# AREA-BASED ASSESSMENT IN AREAS OF RETURN

OCTOBER 2019

## Renk Town, Renk County, Upper Nile State, South Sudan

## Context

Renk Town is located in Renk County, Upper Nile State, near South Sudan's border with Sudan. Since the formation of South Sudan in 2011, Renk Town has been a major transit point for returnees from Sudan and, since the beginning of the current conflict in 2013, for internally displaced people (IDPs) fleeing conflict in Upper Nile State.[1]

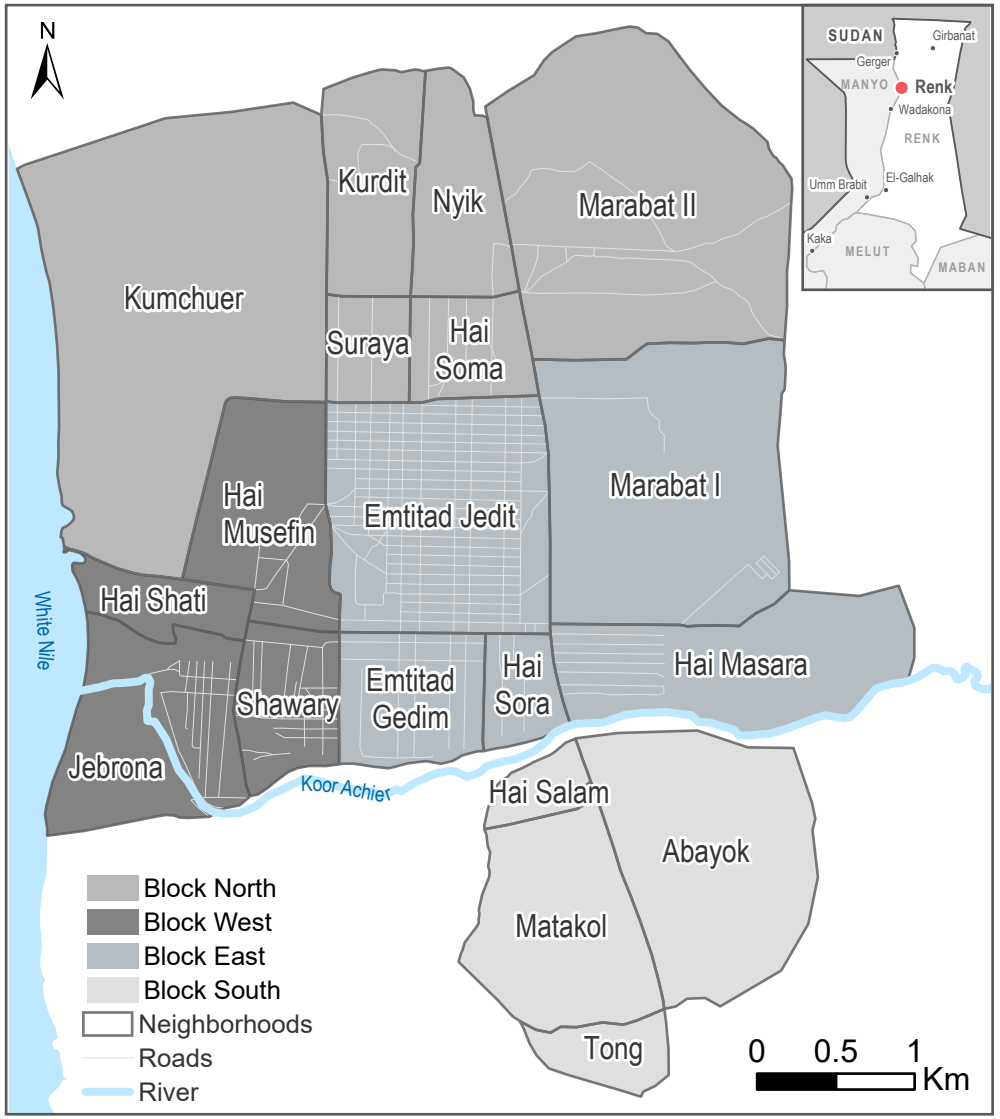
Renk was classified by the Integrated Phase Classification (IPC) Analysis Workshop in August 2019 as Phase 4 'Emergency' with 50% of the population in either Phase 3 'Crisis' (65,997 individuals) or Phase '4' Emergency' (28,284 individuals).[2] Additionally, Renk was classified as Phase 5 'Extremely Critical' for Global Acute Malnutrition (GAM),[3] suggesting the prevalence of acute malnutrition was above the World Health Organisation (WHO) recommended emergency threshold with a recent REACH Multi-Sector Needs Assessment (MSNA) establishing a GAM of above 30%.[4] A measles outbreak was declared in June 2019 and access to clean water was reportedly limited, as flagged by the Needs Analysis Working Group (NAWG) and by international NGOs working on the ground.[4]

Based on the convergence of these factors causing high levels of humanitarian need and the possibility for larger-scale returns coming to Renk County from Sudan, REACH conducted this Area-Based Assessment (ABA) in order to better understand the humanitarian conditions in, and population movement dynamics to and from, Renk Town.

## Overview

This ABA was developed in order to support humanitarian actors in South Sudan to identify priority needs and vulnerabilities of the overall population living in areas of return, to evaluate the functionality and accessibility of basic services and critical infrastructure in the assessed area and to provide an analysis of protection concerns and related topics such as access to justice, housing, land and property (HLP) and social cohesion. A mixed methods approach was used, combining analysis of secondary data and collection of quantitative and qualitative primary data (see **Methodology** section). Data was collected in Renk town from 23 September to the 10 October 2019 through 439 household (HH) interviews, 8 focus group discussions (FGDs), 4 key informant (KI) interviews and 45 mapped infrastructure facilities.

## Assessed Location




1. REACH, Regional Displacement of South Sudanese, Movement and Trade between Renk County. Upper Nile State, South Sudan and White Nile State, Sudan. May 2018.
2. Integrated Food Security Phase Classification (IPC), South Sudan: Acute Food Insecurity and Acute Malnutrition Situation for August 2019 – April 2020.
3. *Ibid.*
3. REACH, Renk Multi-Sectoral Needs Assessment Brief. Renk County, Upper Nile State, South Sudan.
4. Needs Assessments Working Group (NAWG), Summary of Flagged



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## KEY HIGHLIGHTS

**Displacement status and population movements**

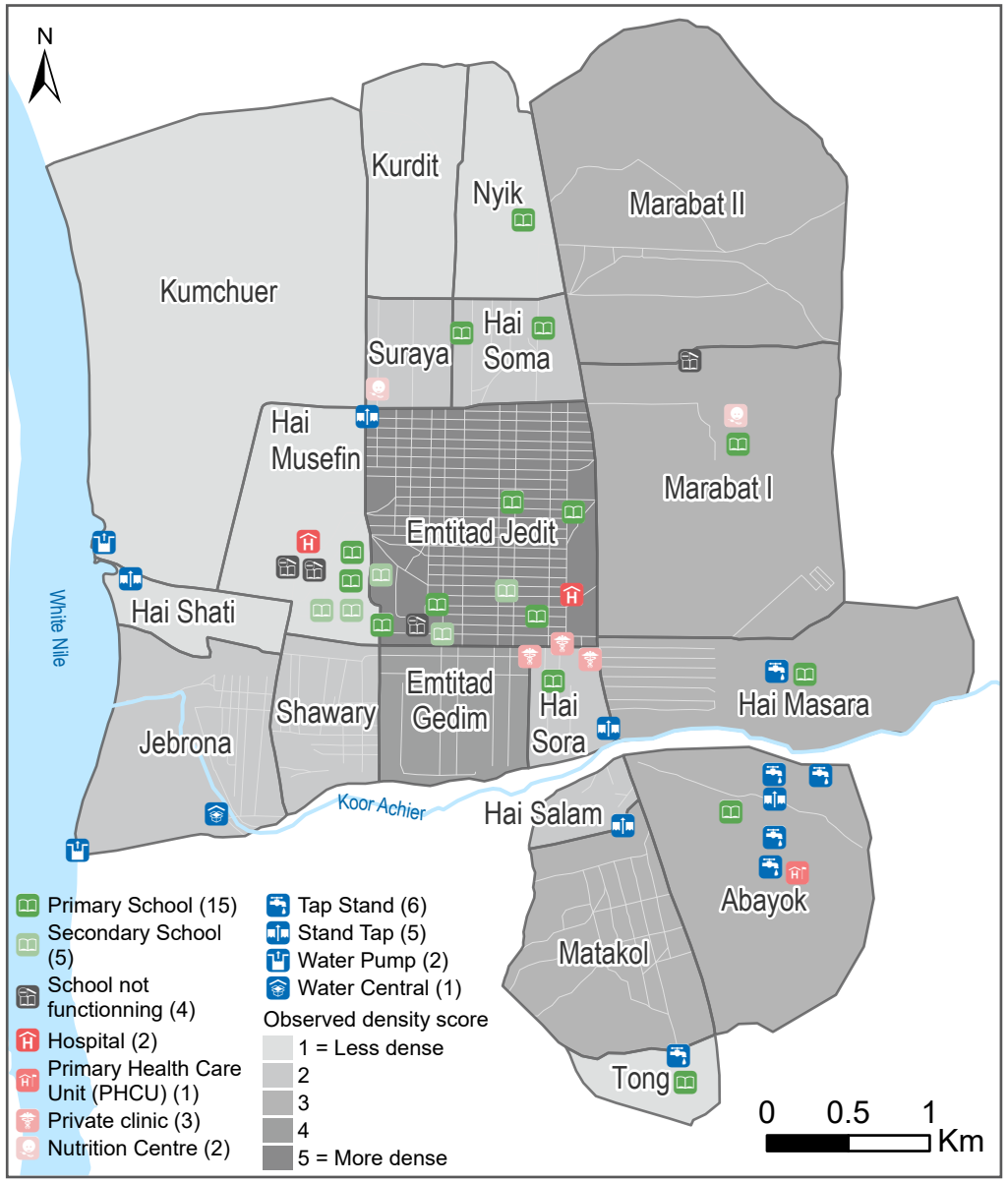
Renk county is in the northern sorghum and livestock livelihood zone,[5] located in the northeast of the country and bordering Sudan. Traditionally households rely on agriculture, arabic gum production, causal and seasonal labour, trading, fishing, as well as sale of natural resources or alcohol. Renk Town is a transit point for movements to and from Sudan: after the independence in 2011, it became a major destination and transit point for returnees from Sudan and since the beginning of the conflict in 2013, IDPs fleeing conflict in Upper Nile State.[6,7] Having one of the largest markets in Upper Nile State, Renk has attracted people from all over the country coming for trade, contributing to the diverse composition of population groups in the area.

