DERO Health and Nutrition Sector Assessment
July 2007

An ACT/Caritas Nutrition Monitor screens for malnutrition in Hamadia Camp, Zalingei.

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1. ACKNOWLEDGEMENTS

It is the hope of the author that this report fully and accurately reflects the health and nutrition activities of DERO's response to the ongoing conflict in South and West Darfur. The author would like to thank staff members from ACT/Caritas, SUDO, Sudanaid, and SCC who went out of their way to provide organizational information, first hand understanding of field activities, and logistical support throughout the assessment.

The author expresses gratitude to the health and nutrition staff that implement and support operations in IDP camps and host communities throughout South and West Darfur. In conjunction with community members and beneficiaries, these individuals provided key insight into the functioning – past, present, and future – of DERO programs in the region. Their availability, enthusiasm, and candid nature provided seminal information to this assessment.

2. ACRONYMS AND ABBREVIATIONS

ACT	Action by Churches Together
AMIS	African Union Mission in Sudan
AU	African Union
CAFOD	Catholic Fund for Overseas Development
CHC	Community Health Committee
CI	Caritas Internationalis
Cordaid	Caritas Netherlands
CPA	Comprehensive Peace Agreement
CRS	Catholic Relief Services
DERO	Darfur ACT/Caritas Emergency Response Operation
DPA	Darfur Peace Agreement
EPRU	Emergency Preparedness and Response Unit
FAO	Food and Agriculture Organization
FC	Field Coordinator
GFD	General Food Distribution
GoS	Government of Sudan
HAC	Humanitarian Aid Commission
IDP	Internally Displaced Person
ITN	Insecticide Treated Nets (mosquito nets)
MoH	Ministry of Health
MoU	Memorandum of Understanding
NCA	Norwegian Church Aid
NFI	Non-Food Item
OTP	Outpatient Therapeutic Feeding Program
PPP	Peace building, Protection and Psychosocial
SCC	Sudan Council of Churches
SLA	Sudan Liberation Army
SFC	Supplemental Feeding Center
SPP	Strategic Planning Process (DERO)
Sudanaid	Caritas Sudan
SUDO	Sudan Social Development Organization
TFC	Therapeutic Feeding Center
UMCOR	United Methodist Committee on Relief
UN	United Nations
UNICEF	United Nations Children Fund
USAID	United States Agency for International Development
Wat/San	Water and Sanitation

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4. EXECUTIVE SUMMARY AND RECOMMENDATIONS

In response to the ongoing conflict in Darfur, the Darfur Emergency Response Operation, or DERO, was formed in June 2004. Funded by over 60 agencies from the ACT and Caritas networks, DERO operates in South and West Darfur through four implementing partners: ACT/Caritas, SUDO, SCC, and Sudanaid. DERO completed a Strategic Planning Process in September 2006, the outcome of which was a mandate to restructure DERO into a support mechanism for national partners. The plan aims to increase SCC, SUDO and Sudanaid's organizational capacity so to directly implement their own programs or to work directly with local partners, CBOs, or government ministries. The plan aims to phase-out all activities directly implemented by ACT/Caritas.

ACT/Caritas and SUDO are the principal DERO partners in the Health and Nutrition Sector, each operating a number of programs that offer primary healthcare services and/or nutritional services. SCC and Sudanaid have well-defined but more limited roles in the Health sector of DERO activities, implementing an HIV/AIDS awareness program and primary healthcare services, respectively. Given the strategic significance of the Health and Nutrition Sector's development, the 2007 Appeal committed DERO to undertaking an assessment of the Health and Nutrition Sector.

The body of this assessment is made up of five geographic area assessments. For each ACT/Caritas field site (El Daein, Kubum, Zalingei, Garsila, and Greater Nyala) the following information are provided: an overview of current activities, including both ACT/Caritas and other agency activities; assessment of local programs' technical capacity; assessment of local programs' organizational and management capacity; discussion of prospects for handover or phase-out of local programs; identification of required capacity developments; and recommendations for future action in the geographical area. Organizational lessons learned, based on the geographic assessment, are then presented for each DERO partner and are followed by overall recommendations.

SUDO

SUDO health and nutrition activities operate with technical integrity in Hamadia and Mershing clinics, however the SUDO operated nutritional clinics in El Daein are lacking this level of technical competency. ACT/Caritas and SUDO share the responsibility of increasing the technical capacity of staff and ensuring proper implementation through improved management in the El Daein clinics.

The organizational management capacity of SUDO is its greatest weakness; its health and nutrition programs lack effective systems of organization, communication, supervision and follow-up. But SUDO cannot be held solely accountable, as ACT/Caritas has an obligation to support and develop the organizational capacity of its national partners. It is recommended that an ACT/Caritas Health and Nutrition Management Advisor be seconded to SUDO's Nyala office. This individual would work with SUDO staff to identify gaps in the existing management system and facilitate the development of organizationally appropriate tools for rectification of those gaps. Among the targeted outcomes of the improved system will be the hiring and retention of competent, qualified staff, improved communication, and reinforcement of reporting lines.

Further, it is recommended that SUDO focus its activities into specialized sectors – those where SUDO is positioned to do exceptionally well. Identification of *what* sectors SUDO should focus on merits a separate study with the intended purpose of identifying organizational strengths and weaknesses; however it is not recommended that health or nutrition be included in the reduced scope of SUDO's work.

Sudanaid

Sudanaid's health and nutrition activities that receive DERO support include the church-run PHC twice weekly at Hicinema clinic and a mobile PHC to Jir, Kereri, and Al Salaam. An additional clinic was planned to open in late July in Bilel, however no reports from this clinic have come in yet. With the exception of food distribution during the months of May and June, the only reported Sudanaid health and nutrition activity on behalf of DERO was out of Hicinema clinic.

Sudanaid appears operate transparently, though technical partners indicate that the quality of care delivered in Sudanaid clinics needs to be improved. Cordaid is working closely with Sudanaid in El Daein to improve quality of care standards. It is recommended that ACT/Caritas contact Cordaid to look at how to collaborate to increase the technical capacity within the organization as phase-out of support progresses.

SCC

SCC plays a much greater role in sectors outside of health and nutrition. As a DERO partner, SCC is not involved in any nutrition activities, and its only health activity is an HIV awareness program in Mershing. The HIV awareness program is running smoothly as one of a number of activities operated by SCC in Mershing. It has 12 members who conduct multimedia IEC sessions in the community. Each session lasts about 2 hours and each of the 12 members rotates through dissemination of a certain component of the presentation.

SCC's greatest challenge is its organizational capacity. All SCC staff were relieved of their duties in mid July, and their DERO programs are staged to be temporarily turned over to ACT/Caritas for implementation. As the technical support partner, ACT/Caritas has an obligation to SCC, not only to support its programs during this transition, but to play an active role in rebuilding SCC as a more effective organization. The recommendation of how and in what capacity ACT/Caritas supports SCC in its reconstruction should come from SCC, however ACT/Caritas should be willing to invest the financial and human resources necessary.

ACT/Caritas

All DERO partners struggle to fill and keep qualified staff, which causes obvious problems in terms of reporting, follow-up, training, and routine operation of activities. However, additional problems are created when staff are bounced from one post to another. There is an extensive history of "post coverage" of this sort within ACT/Caritas, the impact of which has been arguably detrimental to overall programs. It is therefore recommended that this strategy of "post coverage" be used sparingly.

As part of the Strategic Plan, ACT/Caritas looks to phase-out support of current programs and handover to existing partners. Given the variability of contexts within which the health and nutrition programs operate, ACT/Caritas should develop standards by which the appropriateness of handover is determined. Recommendations for consideration during the development of handover criteria are included in this report (8.1.4.2.).

National partners are confused and frustrated by ACT/Caritas's role in the partnership. In order to rectify this situation three action points are recommended: to revitalize the appropriate use of the name ACT/Caritas instead of NCA where possible; to develop TOR for ACT/Caritas staff which are explicit as to their role and responsibility to all partners, particularly program positions and FC positions; and to develop an MoU among all four members of the DERO partnership, defining partnership and the roles and responsibilities of each partner.

Although directly implemented programs of ACT/Caritas appear to be running smoothly and effectively, the success of these programs should not overshadow ACT/Caritas's failure to fulfill the rest of its commitment to the partnership, to maximize the contribution of partner programs. In addition, ACT/Caritas is required by the Strategic Plan to phase-out and handover its directly implemented programs to partners. Thus, in order to more effectively reach both its original mandate and that of the strategic plan, the following action points are recommended: to reduce ACT/Caritas directly implemented programs in favor of support national partner programs (which may include MoH) through support of effective handover practices (see 8.1.4.2. Handover); to second ACT/Caritas staff into national partner offices and programs where appropriate; to focus on organizational and management trainings rather than technical trainings; and to decentralize authority so that FCs can effectively respond to both partner and community needs on the ground.

Recommendations

- ACT/Caritas should second a Health and Nutrition Management Advisor to SUDO's Nyala office in order to increase organizational management skills of health and nutrition programs.
- SUDO should begin narrowing scope of activities into fewer sectors in order to establish an organizational niche; consider independent organizational assessment to determine which sectors, though informal assessment indicates education and PPP.
- ACT/Caritas should contact Cordaid and offer collaboration in Cordaid's efforts to increase the technical capacity of Sudanaid in health and nutrition activities.
- ACT/Caritas should extend an offer of support, and SCC and ACT/Caritas should collectively identify in what capacity ACT/Caritas can most effectively contribute to the organization's reconstruction.
- ACT/Caritas should use the strategy of "post coverage" sparingly, particularly when the abandoned post normally makes direct investment into national partners.

- ACT/Caritas should develop a set of standards by which appropriateness of health/nutrition clinic handover or closure is determined.
- ACT/Caritas should revitalize the appropriate use of the name ACT/Caritas instead of NCA where possible.
- ACT/Caritas should work with CAFOD to develop TOR for ACT/Caritas positions which are explicit regarding the role and responsibility of the position to all partners, particularly program positions and FC positions.
- ACT/Caritas, SUDO, Sudanaid, and SCC should meet to develop a MoU which defines partnership, capacity building, and the roles and responsibilities of each partner.
- ACT/Caritas should continue to reduce directly implemented programs in favor of support of national partner programs (which may include MoH).
- ACT/Caritas should second staff into national partner offices and programs when and where appropriate, present to SUDO offices in El Daein and Nyala.
- ACT/Caritas should focus on organizational and management trainings rather than technical trainings for national partners.
- ACT/Caritas should decentralize authority so that FCs can effectively respond to both partner and community needs on the ground.
- ACT/Caritas should second an administrator/program officer to SUDO's office in El Daein.
- SUDO should invest in operational and technical effectiveness of Wazazeen and Sunta PHCs in preparation for handover to MoH; the first step of which should be development of a rigid monitoring schedule and reporting requirements.
- ACT/Caritas should train all current and previously handed over CHCs as soon as possible.
- ACT/Caritas should conduct bimonthly monitoring visits to CHCs for six months post CHC training.
- ACT/Caritas should initiate discussions and formal negotiations with CARE for the provision of support to Kubum Hospital and Umlabassa PHC/SFP.
- ACT/Caritas should finalize the MoU with MoH to detail handover and responsibilities of each party to the PHCs in Kubum.
- CHCs should reintroduce user fees as soon as possible at PHCs in Kubum.
- ACT/Caritas should develop a timeframe for the gradual reduction and ultimate removal of incentives to health and nutrition staff in Kubum.
- ACT/Caritas and MOH should support CHCs in negotiations with UNICEF and WHO to secure drug supply to PHCs as part of the handover process.
- ACT/Caritas should ensure procurement of hand pumps for previously drilled boreholes and implementation of appropriate training to water committees before final pullout.

- ACT/Caritas should ensure that hygiene promotion tools are photocopied and laminated for community education sessions in each PHC before final pullout.
- ACT/Caritas should coordinate with IMF and IRC to develop and implement a health screening that accompanies registration of new arrivals to the IDP camps in the area.
- ACT/Caritas should decentralize authority enough so that FC can effectively respond to recognized needs, including program developments and capacity building.
- ACT/Caritas should encourage WFP's decentralization so that DERO and other partners receiving food aid can work directly with WFP in Zalingei.
- ACT/Caritas should encourage three-month food supplies from WFP to avoid stock breakages, particularly to tertiary sites.
- ACT/Caritas should financially support the MoH and UNICEF in the construction of a TFC in Zalingei hospital.
- ACT/Caritas should include the train of CHCs at Kurdol Clinic and Deba Camp Clinic in its program for CHC trainings in Zalingei.
- ACT/Caritas should take an active role in facilitating communication between the CHC, MoH, and IMC at Kurdol clinic to ensure sustainability of clinical operations.
- ACT/Caritas should continue to support the SFP in Kurdol until GAM of target population is less than 15%; if GAM is not known, a rapid assessment should be conducted.
- ACT/Caritas should retain the Nutrition Supervisor in Garsila to increase field office technical expertise in health and nutrition.
- ACT/Caritas should provide ITNs to Deba Camp Clinic for distribution to pregnant women.
- ACT/Caritas should provide a number of NFIs to the TFC at Garsila hospital and should rehabilitate the current temporary extension to be a permanent structure, increasing the patient capacity of the TFC.
- ACT/Caritas should assess the current inventory of equipment at Deba Camp Clinic and donate unusable equipment to Garsila Hospital.
- ACT/Caritas should second a Health and Nutrition Management Advisor to SUDO's Nyala office.
- ACT/Caritas should call a meeting as soon as possible to resolve current reporting/drug supply issue at Mershing Health Center.

