



**Humanitarian Support for Conflict Affected Persons and Communities in South Darfur**  
**DFD-G-00-06-00076-00**  
**U.S. Agency for International Development, Office of Foreign Disaster Assistance**  
**Annual Results Report**  
**Report: Feb 1<sup>st</sup> to Sept 30<sup>th</sup> 2006**

## **1. Executive Summary**

The goal for all ARC activities in South Darfur is to improve the wellbeing of war-affected persons by addressing immediate humanitarian needs and contributing to long-term community stabilization. The project is intended to support primary health care, water and sanitation and agriculture livelihood activities in conflict affected communities in South Darfur state.

The situation in the Nyala Gereida and Nyala Tulus corridor steadily deteriorated from December 2005 to May 2006 as major attacks around Gereida and Buram forced tens of thousands of people from their homes into IDP camps, especially around Gereida. As of May 2006, there are an estimated 120-130,000 IDPs in Gereida. With support from OFDA, ARC, also hereinafter referred to as the program, responded to the changing needs by starting a large primary health care center (PHCC) and RH unit in Gereida, operational since June 2006. In addition, the program re-started mobile clinics in Birakatule, Gereiga and Tokomaya to target persons displaced from Donki Dreisa and other communities. The program also proposes to open dispensaries in Tokomaya and Gereiga to serve these IDPs who are settling there due to insecurity in their villages of origin.

For water and sanitation, the program: constructed 6 hand pumps and rehabilitated 84 existing ones; constructed 3 water yards, rehabilitated 4 others and also constructed 9 hand dug wells; carried out several water testing activities; constructed 1372 household and institutional latrines and conducted 23 health and hygiene education trainings for 1149 participants in targeted communities; facilitated the formation of 64 village health and sanitation committees, trained 156 community health volunteers and conducted hygiene education training for 1036 pupils; the program also trained 60 village hand pump technicians.

In agriculture/livelihood, the program established 4 school gardens, distributed 24,000 fruit and tree seedlings from 7 seven nurseries, distributed 26.4 metric tons of seeds and facilitated the establishment of 4 community gardens. The program also distributed 80 foot pumps and 147.5 kilograms of vegetable seeds and conducted water harvesting training for 580 house holds. In total ARC's livelihood activities under this program benefited 10,384 war-affected house holds in South Darfur.

Despite the worsening and difficult security situation this program was able to meet about 85% of its target during the period ending September 30, 2006.

## HEALTH

**Objective:** To improve access to basic health care services in South Darfur through capacity building, provision of material support and emergency preparedness and response

### 1. Progress against indicators

Results/Indicators	Details Feb to Sept 2006	Cumulative Feb to Sept 2006
<b>Results 1.1: Reduced maternal and infant mortality</b>		
Crude infant and maternal mortality rates	<p><u>Crude Infant Mortality Rate:</u> <u>Deaths per 10,000 population per day.</u> Feb: 0.7 March : 1.2 April: 2.4 May: 2.7 June: X</p> <p><u>Crude Maternal Mortality Rate:</u> <u>Deaths per 10,000 population per day.</u> Feb: 1.4 March: 1.3 April: 1.6 May: 3..7 June: X</p> <p>* The above figures appear to be quite high. The reliability of this data is uncertain (the newly trained CHV may have overstated). Follow-up and close supervision are a big constraint. Senior health staff are verifying the data</p>	
<b>Result 1.2: Improved health for women of reproductive age</b>		
# PHCCs and RH units	<p><u>PHCC with RH units:</u> Elwihda, Abouajoura, Gereida, Bulbul Abujazo, Bulbul Tembsko, Abu Ajura, Safya, Abu Selala, Dimso, El Tomat</p> <p><u>RH units alone:</u> Nyala Women's Prison, Tulus</p>	<b>10 operational PHCCs with RH units incorporated and 2 RH units without PHC services :</b>
# midwives per PHCC/RH unit	Gereida has 5 while Elwihda has 7 midwives per RH unit; Nyala-	A total of <b>23</b> midwives work in all ARC RH units

	Tulus corridor and Nyala Gereida corridor have 1 midwife per RH unit except Bulbul Tembsco, Abouajoura, and Al safia which have two each	
# pre and post natal care visits per clinic per month	<u>Prenatal:</u> 580 for February, 270 for March, 405 for April, 429 for May, 429 for June, 2,945 for July 1,348 For August 1,692 For Sept <u>Postnatal:</u> 35 for February, 26 for March, 22 for April, 150 for May, 14 for June, 155 for July, 386 for August 119 for Sept .	Prenatal care visits: <b>7219</b> Postnatal care visits: <b>907</b>  Culturally women do not come to the clinic for post natal care. Instead a midwife would visit her at home. However the trend is slowly changing as most women now try to bring their babies for EPI as early as possible thereby also attending post natal clinic.
# pregnant women vaccinated for TT per clinic per month	TT vaccination services were incorporated in July to the RH unit in Gereida clinic. 61 in February, 304 in March, 507 in April, 114 in May , 109 in June, 494 in July, 89 in August 92 in Sept	<b>1770</b>
<b>Result 1.3: Enhanced protection for women and girls in ARC operation areas</b>		
Number of GBV trainings conducted (Target: 7 trainings (average 1 per month))	February 2006: 1 training March 2006: 3 trainings April 2006: 2 trainings May 2006: 2 trainings June 2006: 1 training July 2006: 5 trainings August 2006: 2 trainings Sept none	Total of GBV trainings for communities: <b>16</b>

