COUNTRY PROGRAMME EVALUATION

UNFPA SUDAN

FINAL EVALUATION REPORT

6th Cycle Programme
2013-2016

September 2015

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ABBREVIATIONS AND ACRONYMS

ANC	Antenatal Care
AWP	Annual Work Plan
AYSRH	Adolescent and Youth Sexual Reproductive Health
BCC	Behavior Change Communication
B/CEmoNC	Basic/comprehensive emergency, obstetric and neonatal care
BoC	Basic obstetric care
CAFA	Community-Friendly Association
CBOs	Community Based Organizations
CBS	Central Bureau of Statistics
CERF	Central Emergency Response - OCHA
CHF	Common Humanitarian Fund
CM	Child Marriage
CMR	Clinical Management of Rape
CO	Country Office
COAR	Country Office Annual Report
CP	Country Programme
CPD	Country Programme Document
CPE	Country Programme Evaluation
CPAP	Country Programme Action Plan
CSO	Civil Society Organization
CVAW	Combating Violence Against Women
DEX	Direct Execution
DFID	Department of International Development
DoWF	Directorate of Women and Family
DRR	Disaster Risk Reduction
ERG	Evaluation Reference Group
EPRP	Emergency Preparedness and Response Plan
F/SMoH:	Federal/State Ministry of Health
FGM	Female Genital Mutilation
FP	Family Planning
FPDO	Friends of Peace and Development Organization
FSW	Female Sex Worker
GBV	Gender based Violence
GF	Global Fund
GFP	Gender Focal Points
GoS	Government of Sudan
GRACe	Gender, Reproductive Health Rights Resource Centre
HIV/AIDS	Human Immuno Virus
HRU	Humanitarian Response Unit
ICPD	International Conference on Population and Development
IDP	Internally Displaced Population
IEC	Information, Education and Communication
IGA	Income Generating Activities
IP	Implementing Partner

I-PRSP	Interim Poverty Reduction Strategy Paper
JICA	Japan International Cooperation Agency
JIP	Joint Initiation Plan
JP	Joint Pogramme
LMIS	Logistics Management Information System
MARPS	Most at Risk Populations
MCH	Maternal and Child Health
MDR	Maternal Death Review
MDSS	Maternal Death Surveillance System
MH	Maternal Health
MHTF	Maternal Health Trust Fund
MICS	Multi Indicator Cluster Survey
MISP	Minimum Initial Service Package
MM	Maternal Mortality
M&E	Monitoring and Evaluation
MNH	Maternal and New Born Health
MNMR	Maternal and Neonatal Mortality Reduction
MoCYs	Ministry of Culture, Youth and Sports
MoGE	Ministry of Guidance and Endowments
MoFNE	Ministry of Finance and National Economy
MoWSS	Ministtry of Welfare and Social Security
MSW	Male Sex Worker
MTC	Mother to Child
NCCW	National Council for Child Welfare
NDP	National Development Plan
NEX	National Execution
NGO	Non-governmental Organization
NNC	Neonatal Care
NPC	National Population Council
NPP	National Population Policy
NSDS	National Strategy for the Development of Statistics
NTF	National Task Force
OF	Obstetric Fistula
P&D	Population and Development
PCWG	Protection Cluster Working Group
PHC	Primary Health Care
PLHIV	People living with HIV
PLWHA	People living with HIV/AIDS
PMTCT	Prevention of Mother to Child Transmission
PoA	Plan of Action
RH	Reproductive Health
RHCS	Reproductive Health Commodity Supply
RMS	Refugee Multi Sector
RRF	Results and Resources Framework
SBHS	Sudan Baseline Household Survey
SHHS	Sudan Household Survey
SI	Strategic Interventions

SNAP	Sudan National AIDS Control Programme
SP	Strategic Plan
SRH	Sexual Reproductive Health
SSDS	State Strategy for the Development of Statistics
STI	Sexually Transmitted Infection
ToR	Terms of Reference
TT-MDF	Thematic Trust Multi-donor Fund
UNCT	United Nations Country Team
UNDP	United Nations Development Programme
UNDAF	United Nations Development Assistance Framework
UNFPA	United Nations Population Fund
UNICEF	United Nations Children Fund
USAID	United States Agency for International Development
VAW	Violence Against Women
VCT	Voluntary Counselling and Testing
VGs	Vulnerable Groups
WHO	World Health Organization

KEY FACTS: SUDAN

Country	Sudan	Source
Geographic Location	Sudan is located in northeastern Africa. It is bordered by Egypt to the north, the Red Sea to the northeast, Eritrea and Ethiopia to the east, South Sudan to the south, the Central African Republic to the southwest, Chad to the west and Libya to the northwest. Sudan is the third largest country in Africa.	
Land Area	728,200 mi²	
Population		
Population	30,504,166	Census 2008
Urban Population	8,998,728 (29.5%)	
Rural Population	18,760,062 (61.5%)	
Nomads	274,537,494 (9%)	
Government		
Type of government	Elected	
Seats held by women in national parliament	27%	2015
Economy		
GDP Per Capita USD	1,753.4	2013
GDP Growth rate	(6%)	2013
Social Indicators		
Human Development Index	0.473 (rank 166)	2013
Human Development Index rank by gender	0.628	2013
Unemployment rate	16%	Census 2008
Poverty rate	46%	National Poverty Survey 2010
Life Expectancy at birth (years)	59	Census 2008
Infant Mortality Rate	52 (per 1000 live-births)	MICS 2014
Under 5 mortality rate	68 (per 1000 live births)	MICS 2014
Maternal Mortality Rate	216 (per 100,000 live-births)	SHHS 2010
Adolescent Birth Rate	87%	MICS 2014
Total Fertility Rate	5.2	MICS 2014
Women married before age of 18	38%	MICS 2014
Contraceptive Prevalence Rate	12.2%	MICS2014
Unmet Need for Family Planning	26.2%	MICS2014
Caesarean Section Rate	9.1%	MICS2014
Skilled attendant at delivery	77.7%	MICS2014
Deliveries in HF	27.7	MICS2014
HIV Prevalence Rate (among the general population)	0.67	IBBS Survey
Net enrolment rate in primary education	51	SHHS 2010
Net enrolment rate in secondary education	45	SHHS 2010

EXECUTIVE SUMMARY

Introduction: This report presents the findings, conclusions and recommendations of UNFPA Sudan 6th cycle (2013 – 2016) Country Programme Evaluation (CPE). The purpose of this evaluation is 'to assess programme achievements and to compile lessons learned to inform 7th cycle programming. The specific objectives are: (1) to examine the soundness of the programme in terms of addressing national needs and gaps; (2) to draw key lessons from past and current cooperation and provide actionable and strategic recommendations; (3) to assess the extent to which the programme has contributed to the on-going humanitarian and development efforts; and (4) to provide an analysis of how UNFPA Sudan has positioned itself within the development community.

Scope: The evaluation covers the six Outputs of the CP for an estimated total four years budget of $ 91 million: Output 1 - Population Dynamics; Output 2 – Reproductive, Maternal & New-born Health and HIV (Demand Creation); Output 3 - Reproductive, Maternal & New-born Health and HIV (Services); Output 4 - Family Planning; Output 5 - Gender Equality & Reproductive Rights; and Output 6 - Data Availability & Analysis. This evaluation covered the first two years of CP implementation (2013 and 2014) and targeted programme geographic coverage at the national and states level.

Methodology: The CP evaluation made use of mixed methods to collect primary and secondary data and to analyze and triangulate data by evaluation question as relevant to each source. Secondary data consisted primarily of programme documents and country assessment reports. Primary data was collected during the field phase from programme stakeholders through semi structured interviews, group' interviews[1], focus group discussions and site visits / observations. The primary data collection reached a total of 286 individuals in five states and federal level (Khartoum).

Limitations: The evaluation team did not encounter noteworthy field challenges when conducting field data collection. Logistic issues and access to people and organizations was facilitated by UNFPA. This CPE was mainly limited by time and the expert resources devoted to conduct the evaluation of a very large and diversified programme implemented over a very large geographic area. However, it should be noted that time and resource limitations did not compromise the integrity of the evaluation findings but affected the time plan with some delays.

MAIN FINDINGS

Relevance & Responsiveness: UNFPA 6th Cycle Country Programme (2013-2016) is based on a clear understanding of the dynamics of Sudan's context and takes into account the policy frameworks, national strategies and action plans as regards to reproductive health, family planning, youth and gender equality issues. The interventions are informed by national baseline surveys such as SHHS 2010 and based on needs assessments, institutional capacity assessment and participatory consultations with implementing partners and stakeholders at the federal and state levels.

UNFPA interventions addressed information and service needs of vulnerable groups such as PLWHA, MARPs, refugees, IDPs, women in the reproductive age, youth and adolescents with primary focus on the states' underserved localities. UNFPA CO was also adequately responsive to the needs of refugees, internally displaced and GBV survivors in conflict- affected areas. Frequent changing of IDP and refugees' numbers, changing locations and entry points of refugee camps hindered at times the timely delivery of services and supplies to the affected populations.

Effectiveness-Reproductive Health: The CP was effective in contributing towards increased demand for information and service-related to RH, maternal and newborn health and HIV. Advocacy efforts and community dialogue enhanced political commitment and sensitization of the targeted communities for the RH and HIV-related prevention.

[1] A group interview is less structured than a FGD in terms of the number of participants and the format followed in the group discussion.

UNFPA programme support has effectively improved the delivery of integrated RH, EmONC and fistula repair services in the UNFPA-targeted states. The capacity building of the facility-based and community-based health care providers has contributed to improve the availability and accessibility of quality family planning services. Fistula repair services were challenged with case finding/detection, provision of surgical repair for the identified cases and lack of reliable information on the magnitude and geographical distribution of fistula cases.

Country Programme support has effectively improved the logistics management information system for RH commodity security at the state and locality levels, utilization of facility-based family planning services and initiation of community-based family planning distribution.

Effectiveness-Population Dynamics; Data & Youth: CP contributed to improving national and state capacities for integrating population dynamics through the revised National Population Policy and its Plan of Action. The revised NPP took into consideration sectoral and states policies and development plans. The present challenge is in coordinating with the states and sectors *for the implementation of the PoA.* Coordination is challenged by limited understanding of some federal ministries of population issues and limited institutional capacity of other ministries to integrate population issues in development plans.

Country Programme contributed to the improvement of data quality, production and availability through enhancement of human resources capacities, development of tools, techniques and strategies for the collection of population data. However, there are still gaps in the human resources capacities and challenges of data production from the locality and administrative unit levels.

UNFPA CP has contributed to youth empowerment and engagement of youth in community education on maternal health and gender specifically GBV related issues. UNFPA support enabled youth in UNFPA- targeted states to access social spaces and to engage in social, educational and cultural activities. Capacity building of youth enabled some youth to access business skills and some others to secure jobs.

Effectiveness-Gender: CP support was effective in raising awareness on the need for gender mainstreaming in national plans. UNFPA support in advocacy and awareness was effective in improving knowledge on reproductive health, gender inequality, GBV issues, FGM and child marriage. CP contributed also to commitments of some communities for abandonment of FGM and early child marriage. However, Al Mawada Wa Rahma initiative needs additional support to improve implementation coherence and to institute follow up strategies on community declarations for abandonment.

UNFPA support for studies, advocacy, debates and trainings for reform/drafting of laws addressing FGM and child marriage has limited results as the laws that were formulated are either still in draft form or are not yet enforced.

UNFPA support was effective in responding to the needs of the GBV survivors specifically in humanitarian settings. Through raising awareness on referral pathways, provision of psycho-social support, training on clinical management, and the establishment of protection groups, GBV survivors find support at community level and access to the relevant services at the health centers.

Efficiency: UNFPA Sudan Country Office was generally efficient in mobilizing financial resources for the Country Programme with 75 percent of budget raised for 2013 and 92 percent for 2014. Also, UNFPA Country Office was relatively efficient in disbursing annual programme budgets to support the implementation of Annual Work Plans (AWPs) through contracts with Implementing Partners as well as Direct Execution (DEX) modality. Programme Annual Review Reports stated a 99 percent and 82 percent implementation rate of available cash for the years 2013 and 2014 respectively. To note though that Outputs 1 & 6 Population Dynamics and Data did not attract any significant financing from non-core resources (1% in 2013 and 0% in 2014).

At the time of the evaluation, in the middle of the programme life span, most of the programme midterm targets were already achieved or overachieved except in cases of 'fistula repair' and 'policy related plans and article of laws'.

Sustainability: Sustainability assessment results varied across programme outputs, implementing partners and types of interventions. Sustainability is challenged by more than the mere availability of financial resources or risks of staff turnover. Likelihood of sustainability is higher in thematic areas where UNFPA strategic interventions have gained traction, government endorsement and community acceptance such as in SRH and Youth. Where UNFPA strategic interventions are still mostly at the level of advocacy to break the cultural taboos, such in GBV and FGM, the potential of sustainability is still weak.

Coordination: UNFPA participates in, is a member of, and at times is leading in multi layered coordination structures with UN agencies, federal and state government institutions in development and humanitarian contexts. Coordination mechanisms proved mostly effective in combining agencies technical resources in joint projects, planning and ensuing complementary interventions by competitive advantage of each agency. Coordination mechanisms, specifically UN Agency coordination mechanisms, were less effective in joint implementation and advocacy. Effective coordination is challenged by competition over resources and effective leadership.

Added Value: In addition to UNFPA comparative strengths and technical expertise historically in Gender, Reproductive Rights and combating GBV, this CP has added value through strategic positioning and interventions at the state-locality level.

M&E: UNFPA M&E System is well aligned with a direct Output- Outcome relationship and adequate indicative measures. Overall, programme indicators do not fully capture the results of Youth interventions nor do they include indicators for capacity building and sustainability of UNFPA Sudan interventions in institutional capacity development of partners.

MAIN CONCLUSIONS

On the strategic level, UNFPA Country Programme 2013 and 2014 interventions are relevant and adequately responsive to the context priorities, dynamics and needs of the population as identified in GoS development plans and participatory consultations with partners and stakeholders. On the other hand, programme sustainability is deemed weak and challenged by dearth of local resources, inadequate institutional and human resource development in addition to prevailing cultural sensitivities in some of UNFPA thematic areas. In spite of dwindling donors' interest, UNFPA CO was relatively efficient in raising financing for the country programme, increasing financing levels from non-core resources and accessing new donors. Still, financing for Population Dynamics and Data from non-core resources is insignificant and financing levels for Development interventions relatively low.

UNFPA Sudan is well positioned within the UN system, with government institutions and local organizations, at the national and states/locality levels to effectively support programme implementation. UNFPA mandate, comparative strengths, services and interventions in the thematic areas of reproductive health, population dynamics, youth, gender, GBV, FGM and HIV/AIDS are well recognized and acknowledged by relevant GoS ministries, other UN agencies and local organizations.

On the programmatic level, Reproductive Health interventions were effective in delivering RH services and information in UNFPA-targeted states. However, integrating the management and prevention of STIs & HIV into RH service outlets and management of the RH programme showed limited coverage. Also, community-based family planning services are at times constrained with irregular supply of the commodities. UNFPA support to MARPs and PLWHA is in need of additional information to assess the effectiveness of IGAs/life skills assistance in improving nutritional status of PLWHA and reducing risky behaviour and stigma of FSW and MSM.

The integration of the population dynamics into the development of sectorial policies and plans is slowly progressing because it is challenged by the limited capacities of the states' population councils, the limited understanding of the population dynamics in the sectorial ministries and by the gaps in capacities for demographic research. Additionally, the nature of the integration process itself is slow as it requires adequate conceptualization and consideration of the process and the effects of population variables and of their interrelations with other social and economic processes both in medium and long terms. UNFPA's support to the development of the statistical systems contributed to the production of data related to gender and maternal heath indicators which were used for planning, monitoring and advocacy. However, still there are gaps in data disaggregated by the locality and administrative levels. The upgraded CBS website provided some statistical data to users but accessibility would remain limited without the operationalization of the National Data Users Committee.

UNFPA support in youth succeeded in strengthening youth structures, building their capacity for employability, civic engagement, networking, and social responsibilities pending additional programme support to further address issues related to youth RH needs. Advocacy and awareness raising on maternal health, gender, child marriage and FGM issues have reached men, women, school boys and girls, and youth at the state, locality and village levels, creating community structures, (CBOs and protection groups) that respond to the safe motherhood needs, and follow up the commitment to FGM and CM abandonment.

