representing returnees (5.1% are females).

Focus Group Discussion (FGD): Focus Group Discussions has been conducted with representatives from communities, including vulnerable poor women and men, community leaders, and youth. 4 FGD conducted with groups of (8-10) participants using check lists for collecting qualitative data about the access to services, community participation with focus on gender related issues.

Data collectors were trained in how to use formats to collect quantitative and qualitative data, and take the necessary precautions to prevent the transmission of COVID-19, in addition to choosing a good entrance, defining the purpose of the survey, giving the respondent the right not to respond, providing the necessary privacy, and emphasizing the confidentiality of the collected information and its use only by the organization.

Limitations:

The assessment witnessed some challenges includes;

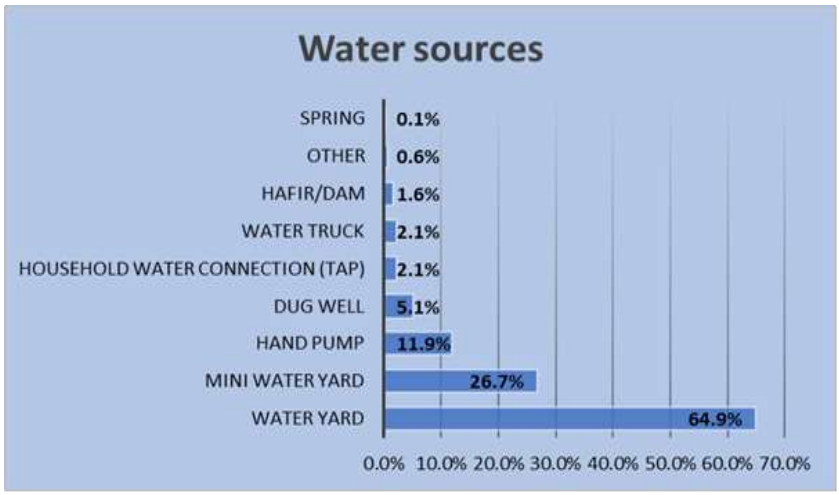
- The long distances to the survey areas in addition to bad roads, specially in the Jabal Mara area.
- Lack of communication means in some of targeted areas affected coordination with these communities ahead of the survey.
- Relatively short time for conducting the data collection and reporting.

Key findings

WASH sector:

Water supply:

Most of the rural areas depend on the ground water from boreholes, and the rest are depending on the service water due to presence of the basement, where water collected in Haffirs in the rainy season for use in the dry season. In all Haffirs water is directly used without any type of treatment, people and animals share use of water from Haffirs. Haffirs became dry at the last months of dry season (April-June) and it became very difficult for people to get water, traveling long distances to fetch water.

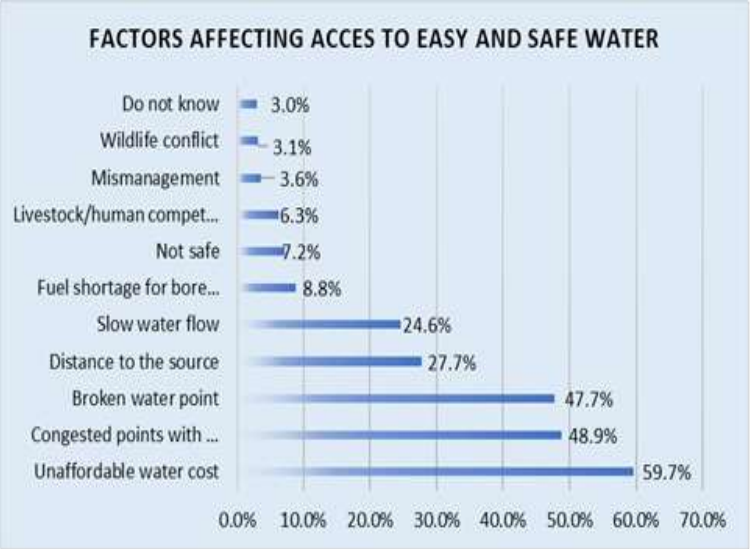


Some people have access to more than one source, 64% of the people getting their water from water yards, 26.7% from mini water yards, 11.9% collecting water from hand pumps, 5.1% from dug well, 2.1% have networks and water taps in their houses, 2.1% depend on water trucking most of them are refugees (1.5%). 2.3 % are depending on service water including Haffirs/small dams (1.6%), springs (0.1%) and 0.1% have other sources.