% of training participants who know at least 3 types of GBV by the end of the training. (Target: 85%)	90%	An average of 90% participants in training could recollect 3 types of GBV modes.
Increased knowledge of GBV among community members	Pre and post intervention surveys were proposed.	Pre-intervention survey was conducted; post-intervention survey is planned for the future
Number GBV focal points created per ARC PHCC target area (in charge of coordinating the community response to cases of GBV) (Target: one focal point per ARC PHCC target area)	66% coverage	<b>8</b> of 12 locations have GBV focal points.
<b>Result 1.4: PHC coverage of 1 PHCC per 20,000 population is provided in targeted gap areas</b>		
# of PHC service per population	1 PHC service per 19,000 population in 10 locations	Average of 1 PHCC per 19,000 population in 10 locations
<b>Result 1.5: Minimum of 70% of health providers are trained on WHO and national protocols</b>		
% of health providers trained	75%	<b>75%</b>
<b>Result 1.6: Regular supply of drugs in place and being prescribed by health providers according to health protocol guidelines</b>		
# PHCC kits distributed per clinic per month	2	2 kits in each functioning PHC.
% of clinics with copies of WHO protocols (target: 100%)	100%	100%
# of trained health providers observed using protocols effectively	8 Medical Assistants and 2 health providers trained were observed using protocols.	All 10 trained health providers were found using protocols.
<b>Result 1.7: Minimum of 80% EPI coverage</b>		
# of children vaccinated per vaccination site for measles and EPI	Only three clinics had Routine EPI services. El wihda, Gereida and Bulbul tembsco. Gereida started EPI services in July.	4514 children were vaccinated during this period.
<b>Result 1.8: ANC/RH is integrated into PHC services in targeted gap areas</b>		
# Of trainings for health providers on RH, HIV & SGBV issues & # of health providers trained.	4 RH trainings 1 HIV training  16 GBV trainings	Total <b>21</b> trainings and <b>285</b> participants
% ARC supported PHCs offering ANC/RH services available (Target: 100%)	100%. All ARC clinics have RH integrated.	100%
<b>Result 1.9: Targeted populations have improved access to EmOC</b>		
# functioning and accessible referral points	Nyala, Gereida and Tulus Hospitals are the referral points in ARC area of operation.	<b>3</b>

	However all of the hospitals are deficient in services and ARC supports referrals.	
# EmOC referrals from ARC clinics per month	Referrals to both Nyala Teaching Hospital and Gereida Hospital February: 25 March: 4 April: 18 May: 16 June: 15 July: 54 August: 77 Sept: 137	<b>346</b>
<b>Result 1.10: The major causes of mortality and morbidity are monitored and managed</b>		
Mortality per 10,000 of population	No mortality reported from our clinics	
The major causes of mortality and morbidity are monitored, documented	ARC worked closely with the MOH and other agencies to monitor the trends.	Weekly EWARN reports. The major causes of morbidity remain to be ARI, Diarrhoea, and malaria.
<b>Result 1.11: Acute malnutrition among vulnerable prevented and 80% of malnourished children rehabilitated; The nutritional status of IDPs and host communities monitored; The Global Acute Malnutrition (GAM) rate maintained to acceptable level for developing country (10%) by the end of the project period</b>		
Malnutrition rates each site (Target: Moderate malnutrition rate < 10%)	A nutrition survey was carried out in the Nyala Tulus corridor in Feb 2006.	GAM of 13.2% SAM of 2.3%
# receiving supplemental feeding in each site	No significant activity due to absence of nutrition coordinator to implement nutrition activities.	
<b>Result 1.12: Micronutrient deficiencies prevented by reaching at least 80% of children under and 60% of Post partum mothers via Vitamin A supplementation and iodized salt promotion</b>		
# children receiving vitamin in ARC clinics each month	Options available were through EPI and nutrition program. ARC did not actively monitor EPI or carry out nutrition program	
# post partum mothers receiving vitamin A and iodized salt promotion in ARC clinics each month	Iodized salts selectively distributed by UNICEF/MOH in iodine deficiency endemic areas. ARC does not work in these areas.	
<b>Result 1.13: Community is aware of preventive measures for common health-related problems and is appropriately using the information</b>		

# community health education sessions conducted	February: 1 March: 3 April: 1 May: 0 June: 18 July: 55 August: 300 ( due to Cholera Outbreak) Sept: 6 (Rainy Season)  The health education program by this time included 2 health educators at Gereida PHC, 2 in Elwihda area, and 1 health education coordinator	<b>384</b> sessions were conducted during this period.
# participants	February: 27 March: 310 April: 76 May: 0 June: 1,863 July: 2,333 August: 3,989 Sept: 5936	<b>14,534</b> participants reached with health education messages.
Pre and post intervention assessments conducted	Pre and post intervention assessments were planned.	1 pre intervention assessment was carried out in January. No post intervention assessment was carried out.