During the time of data collection, small percentages of refugee returnees were reported returning to Renk Town which mainly remained a transit point. Most of the displaced population and refugees living abroad were originally from the West Bank of Upper Nile and reported only passing through Renk Town before returning to their area of origin, as indicated by the August 2019 REACH Port and Road Monitoring[8] exercise. HHs originating from Renk but still living in Sudan were reportedly monitoring the security situation before considering a return, as explained by FGDs and KIs. Future returns movements are related to the perceived security situation in town, but also to the deterioration of living conditions in Sudan that could act as a pull factor for a larger number of people returning.

**Population needs and service availability**

Main needs and vulnerabilities of the population in Renk Town seemed to vary mostly depending on the areas within the town rather than by the HH profile. Because of the inefficiency of the main water station and the pipeline system, only HHs living in the central areas of the city reported accessing water directly to their shelter while HHs living in the other areas of the town had to buy water or rely on public sources. Most primary and secondary schools were also situated in the central areas of the town and therefore more easily accessible for children of these communities. Similarly, permanent structures were identified in the central areas of the town, while fragile shelters like rakoobas and tukuls[9] were observed in the peripheral areas. These areas which are lacking concrete infrastructure were also particularly affected by the recent flooding in 2019, giving rise to additional concerns for the already vulnerable population living in those areas.

## RENK TOWN INFRASTRUCTURE MAP




5. Livelihoods Zone Map and Descriptions for The Republic of South Sudan (Updated). FEWSNET. August 2018.
6. REACH, Regional Displacement of South Sudanese, Movement and Trade between Renk County. Upper Nile State, South Sudan and White Nile State, Sudan. May 2018
7. IOM, DTM South Sudan, Conflict and displacement timeline, Malakal / Upper Nile 2014 - 2016.
8. REACH, Port and Road Monitornig, Renk, August 2019.
9. Rakoobas are temporary shelters made from straw, while tukuls are mud huts.

## HH SURVEY SECTORIAL FINDINGS (READERS CAN FIND HYPERLINKS TO EACH SECTION BY CLICKING ON THE HUMANITARIAN ICONS)

**11%** of HHs in Renk Town were reported being **refugee returnees** who had returned to Renk from another country

Almost **40%** of the HHs reported practicing **open defecation** due to lack of latrines.

**47%** of HHs reported their shelter being **partially or completely damaged** at the time of the assessment

**44%** of HHs reported the presence of **traditional community leadership** structures operating in their neighbourhood

**15%** of HHs reported that boys and girls aged between 6 and 12 years old **were not regularly attending school**

**35%** of HHs reported **not being able to access enough food** during the month prior to the assessment

**94%** of HHs reported having **good or very good relations** with members of the host community, IDPs and returnees

**69%** of HHs reported facing some type of **barriers for accessing health care services**

**21%** of HHs reported **receiving humanitarian assistance** during the three months prior to the assessment

**Displacement status and population movments:** Due to multiple displacement and large scale population movements in the region over the years, it has become difficult to differentiate displaced and non-displaced populations. Findings from the HH assessment show that 31% of the assessed HHs report to be non-displaced, 24% refugee returnees, 18% IDPs, 17% IDPs who have returned home, and 11% seasonal/ temporary migrants.

**WASH:** Level of access to water for HHs differed depending on the geographic area. Due to the inefficiency of the main water station and the pipeline system, only HHs living in the central areas of the city reported accessing water directly within their shelter, with people from the southern block relying on four public tap stands and residents from the northern areas generally buying water.

**Shelter:** Permanent shelter structures were mostly observed in the eastern and western blocks while traditional rakoobas and tukuls were mostly observed in the southern and northern areas of the town, areas also the most affected by flooding during the 2019 rainy season.

**CCCM:** Almost half of the HHs reported the presence of traditional community leadership structures (such as committees, village leaders, etc.) operating in their neighbourhood. Phone networks and television broadcasts were the main sources of information reported.

**Education:** The majority of HHs reported that children in their households have access to primary and secondary education. However, data collected from KI interviews indicated that the overall school infrastructure system was weak: the main issues reported were the lack of qualified teachers compared to the number of students, the lack of feeding programs and the lack of functioning latrines and water points near the education facility.

**FSL:** Over a third of HHs reported not being able to access enough food in Renk Town in the month prior to the assessment. The main reported reason for the lack of food was the high price of goods in the market, likely linked to the closure of the border with Sudan since March 2019.[10] The main income-generating activities were typical of an urban area such as skilled/unskilled labour and owning shops in the market, with only 39% of HHs reporting cultivating and 21% owning livestock as their main livelihood source.

**Protection & HLP:** Strong social cohesion indicators were reported in Renk Town. The majority of HHs reported having good or very good relations with the other population groups. Similarly, minimal housing, land, and property (HLP) and protection concerns were reported in Renk Town.

**Health:** Only one of the three main health facilities in Renk Town scored "very good" on the functionality score index (FSI), a calculation used to compare the functionality of different facilities.[11] The main reported barriers to access sufficient health care were the lack of medical resources such as medication, beds, trained staff, and a limited range of services available to patients.

**Humanitarian Assistance & AAP:** A minority of HHs reported receiving humanitarian assistance (mainly in the form of food distribution) during the three months prior to data collection and the majority reported being satisfied by the type of assistance received.

10. The high price of goods in the market can be attributed to the increased transportation costs of goods coming from Sudan given the closure of the border in mid-March 2019, which resulted in traders using illegal or higher-taxed routes as well as due to poor road conditions in the rainy season.

11. The FSI is based on a list of indicators such as the type of services provides in the facility and the quality of the infrastructure which allows the calculation of a score going from Bad to Very Good and helping classifying each education and health facility assessed in Renk Town.



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## DISPLACEMENT STATUS AND POPULATION MOVEMENTS

Due to multiple displacement and large scale population movements in the region over the years, it has become difficult to differentiate displaced and non-displaced populations. Population composition of the households (HHs) was mixed, comprising of: 31% non-displaced HHs, 24% of refugee returnees, 18% IDPs, 17% IDPs who have returned home, and 11% seasonal/ temporary migrants. IDPs living in Renk Town were mainly displaced during the years of conflict in Upper Nile region between 2013 and 2014, and mostly arrived from locations within Malakal and Renk counties. A small percentage (11%) of HHs reported returning from Sudan to Renk Town; the majority of refugee returnees intended to return to Malakal POC and Juba Town according to October 2019 REACH Port and Road Monitoring data.[12] Additionally, 11% of HHs who arrived in Renk Town did so in order to access livelihoods and trade, as the market in Renk Town is considered to be one of the main markets in Upper Nile region and thus attracts traders and economic migrants from other regions and from Sudan.

