THE STATE OF SUDANESE CHILDREN 2011

المجلس القومي لرعاية الطفولة – الأمانة العامة
The National Council for Child Welfare - Secretariat General

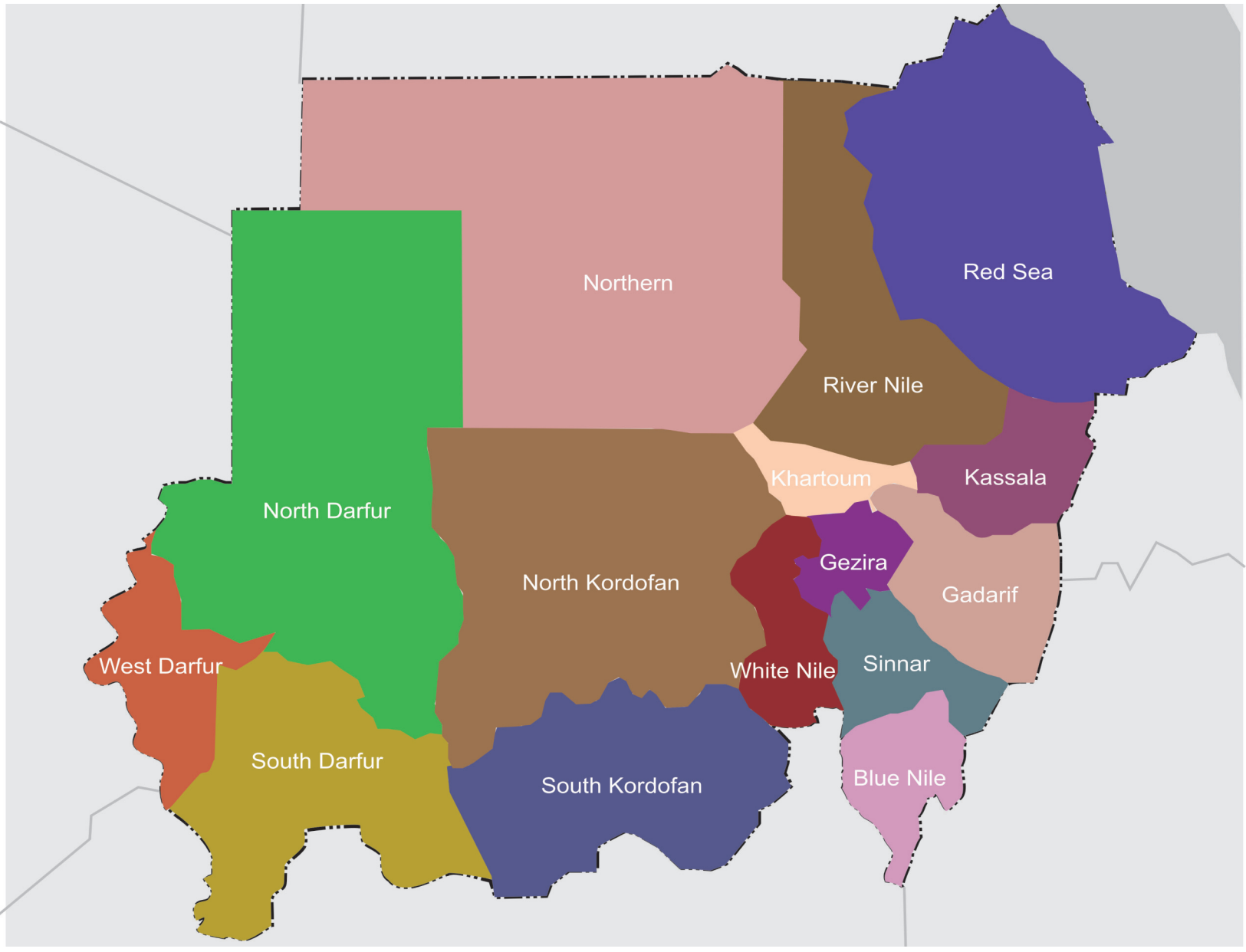
unicef
unite for children

THE STATE OF SUDANESE CHILDREN 2011

المجلس القومي لرعاية الطفولة – الأمانة العامة
The National Council for Child Welfare - Secretariat General

unicef
unite for children

MAP OF SUDAN



Courtesy of the Office for the Coordination of Humanitarian Affairs OCHA

Table of Contents

Acronyms

ALP	Alternative Learning Programme
ANC	Antenatal Care
BCG	BacilleCalmette Guerin
CAAC	Children Affected by Armed Conflict
CBS	Central Bureau of Statistics
CBO	Community-based Organization
CMAM	Community-based Management of Acute Malnutrition
CPA	Comprehensive Peace Agreement
CRC	Convention on the Rights of the Child
CTS	Community Approach to Sanitation
DDR	Disarmament, Demobilization and Re-integration
DPA	Doha Peace Agreement
DPT	Diphtheria, Pertussis and Tetanus
DV	Domestic Violence
ECCD	Early Child Care and Development
EmOC	Emergency Obstetric Care
EMIS	Education Management Information System
ENP	Essential Nutrition Package
EPI	Expanded Programme of Immunization
EPP	Estimation and Projection Package
EPA	Eastern Sudan Peace Agreement
FGM/C	Female Genital Mutilation/Cutting
FMOH	Federal Ministry of Health
FSMS	Food Security Monitoring System
GAM	Global Acute Malnutrition
GDP	Gross Domestic Product
GER	Gross Enrolment Rate
GMP	Growth, Monitoring and Promotion
GPI	Gender Parity Index
GS	Government of Sudan
HiB	HaemophilusInfluenzae Type B
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome
IDP	Internally Displaced Person
IEC	Information, Education and Communication
IMCI	Integrated Management of Childhood Illness
INGO	International Non-Governmental Organization
IYCF	Infant and Young Child Feeding
KAP	Knowledge, Attitude and Practice
LLITN	Long Lasting Insecticide Treatment Net
MENA	Middle East and North Africa
MDGs	Millennium Development Goals
MICS	Multiple Indicator Cluster Survey
MoWSC	Ministry of Welfare and Social Security
NAR	Net Attendance Ratio
NCCW	National Council for Child Welfare
NGO	Non-Governmental Organization
NPC	National Population Council
ODF	Open Defecation Free
OPT	Outpatient Therapeutic Programme
ORT	Oral Rehydration Therapy

PLWA	People Living With AIDS
PMTCT	Prevention of Mother-to-Child Transmission
RH	Reproductive Health
SAM	Severe Acute Malnutrition
SBA	Skilled Birth Attendant
SDG	Sudanese Pound
SHHS	Sudan Household Survey
SHHS2	Sudan Household Survey 2nd
SITAN	Situation Analysis
SMoH	State Ministry of Health
SNAP	Sudan National AIDS Programme
SOME	State Ministry of Education
SPLM	Sudan People‘s Liberation Movement
SRCS	Sudanese Red Crescent Society
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNFPA	United Nations Population Fund
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children’s Fund
UNMAO	United Nations Mine Action Organization
UNOCHA	United Nations Office for the Coordination of Humanitarian Affairs
USD	United States Dollar
UXO	Unexploded Ordnance
U5	Under 5
VCT	Voluntary Counseling and Testing
WASH	Water, Sanitation and Hygiene
WFP	World Food Programme
WHO	World Health Organization

Foreword

Children make up half of Sudan's population. There are 15 million children under the age of 18 and 4.5 million aged five or under. This simple reality underlines the fact that the manner in which we provide for children today will determine the health, education, development, peace and prosperity of Sudan for decades to come.

In 1990, Sudan pledged to protect its children by ratifying the Convention on the Rights of the Child (CRC). This decision guaranteed children the fulfilment of a full range of their human rights: to survival; to develop to the fullest; to have protection from harmful influences, abuse and exploitation; and to participate fully in family, cultural and social life. This acceptance of children's rights was further expanded through the signing of the CRC's two Optional Protocols on the involvement of children in armed conflict and the sale of children, child prostitution and child pornography. In 2010, Sudan reaffirmed those commitments by passing the Child Act.

The State of Sudanese Children, produced jointly by the Government of Sudan's National Council on Child Welfare (NCCW) and UNICEF, shows Sudan's progress in meeting these promises in each of its fifteen states[1]. It reflects the very real improvement in most childhood indicators between 2006 and 2010, as well as the multitude of challenges facing children today, not least as a result of the conflict in Darfur and along the border with South Sudan. The future is further clouded by an economic downturn due to lost oil revenues resulting from separation of South Sudan, at the same time as drought and climate change are pushing families further into poverty while rendering basic resources, like food and water, scarce.

The analytical reports and the data of the Central Bureau of Statistics (CBS) and the Sudan Household Survey (SHHS) used in *The State of Sudanese Children* show us that rural children and poor children are the country's most vulnerable. For example, children from the richest 20 per cent of the population are one and a half times more likely to attend primary school than children in the poorest 20 per cent. Urban households are almost three times more likely than rural ones to access improved sanitation. Full immunization coverage reaches 56 per cent of children in urban areas compared with only 47 per cent in rural localities. Girls in the poorest quintile are more than three times as likely to be married before the age of 18 than girls in the richest quintile. Determinants of disparities are not limited to income level and urbanization. Among nomadic populations, 82 per cent of school age children are out of school. In rural areas, parents' attitudes towards girls' education and child marriage all contribute to the gender disparity in education.

When discussing these disparities, we must beware of the "tyranny of averages" which can hide many gaps in indicators between segments of society in any given state. Even in Khartoum and Northern states, whose indicators are among the best in Sudan, pockets of deprivation still exist in slums and hard-to-reach rural villages. The needs of these children must not be lost in the numbers.

Investing in the future of Sudan means investing in the continuum of care across childhood. Too often, our help reaches the children too late. Our interventions should begin from the moment they are in the womb. Adequate health care and information during pregnancy and delivery must be available to mothers and newborns. Presently, one in every four women in Sudan receives no antenatal care at all during pregnancy.

Investing in early childhood is just as crucial. When children are healthy, nourished and well-cared for, they are more likely to survive, have fewer illnesses, and fully develop thinking, language, emotional and social skills. When they enter school they are more likely to succeed. And, later in life, they have a greater chance of becoming creative and productive members of society.

Adolescence is the next and often forgotten step in the continuum of care. Adolescents and young people have rights - to information and skills; education, health, recreation and justice; a safe and supportive environment; and opportunities to participate in society and to have their voices heard. Moreover, Sudan's adolescents have the right to live out their childhoods. This means protection against early marriage, violence (including recruitment to armed groups), harmful practices, and child labour.

1 When this report was written, there were 15 states instead of 17 (with two additional states in Darfur).

In order to strengthen the systems that provide for the care, development and protection of children, institutional structures must be improved at national and state levels, and coordination and cooperation between all partners must be enhanced. Our hope is that this report will serve as a practical tool for state and federal governments, civil society, academia, and the UN alike in identifying the critical issues related to children that require a concerted response.

In that sense, this publication -- the first on the situation of children to be released in post-separation Sudan -- is a call for action. Drawing as it does on concrete data and recent research to highlight the areas that have the greatest need for investment and prioritization, the analyses the report contains are intended to help leverage the vital resources that will make a real difference in children's lives.

Over recent years, there has been great effort and progress by the government and international community to protect and improve the rights of children in spite of the many challenges the country faced. Now is the time to direct our energies once more towards the citizens who represent Sudan's future: its children.

National Council for Child Welfare
in Collabaration with
UNICEF SUDAN

Introduction
Understanding the State of Sudanese Children

Half of Sudan's population is made up of children; approximately 15 million Sudanese are under the age of 18.[2] However, mortality claims one child in every 30 during the first 28 days of life; more than one child in every 13 dies before his or her fifth birthday. Not all children will live a normal peaceful life; in some states, many children are likely to suffer from a shortage of food, the effects of armed conflict and drought, and limited access to basic services, such as schools. Their future is shaped by factors beyond their control: rising food prices, increasing urbanization, climate change and physical and emotional traumas caused by conflict and malnutrition.

Children in Sudan come from a variety of tribes, religions, climates and economic backgrounds. Whether they come from rural areas or the cities, children in Sudan are equal in their daily struggle to survive, let alone thrive, in the face of challenges that are both natural and man-made.

Armed conflicts affect the security situation in the Border States of South Kordofan and Blue Nile. Despite these, the historical social and economic links between the tribes of the two states endure. The repercussions of the ongoing conflicts are expected to be severe and wide ranging. These include children being separated from their parents, families left without shelter and an interrupted education due to the destruction of schools. It is also anticipated that the delivery of humanitarian supplies before the onset of the rainy season will be difficult due to the security situation and limited transport infrastructure.

Despite the signed peace agreements, some areas of Darfur continue to suffer from a lack of security. Currently the three states are slowly beginning to transition from emergency to recovery, through the mechanism that supports the voluntary return of the internally displaced population. Still 1.9 million[3] internally displaced people (IDPs) continue to live in difficult situations.

Eastern Sudan has the country's largest population of refugees, mainly from Eritrea, and the growing numbers threaten to destabilize this underdeveloped region.[4]

The arid states in the north, such as Northern state and North Darfur, suffer from frequent drought leading to displacement and traditional conflicts over limited resources. Meanwhile, better-than-average statistics are found in Khartoum compared to neighbouring states where poverty and inequality exist in cities as well as in remote rural areas.

Using Data to Understand the Life of a Sudanese Child

This publication highlights key areas of concern by drawing on the most current socio-economic and demographic indicators. Most data was obtained through the second Sudan Household Health Survey (SHHS2) conducted by Sudan's Federal Ministry of Health in 2010. The SHHS2 relies on the Multiple Indicator Cluster Surveys (MICS), an international household survey programme developed by UNICEF and implemented in over 100 countries.

Data from the Sudan Population and Housing Census 2008 and the National Baseline Household Survey 2009 were important sources in the development of this publication. Both were produced by the Government of Sudan's Central Bureau of Statistics. Some sector-specific information such as the Ministry of Health's Expanded Programme on Immunization (EPI) data, the World Bank's 2012 report "World Bank, 2012, The Status of the Education Sector in Sudan, Washington DC" as well as Education Statistics 2008-9, have been used to complement the main sources. Therefore, it is important to note that this publication does not generate new data but rather uses existing official information to illustrate the situation of children in Sudan.

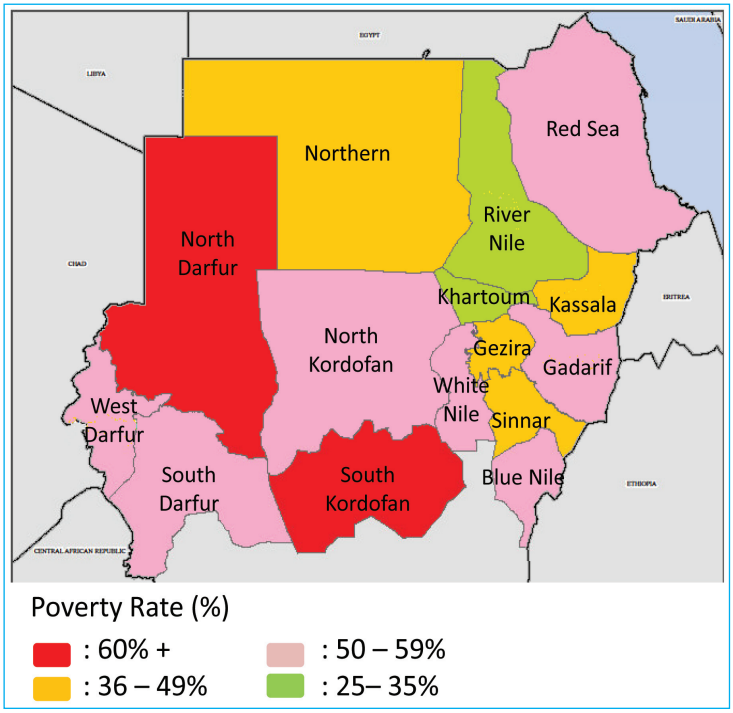
Socio-Economic Analysis

The Sudanese economy shifted from agricultural-oriented to an oil-based economy, which constituted 86 per cent of the export revenue. As economic growth declined from ten to five per cent between 2008 and 2010, per capita income increased from US$1,227 to US$1,500 during the same period.[5]

Sudan is already facing enormous economic challenges following South Sudan's separation in July 2011 due to

2 Sudan Population and Housing Census 2008.
3 According to UNOCHA, as of end 2010
4 United Nations High Commissioner for Refugees, Global Appeal 2010 Update: Restoring Hope, Rebuilding Lives, Geneva, 2011 pp. 52, 53.
5 Department of Economic Studies, CBS - 2010.

Figure 1: Share of population living under the poverty line



Source: Sudan National Baseline Household Survey 2009

the loss of oil revenue coupled with rising prices of food and imports. Additional oil production, from Sudan's oil fields could help reduce the economic burden and revenues from gold mining are expected to help bridge the gap of the lost oil revenues.

The irregular agricultural production and the unstable economic situation are closely correlated with increasing poverty rates, as illustrated by the fact that the Darfur and Kordofan regions have the highest concentration of poverty, with 63 and 59 per cent of the population (close to five million and 2.6 million people respectively) living below the poverty line. This is equivalent to a monthly income of SDG 114[6]. In all states, poverty disproportionately affects rural populations and runs particularly deep in the areas affected by conflict and drought.

Despite multiple constraints and impediments, Sudan has made tangible progress towards achieving the Millennium Development Goals (MDGs). Across the spectrum, however, progress is patchy and uneven. Sudan's most recent MDG progress report identifies conflict as one of the biggest impediments to progress, responsible for diverting resources, impeding development projects, and increasing the need for assistance among women and children[7].

Table 1: Sudan at a Glance: Demographic Composition of Sudan

State	Total Population	Female Share (%)	Rural & Nomad Share (%)	Under-18 Share (%)	Under-5 Share (%)
Northern	699,065	49.4	83.1	41.4	11.5
River Nile	1,120,441	49.0	70.4	42.4	13.0
Red Sea	1,396,110	42.9	60.5	43.9	11.1
Kassala	1,789,806	44.8	73.7	47.6	12.3
Gadarif	1,348,378	50.4	71.5	52.9	17.1
Khartoum	5,274,321	47.0	19.0	40.2	12.4
Gezira	3,575,280	51.8	80.9	47.1	14.3
White Nile	1,730,588	51.0	66.4	49.2	15.5
Sinnar	1,285,058	51.3	78.3	50.1	15.8
Blue Nile	832,112	49.4	75.7	53.2	18.8
North Kordofan	2,920,992	51.9	80.1	51.9	16.9
South Kordofan	1,406,404	50.7	76.5	54.3	18.5
North Darfur	2,113,626	49.0	82.7	51.8	14.9
West Darfur	1,308,225	51.4	82.7	54.6	16.9
South Darfur	4,093,594	47.8	78.4	54.0	15.3
Total	30,894,000	49.0	66.8	48.5	14.7

Highest lowest

Source: Sudan Population and Housing Census 2008

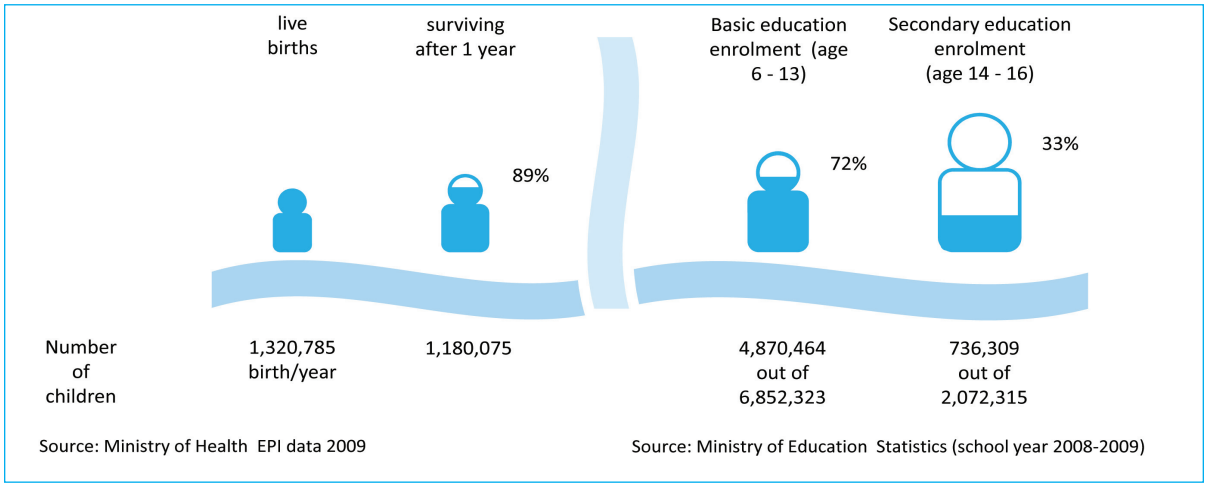
6 Sudan Central Bureau of Statistics, National Baseline Household Survey 2009, North Sudan -- Tabulation Report, 2010.

7 The Republic of Sudan National Population Council (NPC/GS) Ministry of Welfare & Social Security, Sudan Millennium Development Goals Progress Report 2010, p. 4.

Child Survival

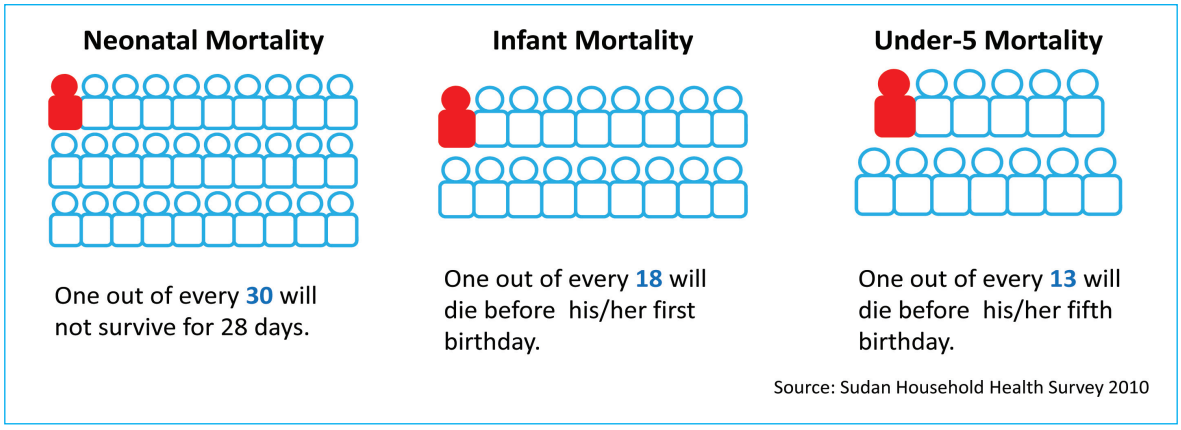
According to the government data, approximately 1.33 million children are born each year in Sudan, although this number continues to rise.[8] Of these, an estimated 76,000 will die in the first year, and 104,000 will die before their fifth birthday.[9] Among the children who are of primary school age (six to 13), almost two million children[10] are out of school, missing the opportunity to reach their full potential in life. The number of children out of school increases to more than 3.3 million if we add secondary school age children aged 14-16 (Figure 2). This figure is likely to be on the optimistic side as the number of enrolled pupils includes children of all ages whereas the denominator is restricted to the population of the specific age group[11].

Figure 2: Infant survival & school enrolment in Sudan



Today, more children are surviving the first years of life than in 2006. Between 2006 and 2010, under-five mortality has decreased from 102 to 78 deaths per 1,000 live births. Infant mortality has fallen from 71 to 57 deaths per 1,000 live births, and neonatal mortality from 36 to 33. However, these rates are still unacceptably high, and efforts toward the achievement of the MDGs should continue.

Figure 3: Child Mortality in Sudan



8 This number is projected denominator used in the Ministry of Health's immunization (EPI) data. According to the Census 2008, the number birth is much lower at 904,000.

9 Estimates for child mortality are calculated based on Sudan Household Health Survey 2010.

10 Ministry of Education Statistics 2008-2009, 1,981,839 children of age 6-13 are out of primary school and 1,336,006 children of age 14-16 are out of secondary school.

11 For Example, the primary school enrolment rate of 72% is calculated by dividing the number of enrolled pupils (who could be out of the age range of 6-13 due to repetition) by the population of this age group. Therefore, this is the best estimate but on the optimistic side.

Health

Although progress has been made in reducing child mortality (MDG4), many more lives could be saved. Preventable and treatable neonatal illnesses are the most common causes of death among children aged below five in Sudan, particularly preterm labour and infection. Malaria, diarrhoea and pneumonia in addition to malnutrition are other common factors.[12]

Unequal distribution of healthcare professionals, limited capacity to deliver services and low government investment are among the factors that have stymied progress in reducing child mortality. In terms of immunization, the data present a mixed picture. According to SHHS2, only half of Sudan's children aged 12-23 months are fully immunized with three doses of polio vaccine, Baccille Calmette Guérin (BCG) vaccine against tuberculosis, measles, three doses of Pentavalent against DPT (Diphtheria, Pertussis and Tetanus), Hepatitis B, and Haemophilus Influenzae type B (HiB). This leaves the rest of the children in this age group unprotected against life-threatening diseases. On the other hand, EPI data shows a better picture. Immunization coverage for oral polio vaccine (OPV), BCG and measles has increased to 95, 91 and 86 per cent respectively in 2010 from 85, 78 and 76 per cent in 2006. Coverage of three doses of Pentavalent has reached 95 per cent. Although this is an achievement, more needs to be done to achieve universal immunization coverage for children[13]. Success has been seen in polio, with no reported cases since 2009. Child deaths due to measles have been reduced markedly after implementation of measles elimination strategies. However, the Case Fatality Rate (CFR) is 1.1 in 2010, and immunization coverage for measles still needs to be increased further.

Nutrition

Although some progress has been made in reducing poverty and hunger (MDG1), almost half of the population (46.5 per cent) still lives below the national poverty line.[14]A third of Sudan's children under the age of five (more than 1.5 million children) are underweight and/or stunted. More than one child in every twenty suffers from severe acute malnutrition (SAM)[15], a life-threatening condition requiring urgent treatment. The immediate causes for SAM are[16] related to diarrhoea and fever against which exclusive breastfeeding can be an effective protective measure. High poverty rates, increasing food prices, on-going armed conflicts and lack of awareness are the underlying factors that are responsible for the slow progress in the improvement of Sudan's nutritional status.

There is little data on micronutrient deficiencies. The World Health Organization (WHO) estimated in 2008 that 58 per cent of pregnant women and 43 per cent of non-pregnant women were anaemic[17] while the level of salt iodization at household level is 9.5 per cent (SHHS2). There has been no progress at passing a federal level food fortification act or salt iodization laws although there is significant governmental commitment to these laws. Six states (Red Sea, Kassala, Gadarif, Sinnar, South Darfur, and West Darfur) now have state laws on universal salt iodization, while the remaining nine do not. Such delays in passing laws eventually have negative effects on children's health.

The SHHS 2010 data shows that 41 per cent of children are exclusively breastfed, while 40.1 per cent continue breastfeeding up to two years. Improving infant and young child feeding practices is key to preventing malnutrition. Knowledge and skills of health care providers remain low regarding infant and young child feeding, meaning that correct advice and support for mothers is not readily available. The law on the Code of Breast Milk Substitutes remains in draft form, although a committee to move this law forward has been formed.

In spite of high chronic and acute malnutrition rates across the country, due to limited resources at federal and state levels, nutrition programming has not been among the priority intervention areas such as Malaria, EPI and other endemic diseases. The nutrition of both mothers and children remains among the most important areas for policy advocacy as evidenced in the salt iodization laws. Treating severe malnutrition effectively in Sudan could save up to 200,000 under-five deaths a year

12 World Health Organization and United Nations Children's Fund, Countdown to 2015 decade report (2000–2010): Taking Stock of Maternal, Newborn and Child Survival, Geneva, 2010.

13 EPI uses surviving infants as a denominator, except for BCG, which uses a total number of live births. In comparison, SHHS uses 12-23 months old as a denominator.

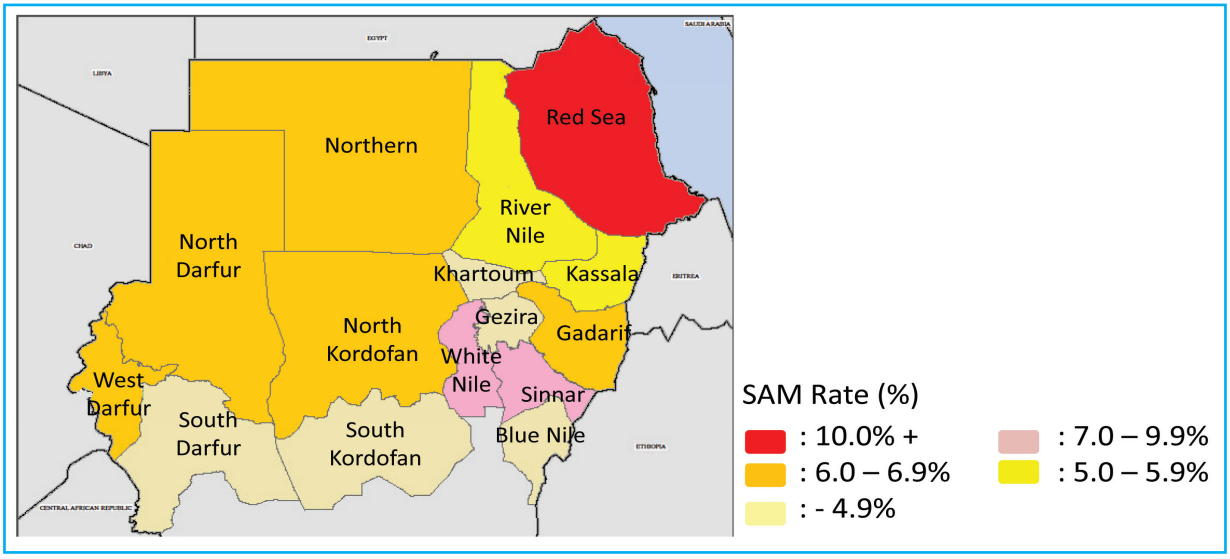
14 'National Baseline Household Survey 2009,' 2010

15 Severe acute malnutrition (SAM) is a severe wasting, defined by a very low weight for height (below -3z scores of the median WHO growth standards).

16 According to (DRAFT) Nutritional Causal Analysis, UNICEF 2011

17 Tracking Progress on Child and Maternal Nutrition, UNICEF, 2009

Figure 4: Red Sea has the highest Severe Acute Malnutrition Prevalence (SAM) Rate in Sudan

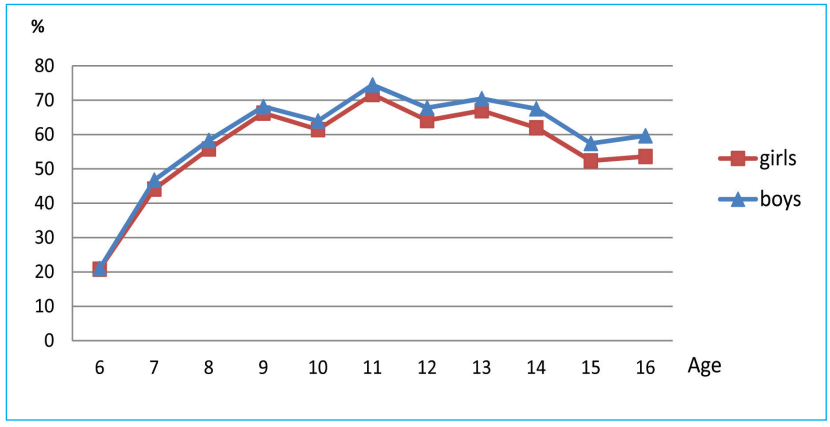


Source: Sudan Household Health Survey 2010

Education

Universal basic education is a fundamental right guaranteed to all children under the Convention of the Rights of the Child and the 2010 Child Act (MDGs 2 and 3). However, only 57 per cent of Sudan's children aged six to 16 are attending school and the school attendance rate gradually declines after peaking during early adolescence, according to the 2008 census (Figure 5)[18]. This means approximately 3.3 million children who should be in a classroom are instead working for their families, supporting domestic duties, prematurely married, or are unaccounted for.

Figure 5: School attendance is at its highest during early adolescence
School Attendance Rate (Children Age 6-16)



Only three out of four primary school age children are receiving a formal education (with almost two million children not attending class). Attendance is lowest in the East, where it ranges between 55 and 69 per cent for primary school. Despite laws requiring universal access to free education, costs associated with uniforms, school supplies, extracurricular lessons, informal compensation for teachers, and school maintenance prevent many children from attending school. Inadequate school facilities such as a lack of clean water latrines, a shortage of trained teachers and child-centred methodology; and overcrowded classrooms lacking sufficient seating, are among the factors standing in the way of education.

Retention can be a challenge as well. The SHHS2 found that once children are enrolled in the first grade, they have an 82 per cent chance of making it to eighth grade[19], with variations ranging from 65 per cent for children in the poorest quintile to 94 per cent in the wealthiest. Similarly, census data recently found that the school attendance rate peaks at age 11 and then drops during the teen years, particularly among girls, when children are needed by families.

Delayed enrolment and grade repetition are common in Sudan. Almost one child in every four (24 per cent) who is old enough for secondary school is, in fact, attending primary school. Only 32 per cent of secondary school age

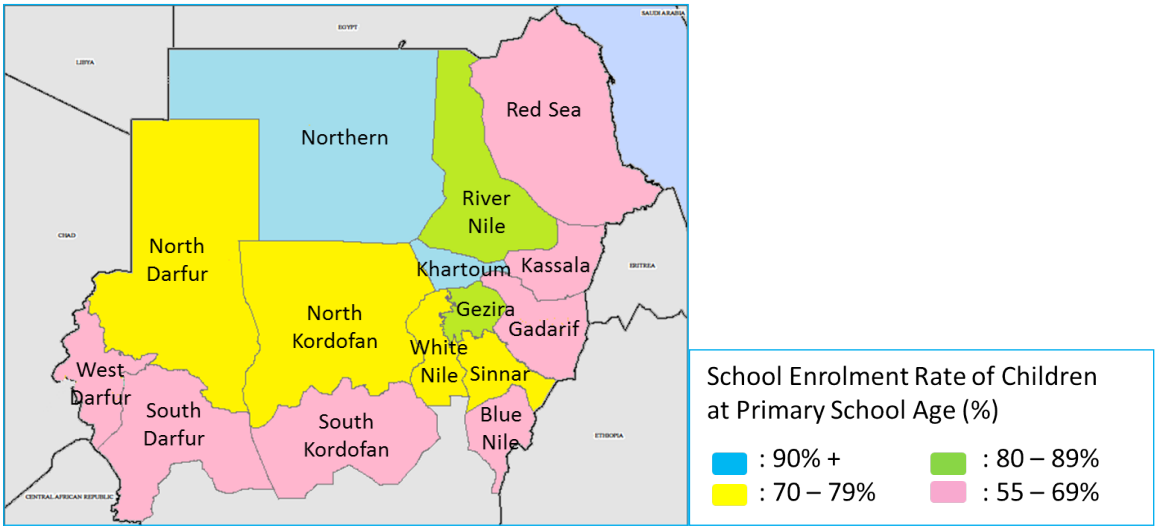
18 The pre-education enrolment (30.2%), basic education enrolment (66.1%); and secondary school enrolment (29.7%), Educational Statistics, 2008/2009, p31.

19 The completion rate is lower according to other sources: only 50% of the children enrolled in grade 1 actually finish grade 8 successfully and on time, according " World Bank, 2012, The Status of the Education Sector in Sudan, Washington DC»

children are actually in secondary school.

With less than three per cent of GDP spent on education, quality is a significant issue[20]. Most states do not have enough trained teachers, classrooms, learning materials and adequate sanitation facilities to make schools safe and child-friendly. Typically, States pay only salaries, leaving other school running costs to be financed by other means. Lack of resources limits the government's efforts to make schools 'child-friendly'.

Figure 6: Enrolment rates for primary school age children are lowest in eastern and border states



Source: Sudan Household Health Survey 2010

Water, Sanitation and Hygiene

Globally, poor water, sanitation and hygiene (MDGs 7 and 4) collectively contribute to roughly 88 per cent of deaths from diarrheal diseases among children under five.[21] In Sudan, 5.8 million people are still drinking from unimproved water sources (19 per cent), and out of 25.1 million people who are drinking from improved water sources, one quarter (6.4 million) are drinking water transported by donkey carts and tankers. Use of improved sanitation is still lagging behind as 22.3 million people are still defecating openly or use unimproved sanitation facilities (73 per cent).

There are wide regional access disparities between urban and rural areas and between different states (Figure 7). Access to improved water is found to be 94 per cent for the urban population (9,641,400) and 75 per cent (15,477,894) for the rural population. Use of improved water sources ranges from 54 per cent in Blue Nile to 98 per cent in Gezira State. Access to improved sanitation is 47 per cent (4,820,700) for the urban population and 18 per cent (3,714,695) for the rural population. On the other hand, only five per cent of the population in South Darfur is using improved sanitation facilities, compared with 74 per cent in Northern state. People using both safe drinking water and improved sanitation facilities range from 3.2 per cent in Blue Nile (266,276) to 68.4 per cent (457,641) in Northern State.

20 Same source as above.

21 United Nations Children's Fund, Progress for Children: A report card on water, sanitation and hygiene, no.5, UNICEF, New York, 2006, p. 3, 6.

Figure 7: Access to improved water among states

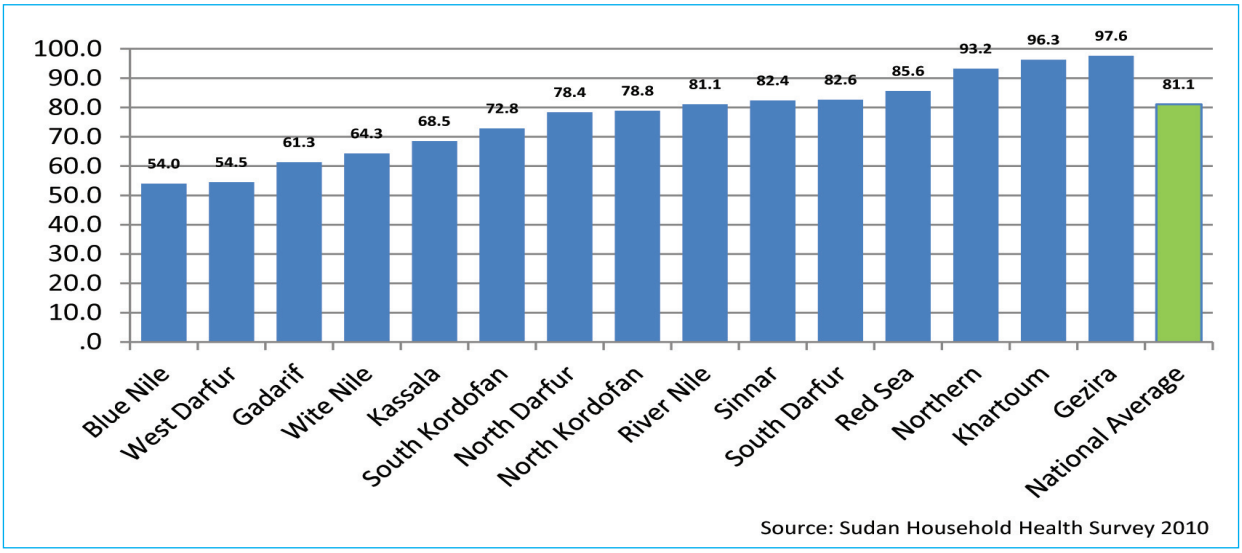
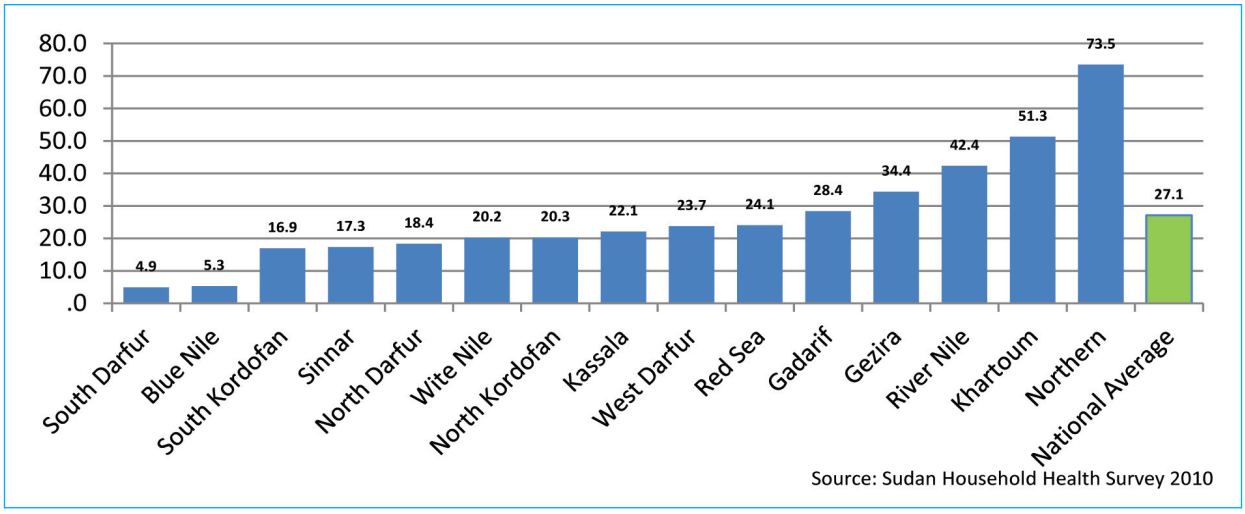


Figure 8: Access to improved sanitation among states



Wealth is a major determinant of access to safe drinking water and improved sanitation. Families in the richest quintile are almost one and a half times more likely to have access to improved water than those in the poorest quintile. They are 35 to 37 times more likely to access improved sanitation, depending on whether shared sanitation facilities are taken into account in addition to private ones. Location and education also influence levels of access.

Figure 9: Wealthier people are more likely to have access to improved water and sanitation
Percentage of people using improved sanitation facilities and improved sources of drinking water by wealth quintile

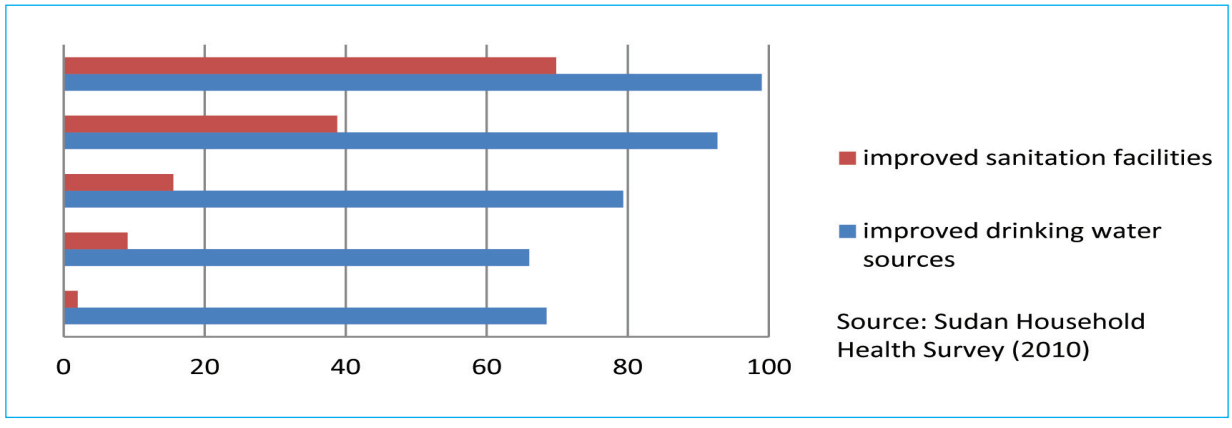


Figure 10: Urban residents are more likely to have access to improved water and sanitation
Access to Improved Drinking Water Sources and Improved Sanitation Facilities

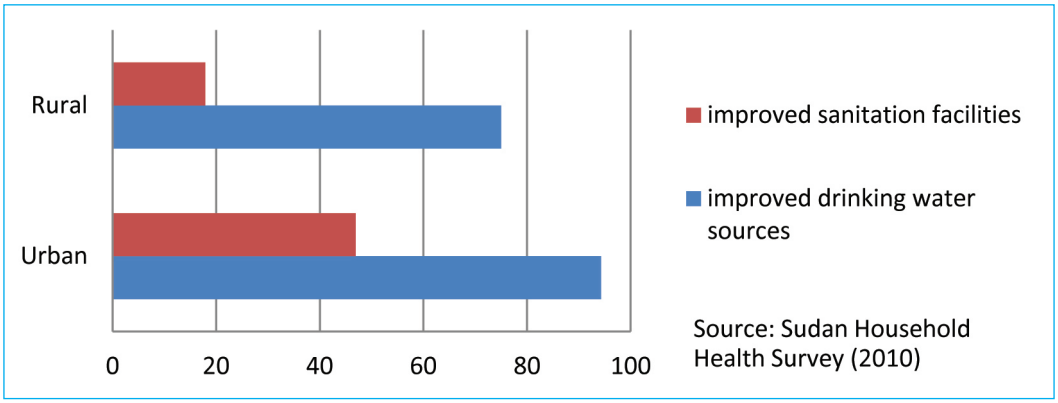
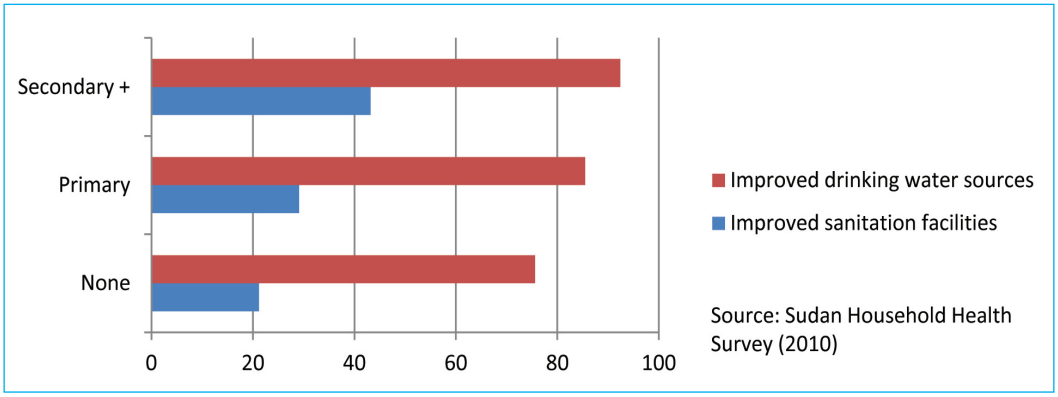


Figure 11: More educated people are more likely to have access to improved water and sanitation
Percentage of people using improved sanitation facilities and sources of water by education



According to the School Health Programme Survey 2009[22], children in 79.4 per cent of schools have access to water sources. Khartoum state came at the top with 83 per cent water coverage, while South Kordofan came at the bottom with 50 per cent coverage. The same survey also found that children in 82.4 per cent of schools have access to latrines. Khartoum state came at the top with 100 per cent latrine coverage, while schools in Sinnar State had only 43 per cent coverage.

Hand-washing is one of the critical hygiene practices' indicators. It was found around 19% reported that they wash their hand before feeding children, 79% before eating, 52% after defecation, 26% before preparing food and 52% after cleaning children faces. Although sensible improvement in hand washing practices took place between 2004 and 2008 KAP (Knowledge, Attitude, Practice) studies, still a lot efforts need to be exerted

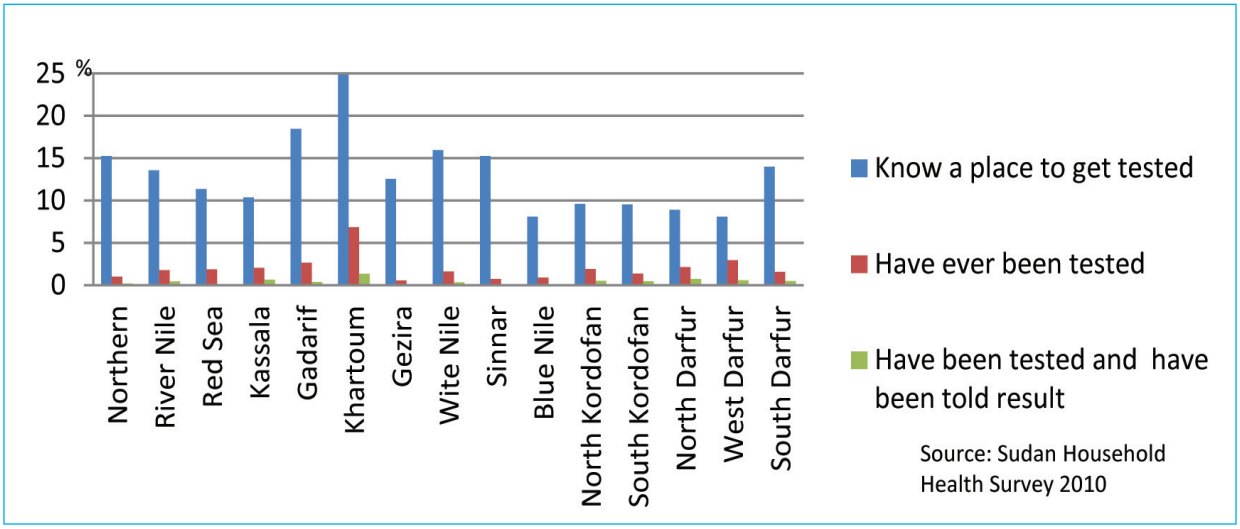
HIV/AIDS

Deeply ingrained stigma surrounding HIV/AIDS (MDG6) makes it hard to track the actual prevalence and thwarts prevention initiatives. Awareness among women aged15 to 49 is alarmingly low: comprehensive knowledge about HIV prevention is a mere 5.8 per cent; one in four have never even heard of AIDS; only half of women in rural areas know that HIV/AIDS can be passed from mother to child and even fewer know how it is transmitted.

Even though many women know where to get tested, very few actually do, according to SHHS2. While 14.4 per cent (1,029,061) of women aged 15 to 49[23] can identify a testing site, only 2.5 per cent (178,656) have ever been tested and less than one per cent of women were tested within the last year (2009). This underscores a serious need to not only facilitate testing, but to identify and address barriers to accessing services. Current efforts to overcome stigma and raise awareness are clearly insufficient.

22 2009 Comprehensive and Coherent Review of the Northern Sudan Schools Health Programme for five North Sudan representative states (Khartoum, Northern, Gadarif, South Kordofan and Sinnar States).
23 Total number of women aged 15-49 is 7,146,254 according to 2008 census data

Figure 12: Many women who know where to get tested for HIV/AIDS still do not get tested
Percentage of women who know where to get tested, who have ever been tested, and who have been tested and have been told results



Due to religious beliefs and limited risky behaviour, overall HIV/AIDS prevalence in Sudan remains low. However, urban areas and places of high migration are of concern. A recent study found that more than half of the people who tested positive for HIV/AIDS in 2010 were in Khartoum, the most urbanized state in Sudan.[24] In Kassala and Gadarif states, the combined presence of refugees, internal migration, and urbanization together create an environment conducive to the spread of HIV/AIDS and other sexually-transmitted infections.

The Estimations and Projections Package (EPP), undertaken by SNAP in 2009 shows that about 72,665 women in Sudan are HIV positive. This figure is projected to increase to 133,871 by 2014. About 5,779 children born to HIV positive mothers are themselves infected by HIV and this number is projected to increase to 9,466 babies by 2014. The overall HIV prevalence among children between 0-14 years is estimated to be 0.07 per cent. New HIV infections among children 0-14 years are projected to range from 2,643 in 2010 to 4,202 by 2014.

The relatively low HIV prevalence compared to other African countries could have been an opportunity to provide quality equitable HIV services to women and children in Sudan. However it is a challenge as it creates an environment of increased stigma not only in the community but also inside the health workforce itself. As a result women and children affected by HIV/AIDS have limited access to health and protection services. In addition, the need to prioritize resources for high HIV burden states (Khartoum, Red Sea, Kassala, Gezira, Gadarif, Blue Nile and South Kordofan) will also mean HIV affected communities in other states have even less access to services.

Child Protection

State legislation in favour of child rights is coming into effect: Child Acts in Gadarif, South Kordofan, Red Sea, and West Darfur have been enacted. In South Darfur the Child Act was signed on 12 October 2011 by the state governor. Some other states are drafting their own Child Acts.

Children living on the streets constitute the largest group of separated and unaccompanied children in Sudan, according to NCCW's family tracing and reunification database. The Khartoum State Ministry of Social Development registered 3,500 children living on the streets in 2010, while the Ministries of Social Welfare in North and South Kordofan, Abyei, South, West and North Darfur, Red Sea and White Nile states registered 5,331 children, mostly boys.

24 Sudan National AIDS Program annual report 2011.p17

Children have also been directly impacted through involvement in armed conflict. Following the signature of the three peace agreements (the Darfur Peace Agreement, the Eastern Sudan Peace Agreement and the Comprehensive Peace Agreement), more than 2,100 children associated with armed groups and forces have been registered for participation in the child disarmament, demobilization, and reintegration (DDR) programme in Sudan.