## 2. NARRATIVE .

### **Primary Health Care services strengthened for and good health practices promoted among the targeted population.**

#### **2.1.Continue to support ARC/MoH existing PHCs in the Nyala- Gereida Corridor (namely Birkatulli, Abujabra, Sanam el Naga, and Ditto with extended PHC services).**

The ARC/MOH PHCs in the Nyala-Gereida corridor, Abujabra, Ditto, Donki Dressa, and Birkatuli were operational up until May when they were closed due to insecurity. Donki Dressa was attacked by janjaweed militia in May which resulted in people fleeing from the neighboring communities of Abujabra, Sanaalnaga Birkatuli and Ditto. The security situation has apparently calmed recently, and the population is resettling in some areas of this corridor. Donki Dressa currently has no civilian inhabitants, but Birkatulli, Abujabra, Sanam el Naga, and Ditto have people coming back to resettle. Community leaders in these localities expressed readiness to collaborate with ARC for re-opening of the clinics. An assessment was carried out in August to see if it was safe to resume services in these locations. Relevant discussions continued and an agreement was reached to resume services. The process of staff recruitment took place in September although several delays were encountered due to

new insecurity. By the end of September the process was completed. A major challenge though was in finding health care workers to work in these health facilities since some of those who were working there fled during the insecurity and have not returned. The reopening was scheduled for October.

**2.2. Continue to support ARC/MoH existing PHC facilities in the Nyala – Tulus corridor (Bulbul Tembsko, Bulbul Abujazo, Abu Ajura, Safya, Abu Selala, Dimso, and Eltomat) as well as an RH unit in Tulus.**

ARC continues to support the ARC/MOH PHC facilities in Abu Ajura, Bulbul Tembsko, Bulbul Abujazo, AlSafia, Abusalala, Dimso, and El Tomat. Each PHC receives 1 UNICEF PHC kit per month and other relevant supplies. The RH unit in Tulus also receives relevant RH supplies. An average of 1.5 supervisory visits per month is carried out to support the staff through supervision and on the job trainings as well as to monitor activities.

**2.3 Support a large PHC (ElWihda West) in Nyala town and two small service delivery points (Women's Prison and Eldomaya in Nyala) with co-funding from private donors.**

a) The PHC in Elwihda West continued to receive ARC support. A minor operating theatre was established in July to provide care for minor obstetric emergencies procedures and it is still operational. So far three minor surgeries have been conducted here since its inception.

**b) Support one small service delivery point (Women's Prison in Nyala) with co-funding from private donors**

ARC supports an RH unit in Nyala Women's Prison including visits by the mobile clinic. On-site antenatal care, deliveries, and postnatal care for inmates and women living in the surrounding area are provided. This RH unit also receives supplies and supervision visits as well as on-the-job trainings for the midwives during these supervision visits.

**2.4. Support 1 new MoH PHC (Abu Selala) in the Nyala – Tulus Corridor.**

Discussions to support Abusalala MOH PHCC started in April. ARC team organized a meeting with the Community leaders and agreed on bilateral responsibilities. ARC opted to support staff with incentives, training and supervision as well as supply of UNICEF PHC Kits. The Community agreed to avail temporary structures as needed. Abusalala was a place worth supporting. Different Darfurian tribes, including Arabs and other ethnic groups and IDPs are living together without animosities. This encouraged people who fled from other villages to settle in the area. The needs increased as IDPs from Twal settled in the area. Considering the way all Omdas (community leaders) participated in various meetings, there was no feeling of one tribe feeling oppressed or excluded. A health worker was identified and given basic drug kit to start giving services and in September PHCC equipments and supplies were delivered. The clinic is now fully operational and offers primary health care services with reproductive health services incorporated.

**2.5 Assess for specific nutrition needs regularly and establish targeted supplementary feeding centers & rehabilitate at least 80% of malnourished children.**

Not started yet but plans underway to start after surveys scheduled for Jan and Feb 2007.

**Supports with referral of severe malnutrition to nearest centers in Nyala.**

Currently cases screened at the Elwihda clinic in Nyala are referred to the Nyala hospital for management.

**Consider establishment of CTC**

Not yet decided till after planned surveys.

**Provide Vitamin A supplementation for 80% of children and 60% of post-partum mothers**

Not started yet.

**Consider blanket feedings and notify pertinent providers assisting with distributions.**

Not yet considered.

**Educate population on nutrition in 2-3 separate planned focus groups per community.**

Two focus group discussions on nutrition issues were conducted in September, along the Nyala Gereida corridor in two communities Gerega and Birkatuli and in total 20 participants were involved in these.

**2.6 Conduct 2 orientation workshops for project specific health workers whenever opening a new PHC.**

Before opening any new clinics, orientations are provided to the health staff responsible on the duties in their various procedure areas. Protocol use has been instituted and procedures explained to them on the use of these protocols. During this period Nyala Tulus corridor staff received orientation workshops before starting health services in their respective health facilities. The orientation comprises of reporting EWARN diseases to Nyala Office, treatment of minor ailments and referring at risk patients to Nyala Teaching Hospital or Gereida, storing of drugs, drug administration to patients and how to do requisition of necessary items from Nyala office.

**2.7. Conduct 2 sensitization campaigns on PHC priorities in emergency settings for targeted populations when opening new facilities or establishing new points for mobile clinics.**

Meetings were held with community leaders in communities where ARC has health facilities to re-emphasize the importance of community support for clinic activities and to explain the criteria for establishing village health committees. Another key issue for discussion in these campaigns was the relationship between community and clinic and to stress the importance of community support for community activities. The process of re-opening clinics in various locations during this period was discussed.

**2.8. In coordination with other health providers in the service area, conduct EWARN, morbidity and mortality surveillance, and implement management and control activities to prevent outbreaks**

ARC is conducting EWARN and submitting reports to WHO and MOH from 12 sites: Elwihda, Gereida, Abojebra, Abu Ajura, Safya, Bulbul Tembsko, Bulbul Abujazo, Dimso, El Tomat, Abu Salala, Ditto, Birkatuli and mobile clinic (which covers Gereiga, Fuluamnuara, Tabaldiat Tucumaya, and Towal.).

