



A Situation Analysis on Basic Social Services in the Darfur States

Health, Nutrition, WASH and Education Thematic Working Group (TWG) report

11/18/2012

Jointly prepared by: UNICEF, WHO & The World Bank



Cover Photographs

- 1) Men standing in line to collect water, in North Darfur. Photograph taken by UNICEF Sudan WASH officer
- 2) Pregnant women receiving antenatal care at a health clinic in El Geneina, West Darfur.
- 3) A child getting weighed at a health clinic in El Geneina, West Darfur.
- 4) Miss Dalifa a teacher in El Geneina teaching Grade 3 children.

Photographs 2-4 taken by Shehzad Noorani for UNICEF Sudan.

This Report mirrors findings observed from the Joint Needs Assessment for Basic Social Services, comprising of several UN agencies and government authorities, and therefore are not personal views of the authors. Likewise this report does not necessarily reflect the position of UNICEF.

1 Foreword

UNICEF:

UNICEF Sudan Country Office is very pleased to share with you the situation analysis presenting the findings of the joint needs assessment for Basic Social Services which includes Health, Nutrition, Water, Sanitation and Hygiene (WASH) and Education, outlining the recovery and development needs in Darfur from 2013 to 2018. The 2012 Darfur Joint Assessment Mission (DJAM) was established to determine the financial resources required for development needs in social areas and infrastructure as outlined in Article 32 of the Doha Document for Peace in Darfur.

The 2012 Darfur Joint Assessment Mission built on the 2006 DJAM process with a modified methodology. The needs assessment was carried out through State consultative workshops which took place August-October 2012. In addition to presenting the current situation in Darfur, the needs assessment also proposes a results framework for basic social services, which identifies immediate (foundational activities), short term (24 months) and long term (6 years) objectives and priorities. This document also states the financial resources required to kick start early recovery and development. Cross cutting actions to address the needs of vulnerable groups, people living with HIV/AIDS, gender and youth concerns, have also been included. The State Consultative workshops which were facilitated by UNICEF specialists in WASH and Education, benefitted from the active and valuable support from the Darfur Regional Authority (DRA), from members of local and national government entities as well as from community leaders.

UNICEF has taken the lead in developing the situation analysis and results framework for Education and WASH with continuous support from the DRA, Federal Ministry of Education (FMoE), Water and Environmental Sanitation (WES), and State level government bodies.

I take this opportunity to thank the World Health Organisation (WHO) for its leadership in the Health and Nutrition needs assessments, who carried out their tasks with critical support from DRA and from the Federal Ministry of Health.

UNICEF, counting on the support from WHO, the World Bank, DRA and all relevant Federal Ministries, would like to endorse the publication of this document in preparation for the Doha Peace Conference.



Ray Virgilio Torres,
Deputy Representative and Officer in Charge
UNICEF Sudan

World Health Organisation:

The World Health Organization (WHO) in Sudan has been fully supporting efforts to forward the health of the people of Darfur. WHO with the Federal Ministry of Health (FMOH) initiated developing the Darfur Early Recovery Strategy for Health and Nutrition in November 2011 which was endorsed during a high-level meeting at the Friendship Hall in Khartoum attended by officials from the Darfur Regional Authority, FMOH, government agencies and the international community, including representatives from the diplomatic corps, donor organizations, nongovernmental organizations and UN agencies.

The health and nutrition strategy which is in line with National Health Strategic Plan supports the Darfur Joint Assessment Mission (DJAM), the vision of Darfur Regional Authority to support the returnee process as well urbanization, the Doha Document for Peace in Darfur (DDPD), and most importantly, it will fulfill the aspirations of the people of Darfur.

This situation analysis on basic social services in the Darfur States encompasses important findings of the joint needs assessment conducted for health and nutrition, and highlights key features such as health and nutrition status, burden of communicable diseases, health and nutrition financing and expenditure, state planning and policies, service delivery, human resources, information systems, and medical supplies.

Along with this situation analysis, a three-pronged framework for health has been completed covering activities over the next 15 years, as well as the proposed total allocation to implement the activities. The first prong which will be carried out in the next 2-3 years focuses on maximizing the outputs of existing health and nutrition services by physical rehabilitation and functional upgrading of the existing health facilities, starting with those with the heaviest workloads, and the most favourable locations. The second prong is strengthening institutions and management instruments necessary to operate an expanded and upgraded integrated health system during the next 5 years. The third prong covers the launching of a long-term investment plan, aimed at making health and nutrition services accessible to the majority of the population during the next 10–15 years.

As one goes through the pages of this analysis, one will understand the strategy and approaches used by WHO in the delivery of services to achieve major priorities for Darfur.

WHO wishes to acknowledge the valuable contributions made by all individuals and expresses its sincere thanks to the Darfur Regional Authority, UNICEF, UNFPA, and the World Bank for their support to ensure that this document is completed and endorsed in preparation for the Doha Peace Conference.



Dr Anshu Banerjee

WHO Representative in Sudan

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3 Glossary

ANC	Antenatal Care
ARI	Acute Respiratory Tract Infection
BD	Bloody Diarrhoea
BSS	Basic Social Services
CHW	Community healthcare Worker
CMR	Crude Mortality Rate
CPD	Continuous Professional Development
CPR	Contraceptive Prevalence Rate
CRED	Centre for the Research of Epidemiology of Disasters
DPA	Darfur Peace Agreement
DRA	Darfur Regional Authority
EOC	Emergency Obstetric Care
EWS	Early Warning System
FGM	Female Genital Mutilation
FMoGE	Federal Ministry for General Education
GAM	Global Acute Malnutrition
GBV	Gender-Based Violence
GDP	Gross Domestic Product
GER	Gross Enrolment Rate
GPE	Global Partnership for Education
HIS	Health information System
iBES	Interim Basic Education Strategy
IDP	Internally Displaced Person
IDPs	Internally Displaced Persons
ISETI	In-service Education Training Institute
KAP	Knowledge Attitude and Practices
NGO	Non -Governmental Organisation
NHA	National Health Account

MDG	Millennium Development Goal
MMR	Maternal Mortality Rate
OCHA	Office of Coordination and Humanitarian Affairs
PHC	Primary Health Care
PMTCT	Prevention of Mother to Child Transmission of HIV/AIDS
PTR	Pupil to Teacher Ratio
RH	Reproductive Health
SAM	Severe Acute Malnutrition
SDS	Second Basic Education Service Delivery Study
SHHS	Sudan Household Health Survey
SOLO	Sudan Open Learning Organisation
SWC	State Water Corporation
TAC	Teacher Assistance Course
TB	Tuberculosis
TBA	Traditional Birth Attendant
U5MR	Under-5 Mortality Rate
UN	United Nations
UNDP	United Nation Development Programme
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UNHCR	United Nations High Commissioner for Refugees
UNESCO	United Nations Educational, Scientific and Cultural Organisation
UWC	Urban Water Corporation
VAT	Value Added Tax
VCT	Voluntary Counselling & testing
VHC	Village health Committee
WAC	War Affected Communities
WASH	Water and Sanitation and Hygiene
WES	Water and Environmental Sanitation
WFP	World Food Programme

WHO World Health Organisation

4 Biopics of Authors

4.1 Health and Nutrition Thematic Working Group Lead Biopic:

A taskforce comprising of representatives from the Federal Ministry of Health (FMoH) and the World Health Organization (WHO) started the process in January 2012 by developing the Darfur health profile and the Darfur Early Recovery Strategy for Health. Fundamental to DJAM's health and nutrition section, the health profile and strategy have supported the development of the whole framework on health and nutrition. The framework on health is a collaborative work between health experts from FMoH, the State Ministries of Health (SMoH) and the Darfur Regional Authority (DRA) with support from WHO and the WB.

4.2 Technical support staff:

For Health and Nutrition, below names were instrumental in discussing, analysing, developing and compiling the situational analysis, putting together the results Framework as well as liaising with the DJAM team at UNDP:

1. FMOH Darfur Early Recovery Task Force and high level committee.
2. Technical assistance from Darfur regional authority.
3. Dr Iman Shankiti, WHO Sudan Emergency, Preparedness and Early recovery coordinator.
4. External consultants namely;
 - a. Dr Enrico Pavignani (WB/WHO Consultant/Health Expert)
 - b. Mr Osmat Azzam (WHO Health Economist).
 - c. Dr Amr Mahgoub, WHO Consultant
5. Ms Isabael Soares, the World Bank.
6. Dr. Pushpa Acharya Head of Nutrition, MCH, HIV and AIDS Section WFP Sudan.
7. Ms Susan Lillicrap chief of Nutrition at UNICEF and Nutrition Sector Lead Sudan Country Office.
8. Dr. Kidane G. ABRAHA, Chief Technical Advisor UNFPA –RH/MNH.
9. Anjala Illemassene, (PhD), (MSc) HIV and Nutrition, UNICEF Sudan.
10. Dr Hala Assad, Technical officer WHO Sudan emergency technical officer.
11. WHO field staff in North south and West Darfur.

4.3 WASH and Education Thematic Working Group Lead biopic

Ms Susan Lillicrap is chief of Nutrition at UNICEF and Nutrition Sector Lead Sudan Country Office and, has been at this position for the past 4 years. Susan's accomplished professional career in humanitarian programming spans over 20 years. Before joining UNICEF Sudan, Susan has worked in public health in emergency and early recovery in Indonesia, Angola, Democratic Republic of Congo, Sierra Leone, Afghanistan, Brazil, Chile, Kenya, Russia, Papua New Guinea, Uganda and Somali. She has a Masters in Community Health from Liverpool School of Tropical medicine, University of Liverpool, UK.

4.3.1 TWGL support staff for WASH and Education

The following people were instrumental in compiling the situational analysis, putting together the findings for the proposed Results Framework from the various TWGs and liaising with the DJAM coordination team at UNDP:

- 1) Anjala Illemassene, (PhD), (MSc) HIV and Nutrition, UNICEF Sudan
- 2) Lori Carruthers, (MPH), Reports officer at UNICEF Sudan

4.3.2 WASH:

- 1) David Babika, WASH specialist, UNICEF Sudan
- 2) Fouad Yassa, WASH, UNICEF Sudan

4.3.3 Education:

- 1) Louise Mvono PhD, Chief of Education, UNICEF Sudan
- 2) Daniel Beheta PhD, Education specialist, UNICEF Sudan

4.3.4 World Bank contribution to the Education Situation Analysis

- 1) Elizabeth Ninan, Human Development Specialist, World Bank
- 2) Aymen Musmar Ali, Education Specialist, World Bank
- 3) Shilpa Challa, is a consultant at World Bank

We would also like to thank the following UNICEF field officers in WASH, Education and Nutrition who facilitated in the consultative technical workshops in the Darfurs:

North Darfur:

- 1) Jasinta Achen, Nutrition Specialist
- 2) Ohidur Rashid, Education specialist
- 3) Said Ahmed Mohamed, WASH specialist

South and East Darfurs:

- 1) Idrissa Diarra, Education specialist

2) Ad Dirdeery Attayeb Salih, Education Project Officer

3) Sulieman Arabi, WASH officer

West and Central Darfurs:

1) Sara McGinty, Education Specialist

2) Khalid Musa, WASH Specialist

5 The Current Health and Nutrition Situation in Darfur

5.1.1 Health and Nutrition status

Health and nutrition indicators for Darfur are always among the poorest in Sudan. The Maternal mortality ratio (MMR) estimated by the Sudan Household Health Survey (SHHS) 2010 was 334 per 100,000, 322 and 177 in South, West and North Darfur respectively. According to the 2006 SHHS, the infant mortality rate was 69 per 1,000 live births in North Darfur, 93 in West Darfur and 67 in South Darfur. The under-five mortality rate was 95, 138 and 98 per 1,000 live births respectively.

Malnutrition is a chronic problem. Children under 5 years in Darfur show prevalence of global wasting (weight for height below -2 z-scores) of around 16%¹, similar to the national average. The long-term impact of malnutrition is apparent with global stunting (height for age below -2 z-scores) above or similar to the national average of 35% (SHHS 2010) with more than a third of children unlikely to ever reach their full growth and development potential. International evidence shows that malnourished children specifically stunted children tend not to reach their potential either physically or mentally, are less likely to go to school, and once in school, register lower levels of learning achievement and are generally poor. Given the complex environment in Darfur, it is likely that children who are displaced are attracted to school sooner when there is a school feeding program compared to when there is no program.²

Among the contributors to poor child nutrition status are low access to nutrient dense complementary food, sub-optimal infant and young child feeding practices, including low rates of exclusive breast feeding (particularly in West and South Darfur), untimely and inadequate complementary feeding practices, and repeated infections. Some studies suggest that micro-nutrient status is likely to be poor. Expansion and access of community management of acute malnutrition services is critical in order to reach these vulnerable children in rural areas.