Reintegration programmes have been implemented in nine states across Sudan, including the three Darfur States. Although it is difficult to estimate the exact number of children who are still associated with armed groups and forces in Sudan, it is worth noting that, for instance, out of the list of 2,000 names that were initially submitted by armed groups for participation in the child DDR program in Darfur in 2009, all children had been verified and 996 children have been registered as children formerly associated with armed forces/groups in Darfur. As of June 2011, 1,288 children formerly associated with armed groups were benefiting from reintegration activities. Limited access due to security and on-going clashes in some part of Darfur and areas bordering Southern Sudan continue to pose a challenge to effective follow-up of demobilized children as well as reintegration activities.

In terms of children in contact with the law, police records reflect a sharp increase in the number of cases of violence against children from 10,491 in 2009 to 12,340 in 2010 (18 per cent). The number of cases of criminal action committed by children also increased from 15,435 in 2009 to 16,464 in 2010 (6.7 per cent). Khartoum state reported the highest percentage of cases of violence against children (48.8 per cent) in 2010) as well as criminal actions committed by children (57.5 per cent) in 2010.[25]

FGM/C

Female genital mutilation and cutting (FGM/C) is still commonly practised in Sudan, 87.6 per cent of girls and women aged 15-49 years have undergone the procedure according to SHHS 2010. However, the SHHS in 2006 and 2010 collected information on the FGM/C status of all women aged 0-50+ living in the household. The global prevalence rate for this broader age group in Sudan was 69.4 per cent in 2006 compared to 65.5 per cent in 2010. Rates are particularly high in Northern (83.8 per cent) and River Nile (83.4 per cent) states.

Support for FGM/C varies significantly according to region, age, educational status and quintile. According to the 2010 data, better educated women and women in the wealthiest quintile are less likely to favour the continuation of FGM/C (20.7 per cent) compared to 2006 (23.7per cent) among the wealthiest women aged 15-49 yrs. Geographically, acceptance of FGM/C is weakest among women in Khartoum (22.2 per cent) and highest among women from South Darfur (66.5 per cent) and Kassala (66 per cent).

Overall, there is clear evidence of a reduction in the number of younger women who think that FGM/C should continue (37.3 per cent of women aged 15-19 in 2010 compared to 41.9 per cent in 2006). Intention to cut daughters decreased from 53.6 per cent in 2006 to 48.0 per cent in 2010 showing an improvement in attitudes of women towards cutting daughters. A notable increase in the prevalence of FGM/C has been especially in West Darfur (46 per cent in 2010 compared to 39.8 per cent in 2006), South Darfur 60.9 per cent In 2010 compared to 59.6 per cent in 2006 while a decrease in prevalence is noted in Blue Nile (48.7 per cent in 2010 compared to 58.2 per cent in 2006) and Gadarif (50.4 per cent in 2010 compared to 59.3 per cent in 2006) for the age group 0-50 yrs. Unfortunately the trend is not uniform across the states.

At the country level, the share of girls and women who have undergone FGM/C jumps from 37.0 per cent before age 14 to 83.1 per cent for those aged between 15 and 17. This may be because girls at this age start to get married. In Darfur the age of cutting is higher than in other parts of the country ranging from eight to 15 years especially among the Fur and Zagawa ethnic groups. Also, many tribal groups in Darfur, who were not used to cutting their daughters, start later when they are displaced to cities and towns, suggesting a link between the practice and the social norms of urbanism.

Campaigning to abandon FGM/C collectively has been promoted through the launching of the national Saleema initiative. This seeks to shift norms in favour of not cutting, and community empowerment that advocates for collective action to abandon the practice. This advocacy for the new norm is about being proud of keeping a daughter uncut. Since 2010, some 600 communities have joined the Saleema initiative.

25 Criminal Investigation Directorate report, 2009/2010

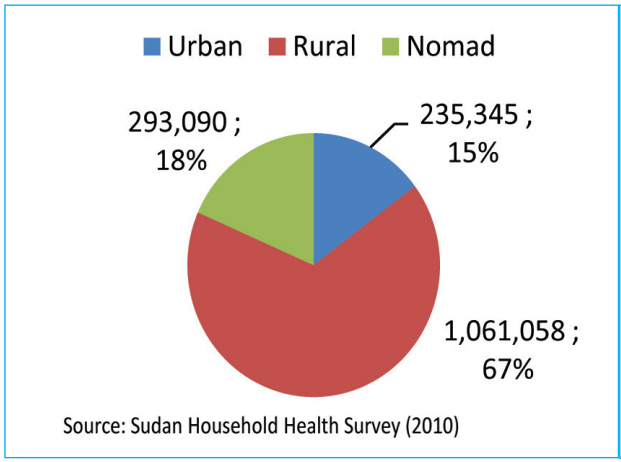
The Current State of Sudanese Women and Girls

Mothers in rural areas travel long distances for essential child health care services, make several trips daily to collect safe drinking water for their families, and scrape together almost non-existent resources to ensure the healthy development of their children. Girls share these responsibilities with women, as they are often pushed into early adulthood through marriage or domestic duties.

At the same time, many women are denied basic rights to education, protection against harmful practices like FGM/C (see separate section above), the freedom to choose when and whom to marry, and access to lifesaving maternal care.

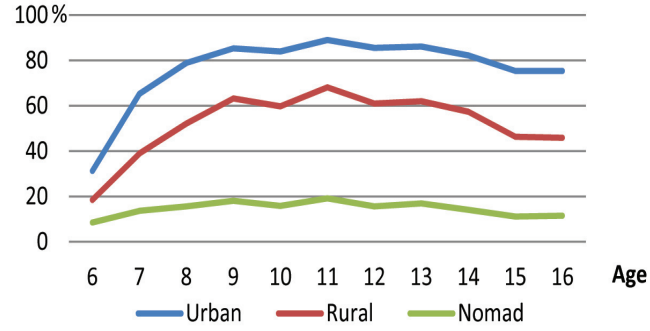
Slightly more than half of Sudan's 4.2 million girls of school age (six to 16 years) are attending school, according to the 2008 census. Nomadic girls are almost four times less likely to go to school than rural girls, and five times less likely than girls in urban areas (Figure 13 and 14). In all cases, drop out rates increase as girls get older due to early marriage or familial responsibilities.

Figure 13: Majority of the out-of school girls live in rural areas
(number of girls age 6-16 who have never attended or only previously attended school)



Source: Sudan Household Health Survey (2010)

Figure 14: Area of residence influences girls' school enrollment rate
Percentage of girls currently attending school among urban, rural and nomad populations



Source: Sudan Household Health Survey (2010)

Seven states have succeeded in achieving a rate of girls' primary school attendance that is equal to or higher than boys', according to SHHS2. In Khartoum, Northern, Gezira, White Nile, River Nile and Blue Nile, equal proportions of girls and boys are attending primary school. Among older children, a nearly equal proportion of girls and boys are attending secondary school in North Kordofan, and more girls than boys are attending in Red Sea, Northern, Kassala and Khartoum. In Red Sea, *more* girls, 73 per cent, are attending primary school compared with only 66 per cent of boys. This trend of a higher female enrolment is more prominent in secondary education where girls' enrolment rate (26 per cent) is almost 1.6 times higher than boys'.

Table 2: States that have equal or larger primary/secondary school attendance ratios for girls

State	Primary school adjusted net attendance ratio (NAR), girls (%)	Primary school adjusted net attendance ratio (NAR), boys (%)	Gender parity index (GPI) for primary school adjusted NAR	Secondary school adjusted net attendance ratio (NAR), girls (%)	Secondary school adjusted net attendance ratio (NAR), boys (%)	Gender parity index (GPI) for secondary school adjusted NAR
Red Sea	73.1	66.1	1.11	25.5	16.4	1.56
Gezira	85.2	84.6	1.01	41.9	44.1	0.95
White Nile	79.9	79.7	1.00	32.3	40.7	0.79
Khartoum	90.5	91.6	0.99	47.9	42.6	1.12
Northern	91.5	92.8	0.99	52.1	42.6	1.22
River Nile	83.5	85.2	0.98	41.4	44.6	0.93
Blue Nile	59.2	60.4	0.98	11.2	12.9	0.87
North Kordofan	70.3	75.0	0.94	19.2	19.9	0.96
Kassala	49.9	63.9	0.78	19.0	16.6	1.15

Source: Sudan Household Health Survey 2010
Note: GPI for adjusted NAR is calculated by dividing girls' adjusted NAR by boys' adjusted NAR.

More than one in three women marries before the age of 18 and one in ten before the age of 15. Women in rural areas and in the poorest quintile have a greater likelihood of marrying early. Estimates of child marriage range from as high as 50 to 60 per cent in South Darfur and Blue Nile, to as little as 20 to 30 per cent in Northern, River Nile, Khartoum and Gezira.

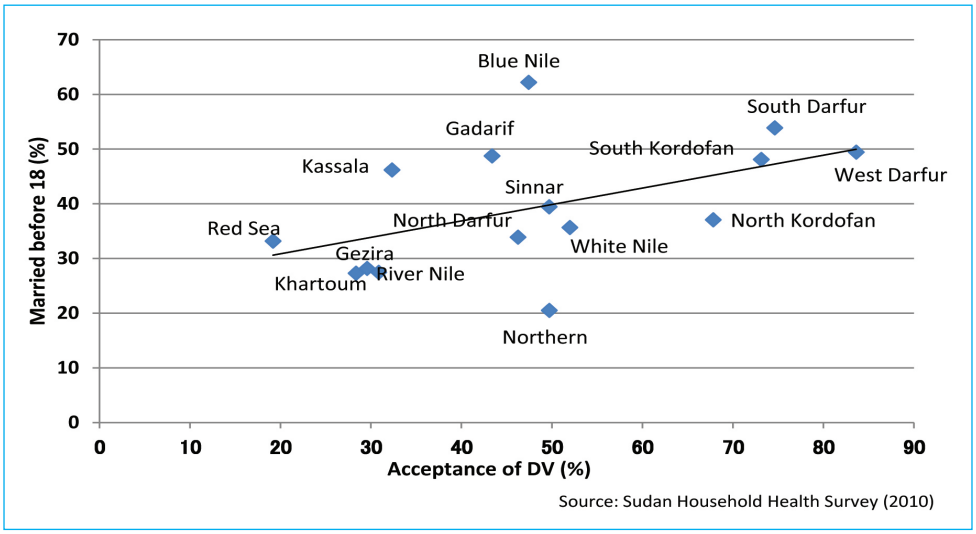
A major negative consequence of child marriage is adolescent and teen pregnancy, when girls are not mentally, emotionally, or physically mature enough to start bearing children. Globally, 15 to 19 year old girls are twice as likely to die from pregnancy-related causes as women in their twenties.

According to statistical data, more than 16 per cent (1,143,401) of 15 to 19 year-old girls have started having children. Compared with urban areas, teen pregnancy is almost twice as common in rural locations, where childbirth is made all the more dangerous due to limited access to emergency obstetric care and health facilities. Only 66 per cent of women in rural areas have skilled attendants at birth, compared with 89 per cent in urban locations (MDG5).

Recent data finds a correlation between child marriage and acceptance of domestic violence. States with high child marriage rates also have high rates of women who tolerate domestic violence. Reasons they give as acceptable include neglecting the children, leaving the house without permission and burning the food.

Figure 15: Women's acceptance of domestic violence is higher in states where the share of early marriage is high

Share of women age 15-49 who married before 18 and who believe a husband is justified in beating a wife if she goes out without telling him, neg



Gender equity (MDG3) is critical to development: girls who stay in school have a greater ability to earn income as adults; reproductive freedom often results in better care of smaller families; and their informed voices in the community lead to better decisions for children. As 30 per cent of Sudan's 15 million females are under the age of ten, investing in their development now will reduce poverty and inequality for future generations and also improve child and maternal health. For the adolescent and teenage girls who are making the transition to adulthood, protective interventions are urgently needed.

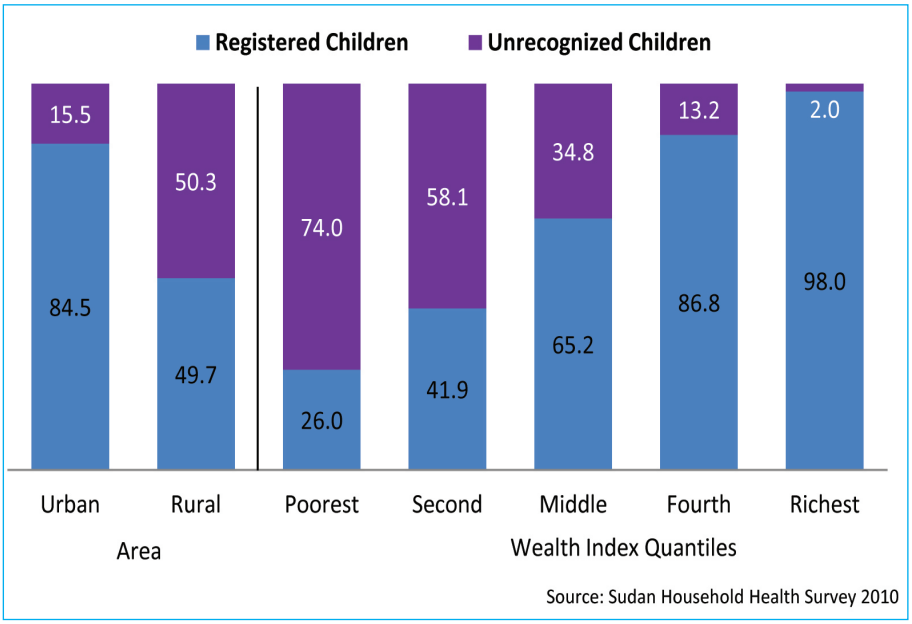
An Equitable Approach to Progress

Progress has been made towards the MDGs, but it has not been equitable. Children of rural and nomadic populations as well as those in the poorest quintile are the most vulnerable because they are the most difficult to reach. Girls, children without parental care, those associated with armed conflict, and those with disabilities are also marginalized groups that are often neglected in policy planning and budget allocations.

Unequal allocation of public and private sector resources is a major reason for these inequalities. Lack of power and wealth sharing between the national and state governments as well as between urban and rural areas are also contributing factors. Inflation is a constant issue that impacts the living conditions of low income and vulnerable groups, especially children and women.

Achieving equitable progress starts with registering every child at birth. Recent data shows that almost 40 per cent of children under five remain unregistered in Sudan, depriving them of their rights to identity and limiting their access to services. Almost all children in the richest quintile of the population are registered (98 per cent), compared with only one quarter of children in the poorest quintile (26 per cent). Only half of children in rural areas are registered, compared with 85 per cent in urban locations.

Figure 16: Birth registration is lower in rural areas and the poorest quintile
(children under age 5)



Poor and rural children are the ones that have the most to gain from birth registration. By providing evidence of a child's age, registration strengthens children's civil and social rights that they are guaranteed as citizens. It also gives them greater access to education and basic services, and helps ensure their protection from early marriage, early recruitment to armed forces and other age-specific laws. As data shows that poor and rural children are the most affected by these issues, birth registration could be the most effective and low cost intervention for protection.

While there is a marginal difference in mortality rates between urban and rural locations, the real difference lies in wealth and education. A child born into poverty in Sudan is nearly twice as likely to die by his or her fifth birthday as those born to the wealthiest families (82 deaths per 1,000 live births compared with 43). Children of mothers that have no education are more than twice as likely to die by age five than those whose mothers have a secondary education (92 deaths per 1,000 live births compared with 44).

Figure 17: Mortality Rate is lower for a child whose mother has higher education
(out of 1,000 live births)

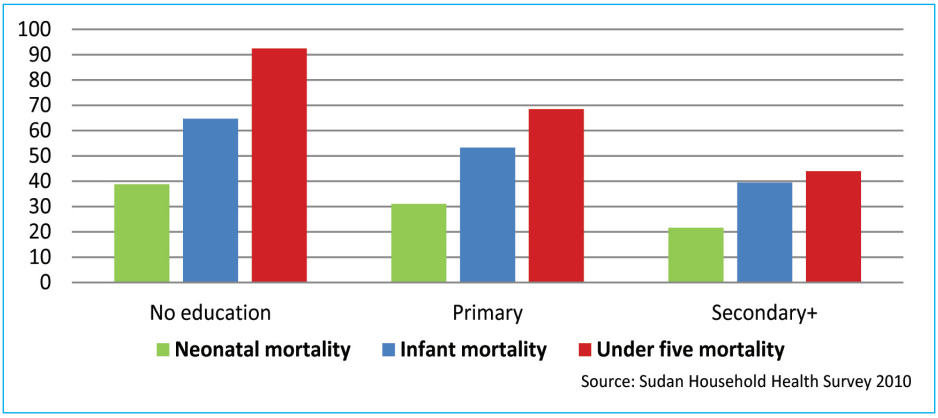
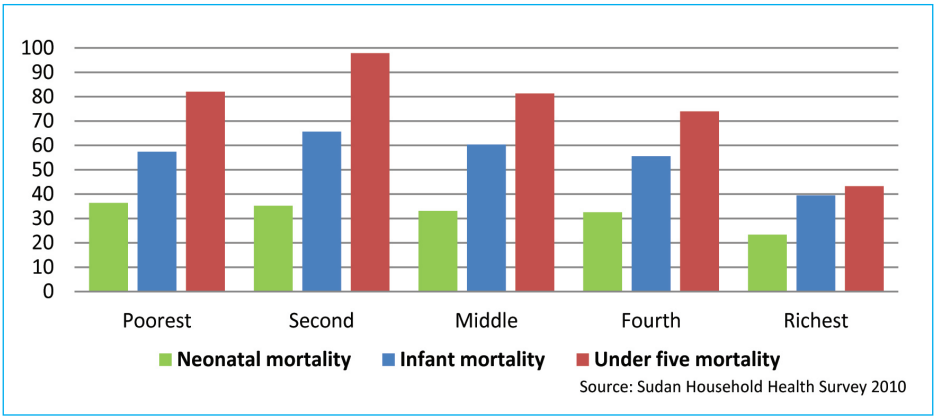
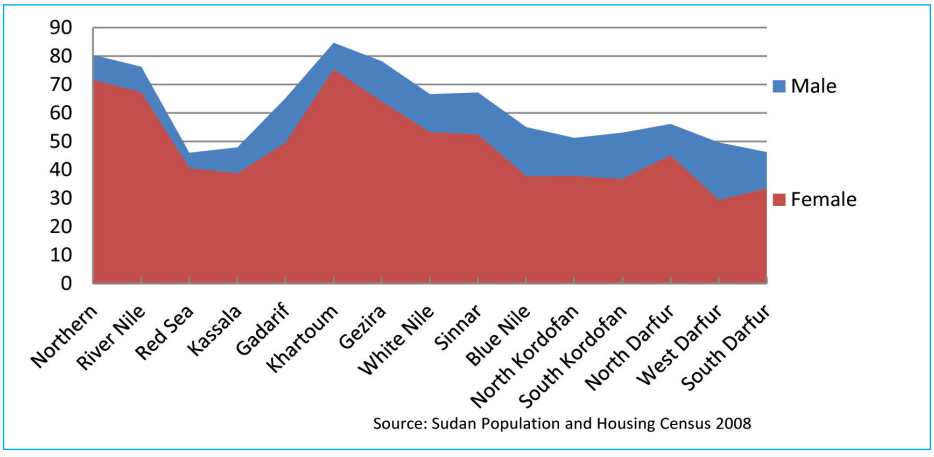


Figure 18: Children born in the poorest quintile are more likely to die than those born in the richest quintile
(out of 1,000 live births)



Literacy rates reflect disparities in education. A greater proportion of men are literate in every state, with the most significant gaps in the Darfur region and Kordofan states (Figure 19). Gender gaps exist at every age among school going children in Sudan. Therefore, providing gender and girl-friendly schools is imperative. Separate sanitation facilities, female teachers, and gender sensitive and appropriate learning materials are critical to increasing girls' enrolment in school.

Figure 19: More men than women are literate in every state
Percentage of males and females 6 years and older who are literate by state



Current data collection methods are not yet sophisticated enough to fully measure the situation of children who are without parental care, trafficked, associated with armed conflict or living with differentiated abilities.

Disaggregating the data

Sudan has made a lot of progress in providing clearer information regarding the situation of children and women. However, while national level data on children can be helpful, it cannot give a full and accurate picture. The chapters that follow provide a state-by-state snapshot of the children in Sudan using available official information. However, the acquisition of locality- and community-level data based on equity, identifying the most vulnerable groups of children and the necessary interventions should continue to receive priority from the government and the development community as a whole. Comprehensive, reliable, disaggregated data at the closest level to individual children is needed to measure how the states are progressing in caring for their children. While it is hoped that the data in this publication can be a significant building block for the future of Sudan, the need for continued collection of disaggregated data that could be utilized for policy development and monitoring of progress.

For example, a lack of reliable data frequently undermines efforts to convince governments of the need to increase their educational provision for children with disabilities (sometimes known as children with differentiated abilities). Relevant policy development and planning is dependent on accurate and reliable data. This is needed to understand the extent of the problems and plan the appropriate interventions. Similar needs for further information exist for street children, children in contact with the law, abandoned children and orphans.

The Way Forward[26]

This report examines the state of children by shedding light on recent successes and the challenges they face in health, education, WASH and protection. The report argues that investing in them now is the way to improve their wellbeing and a guarantee for development, a peaceful environment and better life opportunities.

Inequality and disparities in the distribution and provision of services is a common feature among the different states. The disparities in provision of services also exist within the state, notably between the rural and urban populations of the state. Rural populations, nomads, and the displaced were identified as the most vulnerable population groups. Poverty, lack of safe drinking water, poor sanitation, inadequate health services, the wide practice of female genital mutilation/cutting (FGM/C) are common issues in all the states.

In general, there is a gender gap in education enrolment in all the states -- the gap in even bigger among the rural and nomadic population. Nomadic children, for example, are a highly marginalised population, with less than ten per cent attending school when the 2008 census was taken.

Considering all the above, intensive efforts are still needed to fill the gaps that have been flagged. A strong commitment to children and coordinated efforts are needed more than ever. Continuation could be based on the success seen in recent years through ongoing commitment to the rights of children and the commensurate allocation of resources. This means continuing to collect reliable, disaggregated data that monitors progress and identifies areas of need. Laws and policies - driven by data and backed by sufficient resources and political willpower - can bring about widespread, positive changes when adequately enforced. Strengthening partnerships between government, international organizations, local organizations, community groups, religious leaders, the private sector, and children themselves, is imperative to ensuring that the most marginalized children are reached, making the change equitable and lasting.

26 For sector specific summaries, please see the conclusion chapter at the end.

1 Northern State

Key Indicators from Sudan Household Health Survey 2010 (%)	
Birth Registration	94.3
Fully Immunized	60.4
Global Underweight Prevalence	22.2
Global Stunting	24.0
Global Acute Malnutrition	12.9
Use of Improved Drinking Water Sources	93.2
Use of Improved Sanitation Facilities	73.5
Pre-school education Enrolment[1]	64
Primary School Enrolment	84.7
Secondary School Enrolment	50.7
People with Differentiated abilities[2]	2.5
FGM/C Prevalence	83.8
Early Marriage (before 18)	20.5
Attended by Skilled Person at Birth	96.7
State Child Act – Enacted	No
State Child Act – Under Draft	No
State Child Act – Ban on FGM/C Included	No
Infant Mortality Rate[3] (per 1000 live births)	65
Maternal Mortality Rate (per 100,000)	437

Northern state is privileged with the highest individual per capita income in Sudan. This is reflected positively in the demographic and development indicators of the state. The indicators for women and children are the best compared to the other states of Sudan.[4] According to these indicators, it is the safest state in Sudan in which to have a baby because it has the highest antenatal care coverage. Good access to health facilities contributes to good immunization coverage and nutrition among children. Improved water and sanitation reach a greater proportion of the population than anywhere else, with almost everyone having a private toilet or pit latrine. The only exceptions are the rural Busharieen and Ababda tribes who live in the desert of the eastern and north eastern parts of the State. At 63 per cent, the female literacy rate is nearly four times the national average, according to SHHS2.

High revenues are earned from fishing which has provided a good source of income following the construction of the Merowe dam. In the last two years, gold mining has attracted thousands from different parts of the country. The consequent high demand for support services for the inflow of miners has created work and market opportunities, especially in urban centres which have consequently witnessed increased economic transactions and activities.

However, strategic policy and budget planning backed by strong government commitment and rich cultural heritage is the real driver of progress in this state. This, coupled with limited areas of habitation (mainly along the banks of the river Nile) makes it relatively easy to provide health, education and other services to the people of the state.

Progress is not necessarily equitable, however. Northern state is the largest state geographically but had a population of only 686,000 in 2008. Infrastructure is poor in many areas, leaving many small villages excluded from basic services. Nomadic children, for example, are less likely to go to school and more likely to be economically active, making them the state's most vulnerable group of children.

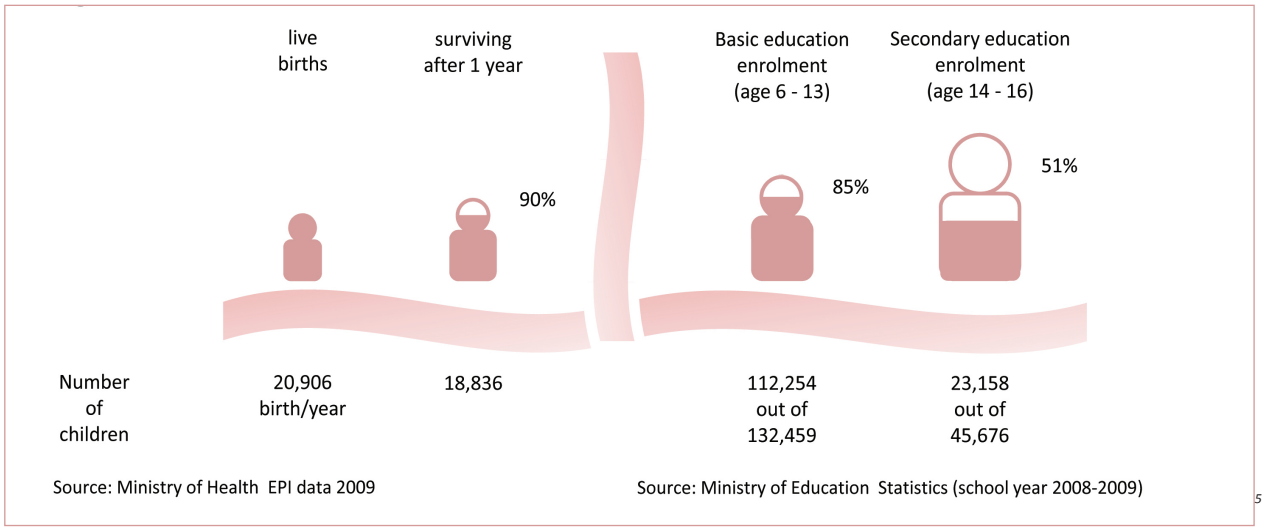
1 Ministry of General Education, Educational Statistics 2008-9

2 Those who are conventionally known as the disabled may develop other abilities to compensate their disabilities (Data from Census 2008).

3 IMR and MMR are from 2008 Census, CBS

4 Financial Management and Procurement Groups, Africa Region, Sudan Country Integrated Fiduciary Assessment (CIFA) 2005-2007, The World Bank, May 2010, p. 25.

Figure 1.1: Infant survival & school enrolment in Northern

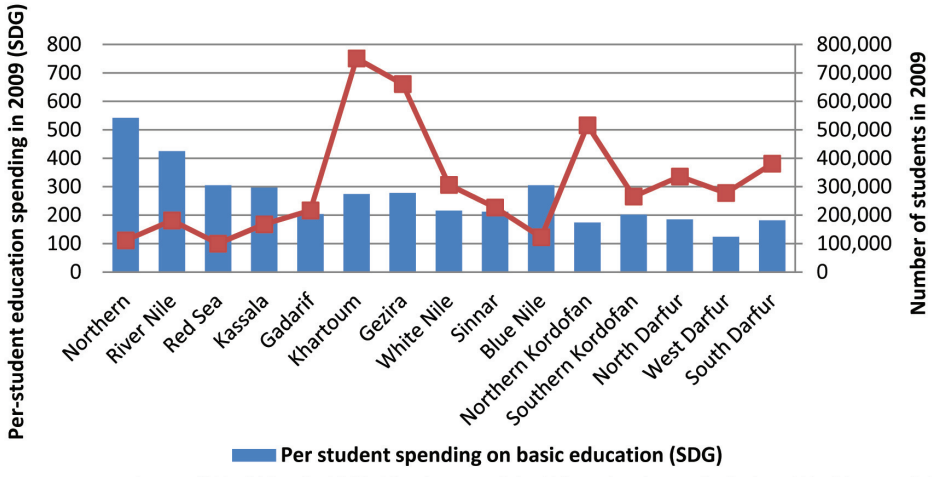


Education

Northern state exemplifies what can be achieved through a strong government commitment to education. The state has invested heavily in basic education, spending more per student than any other state (SDG 542 compared with the national average of SDG 262) (Figure 1.2). As a result, student-teacher ratios are small, most teachers are trained and early education is available to more children than in most other states.[6]

The result is a 92 per cent attendance rate in primary education, the highest in all of Sudan and a five-point increase from 2006, according to SHHS. Secondary school attendance is also the highest in Sudan, having increased from 39 to 47 per cent in just four years. Of the 178,500 children between the ages of six and 16, around 144,500 (81 per cent) were currently attending school when the 2008 census was taken.

Figure 1.2: Northern state has the highest per-student spending
Number of students and per-student education spending in 2009



Source"*World Bank, 2012, The Status of the Education Sector in Sudan, Washington DC*"

Remarkably, the government of this very large and rural state has mostly succeeded in promoting equitable school attendance, with little gap between male and female, or urban and rural populations. In primary school, there is virtually no gender gap. Only in secondary school there seems to be a reverse gender gap, with a higher proportion

5 The number of children enrolled includes children of all ages, whereas the denominator is based on the population for age 6-13 years for primary education and age 14-16 years for secondary. This may result in a higher enrolment rate than is the reality.

6 Source: "World Bank, 2012, The Status of the Education Sector in Sudan, Washington DC"

of girls attending (52 per cent) than boys (43 per cent). The 2008 census found very little gap between urban and rural populations, with rural children slightly more likely to attend school.

However, universal education (MDG2) has still not been achieved and this is arguably where the real challenge begins. Reaching the remaining eight per cent of primary school age children requires scaling up efforts to identify and engage these children. Nomadic children, for example, are a hugely excluded population, with less than ten per cent attending school when the 2008 census was taken. Children with differentiated ability, those living on the street, and children without parental care, are other marginalized groups that may not be engaged in the school system.

The importance of secondary education must not be lost in efforts to reach MDGs for primary education. Greater efforts must be made to understand and address root causes that keep children from attending and completing secondary school. It is known, for example, that child marriage is common in Northern state, with one fifth of women aged 20 to 49 married before their 18th birthday. Household chores are another common reason for adolescents to leave school. These issues must be further understood and investigated.

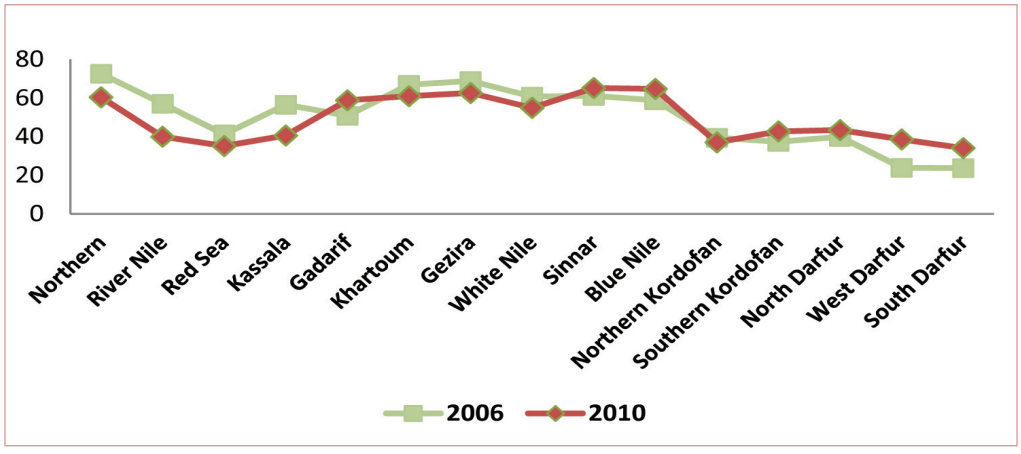
Health

Northern state excels in many areas when compared with other states, which makes it surprising to see a comparatively poor performance when it comes to immunization. Data is, in fact, mixed. Some show declining rates of immunization while others show increasing rates but below average performance. However, all point to the conclusion, that there are areas that need improvements.

According to the Sudan Household Health Surveys for 2006 and 2010, the state has dropped from first place to fifth among Sudan states in terms of the share of fully immunized children (Figure 1.3)[7]. In 2006, it had the highest rate at 73per cent. Within four years, coverage fell to 60 per cent, following Sinnar, Blue Nile, Gezira and Khartoum.

Figure 1.3: The number of children who are fully immunized has decreased between 2006 and 2010

(Months 23-Children Age 12)



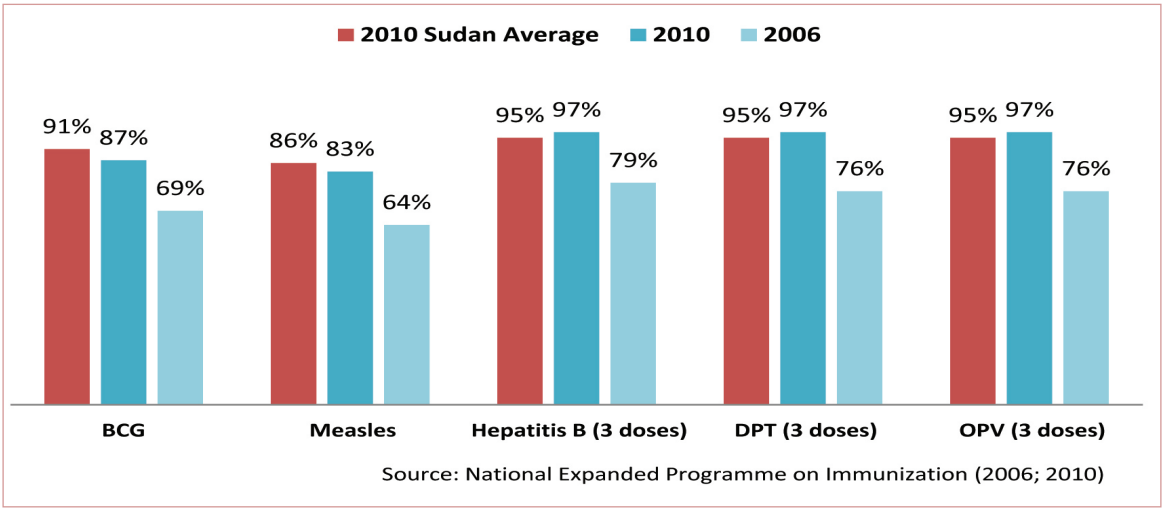
The Federal Ministry of Health data for its EPI, on the other hand, shows trends going in the opposite direction, increasing between 2006 and 2010 (Figure 1.4). Although the data does not include rates of full immunization coverage, it does show increases in measles, BCG for tuberculosis, OPV and Pentavalent.[8] Despite improvements, rates for BCG and measles fall below Sudan averages.[9] One of the problems facing Northern state is a lack of means of transport which limits the implementation of outreach and mobile immunization activities.

7 The denominator is a percentage share of children age 12-23 months for both 2006 and 2010 surveys. However, the definition of full immunization is different in the two surveys. For SHHS1, children were considered to be fully immunized if they had received BCG, measles, three doses of DPT, and three doses of OPV. For SHHS2, on the other hand, children were considered to be fully immunized if they had received BCG, measles, three doses of OPV, and three doses of Pentavalent (DPT, Hepatitis B and HiB).

8Pentavalent vaccine includes DPT (diphtheria, pertussis, and tetanus), Hepatitis B and HiB (Haemophilusinfluenzae type B) vaccines, and it requires three doses to get full protection. Pentavalent immunization started in Sudan from January 2008.

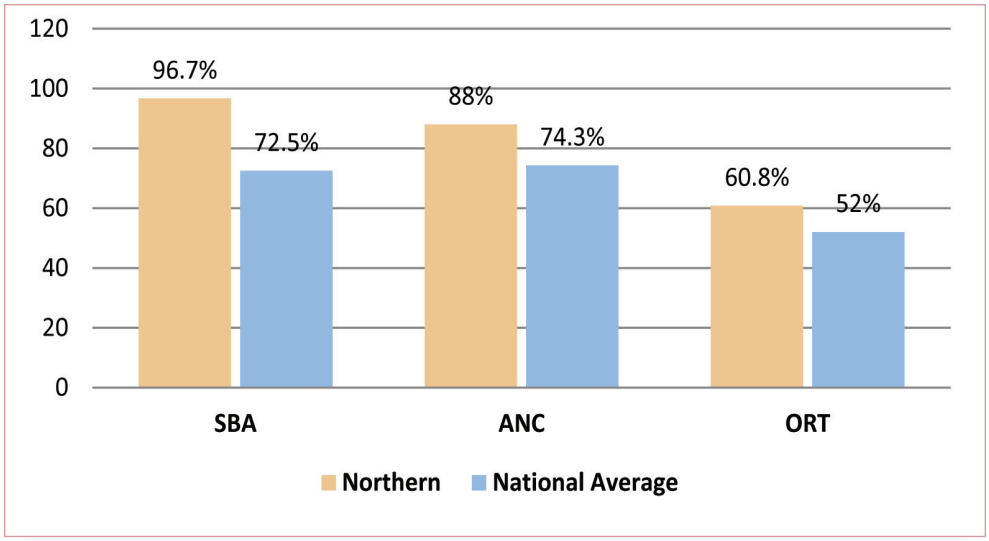
9EPI uses surviving infants (all births minus deaths in the first year of life) as a denominator, except for BCG, which uses total number of live births. SHHS uses 12-23 months old as a denominator.

Figure 1.4: Immunization coverage in Northern state has improved between 2006 and 2010



Almost all health indicators in this state appear to be strong: maternal mortality ratio, under five mortality and neonatal mortality rates show a situation that is better than the national average. For example, almost every live birth takes place in the presence of a skilled attendant, which is important to saving the lives of both mothers and babies. Nearly 97 per cent of women aged 15 to 49 that were surveyed reported having a doctor, midwife, traditional birth attendant or other skilled personnel present during childbirth. Eighty eight per cent received antenatal care while 51 per cent delivered in a health facility, more than twice the average for Sudan. Sixty one per cent of children younger than age five with diarrhoea received oral rehydration treatment – the highest rate in Sudan along with South Darfur, but still no different than in 2006.

1.5: Skilled birth attendants (SBA), Antenatal care (ANC) and Oral rehydration therapy (ORT) in Northern state

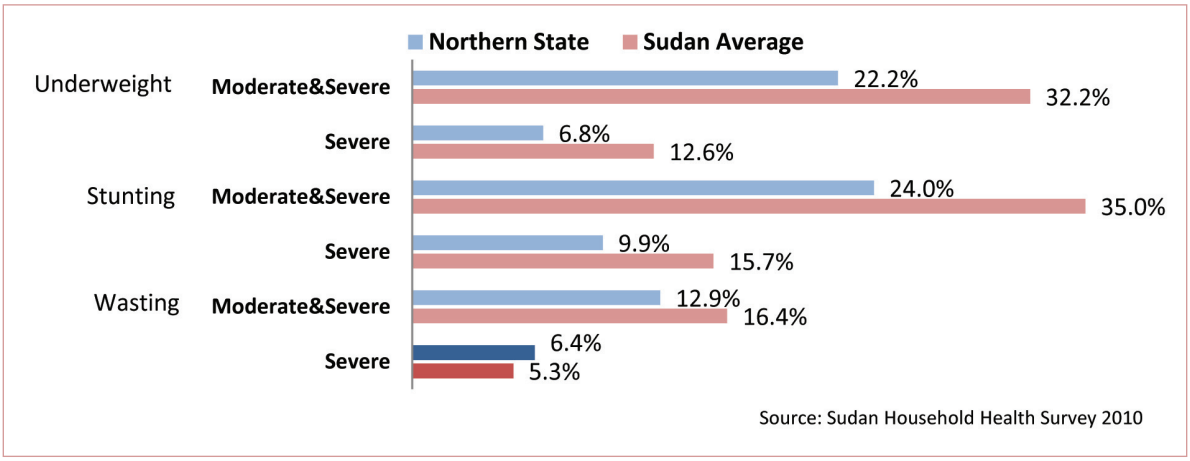


Nutrition

When set against international standards, the level of acute malnutrition shows a serious situation, while levels of chronic malnutrition are classified as medium.[10] Despite this, Northern State is among the best-off states in Sudan for these indicators with most results being below the national average (Figure 1.6). Although the global acute malnutrition (GAM) indicator shows that Northern State is doing far better compared to the Sudan average, the proportion of children suffering from SAM is higher than the national average where it is reported at 6.4 per cent. This will eventually have implications on child survival levels in the State.

10 Physical Status: The use and interpretation of Anthropometry, report by a WHO expert committee, 1995, Chapter 5, p208 & 212

Figure 1.6: Nutrition in Northern state is better than the national average, except for Severe Acute Malnutrition

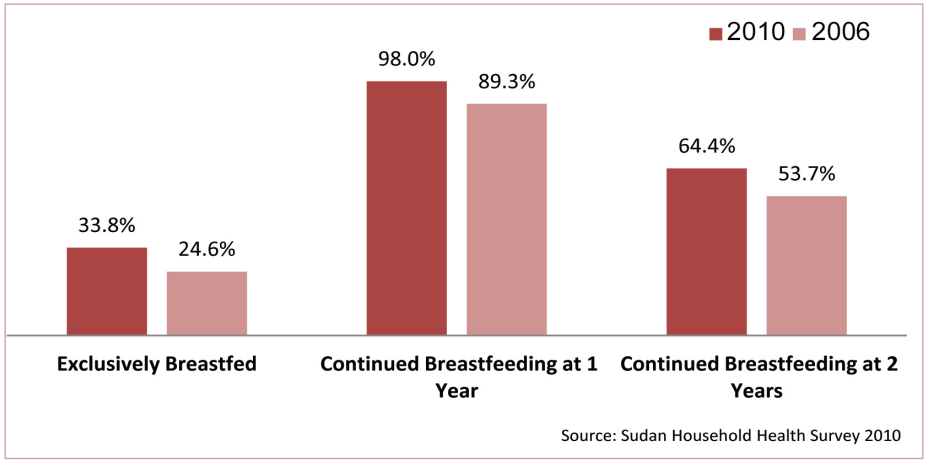


Children in five other states are eating better than in Northern State. About one third of all children aged six to 23 months are receiving the minimum number of meals every day, according to the latest SHHS2. At 35 per cent, the rate is less than Gadarif (50 per cent), Blue Nile (45 per cent), Khartoum (41 per cent), White Nile (37 per cent) and South Kordofan (36 per cent).

Northern state is also average in terms of provision of Vitamin A, according to SHHS2. Sixty-one per cent of children aged six to 23 months in Northern state received Vitamin A supplementation in the six months prior to the survey, falling almost halfway between the lowest ranking state -- West Darfur at 32 per cent -- and the highest ranking, Blue Nile at 83 per cent.

Other areas of nutrition, however, show improvements since 2006 but are still below the national averages. Exclusive breastfeeding rates during the first five months of life have increased from 25 per cent in 2006 to 34 per cent in 2010 (Figure 1.7), nevertheless still below the national average of 41 per cent.

Figure 1.7: Breastfeeding in Northern state has increased between 2006 and 2010



Only one per cent of households are consuming adequately iodized salt (15 PPM or more). This improvement was attained since 2006, when the rate was 0.2 per cent. However, it falls short of the national average of 9.5. Iodine deficiency is the single greatest cause of preventable mental retardation.

FGM/C

Northern State has the highest rate of FGM/C in all of Sudan. Eighty-four per cent of girls and women have undergone the procedure. Put differently, five out of every six women are circumcised. The dangers this practice entails to women are well known, ranging from infection and excruciating pain following the procedure, to complications associated with child delivery.

Women here accept the perpetuation of the practice. More than half of ever married women intend to perform FGM/C on their own daughters. Of all women in the age group 15 to 49, 39 per cent believe that the practice should be continued, compared with only 35 per cent of men.

All members of society are responsible for the abandonment of this harmful practice. However, girls who are cut are more likely to be socially accepted and have a better chance for a prosperous marriage. Therefore, until societal attitudes shift towards the protection of girls, this harmful practice will continue, to the detriment of women's health.

Call to Action

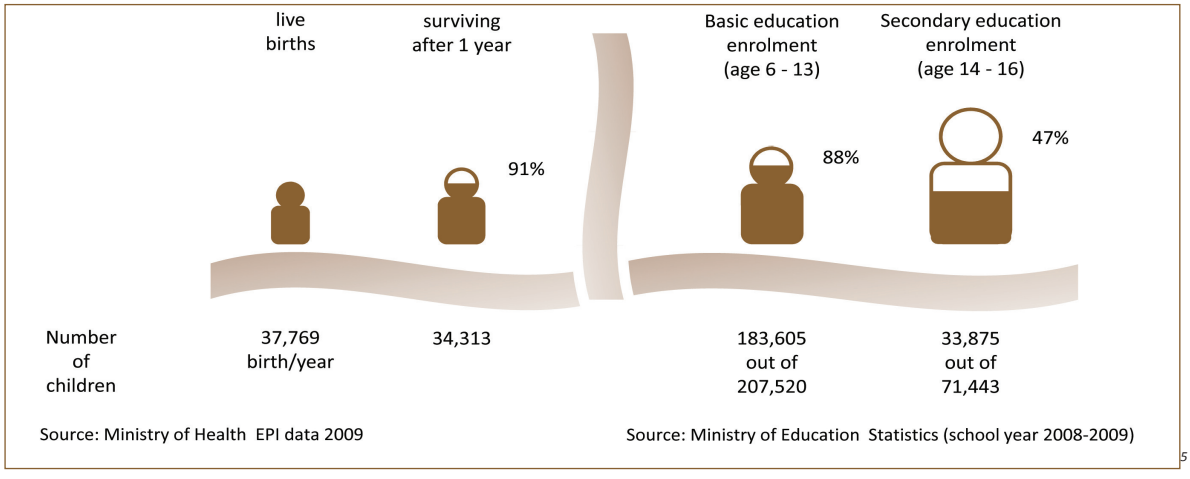
- Build on success of investments in education by reaching the last eight per cent of primary-school age children. This means identifying those children, where they are, and targeting the root causes of school drop-out.
- Identify root causes for low attendance in secondary school and increase efforts to engage secondary-school age children.
- Increase investment in the health sector, by ensuring well-staffed and equipped service delivery points, and a well developed and institutionalized health information system.
- Raise the profile of nutrition as a public health problem that needs to be addressed, by identifying the causes and appropriate interventions required for the reduction of SAM.
- Advocate for placing nutrition among the priority issues of the national and the states' policy to enable promoting strategic planning and increasing fund allocations. For example, salt iodization should become compulsory by law.
- Promote community-based initiatives that raise awareness about the harm caused by FGM/C, and thereby contribute to positive change in social attitudes and behaviour. Enactment of a Northern State Child Act that includes banning of the FGM/C is strongly recommended as a pioneer initiative to be used for further advocacy efforts.
- Share best practices. Northern state's experience of investing in education and reaping of its return can be an example for other states to follow.

2 River Nile State

Key Indicators from Sudan Household Health Survey 2010 (%)	
Birth Registration	82.6
Fully Immunized	40.0
Global Underweight Prevalence	32.2
Global Stunting	30.3
Global Acute Malnutrition	18.5
Use of Improved Drinking Water Sources	81.1
Use of Improved Sanitation Facilities	42.4
Pre-school Education enrolment[1]	62.7
Primary School Enrolment	88.5
Secondary School Enrolment	47.4
People with Differentiated Abilities[2]	5.0
FGM/C Prevalence	83.4
Early Marriage (before 18)	27.3
Attended by Skilled Person at Birth	91.2
State Child Act – Enacted	No
State Child Act – Under Draft	No
Infant Mortality Rate[3] (per 1000 live births)	69
Maternal Mortality Rate (per 100,000)	443

True to its name, River Nile state thrives on the rich resources and fertile soil found along the banks of the Nile. Forty two per cent of the state's workforce is employed in agriculture and fishing while, more recently, gold mining has added economic benefits and provided work opportunities to the population. However, while the workforce for gold mining is growing, the agricultural sector is starting to suffer from a shortage of labour. Another livelihood source of is the hydroelectric Merowe Dam that has encouraged investment in the cement industry. Currently there are three newly established cement plants working beside the old one in Atbara. The state has been relatively untouched by the insecurity and conflict that has affected some of its eastern neighbours, allowing development to continue unimpeded. However, those whose livelihoods depend on the river are also vulnerable to flooding, droughts and decreasing water levels. Meanwhile, those who do not live along the river banks must endure the hot and arid landscapes that offer few resources for survival. Sixty-eight per cent (746,202) of the state's 1.097 million people live in rural areas, 29 per cent (318,233) are urban and only 2.6 per cent are nomadic.[4] Children make up 43 per cent of the state's population. Out of 34,300 children born alive in the last 12 months before 2008 census, only 31,100 (91 per cent) were alive at the time of census.

Figure 2.1: Infant survival & school enrolment in River Nile



1 All Education Enrolment Rates are based on the Ministry of General Education Statistics 2008- 9

2 Those who are conventionally known as the disabled may develop other abilities to compensate their disabilities. Data from Census 2008.

3 IMR and MMR are from 2008 Census, CBS

4 Based on the 2008 census.

5 The number of children enrolled includes children of all ages, whereas the denominator is based on the population for ages 6-13 for the primary education and ages 14-16 for the secondary. This may result in higher enrolment rate than the reality.

Key Issues

Water, Sanitation and Hygiene

Total access to improved drinking water for the state population is relatively high at 81 per cent (888,858). On the other hand, access to improved sanitation is low: 42 per cent of the population (460,890) has access to improved latrines, while 37 per cent (406,022) has access to unimproved latrines and 20 per cent of the state population practice open defecation, with the attendant risks in terms of disease. Access to improved sanitation is also low for school children. The 2011-2016 WASH Strategic Plan by the government estimated access for state schools and health facilities at 59 per cent and 81 per cent respectively.

Health

River Nile has some of the best health indicators in the country. More than 95.1 per cent of health facilities are providing Integrated Management of Childhood Illnesses (IMCI) services to children under the age of five who fall sick fromdiarrhoea, pneumonia, malaria and other common childhood illnesses.[6] Comprehensive Emergency Obstetric Care coverage is 100 per cent[7] and maternal mortality ratio is far below the national average.

River Nile is also one of the highest performing states in terms of immunization coverage. According to 2010 data[8]of the EPI, the coverage rates for children under the age of one included BCG vaccine against tuberculosis, measles, three requisite doses of OPV and Pentavalent[9] is 95, 95, 98 and 98 per cent respectively. Only Blue Nile, West Darfur and Gezira states marginally outperform River Nile.

The state's success in immunization may be largely due to the presence of trained EPI staff in contrast to other states where a large proportion of staff are volunteers with a high turn-over. There is also good access to immunization services -- in the last two years almost 20 new health facilities were established. The state has been quite effective in communication and social mobilization that led to high acceptance and uptake of immunization services.

This success, however, is arguable as other data sources highlight different pictures. The SHHS2 shows that polio immunization coverage is poor when compared with other states. Only a little more than half of all children 12-23 months receive the requisite three doses, with only three states (Red Sea, West Darfur and Kassala) doing worse. This is also a drastic decrease from 73.3 per cent in 2006. Low polio coverage could be explained by the difficulty of reaching the children of nomadic families in these states. Therefore, more analysis is needed to know the real situation.

Nutrition

By global standards, there is a high proportion of stunted children in River Nile State, and critical levels of acute malnutrition. In addition, more than one in every 20 children suffers from SAM[10], which is around the national average for Sudan at present.

