SUDAN TRANSITION & RECOVERY DATABASE

Budi County

Version 3, September 2005

INFORMATION MANAGEMENT UNIT FOR SUDAN
OFFICE FOR THE COORDINATION OF HUMANITARIAN AFFAIRS
IN ASSOCIATION WITH
THE NEW SUDAN CENTRE FOR STATISTICS AND EVALUATION

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Preface

STARBASE has been a collaborative effort and thanks are due to all who have contributed their time and effort. The Government of Sudan , particularly the Humanitarian Aid Commission (HAC) and the Sudan People's Liberation Movement (SPLM), predominantly through the Sudan Relief and Rehabilitation Commission (SRRC) and the New Sudan Centre for Statistics and Evaluation (NSCSE) provided information and staff-time towards the exercise. The project was initiated by OCHA, inspired by an initial idea from UNICEF, who provided some of the original reports; WFP helped in database design and maps; UNDP provided additional funding. These UN agencies, and others such as WHO and FAO, provided much useful data and survey information. Partners in Operation Lifeline Sudan (OLS), as well as non-OLS NGOs provided and reviewed information. Special thanks are due to Save the Children-UK, Catholic Relief Services, Adventist Development and Relief Agency, Medecins sans Frontieres - Belgium and many other NGOs.

Please note that the data on which these analyses are based have their limitations. We have done our best to scrutinise and crosscheck where we can. Coverage, comparability, methodology and verification difficulties have been obvious constraints, so your help in correcting and updating these reports is welcomed and essential.

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Acronyms

AAH	Aktion Afrika Hilfe
ACAD	Abyei Community Action for Development
ACF-USA	Action Contre le Faim -United States of America
ACHA	Africa Centre for Human Advocacy
ACORD	Agency for Co-operation and Research in Development
ACROSS	Association of Christian Resource Organisations Serving Sudan
ACT	Action of Churches Together
AD	Africa Drilling
ADRA	Adventist Development and Relief Agency
AET	Africa Educational Trust
AFP	Acute Flaccid Paralysis
AGC	Africa Growth Creation
AHA	Animal Health Auxiliary
AIC	African Inland Church
AIDS	Acquired Immune Deficiency Syndrome
AMA	Assistance Mission for Africa
AMREF	African Medical Research Foundation
AMURT-S	Ananda Marga Universal Relief Team - Switzerland
ANA	Annual Needs Assessment
ANV	Association for Napata Volunteers
ARC	American Refugee Committee
ARI	Annual Risk of Infection
ASAP	Appeal Process for the Sudan Assistance Programme
AWDA	Aweil West Development Association
BCG	Bacillus Calmette Guérin
BEG	Bahr el Ghazal
BYDA	Bahr el Ghazal Youth Development Agency
C&D	Church and Development
CAP	Consolidated Appeal Process
CAR	Central African Republic
CARE	Cooperation for Assistance/Relief Everywhere
CBAHW	Community Based Animal Health Workers
CC	Community Centre
CCM	Comitato Collaborazione Medica CEAS
CDC	Center for Disease Control
CDS	Church Development Services
CEAS	Church Ecumenical Action in Sudan
CFSAM	Crop and Food Supply Assessment Mission
CHW	Community Health Worker
CISP	Community Initiation Support Programme
CMA	Christian Mission Aid
CONCERN	Concern Worldwide
COOPI	Cooperazione Internazionale
COSV	Coordination Committee for Voluntary Service
CPA	Comprehensive Peace Agreement

Acronyms

CPMT	Civilian Protection and Monitoring Team
CRS	Catholic Relief Services
CS	Comboni Sisters
CTC	Community Therapeutic Centre
DDR	Disarmament, Demobilisation and Reintegration
DEA	Diakonie Emergency Aid
DEO	Diocese of El Obeid
DEPHA	Data Exchange Platform for the Horn of Africa
DOE	Diocese of El Obeid
DOR	Diocese of Rumbek
DOT	Diocese of Torit
DOTS	Direct Observed Therapy Short Course
DOTY	Diocese of Tambura and Yambio
DOY	Diocese of Yambio
DPT	Diphtheria, Pertussis, Tetanus
DRC	Democratic Republic of Congo
ECS	Episcopal Church of Sudan
EP&R	Emergency Preparedness and Response
EPI	Expanded Programme on Immunisation
ESFP	Emergency School Feeding Programme
EWARN	Early Warning Alert and Response Network
FAO	Food and Agricultural Organization
FEWS	Famine Early Warning System
FEWSNET	Famine Early Warning System Network
FFR	Food For Rehabilitation
FFT	Food for-Training
FFW	Food for-Work
FGM	Female Genital Mutilation
FRRA	Fashoda Relief and Rehabilitation Association
FYF	Fashoda Youth Forum
GAM	Global Acute Malnutrition
GARDO	Gajaak Relief & Development Organization
GARDOS	Global Relief and Developement Organisation for Sudan
GED	German Emergency Doctors
GER	Gross Enrolment Ratio
GFD	General Food Distribution
GOAL	GOAL South Sudan
GoS	Government of Sudan
HAC	Humanitarian Aid Commission
HARD	Hope Agency for Relief and Development
HASS	Humanitarian Assistance for South Sudan
HEA	Household Economy Approach
HH	Household
HIV	Human Immunodeficiency Virus
HIV/AIDS	Human Immune Virus/ Acquired Immune Deficiency Syndrome

Acronyms

HN	Healthnet
IARA	Islamic African Relief Agency
IAS	International Aid Sweden
ICRC	International Committee of the Red Cross
IDEAS	Institute of Development Environment and Agricultural Studies
IDPs	Internally Displaced Persons
IMC	International Medical Corps
IMCI	Integrated Management of Childhood Illnesses
IOM	International Organisation for Migration
IRAD	Imotong Ranges Association for Development
IRC	International Rescue Committee
ITNs	Insecticide Treated Nets
JAM	Joint Assessment Mission
JARRAD	Jonglei Association for Relief, Rehabilitation and Development
JRS	Jesuit Relief Services
K	Kononia
KAP	Knowledge Attitude and Practice
Kcal	Kilocalories
Kg	Kilogramme
LDRO	Latjor Development and Relief Organisation
LRA	Lord's Resistance Army
LT	Long-Term
LTA	Long-Term Average
LWF	Lutheran World Federation
MASRA	Magwe Action for Self Reliance Association
MC	Mercy Corps
MCDI	Medical Care Development International
MCHW	Maternal Community Health Worker
MDG/I/T/R	Millennium Development Goal/ Indicator/ Target/Report
MEDAIR	MEDAIR South Sudan
MEDIC	Medical Emergency Development International Committee
MICS	Multiple Indicators Cluster Survey
mm	Millimetres
MMNT	Measles and Maternal Neonatal Tetanus
MMOC	Mary Mother of Christ
MoU	Memorandum of Understanding
MRDA	Mundri Rehabilitation & Development Association
MSF	Medicins sans Frontieres
MSF-B	Medicins sans Frontieres -Belgium
MSF-CH	Medicins sans Frontieres -Swirzerland
MSF-F	Medecins sans Frontieres France
MSF-H	Medicins sans Frontieres Holland
MSF-S	Medecins sans Frontieres - Switzerland
MT	Metric Tonnes
MUAC	Mid Upper Arm Circumference

Acronyms

N/A	Not Available
NCA	Norwegian Church Aid
NCDA	Nasir Community Development Agency
NCDS	Naath Community Development Services
NDO	National Development Organisation
NER	Net Enrollment Ratio
NGO	Non-Governmental Organisation
NIDs	National Immunisation Days
NLC	National Liberation Council
NMPACT	Nuba Mountains Programme Advancing Conflict Transformation
NPA	Norwegian People's Aid
NRRDO	Nuba Relief Rehabilitation and Development Organisation
NSCC	New Sudan Council of Churches
NSCSE	New Sudan Centre for Statistics and Evaluation
NSWF	New Sudan Women's Federation
NWC	National Water Corporation
OCHA	Office for the Coordination of Humanitarian Affairs
OFDA	Office of United States Foreign Disaster Assistance
OLA	Oromo Liberation Army
OLS	Operation Lifeline Sudan
OPV	Oral Polio Vaccine
ORS	Oral Rehydration Salt
OSIL	Operation Save Innocent Lives
OXFAM-GB	Oxfam - Great Britain
OXFAM-Q	Oxfam - Quebec
PACT	Partnership Agencies Collaborating Together
PACTA	Programme Advancing Conflict Transformation in Abyei
PCOS	Presbyterian Church of Sudan
PDF	People's Defence Forces
PHCC	Primary Health Care Centre PHCU
PRDA	Presbyterian Relief and Development Agency
PSI	Population Services International
RASS	Relief Association of Southern Sudan
RDF	Resource Development foundation
RFE	Rainfall Estimates
ROOF	Relief Organization of Fazugli
RUMYU	Rumbek Youth Union
SALT	Serving And Learning Together
SAM	Severe Acute Malnutrition
SBA	School Baseline Assessment
SBEP	Sudan Basic Education Programme
SCF-UK	Save the Children - United Kingdom
SCLS	Save the Children Lives Sudan
SC-S	Save the Children Sweden

Acronyms

SC-UK	Save the Children - United Kingdom
SC-USA	Save the Children USA
SEDA	Sudan Education and Development Agency
SEM	Sudan Evangelical Mission
SFC/P	Supplementary Feeding Centre/Programme
SFM	Swedish Free Mission
SHS	Sudan Humanitarian Services
SIAS	Sub Immunisation Activities
SIC	Sudan Interior Church
SIDs	Sub Immunisation Days
SIL	Summer Institute of Linguistics
SIMAS	Sudan Integrated Mine Action Service
SINGO	Sudan Indigenous Non Governmental Organisation
SMC	Sudan Medical Care
SNIDs	Sub National Immunisation Days
SOE	Secretariat of Education
SOH	Secretariat of Health
SP	Samaritan's Purse
SPDF	Sudan People's Defence Force
SPLM/A	Sudan People's Liberation Movement/Army
SRC	Sudan Red Crescent
SRRA/C	Sudan Relief and Rehabilitation Association/Commission
SRRC	Sudan Relief and Rehabilitation Commission
SRT	Sustainable Returns Team
SSDO	South Sudan Development Organisation
SSI	Sudan Service International
SSIM	South Sudan Independent Movement
SSOM	Southern Sudan Operation Mercy
SSS	Sentinel Site Survey
STD	Sexually Transmitted Disease
STIs	Sexually Transmitted Infections
SUHA	Sudan Health Association
SUPRAID	Sudan Production Aid
SYCP	Sudanese Youth Consolidation Program
T/EFMDA	Tambura/Ezo Farmers Marketing Development Agency
TB	Tuberculosis
TBA	Traditional Birth Attendants
Tearfund-UK	The Evangelical Alliance Relief Fund - United Kingdom
TF	Tearfund
TFC	Therapytic Feeding Centers
TSU	Technical Service Unit
TT	Tetanus Toxoid
UN	United Nations
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund

Acronyms

UNHCR	United Nations High Commission for Refugees
UNICEF	United Nations Children's Fund
UNICEF OLS	United Nations Children's Fund Operation Lifeline Sudan
UNMAS	United Nations Mines Action Service
UNOCHA	United Nations Office for the Coordination of Humanitarian Affairs
UPDF	Uganda People's Defence Force
USAID	United States of America Agency for International Development
UXOS	Unexploded Ordnances
VSF	Veterinaires sans Frontieres
VSF-B	Vétérinaires sans Frontiéres-Belgium
VSF-CH	Veterinaires sans Frontieres - Switzerland
VSF-G	Veterinaires sans Frontieres - Germany
VSF-S	Vétérinaires sans Frontiéres - Switzerland
VST	Vetwork Services Trust
WES	Water, Environmental and Sanitation
WFP	World Food Programme WHO
WHO	World Health Organization
WODRANS	Widows Orphans Disabled Rehabilitation Association for New Sudan
WR	World Relief (Previously WRI- World Relief International)
WUN	Western Upper Nile
WVI	World Vision International
YAFA	Yambio Farmers Association
YARRDSS	Youth Agency for Relief, Rehabilitation and Development for South Sudan
YFA	Yambio Farmers Association
YWAM	Youth With A Mission
ZOA	ZOA Refugee Care

Map 3-05: Budi County

Legend

- Waterpoints
- Health Facilities
- Primary Towns
- Secondary Towns
- Primary Unpaved Roads
- Secondary Unpaved Roads
- Tracks
- Streams
- Swamps and Marshes
- Payam Boundary
- budi_county

0 4.5 9 18 27 36 45 Kilometers

N

The boundaries and names shown on this map are approximate and do not imply official endorsement/ acceptance by the United Nations.

1. Demographic/ Geographical Information

Budi County lies in Eastern Equatoria State in the Equatoria region.[1] It was part of Kapoeta County until 1999, when it was carved out to form a separate county.[2] It borders Kapoeta County to the east, Torit County to the west, Uganda to the south and Kenya to the southeast.

Budi County is inhabited by the *Buya* and *Didinga* tribes who make up 20-30% and 70-80% of the total population respectively.[3] The *Buya* occupy most of the lowlands of Kimatong and Ngarich *payams*, while the *Didinga* occupy the remaining southern payams of the county. Both communities are agro-pastoralists.

A 2004 report by the United Nations Children's Fund (UNICEF) and the New Sudan Centre for Statistics and Evaluation (NSCSE) derived population estimates based on World Health Organisation (WHO) National Immunisation Days (NIDs) campaign figures. The NSCSE figures are believed to be closer to the actual population. The NSCSE population figure for Budi County in 2004 was 128,385.This population figure excludes figures for 5 *payams* (Lotukei, Komiri, Loudo, Ngarich and Nagishot) which were not available. Results of the World Food Programme (WFP) Annual Needs Assessment (ANA) indicate a total population of 190,200 people.

Table 1 shows the NIDs and NSCSE population estimates by *payam* (administrative division) for 2003 and 2004.

Table 1: Population Estimates for the Payams of Budi County

Payam	NIDS 2003	NSCSE 2003	NIDS 2004	NSCSE 2004
Kimatong	49,067	40,422	49,067	40,419
Lotukei	N/A	N/A	N/A	N/A
Komiri (including	58,480	N/A	58,480***	48,176***
Loudo	N/A	N/A	N/A	N/A
Lauro	121,011	100,020	48,300	39,790
Ngarich	N/A	N/A	N/A	N/A
Nagishot	N/A	N/A	N/A	N/A
Budi County	**228,558**	**140,442**	**155,847**	**128,385**

Source: NIDs, NSCSE Assessment Data, ***2003 and 2004***
No NIDs were conducted in the County in 2002.

** *Data Exchange Platform for the Horn of Africa (DEPHA) does not consider Nagishot to be a payam.*
*** *Chukudum town population figures*

[1] *Administrative Divisions in Rebel Areas Of Southern Sudan*, December 2001.
[2,3] WFP, *Annual Needs Assessment 2002/2003 Budi County,* December 2003.

2. Administration

Budi County is divided into seven *payams* (administrative divisions): Kimatong, Ngarich, Lauro, Komiri, Loudo, Lotukei and Nagishot (Central). Each *payam* is further subdivided into a number of *bomas*. An administrator is in charge of the *payam* while another administrator is in charge of the *boma*.[4]

The county has been under the control of the Sudan People's Liberation Movement/ Army since 1987. An SPLM/A county secretary (formerly a commissioner) is the administrative and political leader of the county. Chukudum, in Komiri Payam, is the administrative headquarters of the county.[5]

3. Infrastructure

Budi County has one airstrip located in Chukudum town. It is 15 x 800 m wide and Buffalo aircraft are able to land on it.[6] The county is accessible by road from both Kenya and Uganda, though access is difficult during the wet season. The Kapoeta-Lauro road was opened as a result of the Didinga-Toposa peace agreement of February 2003. This made it possible for an assessment team to physically access Lauro Payam for the first time.[7] The opening of the Kapoeta to Lauro road and Natinga to new Cush and Lotukei road has boosted the economic activities of the county.

[4,5] NSCSE (formerly SRRC), *Data Monitoring Unit - Rumbek,* 2004.
[6] WFP, *Flight Office,* 2004.
[7] WFP, *Annual Needs Assessment 2003/2004 Budi County,* 2004.

4. Security

There have been three main causes of insecurity in the county: fighting between the SPLM/A and a rebel force, cattle rustling and attacks from militia groups.

Firstly, there was frequent fighting between the SPLM/A and the forces of Commander Peter Lorot who rebelled against the SPLM/A in 1999. This dispute is known amongst the *Didinga* as the "Chukudum Crisis". During this crisis, houses and property were burnt down by the SPLM/A and about 16,800 people were displaced from Chukudum to nearby villages in the highlands where they shared land with relatives. The crisis was resolved in August 2002 during the Chukudum Peace Conference organized by the New Sudan Council of Churches (NSCC).[8] As a result, fighting subsided and the situation became more stable.

The second major cause of instability in Budi County is cattle rustling. Frequent cattle raiding attacks from neighbouring tribes - such as the *Logiri* of Torit and the *Toposa* of Kapoeta - continue to be a major threat to general security in Budi County. This is in spite of the Didinga-Toposa peace agreement signed on February 14, 2003.[9] In April 2003, a grass roots peace initiative was organised by a non-governmental organization (NGO) known as PAX Cristi International among the warring groups of Torit and Budi counties in Kipepo Valley.[10] Following the singning of the peace agreement with the Toposa , there was increased road traffic and movement of goods and services to the area in 2004.

In 2004 insecurity continued mainly due to various militia groups, including the Lord's Resistance Army (LRA) from Uganda.[11] The LRA is led by Joseph Kony, and operates in the north of Uganda and operates from a base in Southern Sudan.

Land Mines

During the "Chukudum Crisis", Komiri and Nagishot *payams* were laid with mines by the SPLM/A, forcing the local residents to disperse. The Chukudum -Nagishot road and the Kapoeta road junction from Kimatong to Riwoto are also thought to be mined.[12] The WFP Annual Needs Assessment (ANA) for 2002/03 recommended that the United Nations Mines Action Service (UNMAS) assess Komiri Payam for mines. The effect of landmines in the area is evident from the number of cases treated in the local hospital. Twelve cases of landmine injuries were reported in 2002.[13]

Flight Bans

The long-standing Government of Sudan (GoS) flight ban imposed on eastern Equatoria affected Budi County. However, the county continued to receive humanitarian assistance through land transport.

[8] Reliefweb, *Chukudum Crisis Peace Conference*, (www. Reliefweb.int) 20 Aug 2002.
[9] WFP, *Annual Needs Assessment 2003/2004 Budi County*, 2004.
[10] WFP, *Southern Sudan OLS Monthly Report,* April 2003.
[11] IrinNews.org, *UGANDA-SUDAN: UPDP clashes with LRA inside Sudan,* Wednesday 17 March 2004.
[12] UNMAS list as of 12 December 2002.
[13] NPA, *NORAD Frame Agreement Mid year Report*, 2002.

5. Displacements & Returns

In 1999, the Chukudum Crisis forced the residents of Komiri Payam to seek refuge in the hills of Nagishot Payam. It is estimated that 16,800 people were internally displaced and had not returned by December 2004, due to landmines on their farms.[14] In October 2003, a total of 21,978 Internally Displaced Person (IDP) returnees arrived from North Sudan and settled in Lauro Payam.[15] No information is available on returnees within the county for 2004.

The projected returnees in Budi County in 2005 are expected to be 1,063.[16] The numbers of IDPs that may leave the county are not available due to lack of information. The available information is summarised in Table 2 below.

Table 2: Displacements and Returns in Budi County

Year	IDPs/Returnees	Origin	Payam settled	Number of persons
1999	IDPs	Komiri	Nagishot	16,800
2003	IDPs	North	Lauro	21,978
2004	IDPs/returnees	N/A	N/A	N/A
2005 (projection)	IDPs/returnees	N/A	N/A	1,063

Source: Various

There is no information as to why Budi County has shown a downward trend in the number of returnees from 2003. Since Budi County is an area of tribal conflict,[17] this may be the reason for the decrease.

[14] WFP, *Annual Needs Assessment 2003/2004 Budi County*, 2004.
[15] WFP/TSU, IDP/ *Returnee Database*, 2004.
[16] NSCSE/UNICEF, *Towards a Baseline*, 2004. (Using updated NIDs 2004 figures.)
[17] WFP, *Sudan Progress Report, Road Repair and Demining Activities As At May 10*, 2005,2005.

6. Demobilisation

No information is available for Budi County on the number of demobilised child soldiers. However, the number of child soldiers who were demobilised from Kapoeta County (from which Budi is carved out of) in 2002 was 71 children. The demobilisation programme offered re-adjustment training, material support and tracing of families prior to facilitating the safe return of the children to their original homes.

7. Millennium Development Goals

In September 2000, 189 member states were signatories to the Millennium Declaration (MD) which aimed at realizing global peace, security and human development by 2015. The MD was articulated through the following Millennium Development Goals (MDGs): eradication of extreme poverty and hunger, achievement of universal primary education, promotion of gender equality and empowerment of women, reduction of child mortality, improvement in maternal health, combating HIV/AIDS, malaria and other diseases, ensuring environmental sustainability, and developing a global partnership for development.[18] These goals are in the process of being translated into medium- to long-term economic and human development targets for Sudan and its individual counties.