Surveillance on morbidity and mortality continues in collaboration with the MOH. ARC coordinates closely on reports of outbreaks or impending outbreaks with the MOH and other agencies. In response to the cholera outbreak in Nyala around June, ARC participated in a cholera task force composed of MOH, WHO, and various NGOs. The MOH officially acknowledged the cholera epidemic in July.

At the first signs of an AWD (suspected cholera) outbreak in Safya and Abu Ajura, the cases were reported immediately to MOH, stool samples were given to MOH to be sent to the laboratory in Khartoum for confirmation of cholera, and a rapid assessment and response was initiated. In the month of August, massive house-to-house health education campaigns were conducted in the two localities, in collaboration with NRC and ZOA and utilizing 40 Community Health Volunteers in Safya and 20 CHVs in Abu Ajura. A total of 89 households were reached in Safya and a comparable number in Abu Ajura. ARC supplemented the hygiene promotion with case management (including relevant supplies, staff training, and supervision for AWD and cholera response) and chlorination of local water sources (in conjunction with the ARC water and sanitation program.)

Similar health education sessions were also conducted in Elwihda, as part of the overall NGO response. ARC clinics in areas with reports of AWD received staff trainings on case management of cholera and AWD. ORT corners were put in place in 4 clinics in July (Elwihda, Gereida, Abu Ajura, and Safya). In a joint effort with partners such as UNICEF supporting by provision of IEC materials, promotion of appropriate health messages to help reduce the incidence of occurrence in high risk areas and areas already affected by AWD was done. By the end of September occurrence of new cases started to decline.

**2.9. Provide vaccination coverage as directed by the health coordinating agency, (UNICEF/MoH/WHO) participating in National Immunization Days as in previous 12 months.**

EPI services are ongoing in Gereida, Bulbul Tembsco and Elwihda clinics. During the period of March to May there was rampant breakage of cold chain facilities in most clinics resulting in reduction in EPI services. The MOH alerted agencies that there will be national immunization days and EPI acceleration campaigns starting October and requested agencies to consider various support, including staffing and vehicles.

**2.10. Provide drugs and material support, supervision, and technical training for MCH services in the targeted areas, according to UNICEF approved guidelines.**

Drugs and material support are provided to all ARC RH units monthly, in addition to equipment and supplies needed to supplement existing stocks. Laboratory equipment are provided to the clinics in Gereida and El wihda to establish a basic level laboratory on site.

Supervision and on-the-job training were and are still conducted regularly to midwives and ARC medical staff. In Gereida, training on clinical management of post-rape cases was done in August targeting 11 staff.

Health education for pregnant women at all ARC RH units is ongoing. Additionally, ARC collaborated with ICRC and Oxfam to facilitate 1 workshop on breast feeding and supervision of RH activities for 60 ICRC and Oxfam outreach workers (55 men, 5 women) in Gereida in August and conducted 1 education session on breastfeeding for 45 Oxfam community monitors (women).

ARC began supporting 9 midwifery students for the one-year program at Nyala Midwifery School B, beginning in February. ARC also began supporting 7 new midwifery students from 7 different villages attending Nyala Midwifery School A, beginning in May.

### **2.11. Recruit and train community volunteers and village health committees in all areas of ARC activity, to support ARC activities (e.g. community education, referral system, early warning system, GBV focal points) and to help collect data.**

Eighty-one community health volunteers (41 men, 14 women, 14 boys, 12 girls) from 15 communities (Elwihda, Donkey Dreisa, Ditto, Abojebura, Samnaanlagen, Tucumaya, Gerega, Birkatulli, Tabaldiat, Safya, Abu Ajura, Bulbul Tembsko, Tulus, El Tomat, Dimso) have been trained in community education and data collection. However, the difficulty in accessing the CHV villages regularly to conduct supervision has resulted in data of questionable reliability. Under the circumstances, ARC has chosen to focus on the community education aspect of the CHV role.

Twenty community workers in Abu Ajura and 40 health workers in Safya were trained in hygiene promotion in August and supervised during a 2-week house-to-house health education campaign to spread information to their communities in response to the suspected cholera outbreak.

Forty health education volunteers (20 men, 20 women) were trained in Elwihda at the end of August to disseminate similar health education messages during the month of September. Of these, 10 were teachers who will pass the messages in the schools. In addition, one participant was a midwife working at Nyala Prison. She is promoting these messages in her workplace.

Twenty Elwihda volunteers also participated in a 2-day rapid assessment survey on the results of hygiene promotion in Nyala, receiving training and supervision from UNICEF. ARC regularly collaborates with ICRC and Oxfam in Gereida to train their outreach workers.

### **2.12. Continue to implement MISP as appropriate, consistent with Sphere standards and in coordination with health agencies in new and previous areas of operation with funding from Women's Commission.**

The RH team implemented MISP in Nyala-Gereida corridor and initiated MISP in Nyala-Talus corridor. RH team participated in coordination meetings with other NGOs (UNFPA, UNMIS, UNDP, IRC, Darfur Net, Amel Center, Ahlam, Charitable Organization for the Koran, and others). The team also facilitated GBV trainings for participants from communities along the Nyala Tulus corridor and Tulus. In addition, there was 1 HIV/AIDS training for participants from 3 communities in Tulus. ARC initiated and continues to distribute clean delivery kits to all its RH units and made available boxes of condoms in all ARC RH units. ARC collected community data from community health volunteers

(from the Nyala-Gereida corridor, Safya, Abu Ajura, and Bulbul Tembsko). These CHVs will continue to support MISP activities through data collection and health education.

