CARE International in Sudan

Baseline survey

Multi-sectoral and integrated humanitarian assistance for the conflict displaced and most vulnerable populations

(East and South Darfur)

Draft Report

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Abbreviations and Acronyms:

WASH	Water Sanitation and Hygiene
FGD	Focus Group Discussion
KII	Key Informant Interview
NGOs	Non-Governmental Organizations
INGOs	International Non-Governmental Organizations
WY	Water Yard
MWY	Mini Water Yard
SMoH	State Ministry of Health
HP	Hand Pump
HH	Household
CLTS	Community Led Total Sanitation
SGBV	Sexual Gender Based Violence
ODF	Open Defecation Free
WES	Water and Environmental Sanitation Project
CBO	Community Based Organization
KAP	Knowledge Attitude and practice
CMAM	Community management of Acute Malnutrition
SAM	Sever e Acute Malnutrition
MAM	Moderate Acute Malnutrition
SWC	State Water Corporation
SD	South Darfur
ED	East Darfur
GAM	Global Acute Malnutrition

1. Executive Summary of findings

This baseline survey was conducted for the USAID/BHA funded project "***Multi-sectoral and integrated humanitarian assistance for the conflict displaced and most vulnerable populations in South and East Darfur"*** **implemented by CARE International in Sudan**. The baseline was designed to collect data in selected communities in southern and eastern Darfur State to assess the situation before the start of the project and determine baseline values for project indicators. The baseline used multiple methods for data collection, including desk review of project documents, individual interviews with household leaders using a structured questionnaire, Focus Group Discussions (FGD) with representatives of different groups in the communities, Key Informant Interviews (KII) with the respective institutions.

According to the IPC classification[1], 847,126 people in South Darfur (SD) and 124,351 in East Darfur (ED) are at IPC stage 3 or higher and are unable to meet their immediate needs. Kass and East Jebel Mara in South Darfur have the highest number of people experiencing acute food insecurity with 25 and 35 percent respectively in need of urgent intervention to contribute to the reduction of acute food insecurity caused by the devaluation of the currency, inflation and local conflict both states.

According to the State Ministry of Health (SMoH), the overall trend for severe acute malnutrition (SAM) is expected to be 14% and moderate acute malnutrition (MAM) to be 18% in the state of South Darfur, while these statistics were estimated to be 10% and 9% respectively in the state of East Darfur from April to June 2022. The majority of households (HH) (58%) (65.5% M, 52.2F) do not have access to safe water, with a slight difference between the two states (56.1% in ED and 59.8% in SD). The majority of those consulted (65%) (73% M, 58% F) stated that they do not have enough water from all accessible sources, with a little difference between the two states (63.3% in ED, 66.7% in SD).

When asked how much water they collect per day for all uses, it was discovered that households collect a mean of 5.6 Jeri Can per day (1 Jerrican=20 liters) which gives 17 litters/day/person from all sources including unsafe ones, keeping in mind that this water is collected from all sources including unsafe ones and for all types of uses.

Access to latrine: From the total surveyed families, 39% do not have access to latrines (48.3% M, 31.9% F). Lack of access to latrines is common in SD, with the majority of HH (55.9%) without access compared to ED (21.4%). And from the total families;23.3% of the HH surveyed acknowledged that their family members usually practice open defecation (26.4%M, 20.8%F), 23.5% use community latrines, and 3.8% share latrines with their neighbors. 51.8% of those who have latrines are inaccessible to people with disabilities (61.5%M, 44.2%F).

[1] Sudan: Acute Food Insecurity Situation April - February 2022

Access to solid waste disposal system: Based on observations in the targeted villages, it was discovered that the majority of the villages do not have solid waste management systems, and trash were observed everywhere in communities. Individuals disposed of their wastes in open spaces. This was discussed during FGDs, and all participants stated that they are aware of the dangers of this practice, but they do not have any other options. With waste in the communities causing problems, especially during the rainy season, only 25.5% of the examined HH had a specific location for disposing of their garbage (17.8%M, 26.1% F).

Hygiene: Only 40.5% of the consulted people were able to identify three or more critical handwashing times, with a significant difference between the two states, with 57.2% in Ed compared to only 24.9% in SD. The remaining 59.5% are only aware of one or two critical times for hand washing.

Access to health services: The consulted people were asked about the issues affecting their access to good health services related to primary and maternity health including access to required facilities, medical staff, test and medicines; expensive of the service and lack of money came as the first choice comprising 36.7% (32.7%M, 39.8%F), far distance to health facilities affecting 20.6% of the people (17.3%M, 23.3%F), lack of qualified staff in health facilities affecting 10.7% (14.2%M, 7.8%F), lack of medicines affecting 19.8% (23.1%M, 19.8%F), while 9.3% shared that it is due to bad quality of services (12.7%M, 9.3%F).

Only 40.5% of women delivered at health facilities (35.6%M, 44.2%F) and very few were accompanied by doctors (6%) as confirmed by 5.2% of males and 6.6% of females.

Few people can recall health education massage, which accounts for 23.2% (28.1%M, 19.5%F). The 23.3% who recall some health massages were asked to explain what they knew about them; 79.5% knew about illness prevention (79.1%M, 80%F), 9.6% know where to obtain treatment (4.7%M, 15%F), and 10.8% know about health practices, with males (16.3%) outnumbering females (5%).

Nutrition: Malnutrition is relatively common among children under the age of five, with 39.3% of families with children under the age of five reporting that their children were malnourished (47.7%M, 32.7%F), with SD (45.1%) outnumbering ED (33.2%). Only 54% (0.2% of total) of HHs with malnutrition confirmed receiving therapeutic support, primarily from NGOs.

2. INTRODUCTION

With significant increases in food and other commodity prices, a reduced harvest, and continued conflict, acute food insecurity in Sudan continues to worsen rapidly. Latest acute food insecurity data indicates that around 9.6 million people across Sudan were highly food insecure and classified in Crisis (IPC Phase 3 or above) from April to May 2022. This includes 2.3 million people in IPC Phase 4 (Emergency) and 7.3 million in IPC Phase 3 (Crisis). Latest data shows that an estimated 7.3 million people in Sudan (16% of the population analysed) are

in high levels of acute food insecurity (IPC Phase 3 or above) between April and May (current period) and require urgent action[2]. Despite substantial assistance in the Darfur region over the past decade, there continues to be a significant need as many areas remain prone to conflict and climate shocks. This proposed intervention will provide integrated, sustainable, and lifesaving WASH, health, and nutrition services to crisis-affected and vulnerable host community members and lDPs in East and South Darfur.

WASH: East and South Darfur have chronic WASH needs due to the protracted nature of the crisis and the high number of lDPs and refugees. The key drivers of WASH needs are the deepening economic crisis; lack of investment in an already-weak and aging WASH services; poor knowledge, attitude, and practices related to WASH; lack of community governance of WASH infrastructure in rural areas; huge disparities amongst the rich and poor; and climate change. Additionally, high rates of under nutrition in both states are associated with poor WASH services.

Health: Sudan remains prone to disease outbreaks, including cholera, chikungunya, dengue, malaria, and measles. Childhood immunization rates are in decline across the country. Additionally, during 2021, the availability of emergency medicines declined steadily, reaching a low of 43% compared to 57% during 2020.

Nutrition: The overall number of people in need of nutrition support in Sudan has increased by 8.8% from 2021 to 2022 (3.9 million people), mainly children under-five and pregnant and lactating women.

East Darfur and South Darfur have catastrophic levels of acute malnutrition. The overall number of people in need of nutrition support in Sudan has increased, as shown by the S3M (2018-2023) survey conducted in 2018, the survey shows high prevalence on malnutrition in Sudan as general. In South Darfur, Global Acute Malnutrition (GAM) is estimated at 23.8%, SAM is estimated at 6.2% and in Kass child GAM is estimated at 12.6%, SAM at 2.4%. In East Darfur GAM is estimated at 39.8%, and SAM is estimated at 17.9: in Bahar Al Arab GAM 35.1% and SAM at 16.5% and in Sheria GAM at 39.0%; and SAM is estimated at 22.6%.

Impacts from the previous phase of the project in the areas covered by CARE are noticeable. Based on the capacity building of mother support groups under the previous grant, in complement to other UNICEF interventions, the number of admissions in the stabilization centres have reduced by 15%. In East Darfur, the awareness raising by Mother Support groups and community nutrition volunteers increased the knowledge of PLWs and mothers on early detection of malnutrition through visiting the nutrition unit during the pregnancy. Now the cases arriving at the centres are less severe than they used to be thanks to earlier detection, both for children and PLWs.