**Displacement status:**

| | |
|---|---|
| **Non- displaced** | 31% |
| **Refugee returnees**[13] | 24% |
| **IDPs** | 18% |
| **IDPs who have returned home** | 17% |
| **Migrants**[14] | 11% |

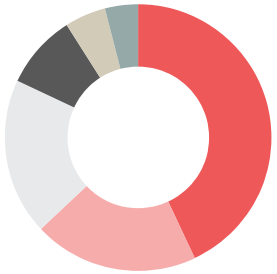
| Displacement status | Year of arrival to / return in Renk | Place previously displaced / originally from | Push factors for leaving previous location | Pull factors for arriving in Renk Town | Movement intentions |
|---|---|---|---|---|---|
| **Non-displaced** | n/a | n/a | n/a | n/a | 38% of HHs are planning to permenantley leave Renk Town (80% of them in more than six months) |
| **IDPs HHs** | 1 15% in 2013<br>2 14% in 2014<br>3 14% in 2015 | 1 27% from Malakal County<br>2 23% from Renk County<br>3 10% from Maban County | 1 59% lack of food<br>2 29% lack of water<br>3 29% lack of education | 1 53% access to healthcare<br>2 48% security<br>3 43% access to education | 49% of HHs are planning to settle permanently in Renk Town |
| **IDPs who have returned home** | 1 32% in 2014<br>2 21% in 2015<br>3 13% in 2016 | 1 64% from Renk County<br>2 8% from Maban County<br>3 7% from Melut County | 1 39% lack of education<br>2 36% lack of shelter<br>3 36% insecurity | 1 39% security<br>2 35% access to healthcare<br>3 28% access to education | 78% of HHs are planning to settle permanently in Renk Town |
| **Refugees who have returned home** | 1 27% in 2015<br>2 27% in 2018<br>3 18% in 2019 | 96% of HHs returned from Sudan (47% of them were living in camps) | 1 39% insecurity<br>2 39% lack of shelter<br>3 39% of lack of food | 1 37% access to education<br>2 35% want to be at home<br>3 27% availability of local food | 80% of HHs are planning to settle permanently in Renk Town |
| **Migrants** | 71% of HHs arrived before 2010 | 96% of HHs were originally from South Sudan | n/a | 1 60% salaried work (public/ private)<br>2 17% trader/shop owner<br>3 10% unskilled casual labor | 65% of HHs are planning to settle permanently in Renk Town |

12. REACH, Port and Road Monitornig, Renk, August 2019.
13. Of these 24%, 11% of refugee returnees who had returned home, 8% of refugee returnees who had relocated in a settlement different form their habitual residence with the intention to settle permanently, and 5 % of refugee returnees were in IDP-like situation, i.e. temporarily living in a settlement different form their habitual residence with the intention to return to their home when possible. Se Annex II for displacement status flow chart.
14. Intended as an HH "where the decision to migrate was taken freely [...], for reasons of 'personal convenience' and without intervention of an external compelling factor'" (FAO, 2017).

# Water, Sanitation and Hygiene (WASH)

Less than half of the assessed households reported having access to a private source of water within their shelter (43%) while the majority (57%) reported relying on different sources such as tap stands and stand pipes (20%) or water vendors (19%). Moreover, a small percentage of the population reported collecting water directly from the White Nile River (4%). Over half (58%) of HHs reported having access to a functioning latrine while 38% reported practicing open defecation. Of those HHs reporting having access to latrines, most of them accessed traditional pit latrine (41%), private latrine shared with neighbours or friends (24%) or non-pit private latrines in their shelter (23%). Nearly half of the HHs (44%) were observed by trained enumerators to face sanitation problems such as living in areas where solid waste, waste water, and open defecation was visible around their accommodation. This highlights the lack of latrines and the practice of open defecation as main issues for residents in Renk Town.

**Most commonly reported sources of drinking water:**



| | |
|---|---|
| Private/home tap | 43% |
| Public tap/standpipe | 20% |
| Water vendor/donkey cart | 19% |
| Other | 9% |
| Borehole/tubewell | 5% |
| River/Swamp | 4% |

## Access To Water

**38%** of HHs reported not having enough water to meet their HH needs

**Most commonly reported barriers to access sufficient water:**
**(Among HHs reporting having barriers to access water; multiple choice was allowed)**

| | |
|---|---|
| 1 Long waiting time | 64% |
| 2 Water insufficient | 43% |
| 3 Bad quality of water | 39% |

**Reported walking distance to nearest water source from the HH shelter:**

| | |
|---|---|
| 1 At the HH shelter (no travel time) | 46% |
| 2 Under 30 minutes | 25% |
| 3 30 minutes to less than one hour | 20% |
| 4 One hour to less than half a day | 6% |
| 5 Half a day or more | 3% |

## Sanitation and Hygiene

**44%** of HHs reported facing environmental sanitation problems[15]

**% of HHs with latrine access:**

| | |
|---|---|
| 1 Yes | 58% |
| 2 No, open defecation in bush | 38% |
| 3 No, defecation in an area designated by the community | 2% |

**Most reported types of latrines:**
**(Among HHs reporting having access to a latrine)**

| | |
|---|---|
| 1 Traditional latrine (pit) | 41% |
| 2 Non-pit shared latrine (neighbourhood, friends) | 24% |
| 3 Non-pit private latrine (in HH shelter) | 23% |

**Most commonly reported hand-washing materials used by the HHs:**

| | |
|---|---|
| 1 Soap | 91% |
| 2 Only water | 6% |
| 3 Ash | 2% |

15. Living in areas where solid waste, water waste, or open defecation was visible within 30 meters of their shelter.



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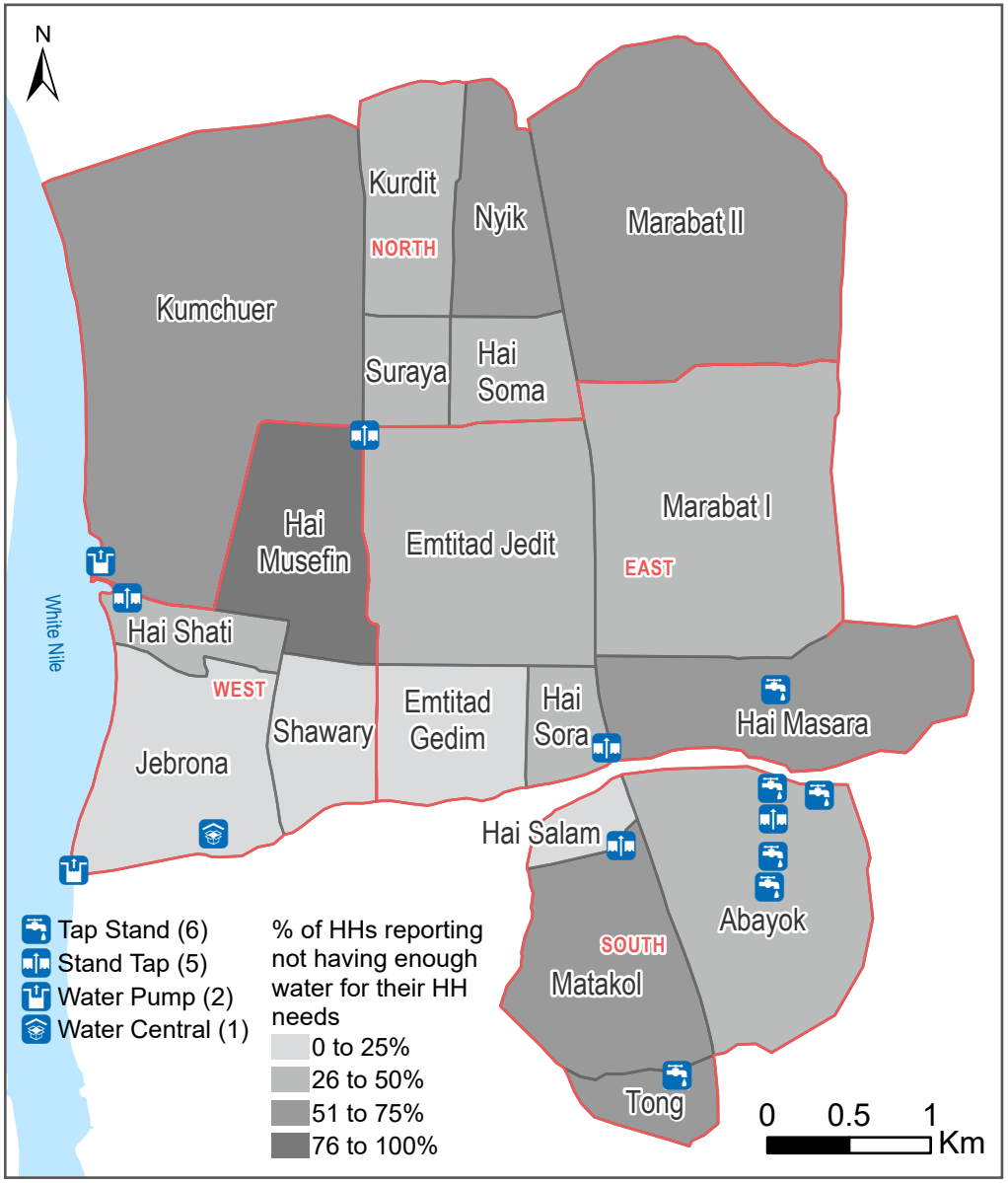
## RENK TOWN WATER INFRASTRUCTURE