5.1.2 Burden of Communicable Diseases

The Greater Darfur Region is considered to be one of the regions of Sudan most vulnerable to the spread and burden of communicable disease, due to poverty, violence and the porous borders shared with four neighbouring countries. In 2011, the re-emergence of vaccine-preventable diseases (diphtheria, measles and whooping cough), in addition to meningitis, was recognised. Sporadic cases of acute jaundice have been reported throughout Greater Darfur. Some cases of chicken pox have been diagnosed in North Darfur³. Acute Respiratory Infections (ARI) and Bloody Diarrhoea (BD) remain the leading causes of morbidity in Darfur. In the period 2004-2011, malaria accounted for 17%, diarrhoea for 27% and ARI for 35% of the 14 health events reported by EWARS. Only 7-12% of the facilities are providing diagnosis and treatment for tuberculosis. Bilharzia is endemic in some areas, especially in South Darfur with rate ranging from 12 to 89% and overall prevalence around 56.6% (FMOH-PHC health map).

Comprehensive data on the HIV/AIDS situation in Darfur are lacking. Heterosexual transmission is believed to be the main mode of infection, followed by blood transfusion and mother-to-child transmission. Anti-retroviral treatment is not available in Central Darfur, but it is offered in the other states. Coverage of voluntary counselling and testing (VCT) is low, ranging from 50% of localities in the South and 20% in East Darfur. The prevention of mother-to-child transmission of HIV/AIDS (PMTCT) is provided in 5.5% of health facilities in North Darfur and 62.5% in West Darfur, while it is unavailable in East Darfur. Only 35% of PHC facilities are providing the syndromic management of sexually-transmitted infections (STI) in North Darfur, compared to 97% in South Darfur (FMOH Health Map 2010).

¹ Sudan Household Health Survey (SHHS) 2010

² Bundy et al, Rethinking School Feeding World Bank and World Food Program June 2009

³ WHO-FMOH-Epidemiology Directorate 2012.

5.2 Health and Nutrition financing and expenditure

According to the National Health Accounts (NHA) 2008, total health expenditure was US\$50 per capita in South Darfur, 75 in West Darfur and 67 in North Darfur. Given the modest contribution of the government to total health expenditure, up to 91% of it was paid for directly by families. Most spending was directed towards curative care. The government spent around 2% of GDP on health. Darfur government revenues are falling, with modest transfers from the centre. There are disparities of public expenditure on health between states. A breakdown of the Darfur state budgets indicate that 10% is allocated to investment and 67% is allocated to salaries (2010). Darfur states had the lowest per capita public health expenditure in the country. The total coverage of the National Health Insurance is around 25% of the total population. The independent financial audit of health programs is performed by the Auditor General Chamber.

A variety of subsidies is provided by the government, thanks to several mechanisms aimed at relieving households of part of their financing burden. Special programmes and NGOs too provide subsidised health services. The fees paid by users vary therefore according to the service accessed and the local. Alongside their obvious benefits, the fragmentation of such well-intentioned subsidies generates several problems in health service delivery, which affect its efficiency as well as its effectiveness. Reliable data on external assistance are lacking. It is concentrated on providing PHC to IDPs in camps. Western aid is perceived as shrinking, while new donors such as Turkey and Qatar are expanding their presence. An assessment of aid flows is badly needed.

5.3 State Planning and Policies

Each state has its own government, which is responsible for formulation and implementation of local policies, plans, and strategies, in line with the national strategic direction. The state MOHs are responsible for overseeing healthcare provision within the respective territory. The management of local health systems is inadequate, due to high turnover of staff, continuous amendments in decentralisation-related provisions, insufficient resources and limited community involvement. The creation of two new states (Central and East Darfur), which lack physical assets, institutions and capacity to fulfil their mandate, has added a further difficulty. The partition of Darfur into five autonomous administrative bodies recommends the establishment of effective regional coordination functions in most healthcare-related fields, such as systems analysis, investment, human resource development, referrals, and supply. Meanwhile, most of the figures provided refer to the previous three-state partition.

The government remains the largest provider of health services, despite the expanded role of NGOs fuelled by humanitarian funding. Public-private collaboration remains limited. Thanks to the growth of for-profit providers, privately-managed health care is increasing its share of the health market. The regulation of private providers by public health authorities is in its infancy. The information related to these new providers is absolutely inadequate, which undermines both the planning of health service delivery and the regulation of private provision.

5.4 Health and Nutrition Service Delivery

More than 77% of facilities have been affected by war, about 67% of facilities need some rehabilitation and around 10% need complete reconstruction (Health facility survey 2010). Urban centres are better served than rural areas. Primary Health Care (PHC) is characterised by poor coverage, whereby South Darfur is estimated to have the lowest (1 facility per 13,000 population, in comparison to North Darfur with 1 facility per 9,000), compounded by the inadequate provision of a minimum package of services. In 2012, NGOs managed or supported 142 health centres (66%) and 103 basic health units (24%).

Accessibility to health services was estimated at 58% in West Darfur, compared to 66% in South Darfur and 78% in North Darfur (SHHS 2010). In 2012, only a dismal 19% of PHC facilities provided all five components of the minimum service package in the whole region (FMOH Health Map 2012), with the

most common service being outpatient care at 90%⁴. Secondary and tertiary care services are provided at a minimal scale with questionable quality. Hospital beds per 100,000 were estimated to be 23, 49 and 55 in South, North and West Darfur respectively.

Information on service uptake and workloads is scanty. However, available data suggest that existing services are used well below capacity, due to their poor quality, limited availability, and cost. For instance, the hospital bed occupancy rate was reported as very low, with 12%, 34% and 45% in South, North and West Darfur respectively (FMOH, Annual health statistical report 2010). Weak referral capacity, noticeable in South Darfur, certainly contributes to under-utilisation.

Private providers are multiplying, with hospitals, clinics, pharmacies, laboratories and health centres being opened in the main cities of the five states. Most of these facilities are providing secondary care and some tertiary services. Elements of informal privatisation are becoming recognisable, as in the case of underpaid health workers attending patients at home or in solo practice. With the drying of the incentives provided by NGOs, this behaviour might be reinforced.

All figures should be taken cautiously, in light of the turmoil in Darfur and security conditions which denies accessibility. PHC facilities in Darfur show huge variations in the distribution of the provided health services and coverage varies from one health facility to another and from state to state⁵.

Essential nutrition services and community management of acute malnutrition, as well as micronutrient supplementation, are provided in PHC facilities, with coverage in North Darfur of 85%, 75% in West Darfur and 26% in South Darfur⁶. Three quarters of nutrition services are provided by NGOs. In 2011, Darfur states have witnessed an increase in the number of children treated for both severe and moderate acute malnutrition. In 2011, 44,181 children were treated for severe acute malnutrition, up from 39,892 in 2010. This represents just 42% of the expected annual caseload (based on SHHS 2010 prevalence estimates). The increase in numbers treated is likely to reflect in part the increase in the numbers of feeding centres, both for moderate and severe acute malnutrition and increase in the quality of the services provided. Insecurity and operational constraints have continued to impact on access to beneficiaries in some localities, most notably Jebel Mara, in addition to the suspension of nutrition activities by some partners.⁷

The Reproductive Health (RH) profile of Darfur is characterized by high maternal mortality, morbidities and disabilities like obstetric fistula. Major contributing factors include poor access to, and quality of RH services; low utilization of existing RH services, high illiteracy especially among women; low level of awareness on RH issues; misconceptions around RH conditions / issues; early marriage and Female Genital Mutilation (FGM). The utilization of services is poor as shown in table 1. Reproductive health services coverage in PHC facilities ranges between 52% in North Darfur to 82% in West Darfur (FMOH PHC Health Map 2012). The coverage of midwifery is only 38, 52, and 56 % for North, West and South Darfur respectively. Coverage with basic essential obstetric care is low (6-20%). A free caesarean-section policy was adopted in 2008 and free delivery care was adopted since 2010, aiming at improving utilization and quality of care.

⁴ Health Resources Availability Mapping System (HeRAMS) 2011.

⁵ Health Health Resources Availability Mapping System (HeRAMS) 2011.

⁶ Health Resources Availability Mapping System (HeRAMS) 2011.

⁷ Darfur Nutrition Update-Summary issue 30

Table 1: Utilisation of reproductive health services

State	Antenatal care	Family Planning	Deliveries attended by any skilled personnel (including VMWs)	Home Deliveries	Hospital Deliveries
North Darfur	66%	3%	65%	91%	6%
West Darfur	59%	4%	33%	85%	9%
South Darfur	69%	2%	50%	88%	7%
Sudan	74%	9%	72%	76%	20%

Source: FMoH PHC Health Map 2012

The conflicts in Darfur have exacerbated women's situation and brought gender-based violence, including rape, to the forefront of the health agenda. Clinical management of rape survivors is provided in 13-25% of PHC facilities (FMoH-PHC health map).

The coverage of the Integrated Management of Childhood Illnesses (IMCI) service is low in all Darfur states. The vaccination coverage rate until 2007 was below 60%, but reached 90% in 2011, with some coverage gaps and fluctuations, due to insecurity, inaccessibility and the high cost of EPI implementation. The resurgence of vaccine-preventable diseases raises serious doubts about the reported high immunisation coverage.

5.5 Human resources for Health (HRH) and nutrition

The National Human Resources for Health and Nutrition 2010 survey estimated that there were 4509 health cadres in Darfur (including 262 physicians, 1258 nurses and 1175 midwives), with a ratio of health personnel to 1000 population of 0.4. The production of new health professionals is confined to a single medical school and 3 allied health professionals' academies. Despite the severe HRH shortage, public health authorities are unable to fill many of the existing vacancies. Civil-service restrictions and budgetary limits concur to leave many new health workers unemployed. Some entrants in the labour market are hired by NGOs and others by private for-profit providers. To offset staff shortages, services rely on community health workers, who are therefore appointed to posts above their training levels.

The instability of the region, concentration in urban settings, low wages in government posts and inadequate continuous professional development (CPD) opportunities add up to the above problems. Incentives are applied by NGOs and special programmes unevenly and irregularly, in this way undermining health service delivery as well as staff morale and commitment. Deployment and retention of skilled health cadres stand out as prominent weaknesses. HRH management practices remains administratively-oriented rather than performance-based, with many HRH functions constrained by civil-service rules.

5.6 Health and Nutrition information systems

The facility-based Health Information System (HIS) captures routine data about human resources, assets and outputs of health facilities, and communicable disease (CD) surveillance. Health information in Darfur is challenged by: fragmentation, multiplicity of formats, duplication, lack of adequately-trained personnel, unavailability of advanced communication tools and technologies, in addition to lack of data sharing and feedback mechanisms. Monitoring is largely executed as supervisory visits mainly by vertical programs, weekly coordination meetings with health partners, different reporting systems and sometimes ad-hoc community complains. There is no established monitoring and evaluation unit or usage of the M&E tools for decision-making.

The Early Warning and Response System (EWARS), with support from WHO, collects data on morbidity and mortality, 13 public health risks, injuries and acute malnutrition from 176 sentinel sites on a weekly basis. Additionally vertical programs also carry out supervision and produce their own regular reports. A nutrition surveillance system comprising locality-level nutrition and mortality surveys, community nutrition surveillance (with anthropometric data collected on a regular basis from different livelihood zones across the region) and routine nutrition program data is in place.

5.7 Health and Nutrition drug supply

Health supply channels in Darfur states are multiple and fragmented. Drug and medicine shortages were one of the major gaps identified by all states and partners. The high prices of medicines constitute an additional problem. Transportation from Khartoum to the field is very expensive, while the distribution of drugs from state capitals to the deep field in many instances is not possible due to insecurity and impassable roads. Slow quality-control procedures delay deliveries to health facilities, thus exacerbating drug shortages. Revolving Drug Funds (RDF) mostly supply rural and secondary hospitals, which raise larger revenues than PHC facilities. NGOs procure medicines independently. A thriving traffic of medicines is reported to occur across the border with Chad. UNICEF and WFP assist with supplies for therapeutic feeding, including vitamin A and folic acid supplements.

Summing up, health and nutrition services appear as a *patchwork* of disparate elements emerged in response to multiple stressors. Despite generous humanitarian assistance, service provision is inefficient, ineffective and inequitable. A variety of factors are at play. Supply is undermined by horizontal and vertical fragmentation, weak (sometimes counterproductive) provisions and linkages, service overlaps and gaps. The limited services being offered are therefore under-used. Derelict infrastructures and insufficient and under-skilled human resources cannot be addressed without robust, sustained investments. An insecure and unstable environment constrains operations and induces high operational costs. Demand is depressed by multiple barriers to accessing health and nutrition services, erected by violence, distance, poverty, culture and gender. Finally, inadequate institutions jeopardise the productive management of available resources, and the alleviation of some of the shortcomings affecting the healthcare arena.