The attainment of the MDGs has not been prioritised in South Sudan because the primary focus has been on meeting emergency needs rather than on development and reconstruction. However, the SPLM/A has since included their achievement as integral to the eradication of poverty in post-conflict South Sudan.

The recently produced interim 2004 Millennium Development Goals Report (MDGR) for South Sudan highlights the status of South Sudan for each of the MDGs. It includes the challenges, as well as the policy and programming environment. The report also makes recommendations for achieving the MDGs and is expected to be the cornerstone in monitoring their future progress. Key to this will be the development of a monitoring mechanism (with Sudan-specific MDG indicators) which will allow for collection of disaggregated data (by gender, region/state, and county).

In the interim and for purposes of this exercise, available data from previously developed proxy indicators from the UN Inter-Agency Consolidated Appeal for the Sudan Assistance Programme (ASAP)[19] and MDGR will be used to show the status of Budi County. The annexes show the global millennium development goals, targets and indicators as they relate to Budi County and South Sudan.

Where possible, an analysis of MDG indicators in Budi County is presented throughout the remaining sections of this document.

[18] UNDP, *Millenium Development Goals: A compact among nations to end human poverty,* 2003.
[19] UN, *Consolidated Appeal for the Sudan Assisstance Programme*, 2004.

8. Agro-ecological Zones

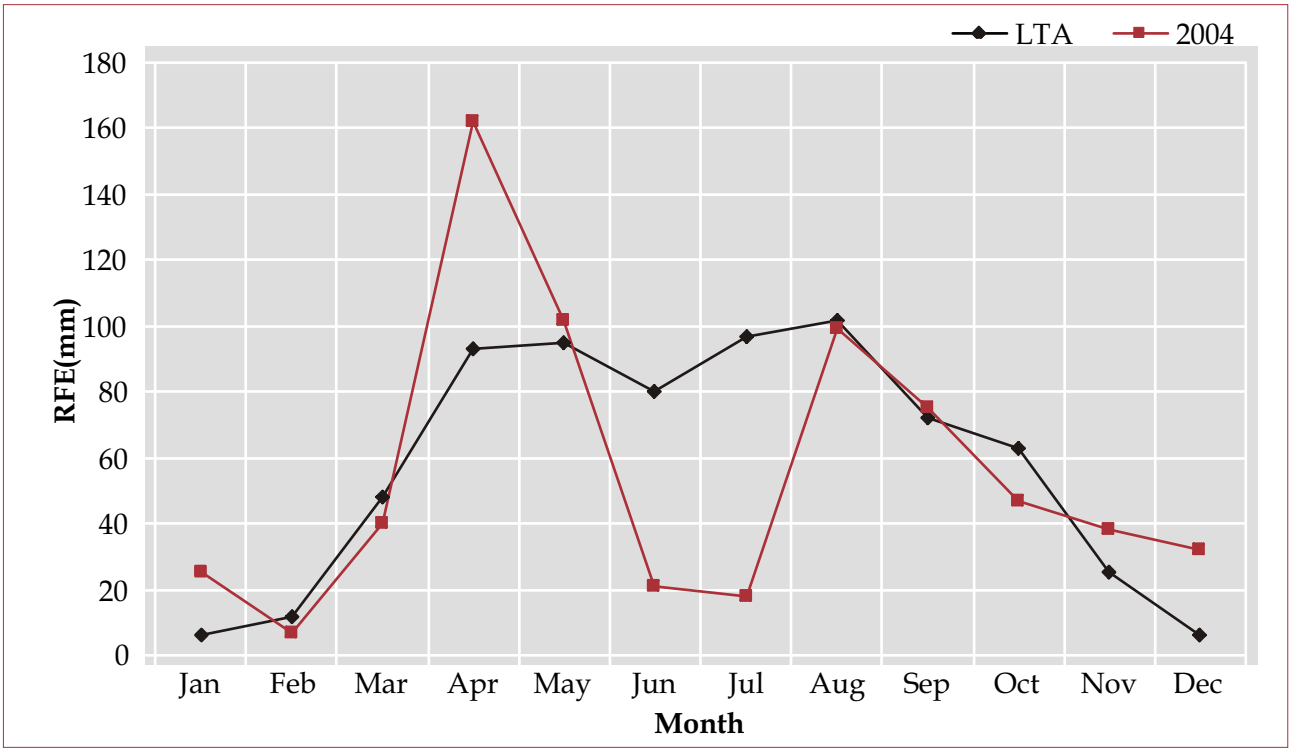
According to the WFP ANA report of 2002, Budi County falls within two agro-ecological zones: the lowlands descending from the east towards the west of the Kidepo River, and the highlands running north-south along the eastern border with Kapoeta County.

The highlands have favourable climatic conditions, with two rainy seasons; March-September and October-February. These areas also experience a food surplus in a normal year. The lowlands have only one long planting season from March to September and are prone to frequent periods of food insecurity.

In a year of sufficient rainfall and relative security, Lauro, Nagishot, Loudo and Komiri experience a food surplus whilst Kimatong, Ngarich and Lotuke suffer a food deficit. For the last few years, Budi County has experienced erratic rainfall patterns, which have reduced the level of food production in most parts of the county.[20]

In 2003 the rainfall pattern was similar to the long-term average (LTA) for Budi County, with the exception of a peak between March to May which was higher than the long term average for the county. In 2004, rainfall not only started late, but was also erratic and inadequate. Figure 2 shows the rainfall pattern for Budi County in 2004 compared to the LTA. The peak for the second rainfall season was below the LTA.

Figure 1: Rainfall Estimate for 2004 Compared to Long-Term Average (LTA) in Budi County.



Source: FEWSNET, *Southern Sudan, County Rainfall Estimates (RFE), 2004 & Long-term Averages (LTA) collated over a period of 30 years.*

[20] WFP, *Annual Needs Assessment 2003/2004 Budi County*, 2004.

9. Food Security

MDG1 proposes to eradicate extreme poverty and hunger by halving the proportion of people whose income is less than a dollar a day, and halving the proportion of people who suffer from hunger by 2015. Although data for some of the indicators for MDG1 are not available, for instance, the poverty gap ratio, the indicator on the proportion of population below minimum level of dietary consumption can be estimated using available socio-economic information. The assumption is that anyone surviving on less than 2100 kcals is below the minimum level of dietary energy consumption.

Insecurity and inclement weather have contributed greatly to a high level of food insecurity in Budi County. The prolonged dry spell in 2004 led to a reduction in crop yields, livestock production and trading opportunities. Insecurity also hampered crop production and led to a decline in livestock. An estimated 60% of the population had a food deficit in 2004 compared to 40-50% in 2003, and approximately a quarter of the 2004 population is projected to receive food aid in 2005. In terms of food security - when considering crops and livestock - the worst *payam* in Budi County is Lotukei. It is followed by Kimotong and Komiri, Ngarich, Lauro, and Luodo. Nagishot/Central is the most food secure *payam*.[21]

Socio-economic groups

The socio-economic categories used in the food security section are derived from the Household Economy Approach (HEA)[22] developed by Save the ChildrenUK (SC-UK). This approach is widely used as a survey approach by food security agencies in southern Sudan. The wealth categories are based on local perceptions of socio-economic status in a particular community.

The *Didinga* and *Buya* tribes depend on agriculture and livestock for their livelihood. Amongst the *Didinga*, ownership of granaries of threshed grain and livestock determine wealth.[23] The *Buya* determine wealth mainly by the number of livestock owned. Livestock play a central role in the lives of the people and are used (either killed for food or exchanged) during initiation and marriage rites.[24] In both communities therefore, livestock ownership is essential. Table 3 shows the socio-economic status of the Poor, Middle and Better-off households of the Budi population in 2003 and 2004.

Table 3 : Socio-Economic Groups in Budi County in 2003 and 2004

	Poor	Poor	Middle	Middle	Better-off	Better-off
	40-50%	60%	20-30%	30%	25-35%	10%
	2003	2004	2003	2004	2003	2004
No. Of cattle/household (HH)	0-5	0-5	6-10	10-13	7-14	15-30
No. of goats and sheep /HH	5-7	5-10	10-12	25-30	15-25	50-80
No. of chickens/HH	N/A	7-10	N/A	7-12	N/A	5-8
*Feddans** cultivated/HH	1-2	1.25 - 2.5	2-3	4.5-7	3.5-4.5	7-9.5
Grain (kg)	325-635	N/A	650-790	N/A	800-1500	N/A

Source: WFP, Annual Needs Assessment2003 and 2004.[25] ** A feddan is approximately 4,200 m^2.*

[21] WFP, *Annual Needs Assessment 2004/2005*, Budi County, 2005. *For the purpose of this exercise, food deficits WFP (ANA) 2003 report has been used as crude proxy, assuming that individuals not able to meet the daily requirements of less than 2100 kilo calories are below minimum dietary energy consumption.*

[22] Refer to www.savethechildren.org.uk

[23] WFP, *Annual Needs Assessment,* 2002/2003.

[24] WFP, *Annual Needs Assessment Chukudum,* 1997/1998.

[25] WFP, *Annual Needs Assessment Budi County*, 2004, 2005.

9. Food Security

Crop Production

The main crops grown in Budi County are sorghum, maize, bulrush millet, potatoes, beans and sesame. The 2002 WFP ANA report noted that Budi County has the potential to be an agricultural surplus area with crops alone contributing 85-140 % of the required household food needs especially among the *Didinga* community. During 2002, crop production contributed 40-over 100% of the required food needs among this group.

Crop production in 2003 was affected by dry spells and flooding. An outbreak of armyworms also occurred in some areas (Kimatong payam) and destroyed crops.[26] As a result it was projected that the poor and middle socio-economic groups would have deficits, while the better-off group would have a slight surplus.[27]

Insecurity in Budi County has affected food production in several ways:
-Displacement of populations means that there are no longer people to work on the land;
-During the Chukudum crisis (1999) part of the agriculturally productive land was laid with mines;
-Fear of attacks has meant limited grazing areas for animals.[28]

The 2004 agricultural season was characterized by a long dry spell that destroyed the crops and reduced crop yields.[29] Crop production in 2004 was lower than in 2003 because of the prolonged dry spell which led to reduced crop yields.[30] The LRA insurgency and recurrent cattle rustling continue to affect mobility, livestock trade and access to markets in East Equatoria.

Livestock Production

In a typical year, livestock products play a significant role in contributing to the annual food basket of communities of Budi County with about 10-40% of the total kilocalories coming from milk, meat and blood.[31] Milk contributes the highest percentage, 5-30% while meat from cattle slaughtered during special occasions (weddings, burials and Christmas) contributes 2-5%[32]. Bleeding of cows which takes place from April to May - serves as a coping mechanism during the hunger gap period (March to June)[33]. The significance of livestock in terms of providing food becomes higher as one moves up the socio-economic classes since they own more livestock.