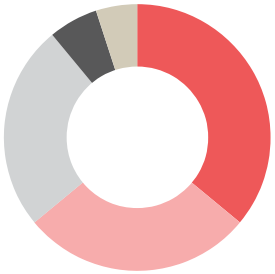

Access to water in Renk Town related to the geographic area in which HHs were living. Central areas of the town were generally better served by the municipality and HHs had overall better access to water compared to the northern and southern areas where HHs had no access to pipeline water and relied on the few communal water sources or buying water. The different proportions of HHs with access to piped water was probably linked to the capacity of the main water station in town: KIs explained that the majority of the neighbourhoods were connected to the main pipeline system, but the lack of materials and engineers working there lead to only the more central areas of the town being linked to the water central, causing a lack of access to piped water to peripheral areas of Renk Town. As a consequence, access to water was reportedly more adequate in the eastern and western blocks of the city (with the exception of Hai Musefin) with 65% and 60% of HHs respectively reporting having access to a private/home tap. On the other hand, HHs in the southern block reported relying mostly on public taps (44%), while in the northern areas of the town HHs access water mainly through donkey carts (45%).

Overall, 38% of HHs reported not having enough water to meet their HH needs. The main reported issues to access water were the long waiting time at the distribution point, and the quality and quantity of water available. FGDs participants in the western block for instance reported that access to water provided by the municipality was not consistent, which sometimes resulted in community members losing access to water for several days at a time. Male FGD participants in the northern block reported that only a minority of HHs had access to water in their shelter, while the majority bought it from water vendors. FGD participants explained that HHs were aware that the water they bought from vendors was untreated water from the Nile River. According to IDP FGD participants in Abayok, water points were generally very crowded and they reported extended queuing times and consequent tensions around water collection points. Water points were located in the central area of Abayok and people from the peripheral areas had to walk long distances to access it.

## SHELTER AND NFIS

Type of shelters varied according to the geographic area. Permanent structures were mostly observed in the eastern and western blocks (31% and 34% of HHs respectively) and in particular in neighbourhoods like Emtitad Jedit, Emtitad Gedim, Shawary and Jebrona, which were observed to be the more urbanised areas of the town. In contrast, more fragile structures were observed in the northern and southern areas of the city with traditional rakoobas accounting for almost half (48%) of the observed homes in the southern block, and 41% of tukuls were observed in the northern block. Lastly, abandoned buildings were most prevalent in the western block (13%), which is likely due to the conflict that happened in 2015, which primarily affected the western neighbourhoods along the river.

**Most commonly reported types of shelter:**

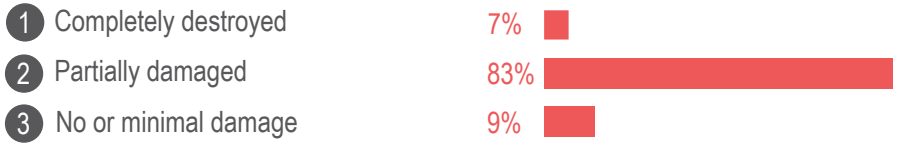


| | |
|---|---|
| Tukul[16] | 36% |
| Rakooba[17] | 28% |
| Permanenet structure[18] | 25% |
| Improvised shelter[19] | 6% |
| Abandoned building | 5% |

## ACCESS TO SHELTER

**47%** of HHs reported their shelter being damaged

**Overall severity of the damage to the shelter:**
(Among HHs reporting having damaged shelters)



| | |
|---|---|
| 1 Completely destroyed | 7% |
| 2 Partially damaged | 83% |
| 3 No or minimal damage | 9% |

**HHs main reported causes for shelter damage:**
(Among HHs reporting having damaged shelters; multiple choice was allowed)

| | |
|---|---|
| 1 Heavy rain | 46% |
| 2 Storm | 46% |
| 3 Fire | 6% |

## NFIS

**Top-three building materials HHs were able to access, either by foraging or by purchasing in the markets:**
(Multiple choice was allowed)

| | |
|---|---|
| 1 Mud | 72% |
| 2 Timber | 68% |
| 3 Grass | 63% |

**Most commonly reported sources of fuel for cooking and lighting:**
(Multiple choice was allowed)

| | |
|---|---|
| 1 Charcoal | 86% |
| 2 Wood | 45% |

**% of HHs with access to the following items:**
(Multiple choice was allowed)

| | |
|---|---|
| Blanket | 3% |
| Bucket | 10% |
| Cooking pot | 12% |
| Jerry can | 16% |
| Mosquito net | 35% |
| Plastic sheet | 45% |
| Pole | 50% |
| Rope | 54% |
| Sleeping mat | 56% |
| Soap | 65% |
| Torch/flashlight | 68% |

16. A round hut known as a tukul, is a shelter made of mud and wood, with a grass roof.
17. A traditional non-permanent shelter made from straw.
18. A shelter built of durable materials such as bricks or concrete.
19. A shelter made of branches, grass, and/or plastic sheet.

## Camp Coordination and Camp Management (CCCM)

Less than half of the HHs (46%) reported the presence of local authority structures functioning and accountable to the community. Similarly, 44% of HHs reported the presence of traditional community leadership structures (such as committees, village leaders, etc.) operating in their neighbourhood. Of these, the majority reported elderly groups to be the most represented in the community leadership structures (62%), followed by women and youth (both 17%). Lastly, the community leadership reported meeting mostly in the case of emergency (41%).

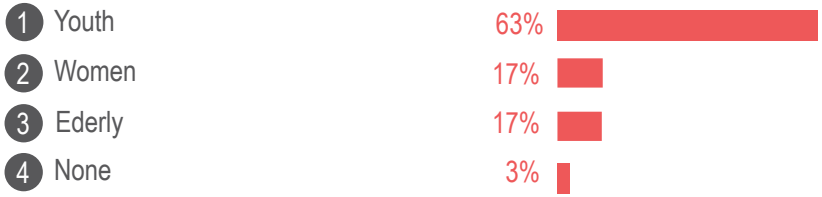
**18%** of HHs reported receiving humanitarian assistance

**46%** of HHs reported local authorities to be present and accountable to the community

**44%** of HHs reported the presence of traditional community leadership structures operating in their neighbourhood

### Most commonly reported groups represented in traditional local leadership:

(Among HHs reporting the presence of traditional community leadership structures)




### Top-three sources of information for HHs:


## Education

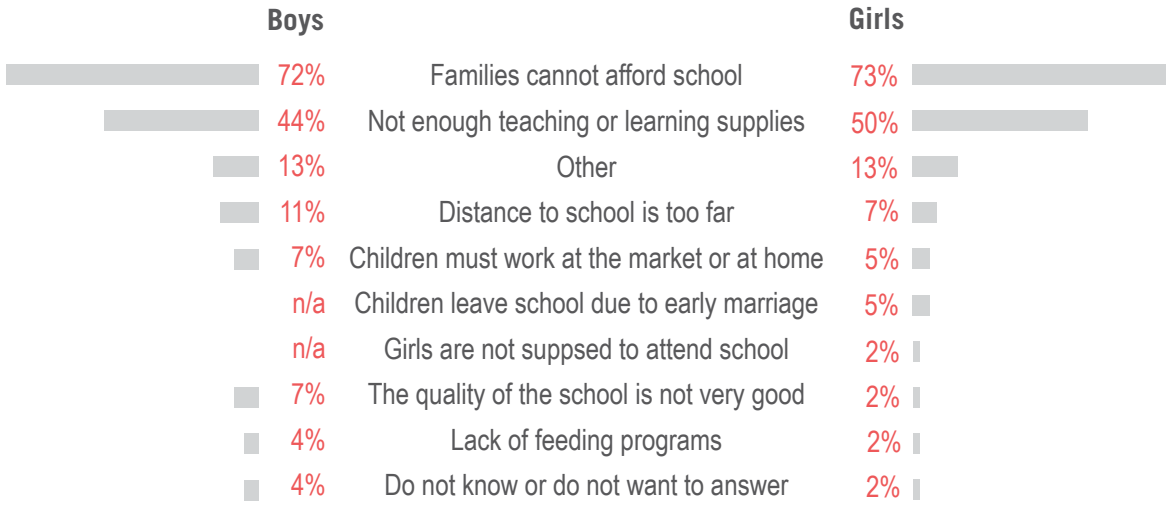
Access to education was high in Renk Town; among the HHs with at least one child aged 6 to 17 years old, approximately 85% of the HHs reported that girls and boys were regularly attending school. Most of the HHs that reported children not attending school cited inability to pay for school fees (72%) as the reason. Other main reasons reported for children not regularly attending school were the lack of school supplies such as uniforms and books (47%), the long distance to school (9%), and the need for boys and girls to work and support their family (6%).