6 The Current Water Sanitation and Hygiene (WASH) Situation

Darfur region is located within arid to semi-arid zones that are characterized by low rainfall of limited duration and intensity.⁸ As a result the region is vulnerable to drought and is dependent on groundwater for water supply. The region hosts high numbers of internally displaced persons (IDPs) in camps and due to the camps high concentration of populations, there is high water demand and abstraction. In addition, OCHA reports that there have been an increased number of returns to the area, both IDPs and refugees from Chad.⁹ As a result, the region often experiences a drop in ground water levels in many IDP locations and other high population density areas when the rainfall is poor¹⁰.

Due to conflict and the humanitarian crisis that ensued in Darfur in late 2003, over 40% of Darfur's rural population has been displaced over the years.¹¹ Following the displacement, the government and other Wash, sanitation and hygiene (WASH) partner's emphasised developing WASH infrastructure for the IDPs. See table below for information on the access to improved drinking water. However, the actual availability of water for human consumption, especially children, is probably much lower as nomads prioritise giving water to livestock. As a result, water for livestock is a source of conflict at water points between nomads and communities along migratory routes. There is a great need to repair and maintain

⁸ Special Report: Quasi Crop and Food Supply Assessment Mission to Sudan, FAO and FEWSNET, January 2012.

<http://www.fao.org/sudanfoodsecurity>

⁹ Sudan Humanitarian Update 2nd Quarter 2012. UNOCHA Sudan

¹⁰ "Darfur International Conference on Water for Sustainable Peace" Final report, Khartoum Sudan, June 2011

¹¹ "Darfur International Conference on Water for Sustainable Peace" Final report, Khartoum Sudan, June 2011

water facilities and sources especially in rural areas, which are not easily accessible due to continued conflict and bad roads.

Table 2: Access to Improved Drinking Water (human consumption only)

	North Darfur	West Darfur	South Darfur
2008 Census	49.9%	44.7%	52.1%
2010 Sudan House Hold Survey	59.8%	44.5%	69.4%

The Darfur region has a total of 3,385 schools and 58-70%¹² of the schools do not have proper functioning water facilities. In many schools where facilities exist, water facilities are shared with communities and often are not close to the school, and school children need to walk a long way to collect water. In addition, 73 -77% of the schools do not have proper sanitation facilities.

Access to proper sanitation lags behind access to improved water supply and most rural communities practice open defecation. There is no equitable distribution of access to proper sanitation among rural and urban communities and access to improved sanitation dropped, especially in rural areas. See table below for the results of 2008 census¹³ and 2010 SHHS.¹⁴

Table 3: Access to Improved Sanitation

	North Darfur	West Darfur	South Darfur
2008 Census	51.2%	42.2%	44.1%
2010 Sudan House Hold Survey	18.4%	23.7%	5.0%

It is assumed that to reduce by half the proportion of people without access to improved sanitation by 2015, about 12,631 flush latrines, 2,718 septic tanks and 76,266 pit latrines are required in North Darfur, 13,472 flush latrines, 2,205 septic tanks and 102,389 pit latrines in West Darfur and 13,528 flush latrines, 3,140 septic tanks and 136,004 pit latrines are required in South Darfur.¹⁵

Maintenance of sanitation facilities is a major problem due to lack of awareness and inappropriate facility design or use. A 2010 KAP survey¹⁶ in the Darfur region IDP camps indicates that 52%-70%, 13%-74% and 78%-81% of IDPs in North Darfur, West Darfur and South Darfur respectively, wash their hands after defecation and before eating respectively. Those percentages indicate that hygiene awareness is high in North and South Darfur but critically lagging behind at the resident community level in West Darfur and could be worse in rural areas and among returnees especially due to poor access of WASH facilities.

High rates of water-borne diseases are attributed to poor hygiene practices such as: open defecation; improper use and maintenance of latrines; lack of hand washing; and unhygienic water collection, water storage, food storage and food preparation¹⁷ In the two weeks before the survey, 24%, 27% and 29% of

¹² Darfur International Conference on Water for Sustainable Peace" Final report, Khartoum Sudan, June 2011

¹³ Census Bureau for Statistics, Sudan. 2008. Personal communication for data on access to improved sanitation

¹⁴ Sudan Household Health Survey 2010

¹⁵ Darfur International Conference on Water for Sustainable Peace" Final report, Khartoum Sudan, June 2011

¹⁶ Knowledge Attitudes and Practices Survey, 2010

¹⁷ Sudan Household Health Survey, 2006

children under-five were reported to have diarrhea¹⁸ in North Darfur, West Darfur and South Darfur respectively. This data indicates that there is a need to monitor and respond effectively to water-borne diseases, especially during rainfall.

7 The Current Education Situation

This note aims to provide a situational analysis of education services in the Darfur region. The note draws on various sources of recent data on education such as the 2012 'Status of the Education Sector in Sudan', the 'Second Service Delivery Study'¹⁹ (forthcoming) and a policy note on out-of-school children. It also draws on the recently finalized interim Basic Education Strategy (iBES) which focuses on strategies for expanding access to quality basic education in line with the Millennium Development Goal 2 to achieve universal primary education by 2015.

While the iBES represents a significant strategic step in a continuum of policy interventions that will build on the 2007-11 education strategy using evidence collated through various research initiatives, the respective state level implementation plans for education are still in development with the support of UNICEF. Given the decentralized nature of education service delivery in Sudan, it is these plans which will identify programs and projects to be prioritized for financing at the state level. As such, this situational analysis focuses on the key strategic issues faced by the Darfur states. The prioritization of these issues at the state level is ongoing and is expected to be completed in the first quarter of 2013.

Also worth noting is that the data presented here is by three states in Darfur (North, West and South), prior to the delineation of the region into five states.

7.1 Access to education

Enrolments in preschool have rapidly increased in Sudan leading to moderately larger schools and higher student-teacher ratios. These developments have been achieved at relatively low cost to the public sector and have mainly been delivered through community-based initiatives. Non-government schools—which include the religious Khalwa schools as well as fee-charging private schools—enrol as many as 38% of all pre-school students and private provision for pre-school is continuing to grow in size over other sub-sectors. While information of the quality of pre-school education in Sudan is limited, evaluations of community-based pre-school programs in Cape Verde and Guinea show that the benefits for children in terms of preparation for primary school were comparable to those of traditional, publicly provided programs.

Table 4 below shows a varied picture in the Darfur region in pre-school education. While West and North Darfur have lower Gross Enrolment Ratio (GER) averages (26% and 32% respectively) compared to the average for Sudan (38%), they are also the states with close to half the pre-schools assisted by the government compared to the average of just under a third of pre-schools assisted by government for all of Sudan. Interestingly, in South Darfur, close to 85% of pre-schools are run privately (many of them supported by non-governmental organizations), with a result of a higher GER (38%) than the average for Sudan (37%).

¹⁸ Sudan Household Health Survey, 2006

¹⁹ The Second Basic Education Service Delivery Survey (SDS2) was conducted December 2010-January 2011 in Blue Nile, North Darfur, Red Sea, and South Kordofan in Sudan. The SDS2 provides data on resources in basic schools and on grade 5 student learning outcomes to inform education policies to improve service delivery and promote student learning. The SDS2 provides a sample representative of the four survey states.

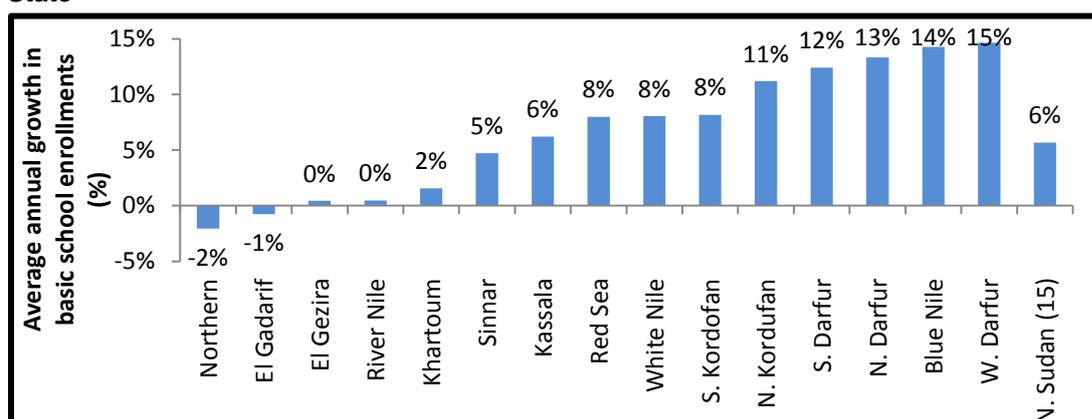
Table 4: Average Gross Enrolment Ratio in Preschool and percent of preschools that are Government-assisted in 2008-2009

State	GER	% Government assisted
West Darfur	25.8%	49.2%
South Darfur	38.3%	16.0%
North Darfur	31.6%	51.2%
Sudan	37.1%	31.7%

Source: Status of the Education Sector in Sudan, 2012

Basic education is by far the largest sub-sector of education in term of student enrolments and, in absolute terms, grew by almost 1.6 million in eight years (average annual growth rate of 5%) from 2000 through 2009. At the state level, evidence points to a positive impact of peace on basic school enrolment for the populations that were affected by conflict prior to 2005. As indicated in Figure 1, all three Darfur states registered double digit average annual growth rates in enrolment between 2004/05 and 2008/09 school years. West Darfur had the highest average annual growth rate of 15 percent compared to all other states and compared to the average for Sudan of 6 percent.

Figure 1: Average annual growth rates for basic enrolment between 2004-2005 and 2008-2009, by State



Source: Status of the Education Sector in Sudan, 2012

The total number of enrolments by State is reflected in Table 5 below. While enrolments in basic education has grown the secondary education sub-sector remains relatively small compared to other states. The share of girls is also lower in basic education for all Darfur states (except North Darfur in basic education) compared to the average for Sudan (46 percent in basic education and 49 percent in secondary education).

Table 5: Total number of enrollments by State and share of Girls in total enrolment, 2008-2009

State	Basic Education		Secondary Education	
	Number of students (public&private)	Share of girls in total enrollment	Number of student (public&private)	Share of girls in total enrollment
West Darfur	283,355	44%	23,348	36%
South Darfur	424,904	43%	52,263	41%
North Darfur	346,779	46%	31,927	42%
Sudan	4,870,464	46%	736,309	49%

Source: Status of the Education Sector in Sudan, 2012

While overall numbers on enrollment have increased in the Darfur region, the Gross Enrollment Rate (GER) for Basic Education on average remains low compared the rest of the country. Only West Darfur has a Gross Enrollment Ratio (GER) for Basic Education which is higher than the average GER for Sudan at 80% compared to 72%. North Darfur has a GER of 65% whereas South Darfur has the worst GER of any state in Sudan. These rates are very low when compared with the regional average for lower-middle-income Sub Saharan African countries (105 percent) and lower-middle-income Middle East and North African countries (106%).

There is limited information and data on the situation of higher education in Sudan. The following analysis results mainly from international organizations internal reports, universities' website, as well as issues raised during the focus group discussions held in preparation of the Darfur Joint Assessment Mission (DJAM).

The higher education system in Sudan is characterized by its spread all over the states and the diversification of providers through the introduction of private institutions that includes various types of establishments, universities, university colleges and public technical colleges and institutes. In 2008, there were 39 universities, 45 university colleges and 20 technical colleges in Sudan. Today, in 2012, the Darfur Region count 3 Universities, 09 associated universities and 19 teachers training institutes (Table 6).

Table 6: Sudan Higher education institutions in 2012

State	State Universities	Private universities/higher education institutes	Teacher Training Institutes
Central Darfur	1	0	1
East Darfur	0	1	3
North Darfur	1	3	5
South Darfur	1	3	9
West Darfur	0	2	1
Total Darfur	3	9	19

Source: Ministry of Higher Education and Scientific Research, 2012

7.1.1 Students' enrolment in public universities

Higher education growth enrolment has been steady over the last two decades. New universities have been established in almost every State and enrolment has been extensively increased. The number of children accessing higher education institutions has more than tripled over the last ten years. The expansion was justified by the acute shortage in university places for eligible students seeking opportunities in higher education as well as the deficiency of university graduates in engineering and technology sectors.