6 Source: FMOH, IMCI Unit, annual report 2010

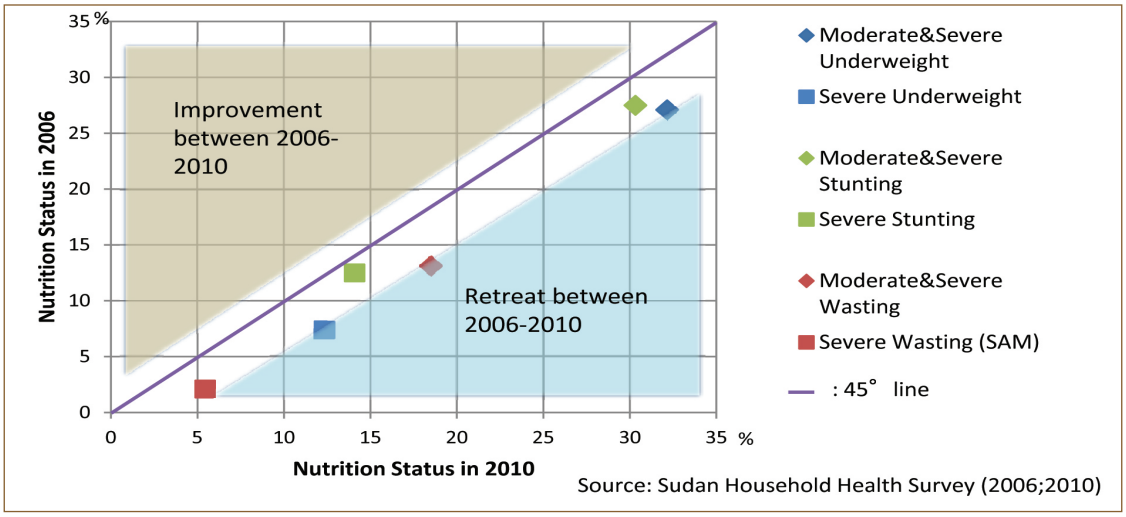
7 Source: FMOH, RH Unit, annual report 2008

8 EPI uses surviving infants (all births minus deaths in the first year of life) as a denominator, except for BCG, which uses total number of live births. SHHS uses 12-23 months olds as a denominator.

9 Pentavalent vaccine includes DPT (diphtheria, pertussis, and tetanus), Hepatitis B and HiB (Haemophilus influenza type B) vaccines, and it requires three doses to get full protection. Pentavalent immunization started in Sudan in January 2008.

10 Severe acute malnutrition (SAM) is a severe wasting, defined by a very low weight for height (below -3z scores of the median WHO growth standards).

Figure 2.2: Malnutrition in River Nile has increased between 2006 and 2010
(children under age 5)



Source: Sudan Household Health Survey (2006;2010)

The percentage of children who are exclusively breastfed at 0 to five months appears to have increased between 2006 and 2010 (from 27.5 per cent to 40 per cent). The majority of babies, however, are still not exclusively breastfed, compromising their defences against childhood illnesses and endangering many children. Vitamin A supplementation among children aged six to 23 months was just 49 per cent in 2010. Consumption of iodized salt is almost two per cent, even lower than the national average, of 9.5 per cent.

More efforts are needed to continue progress and to ensure improvement. This will be a challenge for immunization in particular, where existing high coverage may deceive stakeholders into believing that the work is complete. Reaching the remaining unimmunized children, who may be less than ten per cent of the total, is necessary for equitable development. Efforts must be scaled up to extend access to the hardest-to-reach children. In this context, the significant role of the international community in bringing rates to their current levels is worth noting.

Greater attention must be given to the importance of nutrition in child development in order to reverse negative trends. This is not only necessary for the achievement of MDG1, which calls for the eradication of extreme poverty and hunger, but also for the broader development and progress of River Nile state. Good nutrition greatly improves a child's chance of survival during the first five years of life, as well as their chance for healthy development. Healthy children are more likely to survive life-threatening illnesses, have an improved school performance, engage in economic activity, and have healthy children of their own.

Education

Primary School enrolment and retention rates are strong in River Nile state. The total population of children at school age is 207,520 (according to educational statistics 2008/9). Of those who are primary school age, 88.5 per cent of them (183,655) are currently attending school whereas 47.4 per cent of secondary school age children attend.[11] Both rates are above the Sudanese national average of 72 and 33 respectively. Retention is the highest in all of Sudan, with almost all students (97 per cent) entering grade one staying until grade eight. Walking into a classroom of any age group, one will see approximately the same number of girls as boys.

River Nile's success is mainly attributed to its investment in education: Spending per student is the second-highest in the country at SDG 425 - the national average is SDG 262 (Figure 2.3), resulting in more textbooks, chalkboards and desks than most other states. The government fulfils its commitments to school personnel by paying full salaries, ensuring the recruitment and retention of trained teachers and ultimately smaller classroom sizes. Three out of four schools have clean water on site to prevent waterborne illnesses.[12]

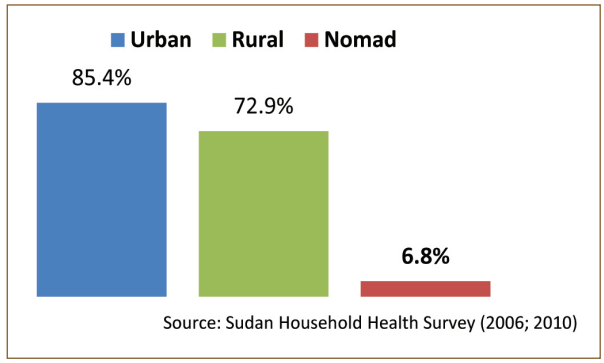
Taken together, the investment by the government in providing a safe learning environment for children adds

11 The percentage of enrolment at primary education is 88.5%, and the secondary school enrolment is 47.4%, Educational Statistics, 2008/2009, P38 & 41.

12 "World Bank, 2012, The Status of the Education Sector in Sudan, Washington DC"

an incentive to families to send their children to school. A 2008 survey found that the main reasons for student truancy in Sudan included lack of textbooks, teacher absenteeism and poor health. River Nile is an example of how addressing these underlying factors can improve education outcomes.[13]

Figure 2.3: Share of Children Currently Attending School
(children age 6- 16)



However, River Nile cannot settle for reaching only *most* of its children. While high rates of rural and urban children are attending school, this is true for only about seven per cent of nomadic children ages six to 16, according to the 2008 census (Figure 2.3). IDPs, orphans, and street children are also groups that often remain invisible to the education sector. In total, over 66,000 children in River Nile were not in school when the 2008 census was taken. Efforts must continue to reach even the most marginalized of children and guarantee education for all.

FGM/C

River Nile state has one of the highest rates of FGM/C in all of Sudan. Eighty-three per cent of girls and women have undergone the procedure. That is five out of every six women. The dangers to women are well known, ranging from infection and excruciating pain following the procedure, to complications in childbirth later in life.

Support for the practice among women is high too. Fifty seven per cent of ever-married women between 15 and 49 intend to perform FGM/C on their own daughters. Of all women aged 15 to 49, 46 per cent believe that the practice should continue compared with only 30 per cent of men.

Halting and banning this harmful practice remain the responsibility of community members, policy makers and the Government alike. The perception that girls who are cut are more socially accepted and have a better chance for a prosperous marriage still persists. Until societal attitudes shift from harm to protection of girls, this violation of their rights will go on.

Call to Action

- Build on success of investments in education by reaching all remaining out-of-school primary-school age children. This means identifying these children, where they come from, and the root causes of school dropout.
- Identify root causes for low attendance in secondary school and increase efforts to engage secondary-school age children.
- Increase investment in the health sector, especially in providing outreach services to nomadic children.
- Raise the profile of nutrition as a public health problem that needs to be addressed. Nutrition should be ranked as a policy priority in order to promote strategic planning and increased funding.
- Promote community-based initiatives that raise awareness of the harms caused by FGM/C and so change social norms
- Mobilize community members to advocate for child rights among the policy makers and to secure their support for pro-child legislation.

13 Baseline Survey on Education in the Northern States of Sudan, Ministry of Education and World Bank Report 2008

3 Red Sea State

Key Indicators from Sudan Household Health Survey 2010 (%)	
Birth Registration	65.0
Fully Immunized	35.1
Global Underweight Prevalence	49.2
Global Stunting	54.1
Global Acute Malnutrition	28.5
Use of Improved Drinking Water Sources	85.6
Use of Improved Sanitation Facilities	24.1
Pre-school Education Enrolment[1]	63
Primary School Enrolment	36.1
Secondary School Enrolment	17
People with Differentiated Abilities[2]	3.7
FGM/C Prevalence	76.5
Early Marriage (before 18)	33.2
Attended by Skilled Person at Birth	72.0
State Child Act – Enacted	Yes
State Child Act – Ban on FGM/C Included	Yes
Infant Mortality Rate[3] (per 1000 live births)	66
Maternal Mortality Rate (per 100,000)	556

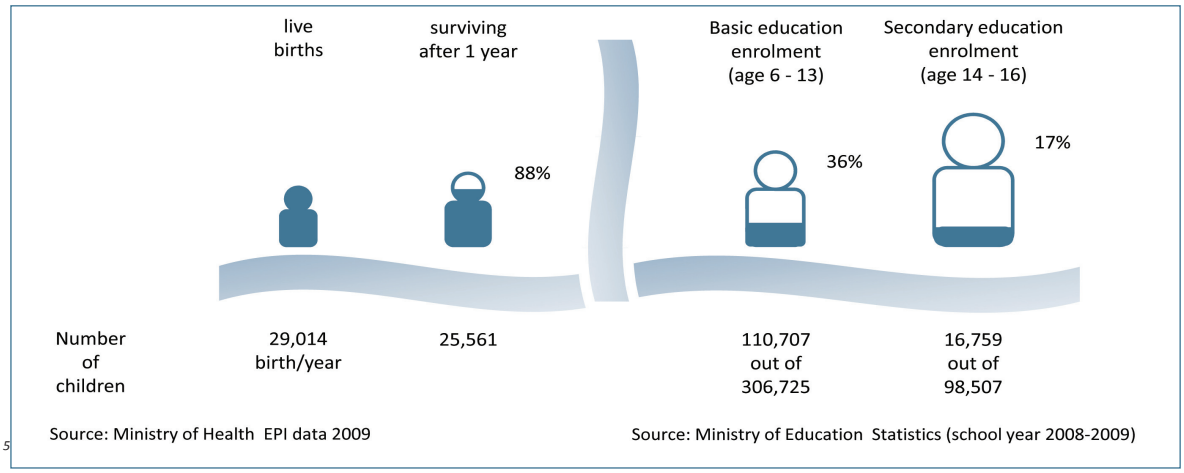
Red Sea state is still recovering from 11 years of civil and political conflict that ended with the Eastern Sudan Peace Agreement in 2006. Development has been slow with infrastructure like health facilities, schools and new roads delayed due partly to a shortage of development funds. The majority of the population is nomadic, rearing goats and camels. Access to drinking water has been the main problem that they suffer from, as they may have to travel for days to reach water sources. The population is tribally homogeneous composed of the Beja and Hedendawa groups. They live scattered in mountains and arid areas that lack the minimum means of life. Port Sudan is the major urban centre in Red Sea state. Work opportunities are very limited for the people of the state many of whom are illiterate and lack basic skills. The presence of large numbers of refugees, IDPs and returnees strains an already weak economy. In rural areas, wage labour is the most common source of income, due to the profitable harvest season. While agriculture plays an important role in the state, many households were affected by the severe drought that took place in 2008. In fact, the poor 2009-2010 harvests pushed families further into poverty while simultaneously exacerbating the state's chronic food insecurity, particularly in rural areas.

In addition, rising commodity prices are forcing families to spend a greater portion of their income on food.[4] With more than a quarter of the population (383,132) living in Port Sudan, urbanization is a central issue in Red Sea state, as is reflected in the government's ambitious urban renewal programme.

While data can contribute to better understanding the condition of children in Red Sea, state averages can be deceptive due to the large number of people who migrated here for work. Disparities are wide among and within localities due to urbanization in and around Port Sudan.

1 All Education Enrolment Rates are based on the Ministry of General Education Statistics 2008-9.
2 Those who are conventionally known as the disabled may develop other abilities to compensate their disabilities. Data from Census 2008.
3 IMR and MMR are from 2008 Census, CBS.
4 World Food Programme, "Food Security Monitoring System Round 3: Red Sea State", February 2011.

Figure 3.1: Infant survival & school enrolment in Red Sea



Key Issues

Water, Sanitation and Hygiene

Although total access to improved drinking water for the state population is 86 per cent (1,176,764), two-thirds of them (58 per cent) are getting their drinking water from animal carts and tankers (Figure 3.2). On the other hand, access to improved sanitation is quite low: only 24 per cent of the state's population (328,399) has access to improved latrines, while 16 per cent have access to unimproved latrines. At 60 per cent (820,998), Red Sea has the highest rate of open defecation among all 15 states (Figure. 3.3). The average for Sudan is 31 per cent (Figure 3.4).

Figure 3.2: Access to improved drinking water

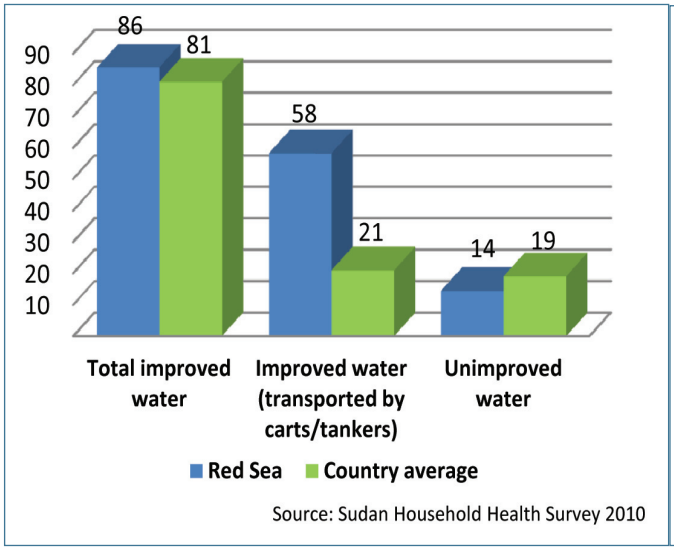
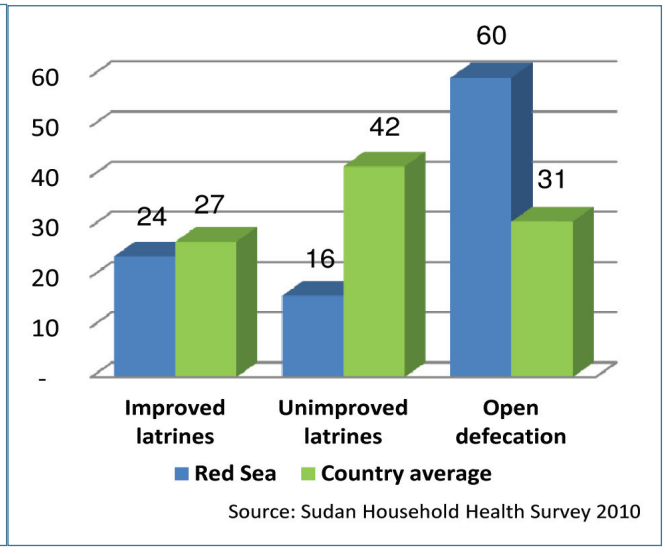


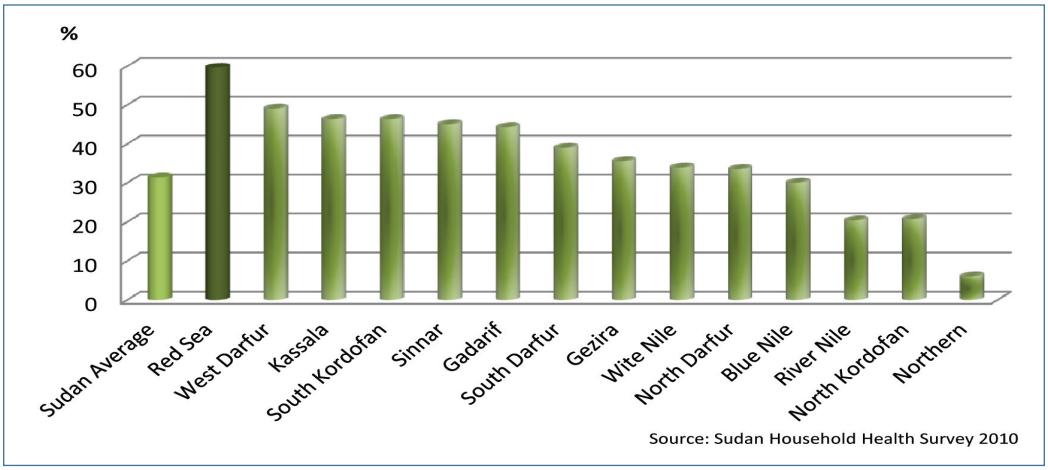
Figure 3.3: Access to improved sanitation



Access to improved sanitation is also low for children in schools and those using health facilities. The 2011-2016 WASH Strategic Plan estimated access at 49 per cent and 33 per cent for the state's schools and health facilities respectively. Progress has been low in sanitation because of a lack of community awareness coupled with the absence of clear sanitation policy and strategies and inadequate financial support.

5 The number of children enrolled includes children of all ages, whereas the denominator is based on the population for ages 6-13 for the primary education and ages 14-16 for secondary. This may result in a higher enrolment rate than the reality.

Figure 3.4: Red Sea has the highest rate of open defecation
Percentage of households practicing open defeication by state.



Education

The number of children in school in Red Sea state is below the national average. Primary school attendance is 69 per cent, compared with 75 per cent for Sudan. Secondary school attendance is 21 per cent, 11 percentage points below the national average.[6] In addition, the net attendance rate has actually decreased from 2006, when 29 per cent of students of the appropriate age attended. For primary school, the rate has stayed the same. For both age groups, girls outnumber boys by seven to nine percentage points. (This could be attributed to the fact that boys are often obliged to look after livestock.)

The government is taking steps to break down barriers that stand in the way of school attendance. Measures include a food-for-education programme that was set up in the eighties. The programme provides incentives by providing school age children with at least one decent meal a day.

Sustainability is the biggest challenge facing this programme. In difficult economic times, social service initiatives are often the first to go, even though they can be the most valuable assets for helping families weather the storm. A school feeding programme can keep children nourished and healthy even though their families struggle to put food on the table. Just as importantly, it keeps them in school so that an educated population can pull the state through the crisis.

Although data on the programme's impact on school attendance rates and the nutritional status of children are not yet available, similar initiatives around the world have shown success in increasing enrolment and improving child nutrition, particularly for the hardest-to-reach children.

Nutrition

Nutrition levels among children under the age of five are worse in Red Sea than in any other state in Sudan. SAM [7] is at a shocking 14.7 per cent (Figure 3.5), almost three times the national average of 5.3 per cent.[8] Half of the state's children are underweight (49 per cent) and more than half (54 per cent) are affected by stunting. Despite Red Sea State's high per capita public health expenditure (Figure 3.6), health services remain very poor and largely unavailable especially in rural areas.

6 The percentage of enrolment in primary education is 36%%, and the secondary school enrolment is 17%, Educational Statistics, 2008/2009, P38 & 41.

7 Severe acute malnutrition (SAM) is a severe wasting, defined by a very low weight for height (below -3z scores of the median WHO growth standards).

8 Severe acute malnutrition (SAM) is a severe wasting, defined by a very low weight for height (below -3z scores of the median WHO growth standards).

Figure 3.5: Red Sea has the lowest nutrition levels in Sudan
Percentage of children (under age 5) experiencing different kinds of severe malnutrition by state

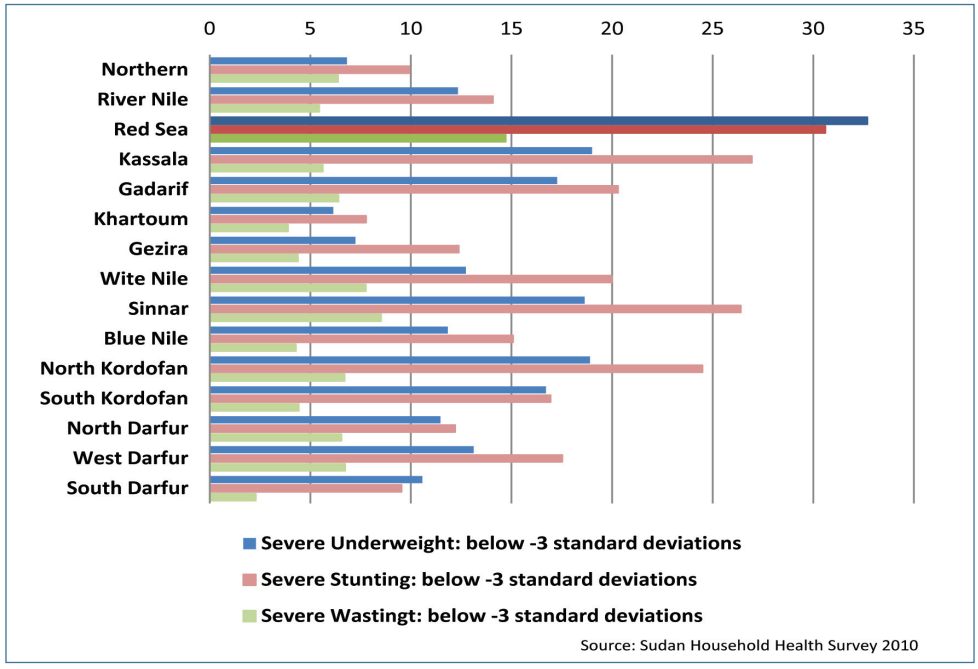
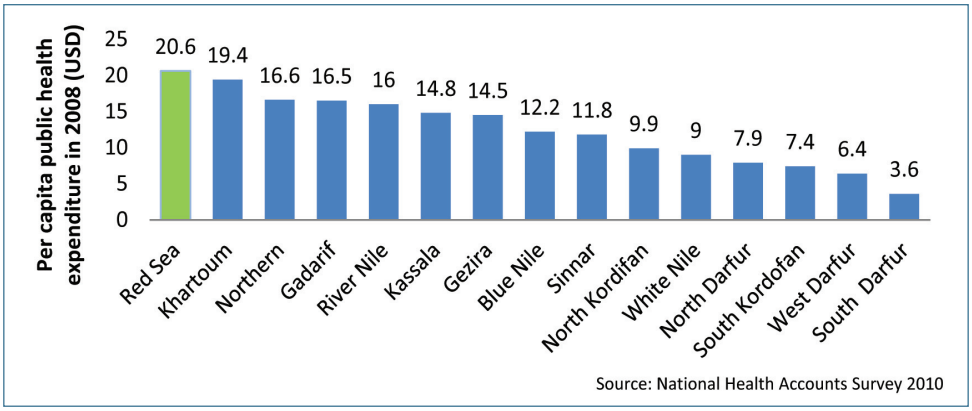


Figure 3.6: Red Sea has the highest per capita public health expenditure



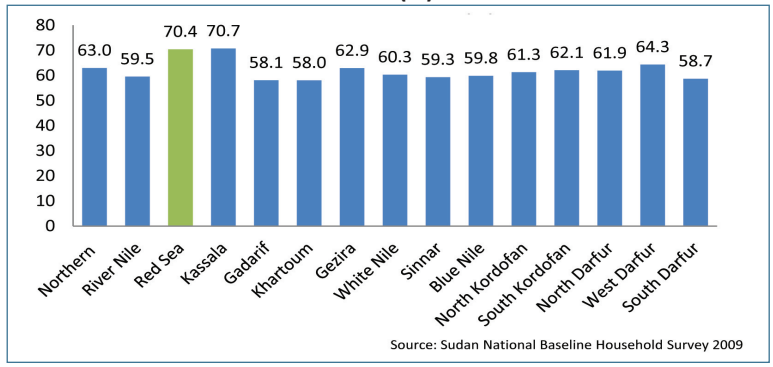
The National Baseline Household Survey 2009, reported that 70 per cent of household spending goes toward food, one of the highest proportions in Sudan (Figure 3.7).

Underlying factors contributing to poor nutrition in the state include the desert terrain across most of the state, a climate which can bring both flooding or drought, and disparities between rural and urban communities, as there is very poor infrastructure and a chronic lack of services in rural areas.

Health

Red Sea has some of the worst health indicators in the country. All mortality figures (maternal, U5 Child and Neonatal) are higher than the national average. Seventy two per cent of births are assisted by a skilled birth attendant; 50 per cent of the population is covered by comprehensive emergency obstetric care[9] whereas only 26 per cent[10] of health facilities are providing integrated

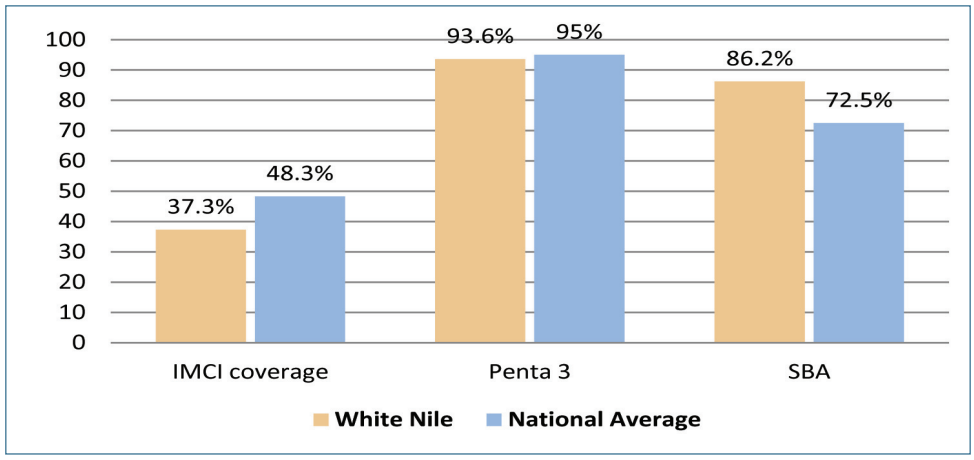
Figure 3.7: Share of Monthly Household Consumption Consumed for Food (%)



9 Source: FMOH, RH Unit annual report, 2008
10 Source: FMOH, IMCI Unit annual report, 2010

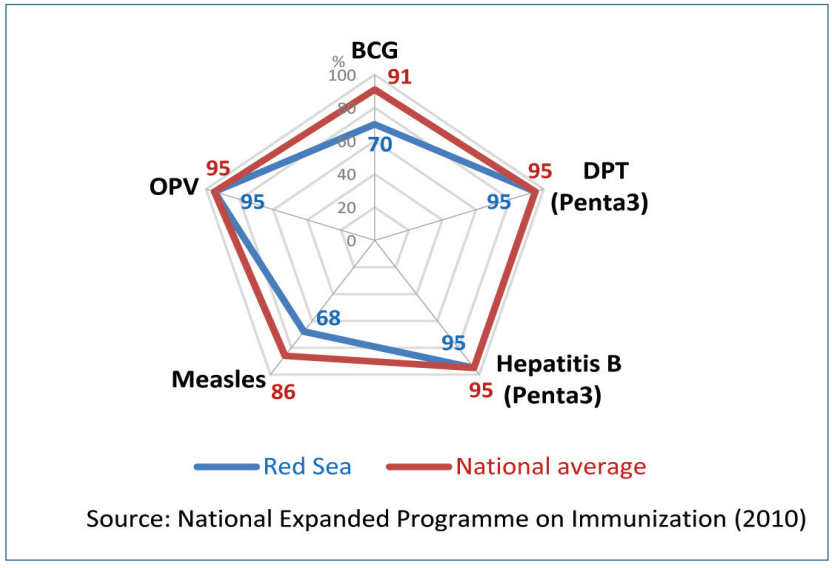
management of common childhood illness services. Regarding malaria prevention, only 26 per cent of the population is using Long Lasting Insecticide Treated Nets (LLITN) and only 5.1 per cent of children under the age of five sleeps under these nets (Figure. 3.8).

Figure 8.3: Coverage of IMCI services and Penta vaccine & skilled birth attendants (SBA) in White Nile State, 2010



Immunization coverage is alarmingly low in Red Sea state. According to SHHS2, less than half (48 per cent) of children aged between 12 and 23 months have received all three requisite polio vaccinations, the lowest figure among the states of Sudan. It also falls below average in reaching children with measles and BCG (for tuberculosis) vaccines, as well as a full three rounds of Pentavalent vaccine (DPT, Hep B and Hib). Only 43 per cent of mothers are fully protected against tetanus -- again, this is one of the lowest rates in Sudan (Figure. 3.9). Exacerbating an already dire situation is that very few children (18 per cent) possess vaccination cards – less than half the national average.

Figure 3.9: Comparing immunization coverage in Red Sea to the national average



Source: National Expanded Programme on Immunization (2010)

While some data sources present higher numbers for Red Sea state, they still place its immunization coverage close to the bottom of the 15 states. According to 2010 data collected through the Ministry of Health's EPI, coverage rates for three doses of Pentavalent[11], three required doses of OPV, BCG and measles is 95, 95, 70 and 68 per cent respectively. Coverage of three full doses of both Pentavalent and OPV is at the average level for Sudan, while BCG

11 Pentavalent vaccine includes DPT (diphtheria, pertussis, and tetanus), Hepatitis B and Hib (Haemophilusinfluenzae type B) vaccines, and it requires three doses to get full protection. Pentavalent immunization started in Sudan from January 2008.

and measles fall well below the corresponding national averages of 91, and 86 per cent (Figure 3.9).[12] Immunization coverage is poor due to the high turn-over of immunization staff (a large proportion of whom are volunteers); poor managerial capacity; and the presence of population pockets who refuse vaccination as well as other health services due to lack of awareness and incorrect social beliefs. The local government's investment in health services needs to increase, not least to overcome the logistical challenge of delivering services to a scattered and mobile population.

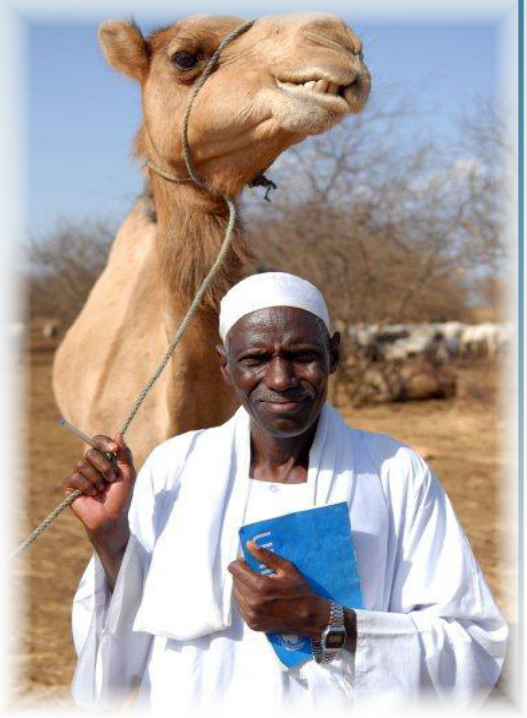
HIV/AIDS

Red Sea is one of the focus states for the National AIDS programme. Evidence shows that knowledge about HIV/AIDS modes of transmission is gradually improving among women aged 15 to 49. In just four years, the proportion of women that can identify two ways of preventing transmission -- having only one faithful uninfected spouse and using a condom every time – has increased from 2.6 to nearly 13 per cent.

By contrast, Red Sea is one of several states where awareness about HIV/AIDs mode of transmission from mother to child has decreased significantly (River Nile and North Darfur are others). In 2010, only 40 per cent of women aged 15 to 49 knew that HIV could be passed to their child, down from 60 per cent in 2006, according to SHHS. The percentage of women who knew the ways that HIV could be transmitted - during pregnancy, delivery and breastfeeding – fell from almost 28 per cent in 2006 to 16 in 2010.

Call to Action

- Advocate for increased government resources and commitment for rural development in order to reverse negative trends in WASH, Immunization, HIV/AIDS awareness, and reduce the inequity between urban and rural areas.
- Introduce measures to reduce open defecation.
- Make effective investment in the health sector's regular staffing and outreach services to communities.
- Advocate among rural communities to enrol their children in school.
- Increase awareness of HIV/AIDS among younger people by incorporating life skills education in the national school curriculum and scaling up programmes for out of school children.
- Raise the profile of nutrition as a vital public health issue. Nutrition should be prioritised at the policy level so as to promote strategic planning and funding.



12 EPI uses surviving infants (all births minus deaths in the first year of life) as a denominator, except for BCG, which uses total number of live births. SHHS uses 12-23 months old as a denominator.

4 Kassala State

Key Indicators from Sudan Household Health Survey 2010 (%)	
Birth Registration	51.8
Fully Immunized	40.6
Global Underweight Prevalence	38.5
Global Stunting	49.1
Global Acute Malnutrition	16.7
Use of Improved Drinking Water Sources	68.5
Use of Improved Sanitation Facilities	22.1
Pre-school Education Enrolment[1]	17.2
Primary School Enrolment	44.8
Secondary School Enrolment	14.6
People with Differentiated Abilities[2]	4.5
FGM/C Prevalence	78.9
Early Marriage (before 18)	46.2
Attended by Skilled Person at Birth	69.7
State Child Act – Enacted	No
State Child Act – Under Draft	Yes
State Child Act – ban on FGM/C Included	Yes
Infant Mortality Rate[3] (per 1000 live births)	76
Maternal Mortality Rate (per 100,000)	466

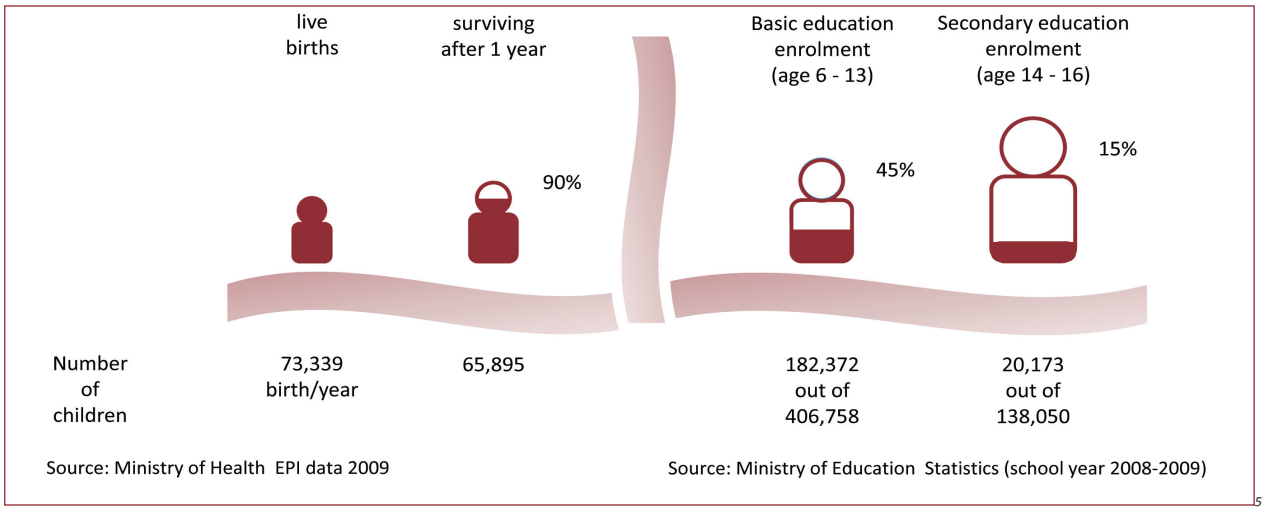
Kassala State's 1.8 million people (2008 census) are some of the most mobile in Sudan. Rural and nomadic populations travel from place to place with their livestock looking for scarce food and water. Conflict and drought have depleted resources in areas that were once rich in agriculture, pushing sedentary populations into migratory lifestyles. A recent census found that eight per cent of households migrate regularly throughout the year, more than any other state in Sudan.[4] The impact on children can be devastating: their education is interrupted; their health difficult to monitor; they are sometimes left to care for younger siblings when parents leave in search of employment, or they themselves can be forced to work in exploitative conditions. In the rural north, the situation is made worse by poor access to education, health, nutrition and water and sanitation. Children in these areas, particularly girls, are considered the state's most vulnerable. Of the 38,600 live births in the 12 months preceding the 2008 census, about 34,300 (88.9 per cent) children were surviving when the census took place.

In 2006, the EPA ended 11 years of conflict in Kassala, Red Sea and Gadarif, and the region continues to rebuild. While efforts are moving toward development, seasonal conflicts between nomads and farmers are regular causes of insecurity, while the state is also vulnerable to floods and droughts. For government and humanitarian organizations alike, the challenge is to develop strategies for both emergency and long-term development.

A particular issue in Kassala is the high number of disabled children, who constitute 5.8 percent of all children in the state. The total number of disabled persons in the state is 4.5 per cent of the total population (80,479). This high number could be a result of the insecurity the state has witnessed, which left wide areas of the state along the Eritrean border contaminated with landmines – to which children are especially vulnerable. The unexploded ordnance (UXOs) threat could explain the high prevalence of disabled children under five.

1 All Education Enrolment Rates are based on the Ministry of General Education Statistics 2008-9
2 Those who are conventionally known as the disabled may develop other abilities to compensate their disabilities. Data from Census 2008.
3 IMR and MMR are from 2008 Census, CBS
4 Sudan National Baseline Household Survey 2009, 2010, p. 14

Figure 4.1: Infant survival & school enrolment in Kassala

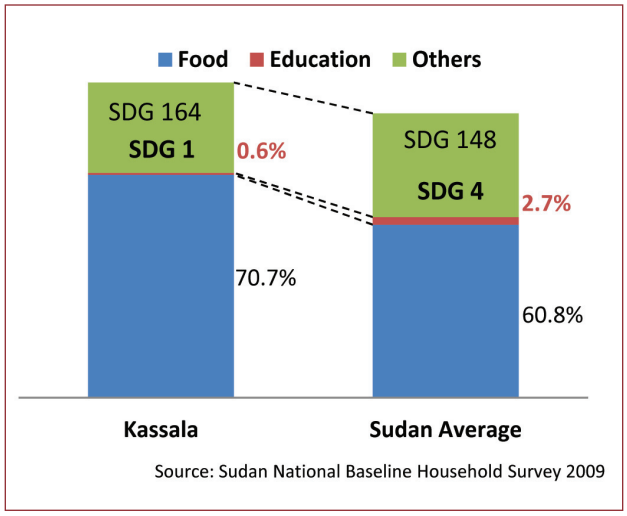


Key Issues

Education

Literacy rates in Kassala are higher for males than females (47.9 per cent and 38.8 per cent respectively) symptomatic of the fact that access to education, particularly for girls, is one of the biggest challenges faced by the state. Kassala has one of the lowest rates of primary school enrolment in the country, with 57 per cent of primary-school age children attending school. When children of secondary school age are included, more than 340,000 children are out-of-school, representing 63 per cent of children of school age. In addition, monthly per capita household consumption in education is lower than the national average (Figure 4.2). The outlook is not entirely bleak, however. The World Bank reports a six per cent annual growth rate in basic education enrolment since the end of the East Sudan conflict in 2005.[6]

Figure 4.2: Kassala has lower monthly household per capita consumption on education compared to the national average



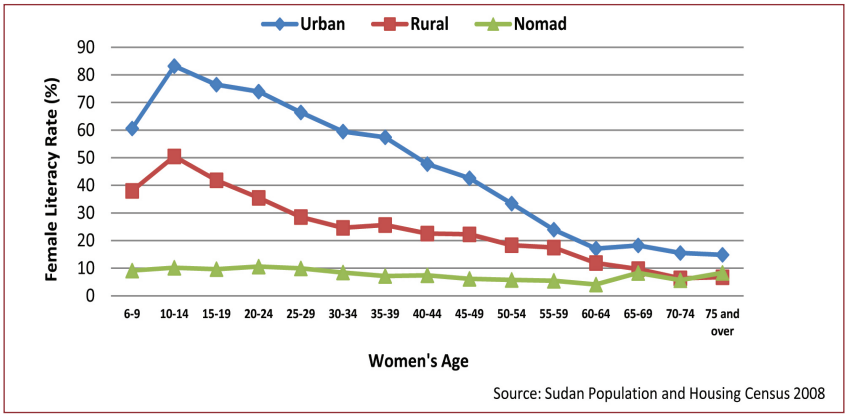
5 The number of children enrolled includes children of all ages, whereas the denominator is based on the population for ages 6-13 for the primary education and 14-16 for the secondary. This may result in higher enrolment rate than the reality.

6 Source: «World Bank, 2012, The Status of the Education Sector in Sudan, Washington DC»

Girls' Education

Gender disparities are widespread, making MDGs 2 and 3 almost unattainable for Kassala by 2015. According to SHHS2, only 50 per cent of girls attend primary school compared with 64 per cent of boys. The 2008 census reflects a slightly different picture: the share of children at primary school age (six to 13) currently attending school is 43 per cent for boys and 39 per cent for girls. Rates of female attendance are even lower in rural areas and among nomadic tribes. Literacy rates reflect these disparities – 46 per cent of rural males over six are literate compared with only 33 per cent of rural females, according to the 2008 census.

Figure 4.3: Female literacy rate is even lower among rural and nomadic population

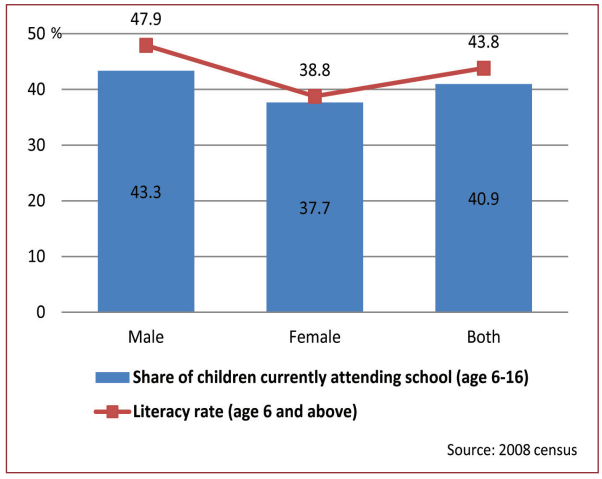


Local laws and conservative customs are some of the biggest challenges to girls' education. In some areas, girls are required to stay at home making it nearly impossible for them to attend school.

Some progress is being made, however. In the village of Talkook, for example, where eight girls have been able to go on to secondary school – an unprecedented achievement in such a conservative community. While attendance is still not equal, this is nonetheless a remarkable achievement towards progress.

Numerous studies have found positive correlations between a mother's education level and child survival and health; communities that promote girls' education tend to be better staffed with qualified nurses and teachers; and an educated woman is more likely to contribute to her household's income.[7] In short, educational equality for women can break the cycle of poverty and set their children on the path of progress.

Figure 4.4: Gender gap in education in Kassala



In many countries, early childhood education has been proven to increase school enrolment.[8] Acting on this, the Kassala government integrated early child care and development (ECCD) into formal education. Despite twenty years of this policy, however, SHHS2 shows that only 5.8 per cent of children aged 36 to 59 months are attending early education, which is the lowest among the 15 states. Lack of enforcement, low awareness of the availability of ECCD and high illiteracy rates contribute to these low numbers.

Creating Incentives

Although the value of an education in itself is an acceptable rationale to encourage action on the issue, school has added purpose when it becomes an entry point for other services. It can promote good water, sanitation and hygiene habits within the community. Teachers may be able to recognize poor nutrition and other health issues in children, and refer them for appropriate services. It can raise issues on the harmfulness of FGM/C and early marriage.

7 Levine, Ruth, et al., 'Girls Count: A global investment & action agenda', Center for Global Development, Washington, D.C., 2008, pp. 19-20; and United Nations Educational, Scientific and Cultural Organization, Education for All 2011: The Hidden Crisis Armed Conflict and Education, Paris, 2011, p. 29.

8 United Nations Children's Fund, A Human Rights Approach to Education for All, New York City, 2007, p. 30.

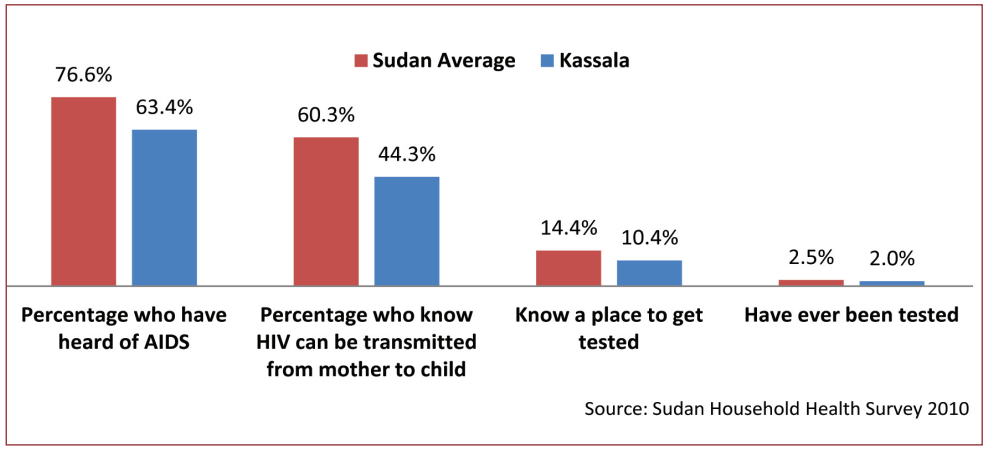
Schools can also serve as a vehicle for social protection programmes such as food-for-education initiatives. Currently, such an initiative is being implemented in Kassala jointly by UNICEF and WFP. However, WFP will phase out of the state by 2012, leaving the state government to take over the programme.

Increasing demand for education must be met with equal efforts to increase the supply of accessible, safe schools. Every child has the right to a quality education, fulfilled through child friendly schools with separate sanitation facilities for girls, adequate learning materials and trained teachers.

HIV/AIDS

Kassala's high migration rate and its location along important routes to Eritrea and Ethiopia make it a condusive environment for the spread of HIV/AIDS. Although no official prevalence rates are available, 128 people tested positive in 2010 (8.5 per cent of total tested).[9] However, high levels of stigma and low access to testing sites make it difficult to make an accurate assessment.

Figure 4.5: Women in Kassala have below-average awareness of HIV/AIDS
(women age 15-49)



The situation is particularly worrying for women of childbearing age (Figure 4.5). Most women do not know their status, or where to go for testing. Only 27 per cent know that HIV can be transmitted to their babies through pregnancy, child birth and breastfeeding. Even fewer (11 per cent) know that HIV can be prevented through regular condom use and having only one faithful, uninfected sex partner.

Prevention of mother-to-child transmission (PMTCT) and testing services are available, but the uptake is low, suggesting that people are either reluctant to visit them or do not know that they exist. Social stigma and cultural barriers impede proper understanding of HIV and other sexually transmitted diseases. Changing such attitudes is a particular challenge in Kassala, where socially conservative views are prevalent.

Even so, Kassala is in a unique position to reverse downward trends rapidly and for good. Non-government organizations (NGOs) and community-based organizations (CBOs) are active in the state and can be guided under the strong leadership of the Sudan National AIDS Programme (SNAP). The 2010 adoption of a four-year National Strategy provides the political coverage and support, while advocacy meetings can raise public understanding about HIV/AIDS issues. Empowering young people with information and knowledge could also contribute to reducing prevalence rates and even reverse the trends of HIV/AIDS (MDG6) in the state.

Water, Sanitation and Hygiene

Water, sanitation and hygiene-related diseases, mainly diarrhoea and acute watery diarrhoea are the most common diseases affecting child health in Kassala. Access to safe water and quality sanitation is limited particularly in the northern part, where long and recurrent drought and prolonged conflict have affected the availability of scarce resources.

The proportion of people accessing improved water represents 69 per cent of the total population, out of which 21 per cent are receiving their water from animal carts and tankers, and yet, Kassala still falls below the Sudan average of 81 per cent (Figure 4.6). Use of improved sanitation facilities, on the other hand, is just 22 per cent, while 32 per cent of the population is using unimproved sanitation facilities and almost half the population (46 per cent) still practices open defecation (Figure 4.7).

9 Surveillance System report, Sudan National Aids Programme (SNAP).

Figure 4.6: Access to improved drinking water

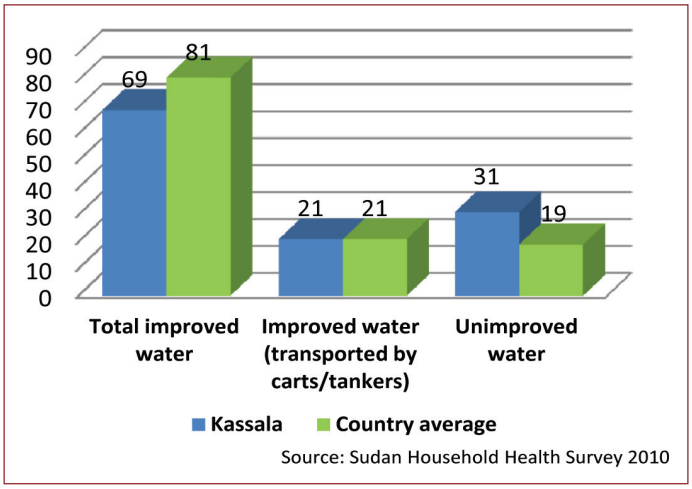
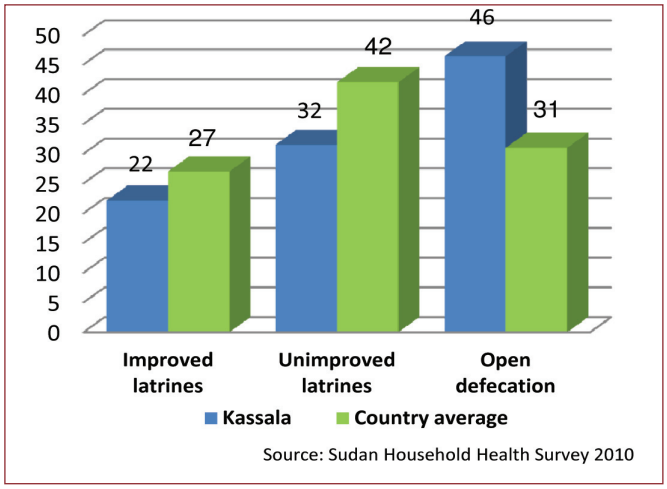


Figure 4.7: Access to improved sanitation



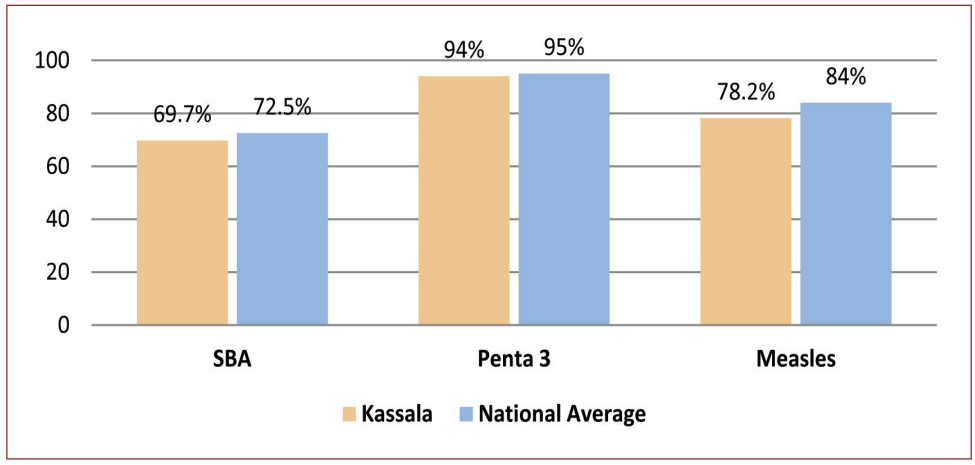
Access to improved sanitation is also low for the school children and health facilities. The 2011-2016 WASH Strategic Plan estimated the access at 59per cent and 46 per cent for the state's schools and health facilities respectively.

Limited government investment remains a major impediment to improving water and sanitation. Community-led initiatives such as Community Approach for Total Sanitation (CATS) have shown promise in promoting behavior change in sanitation and hygiene. However, without the adequate government support, communities have neither resources nor the capacity to effect and sustain improvements.

Health

Skilled birth attendance coverage is 70 per cent which is slightly lower than the national average. EPI administrative data shows measles coverage is also below the national average at 78 per cent indicating poor awareness of the immunization schedule. Therefore, further community awareness-raising efforts and social mobilization should be given priority.

Figure 4.8: Coverage by skilled birth attendants, penta and measles vaccines in Kassala state, 2010



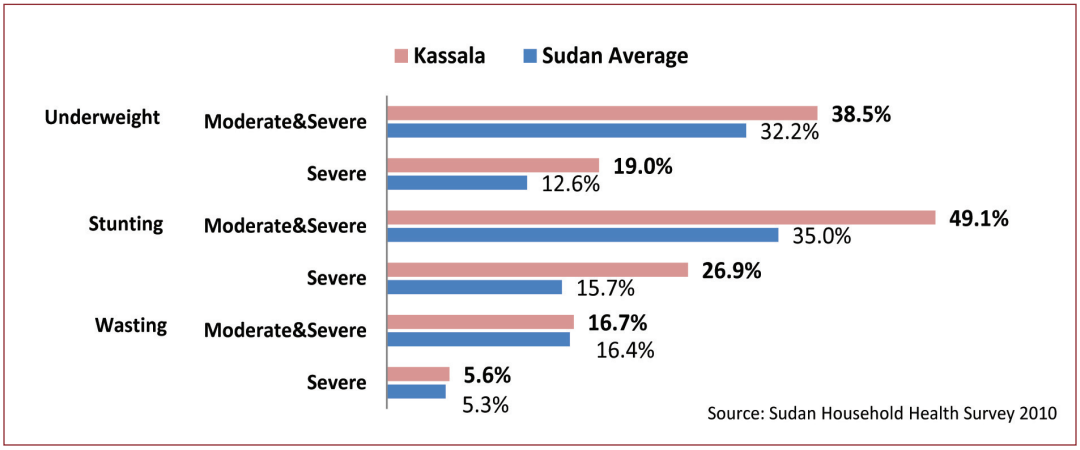
Nutrition

Children's nutrition status in Kassala is worse than the national average in all the three anthropometric indices: weight for age (underweight), height for age (stunting), and weight for height (wasting) (Figure 4.9). Half of Kassala's children under age five are stunted, their growth diminished by inadequate nutrition throughout their short lives. Once stunted, it is unlikely that a child will ever grow to full height. Thirty-nine per cent of children are underweight and will likely face multiple development challenges. One child out of every 18 experiences SAM[10], making her nine times more likely to die than children who are properly nourished.[11]

10 Severe acute malnutrition (SAM) is a severe wasting, defined by a very low weight for height (below -3z scores of the median WHO growth standards).