**86%** of the HHs reported that **boys** aged 6 to 17 years old were regularly attending school

**83%** of the HHs reported that **girls** aged 6 to 17 years old were regularly attending school

### Most commonly reported barriers to access education services:

(Among HHs reporting girls and boys not regularly attending school; multiple choice was allowed)



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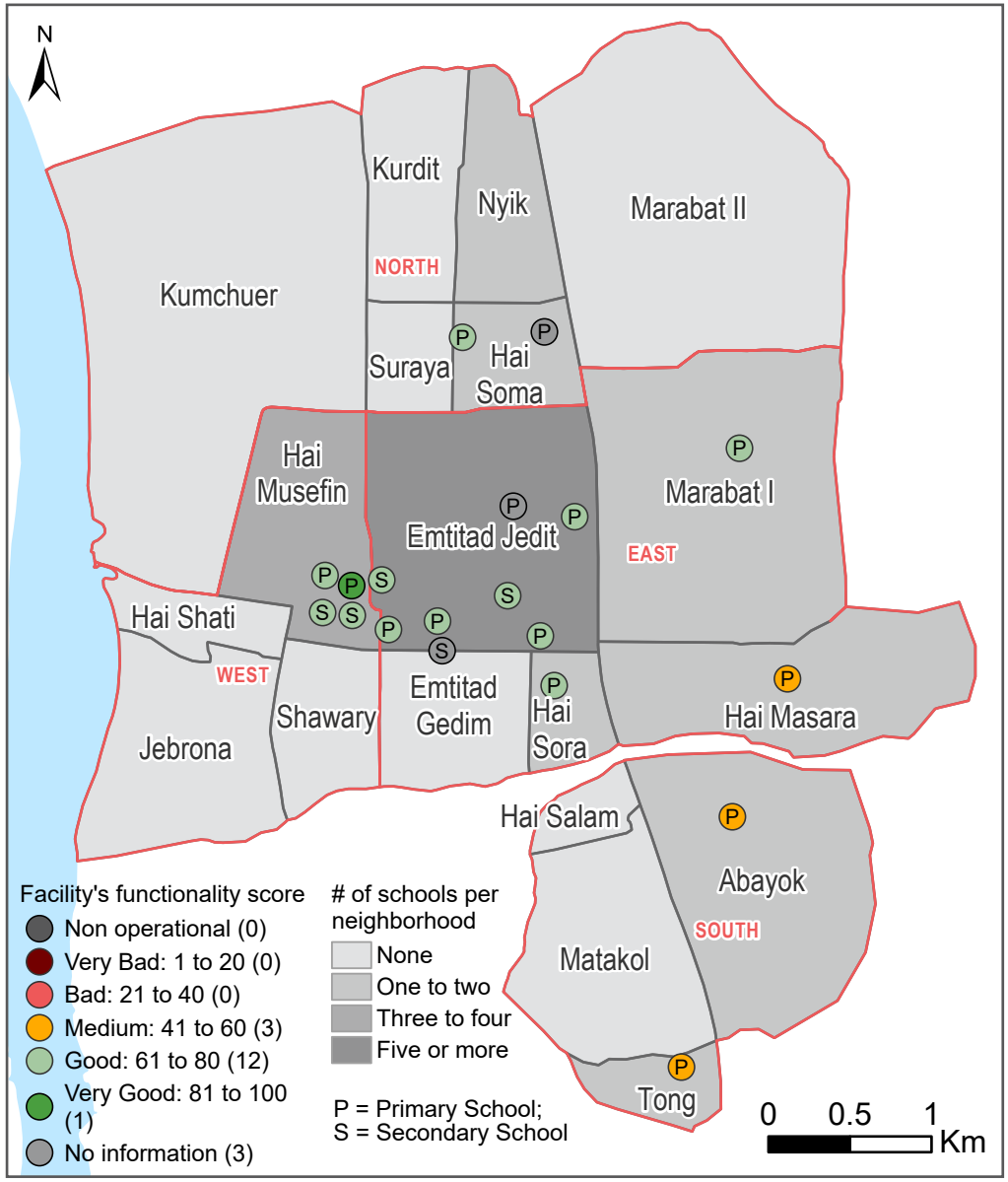
## FACILITY INFASTRUCTURE SCORE: SCHOOLS




Despite the high reported access to education, functionality of the education facilities was not as consistently strong. The functionality score calculation for the 16 education facilities assessed showed that only one facility scored "very good" (See *Annex I: Functionality Score Index (FSI) Calculation*). On the other hand, three facilities scored "medium" and twelve "good", which was linked to the lack of classrooms and qualified teachers as well as the insufficient number of functioning latrines and water points compared to the overall students' population. In particular, three schools were observed lacking a water point and two had no latrines at all. Lack of feeding programes was also reported as a main reason for children not attending school; KIIs reported that only a minority of schools were able to provide food to their students. A teacher working in a primary school in the western block described that a national NGO used to provide food to the school but they had to stop their services in 2018 because of a lack of funds. As a result, only six out of the sixteen schools assessed were observed having a functioning feeding program.

Lack of qualified teachers and school infrastructure were also mentioned as the primary barriers to increasing school capacity in the future. KIs explained that if the number of students enrolled in the school increased due to a future influx of returnees, only few schools would be able to respond to this heightened in demand, further explaining that the absorption of more students would only be possible if more qualified staff were recruited and there was improvement in school infrastructure.

Most of the education facilities were located in the central areas of the town, while few schools were observed in the peripheral areas. The schools in Hai Masara, Abayok and Tong were also the facilities scoring "bad" and "medium" in the facility infrastructure score, showing that not only the quantity but also the quality of services delivered in the peripheral areas of the towns should be improved to cover needs of the population living in those areas.

## FOOD SECURITY AND LIVELIHOODS (FSL)

A high proportion of HHs reported not being able to access enough food in Renk Town (35%). The main reasons for HHs not being able to do so were the high prices in the market (57%) and the lack of land available for cultivation (16%). The high price of goods in the market can be attributed to the increased transportation costs of goods coming from Sudan given the closure of the border in mid-March 2019. As a result of the border closure, many traders started using illegal or higher-taxed routes which combined with the poor road conditions in the rainy season might have impacted the prices in the market. Almost a fifth (19%) of the HHs were found to have a poor or borderline food consumption score (FCS), indicative of limited food consumption and/or food diversity. The main sources of income reported by HHs were typical of urban areas; while 18% of HHs still reported cultivation as main income-generating activity, overall the majority of HHs reported engaging in activities other than cultivation such as unskilled casual labour (18%), owning a shop (17%), or skilled labour (17%).