Livestock products normally contribute 12%, 24% and 32% of food sources for the poor, middle and better-off socio-economic groups respectively.[34] However, the total production from livestock in 2004 was estimated at 2% for the poor and 6.7% for the middle and better of socio-economic groups. This shows a major decline in the contribution of livestock to food in Budi County.Various factors such as disease, limited water and pasture availability, as well as cattle rustling continue to hamper livestock production in Budi County. Veterinaires sans Frontieres Belgium (VSF-B) has provided some veterinary services on a cost recovery basis.[35] Frequent livestock raiding has led to the depletion of stock, which has had a negative effect on food security.[36] In 2004 grazing lands and water sources were also affected by the dry spell. The estimated cattle population in Budi County in 2004 was 240,000[37].

[26] WFP, *Annual Needs Assessment 2003/2004,* 2004.
[27] WFP, *Annual Needs Assessment 2002/2003,* 2003.
[28] WFP, *Annual Needs Assessment 2003/2004*, Budi County, 2004.
[29] WFP, *Annual Needs Assessment 2004/2005*, Budi County, 2005.
[30] WFP *Sudan Annual Needs Assessment* 2004/2005.
[31,32,33,34] WFP, *Annual Needs Assessment 2002/2003*, Budi County, 2003.
[35,36] WFP, *Annual Needs Assessment 2003/2004*, Budi County, 2004.
[37] FAO, *Database*, 2004.

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Wild Foods

Budi County is well endowed with wild foods in most areas particularly in the fertile and green Kedepo valley. The wild foods, which include *komok, lalop* (desert date), *kunyyethit,* tamarind, *leit* and palm fruits, are collected from January to March. From April, the community collects green leaves, which include *Chaboj, Bobu, Kinyari* and *tiroro* that are prepared with sesame or blood and eaten with *asida* (stiff porridge) or maize/sorghum meal.[38]

Wild foods normally contribute 16%, 15% and 6% for the poor, middle and better off socio-economic groups respectively.[39] In the Kidepo area, insecurity due to cattle raiders, the LRA and other militias have limited access to wild foods for the *Didinga* community. In 2003, wild foods were projected to contribute the same as in a typical year, with a contribution of approximately 5-15% across the socio-economic groups.[40]

In 2004, the dry spell severely affected wild food collection. The percentage contribution to the calorific value was estimated to range from 5.4%-5.7% for the poor to well-off groups respectively. The quantity of honey harvested in 2004 was projected to decrease as bees were expected to migrate to the highlands for water, because of the prolonged dry spell.[41]

Seeds and Tools

The community of Budi County relies heavily on their own seeds and tools since few agencies work in the area. The community also exchanges and purchases seeds and tools from neighbouring countries. There is generally a lack of effective tools, which negatively affects agricultural production.[42]

Fish and Wild game

A very small proportion of the community in Lauro and Ngarich *payams* has access to fish from Lake Farasika and River Kuduma. Fish is not considered a major contributor to the daily food requirements of the Budi County residents and therefore its contribution as a major source of food is insignificant.[43]

In a normal year game meat contributes 1%[44] for the poor, middle and well off socio-economic groups. It is thus not a significant source of food for Budi County residents[45] although it may have been an important food source 4-5 years ago[46]. According to the WFP ANA of 2004, the SPLM/A has banned hunting in the area and this source of is not expected to be available.[47]

Trade

Trade alone contributes approximately 5-15% of the annual food needs among the poor, very poor and middle socio-economic groups. The currencies used are the Kenya and the Uganda shillings. Bartering is also commonly used. Internal trading centres include Chukudum, Lotukei, New Cush

[38] WFP, *Annual Needs Assessment 2002/2003*, Budi County, 2003.
[39] WFP, *Annual Needs Assessment 2003/2004*, Budi County, 2004.
[40] WFP, *Annual Needs Assessment 2002/2003*, 2003.
[41] WFP, *Annual Needs Assessment in Budi County/Equatoria*. 2004.
[42] WFP, ANA report, 2003.
[43,44] WFP, *Annual Needs Assessment in Budi County/Equatoria*. 2004.
[45] WFP, ANA report, 2003.
[46] WFP, *Annual Needs Assessment Chukudum payam, 1997/1998*.
[47] WFP, *Annual Needs Assessment in Budi County/Equatoria*. 2004.

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and Kiklai. Items traded include grain, livestock, local beer, firewood, grass for construction, chickens, honey and tobacco.

There is also cross-border trade along the Kenya and Uganda border towns. On the Sudan/Uganda border, residents of Budi trade tobacco, gold and *khaat* or *miraa* (a narcotic leaf with hallucinogenic properties) in exchange for clothes, shoes, salt and soap which is sold or exchanged for grain or livestock in the county.[48]

All socio-economic groups spend more of their income in October-December (Christmas preparations) and April-June (hunger-gap period). In 2003, trade became more significant in contributing to household food needs since there was a decreased harvest.[49] In the 2004/2005 period, trade was projected to play an important role as a coping mechanism, and to contribute an average of 41% of the calorific value for all socio-economic groups.[50] However access to food through trade was adversely affected by the poor crop performance of the 2004 season. Table 5 shows the prices of selected commodities in Budi County in 2002 and 2004.

Table 4: Market Prices in Kenya Shillings, 2002 and 2004*

Item	Price in 2002	Price in 2004
Bull grade 1	6,000-7,000	8,000
Bull grade 2	4,000-5,500	N/A
Bull grade 3	3,750	N/A
He-goat big	1,500	1,500
He-goat medium	850	N/A
Cock	100	100
Hen	50	N/A
She-Goat	500	N/A
Gold per 1 gm	400	600
Meat per 1kg	50	N/A
Sorghum	200* (SD)	200
Maize	N/A	200

Source: WFP, Annual Needs Assessment Budi County 2002/2003 and 2004.
**1,500 Sudanese Pounds=1 Kenyan Shilling; 3 Sudanese Dinar= 1 Kenyan Shilling*

The prices of some commodities, like sorghum, rose in 2004 compared to 2002. Gold mining is done in Lauro and Loudo *payams*. Hence trade in these *payams* is more significant throughout the year as these populations sell the gold and buy grain.[51] Tobacco cultivated in the highlands also contributed to trade and was to be sold by all socioeconomic groups, though the poor were expected to sell tobacco at a much lower price compared to the other groups.[52]

[48,49] WFP, *Annual Needs Assessment 2002/2003*, Budi County, 2003.
[50] WFP, *2004/2005 Annual Needs Assessment in Budi County*, 2004.
[51] WFP, *Annual Needs Assessment 2003/2004*, Budi County, 2004.
[52] WFP, *2004/2005 Annual Needs Assessment in Budi County*, 2004.

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Seasonal Calendar

Although many of the household food production activities are carried out by women, men and young men in particular play a significant role in preparing land for cultivation. Women and young girls carry out the harvesting and threshing of produce. Table 5 below shows the different activities undertaken by different groups during the year.

Table 5: Seasonal Calendar for Budi County .

Activity	Gender	J	F	M	A	M	J	J	A	S	O	N	D
Land clearance	M	■	■							■	■	■	■
Planting	M/F				■	■	■						
Weeding	W					■	■	■					
Harvesting	W								■	■	■	■	■
Threshing/storage	W	■	■	■	■	■							
Selling of grain	M/W				■	■	■	■					
Purchase of grain	W				■	■	■	■					
Sale of livestock	M										■	■	■
Buying of livestock	M										■	■	■
Move to lowland	M	■	■	■								■	■
Return to highland	M			■	■								
Wild foods	W	■	■	■									
Sale of tobacco	M	■	■	■	■	■	■	■	■	■	■	■	■
Gold mining	M	■	■	■	■	■	■	■	■	■	■	■	■

Source: WFP, Annual Needs Assessment for Budi County, 2003 and 2004.

Food Aid and Projected Food Needs

Food aid has been distributed in Budi County among residents and IDPs, who depend on food distribution, as a result of the food deficits in the region.

Between October 2001 and September 2002, WFP delivered 636 metric tonnes (MT) of food aid to 24,891 beneficiaries in Budi County. In 2003, it was projected that WFP would deliver food to 24,000 beneficiaries, approximately 17% of the population.

In 2004, 991.6 MT of food commodities were distributed by WFP to 61,287 beneficiaries 48% of the population. The projected food distribution for 2005 is 1,992 MT of food commodities for an estimated population of 31,879 people.[53]

Table 6 presents information on food distribution in Budi County between 2001 and 2004, and includes projections for 2005.

[53] WFP, *Annual Needs Assessment 2003/2004, Budi County*, 2004.

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Table 6: Food Aid in Budi County, 2001-2005

Year/Month	Amount	Beneficiaries	Ration	Source
Oct 2001-Sep 2002	636 MT	24,891	N/A	WFP
2003	N/A	N/A	N/A	-
2004	991.6 MT	61,287	100%	WFP
2005	* 301	2,700 (IDPs)	100%	WFP

The proportion of the Budi County population below the minimum level of dietary energy consumption (2,100 kcal per person per day[54]) was estimated at 30% in 2003 and over 40% in 2004. It is thus expected that supplementary feeding programmes (SFP) - traditionally carried out by the Diocese of Torit (DoT) with support from Catholic Relief Services (CRS) for malnourished under-fives and pregnant/lactating mothers - are likely to continue. [55]

[54] *For the purpose of this exercise, food deficits (WFP ANA) have been used as a crude proxy, assuming that individuals not able to meet the daily food requirement of 2,100 kilo calories are below minimum dietary energy consumption.*

[55] CRS, *Sudan Quarterly Report,* 2002.

10. Education

Among the eight-millennium development goals, two deal directly with education. These are the MDGs 2 and 3. MDG 2 addresses achievement of Universal Primary Education with the specific target of ensuring children everywhere will be able to complete a full course of primary schooling by 2015. Specific indicators include the net enrollment ratio (NER) in primary education, the proportion of pupils starting grade one who reach grade five, and the literacy rates of 15-24 year olds.[56]

MDG 3 addresses gender inequality and targets the elimination of gender disparity in primary and secondary education by 2005 and to all levels of education no later than 2015. This goal led UNICEF to launch the *25 by 2005 initiative*: 25 countries judged to be most at risk of failing to eliminate gender disparities in education by 2005. Sudan has been identified among them.[57] For MDG 3, target 4, the indicators are the ratio of girls to boys in schools and the ratio of literate females to males aged 15-24 years.