### **2.13. Integrate GBV services into MCH services at PHCC levels, and through workshops, OTJ training, other training/discussion sessions and sensitization campaigns as indicated above.**

STI treatment and post-rape kits were distributed in Elwihda, Abu Ajura, Safya, Tulus Hospital, Dimso, El Tomat, Bulbul Tembsko, Abojebra, Gereida, and the mobile clinic following trainings on appropriate use of these kits (trainings held in February, April, July, and August 2006). Eleven ARC medical staff (8 men, 3 women) in Gereida received a follow-up on-the-job training on management of post-rape cases (August 29-31). The kits were also sent to Ditto, Sanam Al naga, and Donki Dreisa before they were closed due to insecurity. The plans to retrain the staff before supplying the kits are scheduled for early next year.

### **2.14. Plan and implement a community mobilization program on GBV prevention, in PHCCs and mobile clinics.**

With increasing tensions following the signing of the Darfur Peace Agreement, the numbers of rape cases reported in Gereida Camp have increased significantly. The ARC clinic provides medical management of rape survivors who access the health facility in the camp.

The ARC health team is liaising with other NGOs active in Gereida camp to begin discussions on possible ways to improve safety for women. Most rapes occur when women leave the camp to collect firewood, as the camp is surrounded to the West, South, and East by Janjaweed. As previously mentioned, the 8 GBV focal points are responsible for raising awareness and coordinating the community response to GBV cases. The existing focal points are located in Ditto, Gereida, Donkey Dreisa, El Tomat, El Nakhara, Tulus, Abu Ajura, and Safya. However, with displacements after insecurity, it is unlikely that the focal points in Ditto, Gereida, and Donkey Dreisa still function effectively.

In addition, 105 community health volunteers (56 men, 23 women, 14 boys, 12 girls) from 15 communities (Elwihda, Donkey Dreisa, Ditto, Abujabra, Sanam alnaga, Tucumaya, Gerega, Birkatulli, Tabaldiat, Safya, Abu Ajura, Bulbul Tembsko, Tulus, El Tomat, Dimso) have been trained in GBV and community education techniques, to support their local GBV focal points in mobilizing their communities on GBV prevention.

Twenty-seven more community health volunteers (17 men, 7 women, 1 boy, 2 girls) have been selected and trained to assist the GBV focal points in the Tulus area (from Tulus, El Tomat, and Dimso). Twenty-four more CHVs (15 men, 9 women) were recruited and trained in May in health education, including topics related to GBV.

### **2.15. Implement referral service (standardized medical response) for GBV survivors in coordination with focal health agencies and Nyala-based GBV Working Group.**

GBV in Darfur includes rape, domestic violence, Female Genital Mutilation, and early marriage. The referral process depends on both standardized medical response and community awareness and support. In this regard, ARC is conducting awareness raising activities on GBV through health education sessions conducted by ARC staff in the communities. An additional and more sustainable approach to community education is the use of Community Health Volunteers, who are being trained to provide both health education and support for referral system at the community level. As awareness rises, referrals of any occurring SGBV cases may rise as well. ARC has established 8 GBV focal points, as mentioned above.

ARC PHCCs must also be prepared to respond to referral cases. All active ARC clinics have been provided with UNFPA kits for rape response and STI treatment. Two follow-up on-the-job training sessions were conducted for 16 ARC medical staff (8 men, 8 women) in Gereida on the importance of confidentiality in the management of post-rape cases.

As previously mentioned, the number of rapes reported in Gereida camp has jumped as tensions increase following the signing of the DPA. In weekly meetings with community leaders, the PHC supervisor in Gereida has discussed the importance of bringing rape survivors to the clinic for medical management.

#### **2.16. Monitor and report cases of GBV to health services, protection and security officers, in conjunction with the Nyala GBV working group.**

The 8 GBV focal points mentioned above contribute to a supportive community network to assist GBV victims medically, legally, and psychosocially. Community members and leaders have indicated that GBV does exist in their communities, but maintain that awareness and reporting are low. ARC awareness activities aim to change community attitudes and perceptions of domestic violence, early marriage, FGM, and rape, to eventually create a supportive environment for GBV victims. Community health volunteers will play a key role. One hundred and five CHVs from 13 communities have been selected and trained in community education. Seventy-eight of these CHVs have also been trained in GBV and HIV/AIDS. CHVs will be utilized as a link to community members to supplement ARC activity through clinics.

The process of monitoring and reporting GBV is evolving to include sources from a community level in addition to sources from the clinic level. The new CHVs have access to community information that might not otherwise be reported via other data sources. To maintain confidentiality and protect the CHVs in an environment where reporting of details may pose a risk to the survivor or the reporter, no details were asked of the CHVs regarding these cases. ARC reports cases of GBV to UNFPA, who is then responsible for informing relevant parties in a confidential manner.

#### **2.17 Continue to provide supervision and on-the-job/ refresher training in Antenatal and Postnatal Care, Safe Motherhood, Family Planning, Breast Feeding, Growth Monitoring and Nutrition, and Oral Rehydration Therapy (ORT) for the MCH Units at the PHCCs.**

Supervision visits and on-the-job trainings were conducted and are still being conducted regularly for staff working in MCH at the PHCCs. Topics include antenatal care, post natal care, family planning

breastfeeding and nutrition. A total of six ORT corners were started between July and August following trainings of nurses on their management.