[2] Sudan: Acute Food Insecurity Situation April - February 2023

2.1 Background to the project:

CARE received funding from USAID/BHA to implement the project "***Multi-sectoral and integrated humanitarian assistance for the conflict displaced and most vulnerable populations in East and South Darfur***". The project's duration is 24 months starting at 15 September 2022. CARE and partner approaches involve needs-based interventions that respect humanitarian principles and human rights of all affected women, girls, men, boys, elderly, and people with disabilities.

2.1.1 Project goal

The goal of the project is "***to contribute to a reduction in human suffering through integrated humanitarian assistance for the most the vulnerable populations in east and South Darfur***".

2.1.2 Theory of Change (ToC) (statement)

The project's Theory of Change (ToC) draws on evidence from CARE's long-term experience in East and South Darfur implementing humanitarian and development programs, as well as promising practices and lessons learned from recent interventions in the target areas.

IF vulnerable communities and IDPs have access to sustainable, integrated and high-quality WASH, health, and nutrition services **THEN** host communities and IDPs will have reduced suffering and increased resilience and well-being.

2.1.3 Sector Specific Technical Design:

WASH: The WASH interventions have been developed to meet the urgent needs of the targeted people in East and South Darfur states to reduce morbidity and mortality associated with WASH-related diseases and environmental health risks resulting from the ongoing protracted humanitarian crisis and exacerbated by the COVID-19 pandemic.

Health: The health intervention has been designed to provide integrated and quality primary healthcare services, with a focus on communicable diseases and reproductive, maternal, neonatal and paediatric health, to reduce morbidity and mortality of the affected women, girls, men, and boys among the targeted communities and to reduce the secondary impact of the COVID-19 pandemic.

Nutrition: The nutrition intervention has been designed to provide integrated and high-quality curative and preventative nutrition services to vulnerable and malnourished children under the age of five and Pregnant and Lactating Women (PLW) in East and South Darfur based on the Community-based Management of Acute Malnutrition (CMAM) protocol.

2.1.4 Project targeted beneficiaries

Total Number of People Affected in the Target Area: **1,700,000**

Total Number of People Targeted (Individuals): **714,510**

Total Number of IDPs Targeted (Individuals) as subset of total beneficiaries: **293,525.**

3. Baseline purpose and objectives

CARE in Sudan is planning to implement the project in the targeted two States, the project performance will be assessed against the targeted results in regular bases and at the end, the objective of the project baseline survey is to provide a reference point (benchmark) for assessing changes and impact by establishing a basis for comparison before interventions take place. The data will be collected in three sectors: WASH, health, and nutrition.

The goal of this baseline survey is to analyse the current state of service availability and access to services related to project sectors and stated indicators. The baseline survey's specific aims are to:

- Assess the level of availability of services and community access to these services prior to project interventions, which include:

WASH sector: To examine the availability of water supplies, latrines, and solid waste management services, as well as the degree of knowledge and practice in personal hygiene and environmental health.

Health sector: Assess the availability of primary and maternal health care.

Nutrition: Assess the level of knowledge about children's and PLW nutrition, as well as the number of malnutrition cases and treatment support.

- Make recommendations to improve implementation in order to assure the achievement of results and the sustainability of project interventions.

4. Baseline Approaches and methodologies:

This baseline survey conducted in the project targeted areas in East and South Darfur states, the field data collection conducted during 13th to 25th November 2023 prior to implementation of project activities.

Geographic coverage

The survey took place in the project targeted areas in South Darfur and East Darfur States covering 8 localities (5 in East Darfur and 3 in South Darfur state) including Jabal Mara area.

In East Darfur State, the baseline took place in Ad Daien, Bahr Al Arab, Abu Karinka, El-Ferdous and Assalaya localities, while in South Darfur covers Beliel, Gereida, and Kass (localities including East and South Jebel Mara areas).

General methodology:

The baseline report has been informed by a mixed qualitative and quantitative descriptive survey approaches that collects both quantitative and qualitative data. Key informant interviews, focus groups discussions, household interviews, desk reviews, observations and other participatory methods have been used. The acquired data has been used in triangulation and validation to enhance findings.

Desk Review

The baseline survey team examined relevant documents that contained information and secondary data prior to gathering data for the survey to establish a solid foundation for the assignment. Among the documents received from CARE International are the project narrative and the logical frame.

Individual Household Interviews:

The primary method utilized to acquire quantitative data from targeted people was a household survey using structured questionnaires. This method entailed speaking with the head of the HH or a member of the household who was qualified to answer questions. The questionnaires were translated to Arabic for easy use by the enumerators. Tools were tested during enumerator training and at field level for quality assurance.

The survey used a random sampling and stratified random sampling techniques that took gender and the involvement of vulnerable groups into account (women headed HH, poor people, and elderly).

Sample frame and sample size

Secondary data was used to compute the sample size, which included information on the total number of beneficiaries targeted in the two states, targeted localities and villages. The Glenn, I., 2002 approach was used to calculate the total sample size. The population load was used to compute sample size for each state, and the same method was used to distribute samples to localities and villages.

Sample size (n) = Total Population (N) / (1+N*r^2).

R is a margin of error (degree of accuracy), the value of **(r)** lies between **1% up 10%.**

From the given 714,510 targeted beneficiaries and using 5% as margin error (recommended):

(n)= 714,510 / (1+714,510 *0.0025) = 400

Total of **400** individuals has been consulted through individual interviews. According to population load, the 400 samples distributed 204 to SD (51%) and 196 (49%) to ED, see table 1 below. From the total consulted families 110 are from IDPs comprising 27.5% while the remaining 290 are from residents comprising 72.5%.

TABLE 1: SAMPLE DISTRIBUTION TO DIFFERENT SITES

State	Locality	Location	# of samples
East Darfur	Yaseen	Mohajeria	**37**
	EL Ferdose	Al manar	**13**
	Bahr alarab	Surhan	**16**
	Asalaya	Al Sunta	**40**
	Abu Karinka	Jad Alsied	**90**
South Darfur	Kass	New IDPs	**82**
		Dogo	**27**
	Geraida	Umdarfa	**40**
		Moro	**22**
	Jabal Mara	Jabra	**33**
Total			**400**

Focus group discussions:

At the community level, information was gathered through focus group discussions (FGDs) with various groups in the targeted communities to acquire qualitative data. FGDs were held with a group of approximately (10) people representing various community groups, in addition to conversations with the current CSOs, committees, and groups (men, women, and youth). A total of 10 FGDs were conducted, two in each targeted locality. Of these, 5 FGDs were conducted with a mixed group of men, women, and youth in each locality, and 5 FGDs were conducted with selected groups of women and youth.

Key informant interviews (KII)

The evaluation team conducted key Informant Interviews with different key stakeholders with diverse background to facilitate validation of information from different sources and to capture their perspectives and interests. Individual meetings were conducted with the key informants from the relevant institutions including line ministries, water corporations (WES), States ministries of health (SMoH), health facilities and the managers of the camps in the areas that are being studied. Each group of stakeholders received a customized KII tool (check list) that is customised with important questions for each informant or informant group.

Data Analysis and reporting:

To examine the quantitative data gathered in the field, statistical methods were utilized using MS Excel and computer software (SPSS). To find thought trends, outliers, and significant statements, a detailed analysis of the acquired qualitative data was performed.

Quantitative data was analysed for overall participation as well as male and female segregation. Because the number of male and female respondents is not equal, each group was examined independently to obtain the correct percentages for each category[3].

Gender and age group segregation of targeted beneficiaries (men, women, boys, and girls) guided by the portion of each group generated from the assessed HH composition revealed that males are 29%, women are 29%, boys are 21%, and girls are 21% with under 5 children counted with boys and girls.

5. Limitations:

The baseline survey revealed various obstacles and constraints, primarily connected to field work, such as:

- The primary data collection in the field took place during harvesting season, when the majority of people are busy either in their farms or working as laborers, making it difficult to find the targeted people and causing a lot of delay waiting for people to return from the agriculture field.
- Most of targeted areas lacking means of communication which make it difficult to coordinate with them prior to the scheduled visits for arrangement.
- Long distances and bumpy roads were among the main obstacles, particularly in Jabal Mara areas, and cars can not be used in some areas and the only means of transportation is the donkeys or camels in addition to walking long distances on footfood.
- Complication in Jabal Mara areas where it is fully controlled by Sudan Liberation Movement (SLM) – Abdewahid Noor, as they have their own administrations that different from the government, which need addition coordination and getting approval to conduct the survey. In addition, SLM refused to use the trained enumerators from Nyala which required hiring new enumerators from local people and train them in data collection which caused delay.