Table 7: Students' enrolment in Public institutions in Darfur 2003 - 2012

Institution Name	2003-04	2004-05	2005-06	2006-07	2007-08	2008-09	2009-10	2010-11	2011-12
El Fashir University	5,337	4,475	5,800	8,311	8,573	9,471	10,369	11,360	12,491
Nyala University	3,788	6,221	4,791	5,238	5,073	5,976	6,878	8,171	8,550
Zalengei University	1,150	965	1,437	2,994	3,632	3,666	3,699	4,585	5,290
Total Darfur	10,275	11,661	12,028	16,543	17,278	19,112	20,946	24,116	26,331
Total Public Institution in Sudan (1)	262,950	303,438	361,566	390,773	435,216	437,193	441,535	443,322	469,542

(1) Undergraduates students

Source: Ministry of Higher Education and Scientific Research, 2012 and WB estimates 2012

In 2011-12, 469,542 students were enrolled in public institutions in Sudan and 579,528 were enrolled in total excluding graduates students corresponding to 1,759 students per 100,000 habitants and roughly 6.6% of these students (26,331) are from the Darfur region. The gender pattern of higher education in Sudan, in general, is in favour of female participation exceeding 53.4% (52.3% in Darfur) in most disciplines (Table 8).

Table 8: Students' enrolment in Public 2009-2010

University	BSc.			Diploma			Total		
	M	F	T	M	F	T	M	F	T
Fashir Univ.	3455	3936	7391	795	2183	2978	4250	6119	10369
Nyala Univ.	3555	2343	5898	393	587	980	3948	2930	6878
Zalingi	1557	1617	3174	235	290	525	1792	1907	3699
Total Darfur	8567	7896	16463	1423	3060	4483	9990	10956	20946
Total Sudan (public and Private)	197727		4719	45514	47190	93616	243241	302019	565552

Source: Ministry of Higher Education and Scientific Research (2011)

7.2 Delivery of education services to IDPs and nomadic communities

The delivery of basic education to IDPs and nomadic communities poses a unique set of challenges in the Darfur region given their non-sedentary lifestyle. International evidence shows that security, poor quality learning environment, language barriers, and the cost of schooling hinder IDP children from accessing basic education. Data on these population groups is scarce with large variations in available estimates. For example, according to UNHCR there were 4.9 million IDPs in Sudan 2010 with 2.6 million located in the Darfur region alone and 1.7 million in Khartoum state. However, according to the latest Population Census there are approximately 780,000 IDPs with the difference in numbers probably a result of the definitions used. Nomads also make up a large share of the population in northern Sudan. According to the existing estimates, nomads account for 8.5-8.7% percent of the total population²⁰.

According to government statistics, there were 261 government IDP schools in 2008-09²¹ (also Table 9 below). With the exception of 3 IDP schools in Northern State, all are located in the Darfurs—although in the 2007-08 school year, there were also IDP schools in Blue Nile and Kassala. Table 7 below shows that while the number of IDP schools went down by almost 25 percent, the number of students in IDP schools went increased by 94 percent within a year. This has resulted in large IDP schools; with an average enrollment of 815 students in 2008-09, which was about 4 percent of total basic school enrollments in Sudan. This enrollment is quite small if we consider that there are an estimated 2.6 million internally displaced persons in Darfur alone and that almost 700,000 of these, or 25.7 percent, are between the ages of 6 and 13 years²². Many IDP children could, however, be enrolled in normal schools, so it is not possible on this basis to conclude what share of IDP children have access to basic schooling. A later chapter in this report presents the gross enrollment rates for each state, including the three Darfur States, but it has not been possible to further break down these numbers into IDPs and non-IDPs within the States.

Table 9: Number of schools & enrollments in government nomadic and IDP schools, 2007-08 and 2008-09

	2007/08	2008/09	% increase
Nomadic schools			
Number of schools	1,431	1,422	-1%
Number of students	220,535	146,826	-33%
Average students per schools	154	103	-33%
IDP schools			
Number of schools	339	261	-23%
Number of students	109,508	212,602	94%
Average students per schools	323	815	152%

Source: Status of the Education Sector in Sudan, 2012

Outside of Khartoum state, South Darfur had the most number of private schools for basic education at 207, indicating a large number of private NGOs providing educational services in that state. Private schools account for about 10 percent of basic school enrollment in South Darfur. South Darfur also has the highest number of IDP schools (99 percent of all IDP schools according to Table 9 below), several of which are probably run privately by NGOs or UN organizations. Together the three Darfur states host 44 percent of all nomadic schools.

²⁰ UNHCR (2010); The Joint Assessment Mission in 2005

²¹ Not counting the non-government IDP schools. MoGE's 2008-09 yearbook reports more than 250 non-government schools in the Darfurs. It is likely that many of these schools are also IDP schools.

²² According to the population structure for the three Darfur states, as reported by the 2008 population census.

Table 10: Number of basic schools by State and type of school and total enrollments, 2008-09

State	Government				Private	Total enrollment
	Regular	IDP	Nomadic	Total		
N. Darfur	837	65	164	1,066	36	346,779
S. Darfur	997	135	252	1,384	207	424,904
W. Darfur	877	58	213	1,148	21	283,355
Total Darfur	2711	258	629	3,598	264	1,055,038
Darfur schools as a % of total Sudan	21%	99%	44%	24%	20%	22%
Total Sudan	12,934	261	1,422	14,955	1,335	4,870,464

MoGE Statistical Yearbook, 2008-09

7.3 Quality of Basic and Secondary education

While access to basic education has improved significantly over the last seven years in the Darfur region, there are a high number of dropouts in basic and secondary education. For basic education, the completion rate is especially low for South Darfur (refer to Table 10 below) at 21.7 percent compared to the already low average completion rate for Sudan of 54 percent. North Darfur (44%) is also below the average completion rate for Sudan. Interestingly, it appears that once students complete basic education in South Darfur, they are more likely to transition into secondary education as indicated by the 68 percent transition rate for this state compared to the rates for West Darfur (31%) and North Darfur (49%).

All three Darfur states perform well below the average on gross intake rates, completion rates and GERs for secondary education. Access to and completion of secondary education is clearly an issue for all of Sudan but is particularly acute in the Darfur region. The percentage of repeaters in secondary education for West (33%) and South (22%) Darfur is also cause for concern.

Table 11: Education indicators for the Darfur states

State	Basic Education			Transition	Secondary Education			
	Gross Intake Rate	Completion Rate	% Repeaters		Gross Intake Rate	Completion Rate	GER	% Repeaters
West Darfur	83.7%	69.9%	4.5%	31%	22%	13%	26%	33%
South Darfur	57.0%	21.7%	1.4%	68%	15%	11%	17%	22%
North Darfur	79.7%	44.4%	4.5%	49%	22%	15%	20%	7%
Sudan	80.0%	54.0%	6.9%	63%	34%	25%	34%	15%

Source: Status of the Education Sector in Sudan, 2012

While there is no systematic learning assessment within Sudan to assess whether in fact students are learning what is prescribed in the curriculum framework, a recent survey by the Federal Ministry of Education and the World Bank in 2010 found that learning outcomes in mathematics were very weak and point to problems with the delivery of education services in basic schools. The average learning

assessment score for four survey states (Blue Nile, South Kordofan, Red Sea and North Darfur) was only 28%. The results also showed that IDP students in North Darfur performed significantly worse than for other students and the effects were large. Rural IDP students in North Darfur had average scores that were 5.4 points lower and urban IDP students in the State and had scores that were 21.0 points lower than other rural and urban students in the other states. Thus, after accounting for household wealth, gender, age, and school inputs, IDP students in North Darfur still performed worse indicating that other factors impact a students' ability to learn (see World Bank 2012d). Many IDP students are orphans and have been uprooted from their homes, which may partly explain their weaker performance.

7.4 Teachers

There is clearly insufficient numbers of teachers in Darfur. As reflected in Table 11, the pupil teacher ratios for basic education and secondary education in the Darfur states are higher than the average for Sudan. West Darfur has the highest pupil to teacher ratio of all states in Sudan with an average of 64 students per teacher. The classroom to student ratio is also higher in the Darfur states compared to the average for Sudan indicating overcrowded classrooms of more than 60 pupils per class in basic education in West Darfur and more than 55 per class in South Darfur. This points to a lack of not only teachers in the Darfur region, but a general lack of classrooms to accommodate students.

Table 12: Pupil to teacher ratio (PTR) and pupil to class ration in basic and secondary education, 2008-09

State	Basic Education		Secondary Education	
	PTR	P class ratio	PTR	P class ratio
West Darfur	64.4	63.8	23.5	47.5
South Darfur	43.9	56.1	20.3	54.8
North Darfur	46.7	49.1	18.2	49.5
Sudan	32.5	47.7	15.7	48.8

Source: Status of the Education Sector in Sudan, 2012

More than half the teachers in basic education in the Darfur states were female in 2008/09: West Darfur (54 percent); South Darfur (61%) and North Darfur (57%). The average percentage of female teachers in Sudan for basic education was 67%. However, there were far fewer female teachers in basic education in the Darfur Region: West Darfur (22%); South Darfur (33%) and North Darfur (40%); compared to the average of 56% for Sudan. The low percentage of female teachers in secondary education is of concern given that research shows that the presence of more female teachers in schools has a positive influence on attracting girls to school. It is possible that fewer female teachers are qualified to teach secondary education in the Darfur region, which is an issue that needs to be addressed.

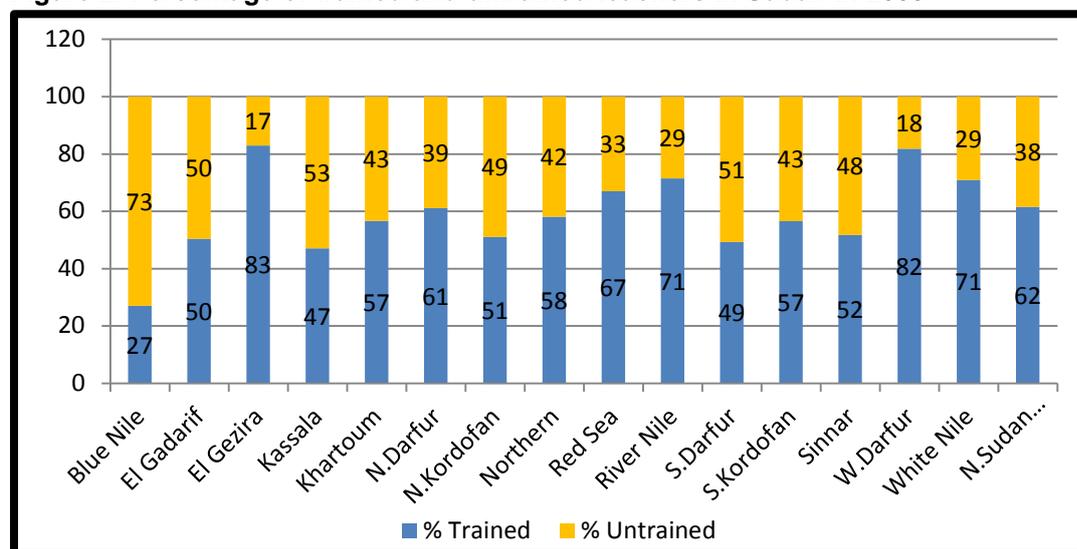
7.5 Teacher qualifications and training

The 2008-09 FMoGE statistical yearbook does not capture the numbers of teachers who are qualified according to the B.Ed requirement, though it does disaggregate teachers by those who received education training (either ISETI diploma, SOLO TAC course²³ or the B.Ed.), who are considered "Trained" and those who did not receive any teacher training, who are considered "Untrained". It should be noted that 'untrained' teachers could include individuals who have a university degree which is not focused on education, for example a Bachelors or Masters in Science.

²³ The Teacher Assistance Course (TAC) is a 9 month open learning course developed and delivered by a national NGO, the Sudan Open Learning Organization (SOLO)

As reflected in figure 2, 38% of teachers had not received any formal education training in 2009 and only a subset of those classified as ‘trained’ have the prerequisite B.Ed. degree. In South Darfur, less than 50 percent of teachers were considered trained. Notably, 82% of teachers in West Darfur were considered trained though it is not known what percentage of these teachers have the minimum requirement of the B.Ed. degree.

Figure 2: Percentage of trained and untrained teachers in Sudan in 2009



Source: 2008-09 FMoGE statistical yearbook

7.6 Out of school

The number of children who are out of school in Sudan was identified as a major challenge by 2012 the Status of the Education Sector in Sudan report²⁴. In 2009, 2 million of 10-19 year olds²⁵ (27%) were out of school and out of these 1.2 million had never attended school and 789,000 had dropped out of school.²⁶ This has implications at the country level in terms of economic growth and development and at the individual level in terms of labor market opportunities, earnings, and health outcomes. More girls than boys, amongst those out of school, have never attended school (61%). In addition, girls also account for 55% of those who dropped out. However, retention through secondary and post-secondary is higher for girls who do stay in school as compared to boys. Rural/urban disparities are stark. Nearly 90% of children who have never attended school live in rural areas. With regards to dropouts, a greater number of rural children, as compared to urban children, drop out without any qualification or less than five years of primary education. For those out of school, it is important to understand their employment status.