**2.18 Provide EmOC in one PHC in Nyala.**

The PHC in Elwihda West provides 24-hour RH services, with midwives on duty to handle minor EmOC cases and an ambulance available for referral cases to Nyala Teaching Hospital. The operating theater for minor obstetric emergencies is always ready to provide services. A new grant that started in December will support training and capacity-building activities to improve the basic EmOC services in Elwihda and to strengthen the comprehensive EmOC services in Nyala teaching hospital which is the main referral hospital.

**2.19. Provide on-the-job training on nursing procedures to health workers at ARC-supported health facilities. Conduct weekly checks on health workers to make sure training has been absorbed.**

On the job training continues to be conducted to nurses and other health workers. However in the process of doing on the job trainings many gaps were noted in their performance thus prompting need to do a staff assessment to identify main training needs for future classroom and on-the-job trainings. These are expected to start from October.

A staff assessment was conducted between August and September to determine the training needs of all health staff in all health facilities. A training plan was instituted and so far a series of trainings have been recommended following these assessments. These were expected to start from October as follows.

<b>Training Topic</b>	<b>Target</b>
Infection prevention	All technical health staff
General clinical consultation	Medical assistants, nurses, CHWs
Emergency preparedness	DR's, MA's, Nurses. Midwives and MW supervisors
Integrated management of childhood illnesses (IMCI)	Medical assistants, nurses, CHWs
Carrying out basic nursing procedures	Medical assistants, nurses, CHW'S
Management of obstetrical emergencies and complications	DR's, midwives, MW supervisors, MAs, Nurses
Community health education and mobilization strategies	Health educators
Drug management	Dispensers, pharmacists
Data collection, entry, analysis and reporting	All technical staff
Supervision and management skills	For top managers

**2.20. Provide Health Education Programs in selected schools in the ARC Area of Operation.**

Two schools were identified in Gereida camp for HE activities in August. In September, a total of 479 participants' 265 female and 214 male received health education messages in these schools. Ten teachers (5 men, 5 women) in Elwihda area were trained in diarrhea, malaria, and IEC (August 22-24). These teachers, under supervision from the ARC health educator in Elwihda, have conducted health education for 3,000 students (1,200 boys, 1,800 girls) in 10 Elwihda schools.

**2.21. Access to priority PHC services with qualified staff person responsible to monitor and enhance access leading to 100% of service areas having protocols, communication, and pre-arranged transportation to referral points or services as needed.**

The PHCs in the Nyala-Tulus corridor (mainly government controlled areas) are staffed by medical assistants, nurses, and trained midwives. These PHCs perform more regularly than those in non-government controlled areas, as they receive more support from MOH and are in a generally more stable security environment.

The Nyala-Gereida corridor (mainly controlled by SLA) is plagued by lack of qualified staff and unwillingness of qualified staff from outside to work in this area due to insecurity and distance from family members. These clinics were closed in May due to insecurity but the Abojebra clinic was re-opened on a basic level in June, and the clinics in Birkatulli, Sanam Elnaga, and Ditto also re-opened in October

To date, 100% of the service areas have protocols, and refresher trainings on these protocols were conducted for 11 medical staff (8 men, 3 women) in Gereida (August 27-31). Only 40% of the areas have access to public telephones from which emergencies can be reported. To address this situation, ARC monitoring teams which pass through on a weekly basis stop to assess the emergency situations and to transport referral cases to the Nyala Teaching Hospital. Meanwhile, those emergency cases which occur in Gereida PHC are referred directly to Gereida Hospital in the ARC vehicle on standby for staff and referrals there.

**WATER AND SANITATION**

**Objectives:** To increase access to water and improve sanitation practices by providing sustainable facilities and community education for target communities.

**1. Progress against indicators**

Results/Indicators	Cumulative
Result 2.1: Improved access to adequate potable water from water supply systems which the communities own, operate, maintain and manage in a sustainable manner	
Average walking distance to water sources (Target: 500 meters)	Assessments to date indicate an average of 450 m to water sources from the baseline of 500m. This is after completing construction/rehabilitation of 7 water yards, drilling 6 shallow boreholes and fitting them with hand pumps, rehabilitating 84 wells with hand pumps and replacing generators and submersible pumps in 4 water yards.

Liters of water available per person per day (Target: 15)	Assessments to date indicate an average of 12.5 l /capita/day. This is after completing construction/rehabilitation of 7 water yards ( giving an average of 672 m3 daily), drilling 6 shallow boreholes and fitting them with hand pumps (giving an average of 47.808m3 daily), rehabilitating 84 wells with hand pumps ( giving an average of 669.312m3 daily ) and replacing generators and submersible pumps in 4 water yards (giving an average of 448 m3 daily). These give a total daily water production of 1837 m3 which when added to the previous program/grant production of 1152 m3 gives a total of 2,988.544 m3 against a population of about 230,000 making a per capita consumption of 12.5 liters.
Adequate number of water points. (Target: 250 persons per water yard tap, 500 persons per hand pump, and 400 persons per single user open well.)	To date, 420 water points ( a tap is a water point and so is a well) were either constructed, rehabilitated or repaired providing water for approximately 238,000 persons
Water quality (Target: No faecal coli forms per 100ml at the point of delivery.)	Results showed that out of 147 samples 25 were contaminated.
# water quality test conducted	147
% of contaminated water sources chlorinated after testing (Target: 100%)	100 %. All water sources tested and found to be contaminated were chlorinated.
# water borne diseases reported in health facilities in the target communities	8013 cases were reported in health clinics operated by ARC .These were mainly acute watery diarrhea and jaundice
<b>Result 2.2: Increased capacity of communities through training in health and hygiene, repairs operation and maintenance and water management</b>	
# health and hygiene trainings conducted / # participants (Target: 26 training sessions / 600 participants)	23 hygiene promotion and education trainings were conducted for a total of 1149 participants.
# trainings on repairs, operation and maintenance conducted of water yards / # participants (Target: 75 )	3 trainings were conducted for 60 operators from both Gereida and Tulus corridors.
# trainings for hand pump technicians/operators conducted / # participants (Target: 50 )	2 trainings were conducted for 25 people representing 12 water management committees.
# trainings on water management conducted / # participants (Target: 3 training sessions ,254 participants )	2 training were conducted for 254 people
# repairs done by trained community members	57 hand pumps were repaired by trained community members during this period.
<b>Result 2.3: Communities are enabled to identify key hygiene risks</b>	