11 United Nations Children's Fund, Tracking Progress on Child and Maternal in Nutrition: a Survival and Development Priority, New York City, 2009, p. 13.

Figure 4.9: Nutrition status in Kassala state is worse than the national average
(children under age 5)



Kassala has consistently high levels of acute malnutrition, particularly in the resource-poor north. In North Delta, where a local survey was taken in February 2011, malnutrition prevalence is as high as 16.5 per cent. The situation is pointing to a nutrition crisis that will likely worsen with escalating food prices and impending food shortages due to low rainfall in 2010.[12]

There are three major underlying reasons for Kassala's poor nutrition levels:

1. *Poverty*: 36 per cent of the population lives under the poverty line.[13] In rural areas, the figure is as high as 48 per cent.
2. *Limited agricultural land*: Fertile land suitable for cultivation is insufficient, forcing many people to earn an income from animal-breeding. However, recent droughts have undercut earnings. According to the 2008 census, the number one factor affecting households in Kassala was the death of livestock, followed by drought.
3. *Cultural taboos*: There are a number of food-related taboos that prevent people from receiving adequate nutrition. For example, pregnant women are told not to eat eggs because it will affect their children. Eating fish is also believed to have negative consequences.

Call to Action

- Ensure universal education through the building and rehabilitation of child friendly schools, school food programmes, and increasing awareness of early childhood education.
- Improve and increase educational facilities, particularly in rural areas and for girls.
- Increase community awareness about the availability of HIV testing sites so as to boost understanding of the disease and provide care to those who test positive.
- Advocate for increasing government budget allocations for water, sanitation and hygiene.
- Expand coverage of SAM treatment services. Build commitment to the prevention of malnutrition, and raise community awareness regarding the long term negative consequences of malnutrition on children's lives
- Continue collection of disaggregated data that could be utilized for policy development and monitoring of progress.
- Strengthen cross-border cooperation with Eritrea regarding migrants and refugees.

12 The Republic of Sudan 'Statistical Yearbook for the Year 2009', Khartoum and USAID and Famine Early Warning Systems Network, 'Sudan Food Security Outlook', April – September 2011http://www.fews.net/docs/Publications/Sudan_OL_2011_04_final.pdf
13 The poverty line is equivalent to SDG114 according to the 2009 Sudan National Baseline Household Survey.

5 Gadarif State

Key Indicators from Sudan Household Health Survey 2010 (%)	
Birth Registration	**64.7**
Fully Immunized	**58.8**
Global Underweight Prevalence	**38.6**
Global Stunting	**39.7**
Global Acute Malnutrition	**17.1**
Use of Improved Drinking Water Sources	**61.3**
Use of Improved Sanitation Facilities	**28.4**
Pre-school Education Enrolment[1]	**36.3**
Primary School Enrolment	**69.4**
Secondary School Enrolment	**31.5**
People with Differentiated Abilities[2]	**4.9**
FGM/C Prevalence	**50.4**
Early Marriage (before 18)	**48.8**
Attended by Skilled Person at Birth	**63.5**
State Child Act – Enacted	**Yes**
State Child Act – ban on FGM/C Included	**Yes**
Infant Mortality Rate[3] (per 1000 live births)	**102**
Maternal Mortality Rate (per 100,000)	**564**

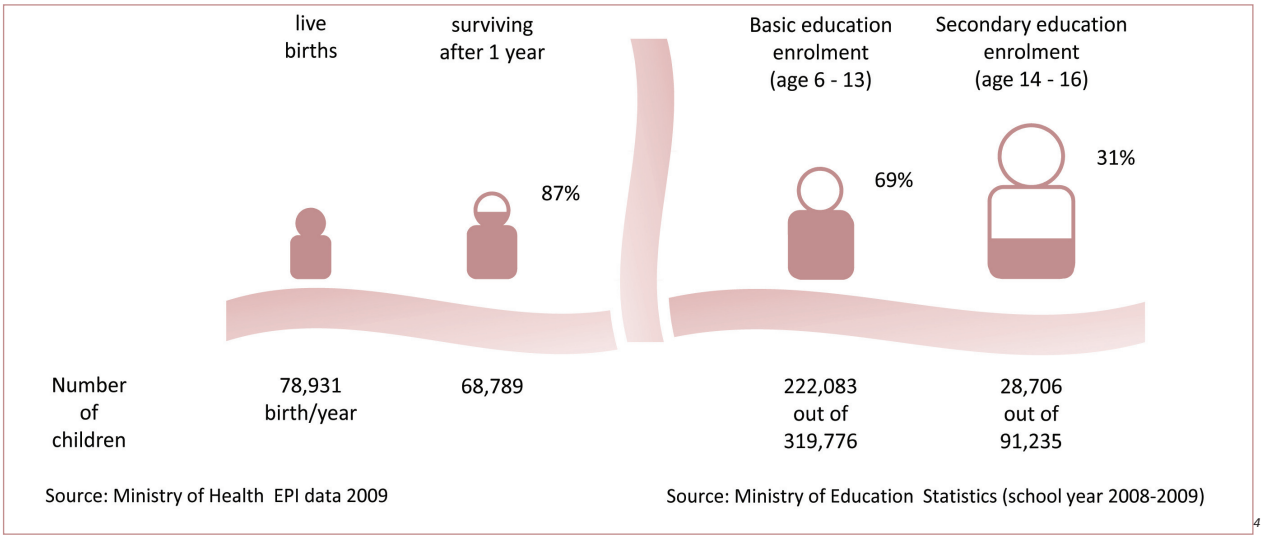
Despite being the 'breadbasket' of Sudan, pockets of poverty illustrate the broad disparities that exist within Gadarif state. Income generated through the profitable production of sorghum does not reach many rural areas, which are home to 70 per cent (934,463) of the state's 1.3 million people according to the 2008 census. There are 709,000 children, making up 53 per cent of the state population. The extent of land under mechanized farming has increased considerably during recent years at the expense of grazing lands. The nomads have become vulnerable groups who have been pushed into small pockets along the Sudan-Ethiopian border, their traditional routes blocked in some places by the expansion of mechanized cultivation. Some find employment during the three-month harvesting season, but earnings are not enough to sustain families through the rest of the year. For six of Gadarif's eleven localities, poverty is exacerbated by isolation due to the five-month rainy season. Family income is further affected by the low earnings from agriculture where the cost of production is very high compared to the low productivity. Children here are particularly vulnerable as they are sometimes left without adequate food and nutrition, immunization and other health services. The situation results in parents sending sons to urban areas to work and daughters to be married before they are physically and emotionally mature.

1 All Education Enrolment Rates are based on theMinistry of General Education Statistics 2008-9

2 Those who are conventionally known as the disabledmay develop other abilities to compensate their disabilities. Data from Census 2008

3 IMR and MMR are from 2008 Census, CBS <?>The number of children enrolled includes children of all ages, whereas the denominator is based on the population for ages 6-13for the primary education and 14-16 for the secondary. This may result in higher enrolment rate than the reality.

Figure 5.1: Infant survival & school enrolment in Gadarif



[4]

Key Issues

Education

The basic education Gross Enrolment Rate (GER) in Gadarif is estimated at 69.4 per cent; this is below the national average of 72 per cent with close to 100,000 out of (primary) school children. There are clear disparities in literacy between boys and girls. The 2008 census shows that literacy among boys aged six and above is 65.3 per cent, while the percentage for girls of the same age is 49.6 per cent. However, illiteracy is even higher among nomadic children where the rate for boys aged six years and above is 91.6 per cent and for girls of the same age, 93.4 per cent.

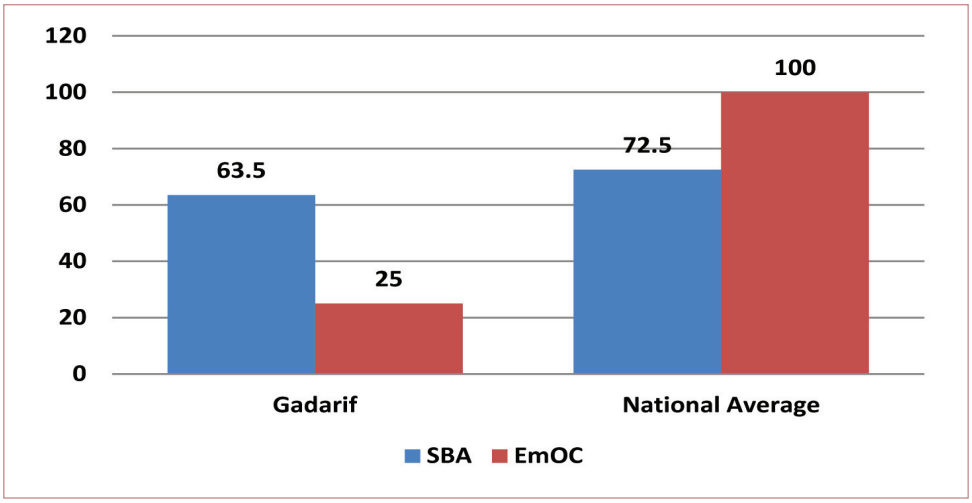
Health and Nutrition

High under-five mortality and malnutrition rates make reaching MDG4 a challenge for Gadarif. Of the 46,110 children born alive in the 12 months preceding the 2008 census, about 41,450 (90 per cent) were still alive when the census took place. The maternal mortality ratio as well as neonatal and U5 mortality rates in Gadarif state are particular areas of concern as the rates[5] are above the national average. High maternal mortality could be attributed to the fact that only 63 per cent of deliveries are attended by skilled personnel and comprehensive Emergency Obstetric Care coverage is 25 per cent only (Figure. 5.2). Access to health and nutrition is unequal, with children in six of the state's localities classified as being particularly hard to reach.

4 The number of children enrolled includes children of all ages, whereas the denominator is based on the population for ages 6-13 for the primary education and 14-16 for the secondary. This may result in higher enrolment rate than the reality.

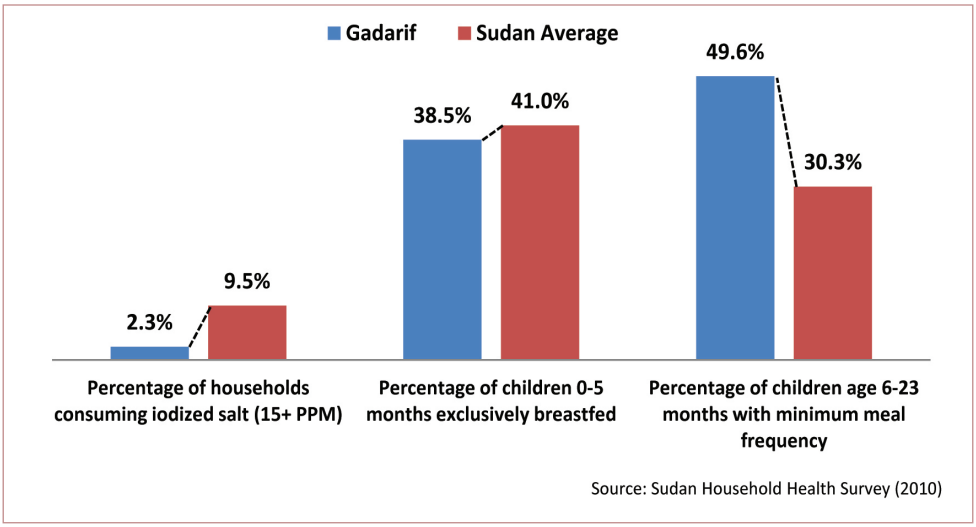
5 SHHS 2006 as state level mortality rates are not available from SHHS 2010

Fig. 5.2: Coverage of skilled birth attendants and comprehensive emergency obstetric care in Gadarif



Poor nutrition contributes to these high mortality rates, with above average rates of underweight (39 per cent), stunting (40 per cent, classified by WHO as 'very high') and global acute malnutrition (17.1 per cent, classified as a 'critical' situation[6]) among children under five.[7] This may seem surprising given the fact that half of all children six to 23 months received the minimum frequency of meals, more than in any other state.[8] However, low levels of exclusive breastfeeding and low consumption of iodized salt may be contributing factors (Figure 5.3).

Figure 5.3: Although Gadarif has a higher share for minimum meal frequency, it is behind the national average in terms of exclusive breastfeeding and iodized salt consumption



Acceleration campaigns that target hard-to-reach areas have successfully increased the proportion of fully-immunized children (aged 12 to 23 months) from 51 per cent in 2006 to 59 per cent in 2010 according to SHHS2[9]. Overshadowing the success of this initiative, however, is its dependence on donor support, thereby limiting its sustainability.

6 Physical Status: The use and interpretation of Anthropometry. Report of a WHO expert committee, 1995. Chapter 5, p208 & 212

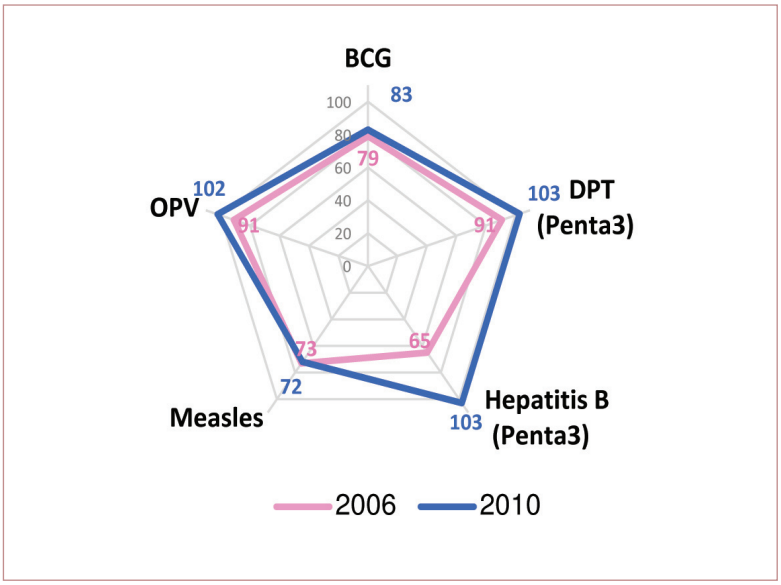
7 Severe acute malnutrition (SAM) is a severe wasting, defined by a very low weight for height (below -3z scores of the median WHO growth standards).

8 Number of children age 6-23 months receiving solid, semi-solid and soft foods (plus milk feeds for non-breastfed children) the minimum of two times or more, according to breastfeeding status, during the previous day. For breastfeeding children, the minimum meal frequency is two times for infants aged 6-8 months and three times for children aged 9-23 months. For non-breastfeeding children, the minimum meal frequency is four times for children age 6-23 months.

9 SHHS1 and SHHS2 use different definitions of full immunization. For SHHS1, fully immunized children are those who received BCG, measles, three doses of DPT (diphtheria, pertussis, and tetanus) and three doses of OPV (oral polio vaccine). For SHHS2, fully immunized children are those who received BCG, measles, three requisite doses of OPV and three doses of Pentavalent vaccines. Pentavalent vaccine includes DPT, Hepatitis B and HiB (Haemophilus influenza type B) vaccines, and it requires three doses to get full protection.

Separate data, obtained through the FMoH's National EPI show high, but imbalanced, rates of coverage. As shown in Figure 5.4, coverage of BCG and measles vaccines has not reached the nearly universal coverage of other immunizations. In fact, both have shown little, if any, progress since 2006 when rates were 79 and 73 per cent respectively.[10]

Figure 5.4: There is little progress in immunization coverage for BCG and measles in Gadarif



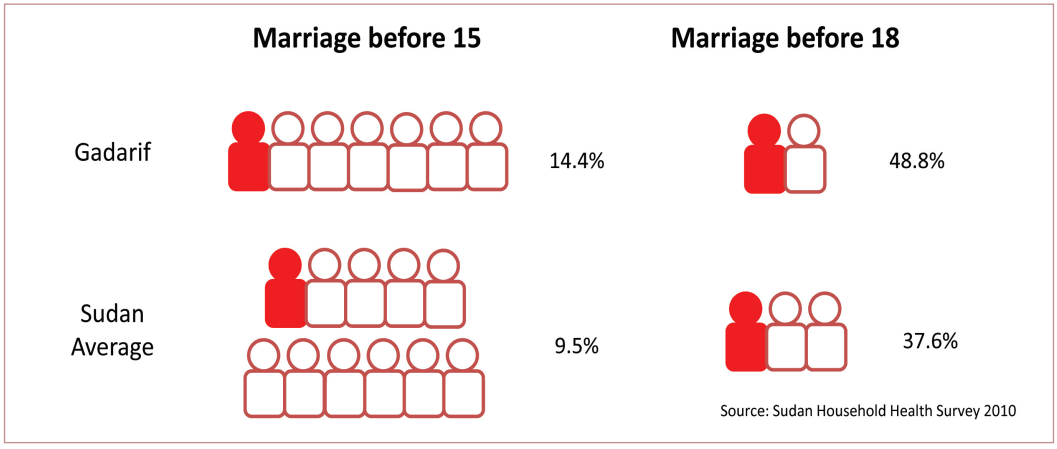
The state government underlined its commitment to health by placing the need for health and nutrition staff at the top of its 2011 agenda for employment. Meanwhile, cash incentives are being provided to unofficial workers in the outpatient therapeutic programmes (OTPs) and at community management of acute malnutrition (CMAM) sites. This is a case-by-case solution to ensure the continuity and quality of CMAM service provision.

These efforts are a start, but much work remains to be done. Improved health facilities and adequate supplies, expansion of evidence-based initiatives such as IMCI, and additional trained mid-level staff are imperative in order to bring rural communities up to the same standard of service as urban areas.

Early Marriage

Reducing rates of early marriage has been a challenge in Gadarif, which has one of the highest rates in Sudan (after Blue Nile, South Darfur and West Darfur), with little improvement over the past four years. One in every seven girls marries by age 15, and one in two before age 18 (Figure 5.5).

Figure 5.5: Early marriage in Gadarif is above average for girls under age 18 and 15.



While early marriage is still prevalent in urban areas, it is more common in rural areas where culture and poverty are underlying factors. The 2008 census found that 17,671 rural and nomadic girls between the ages 12-19 were either currently married or had been married, equivalent to 83 per cent of the total number of females of that age.[11]

10 EPI uses surviving infants (all births minus deaths in the first year of life) as a denominator, except for BCG, which uses total number of live births. SHHS uses 12-23 months old as a denominator.

11 Data from the 2008 census.

Pregnancy, a consequence of early marriage, is the leading cause of death among 15 to 19 year olds globally. When a girl gives birth before her body is fully developed, she increases her risk of obstructed labour and other difficulties. Obstructed labour remains the main cause of maternal death, especially in rural areas, where access to antenatal and emergency obstetric care is particularly limited. In Gadarif, 21 per cent of girls in this age group (15-19) have started childbearing. Most are rural and nomadic.

According to the 2008 census, nine per cent of married women in the rural areas at the age group 12-19, have had live births at the time of census. This number increases to 14 per cent among nomads compared to five per cent of urban married women in the same age group (12-19 years).

The reasons to promote delayed marriage go beyond simply protecting a girl's right to free choice. Doing so benefits the community as a whole: girls who delay marriage are more likely to further their education, leading to cascading benefits for the health and education of the children they eventually bear; their potential to contribute to the economy is increased and to devote more time to their children. Accordingly, an equity would be achieved that would contribute to reduce domestic violence against women.

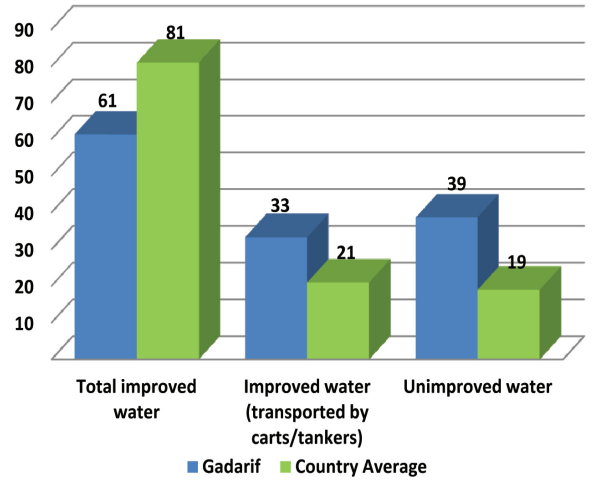
Water, Sanitation and Hygiene

Access to improved water sources and improved sanitation facilities is quite low. Only 61 per cent of the population have access to improved water and half of this figure (33 per cent of the total population) is getting their water from animal carts and tankers (Figure 5.6). Recent data tells us that sanitation is still a serious issue in Gadarif. The SHHS2 finds that only 28.3 per cent of the population have access to improved sanitation facilities, 27.3 per cent are using unimproved sanitation facilities and 44.3 per cent of households have no toilet facility at all and still practicing open defecation, 13 points above the Sudan average (Figure 5.7).

Access to improved sanitation is also low for the school children and health facilities. The 2011-2016 WASH Strategic Plan estimated the access at 54 per cent and 28 per cent for the state's schools and health facilities respectively.

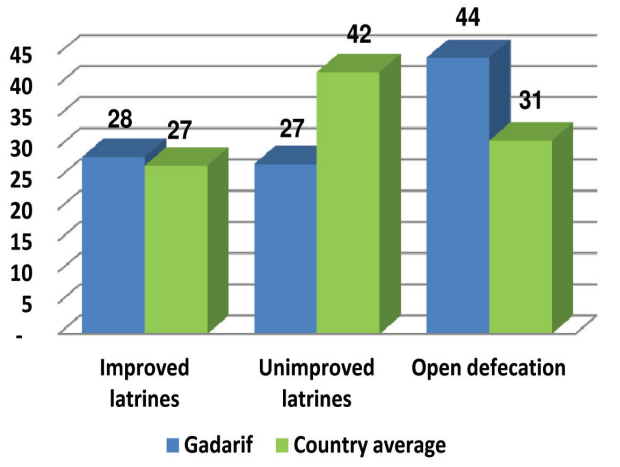
More than in any other state, children under 15 in Gadarif are responsible for collecting water for the household, traveling for up to 30 minutes to bring water that might not even be safe for drinking (Figure 5.8).

Figure 5.6: Access to improved drinking water



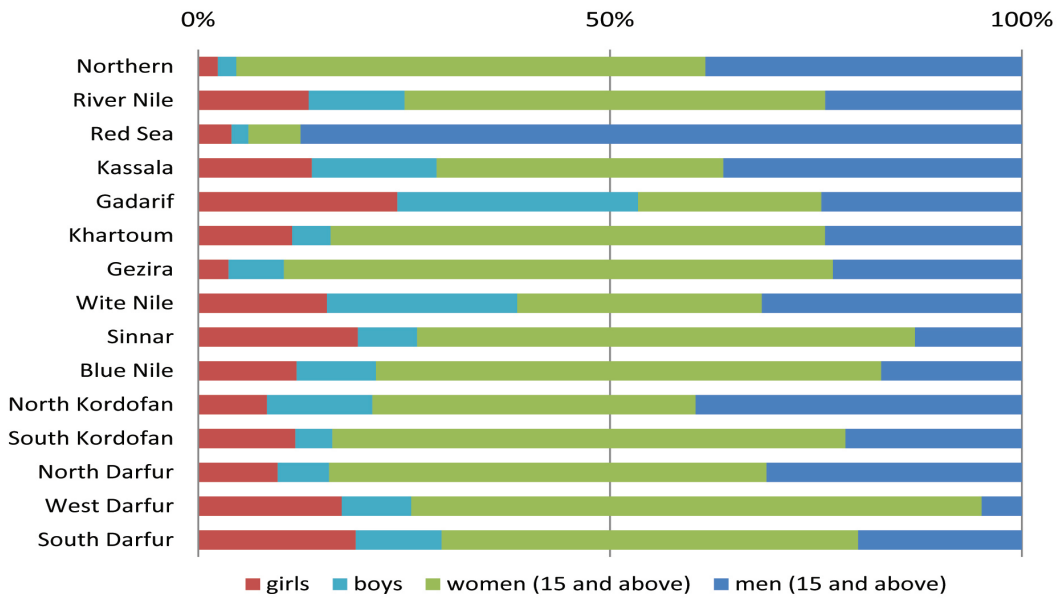
Source: Sudan Household Health Survey 2010

Figure 5.7: Access to improved sanitation



Source: Sudan Household Health Survey 2010

Figure 5.6: Gadarif is the only state there children under-15 are the main person collecting water



Note: The percentage shares excludes households whose data is missing or people who mainly collect water is unknown.

Call to Action

- Invest in mid-level health cadres as well as quality and affordable primary health care services, particularly in rural areas.
- The percentage of primary school-age children attending school is very low, especially among the nomadic population. More child-friendly education facilities and services need to be provided to increase enrolment.
- Foster partnerships to reduce chronic malnutrition and acute severe underweight prevalence. Ensure food security at the household level by investing in preventive nutrition and poverty reduction in rural areas.
- Focus on school health, health promotion and IMCI particularly among rural and nomadic populations. Explore options for sustaining operating costs of immunization service delivery, including cold chain equipment maintenance and transportation.
- Invest in initiatives to open dialogue at the community level around the consequences of child and early marriage. Reinforce the rights of girls by raising the legal age of marriage in the state.
- Continue collecting disaggregated data to better understand the well-being of children and women in all eleven localities of Gadarif.
- Call for IMCI increased coverage not only for Gadarif town, but also for remote rural areas.

6 Khartoum State

Key Indicators from Sudan Household Health Survey 2010 (%)	
Birth Registration	87.6
Fully Immunized	60.9
Global Underweight	19.9
Global Stunting	21.9
Global Acute Malnutrition	12.8
Use of Improved Drinking Water Sources	96.3
Use of Improved Sanitation Facilities	51.3
Pre-school Education Enrolment[1]	42
Primary School Enrolment	93.7
Secondary School Enrolment	65.4
People with Differentiated Abilities[2]	4.1
FGM/C Prevalence	64.8
Early Marriage (before 18)	27.5
Attended by Skilled Person at Birth	93.3
State Child Act - Enacted	No
State Child Act – Under Draft	No
State Child Act – ban on FGM/C Included	No
Infant Mortality Rate[3] (per 1000 live births)	75
Maternal Mortality Rate (per 100,000)	389

Children and women in Khartoum benefit from the best economy in the country. Sudan's oil and other resources generated an estimated USD 15 to 22 billion between 2005 and 2010, with income being concentrated largely in Khartoum state. Only a quarter of the population lives below the poverty line, compared with 63 per cent in Darfur.[4] Khartoum also has the highest monthly average household per capita consumption at SDG 205, nearly twice that of the state with the lowest, North Darfur (Figure 6.2).[5]

Aside from its economy, Khartoum's urban landscape makes it distinguishable from most states in Sudan. Approximately 4.2 million (81 per cent) of the state's 5.2 million people live in urban areas, according to the 2008 census. The national capital is a major city although the number of IDPs[6] has sharply dropped as a result of the departure of southern Sudanese following the referendum and secession of South Sudan in July 2011. There is no updated information about the current number of IDPs in Khartoum.

1 All Education Enrolment Rates are based on theMinistry of General Education Statistics 2008-9

2 Those who are conventionally known as the disabled may develop other abilities to compensate their disabilities. Data from Census 2008, CBS.

3 IMR and MMR are from 2008 Census, CBS

4 Government of Sudan Central Bureau of Statistics, 'Sudan National Baseline Household Survey 2009 North Sudan - Tabulation Report' Khartoum, 2010, p.12. The survey defines a poverty line as a total consumption level of SDG 114 per month.

5 Government of Sudan Central Bureau of Statistics, 'Sudan National Baseline Household Survey 2009 North Sudan - Tabulation Report' Khartoum, 2010, pp. 15, 27.

6 Previous official number, before the return of the southerners was approximately at 1.7 million

Figure 6.1: Infant survival & school enrolment in Khartoum

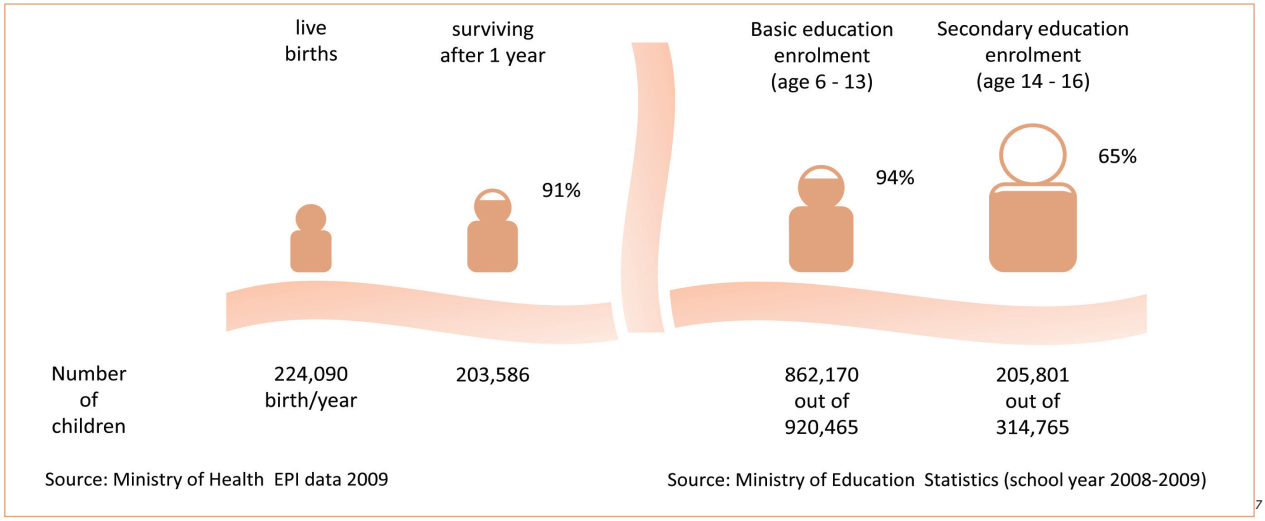
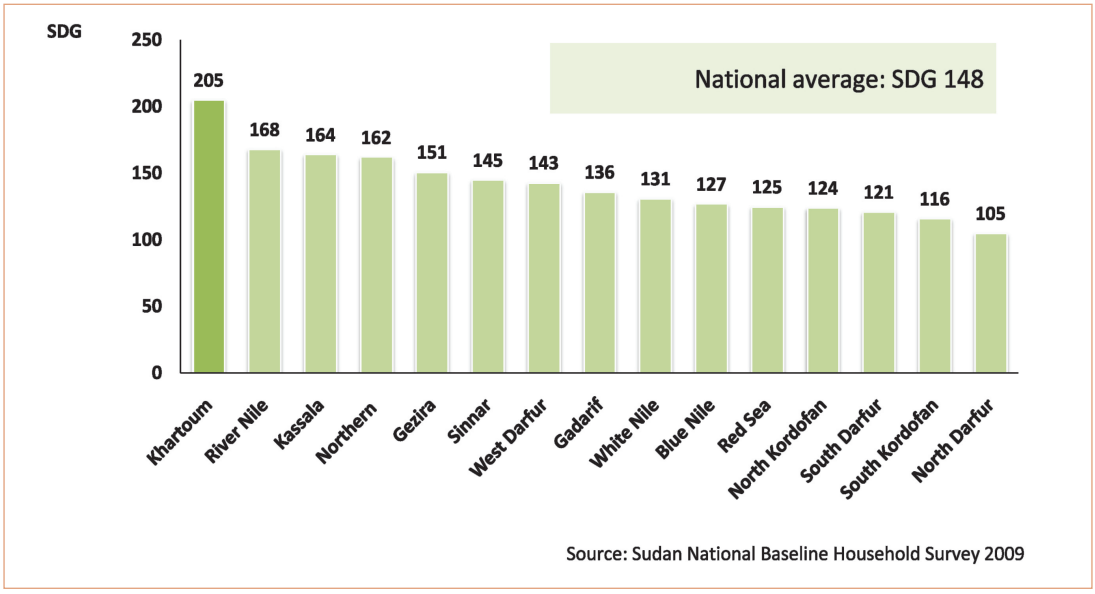


Figure 6.2: Khartoum has the highest monthly household per capita consumption



Key Issues

Health

The 2010 SHHS shows that the health status of women and children is good in Khartoum, compared with other Sudanese states. Immunization coverage is high, so is antenatal care (ANC) as well as births attended by trained assistants. However, being the most populated state in Sudan, Khartoum, remains top priority for reduction of under five and maternal deaths if Sudan is to achieve MDGs 4 and 5.

7 The number of children enrolled includes children of all ages, whereas the denominator is based on the population for aged 6-13 fore primary education and 14-16 for secondary. This may result in higher enrolment rate than the reality.

Education

Khartoum state outstrips other states with regard to the availability of well-established and staffed education facilities. The highest rates of literacy are reported in Khartoum. According to the statistical data of the 2008 census, the average literacy rate among the population six years of age and above reached 80.3 per cent. According to the Educational Statistics, the total school-aged population (aged six-13) is 920,465. The number of enrolled students is 862,476, representing 93.7 per cent of the children of school age. The number of out-of-school children is 57,989, almost 6.3 per cent of the children of school age. However, according to the findings of the Baseline Survey on Basic Education final report (2008), the gross enrolment rate of 76.7 per cent ranked Khartoum state below River Nile, White Nile and Northern states who reported 88 per cent, 81.8 per cent and 78.4 per cent respectively[8]. This could be attributed to the large population of IDPs residing in Khartoum at the time of the survey. Children in remote areas within Khartoum state are not an exception. Therefore, if Khartoum succeeds in reaching out to IDPs and remote rural areas with education, it can be a true model for other states to follow in terms of equity.

Other Sectors

At 51 per cent, the proportion of people using both improved sources of drinking water and improved sanitation facilities is among the highest in the country (only Northern State is higher). Khartoum also has one of the lowest rates of early marriage in the country (27.5 per cent of under-18 year-olds) and one of the highest rates of female literacy (between 58-75 per cent, depending on sources[9]). More women have been tested for HIV/AIDS and know where to get tested than anywhere else in the country. Ninety-one per cent of Khartoum's children are in primary school, with an equal proportion of boys and girls attending.

Khartoum state should be applauded for the progress made in protecting the rights of women and children, but its work is by no means complete. The 2008 census found that more than 206,000 children of school-going age (16.6 per cent) are not attending school (Figure 6.3). There is a 13 percentage point difference in school attendance between urban and rural populations (81 and 68 per cent respectively). More than one in every four women marries before the age of 18 and 65 per cent of girls and women have undergone the harmful practice of female genital mutilation and cutting. While these indicators may compare favourably with other states, they are nonetheless beyond acceptable levels.

Figure 6.3: The share of children out-of-school in rural areas is almost twice as high as in urban areas of Khartoum state

8 The percentage of enrolment at primary education is 93.7%, and the secondary school enrolment is 65.4%, Educational Statistics, 2008/2009, P38 & 41.

9 SHHS2 reports 58 per cent, while the 2008 census reports 75 per cent.

Addressing the above key issues for the children of Khartoum state requires focused attention toward marginalized populations such as street children and expanded outreach to rural areas. Likewise, a strong focus on gender equality through the prevention of early marriage and FGM/C will pay off greatly not only in the socio-economic development of Khartoum state, but also strengthen its leadership in the achievement of the MDG3. A recent UNICEF study found that ensuring an equitable approach in programmes is worthwhile: for every US$1 million spent on hard-to-reach populations, an additional 60 per cent of deaths can be averted.[10]

Separated and Unaccompanied Children

As in any big city, Khartoum attracts children who have left home, whether in search of work, or because they were abused or separated from their parents during conflict, or for a host of other reasons. Although these children are a regular presence in urban life – whether working or sleeping in the streets, or begging – their exclusion from society and denial of their rights makes them, in essence, invisible.[11]

Quantifying children living in the street is nearly impossible -- recent surveys have estimated anywhere from 3,500 in the state as a whole, to 5,000 in Khartoum city alone. Many live outside the law by squatting in abandoned buildings, resorting to sex work or stealing. Without legal or parental protection, children on the streets are vulnerable to discrimination, exploitation, mistreatment and abuse. They are deprived of education and health services and can become involved in criminality. The number of children in contact with the law is increasing. Khartoum is the state that reported both the highest number of cases of violence against children and the highest number of crimes committed by children. There were 3,053 cases of violence against children in 2009 and almost double that number in 2010. The number of crimes committed by children increased by 50 per cent: from 6,632 to 9,461 reported cases between 2009 and 2010. The problems of insecurity in Darfur, East Sudan, South Kordofan, Blue Nile and South Sudan were among the underlying factors that increased migration to Khartoum. These migration waves include children who often find themselves homeless and jobless in Khartoum. There have been some efforts to rescue these children, for example, by providing them with vocational training. But more needs to be done. Any future intervention should start with a survey to obtain disaggregated data on their origin, distribution, age, gender and the type of interventions suitable for them.

Among the most vulnerable of the children without parental care are infants abandoned by unwed mothers. Shamed by the stigma of having a child outside of marriage, mothers (themselves mostly young) abandon their children in the street, in garbage bins or outside orphanages. Stopping these tragic incidents requires a double-pronged approach: strengthening services for children without parental care and addressing the underlying stigmas associated with unwanted pregnancies.

The majority of abandoned babies are brought to Mygoma orphanage where a lack of adequate funding for care has too often limited their chances of survival. Between 2007 and 2009, approximately half of the 2,100 babies that were admitted died. The government has since committed itself to the continuation of services at Mygoma, with the aim of providing immediate care, and strengthening alternative family care.[12] As a result, survival rates improved slightly in 2010. A contributory factor to this was extensive media coverage and an advocacy campaign initiated by journalists who were moved by the increasing numbers of abandoned children.

Older children may end up at one of three institutions for children living on the streets: Elrashad and Tyibah for boys, and Elbashiery for girls. They are admitted mostly as a result of police roundups during public order campaigns.

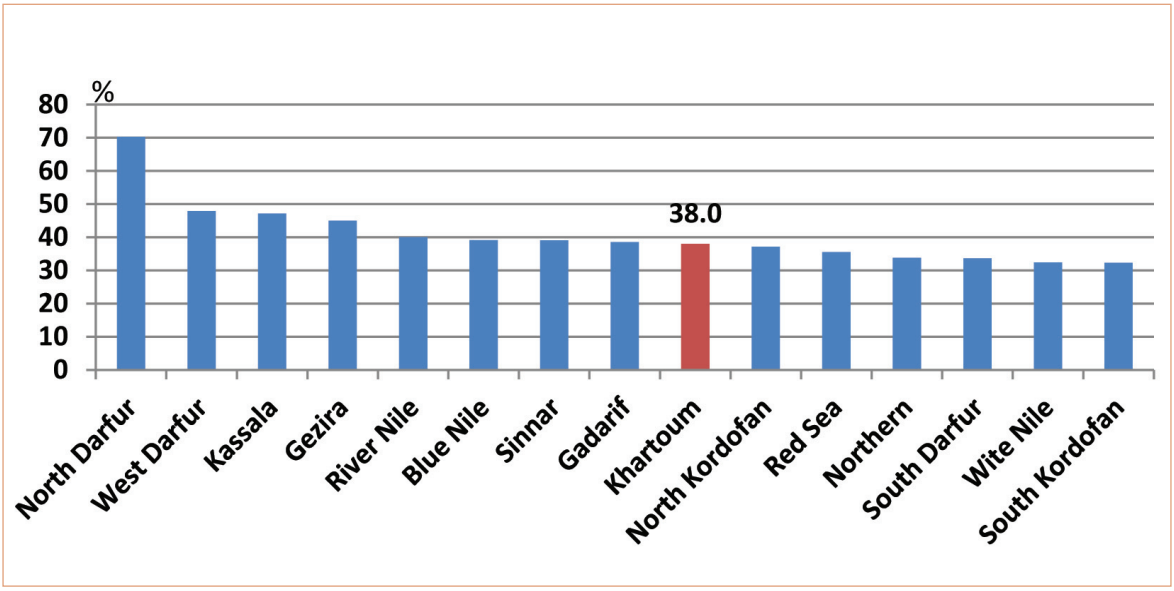
10 United Nations Children's Fund, Narrowing the Gaps to Meet the Goals, New York City, 7 September 2010.
11 United Nations Children's Fund, State of the World's Children: Excluded and Invisible.
12 This information came from the State Ministry of Social Welfare annual Report, 2010.

Recent efforts have highlighted the issue of abandoned babies and children without parental care. In May 2011, the National Council for Child Welfare (NCCW), UNICEF and the Shama' organization jointly hosted a workshop in Khartoum under the theme "Measures taken to protect children without parental care". The challenge now is to build on these discussions and translate them into action.

Nutrition

Khartoum's children are some of the healthiest in Sudan – the state has the lowest proportion of children under the age of five who are underweight, stunted or wasted (suffering from acute malnutrition). Despite this, according to WHO figures, the prevalence of stunting is 'medium', while the prevalence of wasting is 'serious'[13]. However, rates of exclusive breastfeeding are below the national average (of 41 per cent) in Khartoum State (Figure 6.4). Only 38 per cent of children aged 0 to five months are exclusively breastfed, ranking Khartoum ninth out of 15 states. One reason for this may be social stigma; fat babies have become a status symbol that implies wealth and mothers believe that feeding formula will ensure a fatter baby. Formula milk cannot substitute the numerous health benefits of breast milk, including increasing infants' immunity to illness, reducing the risk of diarrhoea and vomiting and reducing the risk of longer-term life-style conditions such as Type II Diabetes and high blood pressure.

Figure 6.4: Khartoum state ranks in the middle in terms of the share of children exclusively breastfed
(child age 0-5 months)



13 Physical Status: The use and interpretation of Anthropometry. Report of WHO expert committee, 1995. Chapter 5, p208 & 212.

Call to Action

- Extend services to hard-to-reach populations, including remaining out-of-school children, women in rural areas who do not have access to antenatal care services, IDPs and areas without adequate water and sanitation.
- Address disparities in education between urban and rural areas by investing more in rural development.
- Engage communities in changing harmful social practices like FGM/C and early marriage towards greater gender equality.
- Invest in identifying and caring for children without parental care. This includes situation analysis, scaling up outreach programmes, improving facilities that care for these children, intensifying reunification efforts, and strengthening alternative family care.
- Promote exclusive breastfeeding by raising awareness of its benefits
- Continue to collect disaggregated data in order to better understand the changing situations of children and to monitor equitable progress.

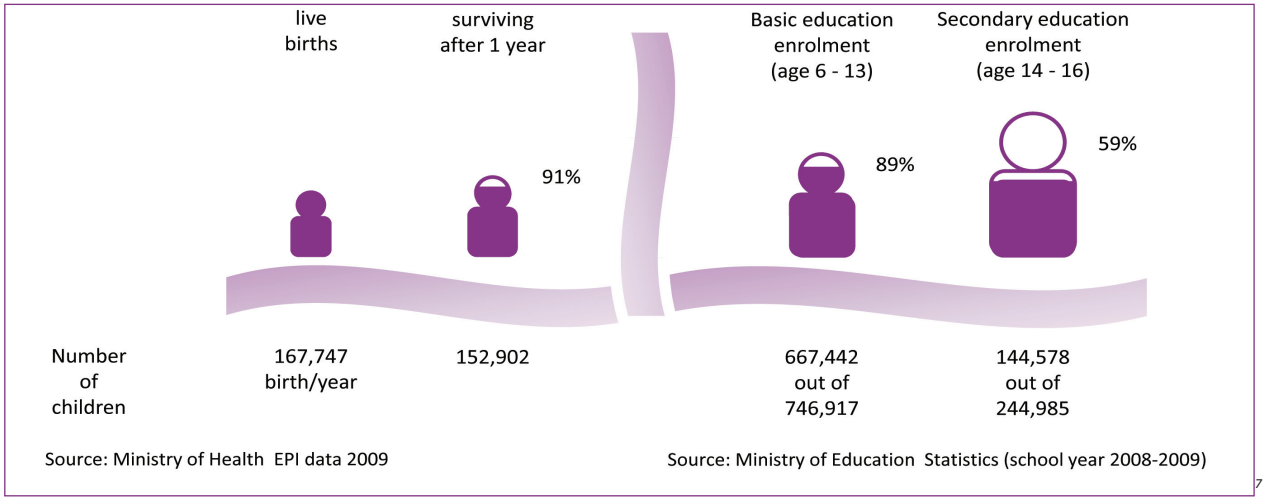
7 Gezira State

Key Indicators from Sudan Household Health Survey 2010 (%)	
Birth Registration	75.9
Fully Immunized	62.6
Global Underweight Prevalence	23.5
Global Stunting Prevalence	29.7
Global Acute Malnutrition	13.2
Use of Improved Drinking Water Sources	97.6
Use of Improved Sanitation Facilities	34.4
Pre-school Education Enrolment[1]	42.7
Primary School Enrolment	89.4
Secondary School Enrolment	59
People with Differentiated Abilities[2]	4.5
FGM/C Prevalence	66.6
Early Marriage (before 18)	28.2
Attended by Skilled Person at Birth	89.4
State Child Act - Enacted	No
State Child Act – Under Draft	No
Infant Mortality Rate[3] (per 1000 live births)	70
Maternal Mortality Rate (per 100,000)	422

Like Khartoum, Gezira state is a hub for economic activity.[4] With a population of 3.5 million, it is the third most populous state after Khartoum and South Darfur. There are 1.7 million children under the age of 18 and nearly 512,000 children under five.[5] Of the 109,600 children born alive in the 12 months preceding the 2008 census, about 98,600 (90 per cent) were still alive when the census took place. As in many states, most families build their lives around agriculture. What makes Gezira different, however, is the presence of the Gezira scheme. Having one of the world's largest irrigation projects means that residents are protected from droughts that push so many other families into poverty. The Gezira scheme provides opportunities for employment in agriculture, weaving, spinning, grain mills, edible oil and the food industry. Although this potential is yet to be fully utilized, the scheme has surely contributed to the state's strong health, education, water, sanitation and hygiene and other systems. In recent years the Gezira scheme has suffered due to the lack of maintenance of the canals. Cotton, wheat and sorghum production dropped to very low levels, and many farmers migrated from Gezira to seek better work opportunities elsewhere. Even though its performance in social indicators surpasses those of many other states, there are areas where progress appears to be slowing. Particularly vulnerable are the 1.4 million rural and 2,000 nomadic children who reside in areas with low access to basic services.[6]

1 All Education Enrolment Rates are based on theMinistry of General Education Statistics 2008- 9
2 Those who are conventionally known as the disabled may develop other abilities to compensate their disabilities, data from Census 2008, CBS.
3 IMR and MMR are from 2008 Census, CBS.
4 World Bank, World Development Indicators, Washington DC, World Bank Group, 2009.
5 Sudan Population and Housing Census 2008.
6 Sudan Population and Housing Census 2008.

Figure 8.1: Infant survival & school enrolment in Gezira



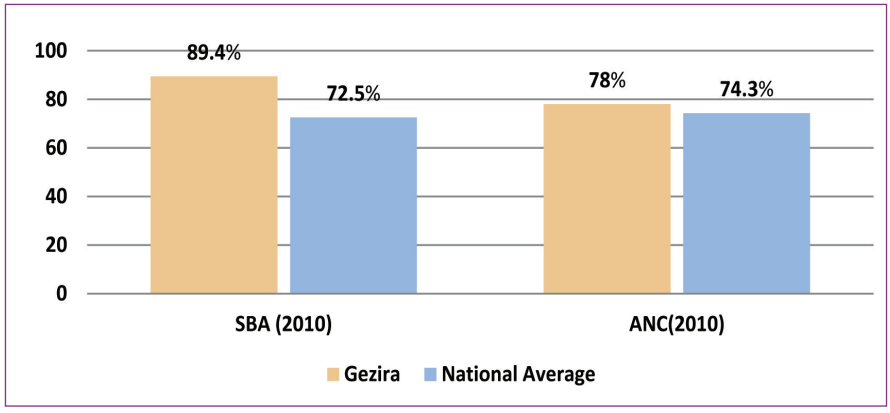
Key Issues

Health

In Gezira, children and women enjoy a relatively good health status compared to other states in Sudan. All mortality figures (neonatal, under five and maternal) are better than the national averages.

Safe motherhood practices in Gezira have slightly improved. In 2006, close to 86 per cent of mothers aged 15 to 49 had delivered at least once with a skilled birth attendant, while 76 per cent received antenatal care at least once from a qualified person during pregnancy. In 2010, those rates increased to 89 per cent and 78 per cent respectively as per the findings of the SHHS2. Gezira state has the infrastructure in place to improve maternal health. A recent assessment by the Population Council found that mothers in Gezira were in a better situation than in other states. For example, the average time needed to reach a health facility is 15 minutes, compared with 29 minutes in South Darfur. More facilities were open 24 hours and more were supplied with the medical supplies needed to treat pregnancy complications[8]. Simple steps such as increasing skilled personnel, expanding the reach of health facilities and increased financial support could lead to additional strides in reducing maternal deaths. In fact, approximately 80 per cent of maternal deaths can be prevented through securing access to quality basic and emergency obstetric care.[9]

Figure 7.2: Coverage by skilled birth attendants (SBA) and ante-natal care (ANC) in Gezira State



7 The number of children enrolled includes children of all ages, whereas the denominator is based on the population for aged 6-13 for the primary education and aged 14-16 for the secondary. This may result in higher enrolment rate than the reality.

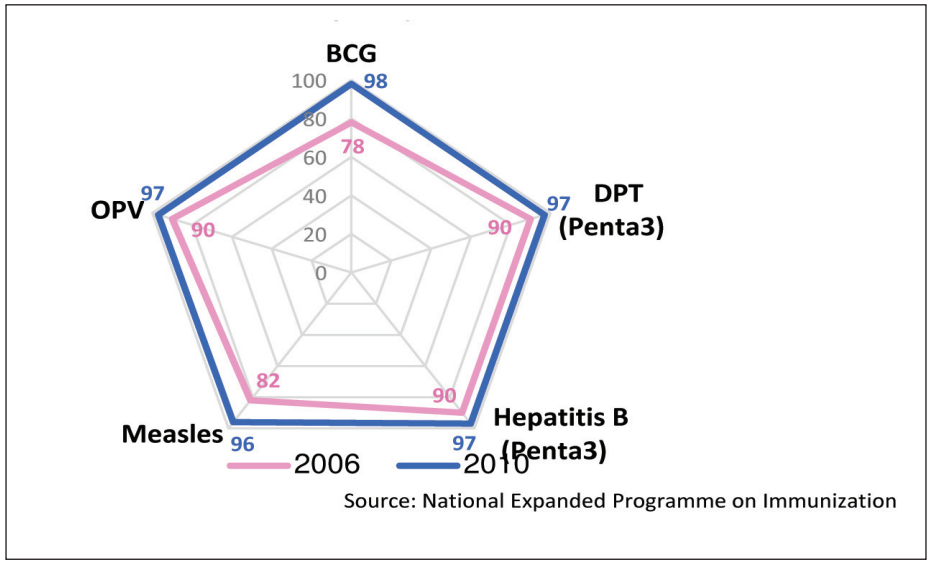
8 Abdel-Tawab, Nahla and Maha El-Rabbat, "Maternal and Neonatal Health Services in Sudan: Results of a Situation Analysis", Project Brief, Population Council, Cairo, February 2010, pp. 4. 10.

9 United Nations Children's Fund, State of the World's Children 2009: Maternal and Newborn Health, New York City, 2009, p. 2.

Gezira claims one of the highest immunization rates in Sudan, although different sources of data disagree about the rate of progress. According to SHHS2, 63 per cent of children aged 12 to 23 months were fully immunized for BCG, polio, DPT and measles in 2010, exceeding the national average of the country which is 49 per cent. However, in 2006 close to 69 per cent of children were covered by immunization services.

Meanwhile, recent data of the National EPI suggests rather higher coverage has been achieved (Figure 7.3). This includes an increase in measles vaccinations from 82 to 96 per cent between 2006 and 2010, as well as increased BCG vaccinations from 78 to 98 per cent.[10] Coverage of three requisite doses of OPV has also increased from 90 per cent to 97 percent during the same period.