5. INTRODUCTION

5.1. Darfur Context

The current crisis in Darfur began in early 2003 when rebel forces launched attacks against the Government of Sudan (GoS), challenging president Omar al-Bashir. President al-Bashir's troops allied with armed militia groups largely of Arab decent, responded with force and determination, brutally attacking Darfuri villages throughout the region. Through violence, disease, and food insecurity, the conflict in Darfur is estimated to have claimed 400,000 lives since its inception four years ago. An additional 2.3 million Darfuris are currently living in internally displaced persons (IDP) camps throughout Darufur, which are operated and supported by humanitarian aid organizations.

In May 2006, the Darfur Peace Agreement offered hope that an end to the crisis might be near. The GOS and one of three feuding rebel groups signed the agreement. Initial hopes that the remaining two factions would sign the DPA quickly dissipated. Since that time, rebel groups have splintered further, with new infighting erupting among rebels as well as with GOS forces. There are currently 7,400 African Union (AU) troops in Darfur whose mandate is to monitor and report ceasefire violations. The GOS have strongly resisted international pressure to replace or reinforce AU troops with United Nations (UN) forces.

The result of these developments has been a sharp deterioration in the security and humanitarian situation since May 2006. Since the beginning of 2007, an estimated 140,000 people have been identified as newly displaced, 10,000 of whom were displaced in May alone[1]. In the first six months of 2007, 57 humanitarian aid vehicles were hijacked and 6 humanitarian compounds were broken into. The increase in attacks on humanitarian personnel creates new challenges for humanitarian organizations working in the region.

5.2. DERO

In response to the ongoing conflict in the Darfur, a coalition of humanitarian organizations came together in June 2004 to form DERO, the Darfur Emergency Response Operation. Funded by over 60 agencies from the ACT and Caritas networks, DERO operates in South and West Darfur through four implementing partners: ACT/Caritas, SUDO, SCC, and Sudanaid.

The Memorandum of Understanding (MoU) signed between ACT, Caritas Internationalis, NCA, and CAFOD in July 2004 identified the objectives of the joint ACT/Caritas response operation in Darfur as being:

1. To maximize the response of the ACT Alliance and Caritas Confederation to the crisis in Darfur so as to honor their duties under the humanitarian imperative;
2. To uphold the value of partnership and ensure that partners are able to maximize their contribution to the humanitarian response in Darfur;

[1] Marie Okabe. "Highlights of the Noon Briefing." UN News 7 June 2007.

3. Where necessary, to develop an operational response to enable the ACT and Caritas to meet the difference between 1 and 2 above; and
4. To coordinate, use and maximize the resources of ACT/Caritas and to establish programs through which the members of the ACT and Caritas can channel their human, financial and other resources.

DERO completed a Strategic Planning Process (SPP) in September 2006. The SPP was overseen by a taskforce which included representatives from the Darfur, El Obeid and Khartoum levels of the implementing partners and Country Representatives of the two lead agencies (NCA and CAFOD). The outcome of the SPP was a mandate that restructures DERO into a support mechanism for national partners. The plan aims to increase SCC, SUDO and Sudanaid's organizational capacity so to directly implement their own programs or to work directly with local partners, CBOs, or government ministries. The plan aims to phase-out all activities directly implemented by ACT/Caritas.

Health/Nutrition is one the largest sectors within DERO, both in terms of expenditure and number of staff. ACT/Caritas and SUDO are the principal DERO partners in the Health and Nutrition Sector, each operating a number of programs that offer primary healthcare services and/or nutritional services. SCC and Sudanaid have well-defined but more limited roles in the Health sector of DERO activities, implementing an HIV/AIDS awareness program and primary healthcare services, respectively. Given the substantial portion of DERO health/nutrition activities directly implemented by ACT/Caritas and the highly technical nature of some health/nutrition activities, the appropriate and timely evolution of the Health and Nutrition Sector is seminal to ultimate alignment with the Strategic Plan.

Given the strategic significance of the Health and Nutrition Sector's development, the 2007 Appeal committed DERO to undertaking a sector review for Health/Nutrition. The full Terms of Reference for the Health/Nutrition assessment are included in Appendix 1.

6. OBJECTIVES AND METHODOLOGY

As outlined in the Evaluation Terms of Reference (see Appendix 1), the objectives of this report are:

- To review the performance, achievements, challenges, and capacity (organizational and technical) of all DERO members
- To review progress and evaluate existing phase-out and handover processes;
- To ascertain which component of each sector should be phased-out or handed over and in the latter case, to whom and over what timeframe;
- To conduct a mapping exercise of other agencies/departments (eg. Other NGOs, WFP, UNICEF, WES and MoH) that operate or plan to operate in DERO areas to ensure DERO operations are adding value as opposed to duplicating the humanitarian services of others;
- Where DERO members show potential to progress and improve, to identify what capacity development inputs would be required;
- To enhance DERO members' understanding of their long-term priorities/ commitments, sectorally and geographically, and how this relates to their current capacities and performance; and
- To set progress indicators for proposed recommendations.

The consultant utilized a mixed-method approach to complete the assessment which included the following elements:

- Semi-structured interviews with partners staff;
- Document review and key briefings in Nyala, prior to field work;
- Key informant interviews with implementing partner staff, in Nyala and the field;
- Qualitative data collection (focus groups, interviews) with program beneficiaries;
- Site visits for observation of ongoing programs;
- Semi-structured interviews with health agents, project staff, volunteers, partners, other NGOs, and beneficiaries; and
- Review of documents and primary/secondary data collected in the field.

The fieldwork for this assessment was conducted from July 2 – 27, 2007 by Sarah McKune, an independent global health consultant. A timetable of all field research conducted is presented in Appendix 3. ACT/Caritas funded the assessment, though the views expressed herein are those of the consultant and do not represent any official view of DERO or its partnering agencies.

Over the course of this assessment, it became clear to the consultant that several of the obstacles facing the Health and Nutrition Sector took root in larger, organizational level constraints. On July 14, the consultant met with the DERO director to discuss the appropriateness of including commentary and analysis of DERO/organizational level issues within the health and nutrition assessment. Given the direct implications of the certain organizational constraints on DERO's health and nutrition programs, the director agreed to their relevance and inclusion in this report.

7. ANALYSIS AND COMMENTARY

The body of this report is made up of the analysis of health and nutrition activities within each of five field sites. In each location (El Daien, Kubum, Zalingei, Garsila, and Greater Nyala) an overview of activities is presented, including DERO program activities and the presence and programs of other NGOs or actors in the area. The overview is followed by an assessment of the technical and organizational/management capacity of DERO partner programs in the area. Technical capacity in this assessment focuses on the clinical and technical skills appropriate and specific to clinical health and nutrition programs. In the field these are the skills required of clinical staff, vaccinators, nutrition monitors, community health workers, pharmacists, and others who perform specialized tasks for the operation of health or nutrition clinics. Organizational and management capacity addresses the overall operation of the program and reaches beyond the clinic level through field offices to Nyala and Khartoum. Issues surrounding reporting may fall under technical capacity or organizational/management capacity, depending upon the nature of the problem. After capacity is assessed, the prospect of phase-out or handover is then explored for each site, followed by a discussion of future capacity development for the area. Finally, recommended future action points are outlined for each geographic area.

7.1. El Daein

7.1.1. Overview of Activities

El Daein is located in the El Daein locality in the state of South Darfur. All DERO health operations in the area have all been conducted through SUDO and have included five supplemental feeding programs (SFP) with health clinics in two of those five areas. Khor Omer, Al Neem, and Saleah nutrition programs are operating within IDP camps, while Sunta and Wazazeen are located within target host communities. Sunta and Wazazeen both have primary healthcare centers (PHC) run by SUDO that operate concurrently with the nutrition programs.

El Daein currently has a number of NGOs working in the region: SUDO, NCA, WES, Solidarité, Cordaid, Merlin, WFP, and Tearfund. The organizations work closely with HAC to coordinate efforts, as OCHA is not currently present in the area.

7.1.2. Technical Capacity

The technical capacity of SUDO staff in El Daein is weak and stands to be improved. A Nutrition Monitor and five Nutrition Workers operate each nutritional center. They are to provide health education, collect anthropometric measurements, register each patient/visit, and mix/distribute appropriate food rations. The nutrition team members have varying degrees of training and understanding of nutrition, and information given by team members is sometimes self-contradicting. Beneficiaries do not have a clear understanding of health/nutrition messages and are unclear as to the overall functioning of the SFP.

ACT/Caritas sent a Nutrition Advisor to El Daein in May 2007 in an effort to increase the technical aptitude and performance of SUDO operating clinics. The Nutrition Advisor

worked with SUDO office and clinic staff in El Daein and some improvements were made.

Partners and stakeholders, including WFP, MoH, Tearfund, have all indicated frustration with and problems in the SUDO nutrition clinics. These difficulties have contributed to poor record keeping and inadequate surveillance, which make interpreting the nutritional status of beneficiaries in the centers very difficult. For example, until recently children admitted to the program who were lost to follow up but reappeared were registered as new admissions upon their return. This type of technical error stands to significantly alters epidemiologic data coming from the nutrition centers.

Cure rates for SUDO's nutrition programs in El Daein (includes Bilel) in May and June are just within SPHERE standards, at 77.6% and 78.9%, respectively. The defaulter rate for May and June increased from 14% and 15.4%, surpassing the SPHERE standard of 15%. Cure rates and defaulter rates for January through April are presumably artificially inflated and deflated, respectively, because they are aggregated with data from Kubum nutritional programs (cure rates of 87%, 86%, 87.3%, and 80.8%; and defaulter rates of 10%, 22%, 5.5%, and 8.8%). When reported data are presented in disaggregated form, beginning in May 2007, Kubum's performance improves dramatically, while El Daein's performance deteriorates.

Security has been a heightened concern in the past two months in El Daein. Movement has been restricted due to increased looting and banditry, and four NGO vehicles (including one of SUDO's) were hijacked in early July. Insecurity in the region has limited the effectiveness of SUDO's operations, drawing the nutrition program in Wazazeen to a halt in June, and stopping clinical services in Saleah, Wazazeen, and Sunta as of July 1. Because of insecurity in the area, the consultant was unable to visit Sunta and Wazazeen, where SUDO is operating PCH activities.

7.1.3. Organizational and Management Capacity

The lack of organizational and management capacity in SUDO operated Nutrition Clinics over the past six months has been a detriment to the clinics and has precluded the programs there from effectively benefiting the population they aim to serve. ACT/Caritas, WFP, and MoH have all documented their frustration with the SUDO operation in El Daein. Each has a history of some collaborative effort to assist and improve SUDO's efforts. However, staff shortages and turnover, insufficient monitoring, stock breakages and general non-response have brought operations to a near halt.

A break in food supply in April led to no new admissions in SUDO clinics throughout the area. Additionally, insecurity in the region ceased all activity at the Wazazeen clinic in June, thus reporting from the SUDO operated nutritional clinics in El Daein is very limited.

7.1.4. Phase-out/Hand-over Plan

The ACT/Caritas and WFP contract beginning in July 2007 does not cover SUDO nutritional clinics in El Daein as it has previously. Since July 1, 2007, SUDO nutrition

centers have been supported instead by a Tearfund contract with WFP; as Tearfund has agreed to work with SUDO in an attempt to more effectively operate the nutrition centers in the area. WFP, MoH, and ACT/Caritas all expressed sincere concern surrounding SUDO's ability to continue operating the centers, however due to a desire to eliminate gaps in any existing coverage, WFP opted to work with Tearfund to support SUDO. WFP are currently not willing to contract directly with SUDO. Tearfund have agreed to work with SUDO for up to 6 months in an attempt to remedy the operational failings of the programs. Based on performance at that time, WFP will determine with whom the subsequent contracts will be made.

Thus, the five nutrition centers previously contracted to ACT/Caritas and implemented by SUDO have been handed over to Tearfund, as of July 1, 2007.

The remaining DERO activities in the area are the PHC in Sunta and Wazazeen. As previously mentioned, these centers have not been operational this month due to insecurity in the region. The MoH staff were pulled out of clinics and into El Daein on July 1.

7.1.5. Capacity Development

Tearfund is currently charged with oversight of the former ACT/Caritas supported SUDO operated nutrition clinics. However, investment in the organizational and management capacity of SUDO will increase the quality of programs in the remaining PHCs and increase the future viability of their nutrition programs.