Of the 24 million girls out of school in sub-Saharan Africa,[58] 2.5% of them are in southern Sudan. Of the school-age southern Sudan population of 1.4 million there are only 82,730 girls in school. Assuming an even number of boys and girls in the schools, only 12% of school-age girls are therefore in school. Even though female enrollment in schools in South Sudan is on the increase,[60] only 27% of the total enrollment is female. Furthermore, of the 8,655 teachers in the schools assessed in southern Sudan, 94% were men.[61]

This section does not have updated information as there has been no comprehensive assessment of schools since the UNICEF School Baseline Assessment of 2003.

Available information for Budi County shows that in 2003/2004, 3,051 children were in school out of a possible 25,677. This represented only about 12% of the school-going age children. 40% of the students were girls while 19 students had physical disabilities.

There were 11 schools in the county, with 89 teachers, giving a teacher to student ratio of 1:34. Only 10 of the teachers 11% - were female and only 15 out of the 89 were trained. There were 21 classrooms made of a permanent structure (brick) while 51 classrooms were semi-permanent structures made of the local plant or clay. Some classes were conducted outdoors. A concerted effort is needed to improve the education sector in Budi County.[62] Information for 2004 is not available but in 2005, Catholic Relief Services (CRS) plans to construct/rehabilitate five classrooms in Kimatong Payam.

[56] SPLM/NSCSE, *Millennium Development Goals*,2004.
[57] UNICEF, *The State of the World's Children, 2004,* 2003.
[58,59] UNICEF, *School Baseline Assessment Report southern Sudan,* 2003.
[60] UNICEF, *The State of the World's Children 2004*, 2005.
[61,62] UNICEF, *School Baseline Assessment Report southern Sudan*, 2003.

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Three Millennium Development Goals, MDG 4, 5 and 6, are specific to the health sector. MDG 4 aims at reducing child mortality, with the indicators including the under-five mortality rate, infant mortality rates and the proportion of 1-year-old children immunised against measles. MDG 5 aims at improving maternal health, and the corresponding indicators are the maternal mortality ratio and the proportion of births attended by skilled health personnel. MDG 6 addresses HIV/AIDS, malaria and other diseases. The specific indicators are discussed in the sections below. Although there is limited specific data available for the Budi County, MDG indicators, available data and possible proxies are explored in the following sections.

Health Services

Although no MDG or even UNICEF's State of the World's Children (SOWC) indicator exists for health facilities and health care coverage, the data is important for evaluating the impact of OLS and for future planning.[63] Southern Sudan operates a three-tier health-care system. The first tier is the Primary Health Care Unit (PHCU), the second is the Primary Health Care Centre (PHCC) and at the top are referral hospitals. The majority of these health facilities are NGO supported. PHCUs are run by Community Health Workers (CHWs), and Traditional Birth Attendants (TBAs). The CHWs attend a nine-month public health course and TBAs attend a two- to four-week training course. The PHCUs provide health education, malaria tablets, oral rehydration salt (ORS) for diarrhoea in children and other basic medicines. PHCUs are often outposts of PHCCs and may be mobile or stationary, with no vaccinations, intravenous or laboratory facilities. UNICEF provides medical kits, through local NGOs or counterparts, to PHCUs that do not have an NGO on the ground. The kits contain basic drugs for treatment of ailments such as malaria, dehydration and skin rashes.[64]

In Southern Sudan there are over 20 general hospitals which provide major medical, laboratory and surgical services. Some of these hospitals are specialised and can handle treatment of kala-azar, sleeping sickness, TB and leprosy. In practice, however, the three-tier classification is non-functional due to logistical and staffing constraints. The distance between the facilities is enormous with no vehicle transport or radio communication between them. thus, patients attend the health facility closest to them.[65]

In Budi County there is one referral hospital located in Chukudum town which is run by Norwegian People's Aid (NPA). Following the loss of Torit and Kapoeta to the GoS in 1992, Aswa hospital was lost to the GoS side and the instability also led to there being a threat to Nimule hospital. NPA therefore decided to choose Chukudum as the location for their hospital (established in 1995) due to its remoteness from the frontlines. The hospital serves the indigenous population, displaced people and war victims. The local administration is involved in all aspects of running the hospital; planning, implementation and monitoring. The hospital receives support from WFP with food for inpatients, and medicines or supplies from Americares, International Committee of the Red Cross (ICRC) and Voice of the Martyrs.[66]

In 2003, there were two PHCCs and seven PHCUs in Budi County. Out of 18 doctors in the Equatoria region, 3 were in Budi County. There were also two medical assistants, nine certified nurses and ten

[63] NSCSE/UNICEF, *Towards a Baseline: Best Estimates of Social Indicators for Southern Sudan*, 2004.
[64,65] UNICEF, Richer M., *Overview of the health Situation In Southern Sudan*, 2002, 2003.
[66] NPA, *NORAD Frame Agreement Mid-Year Report*, 2002.

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trained TBAs compared to the Equatoria regional figure of 89 medical assistants, 409 certified nurses and 1,591 trained TBAs. In 2004[67] there was one major hospital in Chukudum and one PHCC in Lorema managed by the Diocese of Torit (DoT), according to WFP. Table 7 below shows the distribution of health facilities in Budi County.

Table 7: Distribution of Health Facilities in Budi County

NGO / Agency	Location	Type of Facility (2003)	Type of facility (2004)
NPA	Chukudum	Hospital	Hospital
NSCC / AIC	Lotukei	PHCC	-
DOT	Lorema	PHCC	PHCC
DOT	Farasika	PHCU	PHCU
DOT	Chukudum	PHCU	PHCU
DOT	Lotukei	PHCU	PHCU
DOT	Kiklai	PHCU	PHCU
DOT	Kimatong	PHCU	PHCU
DOT	New Cush	PHCU	PHCU
DOT	Natinga	PHCU	PHCU

Source: UNICEF, Richer, M., Overview of Health Situation in Southern Sudan, 2003.

Sphere Standards recommend one central health facility per 50,000 people, [68] while the Sudan Relief and Rehabilitation Commission (SRRC) Secretariat of Health (SoH) recommends one PHCC per 80,000 people.[69] Therefore, with a population of 128,385 people, the available health facilities at referral level are not adequate.

Health services in Budi County are provided by various agencies, the main ones being Norwegian People's Aid (NPA), Catholic Diocese of Torit (DoT), New Sudan Council of Churches (NSCC), Adventist Development and Relief Agency (ADRA) and Americare International Committee (AIC).

Diseases

MDG 6 addresses HIV/AIDS, malaria and other diseases. Indicators include prevalence and death rates associated with malaria, proportion of population using effective malaria prevention and treatment measures, prevalence and death rates associated with tuberculosis (TB), as well as TB cases treated under Directly Observed Treatment Short Course (DOTS). There is insufficient data regarding these indicators on a county basis in southern Sudan.

Available data indicates that HIV prevalence rates range from 0-7% in the few areas studied (one of which was Chukudum), with towns and border areas having the higher rates. Data from Yei, Nimule, Chukudum and Labone showed a prevalence of 13.8%.[70] This high percentage may be due to proximity to the high prevalence areas of the border town of Yei and the major town of Rumbek. No awareness campaigns have ever been carried out in Budi County.[71]

[67] WFP, *2004/2005 Annual Needs Assessment in Budi County/Equatoria Region*, 2005.
[68] The Sphere Project, *Humanitarian Charter and Minimum Standards in Disaster Response*. 2004.
[69] SoH, *Public Health Programs and Priority Diseases*, February 2004.
[70] NPA, *Yei Medical Training School (Department of Medical Laboratory Technology and Nurse Training)*, 2001.
[71] WFP, *Annual Needs Assessment 2003/2004*, Budi County, 2004.

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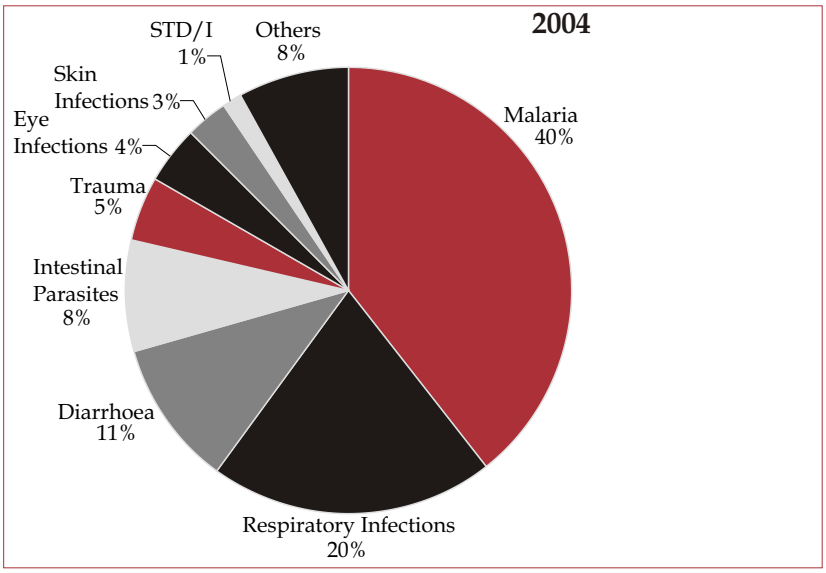
According to the Multiple Indicator Cluster Survey (MICS) 2000, approximately 19.4 % of adults in Eastern Equatoria state had never heard of HIV or AIDS. Some 8.5 % had heard of HIV or AIDS but did not know about problems related to it, while 12.7 % did not know about the relationship between unprotected sexual activity and HIV or AIDS.[72] In 2003 Norwegian People's Aid (NPA) recorded 67 cases of HIV/AIDS in Budi County.[73] According to information from Chukudum hospital, between January and December 2004 126 blood samples were tested for HIV, 13.5% of the samples were found to be positive for HIV.[74] The prevalence of HIV/AIDS is thought to be on the increase as more travel and trade is undertaken with Kenya and as relief trucks pass through the Chukudum area.[75]

Figure 3: Causes of Morbidity in Budi, 2004 compared to 2003.



Source: UNICEF, OLS, *Health Database*, 2003 & 2004.

According to the UNICEF health database, malaria and respiratory infections are the main causes of morbidity in Budi County. Malaria was the cause of 40% of the morbidity in Budi County in 2004. Chukudum hospital alone diagnosed and treated 7,435 patients for malaria in 2004.[76] Figure 3 shows the major causes of morbidity in Budi County in 2004.[77]

The South Sudan Task Force on Malaria met in previous years to discuss the issue and recommended the use of treated bed nets, the seeking of early care, health education, the use of malaria prophylaxis for pregnant women, and environmental prevention of mosquito breeding. These include the slashing of grass, draining of stagnant water and clearing bushes in close proximity to living areas. Available regional data on the proportion of population using malaria prevention, for eastern Equatoria, indicates that 93.5% of children under five do not sleep under bed-nets.[78]

Information from the World Relief (WR) indicates that there has been an increase in the number of Insecticide Treated Nets (ITNs) being distributed (and therefore being used). In the year 2003/2004, 2,000 ITNs were distributed by ADRA in Budi County. The agency is projected to distribute 3,500 ITNs by the end of 2005 and 3,850 by the end of 2006. The percentage of households covered by ITNs is projected to increase from 16% in 2004 to 44% in 2006. This is however still inadequate considering the high prevalence of malaria in the county.