[3] *The percentage of females was determined individually from female responders, and the same for males.*

6. Findings and results

6.1 Demography:

From the total 400 respondents 226 are females comprising 56.5% (62% in East Darfur and 51% in south Darfur) while the remaining 174 are males comprising 43.5% (37.8% in east Darfur and 49% in South Darfur).

Household's composition:

As shown in table 2, the consulted 400 households involved 3199 individuals from various age groups, with boys and girls in school (6-18 years) constituting 38% of the population (19%F, 19%M), adults (19-59 years) constituting 33% (16% males, 17% females), children under 5 constituting 21% of the population (11% males, 10% females), and elderly people over 60 constituting 9% (4% females, 5% males).

THE CONSULTED 400 HOUSEHOLDS INVOLVE 186 PERSONS LIVING WITH DISABILITIES COMPRISING 6% OF THE POPULATION. TABLE 2: HOUSEHOLDS COMPOSITION

State	Male Children under 5 year	Female Children under 5 year	Boys 6 - 18 year	Girls 6 - 18 year	Males 19 - 59 year	Females 19 - 59 year	Males >=60 year	Females >=60 year	Total family size	Disabled person in the family
East Darfur	171	167	288	255	215	231	81	67	**1475**	28
South Darfur	175	157	317	339	283	317	75	61	**1724**	65
Total	346	324	605	594	498	548	156	128	**3199**	93
%	11%	10%	19%	19%	16%	17%	5%	4%	**100%**	2.9%

From the total consulted families 110 are from IDPs comprising 27.5% while the remaining 290 are from residents comprising 72.5%.

6.2 Findings on project targeted results:

The overall objective of the project is ***Improving health and wellbeing through the provision of integrated, lifesaving and sustainable WASH, health, and nutrition services to crisis-affected and vulnerable host community members and IDPs in East and South Darfur.***

Instability of rain fall during the last three years has resulted in drought in parts of the targeted areas, while other parts have been devastated by floods, significantly affecting people's livelihoods and resulting in low agricultural output, animal loss, and limited access to essential services.

Malnutrition is a major public health issue in some parts of East and South Darfur and is brought on by severe food shortages, unstable livelihoods, a lack of access to competent healthcare, poor hygiene practices, and lack access to safe drinking water and sanitary facilities.

According to the IPC classification, 847,126 people in South Darfur and 124,351 in East Darfur are at IPC stage 3 or higher and are unable to meet their immediate needs. Kass and East Jebel Mara in South Darfur have the highest number of people experiencing acute food insecurity with 25 and 35 percent respectively in need of urgent intervention to contribute to the reduction of acute food insecurity caused by the devaluation of the currency, inflation and local conflict both states.

According to the SMoH, the overall trend for severe acute malnutrition (SAM) is expected to be 14% and moderate acute malnutrition (MAM) to be 18% in the state of South Darfur, while these statistics are estimated to be 10% and 9% respectively in the state of East Darfur from April to June 2022. Because of the poverty in the target locations and the poor quality of WASH, health, and nutrition services, the MAM fraction in South Darfur (18%) may create and record a larger value.

6.2.1 WASH sector:

6.2.1.1 Sub sector - Water supply:

Number of individual's directly utilizing improved water services provided with BHA funding.

This indicator counts the number of individual beneficiaries who directly benefit from enhanced water services. Whoever, the baseline value is zero, but information about the current situation is collected to assist in monitoring progress during implementation and at the end of the project.

Access to improved water services:

The accessibility of the targeted people to safe water was assessed by asking them to tell if their HH have access to safe water regardless of the ease and adequate amount. However many people are using water from safe sources (78%) such as water yards, mini water yards and hand pumps, but it is not sufficient for to provide adequate safe water. 300,094 (77604 men, 80215 women, 71790 Boys,

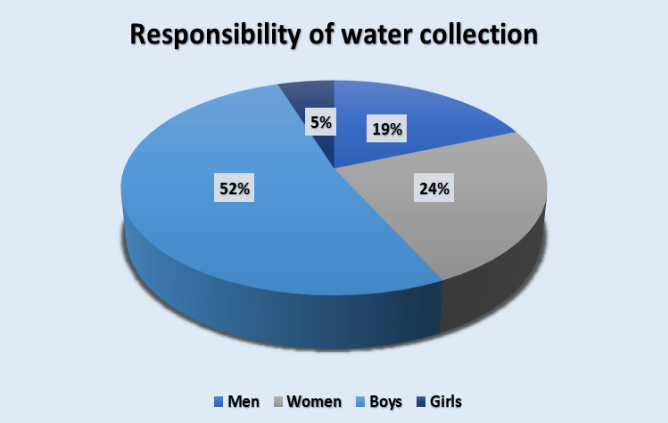

FIGURE 1: RESPONSIBILITY OF WATER COLLECTION AT HH

70485 Girls) are those have access to improved water services comprising 42%, the remain 58% (65.5% M, 52.2F) shared that they do not have access to safe water, with a slight difference between the two states (56.1% in ED and 59.8% in SD).

FIGURE 2: HH COLLECT WATER FROM ANIMAL DRINKING SITES.

TABLE 3: ACCESS TO SAFE WATER

State	Male		Female		Total	
	Yes	No	Yes	No	Yes	No
East Darfur	45.9%	54.1%	42.6%	57.4%	43.9%	56.1%
South Darfur	26.0%	74.0%	53.8%	46.2%	40.2%	59.8%
Total	**34.5%**	**65.5%**	**47.8%**	**52.2%**	**42.0%**	**58.0%**

This was emphasized by consulted people during FGDs as all of them confirmed that lack access to safe water is their major problem.

Authorities in the State Water Corporation (SWC) shared that they are experiencing many challenges and are in a grave situation because they lack the necessary logistics to perform their tasks in the operation and maintenance of water sources, and the majority of water sources are not operational. High infiltration and high fuel prices impacted the daily functioning of water sources, in addition to a personnel problem since most employees quit due to low pay. Under these conditions, communities are struggling and refusing to pay water tariffs, worsening the situation and jeopardizing the stainability of service.

However, SWC does not currently have the capability, but they have stated that they intend to replace the existing operation systems in water sources with solar systems rather than the existing system that uses fuel.

The authorities in SWC shared that; at least 60% of water resources in the two states are in poor condition and require immediate restoration, forcing populations to rely on un safe water sources, endangering their health and spreading water-borne diseases.

Access to adequate water for drinking, cooking and personal hygiene.

The majority of those consulted (65% (73% M, 58% F) stated that they do not have enough water from all accessible sources, with a little difference between the two states (63.3% in ED, 66.7% in SD).

FIGURE 3; HH COLLECT WATER FROM ANIMAL DRINKING SITES.

When asked how much water they collect per day for all uses, it was discovered that households collect a mean of 5.6 Jeri Can per day (1 Jerrican=20 liters) which gives 14 litters/day/person from all sources including unsafe ones, keeping in mind that this water is collected from all sources including unsafe ones and for all types of uses.

Easiness of accessing to water:

To evaluate the ease of access to water, consulted people were asked how much time they spent collecting water. Only 54.3% of total respondents spend 30 minutes or less collecting water (53.4%M, 54.9%F), while the remaining people require more than 30 minutes to collect water from the nearest source, 31% require 31 minutes to one hour, 5.5% spend 1-2 hours (5.3% F, 5.5% M), and 8.5% require more than two hours (9.2%M, 8% F).

In both states, it was discovered that the available water sources are insufficient, that people and cattle share the same sources with no separation in intakes, which increases the likelihood of pollution, and that separate collecting locations of water are required.

Kass IDPs camp relies on HPs as its primary source of water; all of them are either broken or in need of repair. It was discovered that women and children were waiting in huge lines to get water. There is a need to train locals to maintain handpumps and provide them with the necessary tools and equipment to ensure the sustainability of these sources.

Women and boys are primarily responsible for collecting water for the HH; women are responsible for water collection in 30% of the consulted households, as confirmed by 28.7% of males and 32.3% of females, while boys are responsible for water collection in 41.5% of the HH (44.3%M, 41.5%F), 18.8% shared that men are responsible for water collection

21.3M, 18.8%F), and only 9% confirmed that water collection is the responsibility of girls (5.7%M, 11.5%F).