Capacity development in El Daein should focus on organizational capacity building so that SUDO is better equipped to recruit and hire appropriate staff; has a better understanding and practical application of management, budgeting and reporting, so to retain staff; and has an increased capacity to respond to opportunities and needs within the community. Future capacity building should include the development of a strict monitoring schedule of Sunta and Wazazeen PHCs. SUDO should establish benchmarks in the evolution of these PHCs so that appropriately timed handover to MoH can be planned and executed. It is therefore recommended that ACT/Caritas second an administrator/program officer to SUDO's El Daein office.

ACT/Caritas has a responsibility to its DERO partners to provide technical support and build their management capacity, particularly when these areas are so weak as to threaten the viability of a program. The evolution of activities in El Daein does not demonstrate the type of support and partnership outlined in the MoU that was developed at the creation of the DERO partnership. If ACT/Caritas had seconded a Nutrition Advisor to El Daein in late 2006 when reporting problems and complaints from partners began, perhaps the current situation could have been averted.

7.1.6. Recommended Future Action

- ACT/Caritas second an administrator/program officer to SUDO's office in El Daein.

- Increase operational and technical effectiveness of Wazazeen and Sunta PHCs in preparation for handover to MoH; the first step of which should be development of a rigid monitoring schedule and reporting requirements.

7.2. Kubum

7.2.1. Overview of Activities

Kubum is located 157 km west of Nyala in Edd All Fursan locality in the state of South Darfur. ACT/Caritas has operated health and nutrition activities in Kubum since June 2004 and is the only NGO operating from Kubum. Their efforts have included support of PHC, nutrition programs, construction of latrines, digging of boreholes, and development of peace building, protection, and psychosocial (PPP) capacity. CARE International is currently partnered with WFP and has been providing general food distributions to the area monthly from their base in Mukjar.

ACT/Caritas health and nutrition activities in Kubum are currently providing operational support to MoH in PHCs in Dagadousa, Umlabassa, Bulbul, Diri, Kubum Camp, and Kubum Town; a mobile PHC in Hassaballa; and Kubum Hospital. Nutrition programs are operating concurrently in Kubum Town, Kubum Camp, and Umlabassa. ACT/Caritas is providing work incentives to non-MoH funded staff and top-up incentives for MoH salaried staff. Thus ACT/Caritas support is largely funding support staff and drugs. ACT/Caritas is currently working to train Community Health Committees (CHC) which are already established in conjunction with each PHC. The training aims to build the capacity of key leaders in mobilizing community resources towards the sustainability of health services. Health education has been integrated into each aspect of ACT/Caritas's health/nutrition efforts in Kubum: through the PHC, nutrition programs, and CHCs, ACT/Caritas staff work one on one and in groups to educate the community on good health and hygiene practices.

The impact of ACT/Caritas's Wat/San sector on improved health and nutrition in the area cannot be overlooked. Extensive drilling of boreholes and installation of hand pumps (over 90 in the area) has increased the community's access to safe water. Installation of a bladder in Kubum Camp has relieved some of the tension previously existing around water supply. And the ongoing construction of new latrines throughout Kubum Camp and the surrounding area has kept the incidence of Ecoli and other waterborne diseases to a minimum. Given the extremely high water table in the Kubum area, inevitable correlation between health/nutrition and water/sanitation is stronger than in most other locations.

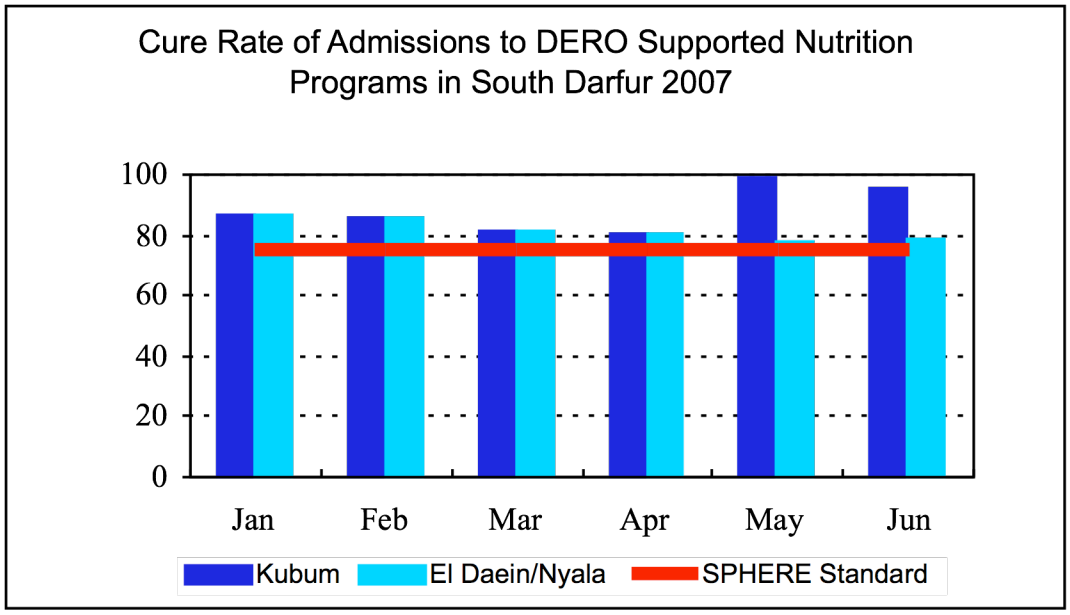
7.2.2. Technical Capacity

A product of three years' investment into trainings and services, the technical capacity of health and nutrition programs in Kubum is good. Current health programs in six clinics, Kubum Hospital, and one Mobile Clinic include curative, preventative and reproductive health services. Routine vaccination and health education is packaged within preventative health services in each location. Nutrition programs in Kubum have evolved since inception in 2004 from blanket feedings to the current operation of two SFP and

OTP programs. Project staff in the health and the nutrition programs have received extensive training through workshops and on the job training.

Reporting from the health as well as nutrition centers in Kubum is good. There was some concern expressed surrounding a reported 100% cure rate within the nutritional program at Umlabassa for. However, records on site indicate that all children admitted into the program have reached or exceeded their target weight for two consecutive visits before 16 weeks has passed. This is in alignment with SPHERE standards for monitoring and classification of a child's nutritional status.

While the cure rate of all DERO partner nutrition programs operating in South Darfur has been well within the SPHERE standard of 75% for all of 2007, the rates have increased dramatically for Kubum since May when nutrition activities in El Daein/Nyala were separated from activities in Kubum. ACT/Caritas operated nutrition centers in the Kubum corridor boasted cure rates of 98.9% and 96% in May and June, respectively.



Likewise, the defaulter rate in Kubum went down dramatically when data are disaggregated from El Daein data; rates for May and June, respectively, were 1.1% and 2.4%, well with the SPHERE standard of 15%.

7.2.3. Organizational and Management Capacity

The organizational and management capacity of ACT/Caritas demonstrated in the health and nutrition centers in and around Kubum is good. The Health and Nutrition Advisor in Kubum has a firm understanding of the local context, and is effective in mobilizing community members to take action towards sustainability. He has developed an extensive training module for the CHC which was pilot tested in Hassaballa and Umlabassa. The benefits of the training are clear in those communities, as the CHCs are working with the clinics to develop creative, grassroots solutions to the health needs of

the community. In Hassaballa, the community has mobilized to build semi-permanent structures for the mobile clinic and has collected money through a user fee on the hand pumps to pay for the guard and cleaner at the clinic. By contrast, clinics and centers that have not yet been trained express a sense of entitlement to ACT/Caritas support and present long lists of needs with little confidence in finding their own solutions.

Within the PHC and nutrition programs, staff are keeping careful records and are reporting to Nyala in a timely manner.

7.2.4. Phase-out/Hand-over Plan

The current plan for Kubum is to phase-out and handover all ACT/Caritas support by December of 2007. There have been ongoing discussions with State and Federal MoH, the latest meeting being held July 24, 2007 in Nyala. It is the recommendation of the assessor that the final handover plan include the following:

1. CHC Training: ACT/Caritas should complete training of all CHCs (Kubum Hospital/Town [shared CHC], Kubum IDP Camp, Diri, Bulbul, Dagadousa, Bido, Falanduge, and Damba Ali Clinics). Perhaps the most vital element in successful handover of clinics to the community, the CHC trainings should be completed by the end of August and bimonthly monitoring visits should be made for six months thereafter (October, December, and February). During the six-month monitoring, ACT/Caritas should provide satellite support and capacity building where possible.

2. MoH Support of Staff and Implementation User Fees: ACT/Caritas should work with MoH to ensure that MoH staff replace ACT/Caritas staff working in clinics without gaps in coverage and to ensure that a drug supply, whether from a revolving fund or from and agreement with UNICEF, WHO, or another partner, is in place. MoH should begin working with CHCs to establish the implementation of user fees as soon as possible. Early establishment will allow for a transition phase as CHC determine and staff become accustomed to criteria used in identifying exemption of a user fee and otherwise regular collection.

3. CARE International: Umlabassa Clinic (health and nutrition programs) and Kubum Hospital should be handed over to another NGO, possibly CARE International. CARE International has expressed interest in expanding services in the Kubum area. CARE's interest is in supporting rural areas, particularly via nutrition programs and potentially by adding one additional PHC. The Kubum hospital serves beneficiaries throughout the rural areas surrounding Kubum and Umlabassa Clinic serves the rural community of Umlabassa (mix of host community and IDPs).

4. ACT/Caritas Phase Out: ACT/Caritas should implement a gradual reduction in incentives currently paid to staff. This reduction should be timed with the introduction of user fees so that the community may begin its own cost recovery and support of operational staff. Specific attention should also be paid to Kubum Camp Clinic which will be operating with only MoH and CHC support. ACT/Caritas should additionally provide six months of monitoring of PHCs after they have been handed over to MoH;

though twelve months is optimal, ACT/Caritas organizational constraints eliminate that possibility, thus six months should allowed.

7.2.5. Capacity Development

Capacity development in Kubum must come through the CHC and the MoH. ACT/Caritas has provided multiple training for medical staff who are technically well positioned to continue health services. Two CHC have been trained and the remainder will be trained in August 2007. ACT/Caritas has been effective in building the capacity of local communities and MoH throughout Kubum, which will contribute to a successful handover as ACT/Caritas pulls out of the area.

7.2.6. Recommended Future Action

- Training of all current and previously handed over CHCs
- Bimonthly monitoring visits to CHCs and clinics for six months post handover
- Negotiations with CARE to support Kubum Hospital and Umlabassa PHC/SFP
- Negotiations with MoH to detail handover and responsibilities of PHCs
- Implementation of user fees (through MoH)
- Gradual reduction and final removal of NCA incentives
- Secure UNICEF or WHO drug supply to PHCs prior to handover
- Hand pumps for previously drilled boreholes and appropriate training
- Hygiene promotion tools photocopied and laminated for community education sessions

7.3. Zalingei

7.3.1. Overview of Activities

Zalingei, located in east West Darfur state and in the locality of Zalingei, is home to over 100,000 IDPs, spread out over four IDP camps: Hassa Hissa (estimated population 50,000), Hamadia (estimated population 37,000), Kamsadagaig (estimated population 17,000), and Taiba (estimated population 4,000). DERO partners play a major role in delivering the health and nutrition services to both the host and IDP populations in Zalingei. ACT/Caritas operates a PHC and SFP in Hassa Hissa Camp Clinic, a PHC in Hassa Hissa Dispensary, and a PHC and SPF in Kamsadagaig Camp (clinic and nutrition center in two separate locations). SUDO operates a PHC and SFP in Hamadia Camp Clinic.

A number of NGOs and partnering agencies are currently working in health and nutrition throughout Zalingei, including ACT/Caritas, SUDO, MSF-F, IMC, and the MoH. WFP and UNICEF both have an office in Zalingei and work with partners throughout the area. Currently, none of the traditional nutrition-oriented NGOs are working in Zalingei (Concern, World Vision, ACF).