[72] UNICEF, *Multiple Cluster Indicator Survey*, 2000.
[73] WFP, *Annual Needs Assessment 2003/2004*, Budi County, 2004
[74] NPA, *NPA Report,* February 2005.
[75] NPA, *NORAD Frame Agreement Mid year Report*, 2002.
[76] NPA, *NPA Report,* February 2005.
[77] UNICEF, *Health Database 2003 and* 2004.
[78] UNICEF, *Multiple Cluster Indicator Survey*, 2000.

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Other major causes of morbidity in Budi County are respiratory tract infections, diarrhea, intestinal parasites and eye infections. Tuberculosis is a major health concern in Southern Sudan, but the proportion of the population covered by DOTS was only 25%,[79] according to a 2003 report. While no data is available on number of cases treated and cured under DOTS, MICS 2000 indicates that approximately 35.2 % of infants - compared to 95% in Bahr el Ghazaal - were not immunised with the Bacille Calmette-Guerin (BCG) vaccine in eastern Equatoria. They were therefore, not protected against tuberculosis.

In September 2003, a Medair mobile team responded to a call for an emergency assessment in Kimatong Payam where an outbreak of whooping cough (also known as pertussis) killed 122 children under 5 years.[80] Medair treated 312 patients and vaccinated 15,846 people. Medecins sans Frontieres-Holland (MSF-H) assisted by vaccinating 29,560 people in Lauro Payam and Chukudum. Tearfund-UK, OXFAM and WHO also assisted by focusing on preventive treatment, laboratory confirmation, health education and distribution of mosquito nets.[78]

According to health statistics for Budi county, a yellow fever mop-up campaign targeting 42,834 people was held in April-May in 2004 by (Adventists Development Relief Agency) ADRA. Coverage of 45% was achieved by vaccinating a total of 19,480 people.

Nutrition

One of the indicators for MDG 1 on poverty and hunger is the occurrence of underweight children under five years of age. For Budi County, no information was available on nutrition in 2003. However, for the Eastern Equatoria state, children whose MUAC (Middle Upper Arm Circumference) was less than 12.5 cm were reported as approximately 10%.[81] A MUAC of 12.5 cm or less indicates severe or moderate malnutrition.

According to WFP, no cases of malnutrition were observed in 2004, though secondary data in the PHCC revealed that an average of 5-10 children brought to the centre were malnourished from other causes, but not directly due to food deficiency.[82]

Immunisation

MDG 4 aims at reducing child mortality in developing countries, with target 5 proposing to reduce by two thirds the under-five mortality rate. The proxy indicators are child immunisation for polio and Triple Vaccine (DPT) for the prevention of the three diseases at the same time: Diphtheria, Whooping Cough and Tetanus.

Despite concerted efforts to immunise children in Sudan, childhood communicable diseases are widespread. The Expanded Programme on Immunisation (EPI) targets all six major childhood diseases; TB, polio, neonatal tetanus, diphtheria, whooping cough and measles. Routine EPI coverage rose during the first five months of 2004 compared to 2003. In 2004 the EPI aimed at reaching a total of 48,000 children under the age of one in South Sudan with DPT3 vaccine. Only 71% of that target children (34,217 children) was reached.[83]

[79] UNICEF, Richer, M., *Proposal to the Global Fund*, 2003.
[80] Relief Web article:MedAir, *Outbreak kills 126 children within 6 weeks in Southern Sudan*, 10 October 2003.
[81] UNICEF, *Multiple Cluster Indicator Survey*, 2000.
[82] WFP, *2004/2005 Annual Needs Assessment in Budi County/Equatoria Region*, 2005.
[83] WFP, *2004/2005 Annual Needs Assessment in Budi County/Equatoria Region*, 2005.

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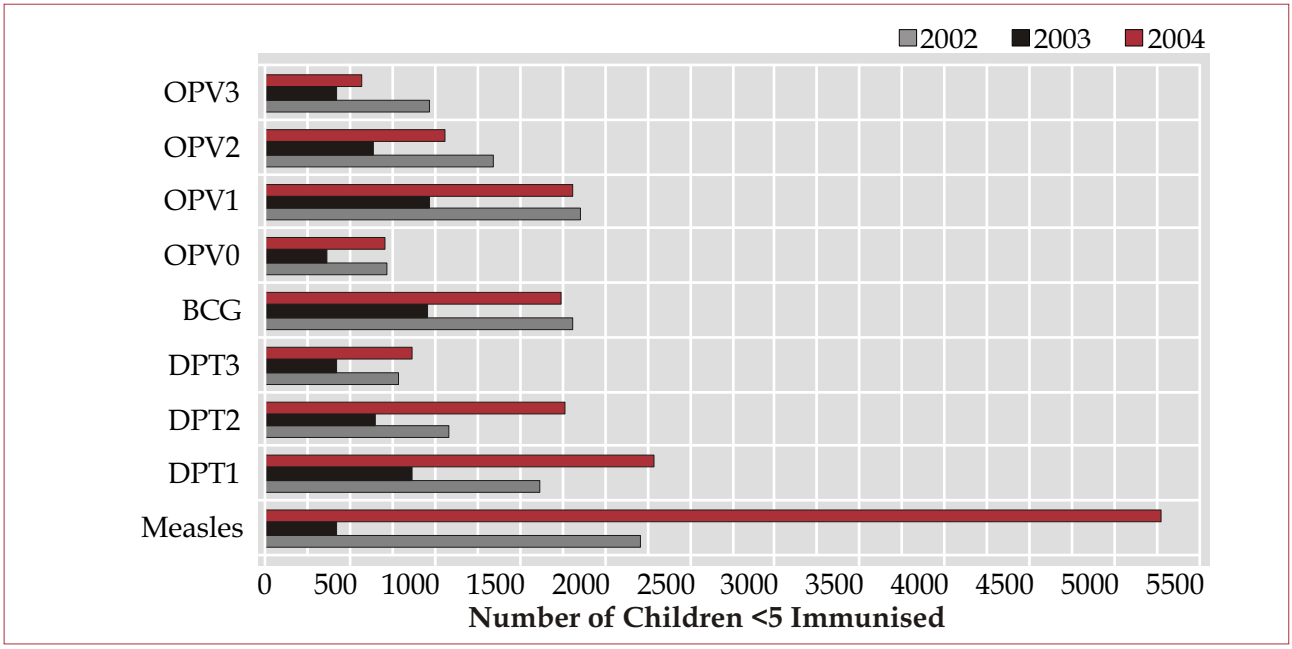
The number of children under the age of 5 reached with DPT3 in Budi County was higher in 2004 compared to those reached in 2003. This is shown in Figure 4.

Figure 4: Comparative Routine EPI Coverage in Budi County from 2002 to 2004.



Source: UNICEF, OLS, Health Database, 2002-2004.

In 2004, UNICEF and its partners continued with their efforts to expand and decentralise the cold chain system in the whole of South Sudan.[84] In 2002, with 49% of its children immunised against measles, Sudan ranked among the bottom 20 countries for measles immunization worldwide. Measles vaccination in Budi County improved greatly in 2004 compared to the previous years. More than 5,000 children under 5 years of age were vaccinated compared to less than 1,000 in 2003, and slightly more than 2,000 in 2002. In April/May 2004 there was mass measles vaccination in Chukudum carried out by ADRA. Out of a targeted 54,635 people, a total of 22,235 people (41%) were vaccinated.

WHO and UNICEF have been successfully conducting National Immunisation Days NIDs) for polio in Southern Sudan since 1998. To eliminate gaps in coverage, sub-national immunisation days (SNIDs) and Sub Immunisation Activities (SIAs) are conducted and where a location is not covered, due to insecurity or access problems, additional rounds are planned as soon as the location becomes accessible.

By October 2004, the targeted under 5 population to be vaccinated in Budi County was 26,961. A total of 10,406 children had been vaccinated at the end of the second round of the polio campaign in Kimatong *Payam* only, out of three *payams*. Thus only approximately 39% of children under 5 years were immunised in Budi County. Vitamin A was also administered to 5,125 children in Kimatong

[84] UNICEF, *Monthly Report*, May 2004.

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Table 8: Polio Immunisation Coverage, NIDs 2002-2004, Round 2

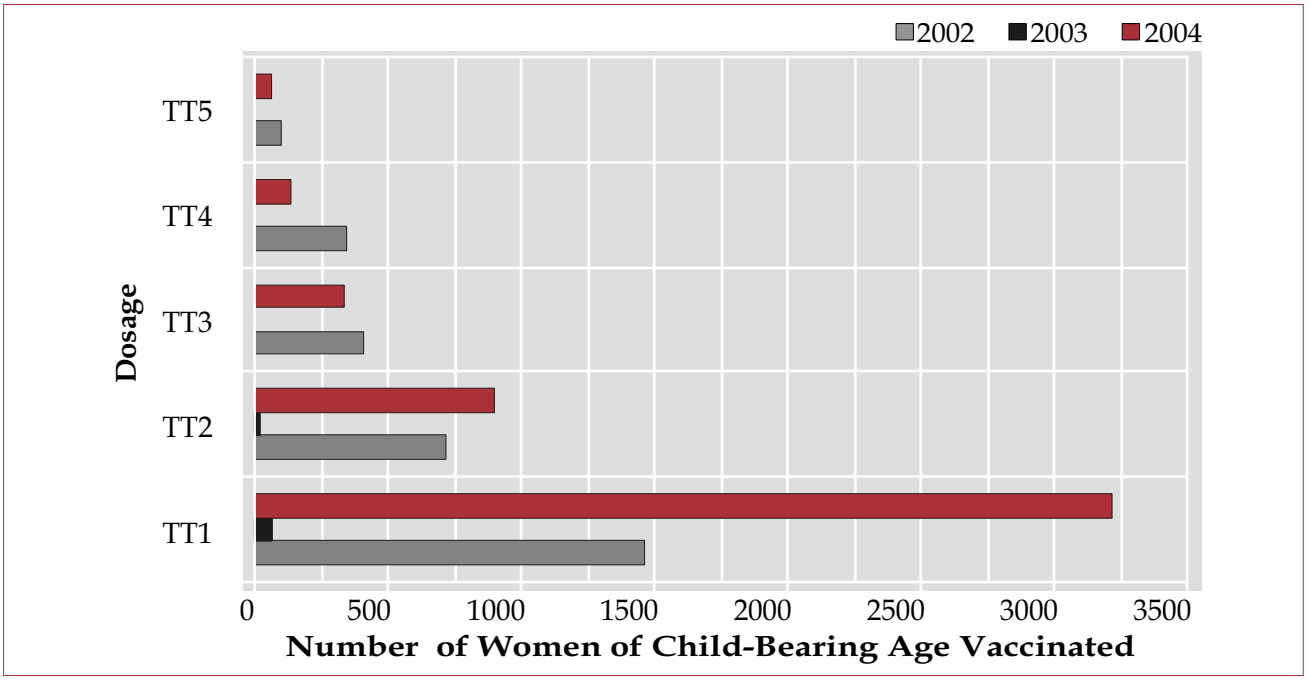
Payam	Target population 2002	No. of children < 5 given 2 doses of polio in 2002	Target population 2003	No. of children < 5 given 2 doses of polio in 2003	Target population 2004	No. of children < 5 given 2 doses of polio in 2004
Kimotong	9,389	5,164	21,004	11,685	8,488	10,406
Lauro/ Chukudum	13,849	8,623	8,489	5,196	18,473	0
TOTAL	**23,238**	**13,787**	**29,493**	**16,881**	**26,961**	10,406

Source: WHO, NIDs Assessment Data, 2002-2004

payam. Table 8 summarises the polio immunisation coverage in Budi County from 2002-2004.