Improved Hygiene practices being used by population (Target: Key hygiene risks of public health importance are identified)	Good hygiene practices are evidenced by the community initiatives in the construction and repair of household latrines in the communities where ARC carried out hygiene and promotion trainings. One hundred and fifty-nine latrines were constructed/rehabilitated through community initiatives.
# of people constructing own latrines (pre and post intervention)	90 people constructed their own latrines in both Tullus and Gereida corridors while 69 people repaired their own latrines in Gereida camp after they collapsed due to heavy rains. This brought the total number of people constructing their own latrines to 159.
<b>Result 2.4: Key hygiene behaviors are addressed through promotion activities and trainings</b>	
Adequate cleanliness of latrines, water points, bathing areas, wash areas (Target: Cleaning and maintenance routines and schedules are in place)	Some Communities have set up schedules for cleaning latrines, bathing areas and rubbish areas as a result of the ARC hygiene promotion trainings. Even though some of the communities have discontinued due to reasons of insecurity, lack of resources and the challenges of daily survival, the overwhelming majority have continued to this day.
<b>Result 2.5: Build the capacity of staff for sustained intervention and delivery of improved access to potable water , hygiene and sanitation services</b>	
% of water and sanitation staff participating in at least one capacity building training (Target: 100%)	No training was held for staff due to the fact that this budget line was not funded.

## 2. Narrative

**Objectives: Access to potable Water sources improved and good Hygiene and Sanitation practices strengthened among the targeted population. (**

### Water

**2.1 Drill and install hand pumps, 6 new shallow boreholes, among which 5 of these will be in selected schools, as part of education Project Cooperation Agreement (PCA) between UNICEF and ARC.**

Six hand pumps were drilled and all are effectively operational. These were in Umlaota-2, Barkatule-2 and Tokomaya-2.

**2.2 Construct 3 water yards (rural water supply systems ) each water yard to include drilling 1 borehole, providing 30 public taps, installing 1 stand pipe, providing 4 livestock troughs, installing one 50m3 elevated steel water tanks and 400m of pipe network.**

Constructed 3 new water yards namely Akroup, Wadajam, Gibebish and installed generator and submersible pumps, pipeline and fittings; elevated steel tanks public taps, separation walls and fencing. 3 water yards were to be funded by OFDA while the other one was to be funded by UNICEF. The program constructed the ones funded by OFDA but did not get funds from UNICEF for the other one. UNICEF cited unavoidable circumstances as reasons for not providing the funds.

**2.3 Construct 9 hand-dug wells and install each with a hand pump.**

Funds for this were diverted with permission from OFDA South Darfur Office to construct household latrines in Gereida IDP camp, which was then an emergency warranting more attention.

#### **2.4 Rehabilitate and support repair of 27 hand-pumps with co-funding from UNICEF.**

Eighty-four hand pumps were rehabilitated.

#### **2.5 Replace generators and submersible pumps in 2 existing boreholes.**

This program replaced generator sets and submersible pumps in 3 water yards namely Tiwal, Dimso and Tullus-Elgarabia and replaced only the generator set in Abusalala water yard because the submersible pump in Abusalala was working.

#### **2.6 Rehabilitate 4 water yards (rural water supply systems) including replacement of generator and submersible pumps, replacing leaky pipes and fittings, repair of elevated steel tanks installation of public taps, separation walls and fencing.**

The program rehabilitated 4 water yards namely Girba, Elnakhara, Barkatule and Delbedyat.

#### **2.7 Sample and test 28 new water sources and 22 old water sources (making a total of 50).**

One hundred and forty-seven water samples were tested from a combination of new and old water sources in our area of operation. All new water sources were tested. Of the 147 tests carried out, 25 were found to contain coliforms above permitted levels. These water sources were chlorinated.

**Note:** The program depended on the WES lab in Nyala for analyzing our samples. The lab is quite expensive charging an average of 7000 SDD per sample. Sometimes samples delayed reaching the lab hence rendering any analysis on them useless.

### **Sanitation**

#### **2.8 Construct 1080 family latrines with co-funding from UNICEF.**

One thousand three hundred and thirty latrines were constructed.

**Note:** More latrines were constructed as a result of construction of emergency latrines in Gereida IDP camp. This was not planned

#### **2.9 Construct 153 institutional latrines (VIP) in schools and health facilities with co-funding from UNICEF.**

Only 42 institutional latrines were constructed in the following schools: Abuajura, Safia, Dimo, Tokomaya, Barkatule, Safia and in PHCC in Gereida and Abujabra. The plan included UNICEF funding but as stated earlier, funds from UNICEF were not forthcoming.