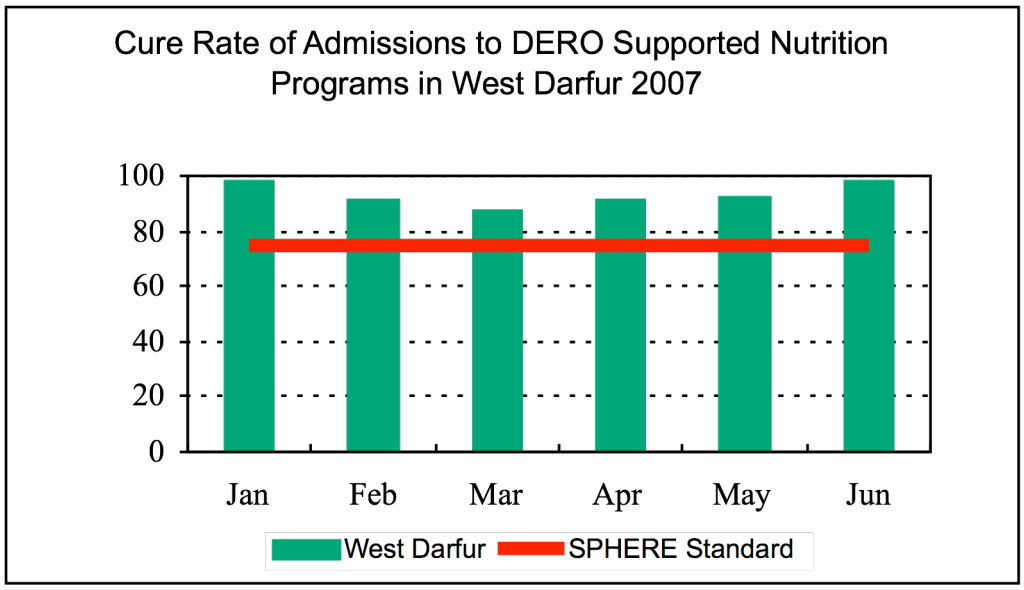
Given the breadth and depth of DERO partners' health interventions and the very limited nature of the site visit to Zalingei (less than 48 hours), attention was focused on health and nutrition activites, although DERO partners are currently implementing a wide array of programs. Some examples of DERO programs with direct links to health include

extensive Wat/San activities, PPP programs that address mental health, and a camp nursery that distributes seedling to IDP households throughout the camp.

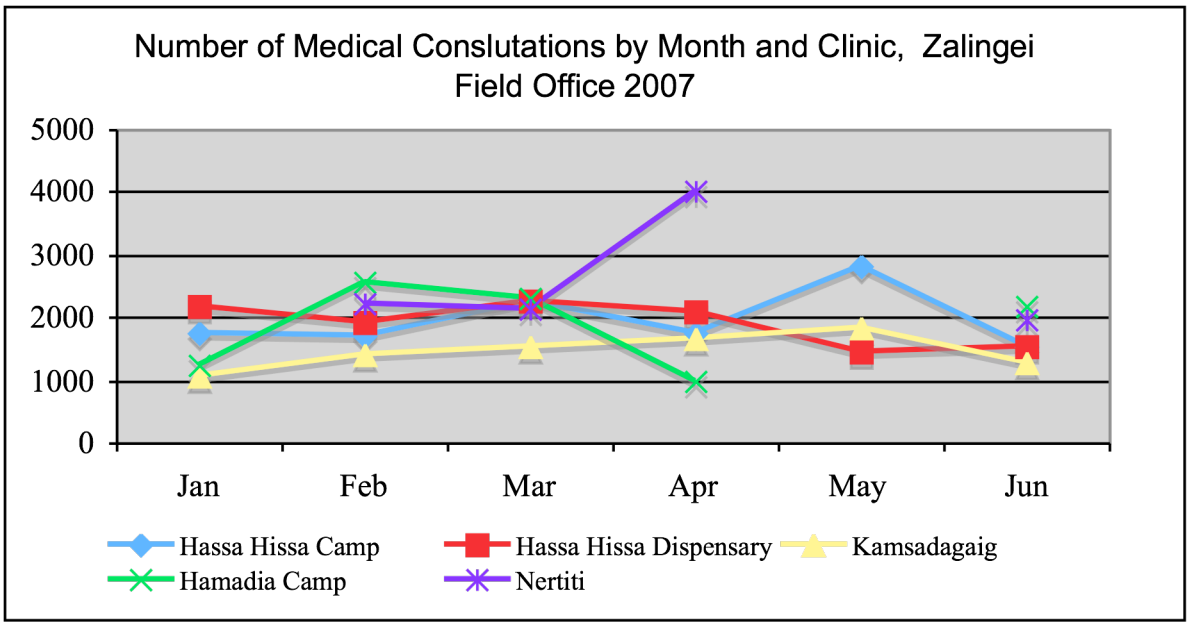
7.3.2. Technical Capacity

The overall technical capacity of SUDO and ACT/Caritas staff in Zalingei to operate its current health/nutrition programs is good. Staff within SUDO and ACT/Caritas nutrition programs are well trained in collection of accurate anthropometric data and careful reporting procedures. Records kept within the nutrition clinics are in alignment with standards set out by the DERO partnership at the beginning of the program. Rations are appropriately mixed, measured and bagged. Nutrition staff understand the health messages they disseminate, although techniques for improving beneficiary comprehension, including varying the message delivery and technique, could be improved. Medical staff at Hamadia, Hassa Hissa, and Kamsadagaig Camp Clinics appear to be well trained and have a solid grasp of the technical skills required for their individual work. Both NCA and other partners, such as MoH or UNFPA, have trained the medical assistants, midwives, nurses, pharmacists, and vaccinators within their area of expertise.

The nutrition programs in Zalingei have seen a steady increase in the number of new under-five admissions over the past five months. Despite the recent increase, West Darfur nutrition programs (includes three in Zalingei plus one in Kurdol) have consistently maintained cure rates and defaulter rates well within SPHERE standards. These data are presented below.



Conversely, Zalingei PHCs have seen a slight decrease in number of consultations recently, although the six-month trend in admission shows insignificant change. See chart below.



Mosquito nets are not currently being distributed in any of the DERO health clinics or at the TFC at Zalingei Hospital. ACT/Caritas should procure enough ITNs so that PLW who attend DERO supported antenatal clinics, as well as malnourished children who are discharged from the TFC, all receive an ITN to take home.

The overall technical capacity of staff within DERO health and nutrition clinics does not appear to be a problem. The only exception to that would be the lack of staff support for SUDO at a Zalingei office level. Though discussed further in the next section, the lack of health/nutrition support staff within the Zalingei field office may ultimately manifest itself to the detriment of the PHC and nutrition programs it operates.

7.3.3. Organizational and Management Capacity

Though the organizational and management capacity of DERO health and nutrition programs in Zalingei is fair, it stands to improve in two major areas: communication and structure. A major impediment to effective programming, communication is breaking down between ACT/Caritas Zalingei and Nyala, between SUDO Zalingei and Khartoum, and between DERO partners and other key players, such as WFP and UNICEF. This lack of communication has effects not only in Zalingei areas of intervention, but also in Garsila, where supplies are sent from Nyala via Zalingei. One recent example of breakdown in multiple layers of communication resulted in a stock breakage of CSB that has presently lasted 3 months (May, June, July). Though Nyala made the request in a timely manner, WFP failed to meet the supply request and ACT/Caritas in Zalingei failed to notify ACT/Caritas in Nyala that no CSB had arrived until two months into the shortfall. As a result none of the three clinics in Zalingei, nor Kurdol from the Garsila office, has received CSB since May.

The current structure of the DERO partnership is encumbering the effective implementation of programs in Zalingei. SUDO and ACT/Caritas are both fairly centralized systems of organizational management. Reporting and funding lines for SUDO pass through Nyala en route to Khartoum, and ACT/Caritas's go directly to Nyala. SUDO Zalingei has experienced ongoing funding delays and shortfalls from Khartoum that are impeding their ability to implement and operationalize their programs as effectively, a major consequence of which has been rapid turn over of staff. SUDO was forced to stop operations for six months in 2006 due to organizational failings. ACT/Caritas in Zalingei have attempted to support the SUDO Zalingei office, though there has been disagreement between Nyala and Zalingei on how to most effectively do so. A more decentralized structure of responsibility and authority within SUDO and ACT/Caritas would allow field staff – those who best know the situation on the ground – the flexibility to respond to organizational challenges together, as a partnership. Field coordinators (FC), in particular, should have enough authority and responsibility to respond to issues as they arise in the field.

7.3.4. Phase-out/Hand-over Plan

DERO health and nutrition operations in Zalingei are not currently positioned to begin phase-out or handover. MoH is the most likely partner for handover, however MoH does not currently have the technical or operational capacity to assume responsibility of the DERO clinics and nutritional programs.

There are a number of realities that must be put into place before SUDO or ACT/Caritas should consider handover to MoH, and it is clear that MoH will be prepared to take over the health clinics before it is prepared to take over nutritional programs. Each of the health clinics has a CHC. These committees must be trained in order to fully understand their role as an intermediary between the community and the clinic. The training developed and implemented by ACT/Caritas staff in Kubum is to be replicated in Hassa Hissa Camp Clinic, Kamsadagaig Camp Clinic, Hamadia Camp Clinic and Hassa Hissa Dispensary. In each case, the CHC should oversee both the nutrition program as well as the medical activities.

Once CHC are trained, benchmarks, including the implementation of user fees, reduction of outside staff incentives, and ultimately handover to MoH must be planned. Ideally this "phase-out" would occur over 12 months, beginning immediately following CHC training. CHCs will have to negotiate with MoH, where possible, for maximum coverage of staff salaries, including CHW and/or vaccinators. CHCs will be responsible for identifying alternate funding sources, either through community mobilization or other NGOs, to ensure non-MoH staff are regularly paid and small operating costs (fuel, charcoal, water, etc.) are covered. Last, CHCs will be responsible for securing a regular drug supply, either from MoH, a revolving fund, independent purchasing, or partnership with UNICEF or WHO. UNICEF has indicated a willingness to discuss drug supply post handover of PHCs to MoH.

ACT/Caritas should continue operating nutrition programs within the IDP camps as long as GAM rates within the target population are at internationally recognized emergency

levels of 15%. Thus, ACT/Caritas should continue to play an active role in nutritional assessments that quantify GAM in each area annually. International NGO support of nutrition programs is justified by the highly technical nature of nutrition programs and the lack of local MoH capacity in nutrition.

7.3.5. Capacity Development

In order to increase the capacity of DERO programs in Zalingei ACT/Caritas should formally define the DERO partnership; decentralize a greater level of authority to field level; train the CHCs; increase structural capacity of the hospital operated TFC; and streamline a health screening into camp registration through the area.

Currently, DERO partners have varying perspectives on the definition, role and responsibility of partner members. This discrepancy is causing tension, specifically around ACT/Caritas's role as either the fourth member of a partnership or the technical/oversight arm of a three-member partnership. According to the Strategic Plan, an amendment to the original MoU between partners that defined "partnership" and "capacity building" was created and approved on 6th September 2004. No one at ACT/Caritas in Nyala could locate this document nor had any of the senior staff ever seen or heard of the document. It is recommended that DERO partners develop an amendment to the MoU that clearly defines the scope of the role and responsibility of each partner.

It is highly recommended that during the process of defining the partnership the role of the FC be reconsidered. By decentralizing a greater deal of responsibility and authority to the field level, the FC will be able to more effectively and efficiently respond to emerging needs within his/her area. The ACT/Caritas FC TOR should clearly detail the position's role and responsibility to all DERO partners. The TOR should be reached by consensus among all partners, and should outline the FC's authority for monitoring DERO activities and instigating capacity building initiatives when needed. All partners should be invited to participate in the hiring process of FC, through a minimum CV screening and, ideally, participation in interviews.

An important milestone for capacity development of health/nutrition programs in Zalingei will be the effective training of the CHCs associated with each clinic/dispensary. The training module developed and used in Kubum should be replicated throughout Zalingei clinics as soon as possible.

The hospital in Zalingei has been supported by MSF-F since 2004. However, MSF-F has decreased its support and is now only actively supporting the TFC and the emergency room. There is some discussion that MSF-F may pull out in December 2007. The TFC is currently located within the pediatric ward. Nutrition and medical cases are mixed, with no physical separation of nutrition patients from medical patients, and no further separation of phase 1, transition, or phase 2 nutrition cases. There is consistent overcrowding, a shortage of beds, and regular overflow into the terrace. UNICEF has supported MoH in developing a formal proposal and plans for the construction of a freestanding TFC within the hospital. It is strongly recommended that ACT/Caritas

identify funds for contribution to this construction, as a well-functioning TFC to receive severely malnourished children is an essential component in the broad nutrition picture.

ACT/Caritas should further current discussions towards the development of a health screening program to be implemented alongside camp registration. Zalingei more than any other area where DERO partners are working, is still seeing a steady inflow of newly displaced people. IMC has already begun looking into the process of integrating a health screening into the basic registration package, and DERO partners should offer their support and services. By implementing a health screening for new arrivals, partners can ensure better vaccine coverage, control of potential epidemics, and nutrition coverage. All efforts to streamline such screening would need to be in coordination with IMC and IRC, camp management for all Zalingei camps.