People in the targeted areas rely on several sorts of water sources. Mini water yards were identified as the major water source by 39.8% of the respondents (33.3M, 44.7F), 20.8% rely on distribution stations (tap stands) (19.5%M, 21.7%F), and 19.3% gather water from open dug wells (25.9%M, 14.2%F), which are not protected and are constantly polluted. 17.8% rely on handpumps as their primary water source (17.2%M, 18.1%F), 0.5% collect water from tankers, and just 2% rely on water yards (2.9%M, 1.3%F). Because of the presence of the basement in most of the locations where water is only found in cracks, most groundwater

sources are from shallow aquifers, either employing pumping with low eild (small water yards) or utilizing hand pumps.

When asked about the main factor affecting their access to safe water, the consulted people identified various reasons; safety of water came in first as 20% of the people shared that safety of water is their problem (23%M, 17.6F), the remaining people shared other factors such as; 15.8% shared that their problem is the long distance to the water source (11.2%M, 19.4%F), and 12.1% confirmed that they don't have money to pay water tariff which is not affordable to them (13.2%M,11.3% 8.7% (10.6M, 7,2F) reported a lack of management, while 13.6% reported that water sources are not functioning properly and are constantly breaking down. 23.4% reported that water sources are insufficient and always congested (22.1%M, 23.4%F), whereas 6.4% reported that available water is insufficient (4.2%M, 8.1%F). see figure 2 below.

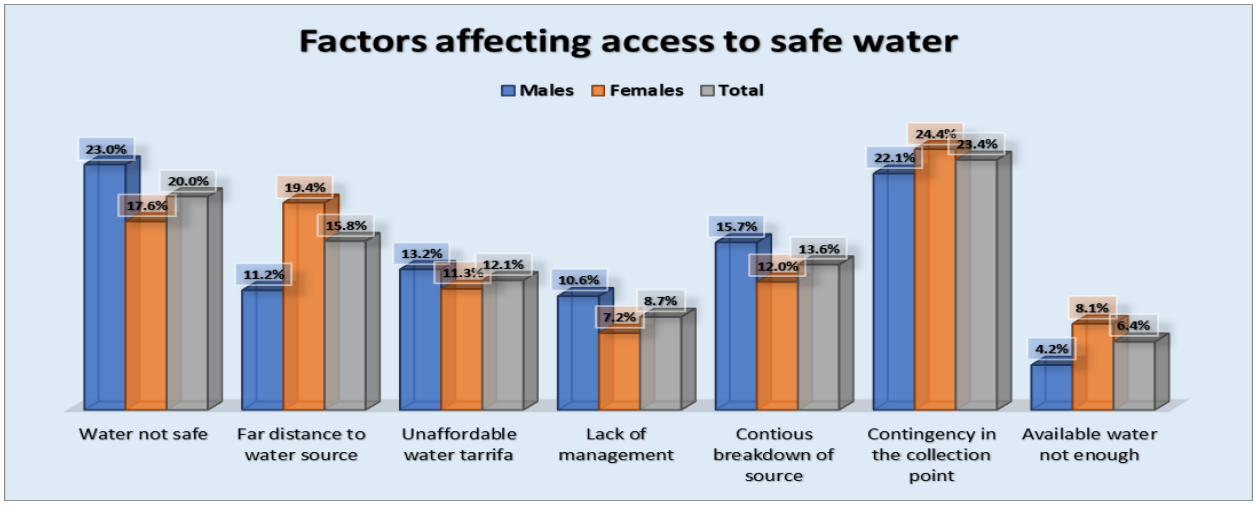

FIGURE 4: FACTORS AFFECTING ACCESS TO SAFE WATER

6.2.1.2 Sub sector - Sanitation:

Access to sanitation services (latrines): Two indicators were developed to track success in the targeted population's access to sanitation; 1) Number of individuals directly utilizing improved sanitation services provided with BHA funding and 2) Number of individuals gaining access to a basic sanitation service as a result of BHA assistance. These two indicators are interconnected and related to project interventions (baseline is zero). The baseline will analyse the present state prior to BHA intervention to aid in analysing progress and measuring improvements in targeted communities.

Latrines are accessible to about 435851 (112711M, 116503W, 104267B, 102370G) of the total targeted population, accounting for 61% of the HH. The remaining 39% of families do not, as affirmed by 48.3% of male consults and 31.9% of female consults. Latrines are frequently unavailable in SD, with HH (55.9%) having less access than ED (21.4%). (See Figure 4).

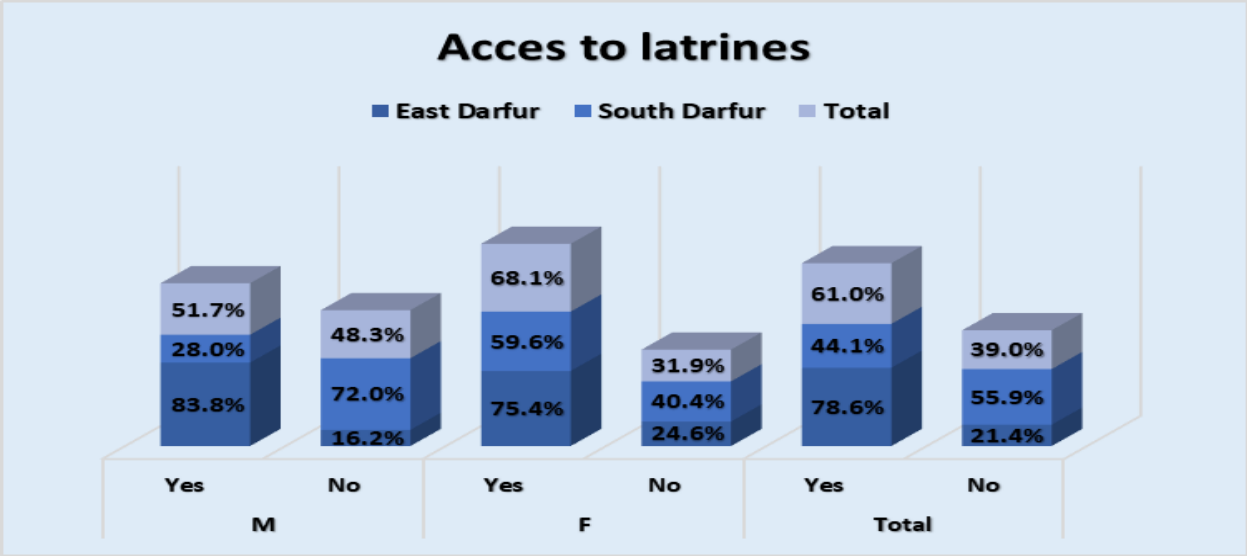

FIGURE 5: HH ACCESS TO LATRINES

Practicing of open defecation was found among 23.3% of the surveyed HH acknowledged that their family members usually practice open defecation (26.4%M, 20.8%F), 23.5% use community latrines, and 3.8% share latrines with their neighbours. 51.8% of those who have latrines are inaccessible to people with disabilities (61.5%M, 44.2%F).

Percent of households targeted by latrine construction/promotion activity whose latrines are completed and clean.

The available latrines were visited, and the majority (60.5%) were not clean (63.2%M, 58.4%F), mainly in SD (74.5%) compared to 45.9% in ED.

Access to latrines is very poor in Kass Camps. The existing communal latrines need to be dismantled because they lack doors and privacy. They are unsafe, especially at night, because there are no lights. Some of them have been rehabilitated by working NGOs, but the work was not done properly, and the materials used are very poor.

In some villages, such as Dogo village in Daien and Jubra in South Darfur, open defecation is common practice, with human feces found in many places in the open. This was raised during FGDs, and participants confirmed that this is due to a lack of latrines, with approximately 10% of the HH having latrines, and they attributed this to a lack of required funds for latrine construction.

FIGURE 6: PHOTO OF POOR LATRINES IN CAMPS AND VILLAGES

6.2.1.3 Environmental health:

The project aims to improve environmental health in the targeted communities through introducing wate management systems. The designed indicator for measuring progress is ***Number of individuals receiving improved service quality from solid waste management, drainage, or vector control activities (without double counting).*** However, this indicator will measured at annual bases and at the end of the project, base line provided information about the existing situation on accessing to solid waste disposal system to support measuring progress during implementation and at end.

Based on observations in the targeted villages, it was discovered that the majority of the villages do not have solid waste management systems, and trash was observed everywhere in communities as individuals disposed of their wastes in open spaces. This was discussed during FGDs, and all participants stated that they are aware of the dangers of this practice, but they do not have any other options, with waste in the communities causing problems, especially during the rainy season.

% of individuals have access to waste disposal system/place (certain containers, dignifies place or waste collection system).