**35%** of HHs reported not being able to access enough food during the month prior to the assessment

**Food consumption score (FCS) index:**

| | |
|---|---|
| Poor | 7% |
| Borderline | 12% |
| Acceptable | 81% |

**Top-three reported primary sources of income:**

| | | |
|---|---|---|
| 1 | Agriculture | 18% |
| 2 | Unskilled casual labour | 18% |
| 3 | Shop owner | 17% |

**Top-three reported barriers for accessing sufficient food:**
(Among HHs reporting having barriers to access sufficient food)

| | | |
|---|---|---|
| 1 | High price of goods in the market | 57% |
| 2 | Not enough land for cultivation | 16% |
| 3 | No food distribution | 6% |

**64%** of the HHs reported not adopting livelihood coping strategies

**Main reported coping strategies adopted by HHs:**
(Among HHs reporting adopting coping strategies)

| | | |
|---|---|---|
| 1 | HH traveled to another village to look for food | 30% |
| 2 | HH borrowed money or purchased food on credit | 10% |
| 3 | HH gathered wild foods more than normal for this time of year | 10% |

**Reported monthly average income:**

| | | |
|---|---|---|
| 1 | More than 5000 SSP | 55% |
| 2 | Between 1000 and 5000 SSP | 29% |
| 3 | Below 1000 SSP | 15% |
| 4 | Do not want to disclose this info | 2% |

**Reported share of income spent to buy food:**

| | | |
|---|---|---|
| 1 | All of the income | 44% |
| 2 | Most of the income | 28% |
| 3 | Half of the income | 26% |
| 4 | Less than half of the income | 3% |
| 5 | Almost none of the income | 0% |

**61%** of HHs reported not having access to land for cultivation

**Main reported reasons for not being able to access land for cultivation:**
(Among HHs reporting not having access to land for cultivation)

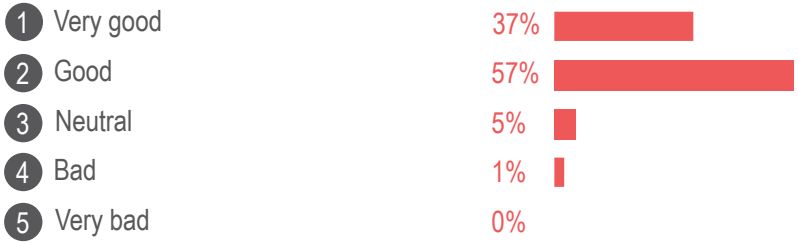
| | | |
|---|---|---|
| 1 | Not owning/no permissions to use land | 49% |
| 2 | HH does not engage in cultivation | 29% |
| 3 | Land for cultivation is too far away | 17% |

## PROTECTION AND HOUSING, LAND, AND PROPERTY (HLP)

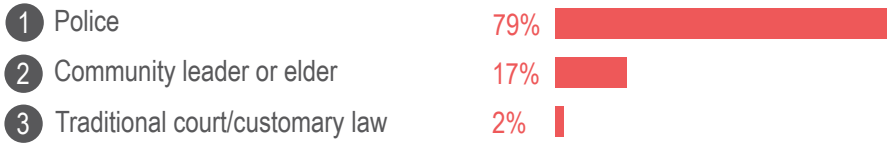
The vast majority of HHs (94%) reported having good or very good relations with members of the host community, IDPs and/or returnees, suggesting positive social cohesion between population groups in Renk Town. Only 9% of HHs reported experiencing insecurity, intimidation or violence in the month prior to the assessment. The vast majority of HHs reported informing either the police (79%) or making an appeal to community leaders or elders (17%) when a crime was committed in the community. Of the IDP and returnee HHs, only 37% reported their shelter was registered, an important procedure allowing HHs to prove the possession of the land on which their shelter was built on, mostly implemented by local authorities (57%). Similarly, 14% of HHs reported being at risk of eviction and 21% reported having to pay money or give goods or services in order to rent the land on which they lived. Finally, 34% of HHs reported not owning the land in which they were settled on.

### SOCIAL COHESION, PROTECTION AND SAFETY

**Most commonly reported type of relationship with members of the host community, IDPs and/or returnees:**




**Most commonly reported justice authority used by HHs in the event of a crime committed against a HH member:**




**Most commonly reported participation mechanisms used by HHs to participate in the decision making processes:**


**9%** of HHs reported experiencing insecurity, intimidation or violence in the month prior to data collection

**Top-three most commonly reported protection concerns[20] in assessed households:**

**Women**

| | | |
|---|---|---|
| 1 | Sexual violence | 24% |
| 2 | Forced marriage | 23% |
| 3 | Domestic violence | 9% |

**Men**

| | | |
|---|---|---|
| 1 | Violence between tribes | 24% |
| 2 | Forced recruitment | 13% |
| 3 | Substances abuse | 8% |

**Girls**

| | | |
|---|---|---|
| 1 | Sexual violence | 29% |
| 2 | Rape | 20% |
| 3 | Violence between neighbours | 9% |

**Boys**

| | | |
|---|---|---|
| 1 | Child labour | 16% |
| 2 | Forced recruitment | 14% |
| 3 | Violence at school | 14% |

20. "No issues" responses excluded from the graph.

## Protection and HLP Continued

### Housing, Land And Property (HLP)

**37%** of IDPs and Returnee HHs reported their shelter was registered with local agencies

**Most commonly reported agencies who registred the shelter:**
(Among HHs reporting their shelter being registered)


**14%** of HHs reported being at risk of eviction

**21%** of HHs reported reported having to pay money or give goods or services in order to rent the land on which they lived

**34%** of HHs reported reported not owning the land in which they were settled on

## Health

In Renk town, 69% of HHs reported facing barriers for accessing health care services. The main issues observed in the two hospitals were related to a lack of medical resources such as medications, beds, trained staff and a limited range of services available to the patients; for instance, Civil Hospital in the western block lacked the in-patient department (IPD) while no vaccine services were available in Military Hospital, located in the eastern block.

**89%** of HHs reported HH members being sick in the two weeks prior to the assessment

**86%** of HHs reported having received the required treatment /medication (among HHs reporting having sick HH members)

**69%** of HHs reported facing some type of barriers for accessing health care services

**Main reported symptoms or illness:**
(Among HHs reporting having sick HH members; multiple choice was allowed)

| | | |
|---|---|---|
| 1 | Malaria-like symptoms | 77% |
| 2 | Fever | 54% |
| 3 | Vomiting | 31% |

**Top-three reported barriers for accessing health care services:**
(Among HHs reporting issues accessing health facilities; multiple choice was allowed)

| | | |
|---|---|---|
| 1 | High cost of medicine | 29% |
| 2 | High cost of services | 23% |
| 3 | No medicine available | 20% |

**26%** of HHs reported a member of the HH having given birth in the three months prior to the assessment

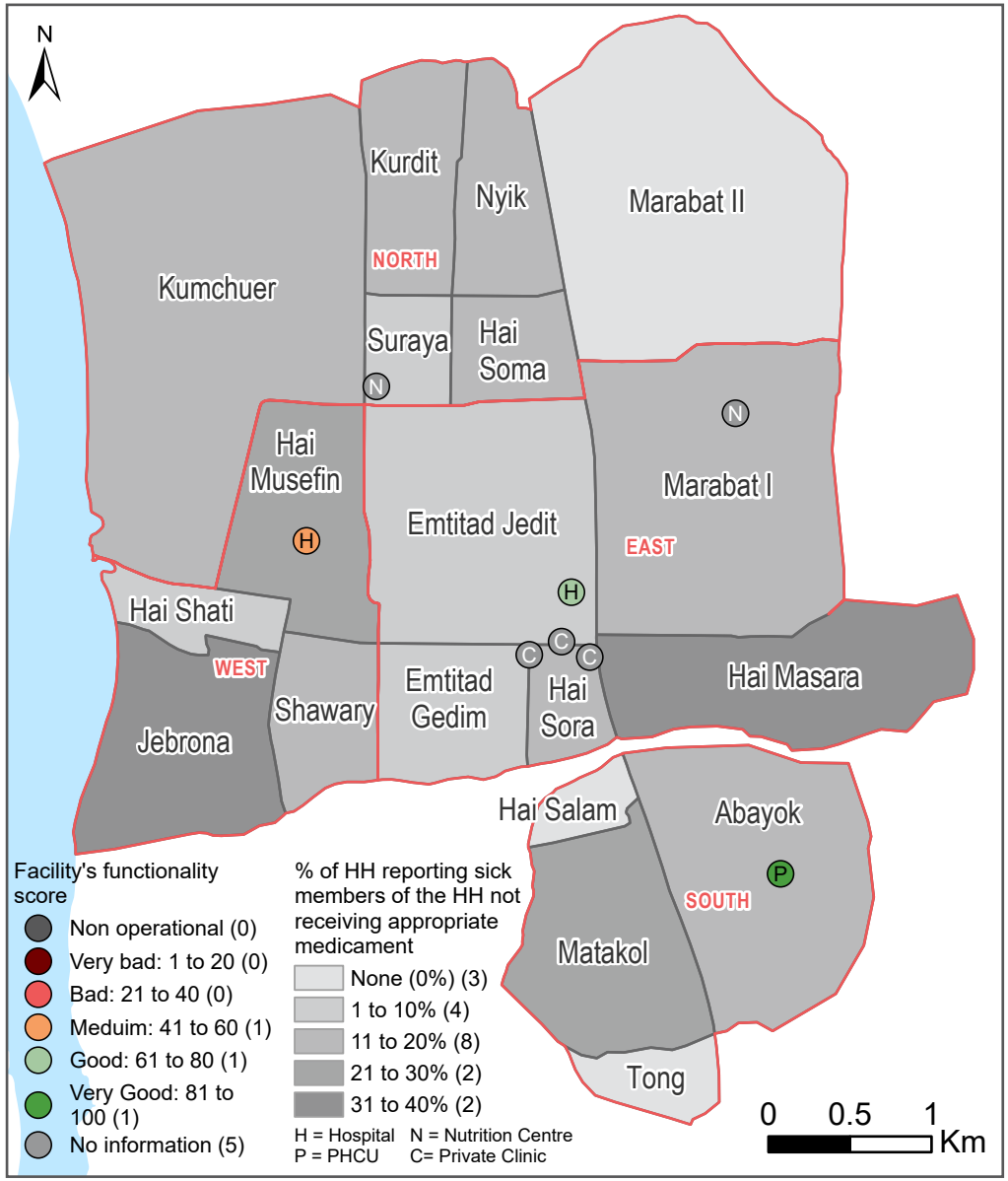
**Main reported places where the HH member gave birth**
(Among HHs reporting a member of the HH having given birth in the three months prior to the assessment)