7.3.6. Recommended Future Action

- Formally define the DERO partnership and roles and responsibilities of each parnter
- Coordinate with IMF and IRC to develop and implement a health screening that accompanies registration of new arrivals to the IDP camps in the area
- Decentralize authority so that FC can more effectively coordinate programmatic and capacity building activities in the field
- Encourage WFP's decentralization of food sources so that DERO and other partners receiving food aid can work directly with WFP in Zalingei
- Encourage three month food supplies from WFP to avoid stock breakages, particularly to tertiary sites
- Financially support MoH and UNICEF in the construction of a TFC
- Provide ITNs to the Hospital TFC and to DERO supported clinics for distribution to children upon discharge from the TFC and PLW

7.4. Garsila

7.4.1. Overview of Activities

Garsila is located in West Darfur State, in the locality of Wadi Salih. The ACT/Caritas office in Garsila opened in 2005 and was originally scheduled to close in March, then subsequently June 2007. Operations scaled down to a minimum in preparation for closure in 2007. However in May, after ACT/Caritas's program office conducted an assessment in the area, ACT/Caritas decided to reestablish the filed office in Garsila. Wat/San, PPP, and Health/Nutrition are currently the major activities out of the Garsila office.

Health and Nutrition activities are limited to an ACT/Caritas supported PHC in Deba IDP Camp and an ACT/Caritas supported SFP in Kurdol. ACT/Caritas previously supported the local PHC, however the clinic was handed over to MoH in June 2007. An ACT/Caritas assessment team traveled to Garsila in late July 2007 to conduct a MUAC rapid assessment of the nutritional situation in Deba Camp. An inordinate number of severely malnourished children (75-80) were admitted to the TFC in Garsila hospital in June. Although data from the July MUAC assessment in Deba Camp do not justify

opening an SFP at this time (GAM of 8%), ACT/Caritas is well positioned to open a SFP at Deba Camp Clinic if data justified the need.

Local NGOs expect the nutritional situation in Garsila to get worse before it gets better. WFP has planned to reduce its general food distribution (GFD) ration by 50%, though recently postponed this reduction until December 2007 because of the current nutritional situation. However, none of the IDPs in Deba Camp have begun returning to their fields; they perceive the security situation to be too risky, so they are not cultivating this year. IDPs in Deba Camp refused to accept seeds during a recently planned seed distribution; they would not take the seeds because they had nowhere safe to plant them, and they expressed concern that if they accepted the seeds they would not receive the GFD. If WFP cuts the GFD to Deba Camp IDPs by 50% in December, the nutritional situation is sure to worsen, given the absence of crop cultivation.

NGOs operating in and around Garsila include ACT/Caritas, Tearfund, IMC, Intersos, and Acted. ACT/Caritas and IMC are supporting PHC and nutrition programs, and Tearfund is conducting health promotion through an extensive network of health clubs and discussion groups.

7.4.2. Technical Capacity

Health and nutrition activities in Garsila are supervised remotely by the Medical Officer in ACT/Caritas's Zalingei office and directly by the MA supervisor in Garsila. There is, by design, an international Health and Nutrition Advisor in Zalingei to oversee all activities of the Garsila and Zalingei field offices. This position was vacated in late June 2007 and a replacement has been recruited to return in mid/late August. Since May of 2007, there have been a number of management failures, including drug shortages and unreported equipment failure, which may be directly related to this turnover in staff. Regardless of the reason, it is clear that there has been limited technical oversight of health and nutrition activities within the Garsila office. Concurrent with this assessment, ACT/Caritas sent a Nutrition Supervisor to Garsila to conduct a rapid assessment in Deba Camp. It is thus recommended that the Nutrition Supervisor remain in Garsila, despite the outcome of the assessment in Deba Camp, so to increase the technical competency and follow through of the field office with matters concerning health and nutrition.

Site visits to Deba Camp Clinic and the Kurdol SFP indicate that staff in both locations are well trained and performing the technical aspects of their work effectively. MoH, UNICEF and ACT/Caritas have all conducted trainings. Where weaknesses exist within either the health clinic or the nutrition program, they are directly linked to organizational and management deficits.

7.4.3. Organizational and Management Capacity

The largest contributing factor to the organizational and management challenges facing the Garsila field office is a lack of communication. Other areas of weakness include the lack of activity by the CHC and dependency upon Zalingei field office for supplies and support.

The deficit in effective communication in the Garsila context exists on multiple levels. First, lines of reporting/communication for health and nutrition from the Garsila field office, which were complex to begin with, have become very difficult to follow due to turnover in staff and vacant positions in Zalingei. A number of problems conveyed over the past three months by Garsila field staff to Zalingei never reached the Sector Head in Nyala.

Next, effective management has been further hampered by a lack of communication and/or follow through from the Garsila field office. The MA Supervisor, the sole ACT/Caritas staff within the field office responsible for health and nutrition activities, has the responsibility of reporting programmatic obstacles to Zalingei and seeing them through to resolution. It appears that even when initial action has been taken to rectify the problem, there is limited if any follow through so that the problem remains unresolved. Examples of this include a refrigerator in Kurdol clinic that does not work and a solar refrigerator at Deba Camp Clinic whose battery doesn't hold a charge overnight. Maintenance of a functional cold chain is imperative for effective vaccine use. These problems were reported to the MA Supervisor who took some initial action, but never followed up to repair or replace the dysfunctional machines.

Last, communication has failed between clinic staff and the MA Supervisor. Through this assessment, the MA Supervisor became aware of several obstacles facing Deba Camp Clinic that he was not otherwise aware of. Examples include the breakage in stock of iron and folic acid for pregnant women and the routine lack of MoH distributed vaccine registration cards. The MA Supervisor should be made aware of problems as they occur within the clinic so that s/he can help resolve these issues.

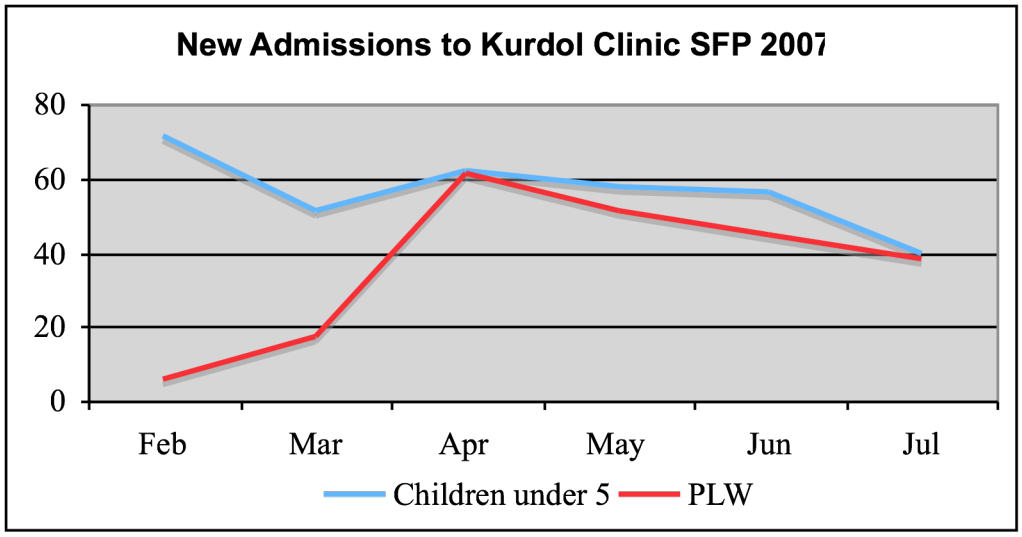
The health clinics operating at Deba Camp and in Kurdol both have limited capacity for sustainability at the moment. Though Kurdol has technically been turned over to MoH (June 2007), ACT/Caritas is providing support through drugs, salaries, and incentives for three additional months. This extension of support is intended to give the CHC an opportunity to look for alternative solutions for support of the clinic. The CHC has already begun implementing a user fee and has met with IMC to discuss possible support in the future. The Deba Camp CHC is inactive at the moment. The CHCs at both clinics need to be trained and supported in order to increase the likelihood of sustained operation after handover to MoH.

Dependency on Zalingei for CSB, drugs, and other supplies means frequent and lengthy delays for commodities coming into Garsila and arriving out to its programs. Though part of this problem may be resolved through increased communication and follow-up, other protective measures such as an increased reserve supply, either in Zalingei or Garsila, should be considered.

7.4.4. Phase-out/Hand-over Plan

Local operation of the nutrition program in Kurdol is good. Despite the onset of the rainy season, new admissions to Kurdol's SFP have followed a downward trend over the past six months (see chart below). However, utilization patterns may contribute to clinic

admissions as much as true prevalence data, thus ACT/Caritas should continue its support of the SFP until GAM in Kurdol drops below 15%. The GAM rate in Kurdol is not currently known, thus ACT/Caritas should prioritize an assessment in this area if program closure is to be considered.



The PHC in Deba Camp is running relatively smoothly and effectively. In order to expedite handover to the MoH, the CHC should be trained and methods for community sustainability of the clinic should be explored. The feasibility of handing over clinics that serve IDP populations is tenuous. Much will depend upon the evolution of the larger political situation and the subsequent security situation in lands surrounding Garsila. Until IDPs have the capacity to cultivate their own crops, the fragility of their economic situation will limit the viability of an independently operated MoH clinic.

By contrast, once the CHC is trained in Kurdol, there is very little reason that the clinic, already turned over to MoH, should not sustain itself. Kurdol Clinic predominately serves a host community with few IDPs. In contrast to Deba Camp's population, a strong majority of families in Kurdol are fully cultivating their land, thus increasing their ability to support and sustain the community costs associated with the PHC. CHC members have met with IMC to explore continued outside support of the clinic; CHC members seem to think that IMC is interested in supporting the clinic in ways similar to ACT/Caritas's support, yet IMC indicated that their intention is to support the Kurdol clinic through trainings and rehabilitation of the clinic, when needed. Given ongoing ACT/Caritas support of the SFP in Kurdol, ACT/Caritas should continue to work with the PHC to ensure effective handover and sustained operations.

7.4.5. Capacity Development

By adding the Nutrition Advisor to the Garsila field office team, ACT/Caritas significantly increases the technical competency and capacity of field staff to respond appropriately and effectively to problems that arise within the Health and Nutrition Sector. It is recommended that the Nutrition Advisor work closely with the MA

Supervisor to monitor, support and follow-up on the daily operation of Garsila's health and nutrition programs.

ACT/Caritas formed the CHCs at Deba Camp Clinic and at Kurdol Clinic 3-5 months ago. Neither CHC has been trained and both are currently more symbolic than functional in their role. The CHC at Kurdol Clinic is aware that the clinic has been turned over to MoH and that they have three months to come up with a plan to compensate for the pending cessation of ACT/Caritas support of drug supply, staff salaries (2), and incentives for all staff. The CHC at Deba Camp Clinic explicitly indicated that they are waiting for a directive from ACT/Caritas on how best to serve the clinic. Both of these CHCs should be trained with the curriculum established by ACT/Caritas staff in Kubum. Training at Deba Camp Clinic should be completed 12 months before handover.

Though Garsila Hospital is not supported directly by ACT/Caritas, its effectiveness and impact are of utmost importance to the success of ACT/Caritas programs. Garsila Hospital operates a TFC which is small and under equipped to deal with the influx of severely malnourished children it has seen since May 2007. It is thus recommended that ACT/Caritas offer operational support to the TFC in the form of NFIs and rehabilitation. Specifically, it is recommended that ACT/Caritas offer the following to the TFC as soon as possible: ITNs and blankets (to be sent home with each discharged child); locally appropriate, fuel efficient cooking mechanism for heating large quantities of milk three times a day; additional hospital beds (17 beds accommodated up to 50 children in June); and rehabilitation of current extension as a permanent extension to increase capacity of TFC.

Further, it is recommended that ACT/Caritas staff assess the inventory of equipment currently housed in storage or closed theatres at Deba Camp Clinic. Those equipment that are not in use should be offered to Garsila Hospital where they have the capacity to utilize the equipment.

7.4.6. Recommended Future Action

- Train CHCs at Kurdol Clinic and Deba Camp Clinic
- Facilitate communication between CHC, MoH and IMC at Kurdol clinic to ensure sustainability
- Continue support of SFP in Kurdol until GAM of target population is less than 15%
- Retain Nutrition Supervisor in Garsila to increase field office technical expertise in health and nutrition
- Request stock of ITN for distribution to pregnant women at Deba Camp Clinic
- Provision of NFIs and rehabilitation extension at Garsila Hospital's TFC (see above)
- Assessment of Deba Camp Clinic inventory for donation to Garsila Hospital

7.5. Greater Nyala

7.5.1. Overview of Activities

DERO partners have a number of health and nutrition activities in and around Nyala. Sudanaid has primary healthcare services in Bilel and Hicinema and operates a mobile

clinic to outlying areas, including Jiir, Kereri, and Al Salaam. SUDO is currently operating the health center in Mershing and a nutrition program in Bilel. SCC has an HIV/AIDS awareness program in Mershing. Partners have a number of other activities in and around Nyala, including Wat/San, PPP, education, and agriculture projects. Given the breadth of these activities, the assessment in Nyala focused on partner activities in health and nutrition. Due to time and security restrictions, this assessment included sites visits within Greater Nyala to only Hicinema Clinic in Nyala and Mershing Camp.