Generally, the out of school perform worse in the labor market, and in Sudan, the majority of those out of school are not regularly employed for wages.²⁷ Among 10-19 year olds in Sudan who have never attended school, 53% report being unpaid family workers compared to a smaller share of 34% for those who dropped out at some stage before completing six years of primary education, and an even smaller share of 19% for those who dropped out between year six of primary education and secondary

²⁴ The Status of the Education Sector in Sudan (2012). African Human and Development Series, World Bank

²⁵ This paper is sourced from The Status of the Education Sector in Sudan (2012), African Human and Development Series, World Bank report and focuses on 10-19 year olds who are out of school in Sudan because those who are older will likely not enter or re-enter formal schooling. Moreover, out of the 20-24 year olds in Sudan who are out of school nearly 43% report being employed.

²⁶ Out of school includes those who never attended school and those who dropped out.

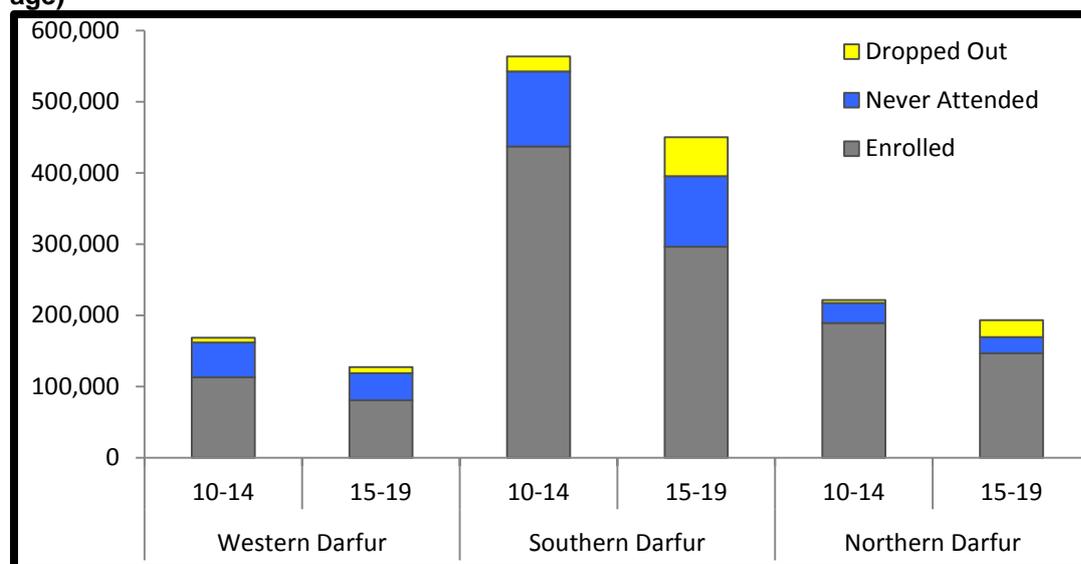
²⁷ [Miller, Cynthia, Porter, Kristin E.](#) Barriers to Employment for Out-of-School Youth: Evidence from a Sample of Recent CET Applicants Manpower Demonstration Research Corp., New York, NY, September, 2005

education (Figure 3). This illustrates the importance of enabling children to access and stay in school to improve their future labor market opportunities.

The out of school situation also differs across states. Although the issue of children out of school is a problem in all states, some are more affected. More than half of those out of school in Sudan between ages 10-19 live in five states: Khartoum (8%), Kassala (10%), North Kordofan (11%), Al Gezira (12%), and South Darfur (14%). Focusing specifically on the Darfur region, approximately 461,500 children were out of school, accounting for over 20% of all children in Sudan out of school. A majority of those out of school, within the three states, lived in South Darfur. The issue of children out of school is especially critical in the Darfur region, where over 50% of the population is under the age of 18 and nearly 80% of the population lives in rural areas or are nomads. The recent history of conflict and continued insecurity in the region makes it more difficult for children, especially girls, to access and stay in school.

Taking into consideration, the total population of school age children in each state, a majority of children out of school has never attended school. Nearly 30% of children out of school in Western Darfur have never attended school. Both Southern (20%) and Northern Darfur (12%) also have a considerable number of school age children, who have never attended school as illustrated in the figure below. Of those who dropped out of school, most children in all three states have left school without any qualifications or less than five years of primary education. Of note In Western Darfur, 22% children who left school reported having had an education at khalwa schools.

Figure 3. Enrolled, Never attended and Dropout Amongst School Age Children (10-19 years of age)



Source: SHHS, 2010

7.6.1 Likelihood of being out of school

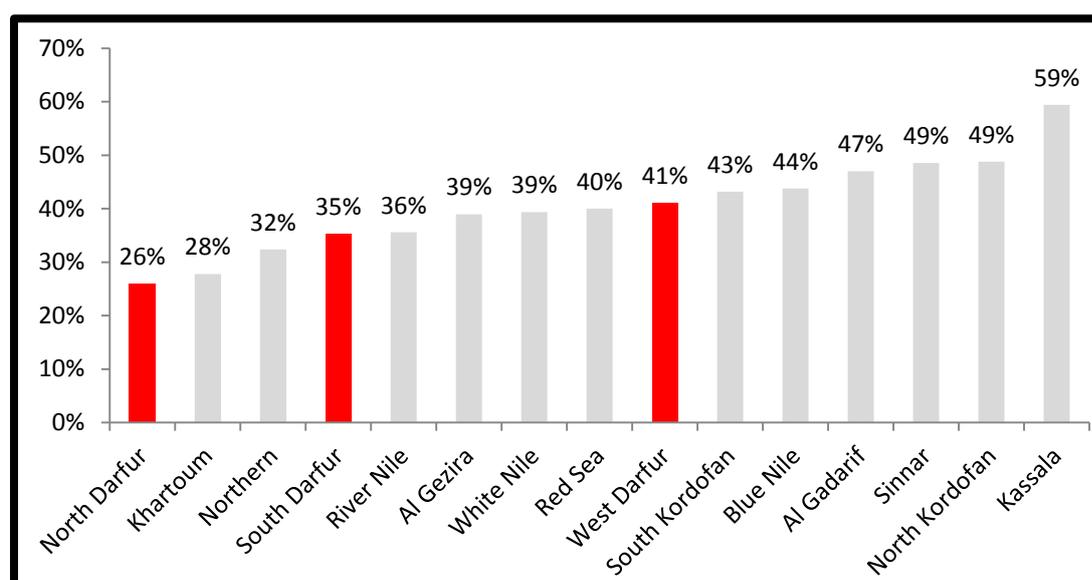
Based on data from the 2010 SHHS it is possible to estimate the likelihood of being out of school by rural/urban location, household characteristics, and gender.²⁸ This provides important insights into who is more likely to be out of school in Sudan and how to best target interventions for those most at risk. The average overall likelihood for a child being out of school in Sudan is estimated at 39%. Rural children are 1.8 times more likely to be out of school compared to urban children and the likelihood of being out of school as a girl is nearly 1.3 times higher than for a boy (Figure 4). Being a girl in a rural

²⁸ The likelihood estimates are conditional on other relevant factors including household income.

area provides the least opportunity for accessing and staying in school: the likelihood of being out of school for a rural girl (53%) is more than double that for an urban boy (21%). This is in line with international evidence, which finds that girls are more likely to be excluded from education, a fact partly explained by within-country ethnic and linguistic heterogeneity.²⁹

By state, the likelihood of being out of school is highest in Kassala (59%). Within the Darfur region, the likelihood of being out of school is highest in Western Darfur (41%) followed by Southern Darfur (35%) and Northern Darfur (26%). Breaking it down by rural/urban location the likelihood of being out school is nearly twice as high in rural areas compared to urban areas across all states. This is especially pertinent to the Darfur region, where a majority of households are in rural areas.

Figure 4. Likelihood of children being out of school by state



Source SHHS 2010

7.7 Infrastructure, Textbooks, chalkboards and other learning materials

Even when schools are close-by, if they are in poor condition and classrooms are decrepit or overcrowded, student learning is adversely affected (Watkins 2000, UNESCO 2007). The status of school infrastructure in Sudan is generally poor.

Results from the 2008 MoGE/UNICEF Baseline Survey and the Service Delivery Study (SDS2) provide an overview on the availability and use of resources in basic education in survey states. The 2008 Baseline Survey found that half of classrooms in Sudan needed to be rehabilitated or completely replaced (MoGE 2008). The SDS2³⁰, found in survey states roughly one in three classrooms were estimated to require rehabilitation or replacement, the situation was even worse than the national average: in Blue Nile 59 percent, in North Darfur 61% and in South Kordofan 68% of classrooms required repair or replacement.

A majority of children, in the Darfur region, are enrolled in nomadic, IDP and rural schools, as described earlier. The SDS2 survey found better infrastructure in IDP schools in North Darfur as compared to non-

²⁹ Lewis, Maureen and Marlaine Lockheed, *Inexcusable Absence: Why 60 Million Girls Still Aren't in School and What to Do About It*. Washington, DC: Center for Global Development. 2006 and Lewis, Maureen and Marlaine Lockheed, 'Social Exclusion and the Gender Gap in Education,' World Bank Policy Research Working Paper No. 4562, Washington, DC: World Bank.

³⁰ The SDS2 builds on a previous education service delivery survey (SDS1) conducted in 2009 in three states (Kassala, River Nile and North Kordofan).³⁰ The SDS2 extends the analysis of service delivery and student learning in Sudan to four additional states selected by the GoS: Blue Nile, North Darfur, Red Sea, and South Kordofan, and unlike the SDS1 is based on a representative sample.

IDP schools in the four survey states primarily because basic school construction in North Darfur is largely funded by international aid agencies. It is estimated that 85 percent of all schools in North Darfur receive external support for construction. NGOs have also been active in providing funding for school inputs.

Table 12 (below) shows that all IDP schools in North Darfur had a roof and walls and the vast majority are built of materials suitable to the local context. 95% of IDP schools had roofs of thatch, grass, or mud and 84% had walls of these materials. The SDS2 also found that students in IDP schools also generally had better access to drinking water and toilets than their rural and urban counterparts in non-IDP schools. 35% of IDP schools lacked a source of drinking water compared to 50% of rural non-IDP schools and 42% of urban non-IDP schools (Table 13). The majority of IDP schools in North Darfur had toilets, 95% whereas only 63% of rural non-IDP schools and 81% of urban non-IDP schools in the four survey states did. For instance, the majority of IDP schools in North Darfur had toilets, 95% whereas only 63% of rural non-IDP schools and 81% of urban non-IDP schools in the four survey states did.

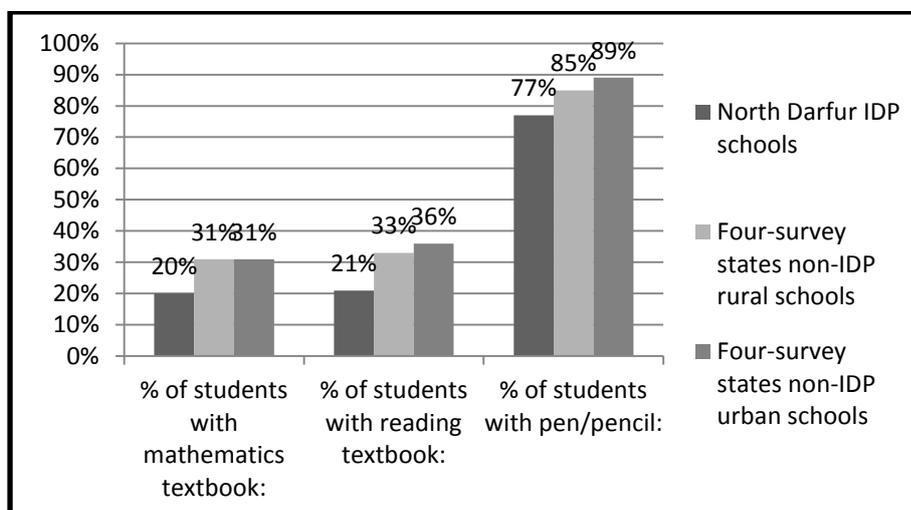
Table 13: Shows differences in infrastructure between IDP and non IDP schools in North Darfur (2010)

	North Darfur IDP schools	Four-survey states rural	non-IDP schools urban
<i>Roof material:</i>			
Wood	5%	4%	0%
Thatch/Grass/Mud	95%	32%	17%
Zinc	0%	48%	72%
<i>Wall material:</i>			
Wood	5%	2%	0%
Thatch/Grass/Mud	84%	26%	15%
Brick	11%	47%	80%
<i>Source for drinking water:</i>			
Tap	12%	1%	15%
Well	6%	14%	13%
Pump	18%	20%	12%
No drinking water	35%	50%	42%
Other	29%	10%	16%
Schools with toilet(s)	95%	63%	81%

Source SDS2 (2010)

While the SDS2 found that infrastructure was better in IDP schools in North Darfur compared to other rural and urban non-IDP schools, IDP schools are much larger in size, have higher student-teacher ratios, and larger class sizes than non-IDP schools (as described earlier). Moreover, the SDS2 found that fewer classrooms in IDP schools had chalkboards and fewer students had desks than in non-IDP schools. There was also a textbook shortage in IDP schools which was more severe than in non-IDP schools. Only about 20% of grade 5 students had mathematics and reading textbooks which was lower than the student-textbook ratios for non-IDP basic schools in the four survey states. By contrast, the majority of IDP students had pens or pencils: 77% of grade 5 students, but still lower than the average for non-IDP schools.