Only 25.5% of the examined HH had a specific location for disposing of their garbage (17.8%M, 26.1 F). The situation is better in SD than in ED, with 28.4% having a specific location for disposing of their wastes compared to only 16.3% in ED. The remaining people have other options for disposing of their household garbage. The majority of people throw their garbage outside their homes in the roads and open spaces, accounting for 60% (60.3%M, 59.7%F), 6% confirmed that other people collect it (10.9%M, 2.2%F), 5% of the HH leave their garbage as it is (4.6%M, 5.3%F), 1.3 of the HH burry it (1.1%M, 1.3%F), and 5.3% burn it (5.2%M, 5.3F).

%of people has good drainage system during rainy season.

When asked about the quality of the drainage system in and around their homes during the rainy season, the majority of the consulted individuals confirmed that it is poor (71.3% (64.4, 76.5%F), with a little difference between the two states (68.4% in ED compared to 74% in SD). This was further confirmed by observations made while strolling around these areas, as remnants of the recently ended rainy season can still be found in several places. Consulted individuals during FGDs verified this; they noted that a lack of a good drainage system is one of the primary difficulties since it affects their movements as well as their dwellings and causes latrines to collapse in many cases.

6.2.1.4 Hygiene promotion:

The indicator is: ***Number of individuals receiving direct hygiene promotion (excluding mass media campaigns and without double counting).*** This indicator is a count of how many people are directly reached by hygiene promotion activities within the project and will remeasured during implementation (quarterly, semi annually and annually) and at the end of the project.

This indicator is a count of how many people are directly reached by hygiene promotion activities. To provide information prior to the start of the project, the baseline assessed the targeted beneficiaries' Knowledge, Attitude, and Practice (KAP) on hygiene issues by determining the presence of hygiene promotion in the targeted communities and measuring the percentage of beneficiaries who received knowledge on best hygiene practices, as well as the percentage of people who have knowledge and practice hand washing with water and soap.

Number of individuals receiving direct hygiene promotion (excluding mass media campaigns and without double-counting):

About 26794 person were received direct hygiene promotion from the total HH in the targeted area comprising 30%, while the 70% said they had never received any type of hygiene promotion, which was verified by 67.2% of the consulted males and 72.1% of the consulted females. Some INGOs working in the areas conducted capacity-building programs.

Percent of individuals targeted by the hygiene promotion activity who know at least three (3) of the five (5) critical times to wash hands.

To assess the targeted people's knowledge of the critical times for washing hands, they were asked to identify these times (after defecation, before eating, after clanging diapers/wiping babies, before food preparation, and before feeding children/infants). Only 40.5% (38.8%M, 41.4 F) of the consulted people were able to identify three or more times, with a significant difference between the two states, with 57.2% in Ed compared to only 24.9% in SD. The remaining 59.5% are only aware of one or two crucial times for hand washing.

From the total respondents, 61% said they use water and soap to wash their hands, with the majority (70.4%) being females, compared to only 48.9% of males using water and soap for hand washing, 37.3% using only water (51.1%M, 26.5%F), washing hands with water and sand/dust found only on females (2.7%), accounting for 1.5% of total respondents, water and ash used by 0.4% of females and 0.3% of total respondents.

Percent of households targeted by the hygiene promotion activity who store their drinking water safely in clean Containers.

Direct observation was used to assess the situation of the water containers HH are using for storing water at home, and it was discovered that approximately half of the HH (50.3%) keep their water containers clean and covered (48.9%M, 51.3%F). 15% of the containers found clean but not covered (17.2%M, 13.3%F), 19 of the containers are dirty but covered (20.1%M, 18.1%F), and 15.8% of water containers are dirty and uncovered (13.8%M, 17.3%F).

6.2.2 Health sector:

Health Systems Support:

During KII with authorities in SMoH and health facilities, they revealed that the ministry's capacity is very low, and it relies on active international groups for assistance. The country's current economic position has a negative impact on providing the necessary health services, with health institutions operating at near capacity.

This was also confirmed by persons who participated in focus groups in various places, who reported that health care is very inadequate, with no qualified doctors and only medical assistants available, as well as poor laboratories and a shortage of medical supplies in most situations. This was also confirmed by these facilities' authorities during KIIs.

With a few exceptions, such as Dogo in SD and Almanar in ED, most visiting communities have existing health center. The combined capacity of all visiting health clinics is insufficient to service all communities. People in the targeted areas rely on these facilities to provide various services such as primary care, maternity care, nutrition services, and vaccinations, but it is in desperate need of improvement due to a lack of medical staff, particularly doctors, a lack of

medication, a lack of equipment such as bed nets and generators, a lack of emergency services such as ambulances, insufficient treatment and medical equipment.

Following a meeting with the health center staff, recommendations were made to support the health by increasing staff capacity (training) and to support the facilities by providing all necessary repairs, furniture, lighting, stationary, ambulances, delivery equipment, and support to ensure proper operation.

A very poor monitoring and reporting system was found in the majority of the visited facilities, making it difficult to measure the average of outpatients during the month. The facilities require special attention, and to ensure providing staff of these facilities with the required capacities in monitoring and reporting system, as well as providing them with the necessary logistics to support measuring project progress and capturing impact on the targeted people.

6.2.2.1 Primary Health Care:

Hygiene and water-related disorders such as malaria, diarrhea, and dysentery are extensively distributed in the targeted areas due to inadequate hygiene practices, a lack of access to safe water, and a lack of sanitation services.

The consulted people were asked about the issues affecting their access to good health services, type of service and lack of money came as the first choice comprising 36.7% (32.7M, 39.8%F), far distance to health facilities affecting 20.6% of the people (17.3%M, 23.3%F), lack of qualified staff in health facilities affecting 10.7% (14.2%M, 7.8%F), lack of medicines affecting 19.8% (23.1%M, 19.8%F), while 9.3% shared that it is due to bad quality of services (12.7%M, 9.3%F).

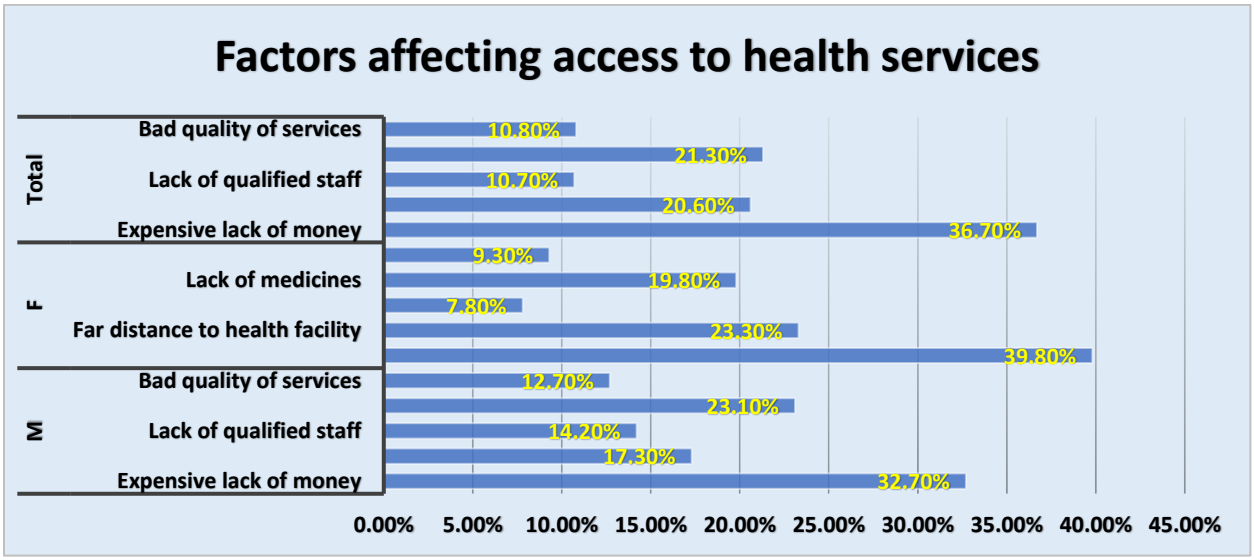

FIGURE 7: FACTORS AFFECTING ACCESS TO GOOD HEALTH SERVICES

When one of their family members becomes ill, people in the targeted villages seek treatment in a variety of locations: 40.1% go to health centers/clinics in their villages (37%M, 42.5%F), 20.1% go to health centers/clinics in other villages (17.3%M, 22.2%F), 5.9% have hospitals in their villages and use them for health treatment (17.3%M, 5.9%F), and 2.5% rely on traditional treatment (2.9%M, 2.3%F).

6.2.2.2 Maternity health:

Poor health services in the targeted areas impede access to good maternity health, and a lack of a monitoring mechanism in state ministries and health facilities makes it difficult to use secondary data to assess the amount of various maternal health assistance.