MAIN RECOMMENDATIONS

On the strategic level, it is recommended that UNFPA continue the good practice of basing programme interventions on research and needs assessments, national strategies and plans and participatory consultations with stakeholders. Furthermore, UNFPA is to maintain its emergency response readiness and improve to the extent possible, responsiveness to priority humanitarian and emergency needs in coordination with other donors and relevant stakeholders. It is also suggested that UNFPA coordinates with partner UN Agencies and discuss with IPs to include in future programming measures to improve degrees of programmes' sustainability.
Additionally, it is recommended that UNFPA CO increase its fund raising efforts to access non traditional donors and to secure financial support for the thematic areas that were least funded in the past couple of years namely Population Dynamics and Development interventions.
UNFPA should always strive to improve its inherent value in RH, HIV Prevention and Gender, to enhance strategic and local positioning at the state level and to improve coordination with other partner UN Agencies for joint advocacy of the government and in the implementation of joint programmes.

On the programmatic level, it is recommended that UNFPA fine-tune RH interventions for improved quality RH services and information to vulnerable groups and to facilitate programme anticipated expansion to new underserved localities. It is also recommended that UNFPA adopt more effective approaches to strengthen FP commodity delivery, monitoring and reporting and to ensure availability at the community level. IGAs/life skills programme support for MARPs and PLWHA needs further research to assess if interventions are empowering target groups and yielding expected results.

In the areas of Population and Data, it is suggested that UNFPA increase programme support for the production of an improved quality of data related to PD and RH. UNFPA should also maintain and further support advocacy and coordination for the implementation of NPP/PoA, for ICPD 2014 and Sustainable Development Goals.

In the areas of Youth and Gender, it is recommended that UNFPA continue its programme support for youth empowerment and engagement in community education on reproductive health while also advocating for identification of the youth/adolescents SRH needs. UNFPA to increase and enhance

community mobilization and advocacy for maternal health and GBV including to law reform and law enforcement for reducing FGM and CM and promoting gender justice.

1 INTRODUCTION

UNFPA Sudan commissioned the evaluation of its 6th Cycle Country Programme (2013 – 2016) to a team of external evaluators. The Terms of Reference (ToR) issued by the Country Office (CO) has identified the evaluation scope and defined its framework. The evaluation design was informed by the UNFPA Evaluation handbook 2013 revised version. The main objective was to evaluate the current programme cycle with a view to support the development of the 7th cycle. .

This report presents the evaluation team findings analyzed and structured on the basis of OECD DAC evaluation criteria and provides specific answers to the evaluation questions. This report is organized as follows: **Chapter 1** provides the introduction where the evaluation objectives, scope, questions, assessment process and methodology are discussed. **Chapter two** provides a bird's eye view of the general country context and specific UNFPA thematic areas; **Chapter three** highlights UN/UNFPA strategies and 6th cycle programme interventions in response to Sudan country challenges; **Chapter four** details the evaluation findings structured along the six evaluation criteria/ eleven questions; and **Chapter five** presents a brief assessment of the programme M&E system. Finally, **Chapter six** summarizes the evaluation conclusions and **Chapter seven** offers related recommendations.

1.1 PURPOSE AND OBJECTIVES OF THE COUNTRY PROGRAMME EVALUATION

The purpose of UNFPA Country Programme Evaluation (CPE) "is to conduct an end of programme cycle evaluation to assess the achievement of the 6th Country Programme, the factors that facilitated or hindered achievements, and to compile lessons learned in respect of each of the programme stages to inform the development of the next country programme cycle (7th Country Programme)[2]."

The specific objectives of the independent evaluation of UNFPA 6th Country Programme for Sudan were to:

a) Examine the soundness of the programme in terms of addressing national needs and gaps vis a vis the UNFPA mandate and comparative advantage;
b) Draw key lessons from past and current cooperation and provide actionable and strategic recommendations for future programming;
c) Assess the extent to which the programme has contributed to the on-going humanitarian and development efforts and provide an analysis of how UNFPA Sudan has positioned itself within the development community and national partners with a view to adding value to the country development results.

The UNFPA 6thcycle programme was planned as a four years cycle period starting January 2013[3] and ending December 2016. This evaluation is taking place around June – July 2015 i.e. after only two years and a half of actual programme implementation. Additionally, programme documentation and data available for this evaluation are mainly covering the first two years (2013 and 2014) of implementation[4]. Consequently, this evaluation is to be considered more of a midterm review *rather than an end of programme performance evaluation*.

1.2 SCOPE OF THE EVALUATION

[2]Evaluation Terms of Reference
[3] Due delays, actual programme implementation started early May 2013.
[4] Country Office Annual Report (COAR), Country Programme Review Reports and Performance Monitoring Plans tracking sheets.

The evaluation scope comprises the CP six Outputs that purportedly contribute to UNFPA Strategic Outcomes one; three and four[5]:

- **CP Output 1 - Population Dynamics:** Strengthened national capacity to incorporate population dynamics, including its linkages with sexual and reproductive health, into relevant policies and development plans, with special attention to the needs of young people and women.(SP Outcome 4)
- **CP Output 2 - Maternal & New-born Health (Demand Creation):** Increased demand for information and services related to reproductive, maternal and new-born health and HIV prevention. (SP Outcome 1)
- **CP Output 3 - Maternal & New-born Health (Services):** Increased availability of high-quality information and services for maternal and new-born health and HIV prevention, especially for underserved populations and people with special needs. (SP Outcome 1)
- **CP Output 4 - Family Planning:** National systems for reproductive health commodity security and for the provision of family planning services are strengthened. (SP Outcome 1)
- **CP Output 5 - Gender Equality & Reproductive Rights:** Strengthened national, state and community capacity to promote gender equality and to prevent and respond to early marriage, sexual violence and female genital mutilation. (SP Outcome 3)
- **CP Output 6 - Data Availability & Analysis:** Strengthened national and state capacity to produce, analyse and disseminate high-quality disaggregated population data for evidence-informed planning and monitoring, with a focus on maternal health. (SP Outcome 4)

The scope of this CPE included programme Strategic Interventions (SI) under the six Outputs as well as all the thematic areas of Sexual and Reproductive Health, Gender and Gender Based Violence (GBV), Population Dynamics (PD), Youth and Humanitarian Response (HR). Additionally, the evaluation targeted assessment of developmental activities as well as humanitarian programs and pilot initiatives implemented during the period under review.

The scope of this CPE covered UNFPA Sudan programme nine states - Kassala, White Nile, Blue Nile, Gedarif and the five Darfur states through targeted field assessment of five out of the nine states in addition to Khartoum.

1.3 METHODOLOGY AND PROCESS

1.3.1 Evaluation Process

UNFPA Sudan CPE was planned and conducted in five subsequent phases as follows:

Preparatory Phase (March 2015)	This phase started with the nomination of the evaluation manager and involved drafting the ToR, constitution of the Evaluation Reference Group (ERG), assembling relevant programme documentation and was completed with the recruitment of the evaluation team.
Design Phase (July 2015)	This phase was mainly concerned with the development of the design report to guide the evaluation undertaking. It covered a desk review of programme documents, elaboration on the initial set of evaluation questions, stakeholders' mapping and sample selection for data collection, design of the data collection tools and development of the evaluation work plan – timeline.
Field – Data Collection Phase (August 2015)	The field phase covered implementation of the data collection plan through interviews, group meetings and focus groups with the programme staff, sample of selected stakeholders and observation of identified

[5] Based on the new alignment with UNFPA Strategic Plan 2014 – 2017 dated October 2014. Previously, the CP six Outputs contributed to five SP Outcomes.

programme sites. This phase concluded with a debriefing meeting (September 8, 2015) that presented the preliminary evaluation findings to UNFPA Sudan programme staff, the Evaluation Reference Group and key programme partners.

Synthesis Phase (September 2015)

Inputs from the debriefing meeting together with synthesis of the data collected during the field phase will feed into the development of the draft evaluation report which will be submitted for review and comments on September 28, 2015.

Dissemination Phase (October 2015)

A second and final CPE report will be completed after addressing UNFPA, ASRO and ERG comments. The final evaluation report will be disseminated in a workshop to be attended by UNFPA CO staff and programme stakeholders including key national partners. CPE report and the management response to the report will be published in the UNFPA evaluation database.

Each evaluation phase concluded with a milestone –deliverable as listed:

CPE Phases	Deliverables
Preparatory Phase	Evaluation Terms of Reference
Design Phase	Design Report (July 2015)
Field – Data Collection Phase	Debriefing workshop – PowerPoint Presentation (September 8, 2015)
Synthesis Phase	Draft evaluation report (September 28, 2015)
Dissemination Phase	Final evaluation report and PowerPoint Presentation (October 2015)

1.3.2 Evaluation Questions

The evaluation questions correspond to the four OECD/DAC criteria of Relevance, Effectiveness, Efficiency and Sustainability. In addition, and following the UNFPA Evaluation Handbook, two additional criteria, Coordination and Added Value were added to assess UNFPA's strategic positioning in Sudan among other UN partners.

The evaluation ToR identified the following 11 Evaluation Questions (EQ) to correspond to the six evaluation criteria earlier listed. These questions formed the basis for the development of the data collection tools (annex 5) and guided data collection and analysis throughout the evaluation.

RELEVANCE CRITERIA	
EQ1	To what extent the Country Programme addressed national priorities and needs of population vis-à-vis the UNFPA mandate and comparative advantage?
EQ2	To what extent has the country office been able to respond to changes in the national development context and, in particular in relation to the humanitarian crisis in Darfur?
EFFECTIVENESS CRITERIA	
EQ3	To what extent has the country programme contributed to improving quality and affordability of RH services particularly the management of delivery and its complications including the surgical repair of obstetrical fistula?
EQ4	To what extent have UNFPA supported interventions contributed (or likely to contribute) to a sustained increase in use of demographic and socio-economic information and data in the evidence-based development and implementation of plans, programs and policies to (improve access to Reproductive Health Services including in areas associated with gender equality, population dynamics and HIV/AIDS)?
EQ5	Has the UNFPA support in the area of gender equality contributed to women empowerment and reduction of some forms of gender based violence especially in war-affected settings?

EQ6	To what extent has UNFPA ensured that the needs of young people have been taken into account in the planning and implementation of UNFPA-supported interventions under the country programme?
EFFICIENCY CRITERIA	
EQ7	To what extent did the intervention mechanisms (funds, expertise and timing) foster or hinder the achievement of the programme outputs?
SUSTAINABILITY CRITERIA	
EQ8	To what extent has UNFPA been able to support its partners and the beneficiaries in developing capacities and establishing mechanisms to ensure ownership and the durability of effects?
COORDINATION CRITERIA	
EQ9	To what extent were the programme coordination and monitoring mechanisms effective to boost the programme implementation and achieve better results;
EQ10	To what extent did UNFPA contribute to the existing coordination mechanisms in the UN system in Sudan?
ADDED VALUE CRITERIA	
EQ11	What are the main comparative strengths of UNFPA in Sudan – particularly in comparison to other UN agencies in the Country?

Furthermore, the evaluation assessment also included an appraisal of the programme intervention logic-Monitoring and Evaluation framework to assess coherence and contributing relationship of programme Outputs, Strategic Interventions and related indicators.

1.3.3 Evaluation Methodology

Mixed methods were used for data collection. They included documentary review of programme documents and other relevant literature to collect secondary data; semi-structured, focus group discussions (FGD) and sites observations to collect primary information from key informants and beneficiaries.

Documentary Review: Review of programme documents including UNFPA Country Programme Document (CPD); Country Programme Action Plan (CPAP); Country Office Annual Reports, programme annual reviews; annual work plans, financial reports, progress and monitoring frameworks/reports as well as facility records/registers. Other sources such as thematic evaluation reports and findings of assessments conducted by other donors and international organizations were reviewed.

Semi Structured Interviews (SSIs): Were used to collect data among UNFPA' programme' Implementing Partners (IPs), government ministries and NGOs at federal and state levels. Interview guides were developed by thematic. Interview questions were structured to align with the evaluation questions / criteria and collect stakeholders' feedback on the relevant evaluation questions. SSIs were also used to target UNFPA programme managers, UN agencies and international donors active in UNFPA thematic areas.

Focus Group Discussions (FGDs): Were used to collect information among programme' primary beneficiary / trainees of UNFPA capacity building interventions (government institutions and NGO partners). Focus group format was assessed to be the most effective approach for data collection with this large group of programme beneficiaries. Focus group guides were prepared and discussions were conducted with beneficiary/ trainees by thematic area/training themes -Population Dynamics, Health and Gender. The aim was to solicit their opinions on the relevance and quality of the trainings with particular focus on the outcome of the trainings in terms of new and improved services to their constituencies. Focus group discussions also entailed stakeholders' assessment of outstanding gaps and needs in each of UNFPA six output level sectors.

Site visits / observation. Field visits were conducted to a selected number of health facilities, women centres and youth facilities that benefitted from UNFPA programme support in rehabilitation, furnishing and or provision of commodities. Site visits aimed to observe and assess UNFPA assistance usage and effectiveness in the provision of services to community beneficiaries. Site visits also included interview with the facility managers, and where possible, an informal short survey of the facility users (beneficiaries) present at the time of the visit.

Selection of the sample of stakeholders

Documentary review facilitated stakeholder's mapping and selection of the evaluation sample - key stakeholders to be met and interviewed during the field phase. Considering the large number of programme Implementing Partners (IPs), the evaluation prioritized selection of the IP sample based on a set of criteria the most important of which are the level of programme investment.

In view of the large numbers of stakeholders involved with UNFPA programme, sample selection has been determined on the following basis:

- UNFPA: Country Office (CO) programme leadership, components' lead, technical officers at national level and other programme staff as relevant to the evaluation questions in addition to the field officers of the states which were visited during the field phase.

- Federal Government: All federal government main counterparts such as Ministry of Welfare and Social Security[6], Ministry of Guidance and Endowments, Ministry of Health[7], Ministry of Youth and Sports and federal government institutions such as National Population Council, the Central Bureau of Statistics, the National Council for Child Welfare and the National AIDS Control Programme.

- Implementing Partners: An illustrative sample of UNFPA implementing partners was selected. The sample covered both government state institutions and non-governmental organizations that implemented UNFPA interventions. Selection of IPs was determined with UNFPA programme managers based on the following criteria by descending order: (1) IPs that implemented the largest amount of investments; (2) IPs that were involved in the implementation of more than one UNFPA output; and (3) Best performing IPs and least performing IPs. Final selection of the IP sample included all six UNFPA outputs and the range of UNFPA supported activities and thematic areas. Sample also covered IPs of humanitarian and development interventions as well as pilot localities to assess potential for replicability to other localities.

- Beneficiaries/ capacity building trainees. In view of the large numbers of beneficiaries that participated in UNFPA programme capacity building events, the evaluation sample was illustrative of the target population rather than a statistically significant sample. Beneficiary sample for focus group discussions were determined on the basis of the following convenience sampling approach: IPs selected earlier for the meetings and interviews were asked to facilitate the organization and participation of their trainees in focus group meetings[8]. Focus groups with beneficiary/ trainees covered the main training themes such as behavior change communication, midwife trainings, youths trainings, reproductive health, gender…etc which entailed the largest investments of programme resources. Additionally, the sample of beneficiary / trainees covered all of UNFPA six programme outputs.

[6]Directors/UNFPA programme focal points at the National Council for Child Welfare; Combating of Violence Against Women Unit; General Directorate of Women and Family

[7]Directors/UNFPA programme focal points at the National Reproductive Health directorate; Sudan National AIDS Control Programme (SNAP); Sudan Health Academy

[8]Provided the selected IP have also been involved in the implementation of trainings and capacity building interventions.

- Government institutions and NGO facilities that were supported by UNFPA physical and commodity assistance for interviews and site visits observation. Facilities were selected on the basis of the amount and type of support. Priority was given to the ones that received the largest amount of investment and type of support. Facilities which were visited covered relevant UNFPA thematic areas and programme outputs.

- International donors: Those implementing/funding projects in UNFPA programme thematic sectors and geographic locations.

- UN Agencies active in similar sectors such as UNDP, UNICEF, UNHCR, WHO and UN Women as determined by UNFPA themes of assistance and six programme outputs.

The evaluation sample covered the full range of UNFPA interventions both humanitarian and development interventions as well as pilot activities. The geographic coverage of the evaluation covered five states – White Nile, Blue Nile, Kassala, Gedarif, South Darfur (out of the 9 UNFPA target states) in addition to the national / federal ministries / institutions. Other stakeholders included UN Agencies active in similar UNFPA sectors such as UNDP, UNICEF and UN Women and international donor organizations such as the Global Fund and DFID. The final evaluation sample covered five states in addition to national level, consulted with 286 individuals and targeted 38 IPs (21 Government Institutions; 15 NGOs; 2 Universities); 8 UN Agencies and 2 International donors.

Data collection tools: They primarily consisted of semi structured and focus group discussion guides. These guides contained evaluation questions for each of the thematic areas including Reproductive Health, Family Planning, HIV/AIDS, Gender, Population and Development and Youth. Interview questions were clustered according to the evaluation criteria and relevant questions to facilitate data collection and later analysis.