Figure 5: A bar chart showing the distribution by percentage (%) of learning materials amongst North Darfur schools, four Survey States non-IDP rural schools, and four survey states non –IDP urban schools.



Source: SDS2 (2010).

7.8 Malnutrition and underperformance in schools

International evidence shows that malnourished children tend not to reach their potential either physically or mentally are less likely to go to school, and once in school, register lower levels of learning achievement. A large number of children (0-59 months) in Sudan are malnourished, with major negative consequences for learning in school.³¹ This is especially an issue in the Darfur region, where between 31-35% of children are stunted.³² A recent multi-country study found that for every 10% increase in levels of stunting among children, the proportion of children reaching the final grade of school dropped out by almost 8%.³³ School feeding programs can help to address this issue by providing an added incentive to households to send children to school. Teachers reported, in the recent SDS2 survey, that 26% of rural children and 27% of urban children dropped out of school because they were unable to pay for school feeding.³⁴ Given the complex environment in Darfur, it is likely that children who are displaced are attracted to school sooner when there is a school feeding program compared to when there is no program.³⁵

7.9 The current situation on Tertiary Education

It was reported during the DJAM State Consultative Workshops 2012 that much of the equipment that is in use in Darfur's universities are old, inadequate and has not been renewed for many years.

Infrastructure is poor in universities; classrooms need rehabilitation and additional classrooms need to be constructed in order to keep pace with the growing demand for tertiary education.

³¹ Status of the Education Sector in Sudan, World Bank 2011

³² Sudan Household Health Survey 2010

³³ Grantham-McGregor, S. et al (2007), 'Child Development in Developing Countries: Developing Potential in the First 5 Years for Children in Developing Countries', The Lancet, Vol. 369, No. 9555: 60-70.

³⁴ Second Service Delivery Study, 2011

³⁵ Bundy et al, *Rethinking School Feeding* World Bank and World Food Program June 2009

Science laboratories need to be updated to meet technological advances and need to be equipped with the relevant tools and supplies in order to adequately provide a good foundation for scientific enquiry for students at the university.

One particular concern arising from the DJAM workshop discussions was the availability of a high-speed communications network. Instead, teachers have to resort to the use of traditional methods of teaching that deprive students of the skills of investigations and exploration, creativity and research. Without adequate investment in computers and communications, higher education institutions are unable to maximize the potential of Information and Communications Technology both for teaching and for research. This is quite inappropriate for preparing students for employment in the modern world.

On the basis of this, a very substantial investment will be required to bring the facilities of Darfur universities up-to-date. An important recommendation from the workshop discussions is the need to rehabilitate/equip higher education institutions in Darfur to enable them to effectively deliver quality services.

In general, there are strong expectations in Sudan about the responsibility of higher education institutions in economic development, social mobility and stability. In Darfur, these expectations are even stronger as the peace talks concerning the conflict in the region are seen as an opportunity to lead to political and economic stability and pave the way for the development of higher education. The community in Darfur see in post secondary education, an opportunity to bring hope by preparing graduates with new skills that balance local educational needs and priorities with standards, practices and skills that can be referenced internationally and requested in the local job market.

7.9.1 Quality and access to Tertiary education

The rapid expansion of higher education in a context of reduced financial resources is resulting in many deficiencies including facilities, materials and qualified staff.

Quality and relevance of learning are key issues facing higher education in Sudan in general as the high youth unemployment amongst graduates is not only due to the inability of the system to create jobs but also an evidence of mismatch between tertiary education outcomes and the skills that employers require. The challenge is even bigger in the Darfur region where many areas remain inaccessible, or hard to reach and, as a result, can hardly attract qualified staff (PhD holders) that universities need to provide quality teaching in a context of globalisation, high technologies and innovations. University Professors represent 2.8% (5% in Sudan) of the total teaching force in Darfur and 60.8% are lecturers (45.76% in Sudan) (Table 12).

Table 14: Teaching Staff (Public) 2009 – 2010

University	Prof.		Assoc. Prof.		Assist. Prof.		Lecturer		Total	
	M	T	M	T	M	T	M	T	M	Total T
Fashir Univ.	11	11	10	10	66	74	71	98	158	193
Nyala Univ.	3	3	5	5	41	51	90	109	139	168
Zalingi	0	0	5	5	36	37	90	97	131	139
Total Darfur	14	14	20	20	143	162	251	304	428	500
Darfur %	2.8		4		32.4		60.8		100	
Total Sudan	569	569	1329	1499	2686	3723	3062	4904	7646	10717
Sudan %	5.31		13.99		34.74		45.76		100	

Source: Ministry of Higher Education and Scientific Research. 2011

In addition, although individual universities may have internal processes for assuring quality, these are by no means widespread or systematic, and there is no national quality assurance process till now, though attempts are in their way for developing national quality assurance standards. Consequently, there are no incentives for universities or the staff within them to ensure high quality and standards in what they provide.

8 The recovery priorities for Basic Social Services

One of the fundamental outcomes from the Darfur Joint Assessment (DJAM) Mission is to expand the coverage of social services, targeting areas of return by displaced people, nomadic areas, rural to areas, and new settlements through a mix of strategies.

Rehabilitation and refurbishing of strategic health, nutrition, education and WASH facilities in the hard to reach areas with vulnerable populations will be given high priority in addition to the construction of new facilities. These interventions will be accompanied by an increased provision of commodities, such as medicines, drugs, lab consumables, learning material including textbooks, hand pumps, latrines, etc.

Another important priority is to improve the quality of service delivery. Examples of action for improving quality include strengthening the workforce by expanding the number of current staff in Healthcare facilities, schools, upgrading their skills, providing attractive benefit packages for re-deployment of health care staff to rural and hard to reach areas, promoting gender balance and improving their working and living environment.

In addition, strengthening planning and management capacity will be critical to ensure that the right resources get to the appropriate point of delivery and are used effectively. This will be done by providing technical assistance to State Ministries, upgrading and technically supporting their monitoring and evaluation data collection and reporting systems to improve planning activities. Lastly increasing awareness amongst communities, especially amongst vulnerable groups such as IDPs, Nomads, malnourished, women, children, HIV positive and mentally ill, elderly, on the types of services offered and their benefits through multi-sectorial and multi-disciplinary approaches will be important. The proposed results framework (pg 38-52) illustrates the main priorities which were gathered and ranked from State consultative workshops in Darfur which included DRA, government entities at State level, local community leaders and members of community. The priorities listed provide estimates of budgets that are required to kick start early recovery and on the path to development in all Darfur States.

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10 Proposed Results Framework

DJAM TWG Objectives based on the DDPD *	Ranked Priorities/Needs	Outputs	Indicative costing of Outputs (a)	Instruments/ Activities		Timeframe			State(s) To which priorities apply
				TA, Policies, Programs, Peace Div. Projects, etc.	Costs subse t of (a) #	F A	ST	L T	
<p>1. Enhance access to and utilisation of comprehensive health and nutrition services, privileging vulnerable and disadvantaged population groups</p> <p><i>Proposed total allocation to implement the strategy (in addition to present funding levels): US\$255 million over five years, or around</i></p>	<p>1. Maximising the outputs of existing health and nutrition services, by</p> <p>1.1. Upgrading and rehabilitating the existing health facilities, starting with those with</p> <p>1.1.1. the heaviest workloads, and</p> <p>1.1.2. the most favourable locations (in relation to population settlements).</p> <p>1.2. Improving supply systems, by reducing their fragmentation and supporting country-wide reforms.</p> <p>1.3. Subsidising the enrolment of poor families in the N.H.I.</p> <p>1.4. Launching a comprehensive supervision + in-service training programme, aimed at upgrading the skills of active health workers and motivating them.</p> <p>1.5. Tapping idle capacity, such as hiring unemployed cadres.</p>	<p>1. <i>Outputs of first prong:</i></p> <p>1.1. Increased number of facilities offering complete packages of health and nutrition services of acceptable quality.</p> <p>1.2. Increased service uptake, particularly by disadvantaged population groups.</p> <p>1.3. Reduced expenses incurred by households in utilising health and nutrition services, obtained through:</p> <p>1.3.1. Pro-poor subsidies (progressively better integrated), and</p> <p>1.3.2. Efficiency gains in the provision of health and nutrition services (increased productivity of staff and assets, reduced operational</p>	<p><i>Total cost over 5 years: US\$150 million for Health & Nutrition interventions :</i></p> <p>1.1. US\$80 million over three years</p> <p>1.3.1. US\$30 million over five years</p> <p>1.4. US\$40 over five years (including supervision, in-service training and</p>	<p>1. <i>Actions to be taken:</i></p> <p>1.1. Facility assessment, to provide the basis for a sequenced upgrading and rehabilitation plan for each state (<i>within 6 months</i>).</p> <p>1.2. Assessment of pharmaceutical supply arrangements in the region, and identification of the measures needed to increase the availability of medicines cut their cost and ensures their quality (<i>within one year</i>).</p> <p>1.3. Feasibility study of expanding access to health care through the subsidised enrolment in</p>		*	*		1. All states, with preferential support provided to Central and East Darfur.

<p><i>US\$6 per capita per year (lower at the start and progressively increasing).</i></p>		<p>costs, enhanced resource allocation etc.).</p> <p>1.4. Human resources upgraded and re-deployed to staff efficiently the strengthened network.</p>	<p>incentives).</p>	<p>the N.H.I. (<i>within 6 months</i>).</p> <p>1.4. Assessment of supervision and in-service training practices, and formulation of a dedicated programme, intended to progressively cover the active workforce.</p> <p>1.5. Establishment of a Darfur-wide health systems observatory, to monitor and coordinate recovery-oriented activities.</p>					
<p><i>Estimated annual recurrent cost of expanded and strengthened health and nutrition services (primary and secondary levels): US\$46 million (including pharmaceutical supplies). Administration, maintenance, training, and other support costs should be added to that direct delivery cost.</i></p> <p><i>Tentative Grand Total for recurrent costs: US\$60 million by year 5.</i></p>	<p>2. Strengthening (or putting in place when the case) the institutions and management instruments needed to ensure a sustained recovery:</p> <p>2.1. Information management (<i>including surveillance</i>)</p> <p>2.2. Supervision and evaluation capacity</p> <p>2.3. Regulation</p> <p>2.4. Management and development of human resource for health and nutrition</p> <p>2.5. Financial management (including external assistance)</p> <p>2.6. Asset management (investment and maintenance)</p>	<p>2. Improved management practices, as means to attain the general objective.</p>	<p>2. US\$10 million</p>	<p>2. <i>Needed studies</i> (within year 1):</p> <p>3.1. Assessment of management practice in each state and design of effective interventions.</p> <p>3.2. Private healthcare provision (with a view at establishing strong regulatory functions and at fostering productive collaborations).</p> <p>3.1. Assessment of health information</p>		<p>*</p>	<p>*</p>	<p>*</p>	<p>2. All states, with preferential support provided to Central and East Darfur.</p>

	<p>2.7. Supply 2.8. Referral 2.9. Regional coordination, negotiation and communication.</p>			<p>management practices.</p>					
	<p>3. Launching a long-term investment plan, aimed at making health and nutrition services accessible to the majority of the population, across the whole region:</p> <p>3.1. Health facilities, and warehouses, offices, staff housing, training institutions etc. 3.2. Human resources for health and nutrition. 3.3. Support systems (transports, laboratories, communication, etc.).</p>	<p>3. 100 new Basic Health Units, 100 new Family Health Centres and 5 new Local Hospitals functioning by year 5. Additional 5 new Local Hospitals and 5 new State Hospital completed and functioning by year 10.</p> <p>3.1. Physical access to primary and referral services improved. 3.2. New facilities staffed with the required personnel and adequately supplied. 3.3. Service uptake boosted, particularly by previously under-served population groups.</p>	<p><i>Total cost over five years: US\$95 million</i> New health facilities: 70 million New human resources: US\$15 million Support systems: US\$ 10 million</p>	<p>3. <i>Actions to be taken ASAP:</i></p> <p>3.1. Strengthening or implantation of an investment management unit in each state. 3.2. Assessment of the health workforce and of regional training capacity (as first step towards formulating a regional HRH development plan).</p>		<p>*</p>	<p>*</p>	<p>*</p>	<p>3. All states, with preferential support provided to Central and East Darfur.</p>