| | | |
|---|---|---|
| 1 | At NGO health facility | 48% |
| 2 | At home | 25% |
| 3 | At government health facility | 22% |

**Main reported health workers who helped attend the birth?**
(Among HHs reporting a member of the HH having given birth in the three months prior to the assessment)

| | | |
|---|---|---|
| 1 | Skilled birth attendant (doctor, nurse, midewife) | 79% |
| 2 | Traditional birth attendant | 11% |

## FACILITY INFASTRUCTURE SCORE: HEALTH FACILITIES




The main health facilities present in Renk Town are the government-run Civil Hospital located in Hai Musefin, Military Hospital in Emtitad Gedim, and the Primary Health Care Unit (PHCU) in Abayok run by Medair. Three private clinics located around the main market Suk Shabir were all reported as functioning. Medair also runs two nutrition centres in Suraya and Marabat I neighbourhoods. The functionality score calculation showed a "very good" score for the Abayok PHCU, a "good" result for the Civil Military Hospital, and a "medium" result for the Civil Hospital.

The main issues observed in the two hospitals were related to a lack of medical resources such as medications, beds, trained staff and a limited range of services available to the patients. Additionally, FGD participants reported the lack of services (such as a laboratory) and the cost and availability of medications in both Civil and Military Hospitals as main issues, which can explain why participants from the eastern and northern blocks reported preferring the PHCU in the southern block, even if located further away. In parallel, the long waiting time and the lack of medications were the main challenges reported in Abayok PHCU. As reported by a KI in the health centre, medications were given freely to patients accessing the facility but not available to satisfy the wider demand. Moreover, participants of FGDs reported the availability of private clinics in town but that high costs and poor quality of services were the main challenges for people accessing them.

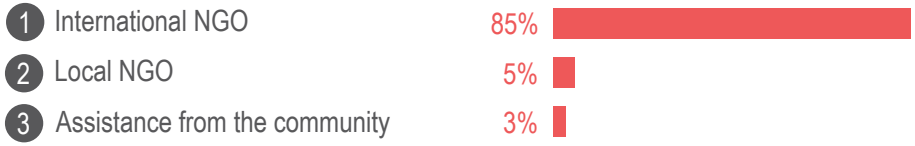
FGD participants explained that drugs were available in the pharmacies but because of the high cost not all HHs could afford to pay for them.

## ACCOUNTABILITY TO AFFECTED POPULATION (AAP)

A small proportion (21%) of HHs in Magwi Town reported receiving humanitarian assistance during the three months prior to the assessment. Of the HHs that had received aid, most were provided food assistance (59%) by an international NGO (85%) and the main type of assistance received was in-kind (55%). The majority of HHs (71%) reported being satisfied by the type of assistance received.

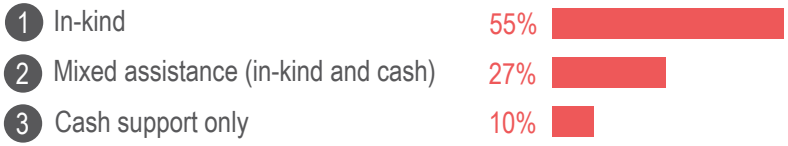
**21%** of HHs reported receiving humanitarian assistance during the three months prior to data collection

**Most commonly reported sources of assistance:**
(Among HHs reporting having received humanitarian assistance in the three months prior to data collection)




**Most commonly reported types of assistance received:**
(Among HHs reporting having received humanitarian assistance in the three months prior to data collection)


**Most commonly reported modalities of assistance received:**
(Among HHs reporting having received humanitarian assistance in the three months prior to data collection)




**71%** of HHs reported being satisfied by the type of assistance received

## CONCLUSION

The population in Renk Town was mostly relying on income-generating activities typical of an urban area such as unskilled casual labour, owning a shop, or skilled labour and work. However, high percentages (35%) of HHs were reported to not be able to access enough food, partially due to high market prices. As reported during FGDs the risk faced by HHs is the dependency on the volatility and fluctuations of prices in the markets accentuated by the regular and frequent closures of the border with Sudan. The dependency on market is likely to explain why the main reported need by the overall population is food.

Finally, because the perceived security situation within the town is strong, and because of the deterioration of living conditions in Sudan, return movements could be expected in the coming months as well as general and internal population movements typical of the region. In that case, health, water and education systems are of high importance to improve living conditions of the population in Renk Town in order to avoid potential tensions over access to services and resources in an area where gaps were already identified. The FSI calculation and the geographical analysis of main education, health facilities and water points in Renk Town showed a weak infrastructure system, in particular in peripheral areas where access to quality services and facilities is more challenging for already vulnerable HHs.

## About REACH

REACH facilitates the development of information tools and products that enhance the capacity of aid actors to make evidence-based decisions in emergency, recovery and development contexts. The methodologies used by REACH include primary data collection and in-depth analysis, and all activities are conducted through inter-agency aid coordination mechanisms. REACH is a joint initiative of IMPACT Initiatives, ACTED and the United Nations Institute for Training and Research - Operational Satellite Applications Programme (UNITAR-UNOSAT). For more information please visit our website: www.reach-initiative.org. You can contact us directly at: geneva@reach-initiative.org and follow us on Twitter @REACH_info.

## METHODOLOGY AND FUNCTIONALITY SCORE INDEX (FSI)

The ABA utilized a mixed method approach by combining analysis of secondary data[21] and collection of quantitative and qualitative primary data.