The State Water Corporation (SWC) does not have capacity for development of new water sources (as confirmed by SWC authorities) and they are now focusing only on the operation and maintenance (O&M) of the current sources. The current water tariff is low and not sufficient to cover the cost of O&M and the SWC, in most cases, depends on international

organizations. Most of the existing water sources are old and subject to continuous breakdown, resulting in deficit of water for most of the year.

To ensure sustainability of water systems, there is a need to shift from using fuel to solar energy. The use of fuel as the main energy source for operating water systems is challenging due to continuous breakdown, high cost of O&M, and lack of fuel year-round. Also, the SWC does not have the staff capacity or required experience to manage water systems due to high turnover and continuous migration of staff seeking better offers.



From the consulted people 58 % have access to easy, safe and adequate water for their family, and the remaining 42% are suffering either from difficulty accessing clean water or insufficient amount of water for their households. People need potable water and ease of collection through networks or sufficient distribution points. Women are most often responsible for water collection, they bear the burden of finding access to safe water.

There is high need for solving the issue of sufficient distribution of water, special consideration should be given to providing sufficient distribution points in the communities to reduce burden on women on daily water collection, as it takes considerable time from other tasks such as childcare. 96% of people indicated that there are long queues in water sources with almost a quarter of the people (25%) spending more than one hour waiting for their turn to collect water. 28.4% spend 15-30 minutes, 23.7% spend 30 minutes to 1 hour, 16,5 % spend less than 15 minutes, while only 6% do not face queues in the water sources.

Communities are facing many problems that affect their access to safe and adequate water, particularly during dry season when natural sources get dry. Most of the people (59.7%) do not have enough money to pay for water fees, 48.9% mentioned that they are suffering from insufficient water distribution points and overcrowding in existing ones, 47.7% reflect that there are continuous breakdowns and authorities do not respond in time, 27.7% shared that water collection points are far, 24.6% mentioned that water flow is slow, 8.8.% experienced problem in operation, and the others mentioned experiencing problems with safety and mismanagement of water sources.

Sanitation:

About a quarter of the people (24.3%), do not have latrines in their houses. Availability of latrines varies between different communities according to the living situation, as most of the

people (92%) in the host communities have access to latrines compared to other places as only 58% of the IDPs have access to latrines, 63% for returnees, and 71% for refugees.

When they asked about the places where they relieve themselves; most of the people who have latrines they use it for defecation (72%), which indicates lack of capacity among part of them, as some people have latrines but they do not use them, 25% of the people are practicing open defecation including 17% in the open, 4% in the bush, 2% in the waters streams and 2% in other places. 6% use shared latrines with their neighbors and 3% in the public latrines.

Waste management:

There is poor management of waste in the targeted communities where it was observed that waste is spread everywhere, including roads between houses. Some people throw trash in the water streams, polluting water sources in the rainy season as it is the same streams that take rain water to the service water sources (Haffirs). There are no existing waste management systems in the assessed areas and no designated places where people can dispose of their waste. Only 8.8% of people have waste containers outside their homes. The remaining 91.2% dispose of their waste in various means: 66.6% throw their waste outside their yard, 24.7% burn their waste inside their house, 18.6% use open pits, 4.4& throw their waste in water streams, 2.6% throw their waste into latrines, and 3.6% do not dispose their waste and leave it in their homes.

Hygiene:

There is a lack of hygiene promotion within the assessed communities where 90% of the people in the targeted areas do not receive any type of capacity building in WASH. This is reflected in the way that communities deal with poor waste management and practice open defecation even if households have latrines in their homes.

About half of the people (47.2%) do not use water and soap for washing their hands. They either use only water (41.6%) or water with other materials including ash, soil and sand.

The part of people who confirmed they usually use soap and water for hand washing, when they asked about the time they usually washing their hand, 39.6% reflect that they use water and soap for hand washing after going to toilet, 33.7% before eating, 28.4% after eating, 25% before preparing food, 19.9 after cleaning baby's bottoms, 10.4 before feeding children while 0.3% do not wash their hands with water and soap in none of the mentioned above.