Data collection: The field work started on August 3rd and was completed on September 3rd 2015. Briefing and debriefing meetings were held with the country office at the start and end of the field mission.

Data validation mechanisms and analysis: Regular debriefing sessions were used to synchronize and validate the accuracy of data collected. Data collected was triangulated with other data sources as relevant to each evaluation question for validation purposes. Secondary data obtained through documentary review were used to complement primary data. Additionally, data validation was sought through regular exchanges with the CO programme managers; technical officers at national and field levels and the evaluation manager. Following the completion of the data collection and validation exercises, a content analysis was performed.

An evaluation matrix, developed with indicators and sources of information to guide data collection, was later used for data analysis and triangulation of the evaluation findings by evaluation question. The matrix (annex 4) ensured that a multitude of data sources were considered and the team was able to triangulate the data in order to adequately provide answers to each question.

Table 1: Coverage of the Evaluation Sample

National/State	Key Informants Interviews	Focus groups/ group interviews		Total
		# of Participants	# of groups	
Federal Khartoum	35	23	5	**58**
White Nile	9	10	1	**19**
Blue Nile	10	20	2	**30**
Kassala	21	23	3	**44**
Gedaref	9	83	4	**92**
South Darfur	21	22	3	**43**
Total	**105**	**181**		**286**

Figure1: Distribution of evaluation questions by evaluation criteria and level of analysis

			SRH	GBV & HR	P&D	Youth & Adolescents
Level of Analysis	**Programme Phases**	**Evaluation Criteria**	**Evaluation Question**			
Programmatic Analysis	Design	**Relevance & responsiveness**	EQ1 &EQ2	EQ1 &EQ2	EQ1	EQ1
	Process	**Efficiency**	EQ7	EQ7	EQ7	EQ7
	Results	**Effectiveness**	EQ3	EQ5	EQ4	EQ6
		Sustainability	EQ8	EQ8	EQ8	EQ8
Strategic Positioning		**Coordination Mechanism**	EQ9	EQ9	EQ9	EQ9
		Coordination with UNCT Added value	EQ 10 & EQ11			

1.3.4 Limitations

This CPE was limited by time (approximately two months) and expert' resources with only three senior experts tasked with data collection and analysis. UNFPA Sudan Country Programme addresses the needs of multiple groups, cooperates with numerous governmental and non-governmental implementing partners, assists large numbers of direct and indirect beneficiaries and covers nine states of Sudan. The evaluation of such a large programme would have required a longer time period than has been allocated and / or a larger evaluation team specifically for data collection considering travel distances to the targeted states and transport challenges with the road conditions.

To address the time and experts' resource limitations, the evaluation team divided into two and sometimes three groups with each expert undertaking data collection separately. This fact put additional burden on the experts during interviews and focus group discussions and required at times the support of junior UNFPA volunteers to assist the senior experts in taking notes during the meetings. Moreover, as experts undertook meetings separately in different states, additional time was needed to share and discuss the data collection results and to validate findings from multiple sources. Time limitations also necessitated that only one team member visit Darfur to conduct meetings and interviews with stakeholders across all UNFPA thematic areas and then share results with the other technical expert. To note that time and resource limitations did not compromise the integrity of the evaluation findings but affected the time plan with delays on the draft evaluation report and additional experts' investment to deliver on quality requirements.

Additionally, some of the preliminary evaluation findings would have required additional assessment through *quantitative surveys* to confirm programme reported results such as the example of the Income Generating Activities for PLWHA and Youth. In light of time constraints, evaluation scope and ToR methodology limitation to qualitative data collection, the evaluation has recommended that future assessments are conducted to evaluate specific 'outcome' issues to confirm some of the programme reported results specifically at the level of indirect beneficiaries (e.g. PLWHA, Youth).

Except for the above noted limitations, the evaluation team did not encounter noteworthy field challenges when conducting field data collection. Logistic issues and access to people and organizations was facilitated by UNFPA. In case people were inaccessible due to travel, the team was flexible in adapting the evaluation timeline and planning later meeting times or alternative ways to reach out to the sources of information.

2 CONTEXT OF UNFPA SUDAN 6th COUNTRY PROGRAMME

2.1 GENERAL COUNTRY CONTEXT

Sudan is situated in northern Africa, with a coastline bordering the Red Sea. It sits at the crossroads of sub-Saharan Africa and the Middle East, with fertile lands, abundant livestock, and manufacturing. However, the country has been beset by conflict for most of its independent history.

Under the terms of the 2005 Comprehensive Peace Agreement, the southern states seceded to form the Republic of South Sudan in July 2011. The secession of South Sudan induced multiple economic shocks. The most important and immediate was the loss of oil revenues (Sudan lost almost 80% of its oil resources) which accounted for over half of government revenues and 95% of exports. With the secession, the country also lost 30% of its total land size, 25% of its population and nearly 75% of its forest resources. This has left huge macro-economic and fiscal challenges, much reduced economic growth, and double-digit consumer price inflation and increased fuel prices.

Sudan has wide and deep swaths of poverty and stark inequality between regions. The country ranked 166 out of 187 countries in UNDP 2014 Human Development Index. Poverty estimates set the average rate of poverty incidence at 46.5% (2009 National Baseline Household Survey), indicating that some 15 million people are poor. But within this the disparities are striking; poverty incidence numbers mask significant regional disparities. Poverty in urban areas (especially Khartoum) is significantly lower than rural areas, which account for 60% of the country's population and 80% of its poor. Poverty incidence in North Darfur is approximately three times that of Khartoum and more than twice that of River Nile State. Also of note are the disparities between settled and nomadic populations who constitute 9% of Sudan's population and 14% of its poor.

The main determinants of poverty in Sudan include: (1) sustained and multiple conflicts, which undermine opportunities for economic and social development, which in turn feeds longstanding grievances driving fresh conflict; (2) a dependence on oil which has resulted in the neglect of agriculture and livestock sectors as well as alternative sources of energy (3) the unequal distribution of fiscal resources and access to natural resources, especially between the center and the periphery, and (4) governance failures as reflected in poor policy credibility and implementation as well as inadequate incentives for private sector investment and participation[9].

2.2 HEALTH SECTOR

The health sector in Sudan is heavily skewed towards tertiary level of care with a very low availability of delivery services in primary health care (PHC) facilities. The health infrastructure in most areas of the country, particularly in the rural areas, is characterized by sub-standard quality of services, limited coverage of health facilities vis-à-vis number of population and unequal distribution. Fourteen percent of primary care facilities are not fully functional mainly due to staff shortages or poor physical infrastructure. Physical accessibility to PHC facilities varies substantially between States, with a national average of 1:6,816 compared to the planned 1:5,000 population[10]. Less than 30% of PHC facilities provide the PHC essential service package[7] and most qualified health personnel including trained Village Midwives (VMW) are concentrated in urban settings such as Khartoum[11].

Curative services are provided in secondary and tertiary care hospitals. The number of hospitals has increased to 416 hospitals with about 8.4 beds per 10,000 populations, while the overall hospital/population ratio is 1: 80,000[12]excluding Khartoum, West Darfur and Sennar states.

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[9] http://data.worldbank.org/country/sudan#cp_surv

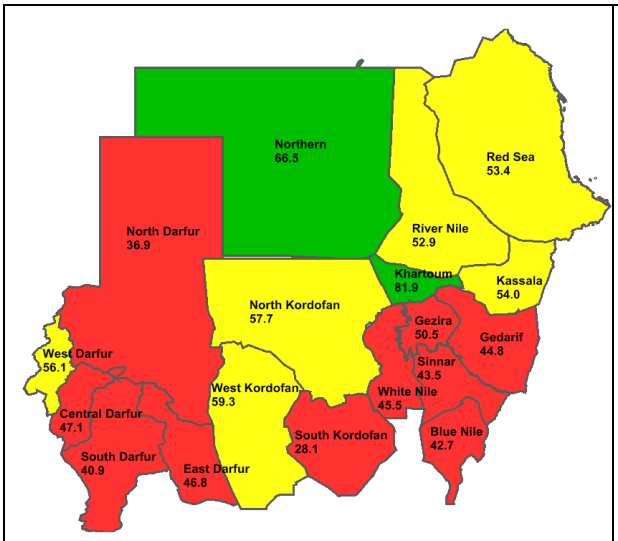
[10] FMOH – PHC Mapping 2011

[11] FMOH Road Map for Reducing Maternal & Neonatal Mortality in Sudan 2009

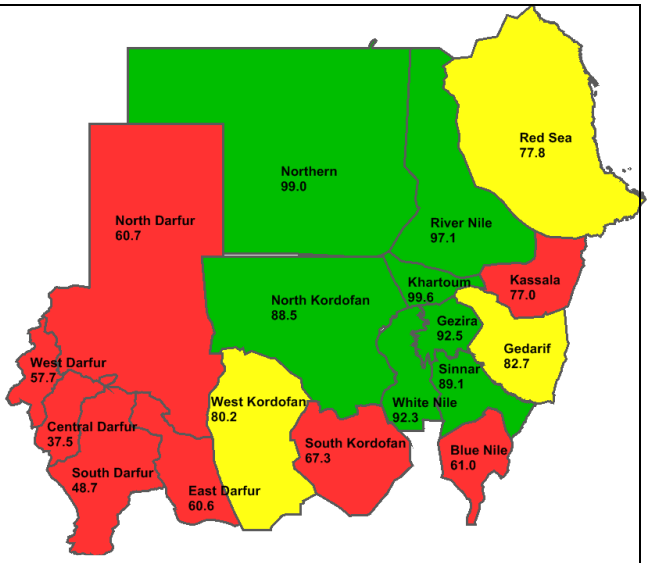
[12] FMOH – National Health Sector Strategic Plan 2012-2016

Neonatal mortality rate is 33 per 1000 live births, Infant mortality rate is 52 per 1,000 live births and U-5 mortality rate is 68 per 1,000 live births[13] . Different sources of official data at different time intervals estimate maternal mortality ratio (MMR) at 428[14] and 216[15] deaths per 100,000 live births with wide variations between and within states. The high MMR levels are linked to poor access to quality reproductive health services, including family planning. The percentage of deliveries attended by skilled health personnel is 77.7% and the institutional deliveries amounted to 27.7%[16].

According to latest statistics contraceptive prevalence rate is low, at 12.2 % with unmet need of family planning at 26.6%[13]. Fistula is a priority for national programs and majority of cases are found in the remote rural areas of Darfur and Kordofan States. However, there are no prevention programs and repair is not adequately available even in many secondary and tertiary health facilities.



Antenatal care coverage –at least four times (%)



Skilled attendant at delivery (%)

Figure 2: Maternal Health Indicators by State: MICS 2014

HIV/AIDS prevalence is 0.2% among the general population according to estimation projection done in 2014. HIV prevalence is 1.62% among the Female Sex Workers (FSWs) and 2.82 % among the Male Sex Worker (MSMs) based on integrated bio-behavioural survey conducted in 2012[17]. Knowledge about HIV prevention among young women is 8.5% while Knowledge of mother-to-child transmission of HIV among women aged 15-49 years is 28.4%. The HIV testing among women aged 15-49 years who were subjected to HIV testing during ANC and received their results is 3.6%[14].

The road map for reducing maternal and neonatal mortality 2009 advocates for the four pillars of safe motherhood: 1) Family Planning; 2) Focused Antenatal Care; 3) Skilled birth attendance (skilled health professional – midwife – and commodities, drugs and equipment; and 4) Emergency Obstetric Care and neonatal care. These services are delivered integrated with PHC package. The delivery of services is accompanied by awareness raising efforts through community heath promoters, VMWs at community level and health cadres at facility level[3]. The Sudan National Acceleration plan for Maternal and Child Health 2013-2015 emphasizes the support of Sudan government which realizes the

[13] Ministry of Cabinet-CBS-Multiple Cluster Indicator Survey (MICS) 2014
[14]Census, 2008
[15]SHHS, 2010
[16]Ministry of Cabinet – CBS Multiple Cluster Indicator Survey (MICS 2014)
[17] HIV estimation and projection 2014

importance of a comprehensive and integrated approach to address health problems in the country. It is an integral part of the PHC expansion plan which aims at operationalizing the National Health Strategic Plan for 2012-16.

2.3 POPULATION DYNAMICS & DATA

Sudan has a history of large-scale population movements and numerous development challenges. Population movements in Sudan have intensified with protracted conflicts. At the end of 2014, about 3.1 million people were internally displaced in Sudan, the majority in Darfur. A further 0.7 million people were refugees recently displaced from their countries of origin[18]. While the situation in Darfur calmed and allowed for some returns and recovery, new tensions in the border areas with South Sudan resulted in significant population displacement and the declaration of South Kordofan and Blue Nile as emergency states. These population movements are in addition to the labour migration and the regular movements of the nomadic groups.

Comparing the age distribution of MICS 2014 with SHHS 2010, no significant differences were observed; for example the percentage of population lying in the age range of 0-14 is 45.1% in MICS 2014 compared to 45.6% in SHHS 2010; while the percentage of those aged 15-64 years is 50.4% (MICS 2014) and 50.5% (SHHS 2010). Lastly, those aged 65 + amounted to 4.5% in MICS 2014, as compared to 3.9% in SHHS 2010.

Women generally outnumber men in every cohort of the population age 20 years and over. Sudan has a very high dependency ratio. 28% of households are headed by women, with a higher proportion in rural areas.

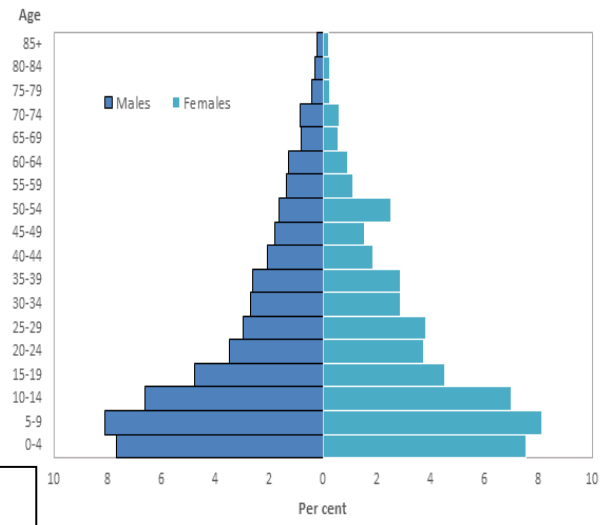


Figure 3: Sudan Population Pyramid
Source: MICS 2014 Report

The Population of Sudan, according to a 2013 estimates, is 35 million of which 62% are less than 25 years of age. About two thirds of Sudanese live in scattered rural localities and 9% of the overall population is nomadic. The population is growing quickly - 2.5% per year - reflecting the relatively high fertility rate and the large proportion of the population in the reproductive age group. According to the last census, on average a Sudanese woman gives birth to 5 - 6 children in her lifetime[19]. Mortality rates remain relatively high in Sudan, and life expectancy at birth is about 60 years for both sexes. High fertility and mortality rates show that Sudan is in its second stage of the demographic transition. Eventually, death rates will drop rapidly due to improvements in socioeconomic factors, which will result in an increase life expectancy and hence, an increase in population of the country.

UNFPA support in earlier programmes has improved the understanding of decision-makers at the federal level to the importance of the population dynamics, and enhanced the engagement of the National Population Council with sectorial ministries for the formulation of the National Population Policy, 2012. The challenge now is at the state level and for the state population councils, most of which are not operational.

[18]Sudan: Humanitarian Snapshot, as of 31st August 2015

[19]Fertility trends show a slight decline during the last 27 years (compared to 7 children per woman according to1973 census data), reflecting some degree of improvement in women's access to education and employment which are almost universally associated with smaller family size. (See UNFPA, 2013, Population Dynamics of Sudan, Http://countryyoffice.org.filemanager/files/sudan.facts/popukation_fact_sheet_final11.pdf)

The population statistics in Sudan depended on the National Census of 2008. Some baseline surveys such as the Sudan Household Survey 2006 and 2010 are valuable sources of information on the population dynamics and maternal health issues. The data in these surveys is disaggregated by gender, age, state and urban - rural level.

UNFPA's previous programmes contributed to the improvement of data production and its availability. The National Strategy for the Development of Statistics (NSDS) and its twin protocols have laid the legal and operational structures for enhancing the collection of quality gender dis-aggregated data. UNFPA support was instrumental to the implementation of the NSDS and its protocols namely: the Statistics Act 2014, and the Statistical Compendium. MICS 2014 is a good example as CBS is back to front lines and has led the whole process of MICS 2014 and other nationwide surveys. However, there are still some gaps as the data is not disaggregated by the locality and administrative units' levels. The availability of information to users and planners has improved with the upgrading of The Central Bureau of Statistics webpage with UNFPA support. The formation of the data users' Committee can further enhance the awareness on data availability and encourage researchers' contribution to data analysis.