From the various forms of maternity health services and support available, a stratified random sample procedures were used to consult 177 HH (92 in ED and 85 in SD) that hadtotal consulted 400 HH, 177 have pregnant women during the last12 months comprising 44% of total HH, this give a total of about 39298 women were pregnant during the last 12 Months.

Attending Antenatal Care (ANC): HH with pregnant women were asked how many ANC visits they had during their pregnancy. 46.3% of pregnant women (18195) attended two or fewer ANC sessions (64.4%M, 34.3%F), including 16% who did not attend ANC at all (21.9%M, 12%F), 19.3% who attended once during pregnancy (28.8%M, 13%F), and 12% who attended twice (13.7%M, 9.3%F). The remaining 54% (21221)went to ANC three times or more, with 19.3% going three times (11%M, 25%F) and 34.4% going more than three times (24.7%M, 40.7F).

Those who did not attend ANC during pregnancy or only attended once were asked why; the majority of them believe there is no need for ANC, 24.2% confirmed that it is due to the distance to health facilities, 17.9% confirmed that they do not have the required money, 3.2% shared that they are dissatisfied with the first visit, 1.1% are concerned about the attitude of the medical workers, and 10.5% are concerned about finding something wrong with their pregnancy.

Deliveries attended by a skilled attendant: From the delivered women 40.5% were attended by qualified person, and 40.5% delivered at health facilities (35.6%M, 44.2%F), and very few were accompanied by doctors (6%) as confirmed by 5.2% of males and 6.6% of females, 32.8% supported by qualified midwives (29.3%M, 35.4%F), and 1.8% assisted by nurse (1.1%M, 1.8%F). The remaining 59.5% were delivered at home, with doctors assisting 8.5% (5.7%M, 10.6%F), trained midwives assisting 8.5% (9.8M, 7.5%F), traditional birth attendants assisting 19% (27%M, 12.8%F), and traditional midwives assisting 23.5% (21.8%M, 24.8%F).

Receive of postnatal care: The majority of delivered women did not receive postnatal care after birth, as verified by 75.2% of respondent HH who had delivery during the last 12 months

when questioned if delivered women had postnatal care within three days of delivery (72.3%M, 77.4%F).

Cases of sexual violence treated: There is no social or community structure for protection issues, and to assess the level of sextual violence, consulted HH were asked if any of their family members experienced sexual violence, 12% shared that they have family members experienced sextual violence, the majority of whom are from SD state (19.1%) compared to only 4.6% cases in ED, 14.9% of respondent males confirmed experiencing sextual violence in their families, compared to 9.7% of respondent females.

Household leaders who acknowledged that a member of their family had experienced sextual violence were asked if this person had gotten any sort of treatment; 94% (95.7%M, 92.7F) confirmed that no treatment or support had been provided.

Number and percent of community members who can recall target health education messages.

The majority of those surveyed (75.3M, 81%F) acknowledged that they had never received any form of capacity building in health issues.

Few people can recall health education massage, which accounts for 23.2% (28.1%M, 19.5%F). The 23.3% who recall some health massages were asked to explain what they knew about them; 79.5 know about illness prevention (79.1%M, 80%F), 9.6% know where to obtain treatment (4.7%M, 15%F), and 10.8% know about health practices, with males (16.3%) outnumbering females (5%).

Number of mothers with children under-five who can identify three or more health danger signs, that need an urgent referral of the children to the nearest health facility.

Only 25% of caregivers can identify three or more danger indications that require immediate referral of children to the nearest health facility when tested (26.5M, 23.6F).

When care givers asked to identify any of the signs, lack of energy/weakness shared by 28.7% (30.5%M, 27.1%F), weakness of immune system shared by 24.9% (29.3%M, 21.0%F), loss of weight shared by 20.0% (18.0%M, 21.8%F), 13.8% shared that children do not grow as they should (14.6%M, 13.0%F), while 17.6% of females do not know any of these signs comparing to only 7.6% from males giving a total of 12.6%.

Pharmaceuticals and other medical commodities:

Targeted health facilities in the visited villages are operating at very low capacities. Authorities of these facilities confirmed that, health facilities are constantly experiencing a lack of required pharmaceuticals and other medical commodities. This was also confirmed by

people consulted during FGDs, who confirmed that health facilities do not have capacities to provide the required services, including testing and medicines.

6.2.3 Nutrition Sector:

To assess the level of support and knowledge on nutrition, a stratified random sampling technique was used through consultation of 278 families have children under-5 comprising 69.5% of the total consulted HHs. Only 26.5% of them confirmed that they received capacity building on best nutrition practices (26.4%M, 26.5%F).

Malnutrition is relatively common among children under the age of five, with 39.3% of families with children under the age of five reporting that their children were malnourished (47.7%M, 32.7%F), with SD (45.1%) outnumbering ED (33.2%). Only 54% (0.2% of total) of HHs with malnutrition confirmed receiving therapeutic support, primarily from NGOs.

Maternal Infant and Young Child Nutrition in Emergencies:

Percent of infants 0-5 months of age who are fed exclusively with breast milk.

When caregivers were asked if they had heard of breast exclusive feeding, 69% acknowledged that they had (69.5M, 68.6%F), while 66.3% knew how long a baby should receive only breast milk (60.9%M, 70.4%F).

Care givers indicated that infants aged 0 to 5 months were solely fed breast milk (75.3%M, 77.9%F).

Percent of children 6–23 months of age who receive foods from 5 or more food groups

This assessed through direct interviews with care givers. The food groups are 1. Breastmilk, 2. Grains, roots, and tubers, 3. Legumes and nuts , 4. Dairy products (milk, yogurt, cheese) , 5. Flesh foods (meat, fish, poultry, and liver/organ meats) , 6. Eggs , 7. Vitamin A-rich fruits and vegetables , and 8. Other fruits and vegetables . From consulted caregivers, 59.8% are those giving children 6-23 months food from 5 group/or more (55.2%M, 63.3%F)

Number of individuals receiving behavior change interventions to improve infant and young child feeding practices.

The consulted people were asked if they received any type of capacity building in best nutrition practices. The majority did not receive any awareness or capacity building, and only 26.5% confirmed that they received awareness raising in nutrition practices; 26.4% of the consulted males received awareness on best nutrition practices, while only 26.5% of females received awareness.

Participants in FGDs noted that the poor economic condition, combined with low agricultural productivity last year, had a detrimental impact on children's and pregnant women's nutrition since people did not have the necessary funds to purchase nutrient-rich food.

Some pregnant women took part in focus groups and confirmed that, while they needed rest and good nutrition, they were forced to work to support their families, including hard labor such as collecting firewood to sell in markets and carrying heavy objects, which harmed their health and caused abortion in some cases.

During talks with State Ministry of Health (SMoH) officials, they revealed that the practice of early child marriage is widespread, particularly in rural regions, raising the risks of maternal death and morbidity owing to childhood pregnancy. In this regard, there is a real need for a strong capacity building and awareness raising program; additionally, there is a need to introduce the approach of Community Health Workers (CHW) and provide them with the necessary capacity, as the government lacks a governing CHW policy/strategy and does not usually recruit, retain, or remunerate CHWs; these are primarily established by NGOs.

According to a Health Clinks responder, trained nutrition professionals working in both health facilities and communities can influence nutrition policies and design, as well as the implementation of nutrition intervention programs at various levels. On the other hand, existing health facilities with the necessary capacities to respond to malnutrition cases for good treatment and mortality reduction. The community should encourage nutrition screening for children under the age of five at the facility and community levels. Screening children early enough will allow for timely intervention before it is too late.

7. Conclusion and

All actors in the two states, including UNICEF, SMoH, WES, and local partners, who met and consulted during the KIIs, confirmed that CARE International is an active partner in WASH, health, and nutrition, regularly attending sector coordination meetings and providing updates and progress, as well as sharing achievements. This provides an excellent chance for further integration and the discussion of gaps in order to achieve a high level and positive impact on the targeted populations.

Despite the fact that they lack the necessary capacity, State Water Corporation (SWC) officials confirm that they have a plan to replace fuel engines with solar systems, which contribute to sustainability, minimize continuous breakdown of water sources, and are simple to operate. They also plan to introduce solar systems instead of fuel, to ensure sustainability as well as environmental conservation.

In addition to lack accessing to easy access to adequate safe water, the available sources measured to be unsustainable due to low capacity of the government authorities which require full engagement of communities in management.