This confirms the strong need to raise awareness of the targeted people about proper hygiene practices, as one third of the population practices washing hands with soap and water three

times, including once after eating, and those who wash their hands before eating do not care when it comes to feeding children, as it was found that only 10.4% wash their hands with soap and water before feeding the children.

Recommended WASH intervention:

Water supply:
Provision of safe water: • Conduction of functionality assessment for all water sources in the targeted area to assess its needs for maintenance, rehabilitation and upgrading. 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. • Provision of water from ground water aquifer need geophysical assessment before drilling particularly for water yards • 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:*** • Construction of water storage tanks and connect it with distribution points to reduce the congestion and time spend for fetching water • Construction of water networks for distribution water to houses or to sufficient water point. • Constructing of water points to reduce overcrowding on water sources. ***Water quality:*** • Continuous monitoring system for water sources including frequent water testing. • Water filtering system for the service water sources (Haffirs, Small dams) • 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, operation & maintenance of water sources, through forming and training of Water Users Committees. • 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.

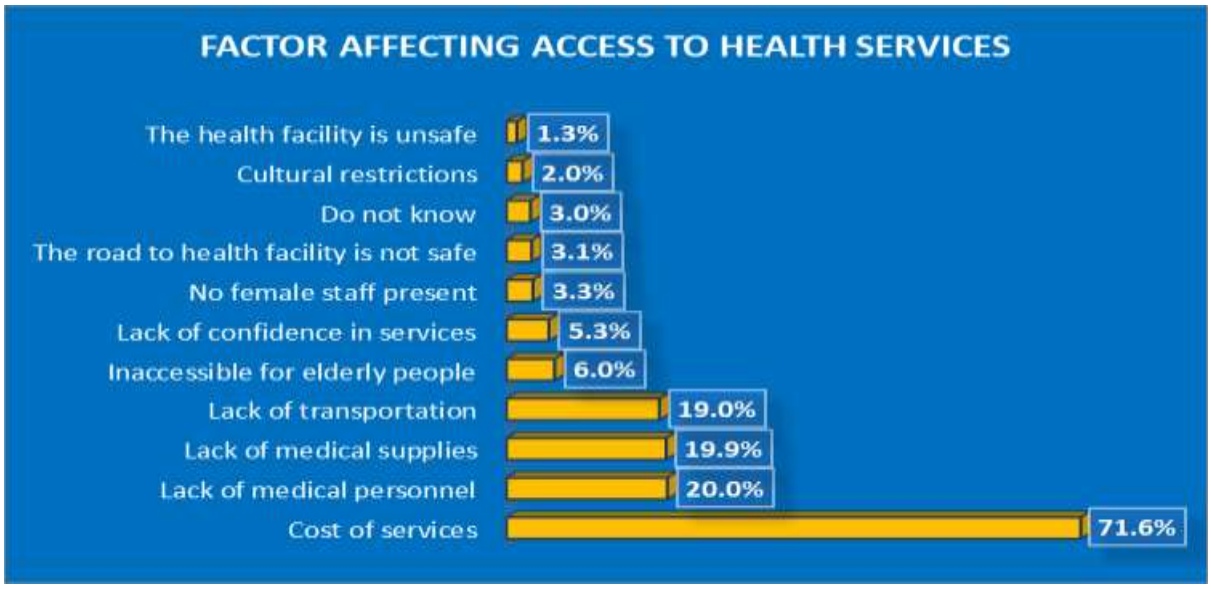
• Introducing of solar system instead of using fuel.
Sanitation:
Stop open defecation: • Improve access to latrines through construction of HH and communal latrines. And construction of latrines in the public facilities specially in schools. • Introducing of Community Led Total Sanitation (CLTS) approach. ***Environmental health:*** • Introducing of a good system for solid waste management including collection, transportation and disposal in proper sites. • 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.)

Health and Nutrition sector

Sub sector Health – Public health:

The assessed areas are suffering from lack of health facilities and most of the available facilities are poor in term of required services, and those who have services are the only supported by the INGOs including the facilities supported CARE. In addition to the lack of adequate health facilities, communities are facing many challenges that affect their access to health services such as not being able to pay for transportation and/or medical services.