Maternal neonatal tetanus coverage is used as a proxy indicator for MDG 5 which is the improvement of maternal health. The coverage for Tetanus Toxoid (TT) coverage in Budi County during 2004 shows an increase for TT1 and TT2 followed by a steady decline in TT3 to TT4. The drop out rate after the women receive TT1 has been high throughout the years as shown in Figure 5.

Figure 5: Comparative Tetanus Toxoid Coverage in Torit County from 2002 to 2004.



12. Water

MDG 7 addresses environmental sustainability and includes MDG target 10, which aims at halving the proportion of people without sustainable access to safe drinking water. UNICEF conducted a Sentinel Site Survey (SSS) on a limited number of households in 2003. The purpose of the survey was to monitor indicators on sanitation and access to clean water. Although these figures are used as a starting point in the discussion below, they are not truly representative of the population within a given county, as they were designed to give an overall picture of southern Sudan. Therefore the numbers from the Sentinel Site Survey (SSS) should only be used as a rough guide in the various indicators discussed.

In 2003, Budi County had 71 constructed water points, of which 28 were still operational, according to Water and Environmental Sanitation (WES). If the 28 water points were equally distributed among the county's current population of 128,386**,** this would translate to 4,585 people per water point. The Sudan Relief and Rehabilitation Commission (SRRC) recommends a water point to people ratio of 1:500 and the Sphere Standard also recommends one hand pump per 500 people (1: 500) with at least 15 litres of water collected per person per day.[85]

The number of boreholes is far from adequate and more than 200 more boreholes would need to be constructed in the county to meet the recommended standards. Adventist Development and Relief Agency (ADRA) plans to build 16 new water points in 2005 in the county.[86]

The Multiple Indicator Cluster Survey of 2000 indicates that in Eastern Equatoria sub-region, approximately 75 % of households drink unsafe water during the dry season and 77.3% drink unsafe water during the cultivation period.[87] To address the severe water problem, several agencies are involved in drilling boreholes in southern Sudan. According to the UNICEF/OLS (Operation Lifeline Sudan) water department, one well would serve approximately 1,000 people on average.

Guinea worm infestation is used as a proxy indicator for areas without access to safe drinking water. Unsafe drinking water acts as breeding ground for the worms, which await ingestion by humans before maturing and continuing their life cycle. No information is available on the occurrence of guinea worm in Budi County.

Regarding sanitation levels in eastern Equatoria sub-region, 41.5 % of households do not use sanitary latrines and 31.3 % of households use sanitary latrines but do not have one for their own household. The Sphere Standard recommends a toilet to people ratio is 1:20.

[85] The Sphere Project, *Humanitarian Charter and Minimum Stardards in Disaster Response,* 2004.
[86] UNICEF, WES *Database, Lokichoggio*, 2004.
[87] UNICEF, *Multiple Cluster Indicator Survey*, 2000.

13. Agencies

The Chukudum crisis led to the steady decline in social services and development activities over [7]the years, partially due to the forced withdrawal of development and humanitarian agencies. In spite of this, there are 10 agencies working in Budi County . Table 9 below provides a list of the main agencies operating in the county.

Table 9: Agencies operating in Budi County

Agency	Activities
ADRA	Health, Water and environmental sanitation
AIC	Health
CRS	Education, Food security
DoT	Health, Education, Agriculture, Water and environmental sanitation
NPA	Health
NSCC	Health, HIV/AIDS
SMC	Health
UNICEF	Education, Water and environmental sanitation
VSF – B	Veterinary surveillance
WFP	Food security

Source: Various

Annexes

Notes

(i) The population estimates in the annex tables are sourced from the WHO NIDs statistics except those for 2000 which are sourced from the MICS 2000 report and those for 2004 which are sourced from NSCSE.

(ii) Some sections of these tables remain unfilled due to lack of data.

Annexes

Table A1: Monitoring MDG 1 Poverty and Hunger

TARGET: Halve, between 1990 and 2015, the people who suffer from hunger.

ASAP 2004 Proxy	'99	'00	'01	'02	'03	'04	Info source	Regularity of Data collected	Type/ Category of Info	Remarks
Estimated Population- Budi				**161,364**	**170,478**	**128,385**	**NIDs,NSCSE**			
% of population with Food deficit				10%	40-50%	60%	WFP	Continuous	Assessment	
Level of child malnutrition (GAM and SAM using weight for height) presented.										
Rain fed subsistence agriculture crop yield (indicate crop in										
Number of livestock per County (cattle)						240,000	FAO	Annually		
Price of grain in the markets (sorghum)			200 SD	200 SD	200 SD	200 Ksh	NSCSE/ WFP	Continuous	Monitoring	
Number of formalised markets						1	WFP	Continuous		

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Table A2: Monitoring MDG 2 –Education

TARGET: Ensuring that children everywhere will be able to complete a full course of primary schooling by 2015 and elimination of gender disparity in primary and secondary education by 2005.

ASAP 2004 Proxy Indicators	'99	'00	'01	'02	'03	'04	Info source	Regularity of Data collected	Type/ Category of Info
Estimated Population--- Budi				**161,364**	**170,478**	**128,385**	**NIDs,NSCSE ,MICS**		
Number of children enrolled in grade 1					852		SBA-UNICEF	Annually	Monitoring
Number of schools that go up to grade 5					6		SBA-UNICEF	Annually	Monitoring
Teacher: pupil ratio in primary schools					1:34		SBA-UNICEF	Annually	Monitoring
Total number of teachers in primary schools					89		SBA-UNICEF	Annually	Monitoring
Total number of trained teachers in primary schools (over 1 year of training)					15		SBA-UNICEF	Annually	Monitoring
Total number of primary schools					11		SBA-UNICEF	Annually	Monitoring
Number of schools receiving external support (materials, training, development etc)					3		SBA-UNICEF		

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Table A3: Monitoring of MDG 3 - Gender Equality

TARGET: Eliminate gender disparity in primary and secondary education preferably by 2005 and

ASAP 2004 Proxy Indicators	'99	'00	'01	'02	'03	'04	Information source	Regularity of Data collected	Type/ Category of Info
Estimated Population--- Budi				**161,364**	**170,478**	**128,385**	**NIDs,NSCSE, MICS**		
Ratio of girls to boys in primary education					0.7:1		SBA-UNICEF	Annually	Monitoring
Number of girls registered in primary schools					2,547		SBA-UNICEF	Annually	Monitoring
Total number of girls-only primary schools existing							SBA-UNICEF	Annually	Monitoring
Number of operational women's associations/training center									
% of women in National Liberation Council					22		NSW		
No. of women in Executive Secretariat					5		NSW		
No. of women in SPLM County Secretariat					5		NSW		
% of women in SRRC County Secretariat					23:1		NSW		

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Table A4: Monitoring MDG 4 - Child Mortality

TARGET: Reduce by three-quarters the under 5 mortality rate between 1990-2015

ASAP 2004 Proxy Indicators Children <5years pop.	'99	'00	'01	'02	'03	'04	Information source	Regularity of Data collected	Type/ Category of Info
Estimated Population- -- Budi				**161,364**	**170,478**	**128,385**	**NIDs,NSCSE ,MICS**		
Number of health facilities					10	9	UNICEF	Monthly	Monitoring
Number of children <5 immunised with DPT3	203	912	565	791	366	870	UNICEF	Monthly	Programming
Number of children <1 immunised with DPT3	96	401	249	304	160	1,610	UNICEF	Annually	Programming
Number of children immunised with a minimum of 2 doses of Polio						10,406	WHO/NIDs	Annually	Monitoring
No.of children <5 vaccinated against measles	576	2,702	919	2,205	196	6,275	UNICEF	Annually	Programming
Number of children who received vitamin A						5,125	WHO/NIDs	Bi-annually	Programming
Number of children admitted in feeding programmes (therapeutic and supplementary)									

Annexes

Table A5: Monitoring MDG 5 on Maternal Health

TARGET: Reduce by three-quarters, the maternal mortality ratio.

ASAP 2004 Proxy Indicators	'99	'00	'01	'02	'03	'04	Information source	Regularity of Data collected	Type/ Category of Info
Estimated Population- - Budi				**161,364**	**170,478**	**128,385**	**NIDs,NSCSE, MICS**		
Number of trained TBA				10	10		HPC	Sporadically	Monitoring
Number of trained mid-wives					9		HPC		
Number of trained nurses							UNICEF	Sporadically	Monitoring
Number of doctors				9	3		UNICEF	Sporadically	Monitoring
Number of hospitals able to manage emergency obstetric cases/ Proxy indicator: Number of hospitals that offer full surgical service				1	1	1	UNICEF	Sporadically	Monitoring

Annexes

Table A6: monitoring MDG6-HIV/AIDS, Malaria and other Diseases

TARGET: Have halted by 2015 and began to reverse the incidents of HIV/AIDS*, malaria and other Major Diseases

ASAP 2004 Proxy Indicators	'99	'00	'01	02	'03	'04	Info source	Regularity of data collected	Type/ Category of Info
Estimated Population--- Budi				**161,364**	**170,478**	**128,385**	**NIDs,NSCSE, MICS**		
Number of people knowledgeable about HIV and how to protect themselves									
Number of condoms distributed by agencies									
Number of schools with HIV/AIDS prevention education included in the curriculum									
Number of religious leaders who spread awareness about HIV/AIDS									
Number of HIV/AIDS voluntary councelling and testing services established									
Number of TB cases diagnosed and managed correctly									
Number of malaria cases diagnosed and managed correctly									
Number of relapsing cases and defaulters in TB programmes									
Number of health emergencies reported and identified rapidly, investigated and appropriate measures immediately instituted to prevent excess mortality									
Number of people treated for Kala-azar, Bureli ulcer & schistosomiasis									

Annexes

Table A7: Monitoring MDG 7 - Ensure Environmental Sustainability

TARGET: Halve By 2015, the proportion of people without access to safe drinking water.