Figure 7.3: Immunization coverage improved between 2006-2010 in Gezira



Source: National Expanded Programme on Immunization

When compared to the national average, Gezira State is one of the better-off States in terms of child nutrition status. Despite this, prevalence of stunting is classified as high, while wasting (acute malnutrition) is classified as serious.[11] Of the acute malnutrition, a third is severe (4.4per cent). Rates of exclusive breastfeeding are above the average, but less than half of all babies are exclusively breastfed. Minimum meal frequency is poor with just a quarter of children receiving food the recommended number of times in 24 hours.[12]

Water, Sanitation and Hygiene

Although access to improved water sources is the highest in the country at 98 per cent, around one fifth of them (626,048 or 18 per cent) are receiving their water through animal carts and tankers (Figure 7.4). On the other hand, only 34 per cent of the state population (1,206,669) have access to improved sanitation facilities, while 30 per cent (1,064,708) are using unimproved sanitation facilities. The rest of the population (1,277,649 or 36 per cent) are still practising open defecation (Figure 7.5), despite the attendant dangers due to its capacity to rapidly spread disease. Progress has been low in this area because of the lack of community awareness, lack of clear sanitation policy, strategies and support.

10 EPI uses surviving infants as a denominator, except for BCG, which uses a total number of live births. In comparison, SHHS uses 12-23 months old as a denominator.

11 Physical Status: The use and interpretation of Anthropometry, report of a WHO expert committee, 1995, chapter 5, p208 & 212

12 Number of children aged 6-23 months receiving solid, semi-solid and soft foods (plus milk feeds for non-breastfed children) the minimum of two times or more, according to breastfeeding status, during the previous day. For breast feeding children, the minimum meal frequency is two times for infants' age 6-8 months and three times for children aged 9-23 months. For non-breastfeeding children, the minimum meal frequency is four times for children aged 6-23 months.

Figure 7.4: Access to improved drinking water

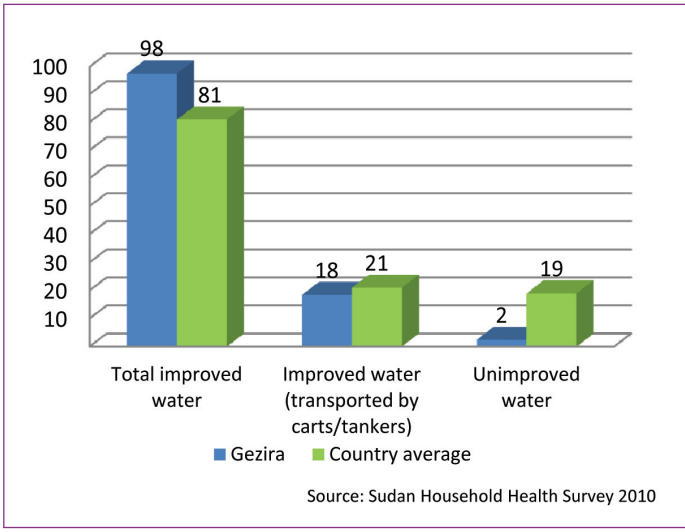
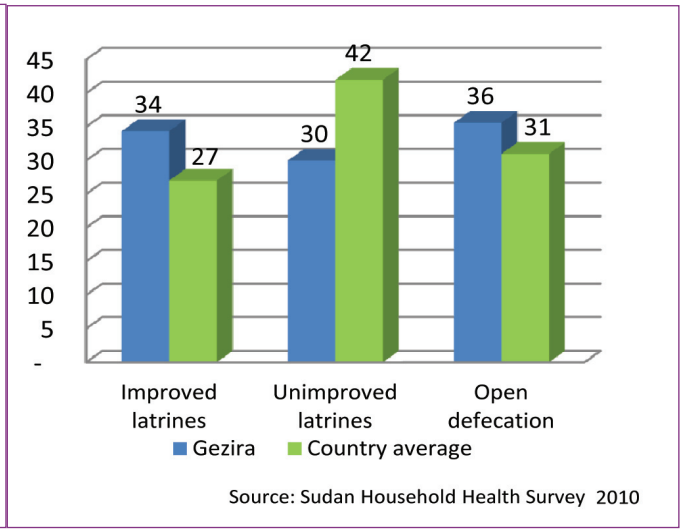


Figure 7.5: Access to improved sanitation



Access to improved sanitation is also low for school children and health facilities. The 2011-2016 WASH Strategic Plan estimated access at 41 per cent and 61 per cent for the state's schools and health facilities respectively.

Child Protection

Gezira is ranked second after Khartoum state in respect of the number of children in contact with the law. No measures have been undertaken at state level to tackle this issue despite the high levels of violence against children and the number of crimes committed by children. There was, however, a fall in the number of cases of violence against children between 2009 and 2010, from 3,441 to 1,914. It was the reverse in regard to the number of crimes committed by children, which doubled to reach 1,582 in 2010.

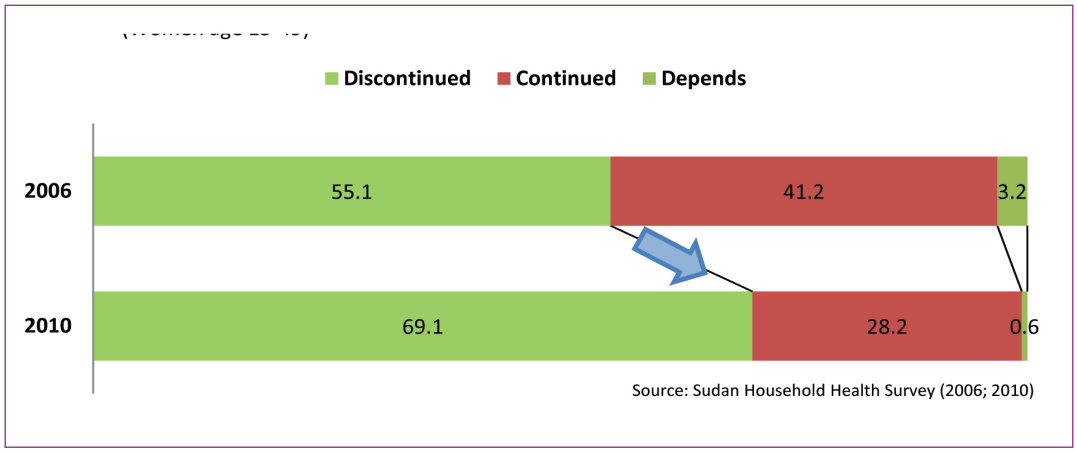
Key to addressing this problem is improved legislative support to child rights through enforcement of the Child Act. This legal umbrella would foster coordinated efforts to support children and protect them from various types of vulnerability. Furthermore, child rehabilitation and vocational training could be introduced to assist their integration into society.

FGM/C

According to SHHS2, 67 per cent of girls and women in the state undergo FGM/C, although there are signs that attitudes are changing. The percentage of women who supported banning FGM/C increased from 55.1 per cent in 2006 to reach 69.1 per cent in 2010 (Figure 7.6). Only 28 per cent of ever-married women say they intend to continue the practice with their daughters (compared to 51 per cent in 2006), one of the lowest proportions of women in any state.

Figure 7.6: Women have become more opposed to practicing FGM/C in Gezira between 2006 and 2010

(Women age 15-49)



FGM/C is a deeply rooted in tradition. So to be effective, campaigns for its abandonment need to involve influential community members to counter the view that girls who are cut are more likely to be socially accepted and have a better chance for a prosperous marriage. This explains why so many mothers and family members are willing to risk their daughters' health in order to ensure their place in society.

Community-based initiatives such as *Saleema* bring together a network of parliamentarians, social actors, religious groups, and women activists in order to build consensus to collectively abandon FGM/C. The project has seen some success in South Kordofan, and has the potential to make further strides in protecting girls against this harmful traditional practice.

Birth Registration

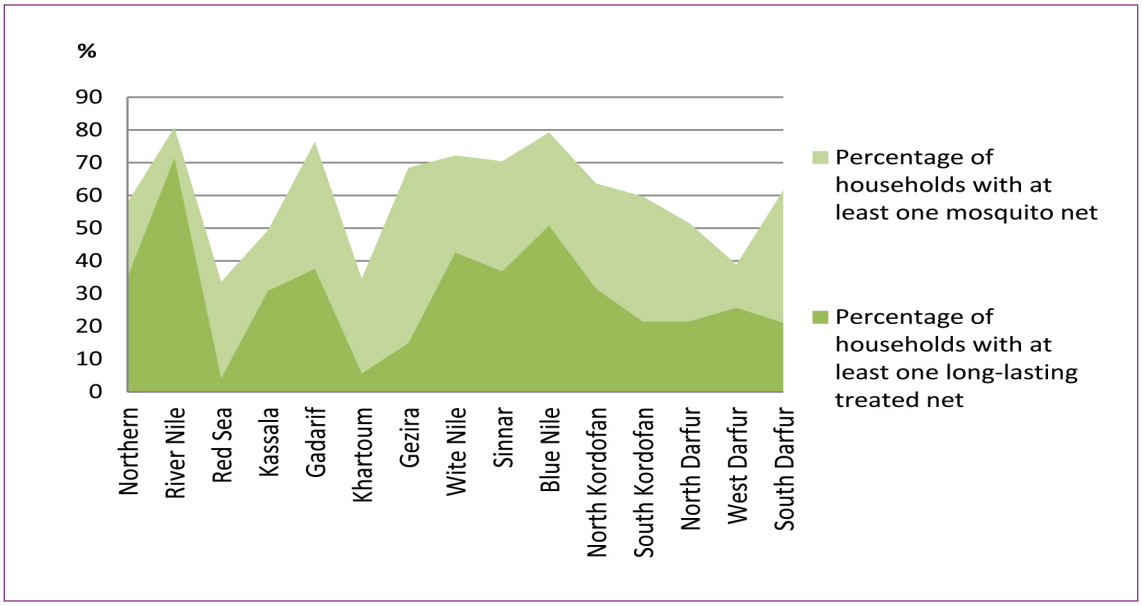
Gezira state managed to increase birth registration by 14.5 percentage points to 75.9 per cent between 2006 and 2010. Birth registration is fundamental to child survival and healthy development as it ensures that children are recognized by the state when budgets are decided and resources allocated. Having official records of a child's age and identity also makes it easier to monitor school attendance and enforce age-specific laws, such as marriage and recruitment to armed forces.[13]

Malaria and Mosquito Nets

Malaria has been one of the leading causes of morbidity and mortality in Gezira state and small children and pregnant women are especially vulnerable. Although 69 per cent of households have at least one mosquito net, less than 15 per cent has long-lasting treated nets according to SHHS2 (Figure 7.7). Further efforts to strengthen awareness and distribution campaigns to promote the use of long-lasting treated mosquito nets may be necessary.

13 United Nations Children's Fund, Progress for Children: A report card on child protection, no. 8, UNICEF, New York, 2009, pp.5-6.

Figure 7.7: Despite a high coverage of mosquito nets, households with long-lasting treated nets are still rare in Gezira

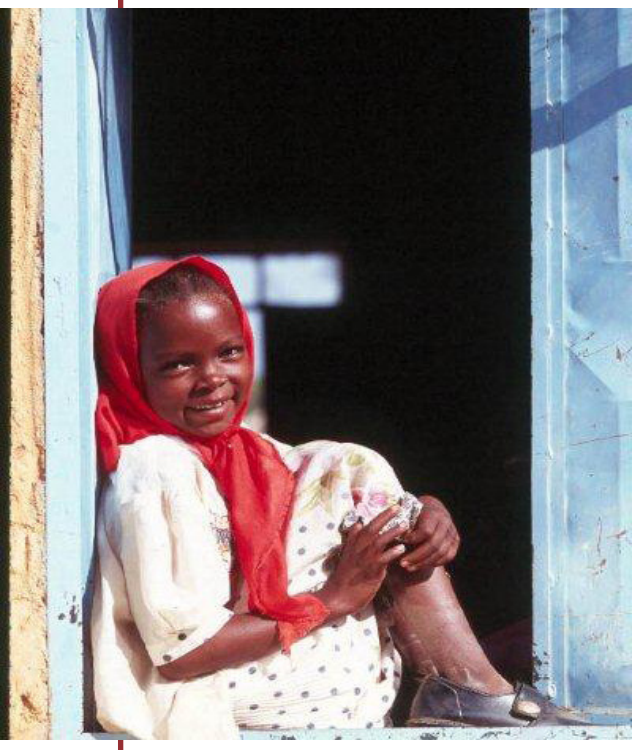


Call to Action

- Build on existing efforts of the State Government to engage in constructive dialogue with the goal of prioritizing child and maternal health in government planning and budgeting. Ensure that particular focus is given to rural areas and locations of high return.
- Promote community-based initiatives like the *Saleema initiative* to change social norms around FGM/C, while also pushing for the introduction of a law banning FGM/C.
- Continue to collect new data that will inform decision-making and monitor progress on the rights of children.
- Introduce measures to combat the practice of open defecation.
- Share best practice in increasing birth registration with other states
- Advocate for child rights to be a central component in government plans for development and budgeting.

8

White Nile State



Key Indicators from Sudan Household Health Survey 2010 (%)	
Birth Registration	**71.7**
Fully Immunized	**54.9**
Global Underweight	**34.1**
Global Stunting	**37.0**
Global Acute Malnutrition	**18.1**
Use of Improved Drinking Water Sources	**64.3**
Use of Improved Sanitation Facilities	**20.2**
Pre-school Education Enrolment[1]	**41.4**
Primary School Enrolment	**84.5**
Secondary School Enrolment	**38.3**
People with Differentiated Abilities[2]	**4.7**
FGM/C Prevalence	**71.7**
Early Marriage (before 18)	**35.7**
Attended by Skilled Person at Birth	**86.2**
State Child Act – Enacted	**No**
State Child Act – Under Draft	**No**
State Child Act – ban on FGM/C Included	**No**
Infant Mortality Rate[3] (per 1000 live births)	**79**
Maternal Mortality Rate (per 100,000)	**503**

White Nile is one of the least developed states in Sudan. Monthly household consumption is SDG 131 per capita, putting 56 per cent of the population under the poverty line of SDG 114.[4] The majority of the population of 1,147,951 is rural or nomadic (67 per cent). A third of the economically-active population works in agriculture, making the state particularly vulnerable during the lean season. In fact, agriculture-related events such as drought, crop disease, pests and livestock loss, accounts for more than 40 per cent of all the events that severely affected households in the state.[5] Several droughts over the past decade have inhibited progress and contributed to poor child nutrition, limited access to clean water sources and high poverty rates. Almost half of White Nile's 1.7 million people are children and 267,300 (16 per cent) are under the age of five.[6] Particularly vulnerable are the 560,000 rural and 21,000 nomadic children who reside in areas difficult to access with basic services.[7]

The majority of the state population live in a narrow strip along the banks of the White Nile. Others live in small villages scattered across the state, many of which are thinly populated and widely dispersed making it difficult to provide them with health, education, water supply and other basic services.

1 All Education Enrolment Rates are based on theMinistry of General Education Statistics 2008-9

2 Those who are conventionally known as the disabled may develop other abilities to compensate their disabilities. Data from Census 2008, CBS.

3 IMR and MMR are from 2008 Census, CBS 4 Sudan Central Bureau of Statistics, Sudan National Baseline Household Survey 2009,North Sudan - Tabulation Report, Khartoum, 2010.

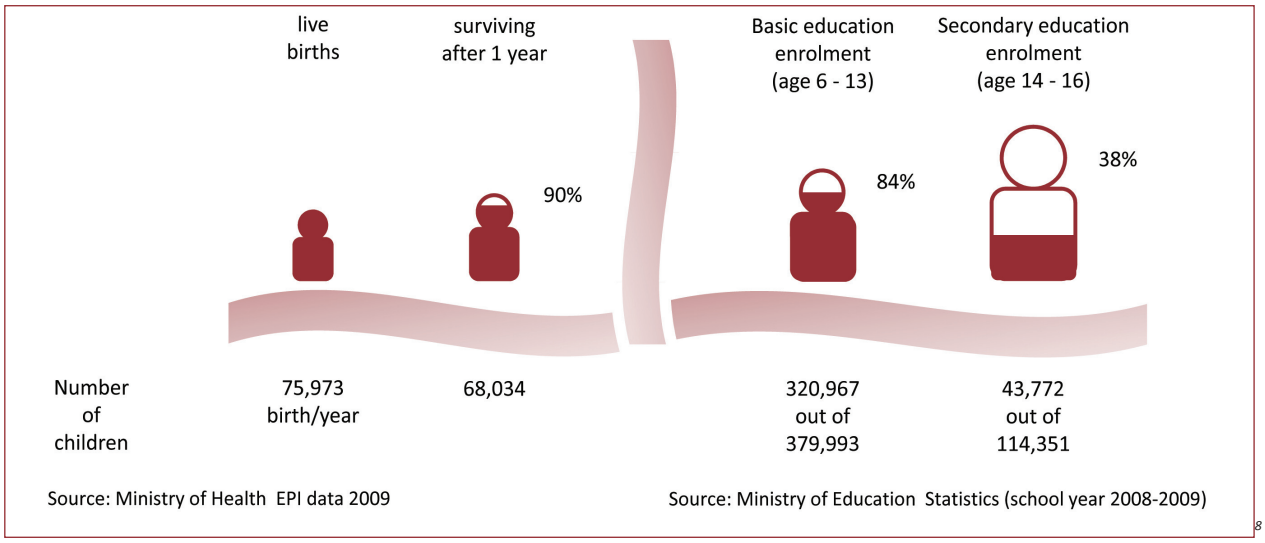
4 Sudan Central Bureau of Statistics, Sudan National Baseline Household Survey 2009, North Sudan - Tabulation Report, Khartoum, 2010.

5 Sudan Central Bureau of Statistics, Sudan National Baseline Household Survey 2009, North Sudan - Tabulation Report, Khartoum, 2010.

6 Sudan Population and Housing Census 2008.

7 Sudan Population and Housing Census 2008.

Figure 8.1: Infant survival & school enrolment in White Nile



[8]

Key Issues

Education

White Nile's investment in education is paying off. Thirty-nine per cent of its total public spending goes towards education, resulting in an eight per cent average annual growth rate in basic school enrolment between 2004/2005 and 2008/2009. While this growth may not be as great as Blue Nile (14 per cent) or the Darfurs (12 to 15 per cent), it still exceeds the national average of six per cent.[9] According to SHHS2, primary school attendance is 80 per cent and 36 per cent of secondary school age children are attending secondary school[10].

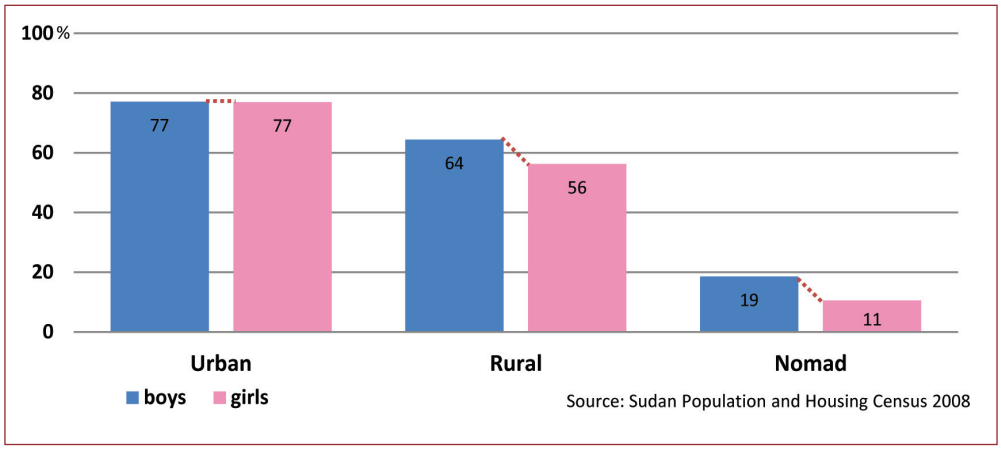
However, the trend is alarming in terms of disparities. The 2008 census found that high proportions of children in urban areas are attending school, with almost no difference between boys and girls. In rural communities, 102,200 children aged six to 16 are not attending school, almost a third of all school-age children in these areas. Unlike their urban counterparts, girls are much less likely to attend and stay in school. Only 56 per cent of girls attend school compared with 64 per cent of boys (Figure 8.2).

8 The number of children enrolled includes children of all ages, whereas the denominator is based on the population for aged 6-13 for the primary education and aged 14-16 for the secondary. This may result in higher enrolment rate than the reality.

9 "World Bank", 2012, The Status of the Education Sector in Sudan, Washington DC

10 The percentage of enrolment at primary education is 84.5%, and the secondary school enrolment is 38.3%, Educational Statistics, 2008/2009, P38 & 41.

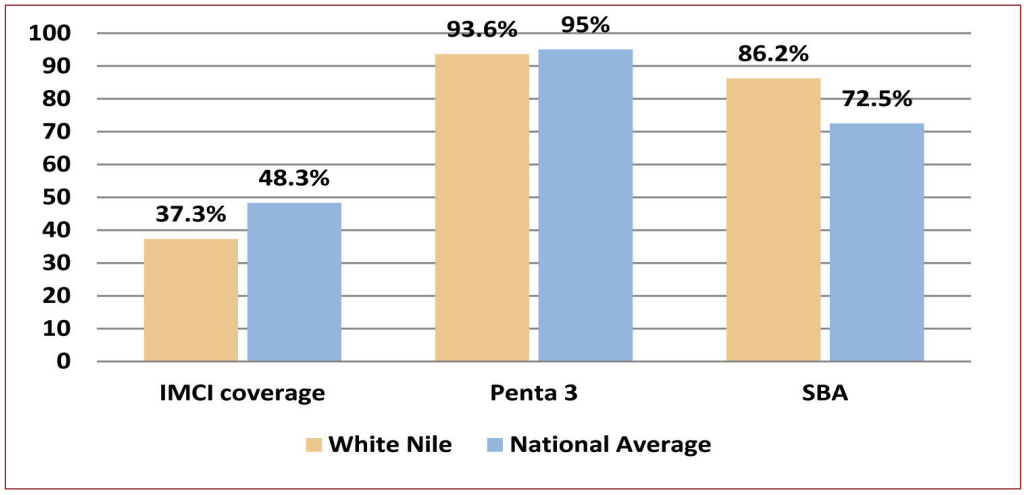
Figure 8.2 Gender gap of school attendance widens among rural and nomadic populations in White Nile
(children age 6-16)



Health

The health status of children and women is closely co-related, especially in the neonatal stage. Rates for under five and neonatal mortality are below the national average.[11] On the other hand, the maternal mortality rate is higher than the national average despite government data that shows 100 per cent access to comprehensive emergency obstetric care,[12] with 86 per cent of births being assisted by skilled birth attendants. The caesarean section rate is at 9.5 per cent, within the acceptable WHO range (five to 15 per cent). In addition, according to EPI administrative data, immunization coverage is high enough to protect children against vaccine-preventable disease, but only 37 per cent of health facilities are providing IMCI.

Figure 8.3: Coverage of IMCI services and penta vaccine & skilled birth attendants (SBA) in White Nile State, 2010

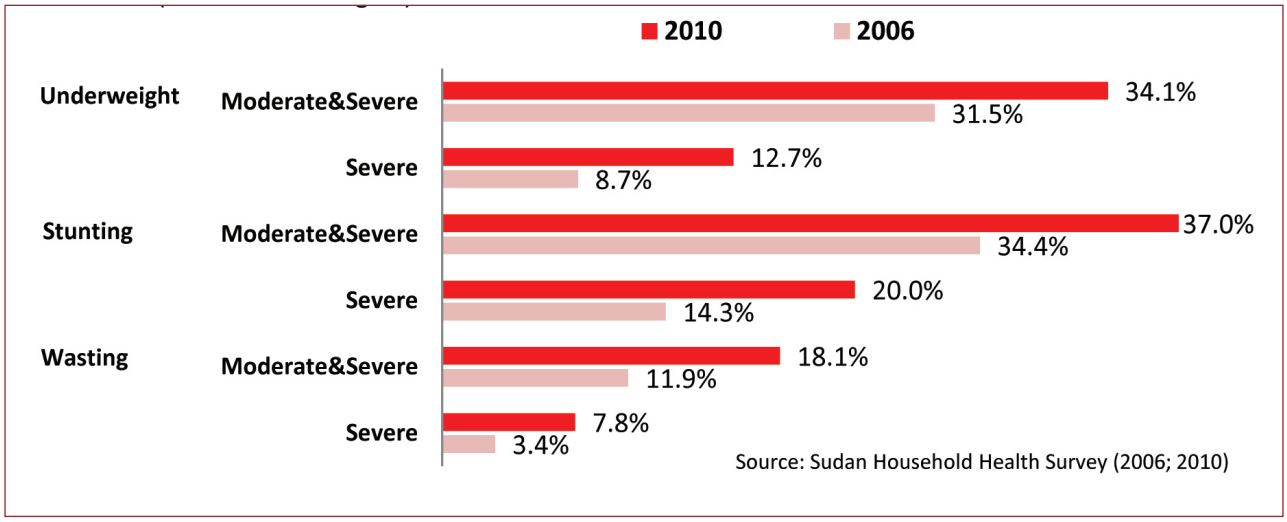


Nutrition

The nutritional status of children under the age of five in White Nile falls behind the national average in all the three anthropometric indices: weight for age (underweight), height for age (stunting), and weight for height (wasting) (Figure 8.4). At 7.8 per cent it has one of the highest SAM rates in Sudan[13]

11 SHHS, 2006
12 Source: FMOH, RH Unit, 2008
13 Severe acute malnutrition (SAM) is a severe wasting, defined by a very low weight for height (below -3z scores of the median WHO growth standards).

Figure 8.4: White Nile has higher malnutrition rates than the national average for underweight, stunting and wasting
(children under age 5)



One possible contributor to the high levels of malnutrition could be poor infant and young child feeding practices as shown by below average levels of exclusive breast feeding (at 32.4 per cent) and low levels of minimum meal frequency[14] for small children (just 36.6 per cent)

Many livelihoods are dependent on agriculture, increasing the vulnerability of households during the lean season. A 2010 assessment by the WFP estimated that five per cent of the population, or approximately 10,000 households, become severely food insecure during this time. Poverty and dramatic increases in market prices are also likely to reduce food consumption.[15]

What makes matters worse is limited access to food assistance. Many NGOs have left the state due to funding constraints, and White Nile remains a low priority for humanitarian agencies due to the crises in Darfur and along the border with South Sudan.[16]

To improve the food security and nutrition status among children at all levels, WFP's assessment recommended reducing taxes on food supplies, implementing school feeding programmes, and voucher/subsidy or Food-for-Work programmes in order to improve food security and nutrition levels among children.[17]

Water, Sanitation and Hygiene

Access to improved water sources and improved sanitation facilities is low. Only 1,069,550 (64 per cent) of the population have access to improved water and two fifths of them (445,474 or 26 per cent of the total population) are getting their water from animal carts and tankers (Figure 8.5). Access to improved sanitation facilities is still a serious issue in White Nile. The SHHS2 finds that only 20 per cent of the population has access to improved sanitation facilities, 46 per cent are using unimproved sanitation facilities and 34 per cent of the households have no toilet facility at all and are still practicing open defecation (Figure 8.6).

14 Minimum meal frequency = Number of children age 6-23 months receiving solid, semi-solid and soft foods (plus milk feeds for non-breastfed children) the minimum of two times or more, according to breastfeeding status, during the previous day. For breast feeding children, the minimum meal frequency is two times for infants aged 6-8 months and three times for children aged 9-23 months. For non-breastfeeding children, the minimum meal frequency is four times for children age 6-23 months.

15 World Food Programme, 'Emergency Food Security Assessment: White Nile', October 2010, p. 3.

16 World Food Programme, 'Emergency Food Security Assessment: White Nile', October 2010, p. 12.

17 World Food Programme, 'Emergency Food Security Assessment: White Nile', October 2010, p. 3.

Figure 8.5: Access to improved drinking water

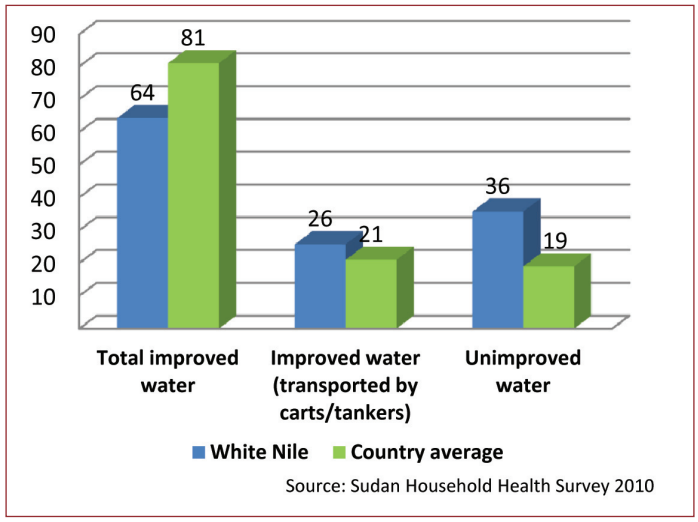
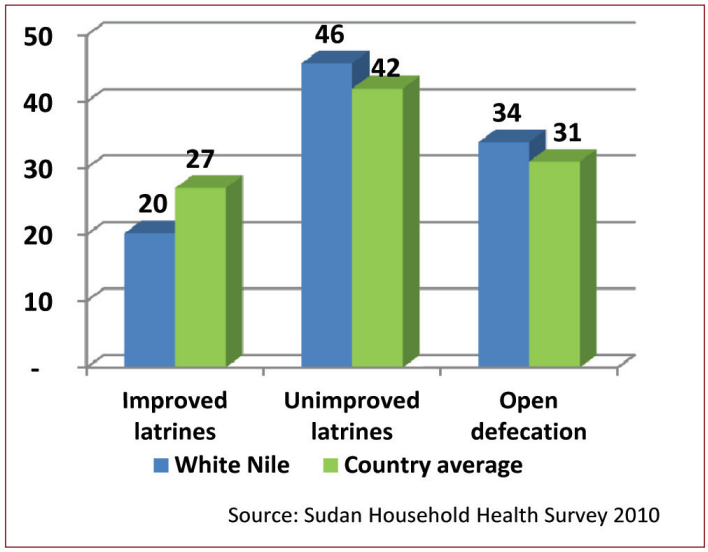


Figure 8.6: Access to improved sanitation



Access to improved sanitation is also low for school children and health facilities. The 2011-2016 WASH Strategic Plan estimated access at 23 per cent and 63 per cent for the state's schools and health facilities respectively.

Birth Registration

The proportion of children under five who were registered at birth has increased from 43 to 72 per cent in just four years. Birth registration is fundamental to child survival and healthy development as it ensures that children are recognized by the state when budgets are decided and resources allocated. Having official records of a child's age and identity also makes it easier to monitor school attendance and enforce age-specific laws, such as marriage and recruitment to armed forces.[18]

18 United Nations Children's Fund, Progress for Children: A report card on child protection, no. 8, UNICEF, New York, 2009, pp.5-6.

Call to Action

- Ensure equal distribution of education resources while exploring incentives for rural children and girls to attend and stay in school, such as more trained teachers and child-friendly schools.
- Expand the coverage of treatment services for SAM. Explore preventive measures of malnutrition, such as the promotion of exclusive breastfeeding, school feeding and subsidy programmes.
- Address the issue of higher (than national average) maternal mortality, which happens in spite of 100 per cent coverage in emergency obstetric care and higher percent of child delivery with skilled attendant.
- Advocate for more resources from the federal government and development community with programmes that will demonstrate concrete results such as Food-for-Work and school feeding.

9 Sinnar State

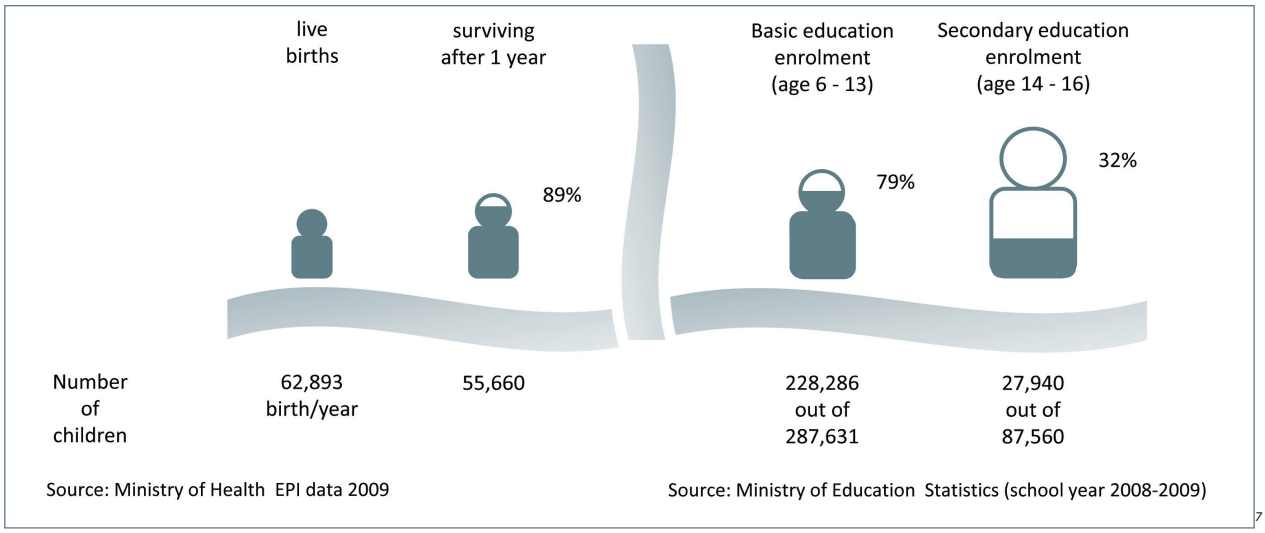
Key Indicators from Sudan Household Health Survey 2010 (%)	
Birth Registration	59.7
Fully Immunized	65.1
Global Underweight	42.6
Global Stunting	47.1
Global Acute Malnutrition	21.6
Use of Improved Drinking Water Sources	82.4
Use of Improved Sanitation Facilities	17.3
Pre-school Education Enrolment[1]	14.3
Primary School Enrolment	79.4
Secondary School Enrolment	31.9
People with Differentiated Abilities[2]	5.0
FGM/C Prevalence	67.4
Early Marriage (before 18)	39.5
Attended by Skilled Person at Birth	83.4
State Child Act – Under Draft	No
State Child Act – ban on FGM/C Included	No
Infant Mortality Rate[3] (per 1000 live births)	90
Maternal Mortality Rate (per 100,000)	509

Agriculture is the centre of life in Sinnar state, sustained by the Sinnar dam and the profitable sugar industry. Most economically active people live in rural areas (73 per cent - 929,119) and work in agriculture, fishing, and forestry (37 per cent), making household income highly vulnerable to natural disasters.[4] Agriculture-related events such as drought, crop disease and livestock loss accounts for more than 50 per cent of all the events that affected households severely.[5] There were 1.3 million people in the state when the 2008 census was taken, and more than half were under the age of 18. That proportion has likely increased due to population growth. Despite the relative progress in the economic development of Sinnar, many children are drinking from unsafe water sources, dying from treatable illnesses, not attending school, nor accessing essential health services,. Particularly vulnerable are the 501,000 rural and 14,000 nomadic children who reside in areas difficult to access with basic services.[6]

In terms of basic education, Sinnar ranks among the best states with 79.4 per cent enrolment. However, there are disparities of enrolment between boys and girls.

1 All Education Enrolment Rates are based on theMinistry of General Education Statistics 2008-9
2 Those who are conventionally known as the disabled may develop other abilities to compensate their disabilities, data from Census 2008.
3 IMR and MMR are from 2008 Census, CBS
4 Sudan Population and Housing Census 2008.
5 Sudan National Baseline Household Survey 2009
6 Sudan Population and Housing Census 2008.

Figure 9.1: Infant survival & school enrolment in Sinnar



[7]

Key Issues

Health and Nutrition

In Sinnar, all health indicators are above the national average.[8] According to SHHS2, it has the highest immunization coverage of any state in the country. Sixty-five per cent of children aged 12 to 23 months were fully vaccinated, more than 15 percentage points higher than the national average.[9]However, this is still unacceptably low, and nine per cent of children in the same age group have never received *any* vaccination.

The EPI shows relatively higher rates of coverage than other states, reaching 99 per cent for three requisite doses of OPV and Pentavalent, 93 per cent for BCG and 88 per cent for measles (Figure 9.2).[10] Sinnar state is continuing to invest in new health facilities, thereby increasing access to services.

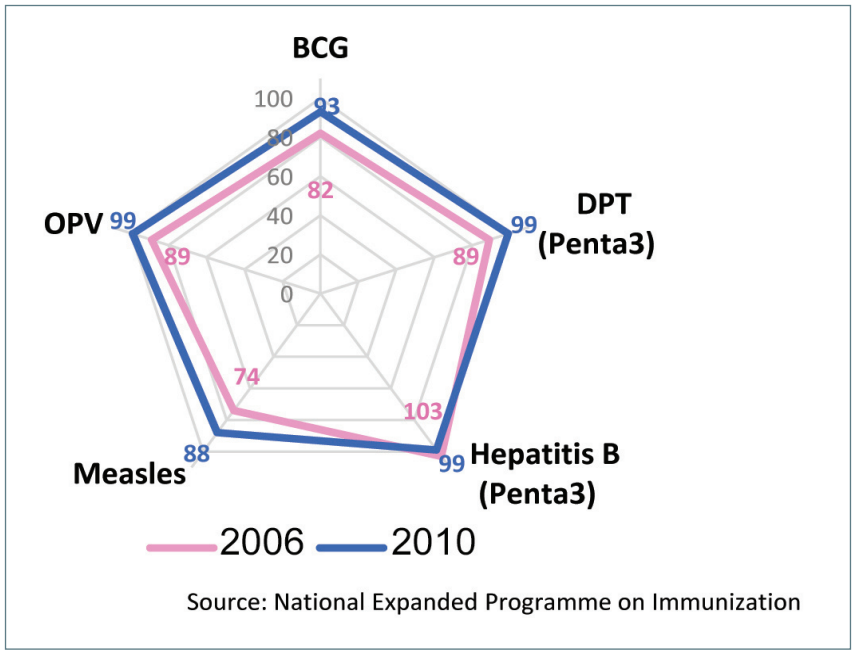
7 The number of children enrolled includes children of all ages, whereas the denominator is based on the population for aged 6-13 for the primary education and aged 14-16 for the secondary. This may result in higher enrolment rate than the reality.

8 SHHS,2006

9 Based on the Sudan Household Health Survey 2010,fully immunized children are those who receive BCG, measles, three requisite doses of OPV (oral polio vaccine) and three doses of Pentavalent vaccines. Pentavalent vaccine includes DPT (diphtheria, pertussis, and tetanus), Hepatitis B and HiB (Haemophilusinfluenzae type B) vaccines, and it requires three doses to get full protection.

10 EPI uses surviving infants (all births minus deaths in the first year of life) as a denominator, except for BCG, which uses total number of live births. SHHS uses 12-23 months old as a denominator.

Figure 9.2: Immunisation coverage improved between 2006-2010 in Sinnar



Source: National Expanded Programme on Immunization

At the same time, the nutritional status of children in Sinnar is among the worst in Sudan. Prevalence of stunting is classified as 'very high' while wasting (acute malnutrition) is 'critical'[11]. At 8.5 per cent, SAM is among the highest in the country, second only to Red Sea state. These high levels of malnutrition require timely action.

Water, Sanitation and Hygiene

Access to improved water sources is slightly better than the country's average: 82 per cent of the total population (1,043,668 people) have access to improved water (Figure 9.3). Half of them (521,834) access improved water through piped sources in their houses, compounds or yards. On the other hand, 22 per cent (or 280,009) get their water from animal carts and tankers.

Only 17 per cent of the state's population (216,370) has access to improved sanitation facilities, while (483,651) 38 per cent are using unimproved sanitation facilities. The rest of the population 572,447 (45 per cent) is still practicing open defecation, one of the most dangerous sanitation practices because of its capacity to spread disease. Little progress has been made in this area because of the lack of community awareness, lack of clear sanitation policy, strategies and supports (Figure 9.4).

11 Physical Status: The use and interpretation of Anthropometry, report of a WHO expert committee, 1995. Chapter 5, p208 & 212

Figure 9.3: Access to improved drinking water

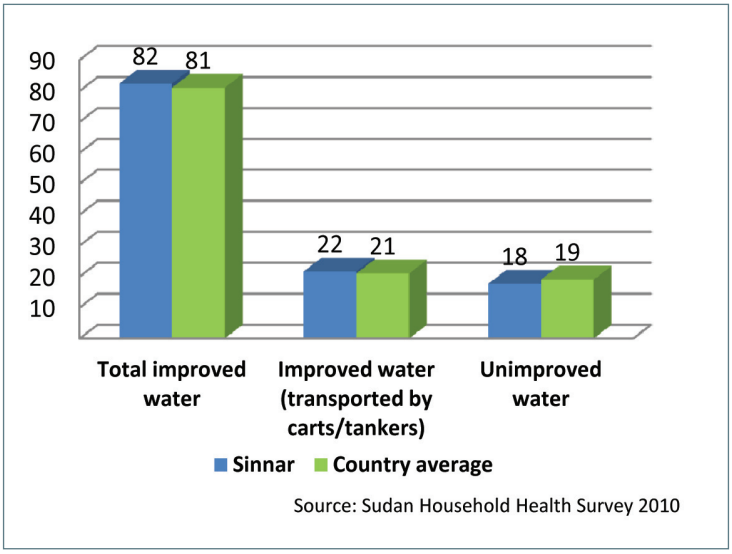
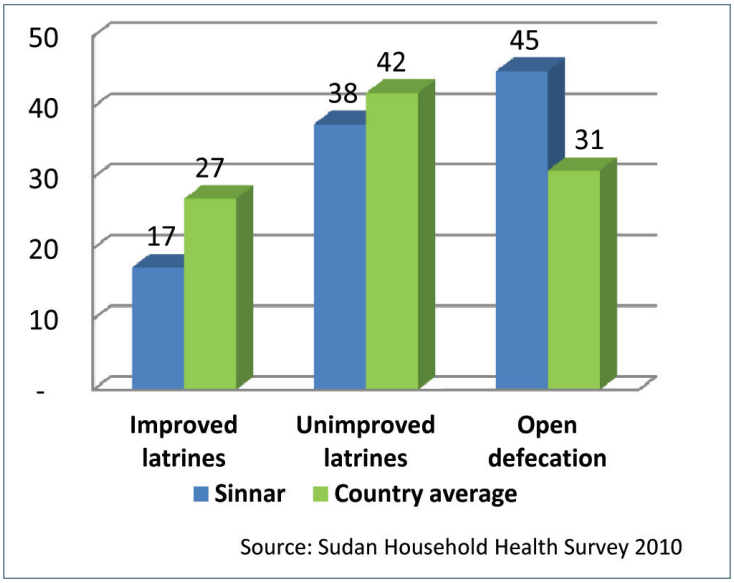


Figure 9.4: Access to improved sanitation

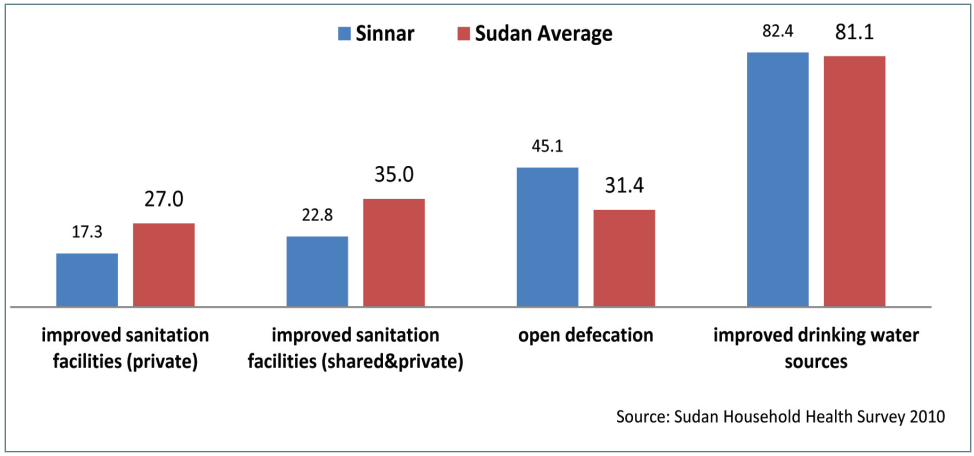


Sanitation is an issue both at home and at school. A 2009 Ministry of Education Survey in five states found that Sinnar had the lowest school latrine coverage at only 43 per cent, well below Khartoum state that has 100 per cent coverage.[12] Good sanitation in schools is not only important to child health, but it can also increase girls' enrolment in school. It is not uncommon for girls to drop out of school entirely because of the lack of latrines or availability of latrines shared by boys and girls (Figure 9.5).[13]

12 Government of Sudan, State Ministry of Education, '2009 Comprehensive and Coherent Review of the Northern Sudan Schools Health Programme for five North Sudan representative states (Khartoum, Northern, Gadarif, South Kordofan and Sinnar States)' 2009.

13 United Nations Children's Fund, Progress for Children: A report card on water and sanitation, no. 5, UNICEF, New York, 2006, p. 7

Figure 9.5: Sanitary situation in Sinnar is worse than the national average, and access to improved water sources is just above the average.
(percentage of household population with access)

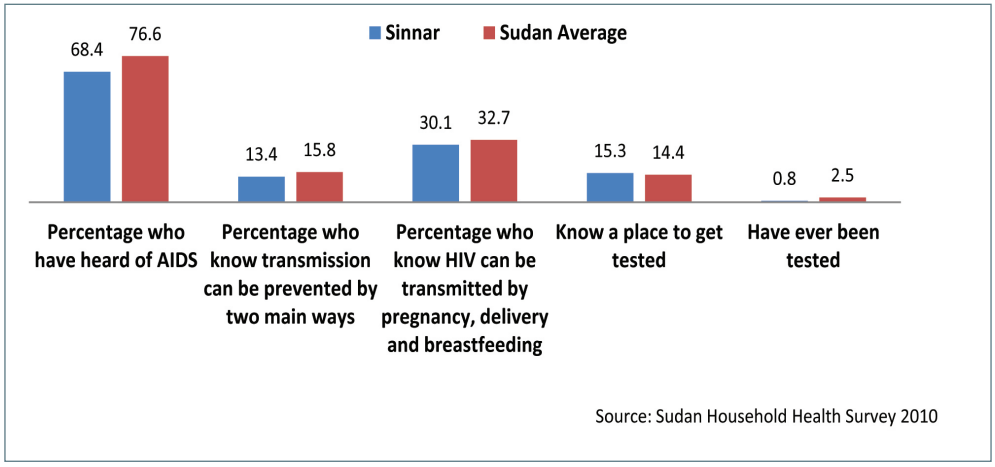


HIV/AIDS

According to recent data from SNAP (Sudan National AIDS Program), out of 1,399 people who were tested, 51 were positive. Determining a more accurate estimate is difficult due to low-testing rates and a limited number of testing sites. For example, the share of women aged 15 to 49 who know where to get tested is higher than the national average, but the share of those who actually get tested is second lowest -- less than one per cent.

Overall knowledge of HIV/AIDS is low among women aged 15 to 49. According to SHHS2, 68 per cent have heard of HIV/AIDS, but just 13 per cent can identify two main means of prevention (Figure 9.6).[14] Only 30 per cent know that mother-to-child transmission can occur during pregnancy, birth and breastfeeding.

Figure 9.6: Women in Sinnar have little knowledge about HIV/AIDS
(percentage share of women age 15-49)



FGM/C

The fact that FGM/C is not perceived as a public health problem of great magnitude in the country including Sinnar state, is testimony to the deep-rooted nature of the practice. In this connection, the same determining cultural factors prevail in Sinnar state as they do in the rest of the country. The challenge remains in identifying the most effective means of curbing this practice.

The main issue is that epidemiological data is lacking (due to its taboo status), making it one of the least- documented health risks in the country.

14 Having only one faithful uninfected sex partner and using a condom every time.

Call to Action

- Build on an established health sector in order to ensure that all children everywhere are fully immunized, including in rural areas and among nomadic populations.
- Increase investment in improved water, sanitation and hygiene interventions, particularly in rural areas and schools. Particular attention should be paid to improving sanitation.
- Increased awareness of HIV testing sites so as to better understand prevalence and provide care to those who test positive.
- Collect baseline information about the epidemiology of FGM/C to enable establishing community diagnosis of the factors favouring and disfavouring it. This would help reinforce negative attitudes towards the continuation of FGM/C and so add momentum towards abandonment.
- Continue to collect disaggregated data in order to better understand the changing situations of children, and to monitor progress.

10 Blue Nile State

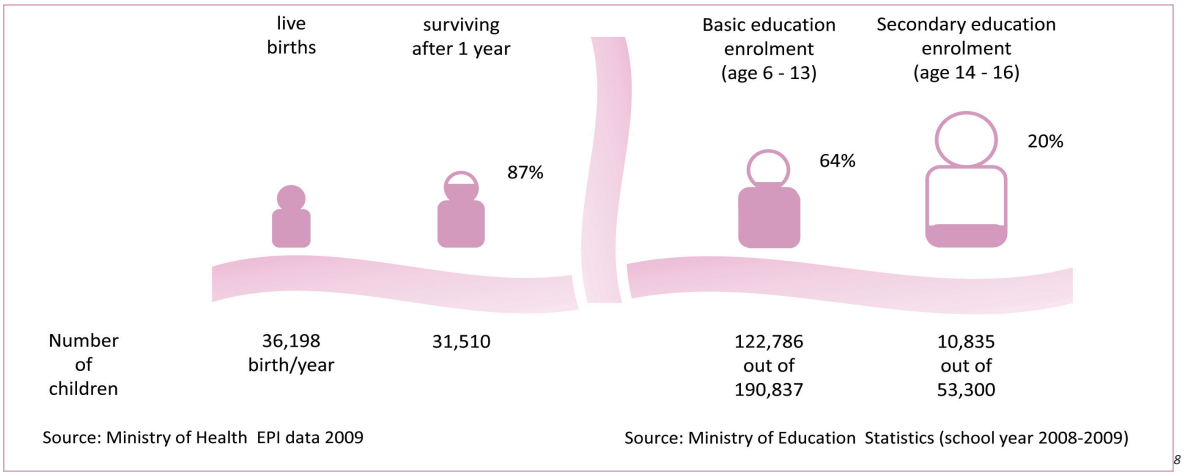
Key Indicators from Sudan Household Health Survey 2010 (%)	
Birth Registration	39.8
Fully Immunized	64.7
Global Underweight	31.7
Global Stunting	37.1
Global Acute Malnutrition	16.2
Use of Improved Drinking Water Sources	54.0
Use of Improved Sanitation Facilities	5.3
Pre-school Education Enrolment[1]	20.3
Primary School Enrolment	64.3
Secondary School Enrolment	20.3
People with Differentiated Abilities[2]	4.6
FGM/C Prevalence	48.7
Early Marriage (before 18)	62.2
Attended by Skilled Person at Birth	45.1
State Child Act – Enacted	Yes
State Child Act – Under Draft	Yes
State Child Act – Ban on FGM/C Included	No
Infant Mortality Rate[3] (per 1000 live births)	137
Maternal Mortality Rate (per 100,000)	578

Children in Blue Nile state are born at a severe disadvantage to most other Sudanese children: they are less likely to be registered at birth, to have access to safe water, and to enrol and stay in school. Girls are more likely to marry and have children at an early age, before their bodies are fully developed. At the same time, they are less likely to receive appropriate and life-saving antenatal care. Blue Nile had the highest neonatal, infant and under-five mortality rate in 2006, when the most recent state-level data was available.[4] For every 1,000 live births, 48 children were expected to die during the first 28 days, 99 children before their first birthday, and 178 children before the age of five.[5] The 2008 census recorded 32,700 children born alive in the 12 months preceding the census, of which about 28,500 (87 per cent) were still alive when the census took place. Limited progress over the years suggests that these high rates of mortality have not improved.

Blue Nile state shares borders with South Sudan and Ethiopia, and is one of the 'Three Protocol Areas' defined by the 2005 Comprehensive Peace Agreement (CPA). Decades of civil war and years of conflict have devastated the physical and social infrastructure and left thousands of people displaced. Refugees and returnees have begun to return to their homes and villages in recent years, only to find limited resources and few basic services. Reaching them is an enormous challenge due to poor roads and infrastructure with some areas becoming entirely isolated during the June to November rainy season. The scars of civil war in Blue Nile are evident in its poverty level. More than half of the population lives under the poverty line, and the situation in rural areas is even worse, with 64 per cent of the population (522,271) living under the threshold.[6] There is every reason to care about child rights because children make up 54 per cent of the state's 816,000 people and bear a disproportionate share of its hardships. Particularly vulnerable are the 325,000 rural and 18,400 nomadic children who reside in areas difficult to access with basic services.[7] As the Blue Nile state is providing the best grazing land in the south eastern part of the state, and will continue to have a significant number of nomadic children, it is very important to reflect the needs of the nomadic population in the state government's policies.