2.4 YOUTH ISSUES

The **youth**[20] in Sudan make up a significant proportion of the population. The 15-35 and 10-35 age groups make up 34% and 46% of the total population respectively[21]. About one fourth of the adolescents (24% of the age group 15-19 years) are married -this percentage is higher in rural areas and decrease with higher education level- and 95.2% had no access to family planning[22]. About a quarter of married adolescents did not receive ANC visits and 18-26% of them are reported to have used traditional birth attendants during delivery[23]. All these factors increase youth's risks of early pregnancy and related morbidities such as obstetric fistula (OF) and maternal mortality. The 2010 RH Adolescent Survey found that 52% of adolescents experience gender-based violence, 11% are sexually active and only a quarter (26%) knows that HIV can be transmitted sexually.

The National Baseline Household Survey (SBHS) 2009 showed that 80% and 75% of the age groups, 15-19 and 20-24 respectively, were literate with lower percentages of females in both groups. Unemployment remains a major problem, as there are no strategies for availing job opportunities. The SBHS 2009, showed that one quarter of the youth in urban areas, and half of those in rural areas are poor.

There is some progress in the political engagement of youth as most of the political parties have their youth's sections. There are young men and women in the legislative assemblies but it is not clear how these youth groups engage with parliamentarians to represent their interests.

One of the recent recognized improvements is the engagement of informal groups and Youth NGOs, at national and state levels, in addressing the needs of poor individuals and communities. Many of these groups have mobilized funds either from local sources or their own resources[24]. Some Youth NGOs are engaged in community education raising awareness. The intergenerational dialogue addresses a growing concern among the youth about the gaps between the generations. The revised 2010 National Youth Strategy has identified several priority areas, including health, but unfortunately its plan has not been fully implemented because of funding issues. Newly established Ministries of Youth & Sport at Gedaref and Kassala states are developing their own "State Youth Strategies" that are aligned to the National Strategy and at the same time giving special consideration to youth concerns at these states.

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[20] Youth African Chart definition

[21] Sudan National Budget Household Survey, 2009.

[22] Sudan Household Survey, 2010; MICS result indicated that 21.2% of adolescents, 15-19 years are married showing slight decline from 2010, SHHS.

[23] Sudan Household Survey, 2006

[24] EL Nagar, Samia, 2014, Youth in Khartoum State. Unpublished memo

2.5 GENDER EQUALITY

The National Women Empowerment Policy 2007 focused on six areas of the Beijing Platform for Action aiming to promote gender equality and justice. This Policy is currently under review to improve its alignment with international and regional frameworks.

Sudan Gender Inequality Index Score ranked 628 in 2013 putting Sudan at 167 out of 187 countries. Eighty-nine percent of females and 93% of males confirm the presence of gender-based violence in communities[25]. The MICS 2014 preliminary findings showed that the percentage of women age 15-49 who were first married before the age of 15 years was 11.2%, and the percentage of women aged 20-49 years who were first married before the age 18, was 38. 86.6 % of the women age 15-49 years reported that they have undergone a form of Female Genital Mutilation (FGM). Still, 40.9 % of the women age 15-49 years stated that FGM should be continued.

There is noticeable progress in girls' enrolment in primary schools: MICS 2014 results demonstrate a gender party of 98 for primary school but only 1.07 for the secondary school level. The education is generally of poor quality and does not challenge the prevalent misconception and gender discriminatory practices. Women employment is increasing in all sectors but they are concentrated in the low earning activities.

Many of the laws do not adequately address the GBV issues, and in practice, women GBV survivors have no access to legal justice system. The laws for banning FGM at the state level are not yet enforced[26]. The constraints to legal reform and reduction of GBV include the contradictory religious discourses, the multiple factors that support the GBV practices, and the recurrent changes in the humanitarian settings.

There are growing efforts from the government and the civil society to address some of the gender gaps. In addition, to the policies and action plans formulated for women empowerment and abandonment of FGM, efforts were exerted to advocate for laws to reduce GBV.

2.6 THE ROLE OF EXTERNAL ASSISTANCE

Sudan is a major aid recipient. In 2012, Sudan received US$441 million in international humanitarian assistance, making it the ninth largest recipient. Initial estimates for 2013 total US$637.3 million. However, a large proportion of Sudan's total ODA is received in the form of humanitarian aid and in 2009 Sudan was the leading global recipient of humanitarian aid for the 5th consecutive year. Humanitarian assistance to Sudan peaked in 2008 at US$1.53 billion. The EU institutions (US$132.9 million) were the largest donor of humanitarian assistance to Sudan in 2012, followed by the United Kingdom (US$67.3 million) and the United States (US$54.2 million). The US provided 44% of all humanitarian assistance to the country between 2003 and 2012. Significant assistance was made to the conduct of Sudan 5th Population and Housing Census during 2006 – 2007 through MDTF and bilateral funding. Census was a critical undertaking – supported by UNFPA – to prepare grounds for power and wealth sharing as well as the referendum for self-determination of South Sudan.

[25] Women Human Rights Center, Ministry of Welfare and Social Security. (Research supported by UNFPA).
[26] Alnadeef, E, 2013, A study on impact of implantation of FGM abandonment Laws in Gadaref, South Darfur and South Kordofan.

3 UN/UNFPA RESPONSE AND PROGRAMME STRATEGIES

3.1 UNITED NATIONS AND UNFPA RESPONSE

The United Nations Development Assistance Framework (UNDAF) 2013-2016 for the Republic of Sudan embodies the United Nations strategic response to the country national priorities. UNDAF development was guided by the goals and targets of the Five-Year National Development Plan 2012-2016, as well as by the Millennium Development Goals and Millennium Declaration. Other relevant development plans in development of the UNDAF include the Three-Year Salvation Economic Programme 2011-2013, the Interim Poverty Reduction Strategy Paper (I-PRSP), and the Twenty-Five Years National Strategy 2007-2031.

Achieving a smooth transition to recovery and longer-term development and continuing to practice responsible humanitarianism represents the cornerstone of the UNDAF. Under this overarching goal, four inter-related Pillars of cooperation were identified:

1) **Poverty Reduction, Inclusive Growth and Sustainable Livelihoods**, with particular attention to youth, women, groups in need and communities at most risk of the impacts of environmental hazards, climate change and recurrent disasters;
2) **Basic Services,** focused at both the policy and service delivery levels;
3) **Governance and Rule of Law**, including broad institutional strengthening and deepening of basic rights and justice for all; and
4) **Social Cohesion, Peace Consolidation and Peace Dividends**, with high-level efforts at the centre complemented by comprehensive development initiatives at local levels.

Crosscutting issues include protection, gender, environment and climate change, emergency preparedness and Disaster Risk Reduction (DRR), and HIV/AIDS. Two Outcomes under each of the four UNDAF Pillars have been identified as 'Results' to be achieved for the attainment of the country recovery and development plans. For each UNDAF Outcome, a set of 'Interventions Areas' were described with 'Contributing Agencies' assigned the tasks of working towards achievement of this Outcome / Intervention Area and raising the required resources.

UNDAF Pillars reflect national development priorities while simultaneously providing for alignment of the UN system cooperation assistance in Sudan. In Sudan, the United Nations is represented by 18 resident Agencies/UNCT members and six non-resident Agencies that operate under the framework of the Resident Coordinator System and the UNDAF. The UNDAF provided for a common operational framework upon which these UN Agencies have formulated their programmes and projects for the period with each agency contributing to the UNDAF based on its competitive strengths and technical advantages.

3.2 UNFPA RESPONSE THROUGH THE COUNTRY PROGRAMME

UNFPA translated its commitment to the UNDAF through its 6th Cycle Country Programme. UNFPA CP contributes to UNDAF Outcome 1 of "People in Sudan, with special attention to youth, women and populations in need, have improved opportunities for decent work and sustainable livelihoods and are better protected from external shocks, thereby reducing poverty."

3.2.1 UNFPA 5th Cycle Programme Achievements and Lessons Learned

The fifth UNFPA Country Programme (CP) (2009-2012) had a budget of $33 million[27] and consisted of three components; 1) Reproductive Health and Rights; 2) Population and Development; and 3) Gender, with crosscutting issues such as human rights based approach, gender mainstreaming, and emergencies and humanitarian response. Programme activities were implemented in five focus states namely Kassala, Gedaref, South Kordofan, White Nile and Blue Nile with a humanitarian response carried out in the Darfur states. Programme main achievements were:

1) **Reproductive Health:** The revision of the Reproductive Health Policy; development of the National Strategy for Scaling up Midwifery and the initiation of professional midwifery trainings; the launch of the 2010-2015 Roadmap for Reducing Maternal and New-born Mortality and the RHCS Strategic Plan.

2) **Population Development** – The adoption of 2007-2031 National Youth Strategy; establishment of youth networks and the analysis and availability of census data from all 15 states; and revision of the national population policy.

3) **Gender** – The development of a national plan to combat gender-based violence; the criminalization of female genital mutilation in four states and its abandonment in anumber of communities; and the establishment of Violence Against Women (VAW) units and Gender Focal Points (GFP). The VAW units and GFP have brought gender issues to the forefront of national development plans in different sectors.

4) **Emergency Preparedness:** Strengthening of government and NGOs' capacity for reproductive health emergency preparedness in 11 states and legalization of the immediate delivery of medical services to survivors of sexual violence.

While the final evaluation of the fifth CP cycle indicated a high rate of achievement of programme results, it also listed several shortcomings/lessons learnt mainly: Programme design and its implementation modality were not well coordinated and integrated as activities from the three programme components did not support each other; resources were spread too thin over a wide geographical coverage of implementation to effectively yield tangible results; capacity building activities through training were inadequate and required more actual practice and on-the-job mentoring to consolidate the theoretical skills; and the lack of coordination between development and humanitarian activities made it difficult to directly attribute interventions to programme outcomes.

3.2.2 Current 6th Cycle UNFPA Country Programme

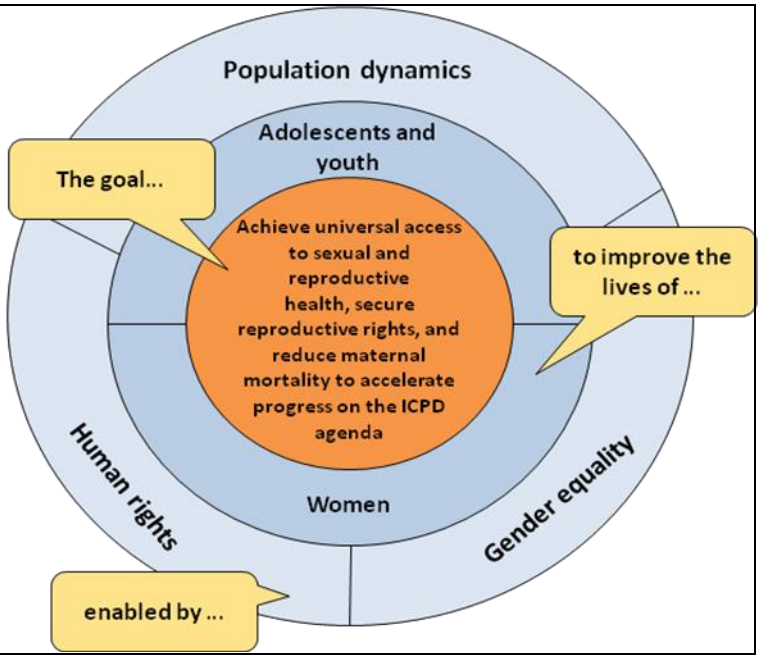
UNFPA Strategic Response- UNFPA Strategic Plan, 2014-2017: The bull's eye is the goal of UNFPA: "the achievement of universal access to sexual and reproductive health, the realization of reproductive rights, and the reduction in maternal mortality". The work of the organization is centred on attaining this goal, through an enhanced focus on family planning, maternal health, and HIV/AIDS.

[27]UNFPA managed to raise approximately US$ 44 million instead of the budget planned US$ 33 million.

UNFPA interventions are guided by a global corporate strategy set out in the UNFPA Strategic Plan. UNFPA Strategic Plan 2014-2017 reaffirmed the strategic direction set out in the midterm review (2011) represented by the "bull's eye" overarching goal:

"To achieve universal access to sexual and reproductive health, promote reproductive rights, reduce maternal mortality and accelerate progress on the ICPD agenda and MDG5."

Figure 4: The "Bull's eye" as the goal of UNFPA



UNFPA Strategic Plan is designed under four Outcomes and fifteen related Outputs deemed necessary to achieve the goal of the bull's eye. Outcome 1: Increased availability and use of integrated sexual and reproductive health services...; Outcome 2: Increased priority on adolescents, especially on very young adolescent girls, in national development policies and programmes...; Outcome 3: Advanced gender equality, women's and girls' empowerment, and reproductive rights...; Outcome 4: Strengthened national policies and international development agendas through integration of evidence-based analysis on population dynamics and their links to sustainable development....

UNFPA 6th Cycle Country Programme: UNFPA Sudan is currently implementing its sixth cycle Country Programme starting 2013 through 2016. The CP has been developed on the basis of a comprehensive Country Population Analysis (CPA) in 2012 which addresses the needs, priorities and national strategies within the mandate and comparative advantage of UNFPA's strategic plan 2008 - 2011 and its extension 2012-2013. The CP took also into consideration achievements/best practices, challenges faced and lessons learnt from the past fifth cycle country programme.

The Country Programme Action Plan (CPAP), signed end April 2013, organizes the CP in six outputs areas -maternal and new born health (demand creation and services), Family Planning, Gender, Data Production and Population Dynamics- with associated strategic interventions designed to support achievements of the related outputs. The CPAP document also included a programme results framework plan with indicators, baselines and means of verification for each of the six programme outputs.

The CP implementation uses a tiered approach (National, State and Community) with specific set of strategies/interventions for each layer. The CP introduced -and for the first time- the notion of direct service delivery to communities in the selected states. To that end, one locality from each state has been identified for implementation of pilot interventions mainly advocacy and awareness promotion for demand creation. Replication to other localities was subject to resource availability and the success achieved. UNFPA programme cover nine states (five of which are in Darfur region) in humanitarian and development contexts. CP priority intervention areas on maternal health and gender will focus particularly on women, youth and vulnerable populations (the poor, rural communities, nomads, conflict-affected and internally displaced people, ex-combatants, disabled, most at risk populations for HIV, and people living with HIV/AIDS). Capacity building is a pivotal element in all outputs. The interventions target all levels, i.e. national, state and locality/community levels.

The CP is managed by the main office in Khartoum, sub-offices in three Darfur states and UNFPA presence in 5 states through one technical officer and administrative/finance personnel accommodated by the States' Ministries of Health.

Alignment of the CP to the new UNFPA Strategic Plan: In 2014, after more than a year of programme implementation, UNFPA Sudan CP had to re-align to the new UNFPA strategic plan 2014 – 2017. Re-alignment meant amendments were brought to the programme intervention logic, mainly alignment / integration of some the programme Outputs to support achievement of new Strategic Plan level Outcomes. This process resulted in three SP Outcomes compared to the original five while keeping the same six initial CP Outputs and mainstreaming humanitarian concerns into the six re-aligned Outputs. While most of the existing CP indicators remained the same, alignment also entailed introduction of new indicators mainly on the Strategic Outcome level and where at times a baseline did not previously exist. To note that the time period of the new SP covers the four years cycle of UNFPA Sudan's 6th cycle CP with 2013 as benchmark for expected results of the SP. The table below depicts the new re-alignment of Sudan 6th cycle CP with UNFPA Strategic Plan Outputs and related SP Outcomes.

Table 2: Alignment of UNFPA Country Programme with UNFPA Strategic Plan

UNFPA SP 2014-17 Outcomes	UNFPA SP 2014-17 Outputs	Sudan Sixth CPAP 2013-16 Outputs
Outcome 1: Increased availability and use of integrated SRH services (including FP, MH, HIV) that are gender-responsive and meet human rights standards	**Output 2:** Quality FP services and information.	**Output 4 on FP:** for strengthened national systems for RHCS& FP services.
	Output 3: Increased national capacity to deliver comprehensive MH services.	**Output 3 on MH:** Quality information and services for maternal and new-born health & HIV prevention.
	Output 4: Increased national capacity to deliver HIV programme free of stigma and discrimination.	**Output 2:** Demand creation for information & services related to reproductive, maternal & new-born health & HIV.
SP Outcome 3: strengthened gender equality, women/girls empowerment, and reproductive rights.	**Output 9:** International and national systems for advancing reproductive rights, promoting gender equality and non-discrimination & addressing GBV.	**Output 5: Gender & reproductive rights:** Strengthened national, state and community capacity to promote gender equality, prevent and respond to early marriage, sexual violence/FGM.
SP Outcome 4: integrating evidence-based analysis on population dynamics & their links to sustainable development, SRH, HIV, & gender equality.	**Output 12:** national capacity for production and dissemination of quality disaggregated data.	**Output 6 on Data:** strengthened national and state capacity to produce, analyse and disseminate high-quality disaggregated data for evidence-based planning and monitoring.
	Output 14: evidence-based policies (integrate evidence on population dynamics, SRH, and their links to sustainable development).	**Output 1 on Population dynamics & investment in youth:** strengthened national capacity to incorporate population dynamics, including its linkages with RH, into relevant policies and plans, with special attention to youth & women needs.