Access to safe water was discovered in 42% of the total population (34.5% M, 48% F). Individuals have access to 17 litters of water every day, implying that both quantity and quality of water must be improved

8. Recommendations

Special consideration is required for community involvement in project planning and implementation, as targeted communities lack functioning community originations such as Village Development Committees (VDCs), Community Health Workers (CHW), and Water Users Committees (WUCs), which must be formed/reformed with gender representation and the necessary capacities to play their roles.

The project, in collaboration with water authorities, can assist in using solar system as sources of energy for water sources in the targeted areas because it is consistent with the project-designed interventions and will make a substantial contribution to the sustainability of water supply.

. In addition to provision of safe water, sustainability should by highly concerned through involving community in operation and maintenance of water sources and probed them with the required capacity building and logistics to do so, in addition to equip water sources with solar system as sustainable energy and have low cost of operation. Furthermore, an efficient water tariff system is essential, which will improve sustainability. In this regard, the most vulnerable HH should be regarded through any type of assistance.

There is a need for institutional capacity building, particularly for SMoH, to improve the level of monitoring and reporting system through capacity building of respective staff and provision of the required logistics. This will support the provision of a good database system, which will support measuring progress of this project, in addition to proper design for future projects and interventions..

Practice of open defecation is common practice among the targeted, which need -beside construction of latrines- extensive capacity building and behavior change programs, in addition to introducing of Open Defecation Free (ODF) and Community Led Total Sanitation approaches.

Lack of water and hand washing facilities in health facilities send negative messages to the targeted individuals, as they are places for receiving treatment and receiving massages on proper hygiene practices to prevent infections.

Annexes

Annex1: project indicators updated with baseline figures:

Indicator	Level of reporting	BL indicator value	Confidence level at 95% level of significant	EL indicator value	Confidence level at 95% level of significant	# of sampling units interviewed	In EL test of different
Sector: WASH							
Sub-sector Name: Water supply							
W01: Number of individuals directly utilizing improved water services provided with BHA funding	**Sex:** female, male	0	95%				
W02: Number of individuals gaining access to basic drinking water services as a result of BHA assistance	N/A	0	95%				
W03 :Average litters/person/day collected from all sources for drinking, cooking, and hygiene	N/A	14 l/P/D	95%				
W04: Percent of water user committees created and/or trained by the WASH activity that are active at least three (3) months after training	N/A	0	NA				
W05: Percent of water points developed, repaired, or rehabilitated that are clean and protected from contamination	N/A	0	NA				

Sub-sector Name: Sanitation							
W06: Number of individuals directly utilizing improved sanitation services provided with BHA funding	desegregate by Sex: female, male	0	95%				
W07: Number of individuals gaining access to a basic sanitation service as a result of BHA assistance	**Disaggregation**: **Sex:** female, male **Residence**: rural, urban/peri-urban	0	95%				
W08: Number of basic sanitation facilities provided in institutional settings as a result of BHA assistance	**Facility Type**: schools, health facilities	0	NA				
W09: Percent of households targeted by latrine construction/promotion activity whose latrines are completed and clean	N/A	0	95%				
W10: Percent of excreta disposal facilities built or rehabilitated in health facilities that are clean and functional	N/A	0	NA				
Sub-sector Name: Environmental Health							
W11: Number of individuals receiving improved service quality from solid waste management, drainage, or vector control activities (without double counting)	**Sex:** female, male	0	95%				

W12: Average number of community cleanup/debris removal events conducted per community targeted by the environmental health activity	N/A	0	NA				
W13 Average number of vector control activities conducted per community targeted by the environmental health intervention	N/A	0	NA				
Sub-sector Name: Hygiene promotion							
W14: Number of individuals receiving direct hygiene promotion (excluding mass media campaigns and without double-counting).	N/A	26794	95%				
W15: Percent of individuals targeted by the hygiene promotion activity who know at least three (3) of the five (5) critical times to wash hands	**Sex:** female, male	**40.5%** (38.8%M, 41.4 F)	95%				
W16: Percent of households targeted by the hygiene promotion activity who store their drinking water safely in clean containers	N/A	**50.3%** (48.9%M, 51.3%F)	95%				
Sector II: Health							
Sub-sector Name: Health Systems Support							
H01: Number of health facilities supported	N/A	0	N/A				

H02: Percent of total weekly surveillance reports submitted on time by health facilities	N/A	0	N/A				
H03: Number of health facilities rehabilitated	N/A	0	N/A				
H04: Number of health care staff trained	**Sex:** female, male	0	N/A				
Sub-sector Name: Basic Primary Health Care							
H05: Number of outpatient consultations	**Sex**[4]**:** female, male	0	N/A				
H06: Number of Community Health Workers (CHW) supported (total within activity area and per 10,000 population)	**Sex:** female, male	0	N/A				
H07: Number and percent of deliveries attended by a skilled attendant	Birth Attendant Type[5]	40.5% (15916)	N/A				
H08: Number and percent of pregnant women who have attended at least two complete antenatal clinics	N/A	64.7% (25426)	95%				

[4] *Age: <5 years, 5-14 years, 15-18 years, 19-49 years, 50+ years. Consultation Type: Communicable disease, reproductive health, non-communicable disease, injury, other (specify). In addition, report disaggregation by Consultation Type and major causes of morbidity (based on the local context) in a table/figure or annex in the Semi-Annual Report, Annual Report and Final Performance Report.*

[5] *Birth Attendant Type: midwives, doctors, nurses with midwifery and life-saving skills Delivery Location: health facility, home, other*

H09: Number and percent of new-borns that receive postnatal care within 3 days of delivery	**Sex:** female, male	24.8%(9746)	95%				
H10: Number of cases of sexual violence treated	**Sex:** female, male **Age:** <5 years, 5-14 years, 15-18 years, 19-49 years, 50+ years	0	95%				
H11: Number of consultations for communicable disease	**Sex:** female, male **Age:** <5 years, ≥ 5 years **Disease:** diarrhoea, acute respiratory infections, malaria, other (specify; define in progress reports)	0	N/A				
H12: Number and percent of community members who can recall target health education messages	**Sex:** female, male	23.2% (28.1%M, 19.5%F) (20721)	95%				
H13: Number of mothers with children under-five who can identify three or more health danger signs, that need an urgent referral of the children to the nearest health facility	**Sex:** female, male	25% (22328)	95%				

H14: Number of women health group established and trained on GBV and awareness raising	N/A	0	N/A				
Sub-sector Name: Pharmaceuticals and other medical commodities							
H17: Number of individuals trained in medical commodity supply chain management	**Sex:** female, male	0	N/A				
H18: Number of health facilities out of stock of any medical commodity tracer products, for longer than one week, 7 consecutive days	**Sex:** female, male	0	N/A				
Sector III: Nutrition							
Nutrition Sector Indicator **1:** Number of children under five (0-59 months) reached with nutrition-specific interventions through BHA	**Sex:** female, male **Intervention Type**[6]	0	N/A				

[6] ***Intervention type include:***

- *Reached through parents/caregiver who received social behaviour change (SBC) interventions that promote essential infant and young child feeding behaviours*
- *Received vitamin A supplementation in the past 6 months*
- *Received zinc supplementation during episode of diarrhoea*
- *Received Multiple Micronutrient Powder (MNP) supplementation*
- *Admitted for treatment of severe acute malnutrition*
- *Admitted for treatment of moderate acute malnutrition*
- *Received direct food assistance of fortified/specialized food products*

Nutrition Sector Indicator **2:** Number of pregnant women reached with nutrition-specific interventions through BHA	**Age**: ≤19, 20+ years **Intervention Type:** [7]	0	N/A				
Sub-sector Name: Maternal Infant and Young Child Nutrition in Emergencies							
N01: Percent of infants 0-5 months of age who are fed exclusively with breast milk	**Sex:** female, male	76.7% (75.3%M, 77.9%F).	95%				
N02: Percent of children 6–23 months of age who receive foods from 5 or more food groups	**Sex:** female, male	59.8% (55.2%M, 63.3%F)	95%				
N03: Number of individuals receiving behaviour change interventions to improve infant and young child feeding practices	**Sex:** female, male	0	N/A				

7 intervention types include:

- *Received IFA supplementation*
- *Received counselling on maternal and child nutrition*
- *Received calcium supplementation*
- *Received multiple micronutrient supplementation*
- *Received direct fortified food assistance/specialized food products*