1 All Education Enrolment Rates are based on theMinistry of General Education Statistics 2008-9
2 Those who are conventionally known as the disabled may develop other abilities to compensate their disabilities. Data from Census 2008, CBS
3 IMR and MMR are from 2008 Census, CBS
4 State-level mortality rates are not available from SHHS 2010; source is the Census 2008.
5 Sudan Household Health Survey 2006.
6 Sudan National Baseline Household Survey 2009
7 Sudan Population and Housing Census 2008

Figure 10.1: Infant survival & school enrolment in Blue Nile



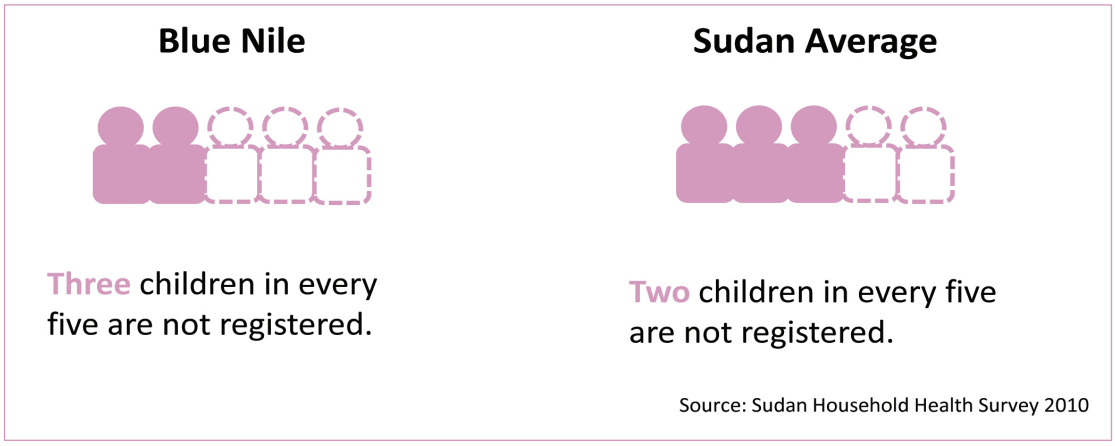
[8]

Key Issues

Birth Registration

Blue Nile has one of the lowest birth registration rates of all 15 states. Only 40 per cent of children under the age of five were registered in 2010, according to SHHS2, well below the national average of 59 per cent (Figure 10.2). Only two states performed worse: West Darfur (23 per cent) and South Darfur (33 per cent). This means that the vast majority of young children (more than 94,000 of them) are not recognized by state and federal laws, [9] and the government has no means of protecting their civil, political, economic, social and cultural rights.

Figure 10.2: Three out of every five children have no birth registration in Blue Nile
(children under age 5)



Registration levels are low despite national laws and international mandates. The 2010 Federal Child Act provides for free birth registration while Article 7 of the Convention on the Rights of the Child specifies that every child has the right to be registered at birth without any discrimination. However, accessible registration facilities, the cost of birth certificates and a lack of general awareness on the importance of birth registration remain serious challenges, particularly in rural areas.

8 The number of children enrolled includes children of all ages, whereas the denominator is based on the population for ages 6-13 for the primary education and ages 14-16 for the secondary. This may result in a higher enrolment rate than is the reality.
9 Based on 2008 population census estimate of 156,404 children under the age of five.

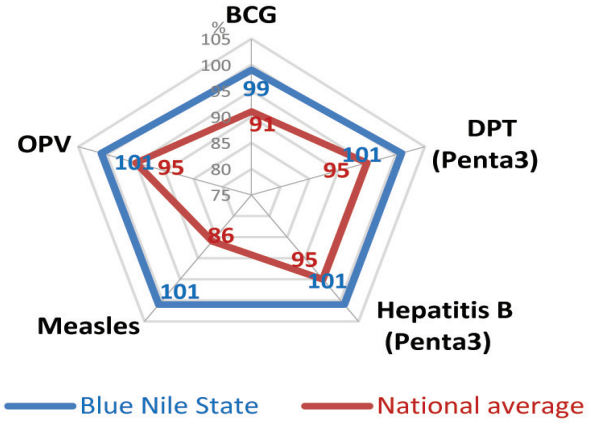
Government commitment and innovation has led to some progress in birth registration; rates increased by 12 points between 2006 and 2010. One recent initiative by the State Ministry of Social Welfare (SMoSW) is the establishment of mobile birth registration teams formed in partnership with community leaders, local courts and health personnel. In 2010, these teams succeeded in registering 5,876 children in remote locations of Bau and Geissen localities.

Health and Nutrition

Several factors contribute to high child mortality rates in Blue Nile. Although full immunization coverage is higher than average at 65 per cent, only 45.1 per cent of deliveries are attended by skilled birth attendants. Incidence of diarrhea -- a leading killer among children under five -- is high at 34 per cent. Food insecurity affects 30 per cent of the population, according to recent WFP assessments, resulting in poor levels of nutrition.[10] Although nutrition indices (underweight, stunting and wasting) are close to the national average, they are high compared to international thresholds and wasting levels are critical.[11] At 4.3 per cent, SAM is a little below the country average. The ongoing insecurity and population movements in the state are likely to contribute to child malnutrition in Blue Nile.

At present, Blue Nile's health systems do not have the strength to support significant improvements. Health facilities fulfil national standards in terms of size and coverage, but do not have the medical staff and equipment to function at full capacity. These factors -- added to the limited coverage of the EPI due to conflict -- might help explain why Blue Nile has the country's highest reported IMR rate (137/100,000). This is an increase of five per cent when compared with data from the 1993 census. All other states in Sudan have reported drops in IMR; Blue Nile remains the exception. Strengthening of the health system to ensure wider coverage of health services would surely contribute to improvements in children's health.

Figure 10.3 Blue Nile has a higher immunization coverage than the national average



Source: National Expanded Programme on Immunization

Indeed, the success of EPI and similar initiatives shows the impact that can be achieved through government commitment. In rural Kurmuk locality, where vaccine coverage is particularly low, effective coordination between the state EPI and international non-government organizations (INGOs) has helped to overcome vaccination coverage constraints. Recent data collected through EPI shows a 101 per cent coverage rate of measles, three requisite doses of OPV and three doses of Pentavalent,[12] and a 99 per cent coverage rate of BCG for tuberculosis (Figure 10.3).[13] Blue Nile state has one of the best-run immunization services with good cold chain functionality, strict and timely supervision and innovative approaches.

Water Sanitation and Hygiene

Fewer people are using improved water sources and sanitation facilities in Blue Nile State than anywhere else in Sudan, according to SHHS 2010; only 54 per cent of the total population are accessing improved water sources either directly (30 per cent) or through animal carts or tankers (14 per cent). On the other hand, only 5.3 per cent of the population has access to improved latrines, 65 per cent have access to unimproved latrines, while 30 per cent are still practicing open defecation. In total, only 3.2 per cent is accessing both improved water and improved sanitation, compared with the Sudan's average of 25.2 per cent.

10 World Food Programme, Sudan Emergency Food Security Assessment: Blue Nile State, May 2010, p. 34.
11 Physical Status: The use and interpretation of Anthropometry, report of a WHO expert committee, 1995. Chapter 5, p208 & 212
12 Pentavalent vaccine includes DPT (diphtheria, pertussis, and tetanus), Hepatitis B and HiB (Haemophilusinfluenzae type B) vaccines, and it requires three doses to get full protection. Pentavalent immunization started in Sudan from January 2008.
13 EPI uses surviving infants (all births minus deaths in the first year of life) as a denominator, except for BCG, which uses total number of live births. SHHS uses ages 12-23 months old as a denominator.

Figure 10.4: Access to improved drinking water

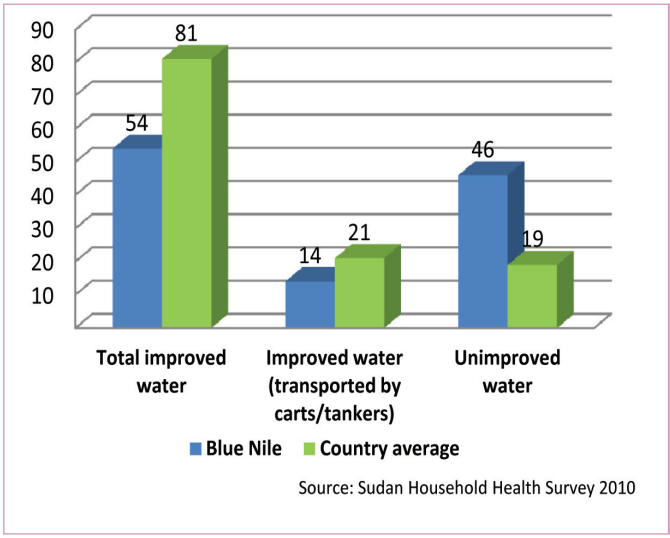
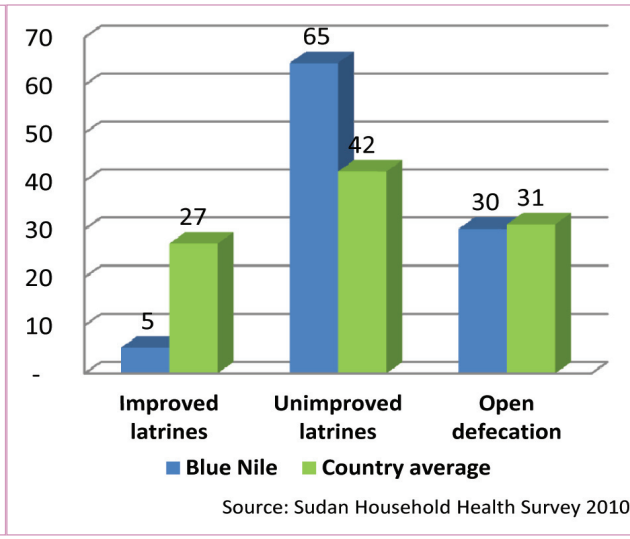


Fig. 10.5: Access to improved sanitation



Access to improved sanitation is also low for school children and at health facilities. The 2011-2016 WASH Strategic Plan estimated access at 54 per cent and 48 per cent for the state's schools and health facilities respectively.

Slow progress in this area needs to be addressed. Unsafe water, sanitation and hygiene contribute to 88 per cent of diarrhoeal diseases globally, making them leading killers of young children.[14] In Blue Nile, a third of children in this age group had diarrhoea in a two-week period before the survey, one of the highest rates in Sudan. Limited access to safe water and sanitation also contributes to pneumonia, neonatal disorders and malnutrition.

Efforts have been made to improve equal access to WASH interventions by targeting areas of high return and repatriation such as Kurmuk, Bau and Geissan.[15] Initiatives such as the community approach to total sanitation (CATS) show promise in mobilizing communities to develop sustainable solutions to sanitation. CATS was rolled out in fifteen Blue Nile communities in 2010, of which five[16] subsequently declared that they are open defecation free (ODF) and have achieved more than 80 per cent coverage with latrines. However, even these simple yet effective interventions are difficult to implement and sustain due to unclear sanitation policies and strategies, together with limited financial support and low capacity at the local level.

Education

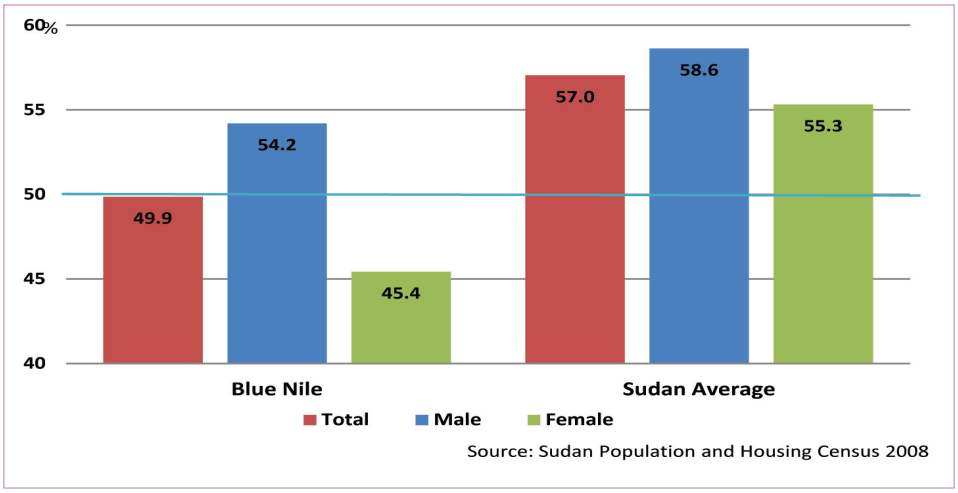
Blue Nile's performance in education is alarming. According to SHHS2, Blue Nile has the third lowest rate of primary school enrolment and the lowest for secondary school too. The percentage of children of primary school age attending primary school is 60 per cent, and just 12 per cent for secondary school. The percentage of children of primary school entry age entering grade one is 32 per cent, the lowest in the country[17].

The state's poor achievements in education are clearly revealed in the 2008 census. The share of children of school age (between six and 16) is lower than the national average at 57 per cent (Figure 10.5). In addition, there is a gender gap in school attendance: only 45 per cent of girls in this age group are currently attending school, compared to 54 per cent of boys.

Attendance levels in secondary school attendance are especially low. Only 10,835 out of 53,300 children (20 per cent) at the secondary school age of 14-16 are enrolled in school, which is much lower than the national average of 36 per cent.

14 WHO. The world health report 2002: reducing risks, promoting healthy life. Geneva: World Health Organization, 2002, p. 221.
15 Blue Nile Zone Office Midterm Review Report, UNICEF, March 2011 (Internal Document)
16 . Banat, Umgingir, Boya, Bangalola and Yarada
17 The percentage of primary school enrolment is 64.3 per cent, and secondary school enrolment is 20.3 per cent; Educational Statistics, 2008/2009, P38 & 41.

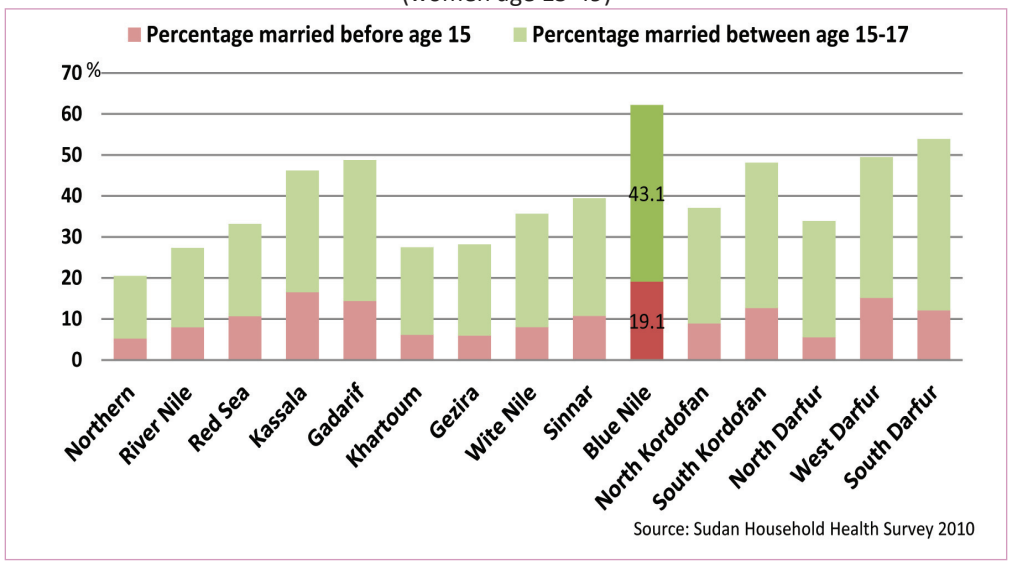
Figure 10.6: Blue Nile has lower school attendance than the national average
(percentage share of children age 6-16)



Early Marriage

Challenges to survival and wellbeing do not end with childhood, particularly for young women. SHHS2 found that one in five women in Blue Nile were married before the age of 15 and 62 per cent of women aged 15 to 49 were married before age 18, more than in any other state (Figure 10.7). This is also six percentage points higher than in 2006, indicating a worsening trend. Contributing factors include strong cultural beliefs and poverty.

Figure 10.7: Blue Nile has the highest share of early marriage in Sudan
(women age 15-49)



There are many dangers associated with child marriage. For example, girls who marry young are more likely to drop out of school, which may be why Blue Nile has the second lowest female literacy rate - 30 per cent - in Sudan. Data shows that their youth also makes them more vulnerable to domestic violence. Nearly half of 15 to 49 year old women think that it is acceptable for a husband to beat his wife for reasons ranging from neglecting the children to burning the food.

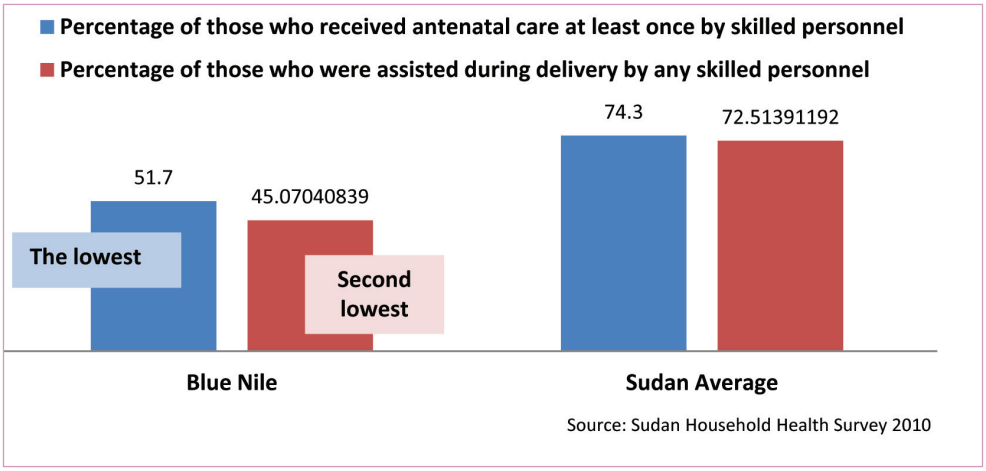
Safe Motherhood

Early pregnancy is another dangerous consequence of child marriage that increases the risk of complications during pregnancy, leading to low birth-weight and even death of the mother and child.[18] In Blue Nile, 28 per cent of women aged 15-19 have started having children, the second highest in Sudan according to SHHS2.

18 United Nations Children's Fund, 'Early Marriage: Child spouses', Innocenti Digest, no. 7, UNICEF Innocenti Research Centre, Florence, March 2001, pp. 10-11.

In addition, the situation regarding reproductive health in Blue Nile is one of the worst in the country. According to SHHS2, only 42 per cent of women aged 15-49 who gave live births in the two years preceding the survey were protected against neonatal tetanus, one of the leading causes of newborn deaths[19] – the lowest rate in the country. Nearly half of these women did not receive any antenatal care, and 91 per cent of births took place at home without access to lifesaving medical treatment (Figure 10.8). While midwives are common, recent data[20] from the State Ministry of Health suggest that most (67 per cent) are concentrated in just two localities (Damazine and Roseires).

Figure 10.8: Reproductive health in Blue Nile is behind the national average
(women age 15-49 who gave live births in two years)



Call to Action

- Focus on birth registration rather than issuing of birth certificates to ensure child registration while simultaneously expanding community-based efforts to register children.
- Invest in the training of birth attendants in order to reduce maternal mortality.
- Build on existing efforts to engage the state government in constructive dialogue with the goal of prioritizing health, WASH and education in government planning and budgeting. Ensure that particular focus is given to rural areas and locations of high return.
- Strengthen partnerships with the water and sanitation sector, SMoH, localities and NGO partners to expand implementation of community-led initiatives such as CATS.
- Provide incentives that encourage girls to stay in school not only as a deterrent to early marriage, but as a path to greater equity and development.
- More focus on rainwater-harvesting projects to address the scarcity of ground water.
- Continue to collect new data that will inform decision-making and monitor progress on the rights of children.

19 Infants who have not acquired passive immunity because the mother has never been immunized are at risk.
20 State Ministry of Health, RH Unit Annual Report 2010

11 North Kordofan State

Key Indicators from Sudan Household Health Survey 2010 (%)	
Birth Registration	49.5
Fully Immunized	37.0
Global Underweight	41.4
Global Stunting	46.7
Global Acute Malnutrition	18.1
Use of Improved Drinking Water Sources	78.8
Use of Improved Sanitation Facilities	20.3
Pre-school Education Enrolment[1]	31.8
Primary School Enrolment	77.2
Secondary School Enrolment	24.8
People with Differentiated Abilities[2]	5.9
FGM/C Prevalence	70.5
Early Marriage (before 18)	37.1
Attended by Skilled Person at Birth	80.2
State Child Act – Enacted	No
State Child Act – Under Draft	Yes
State Child Act – ban on FGM/C Included (in draft)	Yes
Infant Mortality Rate[3] (per 1000 live births)	81
Maternal Mortality Rate (per 100,000)	532

North Kordofan is home to close to three million people, of whom 1.5 million (52 per cent) are under the age of 18 and 494,000 (17 per cent) are under the age of five.[4] Of the 107,900 children born alive in the 12 months preceding the 2008 census, about 97,100 (90 per cent) were still alive when the census took place. With basic services such as health, water and sanitation, and education concentrated in urban areas, demand for resources is high in rural areas where the majority of the population lives. Due to their limited resources, these areas are the most exposed to the impact of drought, poverty and conflict. Getting assistance to these areas is frequently complicated by the ongoing conflicts in neighbouring South Kordofan and Darfur; localities along the main road to North and South Darfur states continue to be adversely affected by rebel activities as well as the movement of arms, commodities and people. Western areas (formerly Western Kordofan State) are particularly in need of assistance. There, food shortages have been severe enough to prompt the looting of vehicles carrying humanitarian supplies to Darfur. In addition, insecure access to quality healthcare, poorly-staffed and -equipped health facilities, and the lack of NGO presence make children in the west the most vulnerable in the state.

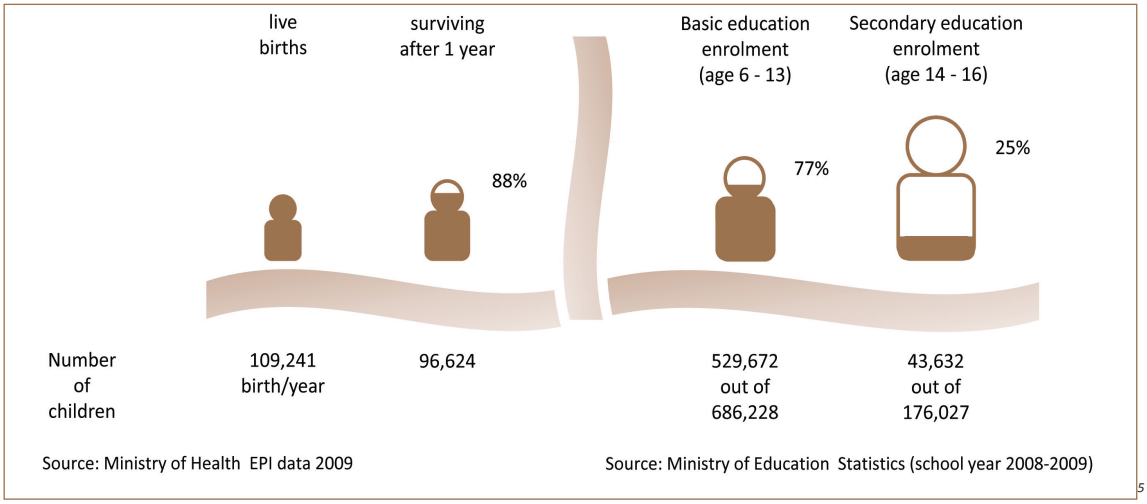
1 All Education Enrolment Rates are based on theMinistry of General Education Statistics 2008-9

2 Those who are conventionally known as the disabled; they have a type of partial disability but they often develop other paramount abilities to compensate their disabilities, data from Census 2008, CBS.

3 IMR and MMR are from 2008 Census, CBS

4 According to 2008 Census

Figure 11.1: Infant survival & school enrolment in North Kordofan



Key Issues

Water, Sanitation and Hygiene

More than a fifth of the population (21 per cent) does not have access to improved water sources. Out of the 79 per cent who have access to safe drinking water, 25 per cent are dependent on deliveries from animal carts and tankers. On the other hand, almost four fifths (80 per cent) of the population is without access to improved sanitation facilities, according to SHHS2 (Figure 11.2). Open defecation is still a common practice for around 21 per cent (606,683) of the population.

Prolonged drought and irregular rainfall have stymied progress: particularly hard-hit localities are Sodari, Jabrat Elsheikh, Wad Banda and Bara West. These areas have experienced shortages of surface and groundwater that have pushed families further into poverty.

Access to improved sanitation is also low for school children and health facilities. The 2011-2016 WASH Strategic Plan estimated access at 32 per cent and 29 per cent for the state's schools and health facilities respectively.

Poor access to improved water, sanitation and hygiene are among the leading killers of young children in North Kordofan. They contribute to diarrhoeal diseases, acute respiratory tract infections, malaria and vaccine preventable diseases which together account for the vast majority of under five deaths.

Figure 11.2: Access to improved drinking water

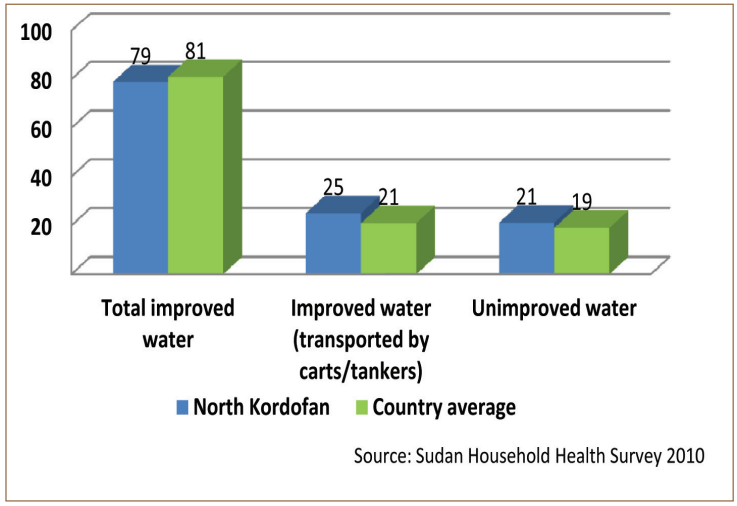
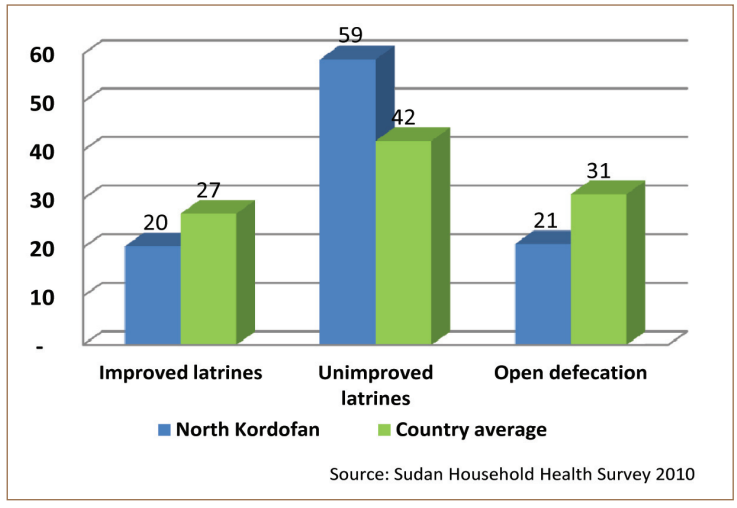


Figure 11.3: Access to improved sanitation



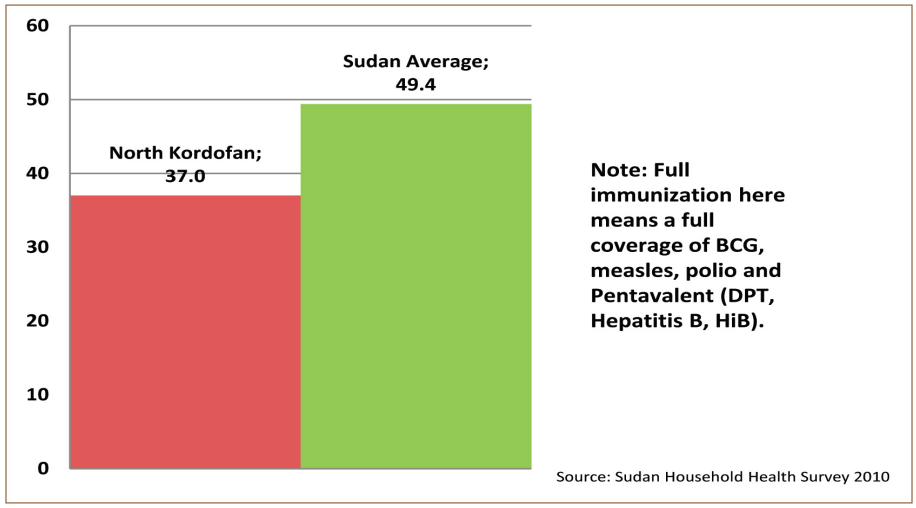
5 The number of children enrolled includes children of all ages, whereas the denominator is based on the population for ages 6-13 for primary education and ages 14-16 for secondary. This may result in a higher enrolment rate than is the reality.

Health

Only 37 per cent of children aged 12 to 23 months are fully vaccinated, which is 12 points below the average for Sudan (Figure 11.4). Immunization coverage of pregnant women is also a major challenge due to the rural nature of the state, making many communities hard-to-reach. In addition, some cultural beliefs link vaccinations to miscarriages. As a result, only half of 15 to 49 year old women who gave birth in the past two years are protected against tetanus.

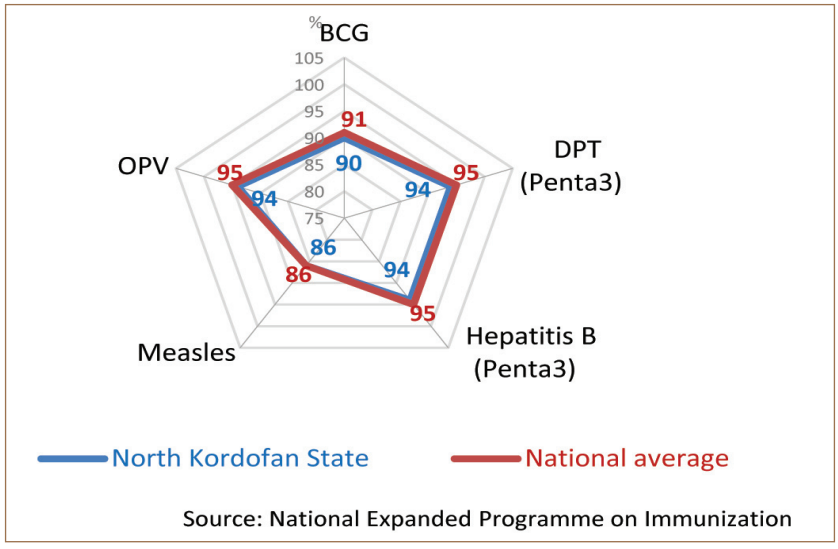
Figure 11.4: Full immunization coverage in North Kordofan is lower than the national average

(Percentage of children age 12-23 months)



At the same time, separate data sources show immunization coverage to be much higher. According to 2010 data collected through the Ministry of Health's EPI, coverage rates are about the national average for three rounds of Pentavalent (94 per cent), BCG (90 per cent), three requisite doses of OPV (94 per cent), and measles (86 per cent) (Figure 11.5).[6]

Figure 11.5 Immunisation coverage in North Kordofan is about the national average

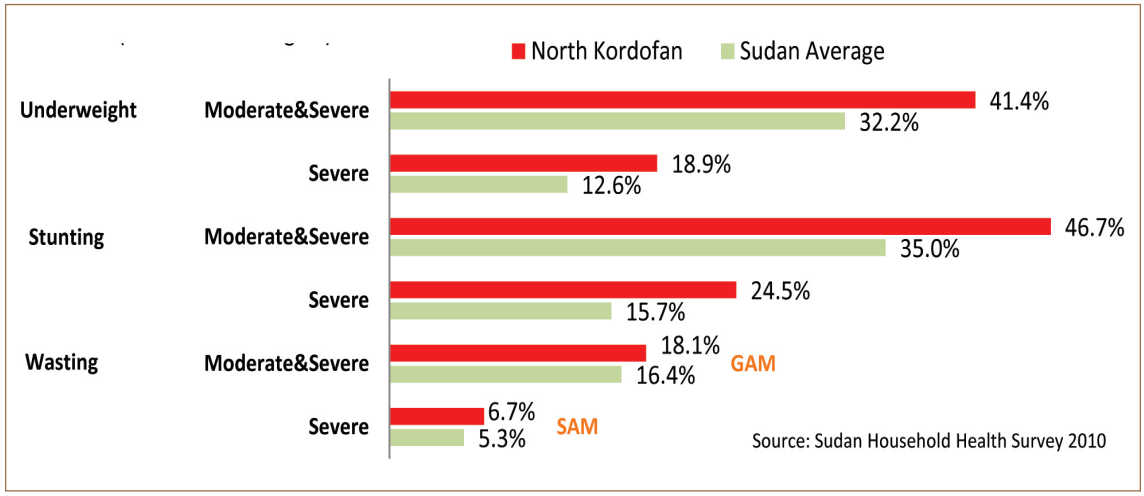


6 *EPI uses surviving infants (all births minus deaths in the first year of life) as a denominator, except for BCG, which uses total number of live births. SHHS uses ages 12-23 months olds as a denominator.*

Nutrition

Increased data collection has highlighted the urgent need for improved nutrition services to treat emergency levels of SAM and prevent further malnutrition in the state. The North Kordofan Nutrition survey in 2009[7] found that, at 16.3 per cent, global acute malnutrition (GAM) of children under five was exceeding the WHO's emergency threshold of 15 per cent. SAM was put at 3.9 per cent.[8] SHHS2 finds these numbers to be much higher at 18.1 and 6.7 per cent respectively (Figure 11.6). In addition to acute malnutrition (low weight for height), the underweight (low weight for age) and stunting (low height for age) prevalence in North Kordofan are among the highest in the country; 41.4 per cent (the third highest) are underweight and 46.7 per cent are stunted (the fourth highest). Despite such a situation, public spending on health remained low; the per capita public spending on health was USD 9.9 in 2008 – ranking tenth out of 15 states.[9] These troubling statistics prompted increased support for supplies and staff training at health facilities and in the community.

Figure 11.6: North Kordofan has higher malnutrition rates than the national average in all three anthropometric indices: weight for age, height for age, and weight for height
(children under age 5)



Birth Registration

Every child has the right to be registered at birth and every government has the responsibility to ensure that right, in accordance with Article 7 of the Convention on the Rights of the Child (CRC). Yet, only an estimated 49.5 per cent of North Kordofan children under the age of five have had their births registered, ten percentage points less than the national average. Efforts are underway to develop a state policy that will enable the system to reach the large number of unregistered children in rural areas.

Birth registration is fundamental to child survival and healthy development as it ensures that children are recognized by the state when budgets are decided and resources allocated to health and other basic services. Enrolling children and keeping them in school is easier when their identities and ages are officially recorded. Enforcing laws against early marriage, the recruitment of children to armed forces and child labour is dependent on being able to verify a child's age. Some states have explored community-level initiatives that have proven successful in increasing birth registration.

7 Report of Nutrition and Mortality in North Kordofan State, November 2009, State Ministry of Health and UNICEF. Results quoted here analysed using WHO GS.

8 Global acute malnutrition (GAM) and severe acute malnutrition (SAM) is a wasting, defined by a very low weight for height (below -2z for GAM and -3z for SAM of the median WHO growth standards).

9 National Health Accounts, Directorate of Planning, Policy and Research, Ministry of Health, 2008

Unaccompanied and Separated Children

Children living on their own are a growing concern, particularly in urban areas like El Obeid where unaccompanied and separated children spend their days in markets and other public spaces. In North Kordofan, more than 53,000 children under 15 years of age have lost one or both parents (four per cent), according to the 2008 census. Another data source shows even higher figures; according to SHHS2, seven per cent of children under age 18 have lost one or both parents – the second highest in the country. An assessment conducted by the SCCW found that most of these 'street' children are boys between the ages of 11 and 15 and an increasing number of girls between six and 10.[10] Other reasons for children leaving home include poverty and violence.

The success of South Kordofan's programme on separated and unaccompanied children led to its replication in North Kordofan (El Obeid, Nuhud and Rahad). As of October 2009, 511 separated and unaccompanied children were reached with reunification and care services. The success of the initiative has underlined the need for greater capacity building in other areas. For example, limited care alternatives for children who cannot be reunified with their families mean that many end up back on the street.

FGM/C

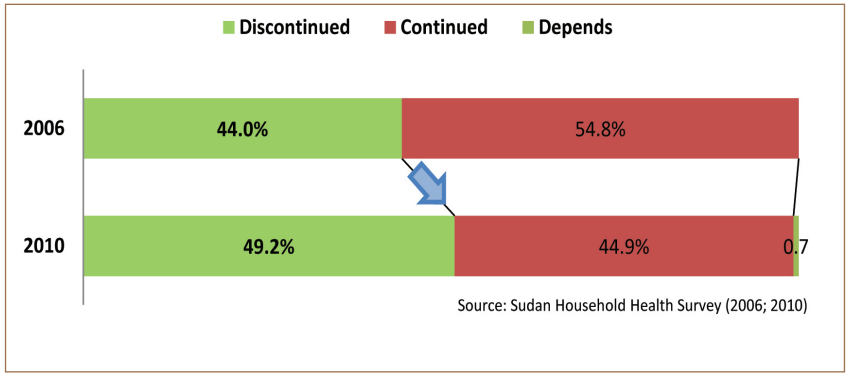
The recorded rate of FGM/C in North Kordofan is even higher than the national average, at 71 per cent. However, the actual figure could well be higher as the practice often goes unreported.

FGM/C causes immeasurable physical and psychological harm to girls and women. Its immediate effects can include infection and ulceration of the genitals, while in the long term it may lead to blood poisoning and obstructed labour during childbirth. Many believe that despite the harm it causes, the social repercussions of not performing the practice will be far more damaging to the girl's wellbeing by ruining the family honour and the girl's eligibility for marriage.

As is often the case, FGM/C in North Kordofan is perpetuated by women, with grandmothers and traditional birth attendants the most common practitioners. Fifty-two per cent of ever-married women aged 15 to 49 say that they intend to continue the practice with their daughters.

Studies have found that FGM/C is tied to ethnicity more than any other variable, and is deeply engrained in social norms at the community level. Community-based approaches like the *Saleema initiative* have propelled social behaviour change towards the collective abandonment of FGM/C. Introduced by NCCW and the Ministry of Social Affairs with support from UNICEF, *Saleema* brings together various social actors in the community to raise awareness about the harms that can be caused by FGM/C. Since its inception in 2008, 24 out of 40 selected communities in North Kordofan have declared abandonment of FGM/C,[11] suggesting a slow but positive change in people's attitudes toward the practice. The share of women aged 15-49 who believe FGM/C should be continued decreased by ten percentage points from 55 per cent in 2006 to 45 per cent in 2010, according to SHHS (Figure 11.7).

Figure 11.7: Women have become more opposed to practicing FGM/C in North Kordofan between 2006 and 2010
(Women age 15-49)



10 NCCW and UNICEF, 'South Kordofan, North Kordofan, and Abyei, Child Protection Assessment', March 2010 (Internal Document).
11 Information obtained from the NCCW annual report, 2010

HIV/AIDS

The number of women and children affected by HIV/AIDS in North Kordofan is not known. However North Kordofan is building an effective system of coordinated efforts and initiatives for the social protection of affected families. The Sudan National AIDS Programme, social services providers (both public and private) and People Living With AIDS (PLWA) meet periodically to discuss needs and undertake advocacy. As a result PLWA have access to some Zakat Funds and food vouchers. When sustained, these efforts can be the basis for the formulation of social protection for families affected by HIV/AIDS at state and federal levels.

Call to Action

- Improve the legal framework protecting children's rights. The North Kordofan Child Act has been reviewed by the Attorney General, ministers and parliamentarians. It is now due to be sent to cabinet for final approval and endorsement.
- Ensure that government budgets for social programmes – such as education, health and nutrition, protection and water and sanitation -- reach necessary levels.
- Raise awareness of the need for water, sanitation and hygiene and encourage good practices at community level so as to reduce mortality among children.
- Improve birth registration policies and systems in order to reach rural and marginalized populations.
- Improve outreach to unaccompanied and separated children by developing alternative care options for children who are not reunified with their families.
- Increase community efforts based on positive messaging to encourage collective abandonment of FGM/C.
- Continue to collect new data that will inform decision-making and monitor progress on the rights of children.

12 South Kordofan State

Key Indicators from Sudan Household Health Survey 2010 (%)	
Birth Registration	49.4
Fully Immunized	42.7
Global Underweight	40.3
Global Stunting	36.6
Global Acute Malnutrition	17.4
Use of Improved Drinking Water Sources	72.8
Use of Improved Sanitation Facilities	16.9
Pre-school Education Enrolment[1]	51.6
Primary School Enrolment	80.8
Secondary School Enrolment	33.5
People with Differentiated Abilities[2]	5.9
FGM/C Prevalence	66.1
Early Marriage (before 18)	48.1
Attended by Skilled Person at Birth	61.4
State Child Act – Enacted	Yes
State Child Act – Ban on FGM/C Included	Yes (with a separate FGM/C Law)
Infant Mortality Rate[3] (per 1000 live births)	100
Maternal Mortality Rate (per 100,000)	591

The signing of the CPA in 2005 ushered in a challenging new era of peace-building and reconstruction, nowhere more than in South Kordofan. Hopes of peace were short-lived as post-war tensions, exacerbated by acute competition for scarce resources, erupted into violence shortly before the secession of South Sudan in July 2011. As during the long years of civil war, children risk being particularly affected by the renewal of conflict and consequent displacements of civilian population. The CPA united South and Western Kordofan and identified the new state as one of three transitional areas directly affected by the civil war, along with Blue Nile State and Abyei. Consequently it was given special consideration in the CPA.

Abyei Administrative Area's position on the border of Sudan and South Sudan made it one of the key battlegrounds of Sudan's civil war, and its long-term future is still undecided. Insecurity made it difficult to include Abyei in the Sudan Household Health Survey. However, a Multiple Indicator Cluster Survey (MICS) conducted by the NGO GOAL in early 2010 helps to give a snapshot of the situation of children in this conflicted area. Education is poor, but improving. Only 62 per cent of children aged six to 16 years accessed school within the last year. Numbers drop drastically between primary education (59.3 per cent) and secondary education (2.9 per cent).

Conflict in the area has led to a large number of unaccompanied and separated children – a direct result of the impact of war on children. The lack of a birth registration system makes it even more difficult to identify these children and reunify them with their families. There have been reports of children associated with armed forces and no formal process of demobilization has taken place. UXO is still a major concern.

More than half of the state's population are under the age of 18; this equates to approximately 760,300 children, of whom 260,200 (19 per cent) are under the age of five.[5] Such a youthful population presents an unprecedented opportunity. By providing them with the necessary resources for a healthy and educated life, and ensuring children live in a protective environment, the state can help ensure its future security and prosperity.

1 All Education Enrolment Rates are based on theMinistry of General Education Statistics 2008-9

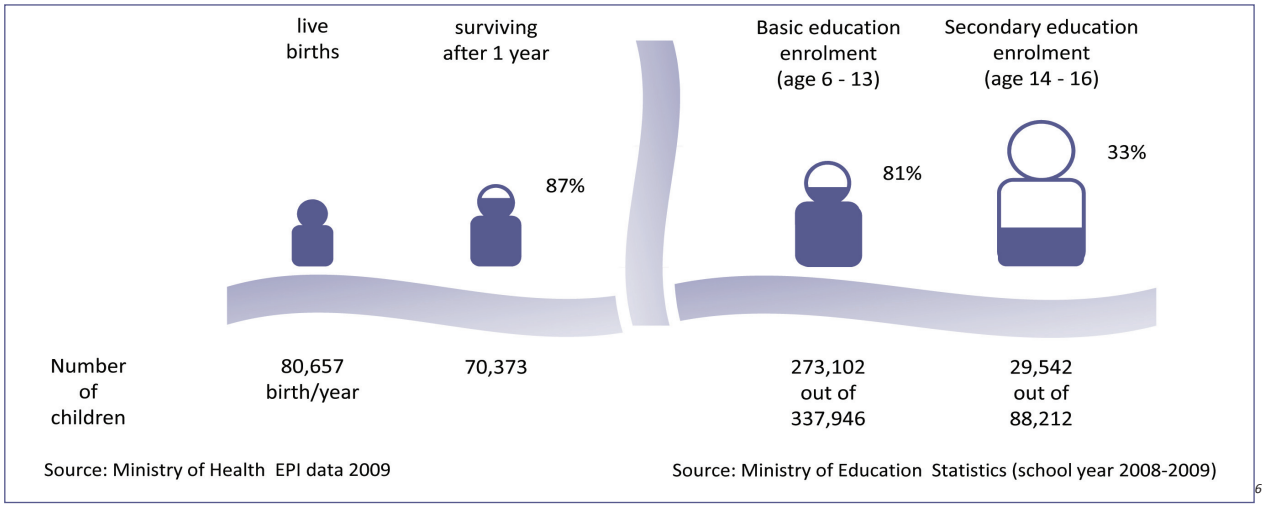
2 Those who are conventionally known as the disabled; they have a type of partial disability but they often develop other paramount abilities to compensate their disabilities, data from Census 2008, CBS

3 IMR and MMR are from 2008 Census, CBS

4 Census 2008, CBS

5 Sudan Population and Housing Census 2008.

Figure 12.1: Infant survival & school enrolment in South Kordofan



[6]

Key Issues

Health

This is one of the states with the worst health indicators. Both[7] neonatal mortality and under 5 mortality rates are above the national average. Only 26 per cent[8] of health facilities are providing IMCI. Measles immunization coverage of 81 per cent[9] is lower than the national average. These poor health indicators are perhaps a reflection of the poor health infrastructure and the fact that the state is still gripped by conflict and insecurity. The number of localities in the state has recently been increased from 9 to 18 with no corresponding administrative or financial support to the newly-created localities.

Nutrition

Of the 53,000 children born alive in the 12 months preceding the 2008 census, about 47,400 (90 per cent) were still alive when the census took place. Low birth weight is the single most common cause of neonatal mortality in South Kordofan, caused by conditions such as maternal malnutrition, infection, malaria, hepatitis and anaemia. High rates of malnutrition exacerbate childhood diseases, contributing to overall under-five mortality in the state which (in 2006) was the second highest in the country.

Recent surveys depict a grim picture of nutrition in South Kordofan. Underweight prevalence is 40 per cent, stunting is 37 per cent, and global acute malnutrition is 17.4 per cent, according to the SHHS2 (Figure 12.2). This is above the WHO's emergency threshold of 15 per cent. Renewed insecurity following the secession of South Sudan will likely lead the state to a further deterioration in child nutrition levels.

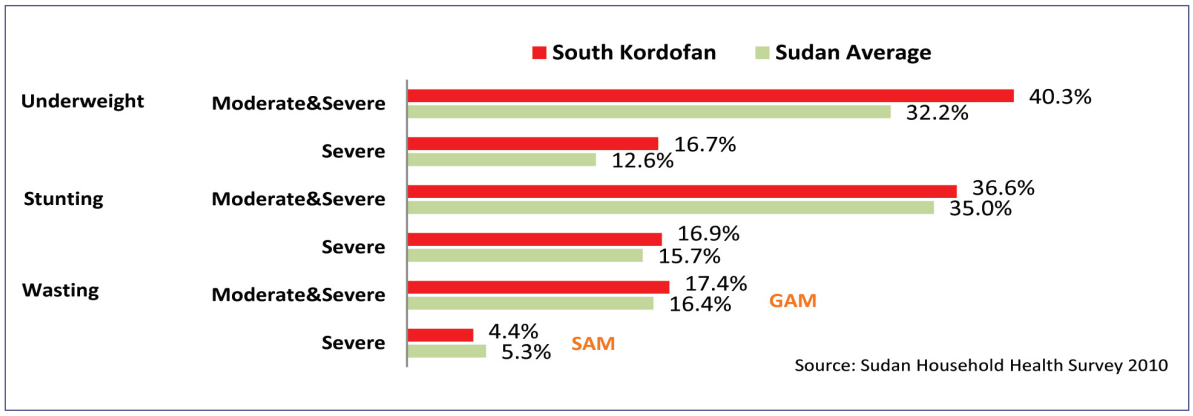
6 The number of children enrolled includes children of all ages, whereas the denominator is based on the population for ages 6-13 for primary education and ages 14-16 for secondary. This may result in a higher enrolment rate than is the reality.

7 Source: SHHS, 2006, State level mortality rates are not available from SHHS 2010

8 Source: FMOH, IMCI Unit, 2010

9 Source: FMOH, EPI Unit, 2010

Figure 12.2: South Kordofan has overall higher malnutrition rates than the national average
(children under age 5)



Recent efforts to scale up access to treatment have shown promise. The numbers of children who accessed growth, monitoring and promotion (GMP) services as well as infant and young child feeding (IYCF) programmes increased between 2009 and 2010. Health personnel trained in Essential Nutrition Packages (ENPs) were better able to enhance knowledge, attitudes and practices among mothers regarding their child's health and nutrition, including breastfeeding practices as South Kordofan has the lowest share of children aged 0 -5 months who were exclusively breastfed (32.3 per cent)[10].

In 2010, the state began to successfully integrate the CMAM model into health facilities, greatly increasing access to services and the number of treated malnourished children. CMAM allows patients to receive treatment at home using nutritional supplements such as "Plumpy Nut", thus reducing the burden on hospitals and allowing the treatment of a larger number of patients. Initiatives such as these are cost-effective and have the potential to greatly improve overall nutrition in South Kordofan.

Water, Sanitation and Hygiene

A leading killer among young children is diarrhoeal disease caused by unimproved water, sanitation and unhygienic practices. South Kordofan has the second highest under -five mortality rate in Sudan (after Blue Nile) according to the most recent census of 2008. The SHHS2 found that use of improved water sources has reached 73 per cent of the population. Of this number, 23 per cent are still using water which is transported by carts and tankers (Figure 12.3). Use of improved sanitation facilities is still very low as only 17 per cent of the state population are using improved latrines, and 37 per cent are using unimproved latrines, while 46 per cent of the population still practices open defecation.

Figure 12.3: Access to improved drinking water

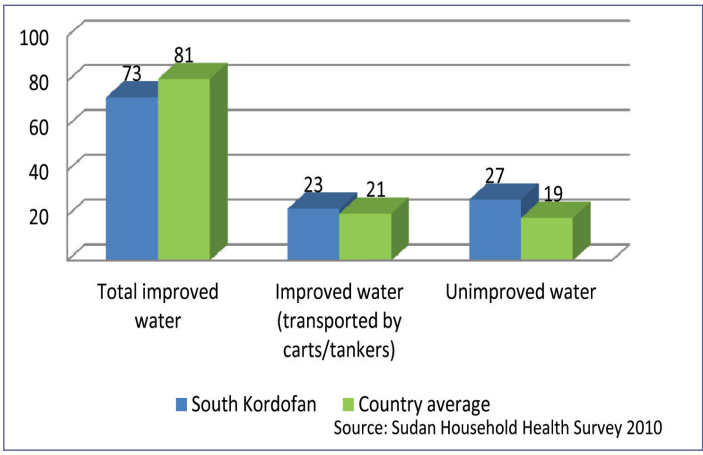
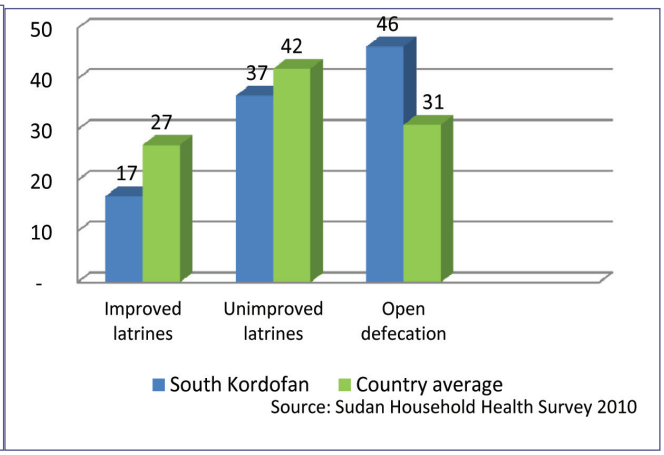


Figure 12.4: Access to improved sanitation

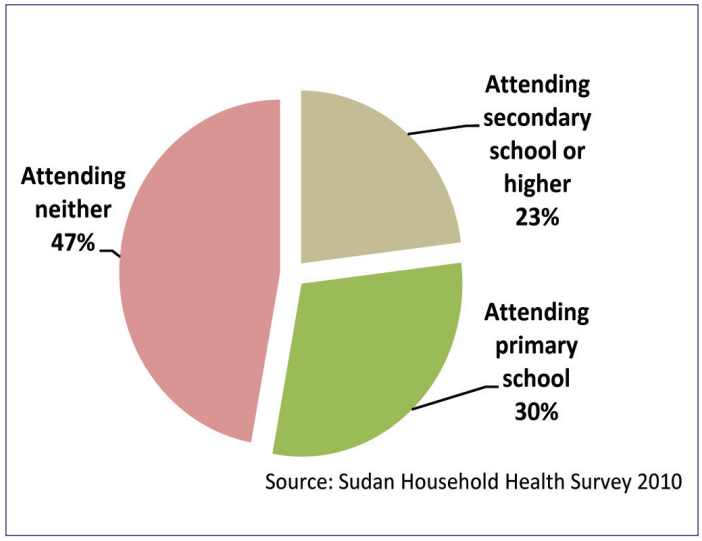


10 Sudan household Health Survey 2010

One quarter of those accessing improved water must travel 30 minutes or more to reach the source, a task undertaken mostly by women and girls. Those who are drinking from unimproved sources very rarely use appropriate means to treat their drinking water. More than 93 per cent of households do not use any water treatment methods. A separate survey by the Ministry of Education found that only 50 per cent of schools have sufficient sanitation facilities.