UNFPA Sudan CP is currently in the third year of its implementation period. As at the end of its second year (2014), the CP has implemented in partnership with 87 government and non-government organizations -37 federal and state ministries and 50 non-governmental organizations (NGOs). Activities in the six output areas were planned with IPs through Annual Work Plans (AWPs) – contracts which identified type of activity – project to be implemented, purpose, budget and expected results. A summary of the CP achievements – results up to end 2014 under each of the six programme Outputs will be presented later under the 'effectiveness' question analysis section of this report.

3.2.3. The Financial Structure of the Programme

Estimated resources for the CP four years' cycle are US$ 91 million of which US$20 million are from regular/core resources and US$ 71 million (78%) non-core resources to be mobilized through different co-financing modalities.

Table 3: UNFPA Sudan 6th Cycle Country Programme Estimated Budget (2013-2016)

Strategic Plan Outcome Area (prior to alignment)[28]	Regular resources	Other	Total
Population dynamics	1.5	1.5	3.0
Maternal and newborn health	9.5	42.0	51.5
Family planning	3.0	16.0	19.0
Gender equality and reproductive rights	2.0	8.0	10.0
Data availability and analysis	2.5	3.5	6.0
Programme coordination and assistance	1.5	0	1.5
Total	20.0	71.0	91.0

Total programme budget allocated in 2013 for the six CP outputs was $ 16,651,774 whereas total budget utilized during the same period amounted to $16,462 342.00 i.e. more than 99 percent cash utilization rate. In 2014, the total programme budget allocated for the six CP outputs totalled $19,555,263 whereas total budget utilized amounted to $17,230,613.62 i.e. around 88 percent cash utilization rate. Breakdown of budget utilization by CP Output for the past 2 years 2013 and 2014 follows in table below.

Table 4: Budget Utilisation by Year and CP Output

Country Programme Output	Budget Utilisation 2013		Budget Utilisation 2014	
	US$	%	US$	%
Output 1: Population dynamics	$472,869.11	3%	$348,646.38	99%
Output 2: MH-demand creation	$6,034,610.00	37%	$7,701,764.33	90%
Output 3: MH-services	$5,239,724.95	32%	$3,967,018.04	84%
Output 4: Family planning	$1,024,871.45	6%	$920,487.24	80%
Output 5: Gender/GBV	$2,322,379.00	14%	$2,896,656.57	88%
Output 6: Data	$418,865.61	3%	$436,181.37	97%
Programme Co-ordination Assistance	$165,236.00	1%	$85,729.85	85%
Programme Management	$783,785.88	5%	$874,129.84	91%
Total CP Budget	**$16,462,342.00**	**100%**	**$17,230,613.62**	**88%**

Further financial details about sources of financing/donors and amounts raised for each thematic area will be presented later under the 'efficiency' question analysis section of this report.

[28] UNFPA Sudan aligned to the new Strategic Plan 2014 – 2017 in October 2014.

CHAPTER 4: FINDINGS

4.1 RELEVANCE

EQ1*: To what extent did the Country Programme address the national priorities and needs of the population vis-à-vis the UNFPA mandate and comparative advantage?*

EQ2: *To what extent has the country office been able to respond to changes in the national development context and, in particular, in relation to the humanitarian crisis in Darfur?*

SUMMARY

UNFPA 6th Cycle Country Programme (2013-2016) is based on a clear understanding of the needs of the country population and takes into account the policy frameworks, development strategy/plans for the population as regards to maternal health, family planning, youth and gender equality issues. UNFPA supported interventions were informed by baseline surveys; needs assessments; institutional capacity assessment of implementing partners both at the federal and state levels and participatory consultations with relevant stakeholders. Some of the surveys that informed UNFPA's 6th cycle CP include SHHS 2006, SHHS 2010, National Health Service Mapping 2011, Sudan Health Equity Report 2012, Situational Analysis of Ministry of Health Midwifery Education in Sudan 2012 and Sudan Health Information Review 2007.

UNFPA interventions addressed information and service needs of vulnerable groups such as PLWHA, MARPs, refugees, IDPs, women in the reproductive age, youth and adolescents with primary focus on the states' underserved localities.

UNFPA CO was adequately responsive to the needs of refugees, internally displaced and GBV survivors in conflict- affected areas. This response was hindered at times with the continuous re-location of the refugees' camps, climatic conditions during the rainy season and frequent changing numbers of the targeted refugees and IDPs. Frequent changing of IDP and refugees' numbers, changing locations and entry points created difficulties in timely delivery of services and supplies to the affected populations.

PROGRAMME RELEVANCE

- **The UNFPA CP 2013-2016 is relevant to the national policies and strategies, and takes into consideration the priority needs of the population and institutions identified in the planning process.**

CP Output 1 & 6 - Population Dynamics: UNFPA supported interventions are informed by prevailing national policies and plans such as the National Population Policy, reviewed 2012, and the National Strategy for the Development of Statistics (NSDS). The development or review of these frameworks involved processes of situational analysis and identification of priorities. The component is based on the lessons learned from the UNFPA support to the 2008 National Census. Additionally, some of UNFPA's interventions are based on the audits done to the institutions (such as Central Bureau of Statistics and National Population Council) capacities, and the priorities identified during the intensive consultations with the UNFPA implementation partners from the Federal and state levels.

UNFPA interventions in **Youth** take account of the National Youth Strategy and its Five Years Action Plan, supported by UNFPA in the previous programme, as well as the Arab Region Strategic Framework for programming on young people. The planned activities were identified by intensive consultation with the youth- serving institutions, at the federal and state levels. The capacity building for youth organizations addresses the priorities identified in the UNFPA supported 2012 needs assessment

among youth organizations[29]. Moreover, UNFPA is also supporting youth livelihoods and life skills training to expand potential for employability. It is noticeable that youth interventions focused on the social, economic and cultural engagement of youth, rather than addressing their sexual and reproductive health needs. Considering the context dynamics and the political and social sensitivity to SRH issues, UNPFA interventions are strategic in starting a momentum of empowering and engaging youth. This momentum would gradually encourage youth to address the challenges related to the RH issues and to realize their sexual and reproductive health needs.

CP Outputs 2, 3 & 4 – Sexual and Reproductive Health: UNFPA Country Programme addressed the national and state SRH priorities and needs of the population as planned in the National Reproductive Health Policy 2010. UNFPA interventions were preceded with baseline surveys and assessment of needs, and institutional capacity assessment of implementing partners both at the federal and state levels[30]. The national surveys findings that were used to rationalize CP included SHHS 2006, SHHS 2010, National Health Service Mapping 2011, Sudan Health Equity Report 2012, Situational Analysis of Ministry of Health Midwifery Education in Sudan 2012 and Sudan Health Information Review 2007. This approach has enabled UNFPA to adequately develop an evidence-based country programme which tallied also with the national needs and priorities as stated in the following national documents: Sudan National Health Sector Strategic Plan 2012-2016; MCH Acceleration Plan 2013-2015; PHC Service in Sudan towards Universal Coverage 2012-2016; Reproductive Health Strategy (RH Strategy 2009); Costed Road map for reduction of maternal and newborn mortality 2010-2015; Multi-sector Maternal Mortality Reduction Plan 2013 and Reproductive Health Strategic Plans of the State RH Directorates.

Strategic interventions designed to achieve Output 2 “increase demand for information and services related to reproductive, maternal and newborn health, and HIV” addressed the needs and priorities of the vulnerable groups such as PLWHA, MARPs refugees, IDPs, women in the reproductive age, youth and adolescents in the underserved localities. CP needs identification was based on the updated National HIV/AIDS Control Policy and HIV National Acceleration Plan 2013. The HIV-related interventions coverage was not limited to UNFPA target states but instead covered all of Sudan 18 states.

Strategic interventions designed to achieve Output 3 “increased availability of high quality information and services for maternal and new-born health and HIV prevention, especially for underserved populations and people with special needs” addressed mainly the service and information needs of the women in the reproductive age and youth as well as those with special needs such as internally displaced populations and fistula patients.

Strategic interventions designed to achieve Output 4 “strengthen national systems for reproductive health commodity security and for the provision of family planning services” focused on advocacy and mobilization of service and commodity utilization, strengthening and standardization of the logistics management information system and capacity building for quality Family Planning service provision. Such approach is adequate to minimize misconceptions around Family Planning issues, securing the supplies and delivering quality Family Planning services. UNFPA supply of Family Planning commodities is handed to the Federal Ministry of Health to secure supplies to the 18 states across the country.

UNFPA programme approach of involving both governmental and non-governmental implementing partners has effectively served the smooth implementation of the designed interventions through ensuring political commitment and accountability of the relevant governmental partners as well as the commitment of the NGOs to implement outreach and community-based interventions. Some implementing partners stated that some RH needs were inadequately addressed in the current country

[29]Sudanese Population Network, 2012, Report of assessment of the training programme for youth institutions, organizations, centers focusing on leadership, management and advocacy. White Nile, Gefaref and Kassala States. (The Sudanese Network, UNFPA and Higher Council of Youth and Sports)

[30] UNFPA Sudan CO: Country Programme Review Reports for2013 &2014

programme such as infertility, post-menopausal care, and Ca cervix and other reproductive organ cancers. Some of these were not streamlined in the current national and state RH strategic plans due to lack of solid information while others are newly arising issues due to increased numbers of the targeted groups such as PLWHA and midwifery candidates.

CP Output 5 - Gender Equality: UNFPA programme interventions take account of the National Women Empowerment Policy, 2007, and its plan of action, the FGM Abandonment Strategy, 2008-2018, and the National Plan of Action for Combating Violence against Women, 2012-2016. The gender interventions adequately responded to the concerns for integrating gender, RH issues into national and state policies and plans. The Gender component took into consideration also the Women Movement's concerns for child marriage and FGM abandonment and law reform for promoting gender justice. The GBV prevention and response are priority and critical issues for the women activists in the civil society organizations, as well as the government institutions.

UNFPA supported interventions in Gender and Maternal Health address the challenges of the rural – urban rift and the state- locality gaps. They strategically engage the beneficiary communities and are implemented in localities and villages where the major needs are. Interventions approaches include: community mobilization, capacity building for leaders, formation of community-based organizations (CBOs) and engagement of these CBOs in raising awareness and managing motherhood fund.

- **Adequacy of the UNFPA Country Programme response to the emergency needs of IDPs and refugees in the war affected states and other states affected by natural disasters such as the floods which occurred during the current CP cycle.**

UNFPA support in humanitarian settings is based on needs assessment undertaken by the international community in collaboration with the government on annual basis or as needed in emergency situations. UNFPA supported interventions addressed all relevant needs for the prevention and response to GBV survivors in coordination with NGOs, youth networks and the government. UNFPA is the lead agency for the GBV working groups in Darfur states. In addition, UNFPA adequately responded to the emerging needs of IDPs and refugees specifically for GBV survivors and refugees from neighbouring countries such as South Sudan and Ethiopia.

The UNFPA Sudan country office has adequately responded to emerging RH issues in the war affected states and other states affected with natural disasters i.e. floods during the current cycle. The UNFPA CO has adequately contributed to Emergency preparedness and MISP (Minimum Initial Service Package) training of RH partners which resulted in the preparation/updating of an Emergency Preparedness and Response Plan (EPRP) for each State vis-à-vis the expected nature of emergency in that State, together with the required prepositioning and storage of RH Emergency Kits[31]. Interviewed stakeholders in White Nile stated that UNFPA response to the emerging RH needs of the refugees included provision of delivery kits, hygiene kits and four delivery rooms to the camps. In addition, UNFPA programme response included maintenance of mobile clinics in the camps and incentives for the health care providers. In order to provide supportive services for the referred cases of EmOBC, Alneemah Rural Hospital was supported for infection prevention and other needs. The hospital is also providing services for the indigenous population. The early emergency preparedness approaches have positively supported the timeliness and effectiveness of UNFPA response to the emerging RH needs.

In Darfur States, UNFPA supported programme operates through sub-sector plans, where UNFPA played a major role in leading and supporting meetings of the RH Sub-Sector and Task Force to strengthen co-ordination between SMoHs, UN agencies, and NGOs.

UNFPA Country Office has responded early and rapidly to the refugees' influx from South Sudan to the White Nile State in 2013 through support of the RH services within the camps and outside the camps in the refugee-affected localities. In 2013 UNFPA CO swiftly responded to the emerging RH needs and

[31] UNFPA Sudan CO: Country Programme Review Reports for2013 &2014

priorities of the internally displaced populations in Blue Nile State through capacity building and necessary supplies. Additionally, UNFPA supported programme responded rapidly to the emerging RH needs in Kassala and Khartoum states with technical support and necessary RH supplies needed by the flood-affected localities. The response was strengthened by the technical support of the state UNFPA offices and facilitated by the availability of updated State Emergency Preparedness and Response Plans (EPRPs) as well as the cumulative experience of the concerned governmental and non-governmental bodies at the federal and state level.

The response to RH emerging issues was hindered by continuous re-location of the refugees' camps, climatic conditions during the rainy season. In addition, the frequent changing numbers of the targeted refugees and IDPs and their changing locations and entry points created difficulties in timely delivery of services and supplies to the affected populations.

4.2 EFFECTIVENESS

EQ3: *To what extent has the country programme contributed to improving quality and affordability of RH services particularly the management of delivery and its complications including the surgical repair of obstetrical fistula?*

SUMMARY

The CP was effective in contributing towards increased demand for information and service-related to RH, maternal and newborn health and HIV. Advocacy efforts and community dialogue enhanced political commitment and sensitization of the targeted communities for the RH and HIV-related prevention. The distribution of condoms among the FSW and MSM has markedly increased and this is indicative of increased demand but no evidence/ guarantee for the condom use.

UNFPA support has effectively improved the delivery of integrated RH, EmONC and fistula repair services in the UNFPA-targeted states. The capacity building of the facility-based and community-based health care providers has contributed to improve the availability and accessibility of quality family planning services. As indicated in programme records, the RH utilization services indicators in UNFPA-targeted states have shown marked increase in the years 2013 and 2014. Also, the utilization of ANC services first visit has improved by 17% and by 39% through fourth visit.

As a consequence of adequate communication for behaviour change, between 2013 and 2014, the number of pregnant women counselled and tested for HIV has increased due to high acceptability as evidenced in the RH Directorates Statistical Reports 2013-2014 in the UNFPA-supported states and interviews with the health visitors in charge of the ANC clinics.

The CP has supported repair of 48 cases of fistula in 2013 and 188 cases in 2014 with a total of 231 cases or about 23. 6% of the CP target of 1000. The fistula repair services were challenged with case finding/detection, the provision of surgical repair for the identified cases and lack of reliable information on the magnitude and geographical distribution of fistula cases

Country Programme support has effectively improved the logistics management information system for RH commodity security at the state and locality levels, utilization of facility-based family planning services and initiation of community-based family planning distribution. LMIS is functioning effectively with an almost zero health facilities reporting stock out during the last 6 months in the UNFPA-targeted states.

The current CP has made strides towards a better integration of health related activities with the aim to improve programme assistance efficiency. This integration can be tracked at the policy level,

services level and advocacy messaging.

PROGRAMME EFFECTIVENESS: REPRODUCTIVE HEALTH (OUTPUT 2, 3 & 4)

CP Output 2: Summary Overview of CP Interventions (2013 – 2014) for Maternal & New-born Health (Demand Creation).

Country Programme Output 2 for maternal and new born health aim to "increase demand for information and services related to reproductive, maternal and new-born health and HIV prevention." The main interventions areas covered under this output are to:

- Support advocacy and policy dialogue to implement policies regarding reproductive health and HIV.
- Develop and implement a strategic communication for behavior change.
- Address the stigma associated with gender-based violence (GBV), obstetric fistula (OF) and HIV.
- Strengthen the knowledge regarding socio-cultural determinants to guide reproductive health interventions.
- Enhance community mobilization to address gender-based violence and create gender-responsive referral mechanisms to promote reproductive health and prevent HIV.