ASAP 2004 Proxy Indicators	'99	'00	'01	'02	'03	'04	Information source	Regularity of Data collected	Type/ Category of Info
Estimated Population--- Budi				**161,364**	**170,478**	**128,385**	**NIDs,NSCSE, MICS**	Sporadically	Monitoring
Number of water points constructed					125	71	Unicef/WES	Sporadically	Monitoring
Number of successful water points					61		Unicef/WES	Sporadically	Monitoring
Number of operational water points					23	28	Unicef/WES		
Number of persons per successful water points									
% of households with sanitary latrines (HH No:5)									
Number /(%)of children experiencing more than one diarrhea episode in a year									
Incidence of guinea worm cases									

Table A8: Budi County Status of Millennium Development Goals

	MDG TARGET (by 2015)	MDG INDICATOR	STATUS	SOURCE
GOAL 1: POVERTY & HUNGER	**MDT 1:** Halve the proportion of people whose income is less than one dollar a day.	1. Proportion of population below $1 per day.	N/A	
		2. Poverty gap ratio.	N/A	
		3. Share of poorest quintile in national consumption.	N/A	
	MDT 2: Halve the proportion of people who suffer from hunger.	4. Prevalence of underweight children under five years of age.		
		5. Proportion of population below minimum level of dietary energy consumption.	30%	WFP, ANA 2002/2003
GOAL 2: EDUCATION	**MDT 3:** Ensure that, children everywhere, boys and girls alike, will be able to complete a full course of primary schooling.	6. Net enrolment ratio in primary education.	22% Gross Enrolment Rate	SBA 2003, UNICEF
		7. Proportion of pupils starting grade 1 who reach grade 5.	N/A	
		8. Literacy rate of 15-24 year olds.	N/A	
GOAL 3: GENDER EQUALITY	**MDT 4:** Eliminate gender disparity in primary and secondary education preferably by 2005 and to all levels of education no later than 2015.	9. Ratio of girls to boys in primary, secondary and tertiary education.	0.7:1 (Primary)	SBA 2003 UNICEF
		10. Ratio of literate females to males of 15-24 year olds.	N/A	
		11. Share of women in wage employment in the non-agricultural sector.**	N/A	
		12. Proportion of seats held by women in national parliament.	22 women	National Liberation Council, SPLM
GOAL 4: CHILD MORTALITY	**MDT 5:** Reduce by two-thirds, the under-five mortality rate.	13. Under-five mortality rate.	N/A	
		14. Infant mortality rate.	N/A	
		15. Proportion of one-year-old children immunised against measles.	<1%	‡UNICEF/Health 2003
GOAL 5: MATERNAL HEALTH	**MDT 6:** Reduce by three-quarters, the maternal mortality ratio.	16. Maternal mortality ratio.	N/A	
		17. Proportion of births attended by skilled health personnel.	N/A	
GOAL 6: HIV/AIDS, MALARIA & OTHER DISEASES	**MDT 7.** Have halted, and begun to reverse, the spread of HIV/AIDs.	18. HIV prevalence among 15-24 year old pregnant women.	1-7% of gen pop. (Southern Sudan)	Richer,2003 health overview, UNICEF
		19. Contraceptive prevalence rate.	N/A	
		20. % Of women 15-49 years with sufficient knowledge of HIV/AIDS Transmission.	N/A	
	MDT 8: Have halted, and begun to reverse, the incidence of malaria and other major diseases.	21. Prevalence and death rates associated with malaria.	32% morbidity	SBA/Unicef 2003 Up to August
		22. Proportion of population in malaria risk areas using malaria prevention and treatment measures.	N/A	
		23. Prevalence and death rates associated with tuberculosis.	N/A	
		24. Proportion of TB cases detected and cured under DOTS.	25% detected (southern Sudan)	Global Fund Proposal, UNICEF
GOAL 7: ENVIRONMENTAL SUSTAINABILITY	**MDT 9:** Integrate the principles of sustainable development into country policies and programmes and reverse the loss of environmental resources.	25. Proportion of land area covered by forest.	N/A	
		26. Land area protected to maintain biological diversity.	N/A	
		27. GDP per unit of energy use.	N/A	
		28. Carbon dioxide emissions and global atmospheric pollution.	N/A	
	MDT 10: Halve the proportion of people without sustainable access to safe drinking water.	29. Proportion of population with sustainable access to an improved water source.	N/A	
	MDT 11: By 2020, to have achieved a significant improvement in the lives of at least 100 million slum dwellers.	30. Proportion of population with access to improved sanitation.	N/A	
		31. Proportion of people with access to secure tenure.	N/A	

Annexes

Table B: South Sudan MDG Status at a Glance

Goal	Target	Indicators	Current Achievement	Year of achievement	Target For 2015	Will development goal be achieved (probably, potentially, unlikely, lack of data)	State of supportive environment (strong, fair, weak but improving, weak)	Monitoring capacity (strong, fair, weak)
(1) Eradicate extreme poverty and hunger	Reduce by half the proportion of people living on less than a dollar a day	The proportion of the population below $1 per day	>90%	2003	45%	Unlikely	Weak	Weak
	Reduce by half the proportion of people who suffer from hunger	Prevalence of child malnutrition (weight /age)% of under five	48%	1995-2001	24%	Potentially	Weak but improving	Fair
		Proportion of population facing food deficit	23%	2003	11%	Potentially	Weak	Fair
(2) Achieve universal primary education	Ensure that all boys and girls complete a full course of primary schooling	Net Enrolment in primary education-boys, girls,	20%	2000	100%	Unlikely	Weak but improving	Fair
		Gross enrolment rate % of cohort reaching G5	23% 28%	2000 2000	100%	Potentially	Weak but improving	Fair
		Primary Completion Rate	2%	2000				Weak
		Literacy Rates of 15-24 year olds	31%	2000	100%	Unlikely	Weak	Weak
(3) Promote gender equality and empower women	Eliminate gender disparity in primary and secondary education preferably by 2005, and at all levels by 2015	Ratio of girls to boys in primary, secondary and tertiary education	40%-primary	2003	100%	Unlikely	Weak	Fair
		Ratio of literate females to males among 15-24 year olds	35%	2000	100%	Unlikely	Weak	Weak
	To empower women	Share of women in wage employment in the non-agricultural sector				Lack of data	Weak	Weak

Annexes

Continued, Table B: South Sudan MDG Status at a Glance

Goal	Target	Indicators	Current Achievement	Year of achievement	Target For 2015	Will development goal be achieved (probably, potentially, unlikely, lack of data)	State of supportive environment (strong, fair, weak but improving, weak)	Monitoring capacity (strong, fair, weak)
(3) Promote gender equality and empower women	To empower women	Proportion of seats held by women in SPLM Leadership Council (Out of 15 seats)	0	2004	50%	Unlikely	Weak	Fair
		Percent of seats held by women in National Liberation Council (15out of 83)	18%	2004	50%	Potentially	Weak	Fair
		Percent of seats held by women in National Executive Body (1 out of 21 Secretariats)	0.05%	2004	50%	Unlikely	Weak	Fair
		Proportion of women holding position of County Secretary (1 out of 50)	2%	2004	50%	Unlikely	Weak	Fair
(4) Reduce child mortality	Reduce by two thirds the mortality rate among children under five	Under five mortality rate	250	2001	83	Unlikely	Weak	Weak
		Infant mortality rate	150	2000	50	Unlikely	Weak	Weak
		Proportion of one-year old children immunised against measles	12%	2003		Potentially	Weak but improving	Fair
(5) Improve maternal health	Reduce by three quarters the maternal mortality ratio	Maternal mortality ratio	1700	2000	425	Unlikely	Weak	Weak
		Proportion of births attended by skilled health personnel	5%	2000	90%	Unlikely	Weak	Weak

Annexes

Continued, Table B: South Sudan MDG Status at a Glance

Goal	Target	Indicators	Current Achievement	Year of achievement	Target For 2015	Will development goal be achieved (probably, potentially, unlikely, lack of data)	State of supportive environment (strong, fair, weak but improving, weak)	Monitoring capacity (strong, fair, weak)
(6) Combat HIV/AIDS, malaria and other diseases	Halt and begin to reverse the spread of HIV/AIDS	HIV prevalence rate	2.6%	2003			Weak	Weak
		Contraceptive prevalence rate	<1%	2000		Unlikely	Weak	Weak
		Number of children orphaned by HIV/AIDS				Lack of data	Weak	Weak
		Prevalence and death rates associated with malaria					Weak	Weak
		Proportion of population in malaria risk areas using effective malaria prevention and treatment measures	36% (%of <5s sleeping under a bed net)	2000		Lack of data	Weak	Weak
			36% (%febrile<5s treated with anti-malarials)	2000		Lack of data	Weak	Weak
		Prevalence rates associated with tuberculosis (per 100,000)	325	2002		Lack of data	Weak	Weak
		Proportion of TB cases detected and cured under directly observed treatment short course (DOTS)	6%	2002		Lack of data	Weak	Weak

Annexes

Continued, Table B: South Sudan MDG Status at a Glance

Goal	Target	Indicators	Current Achievement	Year of achievement	Target For 2015	Will development goal be achieved (probably, potentially, unlikely, lack of data)	State of supportive environment (strong, fair, weak but improving, weak)	Monitoring capacity (strong, fair, weak)
(7) Ensure environmental sustainability	Integrate the principles of sustainable development into country policies and programmes; reverse loss of environmental resources	Proportion of land area covered by forest				Lack of data	Weak	Weak
	Reduce by half the proportion of people without sustainable access to safe drinking water	Proportion of population with sustainable access to an improved water source	27%	2000	64%	Unlikely	Weak	Weak
		Use of safe water	21%	2000	61%	Unlikely	Weak	Weak
	Achieve significant improvement in lives of at least 100 million slum dwellers, by 2020	Proportion of population with sustainable access to improved sanitation	15%	2000	58%	Unlikely		Weak
Develop a global partnership for development	In co-operation with the private sector, make available the benefits of new technologies, especially information and communications	Telephone lines and cellular subscribers per 100 population	<1%	2003		Unlikely	Weak	Weak