Most of the respondent (71.6%) shared that they do not have enough money to receive health services. Other reasons for not being able to receive health services include not having access to health facilities nearby or transportation options to visit facilities in other villages/towns (19%), lack of qualified medical personnel (20%), lack of medical supplies (19.9%), lack of female service providers (3.3%), lack of trust of service (5.3%), inaccessibility for the elderly and people with disabilities (4.4%), and safety concerns either in the health facilities (1.3%) or on the roads traveling to the facilities (3.1%).



Maternal health:

Lack of good health services is also reflected on weak maternal health among the targeted communities. There is a lack of specialized doctors and most of the communities depend on trained/traditional midwifes who do not have formal education and are certified by the Government through basic training. They are found in villages and report into the PHC. Traditional Birth Attendant (TBAs) do not have formal training, are not supervised by government structures, and still undertake harmful traditional practices like female genital mutilation/cutting.

Early or childhood marriage is practiced especially in rural communities, increasing risks of maternal mortality and morbidity due to childhood pregnancy. There is a real need for strong capacity building and awareness raising program to address these issues. Also, there is a need to build the capacity of Community Health Workers (CHW) since the government does not have a governing policy/strategy for CHW and does not usually recruit, retain, or remunerate CHWs, which is primarily executed by NGOs. Although the government is aware of NGO programs that establish CHWs and MOUs exist, the States set different policies, changing in polices in sometimes affects the agreed ongoing work and need revising of the existing agreements/MOUs.

Most of the women who gave birth (78.3%) were assisted by midwives for delivery;36.2 % of them were assisted by traditional midwives in their home. 60.4% were delivered in the health facility, 22.8% of them assisted by trained midwives, 3.4% assisted by nurse while 6% were assisted by doctors and 3.45% delivered in home assisted by Traditional Birth Attendants (TBA).

From the consulted households; 21.2% had a pregnant woman during the last 12 months, most of them (87%) referred to midwives for ANC. When they asked about the frequency of attending ANC during pregnancy, 41.6% of them attended ANC two times or less, including 14.8% attended two times, 9.4% attended one time while 17.4% of the pregnant women have

never attended ANC during pregnancy, 14.8% attended three times while 43.6% are the pregnant women attended ANC more than three times during pregnancy.

In addition to lack of knowledge about sexual and reproductive health, there are different reasons that affect pregnant women accessing ANC: 43% do not have the required money for attending ANC, 27% do not have health facilities in their communities and they need to go far distance to nearest one, 18% think it is not necessary to attend ANC and 12% because there is no female staff in the health facility.

There is a need for providing delivery support as 63.8% did not received postnatal care after delivery. The situation is different according to the status, as most of the women who gave birth in the host communities (63%) received postnatal care after delivery, comparing to only 30% in the IDP camps, 19.5% in the refugees and only 15.4% from delivered women from the returnees received postnatal care after delivery.

From the women who gave birth, 83.2% did not received clean delivery kits before delivery in the returnee's communities, 96.2 % of the women who gave birth did not receive kits compared to 85.4% in refugees' camps, 83.3 % in the IDPs camps while 75% of delivered women in the host communities did not receive them.

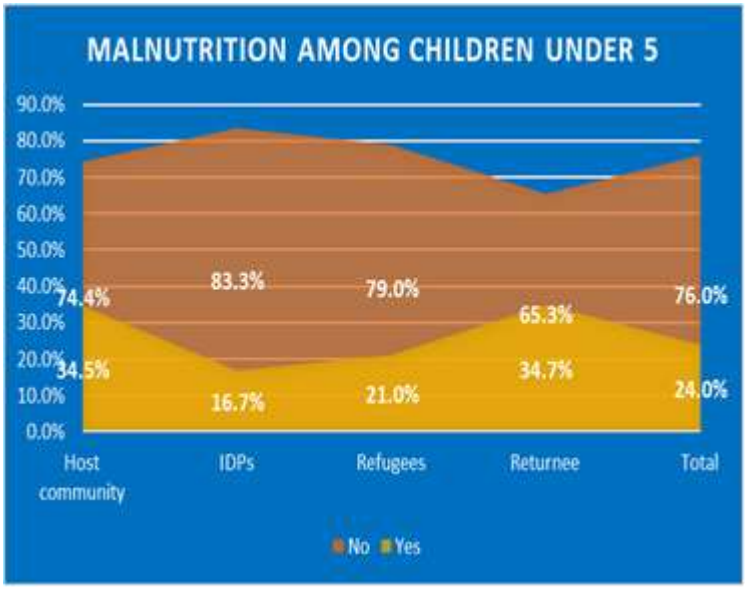
As Shown in table below; 78.3% of the delivered women were assisted by midwives for delivery, 36.2 of them were assisted by traditional midwives in their home. 60.4% were delivered in the health facility, 22.8% of them assisted by trained midwives, 3.4% assisted by nurse while 6% were assisted by doctors and 3.45 delivered in home assisted by TBA.