The advocacy efforts and community dialogue targeted policy and decision makers at both the federal and state levels. Advocacy and community dialogue intended to enhance political commitment and sensitization of the targeted communities for the RH and HIV-related prevention. According to programme reports, in 2013 programme advocacy and dialogue activities reached out to a total of 8,785 individuals-government officials, technical personnel and community leaders (religious and traditional) – to engage them in sending out positive messages to their communities. Advocacy and sensitization sessions for preventing and reducing HIV-risk reached, in 2013 and 2014, a total of 8,321 stakeholders-officials, service providers, media, police, national security, religious leaders, community leaders, youth and NGOs- on the HIV National Strategic Plan and associated programme interventions[32].

Capacity building activities for demand creation and service utilization targeted mainly religious and community leaders, media professionals, social workers, legal assistants, counselors, NGOs, associations of PLWHA, health service providers/cadres, peer educators and MARPs. According to programme reports, the number of trainees in 2013 and 2014 totaled 4,591 individuals out of which 48 percent are females.

The Ministry of Information committed to prioritizing RH issues and increase mass media coverage and wide dissemination of RH information, education and communication messages. Advocacy efforts for HIV-related prevention among MARPs intended to reduce sensitivity/resistance at community level and increase political support. The number of individuals from MARPs and VGs (vulnerable groups) reached by Behavior Change Communication (BCC) outreach activities amounted to 42,021 which is 79.3% of the final CP target.

Provision of Income Generating Activities (IGA) - life skills to MARPs and PLHIV as complementary to the HIV-prevention packages covered 15 states. In each state, UNFPA had a team of experts (sociologist, economist and project manager) who provided counseling on behavioral change including risk-reduction, business /cost-benefit analysis and managerial skills to selected beneficiaries[33].

[32] UNFPA Sudan CO: Country Programme Review Reports for 2013 & 2014.

[33]UNFPA Sudan CO: Country Programme Review Reports for 2013 & 2014; UNFPA Monitoring Reports for 2013 &2014

CP Output 2 - Effectiveness Analysis Findings for Maternal & New-born Health (Demand Creation)

- **The CP was effective in contributing towards increased demand for information and service-related to RH, maternal and newborn health and HIV.**

Advocacy and Community Dialogue: Increased political commitment of the government is reflected in the incorporation of maternal health services within the Primary Health Care Expansion Project and mobilization of additional resources at both federal and state levels. Programme reports and interviews with the stakeholders at the National RH Directorate confirmed the commitment of the government to allocate budgets for maternal health within the Primary Health Care Expansion Programme. The Government of Sudan has committed budgets for $9 million in 2014 and $40 million in 2015 for the Primary Health Care Project and to support the midwifery profession (basic training, kits, equipment to schools, emergencies), EmONC (rehabilitation of rural hospitals), and ANC services. Interviews at the state RH directorates and midwifery schools confirmed the implementation of the scheduled activities related to midwifery profession and delivery of kits and equipment to the state midwifery schools. The interviewed stakeholders in White Nile State reported that the incorporation of the RH within the PHC Expansion Project has contributed to availability of high quality maternal and new born services through establishment of 27 new PHC centers, four delivery rooms, basic midwifery training of 101 midwifery candidates, 60 midwifery kits and in-service training of the health care providers on Basic Obstetrical Care & Help Baby To Breath. The interviewed stakeholders in Kassala State reported that within the period of 2013-2014, five health centres have been renovated to provide basic EmoNC services and one health centre was upgraded to provide CEmoNC services. The expansion programme has supported the basic training of 45 midwives in the new curriculum and refreshment training of midwives as well. As a result, the year 2014 had marked the end of the PHC-EP first phase, graduating 9,000 midwives across the country, which was 69% of the overall target of training of 13,000 midwives with the key objective of at least 1-midwife for each village. Governmental budgetary allocations were also mobilized at the federal level for maternal mortality reduction through support to midwifery jobs. The Government has also pledged its political commitment to include the graduated community/village midwives on the government payroll and the Presidency advised state governments to account for this commitment in their yearly budget plans.

The advocacy efforts have brought positive changes towards support of PLWHA associations especially in Kassala, Gedaref, River Nile and Northern States. This positive support was expressed during interviews with the PLWHA associations and substantiated by the fact that the associations were able to raise extra resources such as provision of residential land to establish premises, health insurance coverage and in some states fuel for associations. However, still according to PLWHA, the response towards the advocacy efforts was limited among the policy-makers in Red sea and Khartoum States.

The advocacy efforts mobilized other institutes to support the IGAs for the women groups. For example, the Faculty of Community Development at the Blue Nile University has established women development centres and IGAs for the women in the villages targeted by this UNFPA-supported NGO. In addition, the political commitment in White Nile State has resulted in the establishment of a functioning partnership between the Consultative Unit of Women and Children and the RH stakeholders at the state level.

Interviewed stakeholders have reported that advocacy efforts at the locality level resulted in the declaration of abandonment of FGC in Alfao Locality. Moreover, the political support of Rural Kassala Commissioner towards RH issues has manifested in the declarations for abandonment of FGC practices in five villages.

Still, some commitment at the locality level in Kassala was poor as only two commissioners out of eleven complied with the Kassala State Governor instructions that “every commissioner should pay monthly incentive for the village midwives”. Also, as stated by interviewed stakeholders, the air space

in the daily programmes of local radios for RH messages in some states is still limited to few radio sessions.

Community Sensitization, Mobilization and Behavioral Change Communication: The distribution of condoms among the FSW and MSM has been included within the integrated HIV prevention package resulting in increased demand but no evidence/ grantee for the condom use. According to programme reports, the total number of distributed male condoms to the FSW and MSM amounted to 285,120 in the years 2013 and 2014.

Interviewed stakeholders in the UNFPA-targeted states have commented on perceived responsiveness to HIV-related BCC messages delivered to the target vulnerable groups and their peers. For example in Blue Nile State 120 MSM were targeted however, 334 were reached and 120 FSW were targeted whereas 220 were actually reached. Achievement and overachievement of targets was facilitated by the programme strategy to train MSM and FSW to deliver HIV-related BCC messages to their peers and clients.

From the start of the 6thprogramme cycle to date, UNFPA has supported 60 NGOs and civil society organizations engaged in behavioural change communication at the community level on gender, RH, early marriage and HIV/AIDS prevention; far exceeding the end of programme indicator target of 26. Focus group discussion with 10 youths from different governmental institutions and NGOs conducted in White Nile State suggests that GBV training is very relevant to them in performing their jobs as peer educators. They described the trainings as effective to provide direct support to internally displaced people in the IDPs camps and to provide counselling services in the hospitals and health centres as some of them are employed as counsellors in state hospitals and health centres. The 5-day training was competency-based with application of innovative methods like real life demonstration by people who were subjected to the GBV situations, case studies, group discussions, role play, and interactive discussion between the trainees and trainers.

According to programme reports, a total of 492 and 306 IGA/life skills projects were provided to MARPs and PLWHA respectively between 2013 and 2014. A recent UNFPA-supported evaluation of the IGA activities for sex workers showed that IGA as part of an HIV prevention was a sustainable approach but changes for long term improvement need to be made with emphasis on quality improvements instead of scaling up the programme. To be noted however that it was not possible during the course of this CP evaluation to appraise if FSW and MSM equally benefited from the IGAs. Also, the scope of this evaluation did not provide the opportunity to assess if the IGA beneficiaries for PLWHA were thus empowered enough to improve their nutritional status nor if they faced less stigma[34].

CP Output 3: Summary Overview of CP Interventions (2013 – 2014) for Maternal & New-born Health (Services).

Country Programme Output 3 for maternal and new born health aim to "increase availability of high-quality information and services for maternal and new-born health and HIV prevention, especially for underserved populations and people with special needs." The main interventions areas covered the following:

- Strengthening the management of the RH programme
- Supporting evidence-based advocacy efforts to mobilise resources to implement the maternal health roadmap
- Expanding community-based MH interventions through:
    - Ensuring youth-focused peer education & counselling.
    - Strengthening the elimination of MTC HIV transmission.

[34] This is an impact/outcome level assessment which is not covered in UNFPA evaluations according to UNFPA evaluation guidebook. Please refer to the Limitations section of this report.

- Integrating the management and prevention of STIs & HIV into RH service outlets; including outlets that have services for young people
- Implementing MISP in humanitarian settings

- Supporting interventions to increase the coverage of skilled birth attendance
- Strengthening the provision of EmONC services, including supporting critical rehabilitation & renovation of facilities
- Supporting the capacity for the repair of obstetric fistula and the social reintegration of fistula patients

The 6thCP contributed to the integration of Gender and Sexual Reproductive Health services (including family planning) into existing health policies and guidelines and endorsement of the national training materials on Adolescence & Youth Sexual Reproductive Health (AYSRH). According to programme reports, the 6th CP has contributed to building the capacity of 2,062 RH providers, stakeholders and volunteers on integrated RH services. These interventions were supplemented with various issue-focused advocacies, awareness, sensitisation campaigns and outreach activities and distribution of RH messages, IEC/BCC materials and emergency RH kits, rehabilitation of health facilities and introduction of mobile clinics for the remote underserved areas. Interviewed stakeholders at the states level stated that the mobile clinics have contributed to the delivery of ANC, PNC, VCT and family planning services to the remote underserved areas for the indigenous population and for the refugees in the refugee-affected states.

In 2013 the Country Programme accelerated the implementation of the prevention of mother to child transmission (PMTCT) activities through launching of state-based community mobilization Initiative in collaboration with Sudan national AIDS Programme (SNAP) to increase HIV counselling and testing among pregnant women.

In 2013 the training curriculum for community midwives and the Teacher's Guide for the community midwife care were updated, tested, validated, endorsed, printed and disseminated. The updated curricula were implemented for qualifying the community midwifery candidates. To note that the community midwife curriculum included also socio-cultural issues such as gender, gender-based violence and female genital cutting. Inclusion of these socio-cultural issues in the midwife curriculum is expected to improve the competencies and professionalism of the midwives graduates.

The 6th CP contributed to updating EmONC integrated training curricula which were later used for in-service training of 259 health cadres in the UNFPA-targeted states. The CP supported the implementation of blood donation campaigns preceded with technical training, awareness raising and media campaigns, and carried out in collaboration with State Blood Banks[35].

CP Output 3: Effectiveness Analysis Findings for Maternal & New-born Health (Services).

➲ **UNFPA programme support has effectively improved the delivery of integrated RH, EmONC and fistula repair services in the UNFPA-targeted states. Case finding for fistula is still a challenge.**

Integrated RH services: At the federal ministerial level, the CO managed to bring together the Federal Ministry of Health (FMoH) and Ministry of Welfare and Social Security (MoWSS) to work jointly on maternal mortality reduction and FGM, which was a key policy breakthrough for establishing inter-sectoral work within the Government systems. Interviewed RH Directorate stakeholders at the states level have noted that the channels of coordination between the Ministry of Health and the Ministry of Welfare & Social Security to work jointly on maternal mortality reduction and FGM were inadequately functioning in most UNFPA- targeted states. These channels were confined to limited participation in some activities such as awareness raising.

[35]UNFPA Sudan CO: Country Programme Review Reports for 2013 & 2014

UNFPA CP support during 2013 and 2014 resulted in availing 37 PHC facilities providing integrated services on sexual, RH, HIV and STIs in UNFPA-targeted states or 80.4 percent of the programme's end target of 46 PHCs in 2016. Moreover, the RH utilization services indicators in the UNFPA-targeted states have shown marked increase. PHCs service registers show that between 2013 and 2014 utilization of ANC services first visit had improved by 17 percent and by 39 percent through fourth visit, which is a proxy indicator for better service availability and use. However, further assessments are needed to confirm behavioral change of the pregnant mothers. Similarly, programme reports likewise indicate improvement in PNC service utilization by 30 percent. Increase in the number of PNC service users is yet another verifying indicator of increased demand and utilization of RH services**.**

Comparing the ANC care coverage rates at least once by skilled health personnel in some UNFPA-supported states based on the SHHS 2010 and MICS 2014, we note that the coverage increased from 78.5% to 83% in Kassala State, from 71% to 80.5% in Gedaref State and from 51.7% to 71.8% in Blue Nile State. However, the ANC coverage in White Nile State dropped from 79.4% to 78.8%. The increase in RH service utilization is partly due to the introduction of mobile clinics to the underserved areas. Nevertheless, the high costs of operating the mobile clinics might jeopardize future continuity of these services if UNFPA support is discontinued.

Comparing the rates of skilled attendance at delivery in some UNFPA-supported states based on the SHHS 2010 and MICS 2014, we note that the trend increased from 69.7% to77% in Kassala State, from 63.5% to 82.7% in Gedaref State, from 45.1% to 61% in Blue Nile State and from 86.2% to 92.3% in White Nile State.

The number of pregnant women counselled and tested for HIV significantly increased. In fact, in 2013 a total of 14,142 pregnant women were counselled and tested for HIV in White Nile, Blue Nile and Kassala states; this number almost doubled to reach 21,986[36] in 2014. HIV testing for pregnant women was made available through health facilities and also through the mobile clinics for the remote rural areas in the UNFPA-targeted states. Interviewed health personnel in charge of the ANC clinics in the three states stated that very few pregnant women refused counselling and HIV testing. Women who tested positive for HIV were supported with post-test counselling by trained counsellors who visited the health facilities on part-time basis specifically for this purpose.

EmONC Services: The rehabilitation of the BEmONC facilities supported by the 6th CP resulted in an increase of 30 percent and the rehabilitation of the CEmONC facilities resulted in an increase of 26 percent in the UNFPA-targeted states[37]. Reported by health personnel during the evaluation interviews, these efforts with capacity building have effectively contributed to improve the services provided for the emergency obstetrical and neonatal cases which are reflected in the increase in the number of managed cases. However, staff turnover especially of medical doctors, is challenging the continuity of these services as trained medical doctors on CEmONC were subjected to transfer within or outside the states.

According to programme reports, the number of blood donors increased during the blood donation campaigns. In 2013, 150 blood bags in White Nile and 223 in Blue Nile were donated while in the year 2014, 183 blood bags were collected through voluntary blood donation campaigns in Kassala and White Nile States. Interviewed IPs confirmed that the donated blood was used for management of the emergency obstetrical cases. While noting that the continuity of the blood donations post-campaign was not significant, interviewed IPs pointed out that these campaigns were effective in raising community awareness with regards to blood donation in supporting emergency obstetrical cases.

The maternal death surveillance system (MDSS) has been established and effectively functioning at the state and locality levels in UNFPA-supported states. Interviewed stakeholders in Kassala stated that the MDR reporting mechanisms were established in all eleven localities of the state. The collected

[36]RH Directorates Statistical Reports 2013-2014

[37]UNFPA Performance Monitoring Reports for 2013 and 2014

information were regularly analyzed and presented to the state MDR committees to discuss and respond accordingly. Interviewed stakeholders in White Nile State provided examples in support of the effective functioning of MDSS:

- The repeated maternal deaths from one of the rural hospitals were investigated and the interventions which were adopted have resulted in reduction of maternal deaths.
- Reported deaths from one of the central hospitals were due to puerperal sepsis and the intervention adopted through infection prevention control.
- Introduction of national protocols of eclampsia was effective in reduction of reported deaths in state hospitals.

According to programme reports, the introduction of 424 mobile phones to be used by the village midwives proved to effectively increase the maternal death notification to the state level and referral of complicated cases. Interviewed stakeholders in White Nile State commented that the effect was noticeable in remote rural areas which were difficult to access especially in the rainy season. However, statistical data could not be traced at the RH directorates to support the average referred complicated cases by the village midwives using mobile phones. Interviewed IPs noted that the challenge remain in sustaining these improvements in the long run due to the inability of the midwives to purchase the mobile service.

Midwifery Services: The . The results of two focus group discussions held in Blue Nile and South Darfur States with senior health visitors and midwives suggest that the in-service trainings were adequate and relevant to their job duties. The acquired competencies during training were effective to improve their abilities to provide RH services to the beneficiaries at the health facility level. In addition the participants were trained on gender-based violence issues which are particularly important in the two war-affected states. As senior midwifery cadres they used the acquired competencies during the training to train other junior midwives.

UNFPA support included 10 midwifery skill laboratories. During the field visits and observations, the visited skill laboratories were functional and effectively serving the training purposes of the midwifery candidates.