	Ranked Priorities/Needs	Outputs	Indicative costing of outputs (a)	Instruments and activities		FA	ST	LT	States to which priorities apply
				TA, Policies, Programs,	Costs subset of (a) #				
<p>2. To improve access and the quality of water and environmental sanitation services, through the choice of appropriate water and sanitation service options and hygiene promotion</p>	<p>1. Increased coverage and access to safe water and sanitation services in order to reduce incidence of water-borne in rural and nomadic areas</p>	<p>1.1 Rehabilitate appropriate water supply systems, such as hand pumps, mini water yards and water yards in rural and nomadic areas. 1.2 Systematically support running costs for 80 water supply units across 5 states which includes fuel, labour, servicing 1.3 Construction of 4,495 new hand pumps in rural and nomadic areas 1.4 Construction of new household and public improved latrines in rural and nomadic areas</p>	<p>\$242.93 million is the Total Budget to implement all WASH interventions listed below over period of 6 years for DJAM</p> <p>1.1 Total cost of \$105,000,000 spread over of 6 years Hand pump rehab: \$200/unit Water yard rehab: mini:\$35,000 – large water yard:\$70,000/unit</p> <p>1.2 Total cost of \$ 4,000,000 spread over 6 years (For 80 motorised systems running costs/year = \$850/month in 5 states Includes manpower, fuel, etc.</p> <p>1.3 Total cost of \$45,000,000 spread over 6 years for mainly immediate</p>			*	*	*	<p>1. All states, with preferential support provided to Central and East Darfur</p>

			<p>needs</p> <p>Hand pumps: 1,037ND + 1,648 WD + 1,810 SD x \$10,000</p> <p>1.4 Total cost of \$35,300,000 to construct improved pit latrines spread over 6 years although it is an immediate need</p> <p>Improved pit latrines: 58,128 ND+216,848 SD 78,295 WD x \$100</p>						
	<p>2. Increased use of safe water and sanitation facilities, multi- sectoral especially amongst marginalised families</p>	<p>2.1 Establish new water facilities health facilities, (based on 400 visitors/daily basis):</p> <p>a) 300 new Basic Health Units,</p> <p>b) 100 new Family Health Centres and</p> <p>c) 5 new Local Hospitals functioning by year 5</p> <p>2.2 Construct water and sanitation facilities at schools</p>	<p>2.1 Total cost of \$3,700,000 spread over 6 years</p> <p>a) 300 health units x \$2000 water facilities</p> <p>b) 300 health units x \$7000 health facility latrine with hand washing facility</p> <p>c) 100 family units x \$7000 for family unit latrine with hand washing facility x \$2000 for water facilities</p> <p>d) 5 state hospitals x \$3000 water facilities</p> <p>e) 5 state hospitals x \$10,000 hospital latrine with hand washing facility disaggregated by gender</p>			*	*	*	<p>2. All states, with preferential support provided to Central and East Darfur</p>

			<p>2.2 Total cost of \$26,000,000 spread over 6 years:</p> <p>a) 2000 schools x \$3000 water facilities</p> <p>b) 2000 schools x \$10,000 school latrine with hand washing facility</p>						
	<p>3. Water facilities for humans and animals are separated.</p>	<p>3.1 Establish suitable water sources for human and livestock drinking and agriculture, such as dams and hafirs with filtration units.</p>	<p>3.1 Total cost of \$ 20,300,000 spread over 6 years:</p> <p>a) 15 dams x \$450,000 for unit</p> <p>b) 30 Hafirs x \$450,000</p>			*	*	*	<p>3. All states, with preferential support provided to Central and East Darfur</p>

	<p>4. Improved hygiene, environmental and sanitation practices</p>	<p>4.1. Sanitation and hygiene/cleaning education campaigns conducted at the community and household levels with a particular focus on gender-specific needs</p>	<p>4.1.1 Sub-Total cost of \$1.5 million 500 WASH/cleaning campaigns per year x 5 states x unit cost x 6</p>			*	*	*	<p>4. All states, with preferential support provided to Central and East Darfur</p>
	<p>5.Improved monitoring and evaluation of safe water use at state level and community level especially among men women and youth a. Environmental sanitation department supported at locality level.</p>	<p>5.1.Train WASH staff at state level and community members from localities on CATS (1000 people trained/year from all 5 States).=total 6 workshops, knowledge attitude and practices (KAP survey)</p>	<p>5.1 Total cost \$960,000 5.2 Sub-Total cost spread over 6 years \$480,000 (80\$/person x 6x 1000) (how to collect and enter data into federal) Need is greater in new states. Maybe the workshops need to take place in CD and ED first. WD, ND established M & E system just require close monitoring support. 5.3 Sub-Total cost is \$480,000 Cost of 6 workshops= \$80/person For 1000 persons=</p>			*	*	*	<p>5. All states, with preferential support provided to Central and East Darfur</p>

			80x1000x6= \$480,000						
	<p>6. Water management is integrated into the state's poverty reduction strategies</p> <p>I. Water policies are revised for more decentralization</p> <p>II. Roles and responsibilities of government water officials are clarified.</p>	<p>6.1. Carrying out training workshops, 3-5 targeted WES units per state per year are supported, including establishment of water testing units</p> <p>6.2 A Workshop per state to revise and clarify roles and responsibilities of government water officials (50 people/state= 250 invited to participate).</p> <p>6.3 Disseminate workshop results (1000 brochures in each state).</p>	<p>6. 1 Total cost of \$1,170,000</p> <p>6.1.1 Sub-total cost is \$750,000 across 6 years (\$5,000 x 5WES unitsx5 statesx6 years)</p> <p>In the new states build this capacity so monitor implementation at community level in terms of quality control of water testing</p> <p>6.1.2 Sub-total cost is \$120,000</p> <p>50 x 5 states x \$80/person x 6 years</p> <p>6.1.3 Sub-Total cost is \$300,000</p> <p>1000 x \$10/brochure x 5 states x6 years</p> <p>(includes design, printing, and dissemination into community as awareness campaign)</p>			*	*	*	6. All states, with preferential support provided to Central and East Darfur

<p>3.To improve access and quality education for all children in Darfur focusing on rural and IDP communities, nomadic children, out of school children particularly girls and other vulnerable groups.</p>		<p>1.1 1000 preschool teachers/facilitators trained 1.2 1000 preschools provided with teaching and learning materials</p>	<p><i>Total cost of USD 138,746,872 for all Education interventions: Break down as follows</i></p> <p>1.1 200 per year (2013-2017) \$100,000 1.2 support 1000 preschools every year (2013-2017) \$250,000</p>			*	*		<p>1. All states, with preferential support provided to Central and East Darfur</p>
	<p>2. Increased number of children enrolled in basic, secondary and tertiary education with specific attention to IDPs, former child soldiers, Nomadic children and girls</p>	<p>2.1 90 blocks of 2 classrooms including desks 2.2 90 latrines (1 per each block) 2.3 4000 PTAs trained in schools management. 2.4 5000 teachers trained in core subjects and child centre pedagogy 2.5 1 million children in selected areas supported with school supplies 2.6 Rehabilitation of 25 tertiary and secondary institutions including labs 2.7 Rehabilitation of existing universities: 3 universities and 2 higher education institutions</p>	<p>2.1 18 blocks of 2 classrooms per year (2013 - 2017) \$2,700,000 2.2 Latrines \$585,000 2.3 4000 PTAs trained in 2014, \$280,000 2.4 1000 teachers trained per year (2013-2017) =\$500,000 2.5 1.1million every year (2013-2017)= \$16,500,000 2.6 (5 by state X \$ 100 000) = \$500,000 2.7 (1 university or 1 higher education institution by state. USD 700 000 by</p>				*		<p>2. All states, with preferential support provided to Central and East Darfur</p>

			University and USD 300 000 by institution) So for 5 states = \$2,700,000						
	3. Increased number of Out of school youth and adolescents having access to ALP	<p>3.1 300,000 children and youth out of school have access to ALP including life and employability skills.</p> <p>3.2 2000 ALP facilitators trained</p> <p>3.3 300,000 children and youth provided with ALP books and kits.</p>	<p>3.1 100,000 in 2013, 100,000 in 2014, 100,000 in 2015 = \$300,000 x \$100 unit cost) total cost = \$30,000,000</p> <p>3.2 \$ 200,000 ALP facilitators trained</p> <p>3.3 100,000 in 2013, 100,000 in 2014, 100,000 in 2015 = 300,000 x 18 = \$ 5,400,000</p>			*	*	*	3. All states, with preferential support provided to Central and East Darfur
	4. Increased number of children (especially girls and nomadic children) accessing secondary schools	<p>4.1 600 teachers trained in core subjects and TVET</p> <p>4.2 Establish/build 10 boarding house (2 in each state) for girls and nomadic children (pilot)</p> <p>4.3 90 blocks of 2 classrooms including desks and water and sanitation facilities rehabilitated/construct. 90 latrines (1 per each block)</p>	<p>4.1 100 per year = \$200,000</p> <p>4.2 5 during in 2014 and 5 in 2016 = \$2,000,000</p> <p>4.3 18 blocks per year (2014 -2018) = \$2,700,000</p>				*	*	4. All states, with preferential support provided to Central and East Darfur

	<p>5. To Strengthen demand for education</p>	<p>5.1 Parents and communities in 1000 selected schools trained on early stimulation, importance of preschool/education for all children including children with disabilities</p> <p>5.2 5 enrolment campaigns conducted in each of the 5 states</p> <p>5.3 Support targeted school feeding programs</p> <p>5.4 Provide teaching and learning materials such as providing textbooks</p> <p>5.5 Provision of secondary school textbooks (120 000 students X 5 core subjects X6 USD)</p>	<p>5.1 One awareness campaign per year per state = \$250,000 for 5 states</p> <p>5.2 One campaign per state each year (2013-2017) = \$250,000</p> <p>5.3 Support school feeding for 20% of all basic school children for five years = \$49,438,202</p> <p>5.4 textbooks = \$9,063,670</p> <p>5.5 \$3,600,000</p>			<p>*</p> <p>*</p> <p>*</p> <p>*</p> <p>*</p>	<p>*</p> <p>*</p> <p>*</p> <p>*</p> <p>*</p>	<p>*</p> <p>*</p> <p>*</p> <p>*</p> <p>*</p>	<p>5. All states, with preferential support provided to Central and East Darfur</p>
	<p>6. Improvement in quality of education by improving the learning conditions, improving teacher skills, provision of teaching and learning</p>	<p>6.1 5000 school heads and 200 inspectors trained in teachers' supervision and school management</p> <p>6.2 One functional printing press in Darfur region</p> <p>6.3 At least 50 (10 in each state) MoE staff trained in project</p>	<p>6.1 1000 school heads and 200 inspectors in 2014.2000 school heads 2015, 2000 school heads 2016 = \$630,000</p> <p>6.2 Printing press functional by 2018 = \$500,000</p> <p>6.3 50 MoE staff trained in 2013 = \$10,000</p>			<p>*</p> <p>*</p> <p>*</p>	<p>*</p> <p>*</p> <p>*</p>	<p>*</p> <p>*</p> <p>*</p>	<p>6. All states, with preferential support provided to Central and East Darfur</p>

		management and supervision							
		6.4 At least 100 teachers per state completed in service Secondary teachers' capacity development	6.4 100 teachers by state X 5 states X USD 500) = \$ 250,000				*		
		6.5 At least 50 teachers' housing per state build in rural and remote areas	6.5 250 housings X USD 30 000.00 = USD 7 500 000				*		
	7. Strengthen school supervision	7.1 One teachers' training model institute in Darfur region	7.1 functional by 2015 = \$1,000,000					*	7. All states, with preferential support provided to Central and East Darfur
	8. Strengthened the education system to support achievement of national goals and strategic objectives	8.1 Technical support, monitoring, research and knowledge management	8.1 \$1,640,000			*	*	*	8. All states, with preferential support provided to Central and East Darfur

Figure 6: A results framework highlighting 3 main objectives for BSS TWG, their ranked priorities, expected outputs and the indicative costings for each output.