#### **2.10 Conduct 16 health and hygiene education training workshops and sanitation promotion campaigns to the targeted communities. The training to reach 570 direct beneficiaries- mainly community leaders, with co-funding from UNICEF.**

Twenty-three trainings were conducted and the number of participants was 1149 coming from 16 villages. The topics discussed in the training included personal and community hygiene, water borne diseases and how to prevent them and nutrition and its importance in childhood diseases.

**Note:** There is always overwhelming enthusiasm from communities for these trainings

**2.11 Conduct 5000 regular household visits to monitor latrine usage (number of latrines being used versus number of latrines available).**

A total of 5386 household visits were made. During these visits, it was observed that water is mainly kept in pots and mostly not covered and that the habit of many people drinking from the same container is very common. Personal hygiene, especially among children still needs to be improved.

**Note:** This program relies on Community volunteers to do the visits and sometimes they require payments for them to carry out the work. The program has been phasing out the payments and therefore experiencing problems with volunteers doing the visits.

**2.12 Conduct 6 health and hygiene education training sessions for 100 school teachers**

Five training sessions were conducted with 100 teachers participating. The teachers showed interest in the training and participated actively in the training sessions

**2.13 Establish and /or strengthen 40 village health committees (VHC) comprising of 10 – 15 persons on health and hygiene education.**

Sixty-four Village Health Committees (VHC) were established comprising of 81 people. These VHCs are active in their communities.

**2.14 Train 200 Community Health Volunteers (CHVs) on Health and Hygiene promotion within their communities, with co-funding from UNICEF.**

Only 156 CHV were trained again due to the failure of UNICEF to contribute to the process.

**2.15 Conduct 10 health and hygiene education training sessions for 1,000 school pupils**

Only 9 health and hygiene education sessions were conducted. However, a total of 1036 pupils benefited from the training.

**2.16 Train 50 pumps operators and cashiers in 2 trainings.**

Sixty hand pump technicians were trained in 3 training sessions.

**2.17 Train 20 hand pump technicians in repair and Operation and Maintenance of water supplies in 2 sessions with co-funding from UNHCR.**

25 hand pump technicians were trained (only from Tullus corridor) in 1 session. The insecurity in the Gereida corridor did not allow trainings in the area. The trainings are planned to be conducted in the future.

**Note:** Most hand pump technicians in Gereida corridor had fled their homes to the IDP camps and therefore could not be traced to be trained. Also, no co-funding was received from UNHCR.

**2.19 Conduct 2 leadership and water management training courses targeting 164 participants with co-funding from UNICEF and UNHCR.**

Two leadership and water management training courses were conducted targeting with 170 leaders, sheikhs, Umdas and other community participants.

## **AGRICULTURE/LIVELIHOOD**

**Objective:** To improve household incomes and strengthen livelihoods of resettled IDPs, the war-affected and resident poor households.

### 1. Progress against Indicators

Expected Results	Indicators
All war-affected vulnerable families in targeted areas receive material support (seeds, tools and livestock) to enable them increase agricultural production. Target: 3000	<ul style="list-style-type: none"> <li>• 1372 families received crop seeds and tools.</li> <li>• 26.4 metric tons of seeds were distributed (Millet-7.3, sorghum-9.1, ground nut-10)</li> <li>• 252 pieces of tools were distributed for school gardens. The tools included hoes, diggers, spade, watering cans, rake among others.</li> <li>• 907 families received kitchen garden seeds.</li> </ul>

### 2. NARRATIVE:

#### 2.1. Establish nurseries to produce and distribute fruit and tree seedlings.

The program established 7 nurseries to produce seedlings. A total of 24,000 were produced at the nurseries and distributed to 4000 house holds.

#### 2.2. Distribute seeds to war-affected households

The program distributed 26 tons of seeds ( millet-7.3, sorghum-9.1 and ground nut-10) to 2372 war-affected house holds. The program also distributed 147.5 kilograms of vegetable seeds to 580 house holds.

#### 2.3 Facilitate the establishment of community gardens

This program facilitated the establishment of 4 community gardens and provided vegetable seeds to participating house holds.

#### 2.4. Establish School gardens

Seven school gardens for 2366 beneficiaries were established.

#### 2.5. Conduct training in new farming techniques for war-affected farming house holds

The program conducted one session of water harvesting training for 80 war-affected house holds in Tulus corridor.

---

### 4. NOTABLE ACHIEVEMENTS

1. Conducting Staff assessments.
2. Starting ORT corners in 6 clinics.
3. Supporting MOH thus enhancing EPI coverage.
4. Equipping and opening the minor theater in Elwihda clinic.
5. Increase in coverage and provision of health services by re opening facilities and mobile clinic sites
6. Effective management of the cholera outbreak in ARC health facilities.
7. Increase water supply reducing tendency for water related disputes
8. Improved sanitation practices among targeted populations

9. Increased food production and house hold income resulting in reduced dependence on handout among war-affected house holds

## **5. CONSTRAINTS/CHALLENGES**

1. Low level of education of most of the staff working in the RH sector, thus some essential service providers are not able to document their work, e.g. midwives.
2. Delays in staff recruitment which resulted in delayed implementation of some activities. To date, the GBV coordinator has not been able to take up position.
3. There is an acute shortage of qualified staff in all sectors
4. The basic PHC kit contents are not adequate to meet the needs of the health program beneficiaries.

## **7. WAY FORWARD**

1. Capacity building through trainings, on the job trainings and supervision in order to improve quality of service.
2. Continue close relations with MOH, WES and other partners