Three hundred and forty three midwifery candidates were fully supported as regards to cost of training (accommodation, uniform, training materials, tuition fees, transport etc) during the current country programme and mostly returned to their villages to provide community-based services. This has contributed to increase the midwifery service coverage in the UNFPA-targeted states. In White Nile State, 87 percent of villages have at least one village midwife. This is the case for 64 percent of villages in Blue Nile State; 61 percent of villages in Kassala and 82 percent in Alfao Locality[38]. However, the midwifery service coverage showed marked variations between localities. The continuous increase and proliferation of new villages constrained the process of midwifery service coverage as the mapping of villages is continuously changing. The current governmental policy is to include the village midwives within the governmental jobs but this policy is not yet fully implemented. The village midwives who have governmental jobs were 8.7 percent in White Nile State, 35 percent in Blue Nile State, 17 percent in Kassala State and 52.7 percent in Alfao Locality[39]. The CP assisted the state midwifery supportive system at the locality level in the targeted states. The system is adequately functioning in four localities in Kassala and Gedaref States. In other UNFPA-targeted states, the system was perceived by interviewed stakeholders as being inadequately functioning due to lack of budgetary allocations and geographical inaccessibility during the rainy season. Three midwifery associations were established and fully functioning to scale up the midwifery professional practice in the UNFPA-targeted states namely in Kassala, Gedaref and Red Sea states.

[38]RH Directorate Statistical Reports 2013 – 2014

[39] RH Directorate Statistical Reports 2013 – 2014

UNFPA support resulted in the establishment of community-based structures and new referral pathways to service delivery points for GBV survivors, fistula and complicated emergency obstetric cases. These CBOs and referral pathways are managed with the involvement of the village midwives and village volunteers. Field visits confirmed that the number of community-based obstetric referral mechanisms established and functional in Rural Kassala locality is nine while also thirty four emergency funds are established and functioning in supporting and referring pregnant women with emergency obstetrical problems. The number of referred pregnant women per month amounted to 30 from the 9 targeted villages as has been indicated by the participants in the focus group discussions held in Rural Kassala Locality.

Participants of focus group discussions conducted with members of the community-based obstetric referral mechanisms in Kassala and Blue Nile States said that the training they received was very useful to improve the delivery of their duties as it included RH issues, EmOC, HIV/AIDS, GBV and FGC etc. They described the training as competency-based and the training materials as attractive for them to ease their learning and adequate to enable them to deliver IEC messages in formal and informal gatherings to other women at the village level. Furthermore, the beneficiaries established women groups and developed their own revolving funds to support those with obstetrical problems and emergencies. The groups were very diversified and included housewives, students, teachers and village midwives. Despite the fact that findings from the focus groups cannot be generalized, they indicate the effect of the implemented training to booster the work of village midwives.

According to the 6th cycle's programme reports, the total number of community-based obstetric referral mechanisms established and functioning in the UNFPA targeted states is 29 exceeding the CP end of programme indicator target of 19.

Fistula Repair Services: The 6thCP has so far supported the repair of 236 cases of fistula (48 in 2013 and 188 in 2014) corresponding to only 23.6 percent of the CP end of programme target of 1000. The fistula repair services were challenged with case finding/detection, the provision of surgical repair for the identified cases and lack of reliable information on the magnitude and geographical distribution of fistula cases. Considering the inherent difficulties in case identification through the current campaign-based fistula repair strategy, it is unlikely that the 6th CP will achieve the set target by 2016. It is worth mentioning that the CO strategy in 2015 is directed to active case finding so that the identified cases could be treated in 2016. This necessitates capacity building of the health care providers and community volunteers with support of the fistula repair centers to provide services on regular basis. UNFPA provided counseling for all the treated cases, and the full rehabilitation/re-integration services for some cases. According to programme reports, the majority of the repaired cases (82 percent) received income-generating/life skills training and there are plans to provide them access to income-generating projects 2015-onwards. In Darfur states, 40 patients have already received inputs for income-generating projects**.**

CP Output 4: Summary Overview of CP Interventions (2013 – 2014) for Family Planning.

Country Programme Output 4 on Family Planning aims to "strengthen national systems for reproductive health commodity security and for the provision of family planning services." The main interventions under this output are:

- Advocating reproductive health commodity security, including the prevention of HIV/AIDS.
- Strengthening the health information & logistics system.
- Enhancing the capacity of health-care providers to deliver high-quality family planning services.

The 6th CP advocacy efforts aimed to create a common understanding among the government stakeholders, religious and community leaders about family planning issues to reduce resistance to FP. Awareness raising, community sensitization and mobilization intended to increase demand for

information and family planning service utilization. Advocacy kits and information, education and communication materials on family planning issues were produced centrally by the Federal Ministry of Health, with UNFPA programme support, and distributed to all states.

UNFPA supported the Logistic Management Information System (LMIS) for thirteen family planning rehabilitated RHCS warehouses and provided furniture and equipment to facilitate the effective functioning of the system and insure availability of family planning services. In addition, the programme built the capacity of the concerned cadres at different levels through training on logistics management and RHCS/FP forecasting and procurement. Monitoring and reporting on utilization of FP commodities is still weak at the HF level. This weakness was noted in the 2014 Management Audit and the CO put in place an action plan to respond to specific recommendations in this regard.

The 6th CP supported the first Sudan Facility Based Assessment for Maternal Health Commodities and Services (started 2013 while findings released early 2014) in 483 service-delivery points across the country. Findings of this survey were the basis for the work planning and interventions in 2014, especially in relation to strengthening the LMIS in terms of stock-out assessment, commodity requests, reporting and capacity building[40].

CP Output 4: Effectiveness Analysis Findings for Family Planning

- **Country Programme support has effectively improved the logistics management information system for RH commodity security at the state and locality levels, utilization of facility-based family planning services and initiation of community-based family planning distribution.**

Capacity building of the facility-based and community-based health care providers has contributed to improve the availability and accessibility of quality family planning services. Under the 6th CP, so far 1,267 health care providers have been trained on family planning, making 42.2 percent of the CP end of programme target of 3000[41]**.** It is unlikely that the CP target will be achieved during the remaining period and it is advised to focus on training of the health care providers who are directly involved on provision of family planning services especially at the primary health care facilities and community-based family planning services.

The logistics management information system for RH commodity security is functioning effectively as noted by the interviewed stakeholders in UNFPA-supported states. The interviewed stakeholders commented that the number of health facilities to report stock out during the last 6 months in the UNFPA-targeted states was almost zero as the supplies from the federal level were regular and continuous. The percentage of national commodity requests satisfied amounted to 61 percent[42]**.** However, it should be noted that other components of LMIS system (inventory, forecasting, storage were not covered within the scope of this evaluation.

Altogether, the direct result of the 6th CP efforts have been an improvement in family planning service utilization by 17 percent in some selected states as indicated in the increase of the number of first-time users of family planning methods from 49,254 in 2013 to 55,683 in 2014 according to programme records. However, and for two consecutive years, Gedaref State has achieved no significant increase in the number of new users of family planning methods. In 2013, the baseline number of first time FP users was 3,327 and it dropped to 3,006 while in 2014, the baseline number of 3,006 remained almost the same with programme records reporting 3,020 FP first time users. This is mostly due to problems associated with the reporting system and limited coverage of the health facilities providing family planning services. Moreover, the results of the first Sudan Facility Based Assessment for Maternal Health Commodities and Services (UNFPA –supported) revealed that the percent of health facilities providing family planning services in Gedaref State was 61.9% in comparison to Kassala State with 88%

[40]UNFPA Sudan CO: Country Programme Review Reports for 2013 & 2014
[41]UNFPA Performance Monitoring Reports for 2013 and 2014
[42]UNFPA Performance Monitoring Reports for 2013 and 2014

of the health facilities providing family planning services. Such situation is unlikely to be related to insufficiency of the CP interventions as similar supported neighboring states i.e. Kassala State have achieved better results with almost the same interventions.

The analysis of the statistical reports of the UNFPA-supported states reveal that the percentage of the health facilities currently providing family services in White Nile and Kassala States, 59.8 percent and 48.8 percent respectively, are currently providing at least three family planning methods[43].

The community-based family planning services have been supported through capacity building of the village midwives and regular supply of commodities at the locality level. However the delivery of services to the end beneficiaries has been constrained with difficult transport of the village midwives to receive FP commodities from the locality level thus making the availability and supply of community-based FP services irregular and weak in most UNFPA-targeted states.

Integration of Programme Support: Following findings and recommendations of the fifth cycle end of programme evaluation, the current CP has made strides to integrate health related activities and programme support with the aim to improve programme assistance efficiency. Review of programme documents and field assessment results confirmed the following programme integration achievements:

- At the policy level: Integration of RH within the PHC policy & Expanded Primary Health Care Project (EPHCP).
- At the service level: Integration of RH services within the PHC packages through the existing health facilities and mobile clinics.
- Integration is well established between the RH Directorate and the State Branch of the Academy of Health Sciences in implementation of the community midwife curriculum.
- Integrated packages services on GBV and PMTCT (Prevention of Mother-to-child Transmission) services are provided by health care providers (UNFPA support) and the community services providers (UNHCR support) for both the refugees at the camp level and hosted populations.
- Integrated training of village volunteers and village midwives on IEC to deliver pregnancy-related messages with technical support of the RH Directorate facilitators.
- Advocacy messages and awareness raising sessions have been integrated to include RH, human rights, gender and GBV issues.

EQ4:*To what extent have UNFPA supported interventions contributed (or likely to contribute) to a sustained increase in use of demographic and socio-economic information and data in the evidence-based development and implementation of plans, programs and policies (to improve access to Reproductive Health Services including in areas associated with gender equality, population dynamics and HIV/AIDS)?*

SUMMARY

Population Dynamics: The 6th CP contributed to improving national and state capacities for integrating population dynamics through the revised National Population Policy (NPP) and its Plan of Action. The revised NPP took into consideration sectoral and states policies and development plans. The present challenge is in coordinating with the states and sectors *for the implementation of the PoA.*

UNFPA support was instrumental in the production of the national ICPD review report, the National Population Situation Report and the Sudan Position Paper on ICPD beyond 2014. The support to advocacy for ICPD Beyond 2014 and the post -2015 Development Agenda was successful in

[43]RH Directorate Statistical Reports 2013 – 2014

enhancing the participation of high level officials, youth, and CSOs and some parliamentarians in the ICPD regional conferences. Sudan delegates have also actively been engaged in shaping the regional agenda as part of global negotiations on the Sustainable Development Goals.

The integration of population dynamics is challenging as it involves institutions at different levels where each one looks at it from its own angle. Coordination with some federal ministries is challenged by the limited understanding of these officials and policy makers of population issues and in some other ministries by the limited institutional capacity to integrate population issues in development plans. The lack of disaggregated population data on locality and administrative unit levels is also a challenge.

Data Availability and Analysis: Country Programme contributed to the improvement of data quality, production and availability through enhancement of human resources capacities, development of tools, techniques and strategies for the collection of population data. Data produced, including maternal health indicators, was used by government institutions to formulate their development plans. In support to establishing a National Statistics System (NSS), UNFPA contributed to the production of four key statistical protocols.

However, the activation of the National "data producers/users" Committee for linking data users and producers and for increasing demand for data remains a challenge. In addition, there are gaps in the human resources capacities and challenges of data production from the locality and administrative unit levels.

PROGRAMME EFFECTIVENESS: POPULATION DYNAMICS & DATA (OUTPUT 1 & 6)

CP Output 1: Summary Overview of CP Interventions (2013 – 2014) for Population Dynamics

Country Programme Output 1 on Population Dynamics aims to "strengthen the national capacity to incorporate population dynamics, including its linkages with reproductive health, into relevant policies and development plans, with special attention to the needs of young people and women." In partnership with the National Population Council (NPC) as output lead, the main interventions in population dynamics under this output are the following:

- Support to evidence based research for integration of population dynamics and linkages with national policies and development plans.
- Advocacy, awareness raising and sensitization to population issues and production of advocacy materials
- Technical support and capacity building in population analysis for incorporating population issues and development of Population Action Plans.

CP Output 1: Effectiveness Analysis Findings for Population Dynamics.

➲ **CP contributed to improving national and state capacities for integrating population dynamics through the revised National Population Policy and its Plan of Action.**

The technical support provided by UNFPA, enabled the National Population Council (NPC) to formulate the Plan of Action (PoA) for the revised National Population Policy (NPP). The PoA clearly differentiated between population dynamics at the national and state levels, between sectors, and priorities and indicators were identified for some of the priority themes. The PoA is a road-map for operationalizing the NPP as the implementation arrangements were designed and budgeted for, and processed for endorsement. The relevant sectorial ministries, the civil society organizations and the state population councils were engaged in the discussion of the priority themes identified for the PoA. The gender sensitivity of the PoA was catered for.

The thematic groups formed from the line ministries and CSOs at the national and state levels worked as a very effective mechanism in the preparation of PoA and succeeded in processing it to the stage of endorsement. The challenge is how these mechanisms can continue functioning, coordinating, and monitoring the implementation of PoA, specifically for the integration of population dynamics in the plans and programs at all levels.

The NPC further succeeded in leading the integration of the population dynamics in the National Strategic Development Plan and in facilitating the alignment of the visions, mission and policies of some sectorial ministries to the revised NPP.

Sixty one planning directors (30% females) from West, North and South Darfur, trained on population projection (using SPETRUM software package) were able to integrate the priorities of the population dynamics in the development plans formulated to help the transition, from humanitarian to recovery and to development. That promoted the recognition of the authorities in Darfur States to the importance of the population dynamics linkages to the development plans. The population offices in Darfur states were granted membership in the states planning committees. The challenge is the availability of the resources for the implementation, and monitoring of such plans. This puts more burdens on NPC to demonstrate its advisory role to government at federal and state levels and to advocate for more considerations to issues related to integration of population into development planning.

The research on causes of fertility decline in Eastern Sudan, funded by the UNFPA, explained that the literacy and the living in urban areas show their indirect influence on the contraceptives use, leading to low fertility among literate women and birth intervals of more than two years among the residents of the urban areas.[44] These findings were disseminated to planners and advocates for improvements of maternal health. The challenge here is that the findings are very general as the research had its limitations. There is no explanation on how the sample was selected from the three states and some of the results were very poor as noted by the authors.

The Sudan National Population Situation Report 2013 was supported by the 6th UNFPA programme. It provides data on important indicators needed for planning and monitoring such as 27% of the states reported that strengthening of youth access to RH services is progressing as planned and 45% of the states reported that the increase in access of women to RH services is weak. Furthermore, the process of the preparation and production of the report demonstrates the enhanced capacities of NPC for coordinating data collection, and analysis.

The support of UNFPA interventions enabled the engagement of the focal points of the states' population councils in the discussion of the draft PoA and in the identification of their priorities and needs for operating and for coordination with the states' line ministries. The consultative process followed by NPC during the preparation phase of the NPP/PoA has created a positive momentum that could further be strengthened to facilitate the implementation of the PoA as it promotes the ownership of the process. The institutional capacity building of three population state councils, in the Red Sea, West Kordofan, and Kassala states is the start of the process of implementation of PoA.

The influencing factors for the results achieved as noted during the interviews include: the technical support through the advisors provided by the UNFPA and the strong partnership and the effective consultation with UNFPA CO, in addition, to the strong commitment of the NPC leadership to the population development.

However, there are some hindering factors, such as the limited capacities of middle level cadre in the NPC; the limited understanding at the state level for the significance of the population dynamics to

[44]Mohamed, Nasr Abdalla, 2015, Research Study on Fertility in the Eastern Region of Sudan:Trends, Rates and Determinants.TechnicalReport (P4). General Secretariat National Population Council, Department of Research

development, and the limited support to states' population councils. The coordination with some federal ministries is challenged by the limited understanding of the officials and policy makers to the population issues. While the integration of population issues in the development plans of some ministries is challenged by their weak institutional capacities. Additionally, the shortage of national, qualified demographers caused delay in the implementation of researches[45].

➲ **CP support through advocacy, policy dialogue and population education has improved understanding of the importance of population issues/dynamics.**

The production of policy briefs (on youth, environment, maternal mortality and fertility and demographic dividends), as advocacy tools, with UNFPA support, is a good practice that would strengthen advocacy messages, and would be effective in reaching the decision makers who cannot be reached personally. The tools are not yet used to identify specific results.

UNFPA interventions enabled the NPC to engage in population education reaching a variety of groups at state level, with knowledge on critical and emerging population issues such as "youth challenges and opportunities", "population and mining"; and "armed conflict and population dynamics".