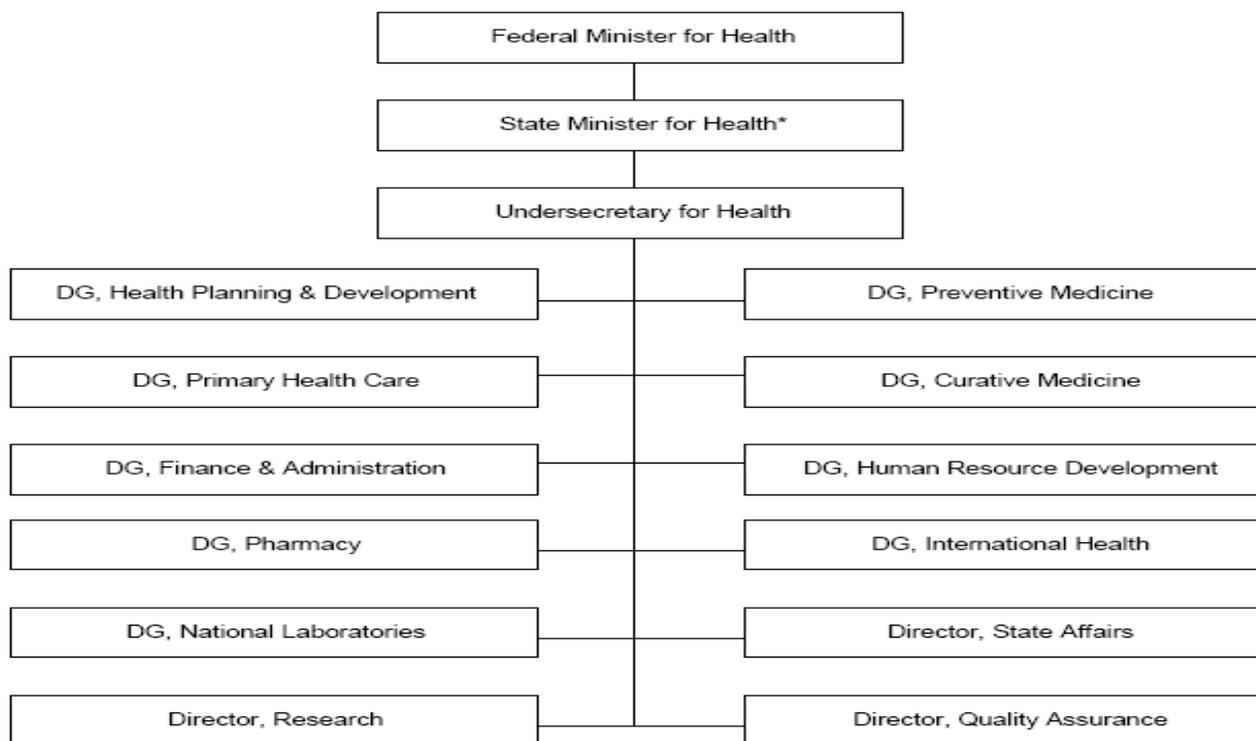
* Whatever is applicable in the DPA and DJAM 2006 Documents is complemented by the DDPD

costing of Instruments is to be done as a subset/portion of the overall costing of the Outputs. These funding requirements are particularly necessary for the Foundational Activities (FAs) if they are to be seen as an early dividend of the Peace process, and be able to start as soon as possible after the conference** FA –

refers to Foundational Activities that need to start within 6-months (targeting community surveys, skill enhancement etc.) as they are crucial to recovery preparation. **ST** - refers to Short-term activities that should be implemented and completed within 24 months. **LT** - refers to long-term activities that are to be implemented during the agreed framework of 6 years

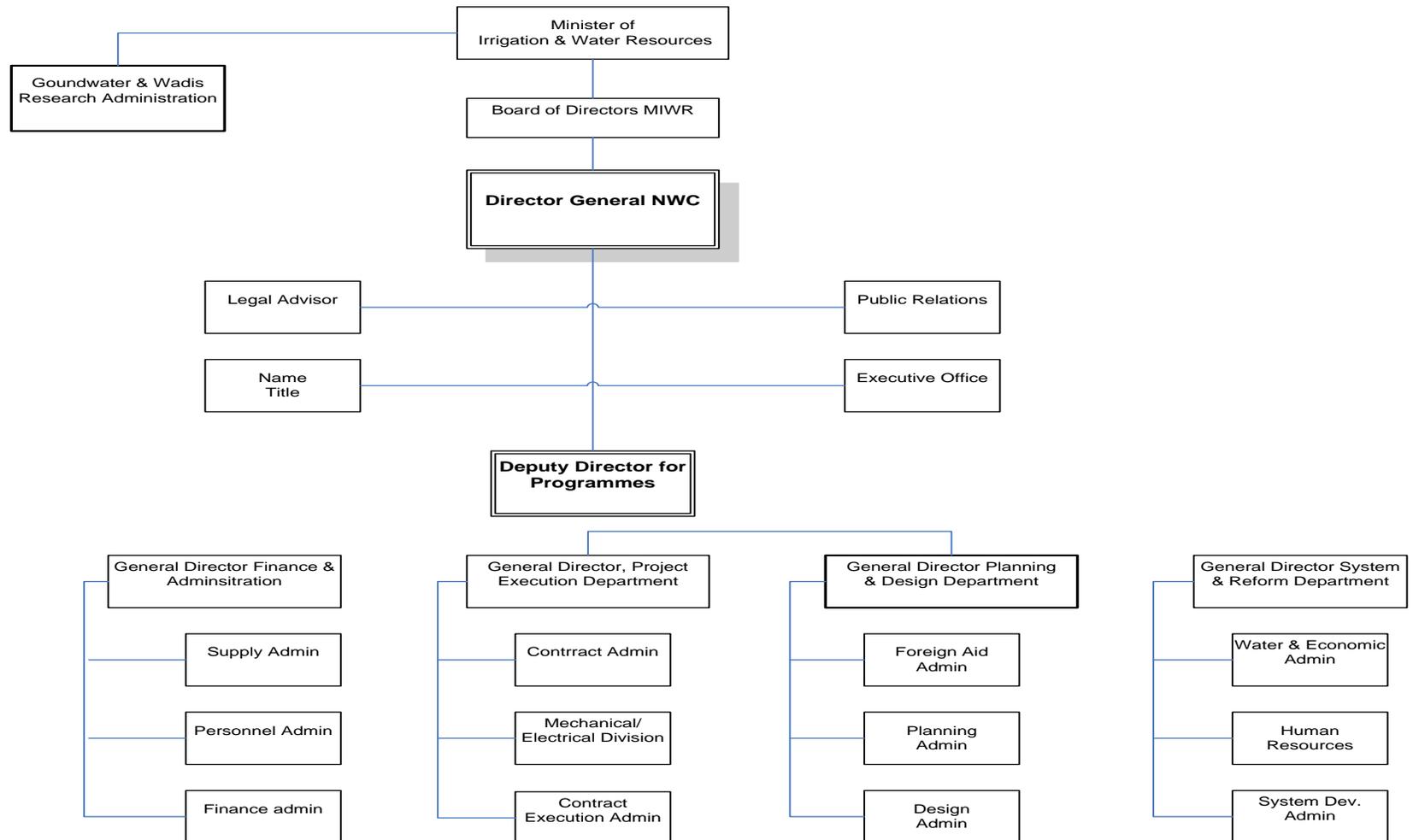
NB: Milestones will be developed as part of the eventual log frames

11 Annex:

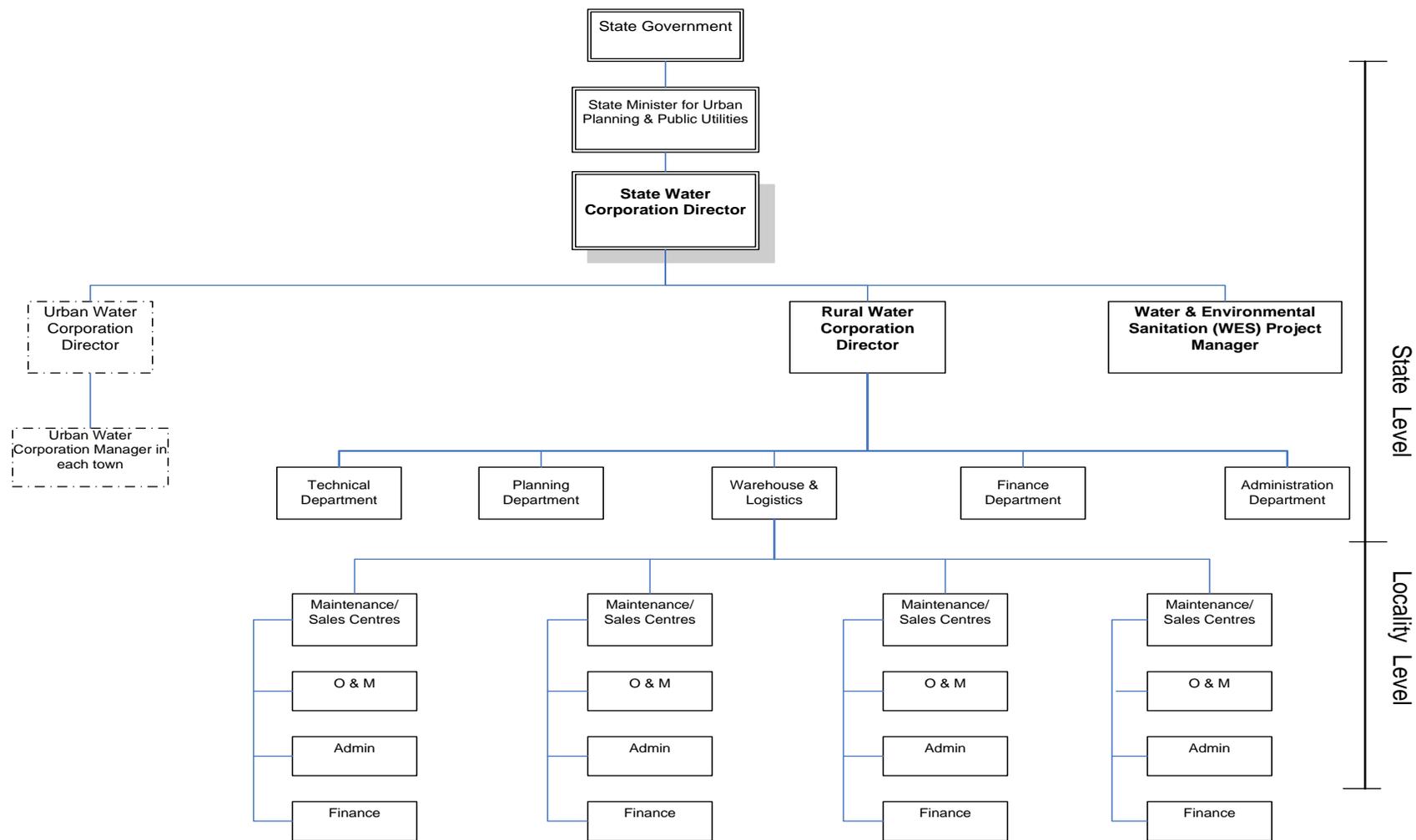


Annex 1: Federal Ministry of Health

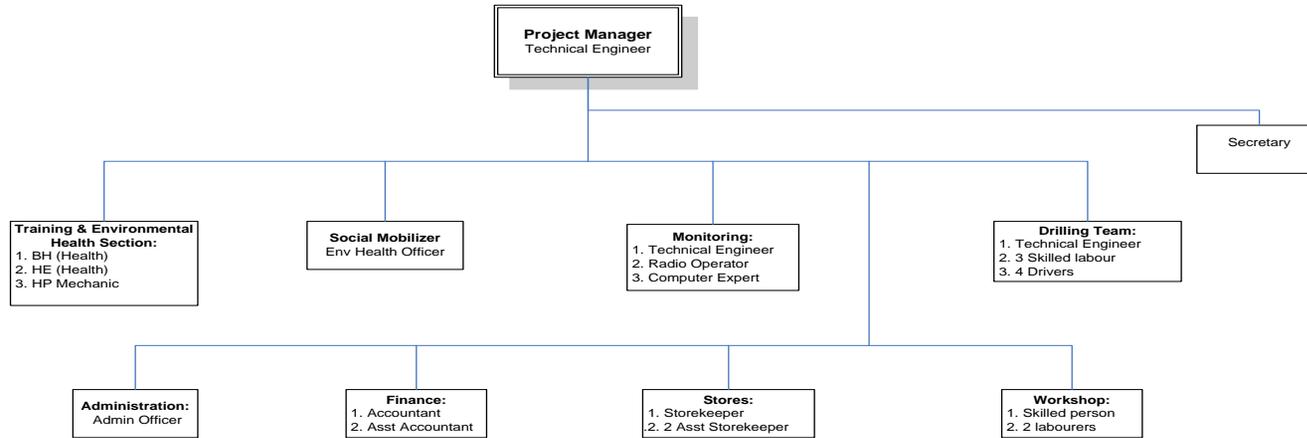
Annex 2. Federal Level National Water Corporation Organizational Structure



Annex 3. State Level Rural Water Institutional Structure



Annex 4. Water and Environmental Sanitation (WES) Project state Structure



Source: World Bank, 2003