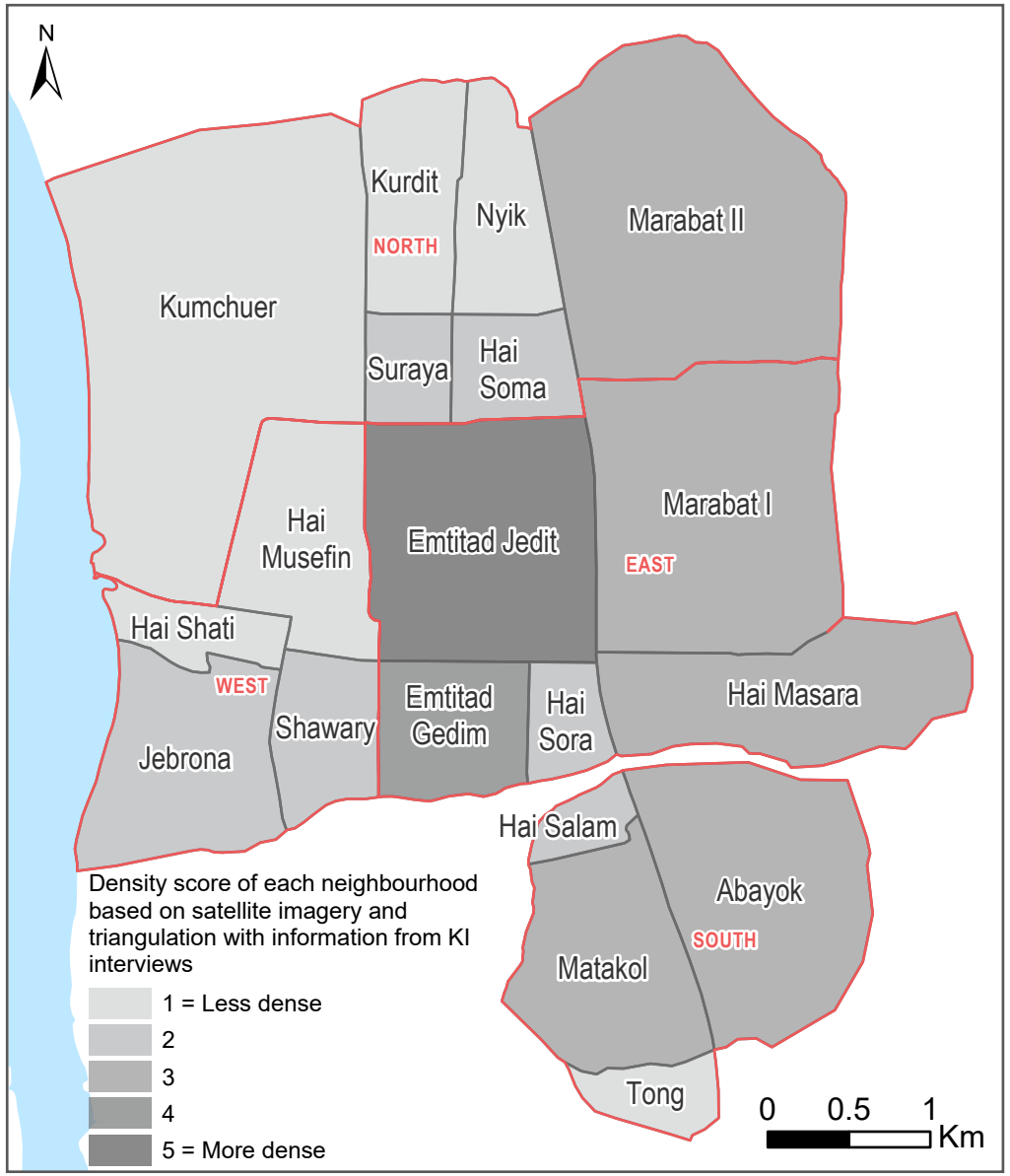
Three KI interviews with members of the municipality, local authorities and community leaders were conducted to draw the boundaries of the urban area during an exercise of participatory mapping using satellite imagery.

Eight FGDs were conducted with community members in order to understand potential drivers of conflict between HHs over access and availability to resources in the area, to identify availability of and access to services and basic infrastructure, as well as conducting a basic infrastructure mapping.

For the collection of quantitative data, a total of 438 households were assessed using mobile data collection through Open Data Kit (ODK). Data is representative at the urban area level with a 5% margin of error and 95% confidence level. Due to the lack of reliable population estimates, REACH calculated the sample size by observing the density of each neighbourhood (using satellite imagery and triangulation with information from KI interviews) and assigned a score between 1 and 5 to each neighbourhood. The sample frame was then proportionally distributed across all neighbourhoods based on the population density.

Finally, key community infrastructure points (healthcare facilities, schools, marketplaces, WASH facilities, etc.) were collected based on a list of facilities provided by local authorities, a snowball approach was then used to cover a maximum of key facilities in the area.[22] KI interviews were conducted with the school principal and medical personnel to understand the functionality and the absorption capacity[23] of education and health facilities in the selected area, allowing the calculation of a functionality score index (FSI) used to compare facilities. The FSI is based on a list of indicators such as the functionality of the infrastructure, the number of personnel working and the overall quality of the infrastructure, including access to water points and latrines. Each indicator scores between 0 (standard not reached) and 1 (standard reached), and the final sum allows the calculation of a score going from Bad to Very Good and helping classifying each education and health facility assessed in Renk Town. See Annex I for a detailed list of indicators used for the calculation of the FSI.

## RENK TOWN: OBSERVED DENSITY OF EACH NEIGHBOURHOOD




21. Such as UNHCR Spontaneous Refugee Returns updates, and IOM DTM Mobility Tracking.
22. Because of time limitation and inaccurate initial list, REACH cannot ensure all facilities in Renk Town were mapped.
23. I.e. the capacity to provide services to an increase in population.

# ANNEX I: FUNCTIONALITY SCORE INDEX (FSI) CALCULATION

## Health FSI

| Indicator | Question | Deficit standard | Scoring | Ref. |
|---|---|---|---|---|
| Functionality | Is the health facility operational? | Not operational | Fully operational (running every day) = 1<br>Partially operational (runnning less than 7 days per week) = 0.5<br>Not operational (closed) = 0 | H1 |
| Number of rooms | How many rooms does the facility have? | Number <= 3 | Number > 3 =1<br>Number <= 3 = 0 | H2 |
| Number of beds | How many beds does the facility have? | Number <= 15 | Number >= 15 =1<br>Number < 15 = 0 | H3 |
| Staff | What staff is available at the facility ? | # of available options / total of options | Available options: Doctors, Nurses, Midwives, Community health workers, Laboratory technicians, Pharmacist) | H4 |
| Staff availability | Is the staff enough to treat all the patients in the health facility? | No | Yes = 1<br>No = 0 | H5 |
| Number of medicine/ medical items available | Which medicines/ medical items are available at this health facility? | # of available options / total of options | Available options: Beds, malaria medication, Syringes/needles, IV solution,<br>Contraception, Painkillers, Heart medicine, Insulin, Blood pressure medicine, Eye drops, Antibiotics, Anaesthetics, Clean bandages, Blood transfusion bags) | H6 |
| Number of health services availables | Which of the following services are available at this health facility? | # of available options / total of options | Available options: Out-patient department (OPD), In-patient department (IPD), Hygiene promotion, Child immunisation, Diarrhoea treatment, Emergency care (accidents/injuries), Skilled care during childbirth, Surgery, Diabetes treatment, MHPSS services, HIV test, CMAM/OTP (nutrition services), Skilled breastfeeding support, Multivitamin nutrient packets) | H7 |
| Vaccines | Are vaccines available at this health facility? | No | Yes = 1<br>No = 0 | H8 |
| Electricity supply | Does the facility have an electricity supply? | No | Yes = 1<br>No = 0 | H9 |
| Water supply | Does the facility have a water supply? | No | Yes = 1<br>No = 0 | H10 |
| Access to functionning latrines | Does this health facility have access to functioning latrines? | No | Yes = 1<br>No = 0 | H11 |
| TOTAL | | | | X/11 |

## School FSI

| Indicator | Question | Deficit standard | Scoring | Ref. |
|---|---|---|---|---|
| Functionality | Is the school operational? | Not operational | Fully operational (running every day, morning and afternoon) = 1<br>Partially operational (running less than 5 days per week and/or only in the morning) = 0.5<br>Not operational (closed) = 0 | E1 |
| Classrooms with surface in sqm below standards | What is the average sqm surface of the classrooms? | Surface < 50sqm | Surface >= 50sqm = 1<br>Surface < 50sqm = 0 | E2 |
| Surface/students/clasrooms | Calculations to be done:<br>- How many classrooms are in this school?<br>- What is the average sqm surface of the classrooms?<br>- How many students are currently enrolled in this school? | Surface/student < 1.2sqm | Surface/student >= 1.2sqm = 1<br>Surface/student < 1.2sqm = 0 | E3 |
| Number of students / classroom | Calculations to be done:<br>- How many classrooms are in this school?<br>- How many students are currently enrolled in this school? | 50 students maximum per classroom | Number of students <= 50 = 1<br>Number of students > 50 = 0 | E4 |
| Number of teachers /students | Calculations to be done:<br>- How many teachers are working at the school?<br>- How many students are currently enrolled in this school? | 1 teacher for maximum 50 students | # students/ teachers <= 50 = 1<br># students/ teachers > 50 = 0 | E5 |
| Teachers qualifications | Do teachers have enough qualifications to teach here? (based on head of teachers' judgement) | No | Yes = 1<br>Some = 0.5<br>No = 0 | E6 |
| School fees | Do students have to pay school fees in this school? | Yes | Yes = 0<br>No = 1 | E7 |
| School with feeding program | Is there a feeding programme active at this school? | No | Yes = 1<br>No = 0 | E8 |
| School with access to water point point | Is there a water point at the school or within 500m? | No | Yes = 1<br>No = 0 | E9 |
| Access to functioning latrines | Are there functional latrines at the school? | No | Yes = 1<br>No = 0 | E10 |
| School with a fence | Does the school have a fence, wall or other boundary? | No | Yes = 1<br>No = 0 | E11 |
| TOTAL | | | | X/11 |

## ANNEX II: DISPLACEMENT STATUS FLOW CHART AND DECISION PROCESS