7.5.2. Technical Capacity

The technical capacity of partners in health and nutrition in and around Nyala is mixed. Though field staff appear to have solid understanding and command over the technical aspects of their work (clinical care, anthropometric measurements, ration distribution, health education, vaccination, etc.), small gaps or mishaps within the organizational systems are routinely preventing beneficiaries from receiving the intended service. Thus, traditional technical skills of health and nutrition field staff are satisfactory; however, problem solving, follow-up, and communications, all of which are arguably essential technical skills, are lacking. This is especially true for SUDO, as exemplified, not only in Mershing Health Center where no new drugs have come in for nearly three months, but also in El Daein and Zalingei.

The nutritional program in Bilel has also presented with additional challenges. The June nutrition data from this clinic indicated only a 54.5% cure rate, which is unacceptably low. Unfortunately, the consultant was not able to visit Bilel center to further investigate this matter, and SUDO office in Nyala had no further information to explain the high number of defaulters.

SCC is in a unique situation at the moment, as all staff have been released and the operation, from Khartoum, is currently being overhauled. Thus, responsibility for SCC activities has temporarily been handed over to ACT/Caritas. As further discussed in the next section, this is a unique opportunity to help rebuild SCC, from the inside out, with strong technical capacity. ACT/Caritas should be mindful of the opportunity as well as the responsibility and work closely with SCC staff – including the 12 members of the HIV/AIDS awareness team in Mershing – to solidify their communication skills (in addressing the public), reporting skills, and fundraising/grant writing skills.

7.5.3. Organizational and Management Capacity

Organizational and management capacity of SUDO, as evidence by the halted operation at Mershing Health Center, is lacking and needs immediate attention. There has been a string of staff turnovers and vacant positions, which has exacerbated an already problematic situation; however, lines of communication and authority are blurred, particularly around reporting.

SUDO staff at the Mershing Health Center maintain that they have submitted monthly reports at the end of each month continuously since the first of the year. Those reports go to SUDO staff in Nyala, who review and correct them before submitting them to the Health and Nutrition Sector Head at ACT/Caritas in Nyala. The Sector Head maintains

having received a report from the Mershing Health Center in only one of the past five months. The Sector head met with Nyala based SUDO staff, as well as Mershing Health Center staff, to explain that no drugs could be released without proper reports to justify use and need. Additionally, SUDO field staff indicate that they have been receiving expired drugs, creating an automatic loss of some portion of those drugs that do arrive. ACT/Caritas Sector head has indicated that this is only possible if there was a delay from the time the drugs were released from ACT/Caritas to their delivery at the clinic.

These breakdowns in reporting/communication between SUDO field staff, SUDO Nyala staff, and ACT/Caritas has resulted in a very limited drug supply and a reduction in number of patients from 80-120 to around 30 daily in Mershing Health Center.

As previously outlined, SCC has recently released all staff and is rebuilding. ACT/Caritas should use this opportunity to help increase SCC's organizational and operational capacity.

7.5.4. Phase-out/Hand-over Plan

Hicinema Clinic predates the current conflict in Darfur, and it will remain operational even if the conflict were to end as it is supported by Sisters of the Catholic church. It is currently receiving additional Sudanaid support from Caritas Switzerland. It is not appropriate to discuss handover of this clinic, as they are currently only supported, not operated, by DERO. Thus, the phasing out of DERO support is that which is to be considered. The clinic is currently receiving drugs, supplies, operational cost support, and salary support through DERO. This assessment observed no specific management or operational constraints that would render handover risky at this point.

It is recommended that SCC continue its HIV/AIDS awareness activities in Mershing. SCC is the only NGO working on HIV/AIDS within the area. They do not currently have testing and counseling services, though they would like to expand to provide these services in the future. Their efforts are justified and needed: the adult prevalence rate in Sudan in 2005 was 1.6%, however this rates is expected to have risen over the past two years due to the return of refugees to South Sudan and due to the ongoing conflict in Darfur. The same UN report indicated that only 2% of men knew that condoms could prevent AIDS.[2]

The Health Center operated by SUDO in Mershing serves IDPs from the ten camps that make up Mershing. In addition to the Mershing Health Center, there are two health clinics operated by World Vision and one dispensary in the area. The Mershing Health Center is not currently positioned to handover for several reasons. First, the daily operation of the center has come to a near halt due to lack of drugs. Monthly drug reports have failed to reach ACT/Caritas, thus drugs have not been released to SUDO for this Health Clinic. Operations should be running - and running smoothly - before handover to MoH is considered. Additionally, it is the only Health Center in the area and one of only three PHC providers for the 40,000 IDPs in Mershing.

[2] UNAIDS Factsheet Middle East and North Africa, December 2006.

Despite its current poor positioning for handover MoH, the Mershing Health Center has some of the key elements firmly in place for successful handover, when that time comes. Internal reporting is strong, and technical capacity of staff appears to be good. Additionally, staff report having a very strong, very active CHC. Members of the CHC fill shortages that occasionally exist at the Health Center and are often recruited to help in community health education programs. The CHC will be important in ensuring sustainability after handover.

7.5.5. Capacity Development

ACT/Caritas should second a health and nutrition advisor to SUDO's Nyala office in order to streamline partner reporting, increase capacity for technically sound supervision, and increase effective coordination between the Nyala SUDO and ACT/Caritas offices.
ACT/Caritas should prioritize capacity development of SCC at two levels during this organizational transition at SCC – at an organizational and a programmatic level. Given the limited scope of SCC activities in health and nutrition, this assessment did not allow for a thorough understanding of SCC as an organization; thus ACT/Caritas and SCC will have to determine collectively how ACT/Caritas can best assist in overall organizational development of SCC. At a programmatic level, during the upcoming period during which ACT/Caritas will operate SCC programs, including the HIV Awareness program in Mershing, ACT/Caritas should provide training and technical support to increase program effectiveness from the ground up. The HIV Awareness program does not require any additional inputs at this time.

7.5.6. Recommended Future Action

- ACT/Caritas Health and Nutrition Management Advisor seconded to SUDO's Nyala office
- Resolve current reporting/drug supply issue at Mershing Health Center by immediately meeting with all three players (Sector Head, responsible SUDO Nyala staff [Omar], and SUDO field staff)
- ACT/Caritas and SCC meet to discuss capacity building of SCC programs while they are being operated by ACT/Caritas

8. ORGANIZATIONAL LESSONS LEARNED

8.1.1 SUDO

SUDO activities within health and nutrition appear to operate with technical integrity, if and when they operationalize. Site visits to Hamadia and Mershing clinics illustrated that SUDO's health and nutrition staff are in large part well-trained, accurate in technique, aware of appropriate protocol, and appropriately responsive to technical questioning. NCA, UNICEF, and MoH have all invested resources into these field staff to ensure their technical ability. The historic turnover in positions of management in Nyala in the Health and Nutrition Sectors has left a gap in technical understanding and competency at a middle management level. However, SUDO is hopeful that this gap has been filled by new hires.

The exception to general competency in technical capacity of SUDO staff is the situation of nutrition centers in El Daein. This was the sole site where nutrition staff were not clear on their roles and responsibilities, beneficiaries were confused about the overall functioning of the clinic, and standard procedures were not followed. As well, El Daein is the only site where SPHERE standards for nutrition were not always met. As previously outlined, this shortfall is not only SUDO's but also ACT-Caritas's; ACT/Caritas has a responsibility to increase the technical capacity of SUDO staff and ensure proper implementation through improved management.

Thus, the largest weakness in SUDO's health and nutrition programs stems from a lack of effective organization, communication, supervision and follow-up – all of which can be termed management. Without exception, the breakdown of effective management within SUDO, from Khartoum through Nyala to the field, is having obvious repercussions on the potential impact of its health and nutrition programs. The problematic situations in El Daein and Mershing, both previously detailed, are the product of dysfunctional management systems. Whether because staff do not show up for work or drugs are not available at the clinic, the ultimate loss is to the beneficiaries who are not served.

But SUDO cannot be held solely accountable for the deficit in effective management in its DERO programs, as ACT/Caritas has an obligation to support and develop the organizational capacity of its national partners. It is therefore recommended, for the advancement of health and nutrition programs as well as all other sectors, that SUDO and ACT/Caritas prioritize increasing the management skills of SUDO operations at all levels. This may be most effectively accomplished by seconding an ACT/Caritas Health and Nutrition Management Advisor to SUDO's Nyala office. This individual will not be responsible for developing or directly implementing new management systems, but for working with SUDO staff to identify gaps in the existing system and facilitating the development of organizationally appropriate tools for rectification of those gaps. Among the targeted outcomes of the improved system will be the hiring and retention of competent, qualified staff, improved communication, and reinforcement of reporting lines.

Further contributing to the organizational management obstacles here outlined, SUDO is currently involved in a broad array of technical interventions. From agriculture, to

education, to health, to PPP, to nutrition, to NFI distribution, SUDO is active in virtually every sector of intervention captured under DERO programs. Based on conversations with SUDO staff, DERO partners, and other international partners, it is recommended that SUDO begin to focus its activities into specialized sectors – those where SUDO is positioned to do exceptionally well. Stakeholders both internal and external to SUDO agree that focusing on fewer sectors would increase SUDO's programmatic effectiveness. Identification of *what* sectors SUDO should focus on merits a separate study with the intended purpose of identifying organizational strengths and weaknesses; however it is not recommended that health or nutrition be included in the reduced scope of SUDO's work. Health and nutrition programs require a high degree of technical support and understanding throughout the organization, not just at the field level. They also require rigorous supervision, organizational maintenance, and reporting, none of which is a SUDO strength at the moment. In addition, health and nutrition programs are inordinately hard to get out of once activities have begun.

SUDO's partners, both DERO and otherwise, agree that SUDO is uniquely poised to effect change in areas that other agencies, specifically international NGOs, may be less effective. By focusing efforts on fewer sectors, SUDO will carve out a niche for its work that is recognized, supported, and differed to by other actors.

8.1.2. Sudanaid

Sudanaid's health and nutrition activities are not all contained under the DERO umbrella, as they operate bilaterally, working directly with donors in some areas such as El Daein (Cordaid). Their DERO health and nutrition programs include support of the church-run PHC twice weekly at Hicinema clinic and a mobile PHC to Jir, Kereri, and Al Salaam. An additional clinic was planned to open in late July in Bilel. No reports from this clinic have come in yet. With the exception of food distribution during the months of May and June, the only reported Sudanaid health and nutrition activity on behalf of DERO was out of Hicinema clinic.

Sudanaid appears operate transparently, though technical partners indicate that the quality of care delivered in Sudanaid clinics needs to be improved. Cordaid is working closely with Sudanaid in El Daein to improve quality of care standards. It is recommended that ACT/Caritas contact Cordaid to look at how to collaborate to increase the technical capacity within the organization as phase-out of support progresses.

8.1.3. SCC

SCC plays a much greater role in sectors outside of health and nutrition. As a DERO partner, SCC is not involved in any nutrition activities, and its only health activity is an HIV awareness program in Mershing. As previously outlined, the HIV awareness program is running smoothly as one of a number of activities operated by SCC in Mershing. It has 12 members who conduct multimedia IEC sessions in the community. Each session lasts about 2 hours and each of the 12 members rotates through dissemination of a certain component of the presentation.

SCC's greatest challenge is its organizational capacity. As previously outlined, all SCC staff were relieved of their duties in mid July, and all DERO programs have been temporarily turned over to ACT/Caritas for implementation. As the technical support partner, ACT/Caritas has an obligation to SCC, not only to support its programs during this transition, but to play an active role in rebuilding SCC as a more effective organization. The recommendation of how and in what capacity ACT/Caritas supports SCC in its reconstruction should come from SCC, however ACT/Caritas should be willing to invest the financial and human resources necessary.

8.1.4. ACT/Caritas

8.1.4.1. Staffing

An important reality for all DERO partners to recognize is that it is difficult to fill and keep qualified staff in both national and international positions. Staff vacancies cause obvious problems in terms of reporting, follow-up, training, and routine operation of activities. However, additional problems are created when staff are bounced from one post to another. There is an extensive history of "post coverage" of this sort within ACT/Caritas, the impact of which has been arguably detrimental to overall programs. It is therefore recommended that this strategy of "post coverage" be used sparingly, particularly when the abandoned post would otherwise be making direct investment into national partners.