Increases in access to improved water sources are due to the efforts of the government and international humanitarian organizations who have contributed to the construction of hand pumps and water yards. These efforts are still unsustainable due to a lack of ownership and effective operation and maintenance systems. More sustainable solutions are required. Low sanitation coverage is attributed to the lack of community awareness, lack of clear sanitation policy and strategies and inadequate governmental and supporting agencies attention.

Figure 12.4: Secondary school age children attending secondary school is low in South Kordofan



Education

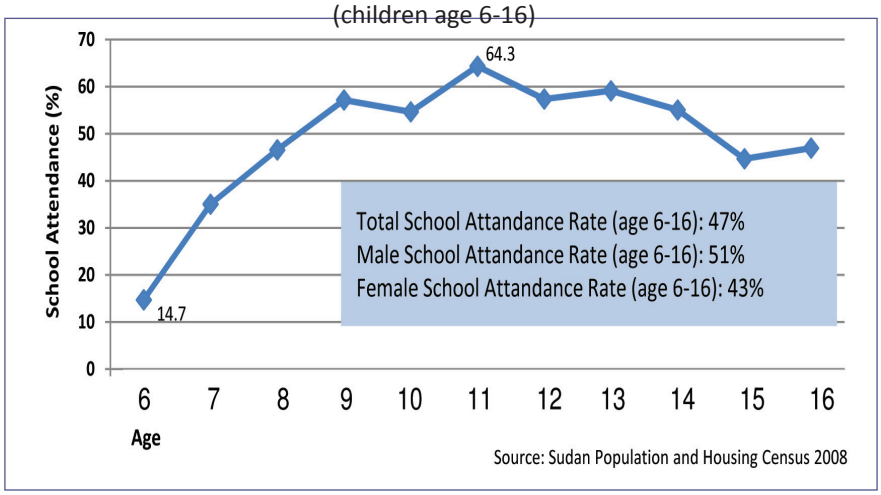
Education indicators are as alarming as those for health. Only 68 per cent of primary school age children were attending school, according to the SHHS2, while a mere 23 per cent of secondary school age children were attending secondary school (or higher).[11] Among both age groups, the attendance rate of boys outnumbers girls by six to eight percentage points.

Repetition and late enrolment is high, with 30 per cent of secondary school aged children attending primary school (Figure 12.5). Retention is the worst in all of Sudan, with only 67 per cent of children entering grade one going on to reach grade eight.

The 2008 national census shows that school attendance peaks at the age of 11, and then decreases gradually as children get older (Figure 12.6). This may be because families pull their children out of school -- boys for cattle herding and income generating activities, and girls for domestic work or marriage. The figure also shows a trend of late admission to grade one of primary school as the share of children attending school at the age of six is less than 15 per cent.

11 The percentage of enrolment at primary education is 80.8 per cent, and the secondary school enrolment is 33.5 per cent, Educational Statistics, 2008/2009, P38 & 41.

Figure 12.6: School attendance rate in South Kordofan (children age 6-16)



A shortage of trained teachers is another contributor to low attendance and a poor learning environment. There were 7,885 teachers during the 2009-2010 school year (43 per cent female), resulting in a pupil to teacher ratio of 1:35. However, only slightly more than half (55 per cent) of all teachers are actually trained.[12]

Dropout rates are high among both sexes during the teen years. Commendably, South Kordofan has been successful in enrolling and retaining students through the early adolescent years - there were more 10-14 year olds attending school in 2010 than any other age group (103,379, 45 per cent of them girls). However, in the 15-19 age group the number of current students drops by almost half (53,380). Family responsibilities tend to be the primary reason for leaving school. As boys become older and stronger, their families depend on them to help with herding cattle and income generating activities. Early marriage and domestic work contribute to high dropout rates among girls.

Unaccompanied and Separated Children

In addition to the reasons mentioned above, many children leave school because they have left their homes. Children living on the streets make up the largest group of separated and unaccompanied children. At the end of 2009, the State Council of Child Welfare and UNICEF conducted a Child Protection Assessment to better understand this marginalized and highly vulnerable group of children. It was found that most are boys between the ages of 11 and 15, along with an increasing number of girls aged 12 to 17. The state has recently increased its efforts to identify these children and, where possible, reunify them with their families.

The SHHS2 also shows that South Kordofan has the highest share of children under the age of 18 who are not living with a biological parent (6.5 per cent– or close to 11,000 children). The state has recently increased its efforts to identify these children and, where possible, reunify them with their families.

Landmines and UXO

According to IFRC[13], 20 per cent of the state is contaminated with landmines and other UXO. During the reporting period, SRCS reported 19 injuries and five deaths in seven localities of South Kordofan. Other reports from UNMAO indicate 45 injuries due to landmine/UXOs between June and July 2011 alone. This could be a contributing factor to the high number of children with disabilities (close to 5,800) who constitute more than seven per cent of the population with disability.

Female Genital Mutilation and Cutting (FGM/C)

FGM/C is widely practiced in South Kordofan. According to the SHHS2, 66 per cent of all females aged 0-50 have undergone the practice, showing little change from the 2006 estimate. In 2008, the state government passed an act against FGM/C, filling the absence of national laws that criminalize this harmful tradition. However, its enforcement is difficult, as the practice is deeply engrained in local traditions especially among nomadic tribal groups.

12 Ministry of General Education, Educational Statistics 2008-9
13 Emergency Appeal Operation Update 26 August 2010.

A 2007 study in South Kordofan found that mothers and grandmothers are the main proponents of FGM/C, believing that it will improve their daughters' marriageability and protect their chastity.[14] The SHHS2 found that 53 per cent of ever-married women aged 15 to 49 intend to continue the practice with their own daughters, a slight increase from 52 per cent in 2006, in spite of the additional risk in terms of infection, bleeding, psychological problems and difficult deliveries that these girls could face.

To reverse the trend, community-based initiatives such as *Saleema* (complete, intact, healthy girl) aim to promote new values and transform discussion at community level, using positive messages to encourage the families to abandon FGM/C. Various actors, including parliamentarians, civil society, religious groups, youth and women activists together form a network that builds consensus towards the collective abandonment of harmful practices. *Saleema* is targeting 85 FGM/C practising communities in South Kordofan, 23 declared abandonment of the practice in the first year of the programme.

HIV/AIDS

South Kordofan is among seven states perceived to have high HIV prevalence due to the security situation and weak health systems. In 2010, only 250 people were reached and tested of whom 40 were HIV positive.

Call to Action

- Build on existing dialogue with the state government and partners to increase resources, commitment and policies toward improving the lives and wellbeing of women and children.
- Raise the profile of the above-mentioned issues through communications and advocacy in order to guarantee their prioritization in high-level decision making.
- Incorporate water, sanitation and hygiene, nutrition and education into peace-building initiatives and plans for returning populations, since these essential services are vital to the prevention of future conflicts.
- Ensure access to quality education for all children by constructing new child-friendly classrooms, budgeting for more trained teachers, and improved water and sanitation facilities in schools.
- Strengthen the social welfare system by developing schemes that facilitate family tracing and reunification of children separated by conflict, as well as policies for alternative foster care arrangements.
- Promote community-based protection initiatives like *Saleema* to change social norms around FGM/C, while also improving the enforcement of laws banning the practice.
- Advocate for the banning and clearing of landmines and UXOs.
- Continue to collect new data that will inform decision-making and monitor progress on the rights of children.

14 UNICEF, 'Child Protection Assessment: South Kordofan, North Kordofan & Abyei Area', May 2010, p. 8.

13 North Darfur State

Key Indicators from Sudan Household Health Survey 2010 (%)	
Birth Registration	58.8
Fully Immunized	43.4
Global Underweight Prevalence	35.7
Global Stunting	35.3
Global Acute Malnutrition	21.6
Use of Improved Drinking Water Sources	78.4
Use of Improved Sanitation Facilities	18.4
Pre-school Education Enrolment[1]	31.8
Primary School Enrolment	66
Secondary School Enrolment	21.5
People with Differentiated Abilities[2]	5.0
FGM/C Prevalence	60.5
Early Marriage (before 18)	33.9
Attended by Skilled Person at Birth	65.2
State Child Act – Enacted	Yes
State Child Act – Ban on FGM/C Included	No
Infant Mortality Rate[3] (per 1000 live births)	59
Maternal Mortality Rate (per 100,000)	618

After years of violence, thousands of deaths and millions of people displaced, the situation in Darfur is slowly transitioning from conflict to recovery, return and development. On 17 July, 2011 the Government of Sudan and LJM (Liberation and Justice Movement) signed the Doha Peace Agreement. Some (IDPs) are cautiously returning home with support from the government and humanitarian organizations. Their villages and communities are scheduled to be rebuilt and improved with help from the government and international community.

North Darfur, which is home to 2.1 million people, still faces many challenges. Prolonged conflict has undercut progress in the survival and wellbeing of children, who account for more than half of the population (1.1 million), out of which 15 per cent are under five (313,600). Infrastructure has deteriorated and poverty has increased. Poverty is rampant in North Darfur; a full 71 per cent of the population live under the poverty line, the highest share of any state. The mean monthly household per capita consumption is only SDG 105 (Figure 13.2).[4] The civil war has left over 500,000 people displaced and living in crowded IDP camps. There are indications that many IDPs are staying where they are, turning their temporary displacement site into permanent settlements, and creating urban realities in a state that has traditionally been overwhelmingly rural.[5] Frequent droughts and an expanding population fuel tribal tensions over resources.[6] Access to some areas remains restricted due to conflict and militia attacks, cutting off health, nutrition, education and other basic services. As a result, children in these areas are especially vulnerable.

1 All Education Enrolment Rates are based on theMinistry of General Education Statistics 2008-9.
2 Those who are conventionally known as the disabled; they have a type of partial disability but they often develop other abilities to compensate their disabilities, data from Census 2008, CBS.
3 IMR and MMR are from 2008 Census, CBS
4 Sudan National Baseline Household Survey 2009.
5 United Nations High Commission for Refugees, Global Appeal 2011 Update: Restoring Hope, Rebuilding Lives, Geneva, 2011, p. 54.
6 United Nations Environment Programme, Sudan: Post-Conflict Environmental Assessment, Nairobi, 2007, pp. 6, 59.

Figure 13.1: Infant survival & school enrolment in North Darfur

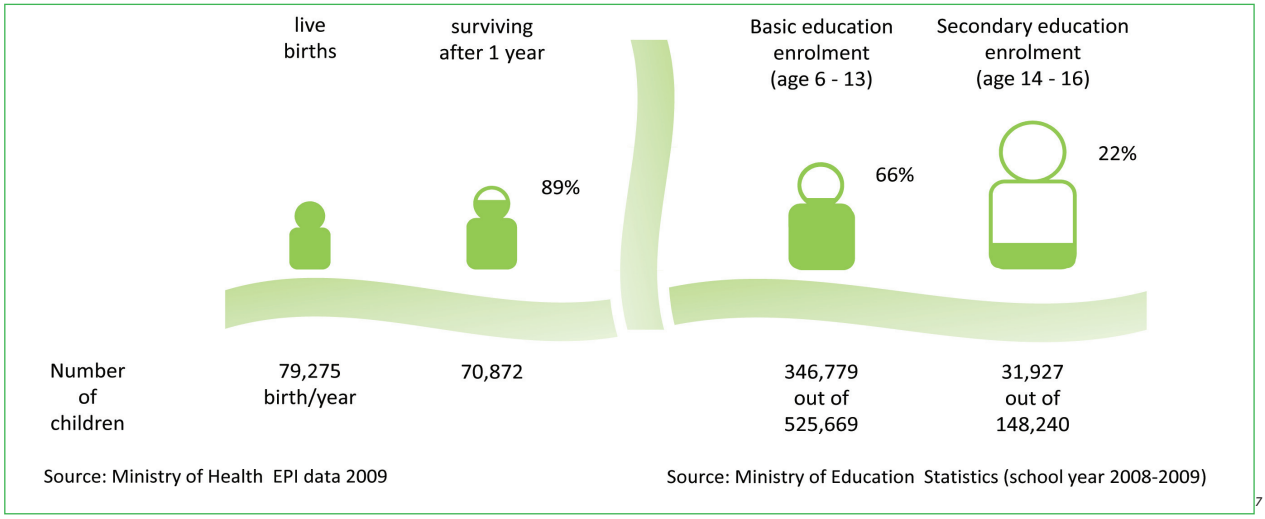
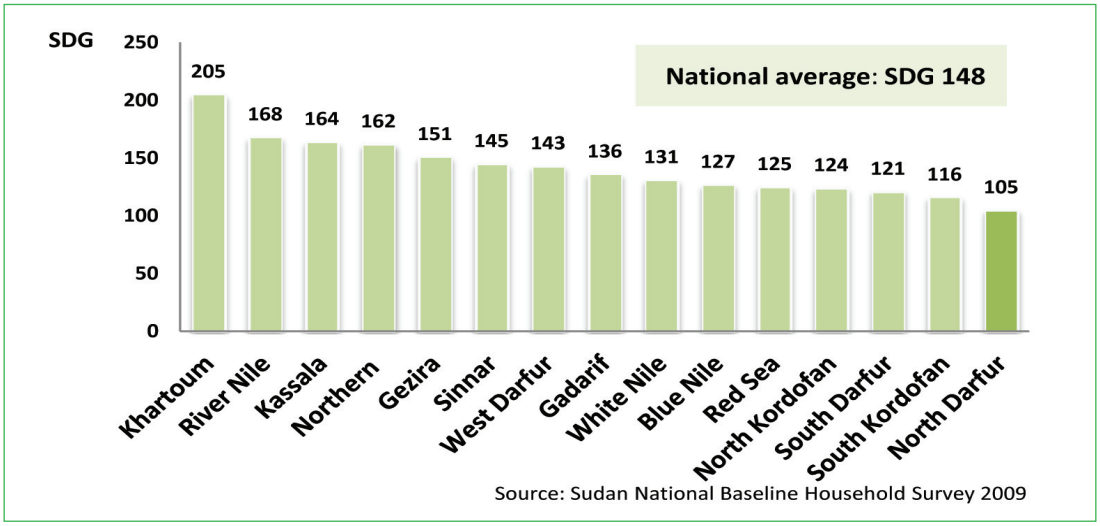


Figure 13.2: North Darfur has the lowest monthly household per capita consumption



Key Issues

Health

The health status of children and women in North Darfur is superior to that of several other states including West and South Darfur. All the three mortality indicators[8] (neonatal, U5, and maternal) are lower than the Sudanese average. However, other indicators need closer attention and action, including implementation of the IMCI which is available at only 40 per cent of health facilities. Another area of concern is immunization: in 2010 Penta 3 and measles[9] coverage was only 85 per cent and 76 per cent respectively due to poor or no access to some areas. Factors contributing to maternal mortality show low indicators as well: for example, only 50 per cent of births are assisted by skilled birth attendants. [10] Comprehensive emergency obstetric care coverage is only 22 per cent and the caesarean section rate is as low as 1.8 per cent.

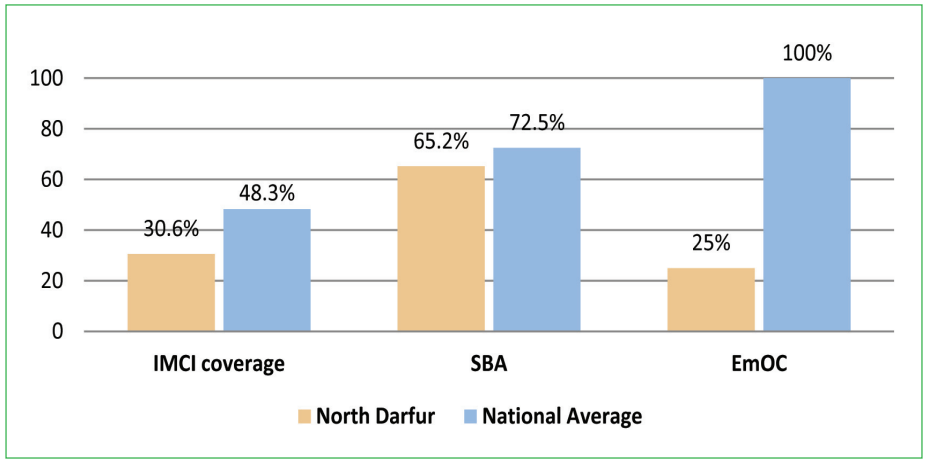
7 The number of children enrolled includes children of all ages, whereas the denominator is based on the population for ages 6-13 for primary education and ages 14-16 for secondary. This may result in higher a enrolment rate than is the reality.

8 Source: SHHS, 2006. State level mortality information is not available from SHHS 2010

9 Source: National EPI Administrative data, 2010

10 Source: FMOH, RH Unit, 2008

Figure 13.3: IMCI, Skilled birth attendants and EmOC coverage in North Darfur State, 2010

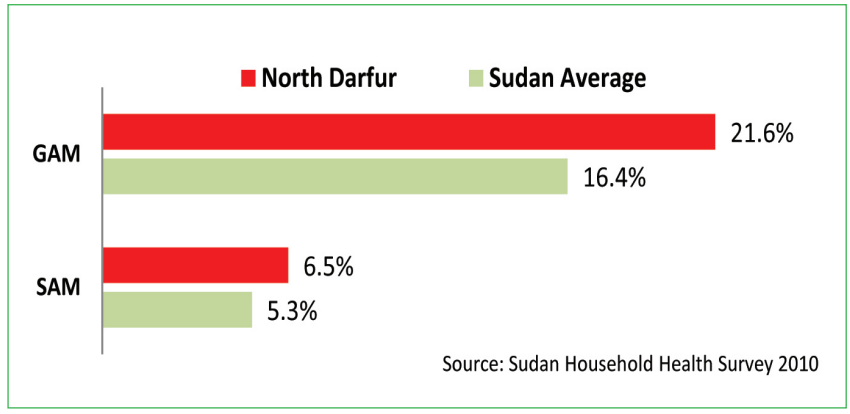


Nutrition

Of the 67,000 children born alive in 12 months preceding the 2008 census, about 57,000 (85 per cent) were still alive when the census took place.[11] A major contributor to child mortality is the critically high rate of SAM and global acute malnutrition (GAM) (Figure13.4).[12] At 6.5 per cent, SAM is well above the national average (5.3 per cent). GAM rates in IDP camps and rural localities range from about 15.6 per cent to 28.1 per cent, according to recent local nutrition surveys.[13] Such levels of malnutrition are well above the WHO's emergency threshold of 15 per cent and require immediate and intensive intervention. Levels of stunting in North Darfur are equal to the national average (35 per cent or 'high' according to WHO benchmarks).[14] Because of population density, North Darfur has the largest number of children suffering from malnutrition (both acute and chronic), although other states have a higher proportions of children suffering from either acute or chronic malnutrition.

Despite the on-going humanitarian aid effort, there are still seasonal fluctuations in malnutrition, as shown by both feeding centre routine statistics and seasonal nutrition surveys. The May to October rainy season creates a "hunger gap" when food is not being produced and rural areas are often inaccessible due to flooding.

Figure 13.4: North Darfur has higher wasting prevalence (low weight for height) than the national average
(children under age 5)



Some recent initiatives have shown promise in reversing negative trends in nutrition. CMAM programmes, for example, have resulted in an over 80 per cent recovery rate of children under five during 2010. In 2010, the SMoH expanded the reach of CMAM by integrating Infant and Young Child Feeding (IYCF) programmes. Nutritionists, health workers and even religious leaders have been trained in the integrated approach and are making strides in promoting breastfeeding and healthy nutrition practices. In addition, a Nutrition Surveillance System was introduced in 2005 that monitors progress through monthly state-wide updates. However, many challenges remain, including limited financial and human resources, ongoing insecurity, and restricted access to areas of high need.

11 Based on 2008 Census data.

12 Global acute malnutrition (GAM) and severe acute malnutrition (SAM) are wasting prevalence, defined by a very low weight for height (below -2 z-scores for GAM and -3 z-scores for SAM of the median WHO growth standards).

13 Based on 11 localized nutrition surveys conducted by State Ministry of Health, Relief International and German Red Cross/Sudanese Red Crescent Society in late 2010.

14 Physical Status: The use and interpretation of Anthropometry, report of a WHO expert committee, 1995, chapter 5, p208 & 212

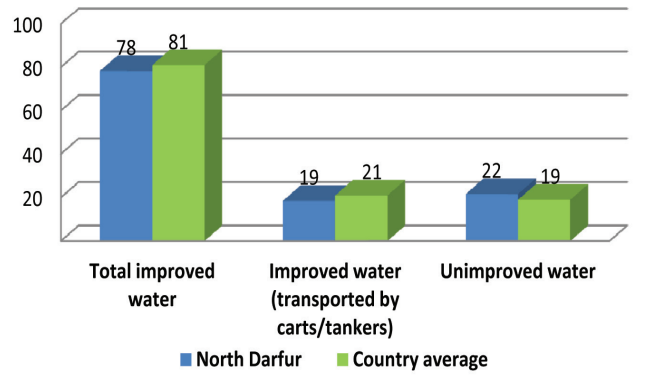
Water, Sanitation and Hygiene

The effects of climate change -- compounded by the impact of increased human activities -- are creating serious challenges to the environment in Darfur. Rapid population growth is leading to greater numbers of people consuming more natural resources leading to water scarcity and deforestation. Rainfall is very important as it replenishes diminishing water tables, which is the source of drinking water for the urban population. North Darfur's water resources are under severe strain, and as a result the southward movement of nomad groups begins after only two months in the northern fringes of Darfur. People use the water harvested in water yards and -- during the rainy season -- from running streams.

According to the latest SHHS data, 78 per cent of the population is using improved sources of drinking water. Of these, 19 per cent are receiving their water requirements from either animal carts or water tankers (Figure 13.5). On the other hand, use of improved sanitation facilities is still very low at 18 per cent. Forty-eight per cent of the population are using unimproved sanitation facilities while 34 per cent of the population is still practicing open defecation (Figure 13.6), one of the most dangerous sanitation practices linked to the rapid spread of disease.

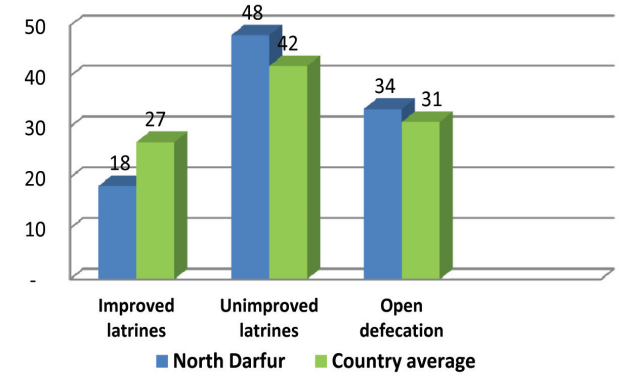
Behind the positive trend in access to drinking water, however, are grim figures that paint a different picture. Twenty nine per cent of people using safe drinking water must travel long distances -- 30 minutes or more -- to reach the source, according to SHHS2. If those people travelling for unimproved sources are included, the share increases to 44 per cent (twice the country average) (Figure 13.7). Meanwhile, only a small fraction (less than one per cent) of those drinking from unimproved sources is properly treating their water.

Figure 13.5: Access to improved drinking water



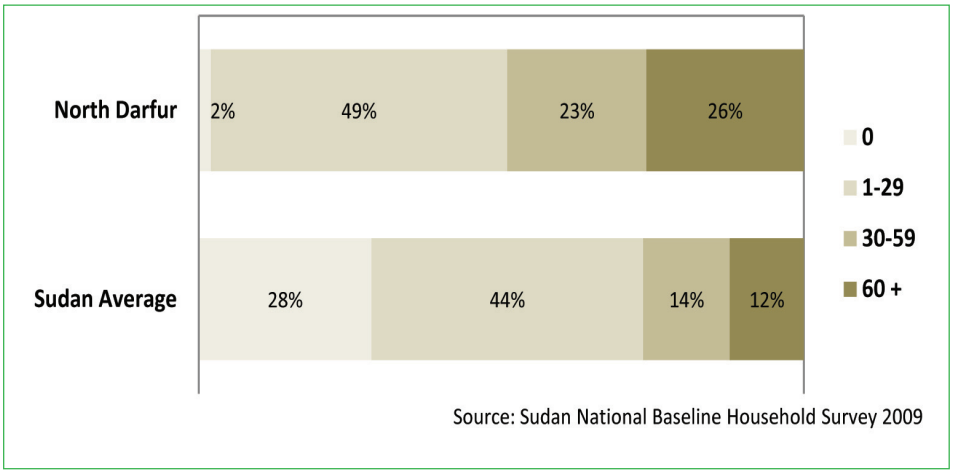
Source: Sudan Household Health Survey 2010

Figure 13.6: Access to improved sanitation



Source: Sudan Household Health Survey 2010

Figure 13.7: People in North Darfur needs to travel a longer distance than the national average
(time used to walk one way to water sources (minutes))



Source: Sudan National Baseline Household Survey 2009

Several factors pose challenges to progress: limited capacity of institutions, inadequate policies and structures, insufficient staff and equipment, lack of understanding of animal growth rate and water use, and accessing hard-to-reach rural villages.

Women and girls are disproportionately affected by poor water, sanitation and hygiene. Collecting water is often seen as 'women's work' because it is used for cooking, cleaning, bathing, drinking and for other domestic purposes. In North Darfur, women and girls (mostly above the age of 15) make the long trip to the water source 62 per cent of the time. They also care for family members who become sick from water-borne diseases.

These activities impede girls' school attendance and hamper income-generating opportunities for women. In addition, a significant decrease in girls' attendance has been reported due to poor school sanitation facilities, especially in secondary schools. These factors help explain the low (58 per cent[15]) rate among girls aged 15-17 attending primary school or higher.[16]

There are, however, signs that the situation is improving. The government has identified water and sanitation as a priority issue, increasing the budget and developing a six-year strategic plan. There remain many more challenges, however. Regional insecurity restricts access, the large number of IDPs strains existing resources, and local capacity to implement and manage proper systems is limited.

Education

Positive trends in education have been seen in recent years. In 2010, out of 573,459 school-aged children a total of 356,747 children were enrolled, equivalent to 62 per cent. This shows a slight improvement from the 2008 rate of 60 per cent.[17] Out of those that participated in grade 8 final examinations, the proportion that passed increased from 50.5 per cent in 2008 to 73.5 per cent in 2010.

The SHHS2 also shows improvements. Primary school enrolment increased from 67 to 79 per cent, while secondary school attendance doubled from 18 to 38 per cent.[18] At 68 per cent, North Darfur has the highest rate of secondary school age children attending school. However, 30 per cent of these children are actually attending primary school due to late enrolment and high rates of repetition.

In 2009, the state allocated 43 per cent of its public expenditure toward education – higher than the national average of 31 per cent.[19] This contributed to ongoing efforts to rehabilitate and build classrooms, provide separate latrines for boys and girls, obtain education supplies, train teachers, and build awareness among parents through media and social mobilization. Such activities were essential to achieving the progress noted above.

Still, North Darfur only spends SDG 185 per student on basic education, while the national average is SDG 262.[20] Teacher-to-student ratio is 1 to 44, making classroom sizes some of the largest.[21] Despite progress, many schools are still in a poor condition, too many teachers are not trained and school fees are beyond the reach of many families. As a result, about 221,100 children of school age are being deprived of their right to an education.[22]

As the Darfur region begins to transition from emergency to development phase, local governments must plan to address the low levels of education among returnees. Seven years of conflict have impacted an entire generation of school children. UNESCO recently reported that only half of primary schools in IDP camps provide instruction in all eight grades.

Accelerated learning programmes are one way to help raise the levels of literacy and numeracy skills among returning children. This approach was effective in Liberia following the civil war in that country, helping 75,000 children complete primary education in three years instead of six. Other effective ways to reach out-of-school youth include: vocational training, integrating education and skills training into disarmament, demobilization and reintegration (DDR) programmes; recruiting skilled teachers and providing psychosocial support to improve school retention.[23]

HIV/AIDS

Knowledge about HIV/AIDS among North Darfur women fell between 2006 and 2010 (Figure 13.8). The number of women aged between 15 and 49 years old who have heard of HIV/AIDS decreased from 67 per cent in 2006 to 60 per cent in 2010. Only one fifth of women know that HIV can be transmitted from mother to child during pregnancy, birth and breastfeeding. This is down more than 14 points from 2006.

---

15 58 per cent is the sum of 36 per cent (attending secondary school or higher) and 22 per cent (attending primary school).

16 Sudan Household Health Survey 2010

17 Educational Statistics, 2009/2010, Ministry of General Education

18 The percentage of enrolment at primary education is 66 per cent, and the secondary school enrolment is 21.5 per cent, Educational Statistics, 2008/2009, P38 & 41.

19 "World Bank, 2012, The Status of the Education Sector in Sudan, Washington DC»

20 From «World Bank, 2012, The Status of the Education Sector in Sudan, Washington DC»

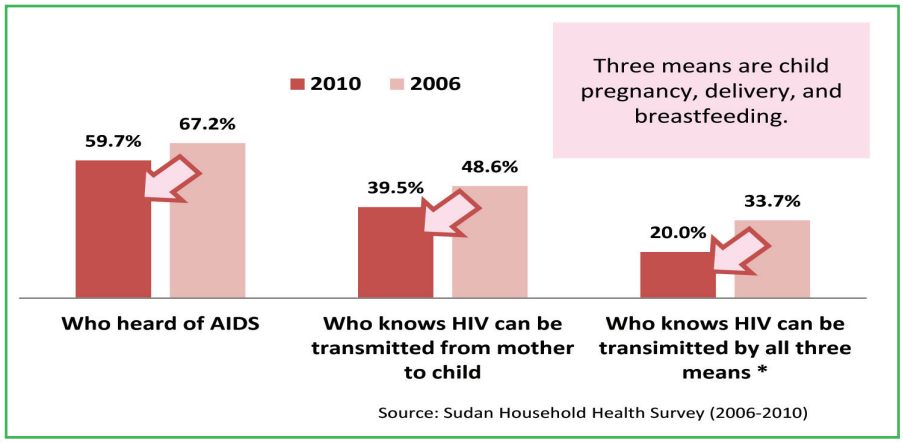
21 From «World Bank, 2012, The Status of the Education Sector in Sudan, Washington DC»

22 According to the 2008 census, there were 221,133 children at age 6-16 who had never attended or only previously attended school.

23 United Nations Educational, Scientific, and Cultural Organization, Education for All, Global Monitoring Report 2011 – The Hidden Crisis: Armed Conflict and Education, Paris, 2011, pp. 158, 212, 225-226; and Lloyd, C., El-Kogali, S., Robinson, J. P., Rankin, J. and Rashed, A., Schooling and Conflict in Darfur: A Snapshot of Basic Education Services for Displaced Children, New York, Population Council/Women's Refugee Council, 2010.

Just because a woman knows where to get tested does not mean that she will, indicating clear barriers to testing. Nine per cent of women aged 15 to 49 say they know where they can get tested, yet only two per cent have ever been, and only a third of those have received their results.

Figure 13.8: Kowledge on HIV/AIDS has decreased in North Darfur between 2006 and 2010
(women age 15-49)



Low testing rates mean that no reliable data for HIV prevalence exists. However, records from 12 voluntary counseling and testing (VCT) centres in 2010 found that more than nine per cent of people tested for HIV/AIDS were positive. Table 13.1 gives details of trends since 2006.

Weak political commitment and government funding, limited community involvement, and the low capacity of partners to deliver services, have all contributed to the declining trend. Some areas are inaccessible and insecure, restricting primary prevention and other services. The trans-boundary movement of nomads is another threat to the preventive measures established against HIV/AIDS. The nomads often cross the borders to Chad, Central Africa and even further, and they lack knowledge about HIV/AIDS, its modes of transmission and prevention. With their lack of awareness they can act as vehicles for the spread of the disease.

Unless women and young people are equipped with the knowledge to protect themselves and their children, HIV rates will inevitably rise in North Darfur. They are particularly vulnerable in the context of the ongoing insecurity in the region, where high population movement and crowded IDP camps create an ideal environment for the rapid spread of HIV and other sexually transmitted diseases.

Call to Action

- Improve access to allow all parts of the state to be assessed and humanitarian assistance provided where needed.
- Develop child friendly budgets that allocate more resources to children, ensuring their sustained access to services as they and their families transition from IDP camps to their communities.
- Greater investment is needed in tackling the underlying causes of malnutrition, as well as promoting evidence-based interventions for its prevention among children under two.
- Increase incentives for both students and teachers, such as school feeding initiatives, better learning materials, and more child-friendly schools. For teachers, this means better training and higher salaries.
- Strengthen partnerships with the Water and Sanitation sector, SMoH localities and NGO partners to develop concrete plans and policies that include capacity building.
- Increase access to HIV/AIDS testing and treatment services by building the technical and programmatic capacity of national health authorities and other actors in the HIV/AIDS sector (including national and international NGOs). This includes expanding fixed and mobile VCT and PMTCT centres throughout the state.
- Greater efforts must be made to bring competent NGO partners into the state. Rebuilding the capacity of national NGOs will greatly increase the quality of and access to life-saving services.
- Continue to collect new data through surveillance systems, surveys and regular monitoring systems (field visits) that will inform decision-making and monitor progress on the rights of children.

14 West Darfur State

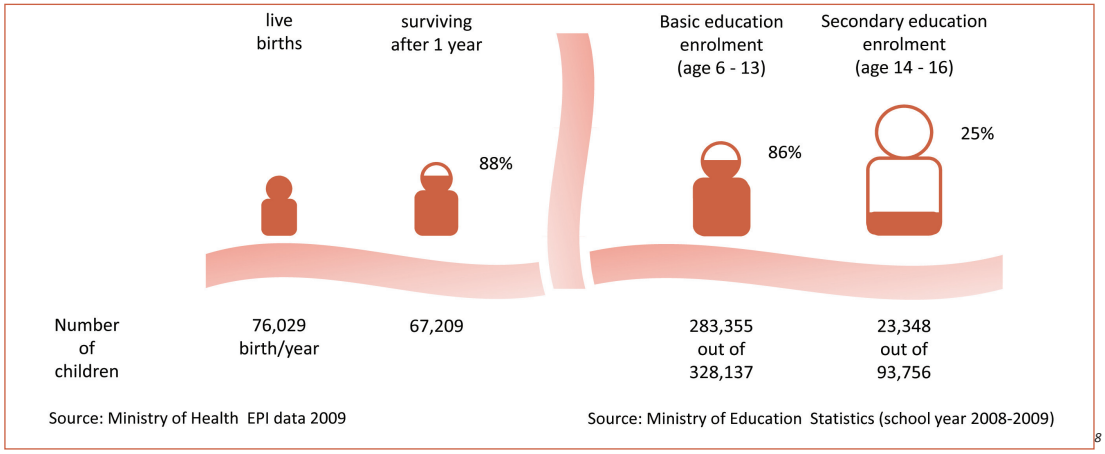
Key Indicators from Sudan Household Health Survey 2010 (%)	
Birth Registration	23.3
Fully Immunized	38.6
Global Underweight	33.1
Global Stunting	36.6
Global Acute Malnutrition	18.6
Use of Improved Drinking Water Sources	54.5
Use of Improved Sanitation Facilities	23.7
Pre-school Education Enrolment[1]	25.5
Primary School Enrolment	86.4
Secondary School Enrolment	24.9
People with Differentiated Abilities[2]	6.2
FGM/C Prevalence	46.0
Early Marriage (before 18)	49.4
Attended by Skilled Person at Birth	33.4
State Child Act – Enacted	Yes
State Child Act – Ban on FGM/C Included	No
Infant Mortality Rate[3] (per 1000 live births)	88
Maternal Mortality Rate (per 100,000)	615

The conflict that began in Darfur in 2003 has displaced millions and claimed many civilian lives. Its effects remain the biggest threat to development as the region looks toward a new chapter of post-emergency recovery. The deep scar that the conflict left in West Darfur can be seen in levels of poverty, which affect up to 56 per cent of the state's 1.3 million people.[4] Development is above all crucial for the state's children who account for more than 55 per cent (711,500) of the population – the highest proportion of any state in the country.[5] Not all will survive, however, as under-five mortality was the third highest nationwide in 2006 (138 out of 1,000 live births).[6] Of the 47,000 children born alive in 12 months preceding the 2008 census, about 42,100 (90 per cent) were still alive when the census took place.[7] Past years of conflict between the opposition and the Chadian government impacted the development of the region. This, coupled with dwindling rainfall in the last two years has affected the earnings of many people and increased poverty levels. Inter-tribal fighting between nomads and farmers – usually over grazing rights and water -- has been another source of insecurity in recent years.

IDPs in West Darfur and refugees in Chad are beginning to return voluntarily, often with the government's support.

1 All Education Enrolment Rates are based on theMinistry of General Education Statistics 2008-9
2 Those who are conventionally known as the disabled; they have a type of partial disability but they often develop other paramount abilities to compensate their disabilities, data from Census 2008, CBS.
3 IMR and MMR are from 2008 Census, CBS
4 Sudan National Baseline Household Survey 2009
5 Sudan Population and Housing Census 2008
6 Sudan Household Health Survey 2006
7 Sudan Population and Housing Census 2008

Figure 14.1: Infant survival & school enrolment in West Darfur

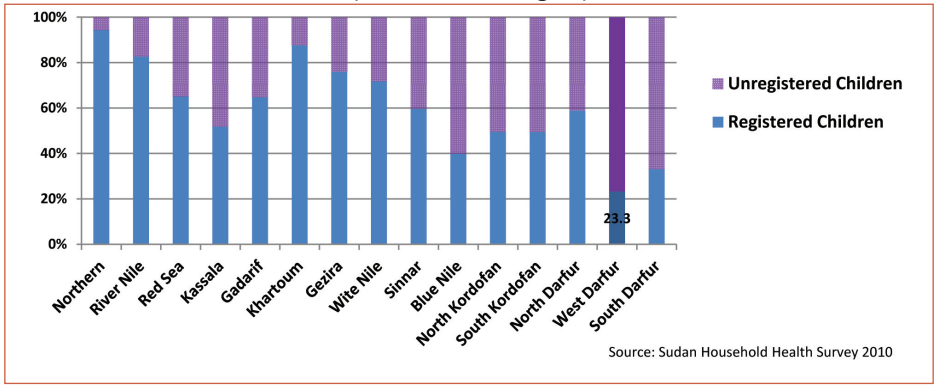


Key Issues

Birth Registration

Birth registration may be one of the most important challenges facing West Darfur. According to the SHHS2 (Figure 14.2), the state has the lowest proportion of registered children -- just 23 per cent against a national average of 59 per cent.

Figure 14.2: West Darfur has the lowest birth registration rate
(children under age 5)



As the state transitions from emergency to recovery and IDPs begin to return home, understanding the identity, community of origin and needs of the state's children will help reunite children who were separated during travel and conflict. It will also help government to better plan how many schools and health facilities are needed across the state, along with other basic social services.

Registering children today is necessary not only for the immediate future of the state but also for the long term. Official records of identity protect the rights guaranteed to a child as a citizen and human being. It means that he or she will be able to vote, receive justice through the legal system, and remain protected against early marriage and recruitment to armed forces.

Perhaps recognizing the importance of registration, the government established the West Darfur Plan of Action in 2009. A limited capacity to implement registration systems, low access to registration facilities, the cost of birth certificates and the lack of general awareness on the importance of birth registration remain serious challenges, particularly in rural areas.

8 The number of children enrolled includes children of all ages, whereas the denominator is based on the population for ages 6-13 for primary education and ages 14-16 for secondary. This may result in a higher enrolment rate than is the reality.

Water, Sanitation and Hygiene

Use of improved water and sanitation sources are among the lowest of all 15 states. The SHHS2 found that only 55 per cent of households have access to improved water (the second lowest of any state in the country). Almost one fifth of this number depends on water delivered by carts and trucks.

Only 24 per cent of the state population has access to improved sanitation facilities, while 27 per cent is using unimproved sanitation facilities. On the other hand, 49 per cent of the population is still practising open defecation (the second highest rate in the country).

Figure 14.3: Access to improved sanitation

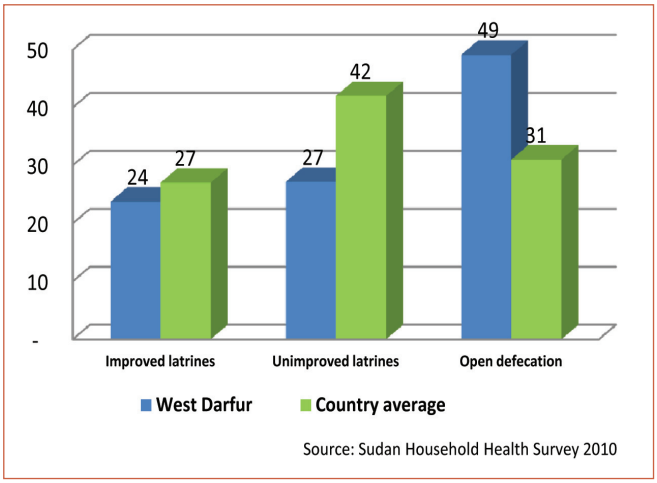
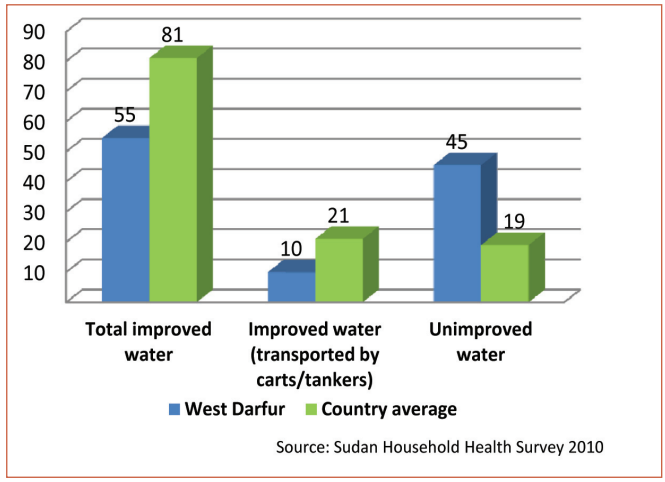


Figure 14.4: Access to improved drinking water

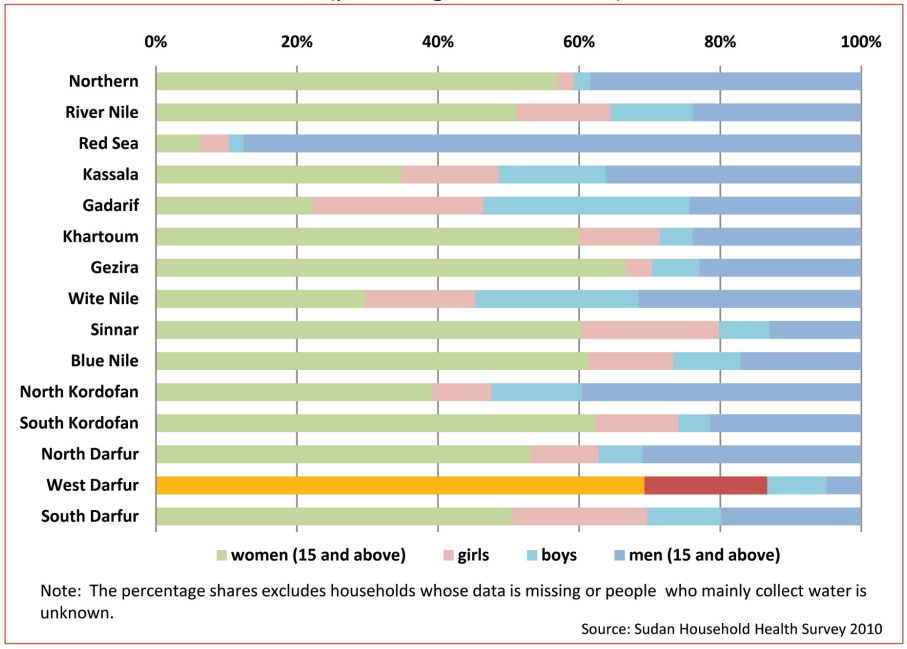


Access to improved sanitation is also poor in schools and health facilities. The 2011-2016 WASH Strategic Plan estimated access at 27 per cent and 48 per cent for state schools and health facilities respectively.

Thirteen per cent of the people who are accessing improved water have to travel over 30 minutes each way to reach the source, sometimes several times per day (Figure 14.4). In more than 85 per cent of households, it is the girls and women who collect water – the highest share in the country (Figure 14.5). In 25 per cent of cases, children under the age of 15 are the ones undertaking the task.

Figure 14.5: West Darfur has the highest share of households that have women/girls as the person who usually collects water

(percentage of households)



Efforts to strengthen the water, sanitation and hygiene sector are seriously compromised by insecurity and flooding which make several locations inaccessible. The consequent limited capacity could jeopardise the shift of

interventions from emergency to early recovery. Moreover, inside the IDP camps, the needs of a large population for water and firewood are depleting resources and probably impacting future rainfall levels.

Nutrition

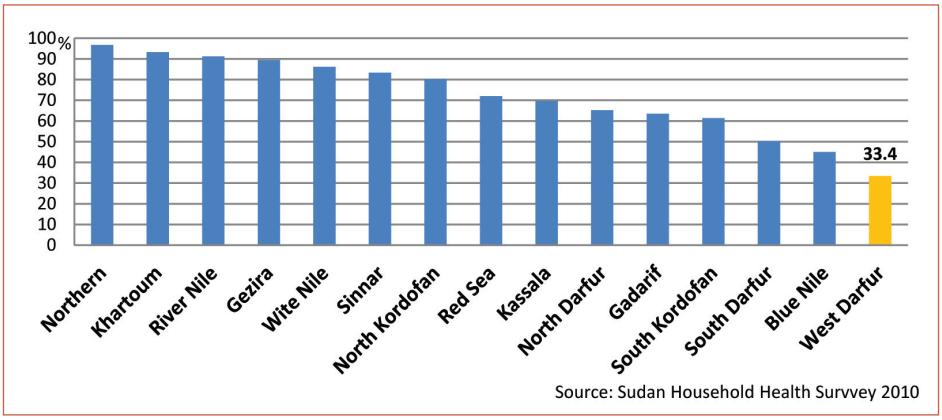
Levels of stunting in West Darfur are high, while wasting (acute malnutrition) is at critical levels[9], 6.7 per cent of children suffer from SAM . Incidences of acute malnutrition in West Darfur are slightly better than North Darfur but worse than South Darfur. West Darfur has the lowest level of immediate initiation of breastfeeding (88.1 per cent of mothers start breastfeeding within one hour of birth). This is important because infants for whom initiation of breastfeeding is delayed more than 24 hours after birth are 2.4 times more likely to die during their first month of life. The risk of neonatal death is increased approximately four-fold if milk-based fluids or solids are provided to breastfed neonates.[10] Although above average for Sudan, less than half of infants are exclusively breastfed (48 per cent).

Safe Motherhood

West Darfur is one of the worst places in Sudan to be a mother. Of the 47,000 women who gave birth in the 12 months preceding the 2008 census about 325 (0.7 per cent) died; a higher proportion than in any other state. Sadly, many women die from complications that are both preventable and treatable like anemia, malaria, tetanus and poor nutrition. For every mother that dies, an estimated 20 more suffer postnatal complications.[11]

Such high maternal mortality rates reflect a weak health system that is either inaccessible or inadequate for many women. A shortage of trained heath service providers is one factor. According to the SMOHs, there are just 689 village midwives currently serving in West Darfur. As a result, 41 per cent of pregnant women receive no antenatal care at all, according to SHHS2. Only one in ten mothers delivers in a health facility where they can receive lifesaving medical treatment, an alarmingly low number when compared with Northern State where the figure is one in two. Moreover, only a third of women were attended by skilled personnel during delivery (Figure 14.6). Simple steps such as increasing skilled personnel, expanding the reach of health facilities and increased financial support could yield important results towards reducing maternal deaths. In fact, approximately 80 per cent of maternal deaths can be prevented through greater access to basic and emergency obstetric care.[12]

Figure 14.6: West Darfur has the lowest share of women who were attended by skilled personnel during childbirth
(women age 15-49)



Research has found a strong connection between child marriage and complications during pregnancy. A UNICEF report found that worldwide, nearly 70,000 girls aged 15 – 19 die each year in pregnancy and childbirth.[13] It is no surprise, then, that West Darfur not only has some of the highest maternal mortality rates, but also some of the highest occurrences of early marriage. About half of all women are married before the age of 18, and 15 per cent are married before the age of 15. Thirty per cent of women aged 15 to 19 have begun childbearing, more than in any other part of Sudan.

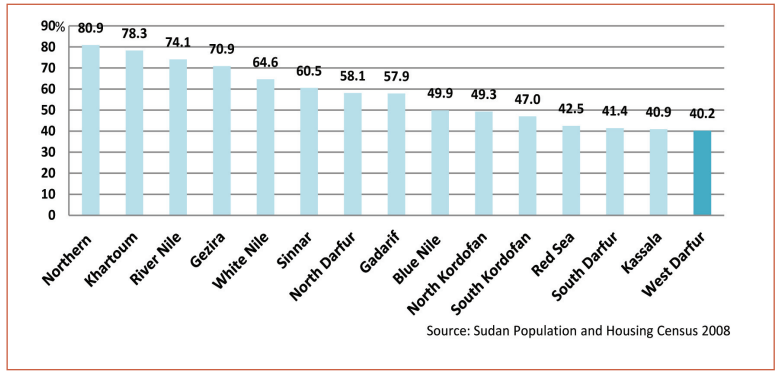
9 Physical Status: The use and interpretation of Anthropometry. Report of a WHO expert committee, 1995. Chapter 5, p208 & 212
10 Edmond KM, Zandoh C, Quigley MA, Amenga-Etego S, Owusu-Agyei S, Kirkwood B (2006).Delayed Breastfeeding Initiation Increases Risk of Neonatal Mortality.Pediatrics 2006;117;380-386
11 United Nations Children's Fund, State of the World's Children 2009: Maternal and Newborn Health, New York City, 2009, pp. 4, 50.
12 United Nations Children's Fund, State of the World's Children 2009: Maternal and Newborn Health, New York City, 2009, p. 2.
13 United Nations Children's Fund, State of the World's Children 2009: Maternal and Newborn Health, New York City, 2009, p. 14.

Gender Equity

Gender disparities in West Darfur are particularly acute. Almost half of all girls undergo FGM/C, are either never enrolled in school or drop out early to help with household chores and assume adult responsibilities at an early age through marriage and childbirth.

In the absence of a federal law banning FGM/C, West Darfur has passed one of its own: the 2008 West Darfur Child Act. This legislation could help explain why, compared to Sudan's average of 66 per cent, the share of girls and women in West Darfur who went through the practice is 46 per cent. Still, important social factors need to be addressed in order to reduce the practice further. Almost half of women of childbearing age (15-49) 310,667 said they intend to continue the practice with their own daughters. In response, West Darfur has joined the community-driven approach of the *Saleema initiative.* So far, more than 9,500 people in four communities have joined a positive dialogue about abandoning FGM/C.

Figure 14.7: West Darfur has the lowest school attendance
(children age 6-16)

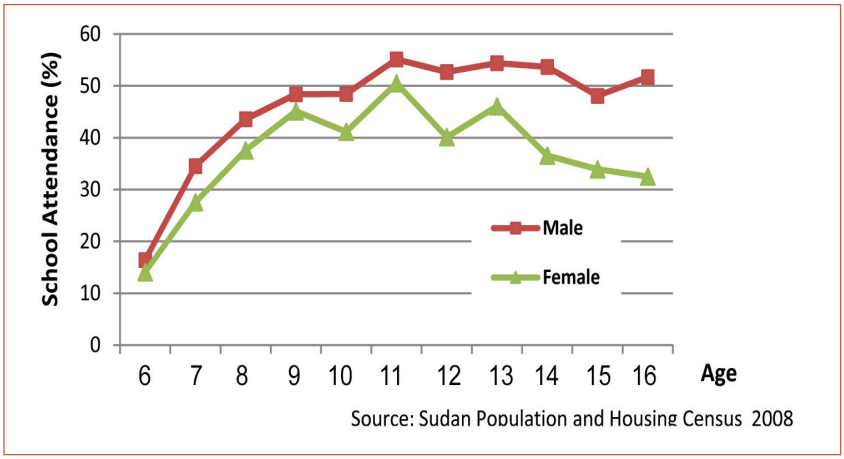


School attendance in West Darfur is the lowest in the country and girls are particularly affected. According to the 2008 census, the share of school-age children (age 6-16) in class was only 40 per cent (Figure 14.7), a figure that dropped to 36 per cent in the case of girls.