N04: Number of individuals receiving micronutrient supplements	**Disaggregation**[8]	0	N/A				
Sub-sector Name: Management of acute malnutrition							
N05: Number of health care staff trained in the prevention and management of acute malnutrition	**Sex:** female, male	0	N/A				
N06: Number of supported sites managing acute malnutrition	**Facility Type**: OTP, SFP, SC	0	N/A				
N07: Number and percent of individuals admitted, rates of recovery, default, death, relapse, and average length of stay for individuals admitted to Management of Acute Malnutrition sites	**Disaggregation**[9]	0	N/A				
N08: Number of Management of Acute Malnutrition sites rehabilitated	N/A	0	N/A				
N09: Number of individuals screened for malnutrition by community outreach workers	**Sex:** female, male **Individual type:** children under 5 years, pregnant and lactating women	0	N/A				

[8] *Review BHA EAG Indicator Handbook 8*
[9] *Review BHA EAG Indicator Handbook 8*

Annex2: CARE staff met HQ

#	Name	Position	Telephone #
	Khartoum Care office		
1	Nasrelin Saeed	MEAL Coordinator	0124532678
2	Bader Hamid	WASH officer	0993333364
3	Hanadi Al gaali	Health and Nutrition officer	0923333811

CARE staff met In Nyala and AL Daian during the survey

#	Name	Position	Telephone #
	Nyala Care office		
1	Eltigani Mohamed Salih	Head of Office	0124532678
2	Abdulraheem Brima	WASH officer	0993333364
3	Faroug Mohammed	Health and Nutrition officer	0923333811
4	Jedo Omer	Logistic officer	0916915899
	Al daien Care Office		
5	Mousab Ibrahiem	Office manger	0966635350
6	Osman Salih	WASH officer	
7	Fatima Mohammed Jebreal	Health and Nutrition Officer -	0953333387
8	Bader Al Zaman Essa	WASH Officer -Kass	0993333361
9	Adam Yusif Adam Salih	WASH Officer -Kass	0923333398
10	Essam Mohamed Al hafiz	WASH manger	0915025379
11	**Kass Care office**		
12	Bader Al Zaman Essa	WASH manger	0993333361
13	Fatima Mohmed jebreel	Healtg and Nutition Officer	0993333387
14	Adam Yousif Adam	WAH officer	0923333898
15	Abad Al Wahab Mohammed	Office Manger	0992533337

Annex List of (KII) FGD- East Darfur

KII Mohajria-SD			
#	**Name**	**Position**	**Telephone #**
1	Noreddien Al doma	Nurse	09821559530
2	Alm Aldien Tbin	Nurse	0928353924
3	Maraim Mhmood Salih	Nurse	0924772586
4	Abad al majd Ebied Al saig	Medical assistant	0924866561
5	Asma Mohammed hammed	Social mobilizer	0999260858
6	Igbal Ibrahiem Omer	Clark	0920327897
7	Halima Ibrahiem	Cleaner	09993372382
9	Salma Ahmed Abdalla	Midwife	0991924217

10	Rashida daffala Ak ebied	Midwife	0991144497
KII - Surhan-SD			
1	Rudwan Ismaeal Ali	Health Centre manger	0997401747
2	Asha Abaker Al rehima	Assistant Health centre Manger	
3	Abaker Ahmed Hamdan	Pharmacist	0927123963
4	Amina Husen Al Taher	Social Mobilize	0993623838
5	Adam Yousif Salih	EPI assistant	0993379000
6	Zahra Zakaria Abaker	Immunization technician	0298037080
7	Abaker darob Al Emam	Volunteer	
9	Abad Al Azieam Mohammed	Health committee	0925743729
FGD – Sunta village - ED			
	Al hakh Jumaa Mohammed	Shakh	0995259071
	Ibrahiem Ali dress	Community member	0121588502
	Adam Ibrahiem Al safi	Community member	0966130597
	Haj Musa Bakit Manzool	Community member	
	Bakieet musa bakhit	Commercial chamber	
	Mohamed Juma Mohamed Manjool	Health unit	09661943099
	Musa Mahamed Bakhit	Social worker	0911684700
	Adam Issag	Volunteer	0911694690
	Mhmood Mohammed fadol	Commercial chamber	
	Adam Abad Rahman Hajar	Medical assistant	
KII – Sunta village - ED			
	Sitahoum Abad Alwahab Haroon	Midwife	0991314628
	Huda Al mahadi Mohammed	Health committee	0960234320
	Khadiga Aldallla	Health committee	0966006854
	Nima Osman Ibrahiem	Register	0960234320
	Dawood Musa Ali	Nutrition	0927575555
	Tarbo Mohammed Jad	Nutrition	0911488723
	Brima Huseen Mutwal	Nutrition	0963383663
	Al nour Hamid Yahya	EPI tech.	0981289185
	Al Deaf Abdrahman Abass	Pharmacy	0911345650
	Sharifa Ahmed Khalifa	Nurse	0995036667
FGD – Mohajeria- SD			
	Khadiga Osman	Community member	
	Asia Ahmed Ibrahim	Community member	

	Hawa Musa	Community member	
	Mona Abdel Aziz	Nurse	
	Fatima Yousife Saeed	Volunteer	
	Zahra Hassan Ibrahim	Teacher	
	Kmalda Mohammed	Community member	
	Rahma Ahmed Ibrahim	Community member	
	Hawa Musa Ibrahim	Nurse	
	Hafssa Musa Osman	Community member	
	Zolfa Hussain Omer	Community member	
	Arafa Mohamed	Community member	
	Kalthom Sulaiman	Midwife	
FGD – Dogo- E.D			
1	Abdalla Idress Shobar	Shakh	0920783027
2	Bakeet Haroon Shareef	Youth	092028873
3	Al taher Khamees Nori	Education council	0921689861
4	Abad All Ahmed Abadalla	Youth	0925486677
5	Ismaeal Haroon Shareef	Education council	0991324805
6	Babiker Ibrahiem Mohamed	Youth	0996802411
7	Abad all Diafalla	Council member	0929535593
9	Mohammed barai Abad Al Kariem	Youth	0929889338
10	Al Taher ahmed Al sharief	Police man	0993838531
11	Al taher Abadall idres	Youth	0929152711
12	Mohammed Ibrahiem Mohamed	Shakh assistant	0997516656
13	Hawa Ahmed Abadalla	Teacher	0997947911
KII – Al Manar - E.D			
1	Mhmoud Mohamed Mhmooud	Shakh	0122188539
2	Al toum Ahmed Osman	Environ, Health	0111383460
3	Hamdan Hamid Makean	Shakh	0114634347
4	Ibrahiem Al Hassan Ahmed	A.Shakh	0922853377
5	**Adam Abad Rahman**	Public Health	0121148116
KII Gebra- S.D			
	Mouneim Youness Mohamed	Beneficiary	0924092946
	Ameir Hamed Mohamed	Nurse	0908616252
	Abdalla Suleeman Abdalla	Beneficiary	0920849674
	Saber Abdalla	Register	0924486655
	Behareldeen Abdelrahaman	EPI tech.	0926302239
	Ibrahim Abdelrahman	Sheikh	0926686830
	Yousef Adouma Yousef	Medical Assistance	0960259572

	Aziz Adam Suleman	Nutrition	---
	Omer Ahmed Mohamed	WASH	0928310449
	Safeia Ahmed Mohamed	Vaccination	0927177331
FGD- Gerada –S-D			
	Adoma Adam Mohamed	Beneficiary	0924689978
	Abdelmouneim Salim Fadel	Sheikh	0925806597
	Eltaher Adam	Beneficiary	0929597354
	Zain Elabdeen Mohamed	Water controller	0998303353
	Sadeig Ismaeil	Beneficiary	0929587634
	Abdalla Abdelkareem Ibrahim	Water controller	0991436893
	Mohamed Abdelrhaman Noreen	Beneficiary	0998140775
	Jalal Adam	Youth Committee	0929000778
	Abdelgader Elnour Yassin	Youth Committee	0926571223
	Adam Mohamed Abdelrahman	WASH Committee	0922586767
	Hawaa Mohamedeen	Community member	----
	Fatima Ibrahim Adam	Community member	------
	Husna Abdelgader Ahmed	Community member	------
Enumerator East Darfur			
	Habieb Al hadi	Enumerator	0122489118
	Rowda Adiem Real	Enumerator	0125650801
	Fatima Gasim Barsham	Enumerator	0121295838
Enumerator South Darfur			
	Samia Terab	Enumerator	0122120991
	Al Daef Mohammed	Enumerator	0926398457
	Jalal Adam	Enumerator	0929000778
	AbadAlla Alnour Yasin	Enumerator	0926571223
	Adam Mohammed Ahmed	Enumerator	0922586767
	Manal Musa Adam	Enumerator	0912430607
	Adam Musaa Kharif	Enumerator	0914019032