8.1.4.2. Handover

ACT/Caritas is currently a key player in the provision of health and nutrition services in South and West Darfur, largely through operational support of health clinics and nutrition feeding programs. As part of the Strategic Plan, ACT/Caritas looks to phase-out support of current programs and handover to existing partners. Given the variability of contexts within which the health nutrition programs operate, ACT/Caritas should develop standards by which the appropriateness of handover is determined. The following recommendations should be considered during the development of handover criteria:

- Handover to MoH should be the ultimate goal for all health programs;
- All health facilities should have a trained, functional CHC at least 6 months prior to handover (optimum 12 months);
- A transitional period, or phase-out, between CHC training and handover of any PHC should include a gradual reduction of incentives and the initiation of community generated income to support the clinic;
- Handover of PHC serving IDP communities should consider the varied economic viability of IDP communities;
- Handover of PHC to international NGOs with an interest in development should be considered where viability of clinics is deemed highly unlikely;
- Nutritional programs should close only after GAM in a target population drops below 15%;
- Handover should include a 6 month follow-up period consisting of bimonthly monitoring visits to CHC and clinic staff; and
- Nutritional surveillance in all areas where DERO partners operate nutrition programs will be necessary in order to justify closure.

8.1.4.3. Partner Relations

It is clear after a short time with ACT/Caritas that national partners are confused and frustrated by ACT/Caritas's role in the partnership. ACT/Caritas staff, with few exceptions, see themselves and call themselves NCA, and NCA, as such, has taken on a supervisory role to the national partners, playing the part of the donor/auditor rather than the part of the technical support partner. In order to rectify this situation three action points are recommended: to revitalize the appropriate use of the name ACT/Caritas instead of NCA where possible; to develop TOR for ACT/Caritas staff which are explicit as to their role and responsibility to all partners, particularly program positions and FC positions; and to develop an MoU among all four members of the DERO partnership, defining partnership and the roles and responsibilities of each partner.

8.1.4.4. Capacity Building

As evidenced by the organizational and management challenges previously outlined within most partner programs, ACT/Caritas has failed in its role to maximize the contribution of partner programs. Although directly implemented programs of ACT/Caritas appear to be running smoothly and effectively, the success of these programs should not overshadow ACT/Caritas's failure to fulfill the rest of its commitment to the partnership, as outlined in the original partner MoU. In addition, ACT/Caritas is required by the Strategic Plan to phase-out and handover its directly implemented programs to partners. Thus, in order to more effectively reach both its original mandate and that of the strategic plan, the following action points are recommended: to reduce ACT/Caritas directly implemented programs in favor of support national partner programs (which may include MoH) through support of effective handover practices (see *8.1.4.2. Handover*); to second ACT/Caritas staff into national partner offices and programs where appropriate; to focus on organizational and management trainings rather than technical trainings; and to decentralize authority so that FCs can effectively respond to both partner and community needs on the ground.

9. RECOMMENDATIONS

9.1. Organizational Recommendations

9.1.1. SUDO

9.1.1.1. ACT/Caritas should second a Health and Nutrition Management Advisor to SUDO's Nyala office in order to increase organizational management skills of health and nutrition programs.

9.1.1.2 SUDO should begin narrowing scope of activities into fewer sectors in order to establish an organizational niche; consider independent organizational assessment to determine which sectors, though informal assessment indicates education and PPP.

9.1.2. Sudanaid

9.1.2.1. ACT/Caritas should contact Cordaid and offer collaboration in Cordaid's efforts to increase the technical capacity of Sudanaid in health and nutrition activities.

9.1.3. SCC

9.1.3.1. ACT/Caritas should extend an offer of support, and SCC and ACT/Caritas should collectively identify in what capacity ACT/Caritas can most effectively contribute to the organization's reconstruction.

9.1.4. ACT/Caritas

9.1.4.1. ACT/Caritas should use the strategy of "post coverage" sparingly, particularly when the abandoned post normally makes direct investment into national partners.

9.1.4.2. ACT/Caritas should develop a set of standards by which appropriateness of health/nutrition clinic handover or closure is determined (for recommendations see *8.1.4.2. Handover*).

9.1.4.3. ACT/Caritas should revitalize the appropriate use of the name ACT/Caritas instead of NCA where possible.

9.1.4.4. ACT/Caritas should work with CAFOD to develop TOR for ACT/Caritas positions which are explicit regarding the role and responsibility of the position to all partners, particularly program positions and FC positions.

9.1.4.5. ACT/Caritas, SUDO, Sudanaid, and SCC should meet to develop a MoU which defines partnership, capacity building, and the roles and responsibilities of each partner.

9.1.4.6. ACT/Caritas should continue to reduce directly implemented programs in favor of support of national partner programs (which may include MoH).

9.1.4.7. ACT/Caritas should second staff into national partner offices and programs when and where appropriate, present to SUDO offices in El Daein and Nyala (see 9.2.1.1. and 9.2.5.1.).

9.1.4.8. ACT/Caritas should focus on organizational and management trainings rather than technical trainings for national partners.

9.1.4.9. ACT/Caritas should decentralize authority so that FCs can effectively respond to both partner and community needs on the ground.

9.2. Site Specific Recommendations

9.2.1. El Daein

9.2.1.1 ACT/Caritas should second an administrator/program officer to SUDO's office in El Daein.

9.2.1.2. SUDO should invest in operational and technical effectiveness of Wazazeen and Sunta PHCs in preparation for handover to MoH; the first step of which should be development of a rigid monitoring schedule and reporting requirements.

9.2.2. Kubum

9.2.2.1 ACT/Caritas should train all current and previously handed over CHCs as soon as possible.

9.2.2.2. ACT/Caritas should conduct bimonthly monitoring visits to CHCs for six months post CHC training.

9.2.2.3. ACT/Caritas should initiate discussions and formal negotiations with CARE for the provision of support to Kubum Hospital and Umlabassa PHC/SFP.

9.2.2.4. ACT/Caritas should finalize the MoU with MoH to detail handover and responsibilities of each party to the PHCs in Kubum.

9.2.2.5. CHCs should reintroduce user fees as soon as possible at PHCs in Kubum.

9.2.2.6. ACT/Caritas should develop a timeframe for the gradual reduction and ultimate removal of incentives to health and nutrition staff in Kubum.

9.2.2.7. ACT/Caritas and MOH should support CHCs in negotiations with UNICEF and WHO to secure drug supply to PHCs as part of the handover process.

9.2.2.8. ACT/Caritas should ensure procurement of hand pumps for previously drilled boreholes and implementation of appropriate training to water committees before final pullout.

9.2.2.9. ACT/Caritas should ensure that hygiene promotion tools are photocopied and laminated for community education sessions in each PHC before final pullout.

9.2.3. Zalingei

9.2.3.1 ACT/Caritas should coordinate with IMF and IRC to develop and implement a health screening that accompanies registration of new arrivals to the IDP camps in the area.

9.2.3.2. ACT/Caritas should decentralize authority enough so that FC can effectively respond to recognized needs, including program developments and capacity building.

9.2.3.3. ACT/Caritas should encourage WFP's decentralization so that DERO and other partners receiving food aid can work directly with WFP in Zalingei.

9.2.3.4. ACT/Caritas should encourage three-month food supplies from WFP to avoid stock breakages, particularly to tertiary sites.

9.2.3.5. ACT/Caritas should financially support the MoH and UNICEF in the construction of a TFC in Zalingei hospital.

9.2.4. Garsila

9.2.4.1. ACT/Caritas should include the train of CHCs at Kurdol Clinic and Deba Camp Clinic in its program for CHC trainings in Zalingei.

9.2.4.2. ACT/Caritas should take an active role in facilitating communication between the CHC, MoH, and IMC at Kurdol clinic to ensure sustainability of clinical operations.

9.2.4.3. ACT/Caritas should continue to support the SFP in Kurdol until GAM of target population is less than 15%; if GAM is not known, a rapid assessment should be conducted.

9.2.4.4. ACT/Caritas should retain the Nutrition Supervisor in Garsila to increase field office technical expertise in health and nutrition.

9.2.4.5. ACT/Caritas should provide ITNs to Deba Camp Clinic for distribution to pregnant women.

9.2.4.6. ACT/Caritas should provide a number of NFIs to the TFC at Garsila hospital and should rehabilitate the current temporary extension to be a permanent structure, increasing the patient capacity of the TFC.

9.2.4.7. ACT/Caritas should assess the current inventory of equipment at Deba Camp Clinic and donate unusable equipment to Garsila Hospital.

9.2.5. Greater Nyala

9.2.5.1. ACT/Caritas should second a Health and Nutrition Management Advisor to SUDO's Nyala office.

9.2.5.2. ACT/Caritas should call a meeting as soon as possible to resolve current reporting/drug supply issue at Mershing Health Center.

10. APPENDICES

10.1. TOR: Health& Nutrition Sector Review

1. Background of the sector review

The Darfur Emergency Response Operation (DERO) was established in June 2004 as a joint response to the humanitarian crisis resulting from the conflict in South and West Darfur. The coalition is supported by more than 60 humanitarian agencies belonging to the ACT and Caritas networks globally, with an operational presence in Darfur comprising NCA ACT/Caritas and 3 national non-governmental organisations, SUDO, SCC and Sudanaid.

Between June and September 2006, DERO conducted a Strategic Planning Process. The process was based on stakeholder involvement and was undertaken by a taskforce representing the Darfur, El Obeid and Khartoum levels of the implementing members (ACT/Caritas, SCC, SUDO and Sudanaid), and the Country Representatives of the two lead agencies (NCA and CAFOD).

The plan envisages restructuring DERO so that by mid-2008 SCC, SUDO and Sudanaid will have responsibility for their own direct implementation, either by implementing their own projects or in cooperation with local partners, community based organisations or relevant government ministries. Activities directly implemented by ACT/Caritas will be gradually phased out.

By a significant margin, Water and Sanitation (Wat/San), Health and Nutrition are the largest sectors within DERO in terms of both expenditure and number of staff. ACT/Caritas and SUDO are the principal DERO partners in both sectors, although SCC and Sudanaid have well-defined but more limited roles in the Health sector, implementing activities in HIV and AIDS awareness and Health services respectively.

Consequently both sectors are of strategic significance to DERO according to the Strategic Plan objectives which are centred on phasing-out and handover of ACT/Caritas's direct operational activities.

The 2007 Appeal, therefore, committed DERO to undertake sector reviews for Wat/San and Health and Nutrition (the latter were merged in 2006 and are under a single management structure). Whilst the sector review will enhance our understanding of the technical capacities of the national partners in the Wat/San and Heath and Nutrition sectors, concurrent capacity assessments of the national partners will focus on organizational and management issues.

2. Purpose

To enable DERO members (through the National Coordination Group (NCG) and DERO Board) to make informed and appropriate decisions about the future of the Health and Nutrition Sector in the evolving Darfur context.

3. Focus

To determine which health/nutrition activities should be retained/phased-out, handed over, how and to whom.

4. Objectives

Specific duties:

4.1. To review the performance, achievements, challenges and capacity (organisational and technical) of all DERO members in the Health and Nutrition Sector in relation to the below guidelines.

4.2. To review the progress and evaluate existing phase-out and handover processes

4.3. To ascertain which component of health and nutrition should be phased-out or handed over and in the latter case, to whom and over what timeframe

4.4. To conduct a mapping exercise of other agencies / departments (eg. Other NGOs, WFP, UNICEF, WES and MoH) that operate or plan to operate in DERO areas in order so to a) ensure DERO operations are adding value as opposed to duplicating the humanitarian services of others b) identify other non-traditional partners to handover implementation to if required, and/or c) identify existing gaps in services/coverage.

4.5. Where DERO members show potential to progress and improve, to identify what *capacity development* inputs would be required.

4.6. To enhance DERO members' understanding of their long term priorities/commitments, sectorally and geographically, and how this relates to their current capacities and performance. This should also be related to the current focus upon protection and participation and how DERO members relate to the humanitarian guidelines in this area.

4.7. To set progress indicators for proposed recommendations.

5. Intended users of the sector review

- All DERO members (findings of the sector review will feed into the National Coordination Group and DERO board's discussions and reflections about the future of Health and Nutrition and about the review of the strategic plan due to take place in September 2007).

- Particularly Heads of all four DERO members, as well as the NCA ACT/CARITAS Organisational Development and Capacity Building (ODCB) Unit and Health and Nutrition Sector in order to facilitate improved support and implementation.

- Donors to the program

6. Sector reviews methodology and use of guidelines

Guidelines

The evaluator will take into account the framework and guidelines described in the SPHERE handbook, the Red Cross Code of Conduct, and HAPI. In addition, the evaluator will utilize guidelines and standards for appropriate consideration of gender within the context (UNSCR 1325, CEDAW, IASC).

Approach

The evaluator will propose the methodology for the evaluation. However, in addition to considering international aforementioned guidelines, the final methodology should:

- Ensure good representation, particularly in relation to gender;
- Data should be gender disaggregated, where relevant and possible; and
- Use participatory approaches and enable feedback from participants.

The consultant(s) will initially meet with key stakeholders including relevant sector staff from all DERO member organisations and a representative from the OD/CB Unit. This meeting will enable the consultant to review the work plan, focus and proposed participants / stakeholders identified for inclusion in the consultancy.

Timeframe

It is anticipated that the evaluation will last 4 weeks, with 3 days in Nyala offices, up to 2 weeks of field visits, and 1 week of writing up the report, feedback, revisions and dissemination workshop. 2 additional days will be allocated for unforeseen delays in the process.