According to the State Ministry of Education (SMOE), gross school enrolment of boys is 58 per cent while it is only 41 per cent for girls. The SHHS2 found similar disparities, reporting primary school attendance rates of 67 and 52 per cent respectively.[14] According to Educational Statistics, the number of enrolled children aged 6 – 13 is 283,510 (86.4 per cent) out of 328,137 children of school age. The number of out-of-school children is 44,627, representing 13.6 per cent of the children at the school age.

Girls are more likely to drop out of school during adolescence, according to the 2008 census (Figure 14.8). For both boys and girls, the attendance rate peaks at age 11. After age 11, however, attendance rates for boys and girls start to diverge. For girls, attendance drops from 50.5 per cent at the age of 11 to 32.5 per cent at the age of 16, a 40 per cent decline. Boys, on the other hand, have maintained consistent attendance at around 50 per cent. Early marriage and economic factors are possible reasons for keeping girls at home. The result is the lowest female literacy rate in Sudan -- only 17 per cent according to the SHHS2. The 2008 census shows a slightly improved figure of 29 per cent, but this is still the lowest in the country, and is only a little over half the state's male literacy rate (Table 14.1).

Figure 14.8: Female school attendance decreases after peeking out at age 11 in West Darfur



14 SHHS2 measured primary school attendance rates of children age 7-14.

Table 14.1: Literacy rate in Sudan

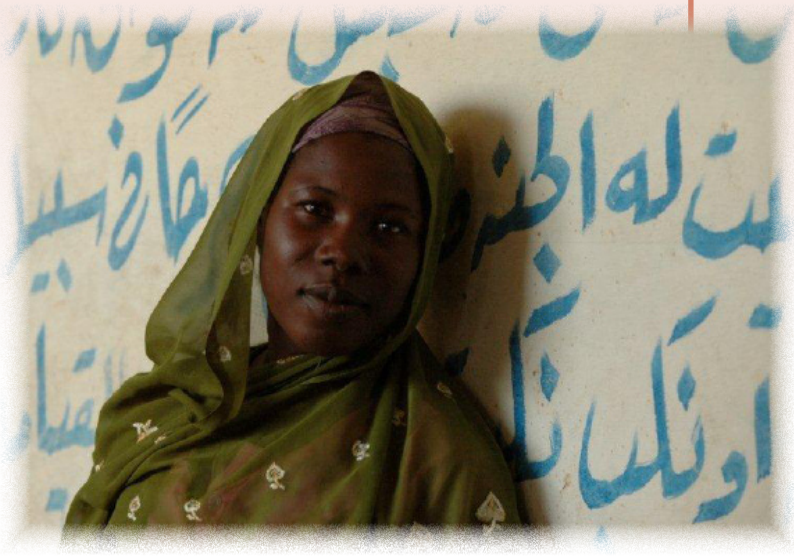
State	Male Literacy Rate (%)	Female Literacy Rate (%)
Northern	80.42	71.63
River Nile	76.28	67.31
Red Sea	46.01	40.66
Kassala	47.92	38.77
Gadarif	65.26	49.57
Khartoum	84.66	75.33
Gezira	78.20	63.99
White Nile	66.62	53.29
Sinnar	67.22	52.49
Blue Nile	55.02	37.79
North Kordofan	51.23	37.84
South Kordofan	53.05	36.82
North Darfur	56.12	45.11
West Darfur	49.66	**29.43**
South Darfur	46.24	33.43

Source: Sudan Population and Housing Census 2008

Child marriage makes women vulnerable to early pregnancy but there are other dangers too, including a higher risk of exploitation and abuse. Eighty-four per cent of women in West Darfur -- more than in any other state -- report that it is acceptable for a husband to beat his wife for reasons ranging from going out without telling him, arguing with him, burning food, etc. Such attitudes clearly present an additional challenge to reducing gender disparities.

Call to Action

- Build on and expand existing birth registration policies and systems, exploring partnerships with local governments and communities.
- Advocate for and mobilize increased resources toward joint planned activities that scale up interventions in hard-to-reach areas and benefit the most needy children.
- Expand accelerated child survival and development strategies to cover more localities.
- Implement an integrated community recovery and development approach, focusing on support of women and children wishing to return to their original places.
- With increased numbers of people returning to their places of origin, interventions should be designed to cover early recovery and emergency response. This applies to WASH as well as other sectors such as health and nutrition, education and child protection.
- Greater focus should be placed on community-based initiatives promoting maternal health, using new modalities to ensure community participation from the earliest stages of programme interventions.
- Improve monitoring and enforcement mechanisms relating to child protection laws, including the ban on FGM/C. This includes extending legal and social welfare services beyond urban areas.



15 South Darfur State

Key Indicators from Sudan Household Health Surveys 2010 (%)	
Birth Registration	33.0
Fully Immunized	34.1
Global Underweight Prevalence	31.2
Global Stunting	31.1
Global Acute Malnutrition	14.0
Use of Improved Drinking Water Sources	82.6
Use of Improved Sanitation Facilities	4.9
Pre-school Education Enrolment[1]	38.2
Primary School Enrolment	39.5
Secondary School Enrolment	17.1
People with Differentiated Abilities[2]	4.4
FGM/C Prevalence	60.9
Early Marriage (before 18)	53.9
Attended by Skilled Person at Birth	50.3
State Child Act – Enacted	No (but signed)
State Child Act – Under Draft	Yes
State Child Act – Ban on FGM/C Included	Yes
Infant Mortality Rate[3] (per 1000 live births)	70
Maternal Mortality Rate (per 100,000)	581

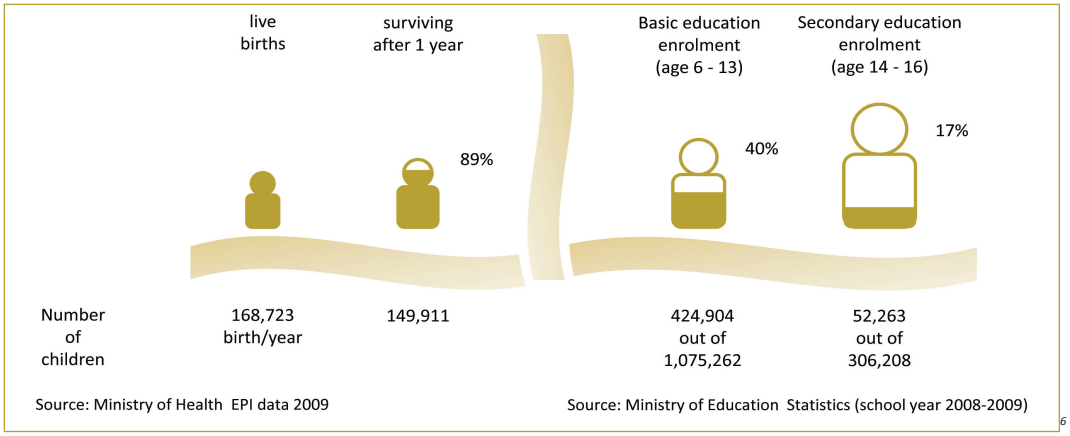
The situation in Darfur is slowly transitioning from conflict to recovery, return and development. Some IDPs are cautiously, but voluntarily returning home with support from the government and humanitarian organizations. Their villages and communities are scheduled to be rebuilt and improved with support from the government and international community. However, the challenges confronting South Darfur, the second most populous state in the country, are far from over. Nearly 60 per cent of the population live under the poverty line[4]

While the security situation is improving in South Darfur, humanitarian assistance is still badly needed, especially to extend services to the remotest areas. This is critical, since nomads account for more than 24 per cent of the population – the highest of any state in Sudan – and the most in need, but they are not accessible. Moreover, some parts of the state still suffer from militia attacks that hinder delivery of services.

Surveyors for the 2008 Census and the SHHS2 were unable to access some insecure areas, resulting in an incomplete picture provided by the most recent data. Available information, however, suggests that children born in 2010 have a better chance of survival than children born four years earlier. Immunization coverage has improved, access to clean water sources has increased, and antenatal care coverage is more widespread. Sustaining this progress for the state's 2.2 million children (54 per cent of the population) in a post-conflict setting presents a challenge that requires significant effort and commitment from the government and its partners.[5]

1 All Education Enrolment Rates are based on theMinistry of General Education Statistics 2008-9
2 Those who are conventionally known as the disabled; they have a type of partial disability but they often develop other paramount abilities to compensate for their disabilities,data from Census 2008, CBS.
3 IMR and MMR are from 2008 Census, CBS
4 Sudan National Baseline Household Survey 2009
5 Based on 2008 Census data.

Figure 15.1: Infant survival & school enrolment in South Darfur

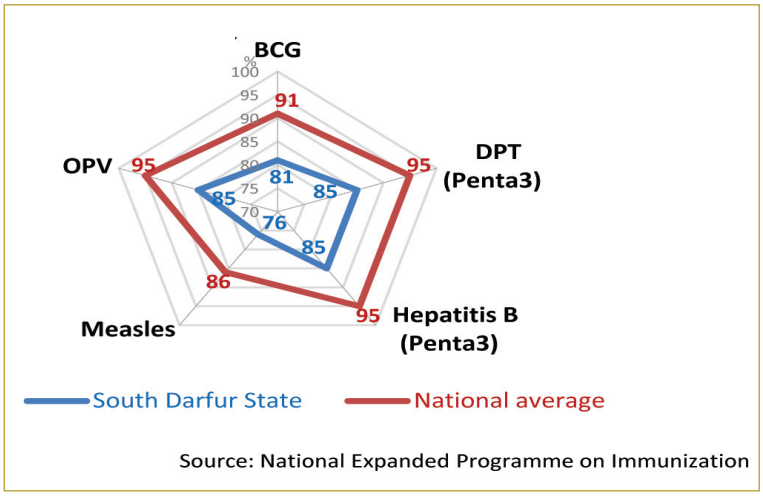


Key Issues

Health and Nutrition

Of the 107,200 children born alive in 12 months preceding the 2008 census, about 93,000 (87 per cent) were alive by the time the census took place.[7] The death of 17,000 babies (17 per cent) during that year could be partly blamed on low immunization coverage. While South Darfur's immunization rates have improved by ten points since 2006 to 34 per cent, it still has the lowest proportion of children aged 12 to 23 months that are fully immunized, according to the SHHS2.[8]

Figure 15.2 South Darfur has a lower immunization coverage than the national average except for OPV



However, data collected in 2010 for the Ministry of Health's EPI shows much higher rates of immunization among children aged less than one year.[9] Measles coverage is 76 per cent, BCG for tuberculosis is 81 per cent, three rounds of Pentavalent is 85 per cent, and coverage of three requisite doses of OPV is 85 per cent.[10] However, these coverage rates are still alarming as all of them are below the national average (Figure 15.2). South Darfur has security problems that affect negatively the implementation of immunization services. Other worrisome health indicators that need immediate attention include: IMCI coverage (32 per cent of health facilities providing integrated management services for common childhood illnesses[11]); the number of skilled birth attendants which is reported at 50 per cent of the actual needs; Comprehensive Emergency Obstetric Care coverage which is reported at 22 per cent[12] and a caesarean section rate of 2.6 per cent.

6 The number of children enrolled includes children of all ages, whereas the denominator is based on the population for ages 6-13 for primary education and ages 14-16 for secondary. This may result in a higher enrolment rate than is the reality.

7 Based on 2008 Census data.

8 SHHS1 (2006) and SHHS2 (2010) use different definitions of full immunization. For SHHS1, fully immunized children are those who received with BCG, measles, three doses of DPT (diphtheria, pertussis, and tetanus) and three doses of OPV (oral polio vaccine). For SHHS2, fully immunized children are those who received with BCG, measles, three requisite doses of OPV and three doses of Pentavalent vaccines.

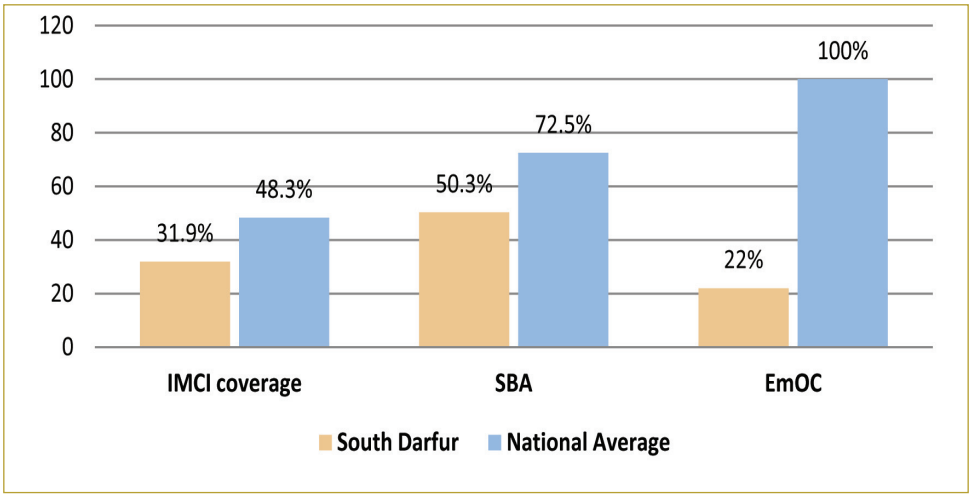
9 EPI uses surviving infants (all births minus deaths in the first year of life) as a denominator, except for BCG, which uses total number of live births. SHHS uses 12-23 months olds as a denominator.

10 Pentavalent vaccine includes DPT (diphtheria, pertussis, and tetanus), Hepatitis B and HiB (Haemophilus influenza type B) vaccines, and it requires three doses to get full protection. Pentavalent immunization started in Sudan from Jan 2008.

11 Source: FMOH, IMCI Unit, 2010

12 Source: FMOH, RH Unit, 2008

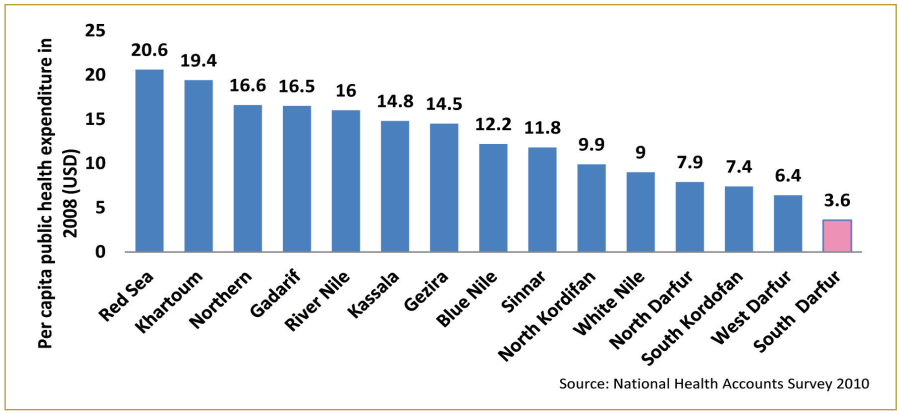
Figure 15.3: Coverage of IMCI, SBA & EmOC in South Darfur, 2010



The nutrition situation in South Darfur is better than the national average.[13] In 2010, at 2.3 per cent, SAM prevalence is the lowest in the country. Just under a third of children are stunted and/or underweight, levels classified as 'high' internationally.[14] Localised nutrition surveys conducted in 2010 show that prevalence of malnutrition is influenced by season, with lower rates in post-harvest months (typically December to March). Despite the humanitarian aid effort, there are still seasonal fluctuations in malnutrition. A hunger gap is common during the May to October rainy season. More research into the context-specific causes of malnutrition is needed in order to tailor interventions to needs.

Recent SHHS2 data, however, sounded an alarm regarding the nutritional status of children. Only 23 per cent of children aged 6-23 months receive minimum meal requirements.[15] Only one child in every three is exclusively breastfed during the first six months, one of the lowest rates in the country. Exclusive breastfeeding is essential in preventing under-nutrition and strengthening a child's immune system.[16] Considering these underlying factors, as well as continued insecurity in parts of the state, South Darfur's better-than-average malnutrition status may deteriorate. Studies have shown that optimal infant and young child feeding, such as exclusive and continued breastfeeding combined with nutritionally adequate and safe complementary foods, can prevent an estimated 19 per cent of all under-five deaths in the developing world.[17]

Figure 15.4: South Darfur has the lowest per capita public health expenditure



Vulnerable locations can be targeted to implement integrated treatment and prevention interventions according to the nutritional conceptual framework.

Any improvements seen in health and nutrition indicators are likely due to growing IDP camps, where children are easily reached with immunization and targeted feeding

13 Severe acute malnutrition (SAM) is a severe wasting, defined by a very low weight for height (below -3 standard errors of the median WHO growth standards).

14 Physical Status: the use and interpretation of Anthropometry, report of a WHO expert committee, 1995, chapter 5, p208 & 212

15 Number of children age 6-23 months receiving solid, semi-solid and soft foods (plus milk feeds for non-breastfed children) the minimum of two times or more, according to breastfeeding status, during the previous day

16 FEWSNET Outlook for Sudan: Darfur, May-Dec 2010.

17 United Nations Children's Fund, Tracking Progress on Child and Maternal Nutrition: A Survival and Development Priority, New York City, 2009, p. 13.

programmes.[18] As the government rolls out its plan to facilitate the return of IDPs, health systems must be strengthened in places of return so as to ensure continuity in services. This includes improving access to areas that are difficult to reach due to poor roads and regular attacks on humanitarian workers. The state government may need to increase its per capita spending on health, which was the lowest in 2008 at USD$ 3.6 per year (Figure 15.4).[19]

Birth Registration

According to the SHHS2, South Darfur registers the second lowest number of births among children under five; at 33 per cent, the state's birth registration rate is only half the national average. Although this is still an improvement since 2006 (when the share was just 19 per cent) a more concerted effort is essential to improve the situation of children in South Darfur. The result is that the vast majority of young children – approximately 419,000 (67 per cent) -- are not recognized by state and federal laws.[20]Knowing their identity and their community of origin will help reunite children who have been separated during travel and conflict. It will allow government and community to better estimate the needs of returnees, including how many schools and health facilities will be needed across the state, as well as other basic social services.

Registering children today is necessary not only for the immediate future of the state but also for the long term. Official records of identity protect the rights guaranteed to a child as a citizen and human being. It means that he or she will be able to vote, receive justice through the legal system, and remain shielded against early marriage and recruitment to armed forces.

Water, Sanitation and Hygiene

New SHHS2 data shows good progress in extending access to improved water but – equally -- very low access to improved sanitation (Figure 15.5 & 15.6). Around 83 per cent of the state population has access to improved water sources. Of that number, 13 per cent rely on water delivered by animal carts and trucks. When it comes to sanitation, just five per cent of the population have access to improved facilities, 56 per cent are using unimproved facilities, while 39 per cent are practising open defecation, with the attendant risks in terms of disease. Progress has been low in this area because of the lack of community awareness, lack of clear sanitation strategies, and inadequate attention from the government and supporting agencies.

Figure 15.5: Access to improved drinking water

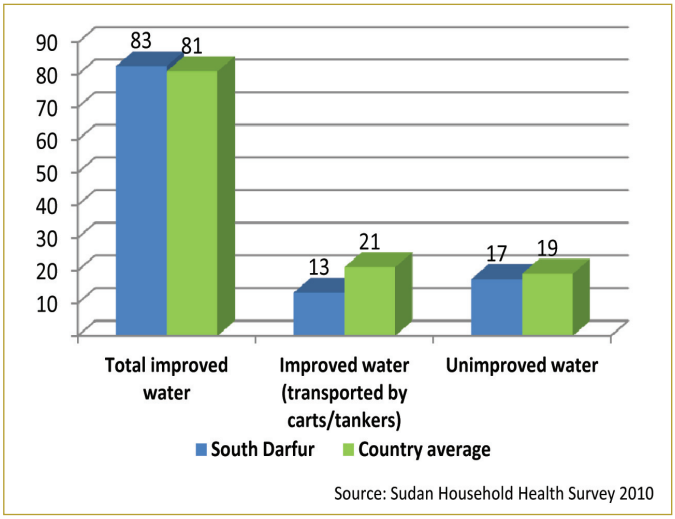
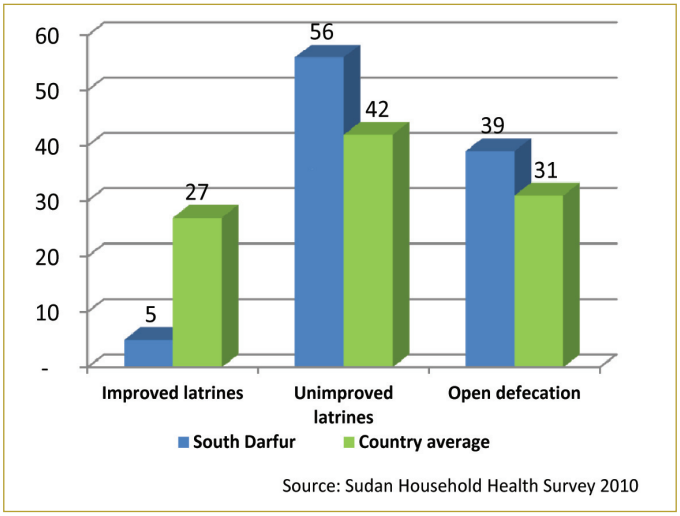


Figure 15.6: Access to improved sanitation



Few school children have access to adequate toilets either. The 2011-2016 WASH Strategic Plan estimated access at 23 per cent and 98 per cent for the state's schools and health facilities, respectively.

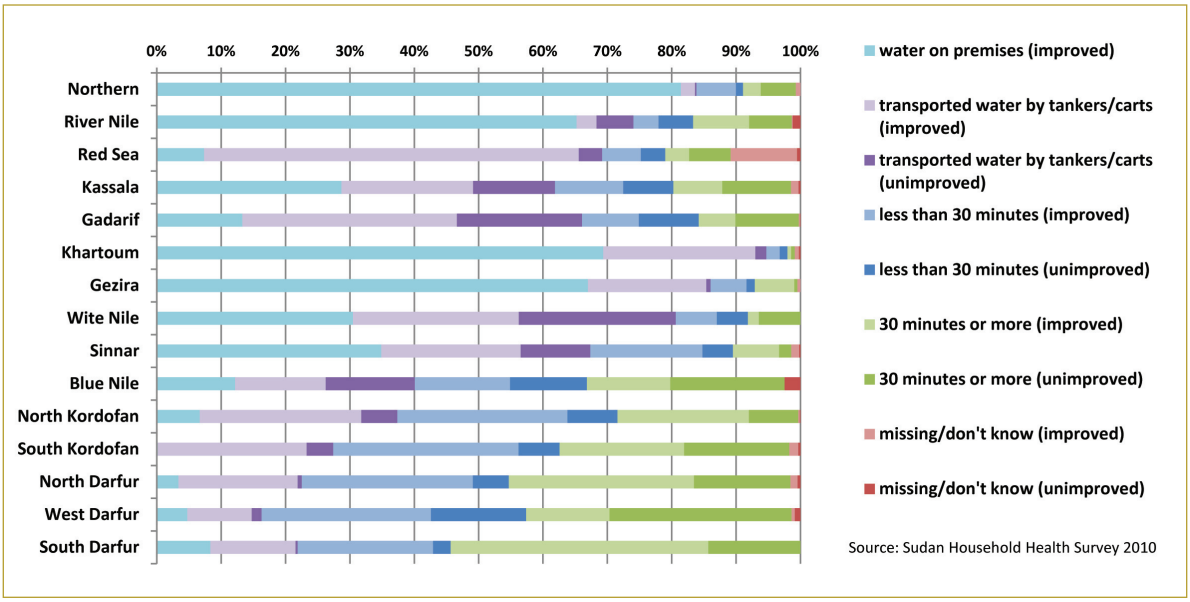
18 UNICEF and Government of Sudan, Government of Sudan and the United Nations Children's Fund 2009 – 2012 Country Programme Mid Term Review: Update of the Assessment and Analysis of the Situation of North Sudan Children and Women, Khartoum, April 2011 (Internal Document)

19 National Health Accounts, Directorate of Planning, Policy and Research, Ministry of Health, 2008

20 According to the 2008 census, there were 625,560 children under the age of five

Women and girls in South Darfur are disproportionately affected by unsafe drinking water and poor hygiene. Forty per cent of the time, people accessing safe drinking water have to travel for more than 30 minutes each way to reach the source, sometimes multiple times per day (Figure 15.7). More often than not, it is women and girls who have to undertake this task. They are also the ones who must care for family members who fall sick because of waterborne illnesses. It is not hard to see why, globally, poor water and sanitation is one of the most common reasons for girls to miss school.[21]

Figure 15.7: People in South Darfur need to travel the longest distance to water sources

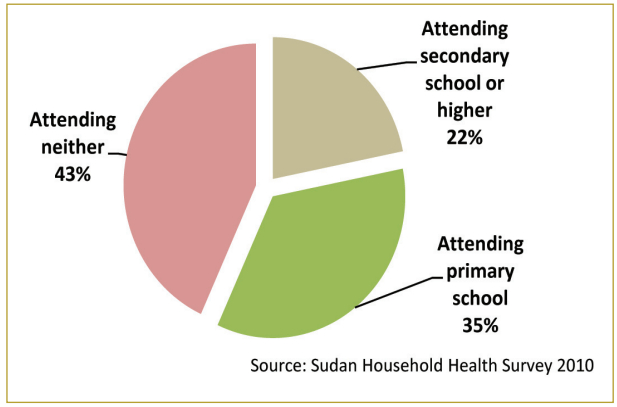


Improving water and sanitation is a major challenge in the current context of South Darfur. The government's limited financial contribution hampers implementation, as does insecurity and poor roads. The recent establishment of a new State Ministry of Water Resources and Environment gives hope that these efforts will be sustained.

Education

Sixty-eight per cent of primary-school age children are attending school. The average classroom has more boys than girls, as 74 per cent of boys attend, compared to 62 per cent of girls. According to educational statistics, only 39.5 per cent of children are attending basic education with the number of out-of-school children at 650,533. The situation is even more serious in respect of secondary education which has an enrolment rate of 17 per cent, the lowest among all states.

Figure 15.8: Secondary school age children attending secondary school is low in South Darfur



The average primary school classroom is likely to contain several above-age children. In fact, among children of secondary-school age, more attend primary school (35 per cent) than secondary (22 per cent) (Figure 15.8). Late enrolment in formal education is common, according to recent data. The 2008 census found that only 191,200 (34 per cent) of six to nine year olds were attending school when the 2008 census was taken. That number doubles in the ten to 14 age group to 286,700 (48 per cent). School attendance peaks at age 11 at 53 per cent.

This phenomenon, common in several states, may be explained, in part, by Accelerated Learning Programmes (ALPs). Children attend ALPs during their early years and then transfer to formal education as they get older. Such programmes are essential in post-conflict situations, as children eagerly work to make up for lost years of education.

21 United Nations Children's Fund, Progress for Children: A report card on water, sanitation and hygiene, no.5, UNICEF, New York, 2006, p. 6.

Retention is among the lowest in Sudan, with only 72 per cent of children who enter first grade staying in school until eighth grade, according to the SHHS2. Significant gender disparities are seen among older children, where 74 per cent of boys attend primary or secondary school compared with only 42 per cent of girls. Girls are more likely to give up education, which contributes to the low literacy rates among women (35 per cent).

Serious concerns loom over the quality of education. Classrooms are overcrowded, teachers are not trained and learning supplies and classroom furniture are insufficient. According to the baseline survey on education in northern states, at least 10,881 additional teachers are needed, particularly in conflict-affected areas.[22] Inadequate incentives mean qualified teachers are working in urban and non-conflict areas. UNICEF recently supported the State Ministry of Education in providing volunteer teachers with in-service training, but this is only a temporary solution.[23]

FGM/C

More than 60 per cent of girls and women living in South Darfur went through female genital mutilation/cutting (FGM/C), slightly less than Sudan's national average (66 per cent). People's attitudes towards the practice, however, are not reassuring. Indeed, more women than in any other state (67 per cent) approve of FGM/and believe that the practice should be continued. More than 71 per cent of married women in the age group 15-49 confirmed that they will circumcise their daughters.

Call to Action

- Improve access to all areas and establish mechanisms to conduct assessments and ensure delivery of humanitarian assistance wherever needed.
- Develop and implement child-friendly budgets that allocate more resources towards children, in order to ensure sustained access to services including IDP camps
- Invest in youth as a means of supporting change and promoting peace and reconciliation.
- Greater investment is needed in preventing malnutrition. This means investing in efforts to combat its underlying causes, as well as evidence-based interventions for its prevention among young children.
- Increase incentives for both students and teachers in order to improve educational attainment. For students, this means school feeding initiatives, better learning materials and more child-friendly schools. For teachers, this means better training and higher salaries.
- Support delivery of health services by expanding service delivery networks, improved technical skills, logistics supply and strengthening the emergency referral system while working to improve utilization and encourage voluntary RH/HIV testing.
- Increase investment in improved water, sanitation and hygiene interventions, particularly in rural areas and schools. Greater efforts must be made to bring more actors including national and international NGO partners into the state. Rebuilding these partnerships will greatly increase quality of and access to life-saving services.
- Continue to collect new data that will inform decision-making and monitor progress on the rights of children. Increase efforts to reach areas that have been excluded from recent surveys and assessments.

22 Baseline Survey on Education in Northern States, Ministry of Education, 2008.

23 UNICEF and Government of Sudan, Government of Sudan and the United Nations Children's Fund 2009 – 2012 Country Programme Mid Term Review: Update of the Assessment and Analysis of the Situation of North Sudan Children and Women, Khartoum, April 2011 (Internal Document)

Red cells are alarming indicators.
Green cells are states that are performing relatively better.

Summary Report Card by State

		NATIONAL	SOUTH DARFUR	RED SEA	BLUE NILE	WEST DARFUR	KASSALA	NORTH DARFUR	SINNAR	SOUTH KORDOFAN	NORTH KORDOFAN	GADARIF	WHITE NILE	RIVER NILE	NORTHERN STATE	GEZIRA	KHARTOUM	Standard deviation
	Population (Millions)	30.9	4.09	1.40	0.83	1.31	1.79	2.11	1.29	1.41	2.92	1.35	1.73	1.12	0.70	3.58	5.27	
MDG 1	Global Underweight	32.2	31.2	49.2	31.7	33.1	38.5	35.7	42.6	40.3	41.4	38.6	34.1	32.2	22.2	23.5	19.9	8.05
	Global Stunting	35.0	31.1	54.1	37.1	36.6	49.1	35.3	47.1	36.6	46.7	39.7	37.0	30.3	24.0	29.7	21.9	9.16
	Global Acute Malnutrition	16.4	14.0	28.5	16.2	18.6	16.7	21.6	21.6	17.4	18.1	17.1	18.1	18.5	12.9	13.2	12.8	4.08
MDG 2	Pre-School Education Enrollment	30.2	38.2	63.0	20.3	25.5	17.2	31.8	14.3	51.6	31.8	36.3	41.4	62.7	64.0	42.7	42.0	16.21
	Primary School Enrollment	66.1	39.5	36.1	64.3	86.4	44.8	66.0	79.4	80.8	77.2	69.4	84.5	88.5	84.7	89.4	93.7	18.74
MDG 3	Secondary School Enrollment	29.7	17.1	17.0	20.3	24.9	14.6	21.5	31.9	33.5	24.8	31.5	38.3	47.4	50.7	59.0	65.4	15.93
	FGM/C Prevalence	65.5	60.9	76.5	48.7	46.0	78.9	60.5	67.4	66.1	70.5	50.4	71.7	83.4	83.8	66.6	64.8	11.80
	Early Marriage (before 18)	37.6	53.9	33.2	62.2	49.4	46.2	33.9	39.5	48.1	37.1	48.8	35.7	27.3	20.5	28.2	27.5	11.65
MDG 4	Fully Immunized	49.4	34.1	35.1	64.7	38.6	40.6	43.4	65.1	42.7	37.0	58.8	54.9	40.0	60.4	62.6	60.9	11.90
	Infant Mortality Rate	8.2	7.0	6.6	13.7	8.8	7.6	5.9	9.0	10.0	8.1	10.2	7.9	6.9	6.5	7.0	7.5	1.98
MDG 5	Attended by Skilled Person at Birth	87.0	50.3	72.0	45.1	33.4	69.7	65.2	83.4	61.4	80.2	63.5	86.2	91.2	96.7	89.4	93.3	19.00
	Maternal Mortality Rate	0.417	0.581	0.556	0.578	0.615	0.466	0.618	0.509	0.591	0.532	0.564	0.503	0.443	0.437	0.422	0.389	0.07
MDG 6	Percentage with comprehensive knowledge of HIV/AIDS	5.7	5.4	4.2	5.4	0.8	4.8	3.5	2.0	5.1	3.7	11.0	7.1	3.8	4.8	5.8	9.0	2.54
MDG 7	Use of Improved Drinking Water Sources	81.1	82.6	85.6	54.0	54.5	68.5	78.4	82.4	72.8	78.8	61.3	64.3	81.1	93.2	97.6	96.3	14.01
	Use of Improved Sanitation Facilities	27.0	5.0	24.1	5.3	23.7	22.1	18.4	17.3	16.9	20.3	28.4	20.2	42.4	73.5	34.4	51.3	17.74
CP	Birth Registration	59.3	33.0	65.0	39.8	23.3	51.8	58.8	59.7	49.4	49.5	64.7	71.7	82.6	94.3	75.9	87.6	20.10
	People with Differenciated Abilities	4.9	4.4	3.7	4.6	6.2	4.5	5.0	5.0	5.9	5.9	4.9	4.7	5.0	2.5	4.5	4.1	0.92
		NATIONAL	SOUTH DARFUR	RED SEA	BLUE NILE	WEST DARFUR	KASSALA	NORTH DARFUR	SINNAR	SOUTH KORDOFAN	NORTH KORDOFAN	GADARIF	WHITE NILE	RIVER NILE	NORTHERN STATE	GEZIRA	KHARTOUM	Standard deviation

Conclusion
Uniting for the Children of Sudan

Sudan's 15 million children are part of a new era. Their Sudan is a very different place from that of their parents', its geography and economy transformed, for better or worse, by the secession of the Republic of South Sudan. Meanwhile, the July 2011 signing of the Doha Peace Agreement marks a potentially significant step towards ending eight years of conflict in Darfur; while in the East, recovery is ongoing since the 2006 Eastern Sudan Peace Agreement. The challenge now is to build on these historic events by making the right investments in children.

Already, children born today are much better off than they were when the MDGs were set more than a decade ago. As this report has shown, more children are surviving those first fragile months and years of life. More are enrolling and staying in school, with both primary and secondary school attendance rates higher than before. Fewer girls are being stripped of their basic human rights through early marriage and female genital mutilation and cutting (FGM/C).

Challenges remain, however, that will continue beyond the MDG deadline of 2015. Although enrolment in basic education has grown by almost 1.6 million children since the academic year 2000-2001, one out of six children -- or close to one million children still did not have any access to school in 2010.[1] Water from improved sources was still not accessible to 5.8 million people while three million people are still using unimproved sanitation facilities or practising open defecation. There are wide disparities between the states and localities. People living in IDP camps have more access to basic services than ever before, but it is unclear whether states have the capacity to sustain this coverage once IDPs return home.

Climate change and other environmental issues will continue to alter the livelihoods of families, prompting national and state-level governments to develop systems that protect children from drought, flood, and dwindling resources.

This report has tried to illustrate the situation of women and children in Sudan with the best available data. On the basis of this information, it is up to the government and its partners to take the next steps and build on the progress that has been achieved to date.

Greater Commitment

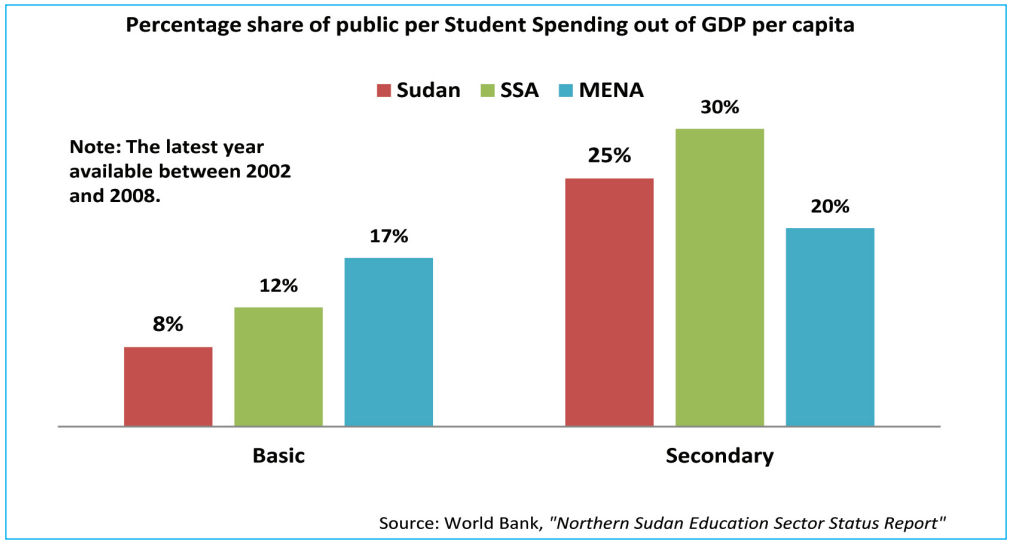
A common thread throughout this report is the need for greater commitment to equitable development for children at both state and federal levels. Identifying sectors that require the most attention and increasing financial allocations is necessary to sustain achievements and continue making progress. Strong legislation that is properly enforced is needed to identify vulnerable children and protect their rights.

1 "World Bank, 2012, The Status of the Education Sector in Sudan, Washington DC"

Investing in Children

While education spending has significantly increased over the past decade – reaching 2.7 per cent of GDP spending on basic education - it is still lower than average for the Middle East and North Africa (MENA) Region. The average public spending per student on basic education as a percentage of GDP per capita is only eight per cent, whereas the average for MENA countries is 17 per cent (Figure 1). Despite Sudan's policy of providing free basic education for all, families are actually bearing the majority of costs associated with school. A recent study by the World Bank estimates public expenditures on school running costs at approximately SDG 12 per student per year, mainly for recurrent expenditures like teacher salaries. This leaves families to pay around SDG 15 per student per year for other costs such as school maintenance, water and electricity, and supplementary teacher payments. In addition to this, households must pay for other items such as textbooks and uniforms.

Figure 1: Sudan has lower public per student spending on basic education compared to Sub-Saharan Africa (SSA) and Middle East and North Africa (MENA)



WHO and UNICEF recently reported that investing in connecting piped water directly to people's homes does contribute to broader social development. Between 1990 and 2008, 61 million people in North Africa gained such access. Consequently, a greater number of people had easy access to improved water and 14 million fewer people had to rely on hand pumps, boreholes and other shared sources.[2] As this report has shown, women and children often spend valuable time fetching water, time that could be spent in school, earning income for the family, or caring for children. In Sudan, the SHHS2 reports that only about a third of the population (33 per cent) has water piped into their dwelling or compound, leaving much room for improvement.

Maternal deaths could be reduced by 75 per cent if women had greater access to emergency obstetric care and skilled birth attendants, according to the United Nations Population Fund (UNFPA).[3] Shortages of trained staff and highly rural populations limit the availability of these services. For this reason, a recent assessment from the Population Council recommended that "the Government of Sudan should consider policies to encourage health care providers to work in remote areas, for example, by paying them a salary supplement or exempting them from taxes." The Ministry of Health should continue to build on their successful experiment of recently opened midwifery schools, and incorporate the training of nurses and midwives to manage obstetric emergencies. Similar initiatives have proven successful in Malawi and Mozambique.

Sudan can also look within its own borders for successful government investments. As this publication has shown, when states invest in children, promising results are seen. For example, River Nile state's investment in education resulted in increased attendance, greater gender equity and improved quality of education. (Low levels of child registration remained a barrier for proper planning for child education, health service delivery and enactment of child protection legislation). In Blue Nile state, the establishment of mobile birth registration teams ensured

2 World Health Organization and UNICEF, Progress on Sanitation and Drinking-Water: 2010 Update, Geneva and New York, 2010, p. 25

3 United Nations Population Fund, 'No Woman Should Die Giving Life, Facts and Figures 1', cited in the Population Council, 'Maternal and Neonatal Health Services in Sudan: Results of a Situation Analysis', Project Brief, Khartoum, February, 2010.

that more children in remote areas were officially recognized by the state. In North Kordofan, the SCCW has established a Family Tracing and Reunification programme that is putting hundreds, if not thousands, of separated and unaccompanied children in touch with reunification and care services.

There is a real risk that these services, as well as the potential for new ones, will be disrupted by the economic situation. Sudan's economy is likely to face enormous economic challenges with the loss of oil revenue potentially dropping by as much as 75 per cent[4] following the secession of South Sudan. This has been compounded by decreased foreign aid as the world struggles to recover from the financial crisis. Every effort must be made to preserve programmes that help Sudan's children, so that progress made over the past several years is not lost. Government safety nets, such as conditional cash transfers and food-for-education programmes, make it possible for people to keep their children in school, ensure that their children are healthy and fed, and protect them against exploitative situations. These are counter-recurring measures that will protect the vulnerable population in times of economic crisis or recession.

Establishing Protective Legal Frameworks

Children's rights must be recognized in the eyes of the state and rigorously protected and enforced by concrete laws. At national and state levels, much progress has already been made in introducing and passing legislation that establishes social protection and safety nets for children. Some states, such as South Kordofan, have persisted and succeeded in this area despite ongoing conflict and political turmoil. The following laws are already in existence, and serve as examples of what can be accomplished for child rights:

- *Child Act (2010):* Sudan promulgated the Federal Child Act in March 2010. This landmark law defines any person under the age of 18 as a child, increases the age of criminal responsibility from seven to 12, and criminalizes child exploitation and abuse. The Act also outlines a comprehensive juvenile justice system, bans the recruitment of children to armed forces and groups and contains provisions for their release and reintegration.
- *State Laws Criminalizing Female Genital Mutilation/Cutting:* Although the National Child Act does not criminalize FGM/C, the practice has been made unlawful in four states: South Kordofan (FGM/C Act, 2008), Red Sea (State Child Act 2011) Gadarif (State Child Act 2009) and West Darfur (State Child Act 2008). National replication is imperative, along with greater enforcement where laws already exist.
- *National Plan of Action for Birth Registration:* The plan has already been drafted and mandates of the various stakeholders that include civil register, Ministry of Interior, Ministry of Health and National Bureau of Statistics.
- *The Sudan Armed Forces Act (2007)*: In line with the Child Act, the SAF Act bans the recruitment of persons below 18 years of age to the armed forces.
- *Draft WASH Policy:* Currently in the process of approval by the Cabinet of Ministers, the policy aims to provide access to improved water and sanitation services to all schools by 2016.

Progress on the reform of children's legislation is laudable. However, some inconsistencies have emerged between the implementation of children's rights and other existing legislation. This has resulted in situations, for example, where children have been sentenced to death in clear violation of the Child Act. The incorporation of specific articles on children's rights in the new Sudanese Constitution would guarantee that child protection standards are incorporated into all national laws. Resources and commitment must be scaled up in order to ensure the enforcement of existing laws.

The establishment of Family and Child Protection Units in the police in 14 states has provided a building block for achieving justice for children. The quality of services requires further strengthening to combat the impunity of perpetrators of violence against children, and to guarantee the rights of children accused of offences. A major effort is also required to strengthen the capacity of social workers in implementing their statutory responsibilities for the care and protection of children.

Finally, the Sudanese Government will need to ensure that care and protection services are extended to all children

4 International Monetary Fund, 'Regional Economic Outlook: Middle East and Central Asia,' 2011, p. 18.

under its jurisdiction, regardless of their nationality or immigration status. In the context of the separation of Southern Sudan, a significant number of southern children residing in the north have been left without citizenship. Special efforts are required to combat discrimination against these children and to ensure their rights are guaranteed.

Addressing Inequity

As this publication has illustrated inequities exist in every state. Poverty and illiteracy are largely rural phenomena. Urban boys are the most likely to enrol and stay in school, and rural girls and nomads are the least likely. Children in the richest quintile are almost twice as likely to receive all the vaccinations they need to protect themselves as those in the poorest. Nomadic children are rarely registered at birth, rendering them invisible to the state. Urban children are almost three times as likely to have access to improved sanitation facilities as rural children. Even within the better-performing urban areas, street children remain excluded from basic social services.

Such disparities result from unequal allocation of public and private sector resources, and imbalances in power between urban and rural areas. In addition, efforts by the government and international communities to achieve MDG targets have often neglected marginalized children in favour of those who are easier to reach.

Reaching the most marginalized children is imperative to social equality and economic growth. A recent UNICEF study found that targeting marginalized areas can actually accelerate progress toward the MDGs. For every US$1 million spent in these areas, an additional 60 per cent of deaths can be averted. The reason for such high returns is that most excluded populations tend to have higher fertility rates and thus there are more children to reach; they also tend to have higher child mortality rates due to causes that are easily prevented, and they have the most to gain from cost-effective interventions.[5]

The first step is to identify the most vulnerable children. Reliable data gathered through the SHHS2, the National Baseline Household Survey, the National Census and other disaggregated surveys are a starting place for pinpointing excluded groups.

Policies and programmes too often neglect the most vulnerable and data can be a powerful tool to address this. For example, policies such as free and compulsory education and free birth registration are important, but data shows that there are still barriers to their utilization in rural areas. Incentives such as cash transfers and school feeding programmes have proven effective in increasing school attendance among girls and marginalized groups. In other cases, it is simply a matter of building capacity through increased and improved resources, such as more health facilities with qualified staff.

In Blue Nile state, for example, the combined incentives of child-friendly classroom construction and rehabilitation, teacher training and a school feeding programme resulted in increased enrolment of first grade children between 2009 and 2010, including 1,320 nomadic children. During the same period, the percentage of girls enrolled in first grade also increased from 43 to 47.6 per cent.

Meanwhile, the recently finalized WASH national policy has clear community prioritization statements based on the level of access to WASH services which will help reduce disparities.

Ensuring Smooth Transitions from Conflict to Development

Ongoing armed conflict is a reality in Sudan. This has had both a direct and an indirect impact on the quality and level of the country's past performance and its progress towards achieving the MDGs. In such situations there is a need to ensure that coping mechanisms for children are established. These should include:

- The provision of safe education in emergencies;
- Release and reintegration of children associated with armed groups and forces;
- Identification and reunification of children separated from their families during conflict situations;
- Provision of safe access for humanitarian workers to conflict-affected areas;
- Ensuring the continuity of health, education, water and sanitation and other basic services as displaced people return home to their communities.

5 United Nations Children's Fund, Narrowing the Gaps to Meet the Goals, New York City, 7 September 2010.

Resolving the situation of millions of displaced people is raising a new set of challenges. An estimated 2.5 million IDPs are living in Sudan.[6] For many, access to basic services -- such as health, nutrition, education and water and sanitation – has never been better than in IDP camps. Now, the UN and the Government of Sudan are supporting the voluntary return of IDPs, particularly in the Darfur region. It is therefore important to improve the situation in the places of return so that the returnees will have sufficient access to basic services.

In South Darfur, the State Ministry of Education reports that at least 385 schools are not functioning due to insecurity. The shortage of facilities is compounded by a limited number of teachers and supplies. In West Darfur, there are only ten hospitals and 13 health centres serving the entire state of 1.3 million people, according to the 2008 census.[7] Landmines and UXOs are still a major threat in South Kordofan. One survey identified 48 mine-impacted communities affecting some 293,000 people. (That number is likely to have increased in light of the 2011 conflict.[8]) Ensuring that progress continues will take significant and ongoing efforts.

In the absence of a National IDP Policy, international guidelines must be promoted to ensure the protection and assistance of IDPs while they are displaced as well as during their return and reintegration. The Guiding Principles on Internal Displacement[9] and the Framework for Durable Solutions[10], for example, should be disseminated and considered when determining the sustainability of return.

Partnerships

Sudan's progress to date has been made possible by partners coming together for children. This includes not only government members and non-government organizations, but also community groups, religious organizations, parents and children themselves.

One good example of partnership is the recent initiation of the cluster approach through the establishment of sectoral working groups. These working groups provide a coordinated response to emergencies by drawing on the individual expertise of multiple organizations. Government is progressively taking on a role as a leading partner at the field level.

One of the biggest obstacles to partnerships today is the limited access to some of the country's most vulnerable areas due to poor road infrastructure and insecurity for humanitarian actors.

Another challenge is the struggle to maintain partnerships in non-conflict affected areas. In today's difficult financial climate, limited government and international funding is being allocated unevenly. Immediate crises in Abyei, South Kordofan and Darfur are diverting attention away from daily struggles in Sinnar, River Nile and Kassala. In Red Sea, for example, an important food-for-education partnership between UNICEF and WFP will be dissolved in 2012 when WFP pulls out of the state due to financial constraints. When national budgets are being decided, children in these states must not be forgotten.

Data Collection

Data that is disaggregated by gender, income, age and location is a precondition to understanding how best to respond to the needs of children. It drives decision-making in all areas, from education planning, to ordering supplies for health clinics, to preparing for the return and resettlement of IDPs. Sudan has made significant strides in the area of data collection.

For example, the National Baseline Household Survey, conducted by Sudan's Central Bureau of Statistics, has contributed to the analysis and understanding of living conditions in Sudan through three rounds of surveys (1967, 1978, 2009). The population census has also had a significant impact, and has been tracking demographic trends

6 Latest figures from UNOCHA. The number is expected to have dropped due to the return of southerners.

7 Government of Sudan Central Bureau of Statistics, 'Statistical Year Book for the Year 2009', Khartoum, 2009, p. 231.

8 United Nations Mine Action Office, Landmine Impact Survey, 2010

9 Prepared by the Representative of the UN Secretary General on Internally Displaced Persons following the request of the UN General Assembly and UN Commission on Human Rights; UN Doc. E/CN4/1998/53 Add2; Available under UNOCHA, Guiding Principles on Internal Displacement, September 2004.

10 Brookings I, Project on Internal Displacement, When Displacement Ends, Framework for Durable Solutions for Internally Displaced Persons, May 2007.

since 1957. A recent contributor to data on children is the Sudan Household Health Survey, released jointly by the Government of Sudan and UNICEF. Web-based SudanInfo (http://www.devinfo.info/sudaninfo) will be updated accordingly.

A growing emphasis is being placed on the importance of data collection. Some institutions -- such as the SCCWs -- are developing the ability and systems to collect information based on programme requirements from agencies. While they are being used mainly to satisfy reporting requirements, they have the potential to inform decision-making. Also worthy of mention are the teams of social workers that are reaching out to communities and documenting cases.

The WASH sector is maintaining a functional countrywide database with good reporting and mapping systems that includes around 30,000 records on available water and sanitation facilities and hygiene interventions at community and schools levels. A website is also functioning (http://www.wes-sudan.org/) and provides WASH technical and management reports. However, improvements are still required on the completeness, quality and utilization of the information.

In addition, there has been some improvement in the health and nutrition information system. The results of a completed study on the National Health Accounts will provide a better understanding of household health service utilization, expenditure and financing sources, and of major health providers in Sudan.

The Education Management Information System (EMIS) Development Project, launched by the Ministry of Education, meets the need to have an information management system that can monitor learning outcomes and assist policy makers in making informed, evidence-based decisions for sector management and policy formulation.

Challenges remain. In some areas, such as South Darfur's Jebel Marra region, poor data collection is an indication of the limited contact stakeholders have with the communities. In the area of child protection in particular, reliable data is generally lacking.

Sudan must continue to develop new and improved existing data collection systems so that they are routine, disaggregated by sex, income, geography, and age, and are better able to identify vulnerable groups. Qualitative data is also essential for in-depth analysis especially in sensitive and complex issues such as FGM/C and other traditional practices affecting children and women.

To build consensus on data collection strategies and avoid duplication of efforts, the Central Bureau of Statistics needs to collaborate with national agencies as well as with International organizations for the standardization of tools and methods in carrying out household surveys, and support establishing sectoral databases. UNICEF and other sister UN agencies should support the government's capacity in quality assurance and analytical survey techniques.

Uniting for Women and Children

Progress made in Sudan over recent years has saved and added value to many lives. The opportunity for peace and equitable human development is within reach. There is no need to wait -- the necessary data and knowledge on what to do is available to clearly determine the areas, the needs and the anticipated achievements. With strong political will, adequate financial commitment and dedicated partnerships, Sudan can guarantee the protection and enrichment of its most important resource - its children.

The National Council for Child Welfare - Secretariat General.
Parliment Street, South of Administration Development Centre
E-mail: info@nccw.gov.sd- www.nccw.gov.sd

United Nations Children's Fund. Sudan Country Office. P.O Box 1358.
Block H, Plot 6, Manshiya,Telphone:+249 (0) 156 553 670
E-mail: khartoum@unicef.org - www.unicef.org/sudan