Place and assist in delivery	Host community	IDPs	Refugees	Returnee	Total
Home based traditional midwife	15.4%	40.0%	56.1%	42.3%	36.2%
Home based trained midwife	46.2%	23.3%	19.5%	11.5%	28.2%
HF trained midwife	25.0%	20.0%	14.6%	34.6%	22.8%
HF doctor	7.7%	3.3%	4.9%	7.7%	6.0%
HF nurse	1.9%	6.7%	2.4%	3.8%	3.4%
Home based TBA	3.8%	6.7%	2.4%	0.0%	3.4%

Child nutrition:

Cultural practices exist that undermine nutrition such as low rates of exclusive and continued breastfeeding (almost 40% for both), limited dietary diversification due to lack of food variety or limited knowledge, and intra-household food distribution with a priority given to

men. Caregivers' knowledge on danger signs (e.g., convulsions, difficulty breathing, etc.) is also lower than national average.



The communication program at the national and state levels is facing challenges 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%.

Only 35% of households own a radio, and 40% have a television; men usually control ownership of radios.

The demography of the consulted communities shows that, children constitute 18.8% of the population. From the consulted households, 53.8% have children under 5. The average of meals they give to their children is three per day using the available food in the house.

From the children under 5, 24% experienced malnutrition. The existence of malnutrition among children under 5 has two dimensions: 1) the lack of capacity among mothers on the importance of intensive breastfeeding for infants and other best nutrition practices for other children, 2) the poverty and low level of livelihood among the targeted communities which limits their access to food.

The cases of malnutrition are relatively high in returnees and host communities comprising 34.7% and 34.5% respectively, 21% in refugees while 16.7% of children in IDPs experienced malnutrition.

From the households who have malnourished children, 34% did not received any type of support for treatment while the remaining received some support, mostly from the INGOs working in the area.

There is a lack of capacity and knowledge on child nutrition as 91% of the consulted households confirmed that they never received information on child nutrition.

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 harmful 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 clean 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 respond to malnutrition cases.

Recommendations:

- Women-headed household are one of the most vulnerable groups in the targeted communities, special consideration should be given to them, as the targeted areas witnessed a long period of armed conflicts which resulted in continuous absence of men due to death or involvement in the armed action.
- State Water Corporation (SWC) is the responsible body for provision of safe water for communities, strong corporation is needed with its different departments like Water and Environmental Sanitation (WES) to identify the needs and types of required interventions.
- One of the main problems that affects communities' access to safe water is the continuous breakdown in water sources, in addition to the high cost of operation and maintenance, thus introduction of solar system is essential to insuring sustainability in addition to environmental consideration. This can include upgrading of the existing sources and designing new construction of water sources.
- In most cases, communities may have available safe water, but they are suffering in the collection process, as distribution points are not sufficient, which lead to a long queuing time. Special consideration should be given to improving the water distribution system in the targeted areas, as there is a high need for construction of sufficient distribution point to reduce congestion and make it easy to access safe water, thereby reducing the burden of women and girls.

- Open defecation rates remain high, driven by either lack of latrines or lack of knowledge on the importance of using the latrines, to insure good knowledge, attitude and practices, construction of latrines should be integrated with intensive capacity building and awareness on proper use of latrines, in addition to associating latrines with the required water and soap for hand washing.
- Community Led Total Sanitation should be integrated to the package, including awareness and capacity building, cleaning campaigns. In terms of sustainability, there is a need to introduce a good system for waste management, as only few people have existing containers outside for waste disposal, most of the population disposes of waste in such location as the roads, between houses and in water sources, this has a negative impact on the communities' health.
- Support to SMoH is needed 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 caregivers, as most of the targeted household are under the poverty line and have limited access to food.
- There is a need for capacity building particularly for caregivers in intensive breastfeeding and nutrition practices and referral to doctors to reduce malnutrition and mortality rate among children under 5 Year.