The evaluation will commence in early July 2007.

Process

- Initial meetings in Nyala to review background information to inform the assignment and to review proposed methodology

- Write-up methodology and timeline
- Desk-based review of key documents
- Stakeholder meeting in Nyala
- Identify programme areas/partners to visit
- Field visit – interviews/ focus group discussion with stakeholders: beneficiaries, NGOs, local government, and relevant co-ordination networks
- Presentation of preliminary findings to partners
- Produce draft evaluation document
- Presentation of draft report to DERO
- Incorporation of comments received and preparation of the final report
- Half-day workshop to present final findings

The report
The evaluation report should consist of:

- Executive summary and recommendations (not more than five pages).
- Commentary and analysis addressing the issues raised in the TOR in particular: analysis of the capacity (organisational and technical) of all DERO members in the Health and Nutrition Sector, phasing-out and handover plan, timeframe and indicators, and *capacity development* inputs. Capacity development inputs should include both technical as well as training of standards.
- Conclusions and Recommendations with a section dedicated to drawing out specific lessons with suggestions for taking forward lessons learned (not more than 50 pages in all), with reference to specific locations and partners.
- Evidence for the beneficiary study.
- Appendices, to include evaluation terms of reference, maps, sample framework, beneficiary research and bibliography.
- The report and all background documentation will be the property of DERO (as the contracting organisation) and will be disseminated and publicised as appropriate by DERO.

The consultant will submit a draft report for comments to generate feedback, which should be incorporated to produce a final sector review report. The consultant is required to submit 2 hard-copies and an electronic copy of the final sector review report before the deadline agreed.

7. Key person specification

It is anticipated that the evaluation will be conducted by one individual who will have the following experience and skills:

- Relevant experience of evaluating humanitarian aid programmes, especially focused on Health and Nutrition
- An understanding of organisational development, capacity development/assessment and strategic planning, including exit strategies
- Relevant experience of working in humanitarian relief and development
- Ability to analyse and synthesise in writing relevant information relating to humanitarian situations
- Ability to work respectfully with national NGO partners and stakeholders

Desirable:

- Knowledge of the structure and function of Government of Sudan ministries in the relevant sectors (WES, MoH)

8. Key reference documents

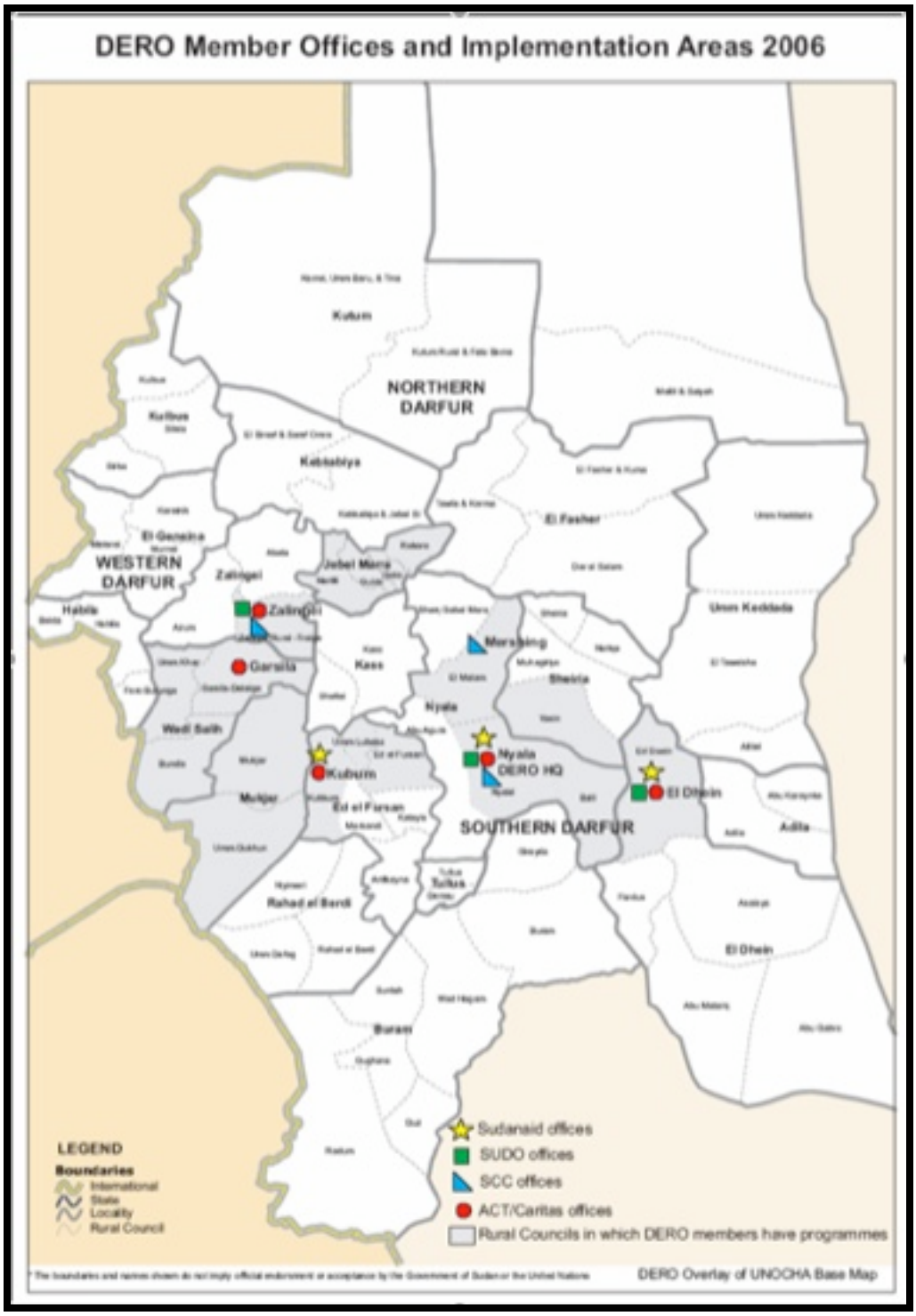
- Strategic plan for ACT/Caritas and national partners in Darfur 2007-10
- DERO Appeal for 2007
- Meetings / DERO board, National Coordination Group meeting minutes
- Completed capacity self-assessment reports,
- Sector monthly and quarterly reports – qualitative and quantitative
- Monitoring trip reports

9. Tenders

Tender proposals (including financial proposal, proposed methodology and CV of consultant) should be submitted not later than 16th May 2007 to:

Wilfred Kibwota
OD/CB Coordinator
NCA ACT/CARITAS Nyala
E-mail: wilfred@ncasuda.org

10.2. Map of DERO Partner Programs



Borrowed from the Darfur Emergency Response Operation Appeal for 2007, does not reflect all current opening and closing.

10.3. Field Research Program

Location	*Date*	*Partner*	*Meeting/Purpose*	*Contact*
Nyala	7/5-7/7	NCA	Introduction and briefing	Sheila, Philippe, and Partner Staff
El Daein	7/8/07	HAC	Commissioner	Ishmael
El Daein	7/8/07	NCA	Health Nutrition Officer	Abdulaziz
El Daein	7/8/07	SUDO	Health Nutrition Officer	Braham
El Daein	7/8/07	Tearfund	Acting Head of Office	Betsy
El Daein	7/9/07	WFP	Acting Director	Magdadene
El Daein	7/9/07	Khor Omer Nutirtion Clinic	SUDO Nutrition	Nutrition Monitor Nutrition workers Beneficiaries
El Daein	7/9/07	Al Neem Nutritional Clinic	SUDO Nutrition Team	Nutrition Monitor Nutrition Workers
El Daein	7/9/07	Al Neem Nutritional Clinic	IDP Camp High Committee	High Committee Chief and Second
El Daein	7/9/07	Cordaid	Country Director	Isabel
El Daein	7/9/07	HAC Coordination Meeting	All NGO's from the area	
El Daein	7/9/07	NCA Office	Health Nutrition Officer	Abdulaziz
El Daein	7/10/07	WFP	Head of Program	Magdadene
Kubum	7/11/07	NCA	Health Nutrition Advisor	Dr. Raymond
Kubum	7/11/07	Hassabala Mobile Health Clinic	Health Team	Staff CHC Beneficiaries
Kubum	7/12/07	Damba Ali Health Clinic	Health Team	CHC Staff (Health) Beneficiaries
Kubum	7/12/07	Umlabassa Health and Nutrition Clinic	Health Team Nutrition Team	CHC Staff (Health, Nutrition, and Operational) Beneficiaries
Kubum	7/13/07	Kubum Camp Clinic	Health Team	Staff(Health, Nutrition, and Operational) CHC
Kubum	7/13/07	NCA Office	Health and Nutrition Advisor	Dr. Raymond

Kubum	7/14/07	Kubum Hospital	Health Team	CHC Staff
Nyala	7/15/07	OCHA Coordination Meeting	All coordinating NGOs	
Nyala	7/15/07	CARE	Health and Nutrition Director	Benson
Nyala	7/15/07	MoH	Nutrition and Acting State Director	Dr. Muhammed Omar
Nyala	7/15/07	NCA	Wat/San Sector Head	Paul
Nyala	7/15/07	NCA	OCDU Dept Head	Wilfred
Zalingei	7/16/07	NCA Office	Field Coordinator	Matthew
Zalingei	7/16/07	Hassa Hissa Camp Health and Nutrition Clinic	Health Team Nutrition Team	Health Team Nutrition Team Beneficiaries
Zalingei	7/16/07	Nutrition Coordination Meeting	NGO's working in nutrition in the area	IMC, UNICEF, SUDO, NCA, OCHA
Zalingei	7/16/07	SUDO	Head of Zalingei Office	Issam
Zalingei	7/17/07	Hamadea Camp Health Clinic and Nutrition Clinic (SUDO)	Health Team Nutrition Team	Medical Assistant Nutrition Monitor Beneficiaries
Zalingei	7/17/07	SUDO Nursery at Hamadea Camp	Head of Zalingei Office	Issam
Zalingei	7/17/07	Kamsa Dagaig Camp Nutrition and Health Center (NCA)	Nutrition Team Health Team	Nutrition Workers Nutrition Monitor Medical Advisor
Zalingei	7/17/07	IMC	Head of Office	Muang
Zalingei	7/17/07	UNICEF	Project Officer	Ahmed Zaroug
Zalingei	7/17/07	MSF-F	Field Coordinator	Unknown name
Zalingei	7/17/07	Health Coordination Meeting	NGO's and partners working in health sector	MoH, MSF, IMC, NCA
Zalingei	7/18/07	NCA	Field Coordinator	Matthew Mpitapita
Zalingei	7/18/07	NCA	Health and Nutrition Staff	Unknown name Muhamed Ishmael
Nyala	7/18/07	OCHA	?position?	Clea
Nyala	7/18/07	UNICEF	Nutrition Officer	Talal
Nyala	7/18/07	MoH	Federal MoH Emergency Response	Dr. Hamed

			Coordinator	
Garsila	7/19/07	Garsila Hospital and TFC	Overall Medical Coordinator and Nutritional Supervisor	Unknown name Dr. Bakri Bashir
Garsila	7/19/07	IMC	Health Coordinator Program Officer, and ??	Three international staff members
Garsila	7/21/07	Deba Camp Clinic		Staff, CHC, and Beneficiaries
Garsila	7/21/07	Dilieg PHC & OTP	Medical Director	Name??
Garsila	7/21/07	Tearfund	Office Coordinator	Mike
Garsila	7/22/07	Kurdol PHC and SFP	Staff, CHC, and Nutrition staff	MA, MW, Head of CHC and assistant, and Hassan
Garsila	7/22/07	NGO Coordination Meeting	Tearfund, Intersos, IMC, NCA	
Mershing	7/24/07	SUDO Mershing activities	PPP Center Health Center	CHC, Staff (Aboud from Nyala and field staff)
Mershing	7/24/07	SCC Mershing Activities	HIV/AIDS Committee	Members (2) and SCC staff

10.4. Bibliography

ACT/Caritas Health and Nutrition Sector. Cooperating Parnters Monthly Reporting Forms, February – June 2007.

ACT/Caritas. Darfur Emergency Response Operation Appeal for 2007.

ACT/Caritas. Health, Nutrition, and Hygiene Promotion Activities Report for OCHA: April to June 2007.

ACT/Caritas. Kubum Health and Nutrition Program Briefing. July 11, 2007.

ACT/Caritas. Strategic plan for ACT/Caritas and national partners in Darfur 2007-10: A strategy for the transformation of the Darfur Emergency Response Operation.

Draft MoU between ACT/Caritas and Federal and State MoH regarding Handover of Health Facilities in Kubum Corridor.

Marie Okabe. "Highlights of the Noon Briefing." UN News 7 June 2007.

UNAIDS. UNAIDS Fact-sheet Middle East and North Africa, December 2006.