The advocacy, orientation sessions and the policy dialogue on population issues, the MDGs and the ICPD Beyond 2014, organized for the policy makers, parliamentarians, religious leaders and media figures at national and state levels emphasized the importance of population dynamics. As a consequence, the Ministry of Welfare and Social Security (MoWSS) allocated funds in the national budget for some of the activities of the National Population Council. In addition, advocacy efforts encouraged the participation of high level officials and parliamentarians in the ICPD regional conferences organized in Cairo and Addis Ababa in 2013.[46]

UNFPA support enabled the NPC to respond to the international ICPD 2014 survey, to prepare the Sudan Position Paper on ICPD beyond 2014, and the Sudan ICPD review report. The support was instrumental in the effective engagement of Sudan in the ICPD 2014 regional conferences in Egypt (June 24-26, 2013[47]) and Addis Ababa (3-4 October, 2013)[48]. Sudan was one of two countries selected to present its experience to other countries in the ESCWA meeting 26-27 November, 2014. Following the Regional Arab ICPD conference in Cairo, the ESCWA offered support for the assessment of the national capacities and knowledge for the development of comprehensive sustainable population policies in the Arab world. Some radio sessions were presented and newspaper articles were written by the media personnel who attended the UNFPA's supported sessions on 'lessons learned from ICPD 2014' and 'Beyond 2015 Development Agenda'.[49]

CP Output 6: Summary Overview of CP Interventions (2013 – 2014) for Data Availability and Analysis.

Country Programme Output 6 for Data Availability and Analysis aim to "Strengthen national and state capacity to produce, analyse and disseminate high-quality disaggregated population data for evidence-based planning and monitoring, with a focus on maternal health." In partnership with the Central Bureau of Statistics (CBS) as output lead, the main interventions under this output were:

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[45] Interview with the National Population Council, Head of Planning, and UNFPA project Director, 4th August, 2015

[46] Interview with the National Population Council, Head of Planning, and UNFPA project Director, 4th August, 2015; and UNFPA review report, 2014.

[47] Development Challenges and Population Dynamics, Regional Conference of Population and Development in the Arab States, 24-26 June, 2013.

[48] Population and Development in Africa: Beyond 2014, Regional Conference of Population and Development, 3-4 October, 2013.

[49] Interview with the National Population Council, Head of Planning, and UNFPA project Director, 4th August, 2015; and UNFPA Review Report, 2014.

- Improving quality standards & techniques for collecting population data
- Establishing national indicators on population development and MH
- Building national capacity in preparation for the 2018 census
- Strengthening the capacity for qualitative data collection, analysis and dissemination, including in humanitarian settings
- Strengthening quality of maternal & RH data collection, including HIV

CP Output 6: Effectiveness Analysis Findings for Data Availability and Analysis.

➲ **Country Programme contributed to the improvement of data quality, production and availability through enhancement of human resources capacities, development of tools, techniques and strategies for the collection of population data.**

The 6thUNFPA programme support for capacity building of 208 statistics personnel enabled the CBS to collect and produce quality data for the production of the National Baseline Household Survey 2014, as well as the data collection for the survey of the UNICEF Child Friendly Villages.

With the support of the UNFPA 6th programme, a National Strategy for Development of Statistics (NSDS) and the statistical protocols (National Statistics Act, National Compendium) were developed in 2013 and used. The National Statistics Act emphasized the leading role of CBS in production of the national data, and this created a higher demand for CBS services[50]. The Compendium produced included a set of concepts, methodologies and indicators related to population development, and maternal health. These preparations are essential for the upcoming Sixth National Population and Housing Census 2018 and for the production of data for maternal health indicators[51].

As a result of UNFPA support, the CBS has developed the capacity to collect and analyze qualitative data and this is a great opportunity to include humanitarian settings in the next census.

In addition, 24 (out of 33) Sectorial and 7 (out of 18) States Strategies for the Development of Statistics (StSDS), were formulated to enhance the coordination of the data collection and production at state level and across sectors. The evaluation interview with CBS staff revealed that the collection and availability of data from locality and administrative levels remains a challenge, due to the vastness of the country, and the limited awareness on the importance of statistics.

The 6th CP's support and leadership was instrumental in the inclusion of maternal mortality, FGM and Child Marriage (CM) indicators in MICS[52]. Important results on some population aspects, MM and GBV indicators are accessible in MICS report, 2014. Updated data on all current national statistics such as 2008 census results and Sudan Health Household Survey 2010 is accessible for users at the upgraded CBS Website. Soon the Baseline Household Survey, 2014 and the MICS 2014 results will also be accessible, ensuring the effectiveness of CBS in data production, analysis and availability to users.

The census and surveys' data produced by the CBS was utilized for the design of development plans by the Federal and State Ministries, such as Khartoum State government, the Bank of Sudan, the Ministries of Health, Welfare, and Education.

The National producers/Users Committee was formed with clear terms of reference, but it is not yet operational. The terms of reference for the Committee give it an instrumental role in generating dialogue among the data users, producers and policy makers. Putting such linkage in practice makes the CBS more responsive to the needs of the users and is likely to increase demand for data.

[50]ibid
[51]Ibid
[52]Interview with CBS, UNFPA Project Director, 3 August, 2015; UNFPA Review Report, 2014.

UNFPA 6th CO supported two study tours (5 members each) for statisticians from the CBS and line ministries (national and state level) to (Ethiopia and Uganda). The interaction during the study tour and the exposure to different systems and methods of data production, were significant learning processes. In addition, the CO support for 2 fellowships to CBS staff for 1-year diploma on Population and Development at the Cairo Demographic Centre (Egypt) is a contribution to the reduction of the gaps in capacities of the CBS[53].

The complementarity of the interventions components and the opportunity provided to apply the training skills enhanced the effectiveness of the trainings. However, one of the hindering factors noted in the evaluation interviews is the limited capacity for report writing.

EQ6: *To what extent has UNFPA ensured that the needs of young people have been taken into account in the planning and implementation of UNFPA-supported interventions under the country programme?*

SUMMARY
The UNFPA 6th cycle CP has contributed to youth empowerment and engagement of youth in community education on maternal health and gender specifically GBV related issues. UNFPA support enabled youth in UNFPA- targeted states to access adequate social spaces (rehabilitated centers), to engage in social, educational and cultural activities. Capacity building of youth enabled some of them to access business skills, and some were able to get jobs. Effectiveness of UNFPA supported interventions is evident in the engagement of the trained youth in community education on maternal health and GBV issues.

PROGRAMME EFFECTIVENESS: YOUTH (OUTPUT 1)

CP Output 1: Summary Overview of CP Interventions (2013 – 2014) for YOUTH

Country Programme interventions in Youth fall under Output 1 for Population Dynamics which aim to"strengthen the national capacity to incorporate population dynamics ... with special attention to the needs of young people and women". The main interventions under this output are:

- Strengthening the management and advocacy capacity of youth-serving organizations
- Supporting the coordination and networking among youth organizations and women's organizations
- Supporting livelihood and life-skills training for young people addressing employability, gender and reproductive health concerns
- Promoting civic participation and social responsibility

Programme interventions in Youth were implemented by the Ministries of Youth and Sports at the federal and state level and NGOs -the Community-Friendly Association, (CAFA) Khartoum, the Friends of Peace and Development, (FPDO) and the Sudanese Population Network.

CP Output 1: Effectiveness Analysis Findings for YOUTH.

➲ **UNFPA CP has contributed to youth empowerment and engagement of youth in community education on maternal health and gender specifically GBV related issues.**

[53]UNFPA Programme Review, 2013 (p 53) and 2014 (p 53)

With UNFPA support twenty two youth centers, were rehabilitated and became 'social spaces' for male and female youth engagement, hosting dialogue sessions, youth forums, community educational sessions, and cultural events such as the case of Salamnat Albeih Youth Center in Gadaref.

In 2013 and 2014, the CP supported training of 686 young persons (40% female) on advocacy, management and leadership at national and state levels. Youth trained on management, programming, leadership and participation, are actively managing their groups and youth centers. They are engaged in community education in Gedaref, Kassala, White Nile, and South Darfur.

Female and male youth, trained through UNFPA support engage in sports, youth day celebrations, music and theatre events with the youth at the localities and villages in UNFPA supported states. These events were organized at the youth centers or in public spaces to relay messages on gender, RH, and GBV issues to the community leaders, men and women, youth and children. Educational sessions were also extended to individual families through house-to- house visits by the youth to raise awareness on maternal health, gender, and GBV. The dialogue sessions organized for the community youth encouraged them to identify their social and economic challenges.

> Quote from an interview with a youth NGO: "'we are recognized as partners by CBOs in Alfath, Omdurman, and since we are working with them to achieve significant results, we developed a checklist to monitor them'

The 'camp' initiative was instrumental in providing the communities with change agents aware of the high value of volunteerism, and their social/civic responsibilities towards their communities and the country, specifically in emergency situations.

Training of 200 youth on 'life skills' / vocational training and 'know about your business' contributed to the employability of some of the trained youth (including those with disability). Twenty percent of those trained and provided with toolkits are self-employed. In addition, some of the trained youth formed vocational groups to access micro-finance. The effectiveness of such training is evident in its impact on state government decisions towards youth needs. UNFPA support to youth programs has yielded the establishment of "State Youth Empowerment Projects" in Kassala and Gedaref. These projects are under direct supervision of state ministers of youth and sports who have committed local funding from state governments to youth programming. As a result of UNFPA support, the States Ministries of Culture, Youth and Sports (MoCYs) has contributed to the availability of youth funded projects such as the case in Gedaref. Financial institutions, such as the Bank of Sudan and the Zakat Fund, provided support to trained youth for establishing projects for generating incomes[54].

Moreover, the Y-Peer which had been operational in Sudan since 2008 to support young people in having meaningful participation in decision making related to their health to live a healthy, content life, have expanded to more than ten states: Blue Nile, White Nile, Kassala, Gedaref, South Kordofan, West Darfur, East Darfur, North Darfur, South Darfur, and Central Darfur. Y- Peer groups in 5 UNFPA-targeted states, (Gedaref, West Darfur, White Nile, South Darfur, and Kassala) succeeded in registering themselves as NGOs, and are actively engaged in mobilizing and educating youth and their communities on RH, maternal mortality (MM) socio-economic determinants, gender and GBV issues. The Y-Peer competence in the mobilization, education and training of youth is well recognized by the states' government ministries such as MoCYS and MoH. These ministries used to engage the Y-Peer networks in the implementation of some of their activities. In the UNFPA-targeted states, the trained youth and Y-Peer groups lead the mobilization and engagement in some public international events. For example, the Youth Network in South Darfur mobilized communities in several localities in the 16 Days Activism against Violence reaching thousands of men and women in the humanitarian settings. Some active youth groups, as those in Salamt Al Baih Youth Center in Gedaref, developed interests to involve the adolescents in the center's educational and recreational activities.

[54] Interview with the UNFPA Project Director, Federal Ministry of Youth, and Sports, 6th August, 2015.

The effectiveness of UNFPA supported interventions is boosted by the mode of engagement which is dominantly building the youth's capacity (knowledge and skills) to better engage on issues of common interest with their peers and communities.

There are efforts at the state level to involve youth from diverse groups and areas in the trainings supported by UNFPA, but the Federal level interventions focus their trainings only on the youth groups affiliated with the Ministry of Youth and Sports. The challenge is how to cater for the social and ethnic diversity among the various existing youth groups.

As confirmed in interviews with some youth engaged in community mobilization, the messages used integrate gender, RH, socio-economic determinants of MM and GBV issues. However, from the interview discussion, it was not clear what gender inequality issues were considered in the educational messages and how these are related to maternal health although the training manual designed by GRACe, 2014[55] is very clear about gender and reproductive rights.

The training targeted at youth created demand for visionary leadership training. UNFPA addressed the emerging need and provided technical support for the preparation of the leadership training programme to facilitate the emergence of young leaders with vision and creativity.[56]

EQ5: *Has the UNFPA support in the area of gender equality contributed to women empowerment and reduction of some forms of gender based violence especially in war-affected settings?*

SUMMARY

The 6th cycle CP support was effective in raising awareness on the need for gender mainstreaming in national plans. However, improved coordination with relevant ministries is still needed to effectively actualize this integration.

UNFPA support in advocacy and awareness was effective in improving knowledge on reproductive health, gender inequality, GBV issues, FGM and child marriage. CP contributed also to commitments of some communities for abandonment of FGM and early child marriage. However, Al Mawada Wa Rahma initiative needs additional support to improve implementation coherence and follow up strategies on community declarations for abandonment. Main hindering factors for improved effectiveness are: a unified message and approach between 'Al Mawada Wa Rahma' and 'Saleema'; lack of monitoring of the CBOs and protection groups established at the community level and an overlap between the roles and responsibilities of the various government actors.

The establishment of CBOs and protection groups at the community level for managing the safe motherhood fund and monitoring the commitment for the abandonment of FGM is an innovative approach for linking FGM and child marriage with safe motherhood.

UNFPA support for studies, advocacy, debates and trainings for reform/drafting of laws addressing FGM and child marriage has limited results as the laws that were formulated for FGM abandonment are not yet enforced; and the national FGM abandonment law and CM abandonment strategy are still not finalized.

UNFPA support was effective in responding to the needs of the GBV survivors specifically in humanitarian settings. Through raising awareness on referral pathways, provision of the psycho-social support, training on clinical management, and the establishment of the protection groups, GBV

[55] Mustafa, S and Radwan, G. 2014, training manual on gender and reproductive rights. Khartoum: GRACe, and UNFPA.

[56] Interview with Sudan Population Network staff, 5 August, 2015.

survivors find support at community level and access to the relevant services at the health centers.

PROGRAMME EFFECTIVENESS: GENDER EQUALITY (OUTPUT 5)

CP Output 5 – Gender Equality & Reproductive Rights: Summary Overview of CP Interventions (2013 – 2014)

Country Programme Output 5 for Gender Equality and Reproductive Rights aim to "Strengthen national, state and community capacity to promote gender equality and to prevent and respond to early marriage, sexual violence and female genital mutilation." In partnership with the Ministry of Welfare and Social Security as output lead. The key interventions under this output are:

- Supporting the implementation of the national legislation that supports gender equality and youth empowerment.
- Building the capacity to prevent and respond to gender inequalities affecting maternal health, including GBV.
- Strengthening strategies to increase the involvement of young men and boys in efforts to improve women's health.
- Strengthening the provision of comprehensive services for gender-based violence survivors.

CP Output 5 – Effectiveness Analysis Findings for Gender Equality and Reproductive Rights

- **CP support was effective in raising awareness on the need for gender mainstreaming in national plans. Coordination with relevant ministries is still needed to effectively actualize this integration.**

UNFPA support to the General Directorate of Women and Family for mainstreaming gender, including maternal health issues, raised the awareness of planning directors at the line ministries for gender sensitive plans, ensured commitment for the implementation of the National Women Empowerment Policy, and created demand for strengthening of the capacities for gender review/auditing and advanced training on gender integration, and gender-sensitive monitoring and evaluation. Although the interventions started an important momentum for promoting gender equality, and plans for follow-up activities were put with the ministries reached, the activities were discontinued. One shortcoming is that the activities were not well-coordinated with the relevant sectors to address maternal health issues properly. However, the formulation of PoA for NPP is an opportunity to reconsider the integration of gender and the population dynamics.

- **CP contributed to enhanced awareness and commitment for abandonment of FGM and child marriage. Al Mawada Wa Rahma initiative needs additional support to improve implementation coherence and follow up strategies on community declarations for abandonment.**

The initiation of the Al Mawada Wa Rahma (Affection and Mercy) as a unified socio-cultural discourse for addressing the FGM and CM abandonment is instrumental in addressing the challenges of diverse and contradicting religious discourses and the social norms supporting the GBV practices. The messages of this discourse are used by some UNFPA partners for advocacy. Efforts are still going on to articulate the discourse to address the relevant gender injustices and GBV related to maternal health and reproductive rights.

The National Task Force (NTF) for FGM and CM abandonment is operational. The NTF formed a social norm committee to address the socio-religious perspective of the practices. In coordination with the States' ministries of health and child councils, the NTF established state task forces in six states, and formed the locality coordinating teams in two states. Furthermore, the FGM abandonment strategy

was reviewed, and a strategy for CM was designed. A communication strategy for the Al Mawada Wa Rahma was written and discussed by the NTF[57].

With the support of UNFPA, more than 399 religious leaders, trained on "Al Mawada Wa Rahma" messages, by the Federal Ministry of Guidance and Endowment (MoGE), are engaged in raising awareness on FGM and CM abandonment, specifically through mosques, and half of them made public declarations delinking FGM from Islam. The regular reports of the Minister of MOGE to the Ministers of Cabinet on "Al Mawada Wa Rahma" initiative for abandonment of FGM and CM found acceptance, which *"strengthens the political will of the high level officials for the abandonment*" as stated by an interviewee from MOGE.

The community mobilization and education resulted in 48 community declarations for FGM and CM abandonment. The declarations enhanced the social and political commitment of the politicians and community leaders specifically the midwives. However, the challenge is in how the mobilization for declaration is implemented. A religious scholar supporter of FGM abandonment noted that"*when mobilization is done quickly in a few days, the declaration for abandonment is unlikely to be effective as it is voiced for pleasing actors/initiators of the intervention. But if intensive awareness raising is done, then the declaration can become a real commitment*". The review of reports of some community mobilization activities demonstrated that in some sessions contradictory messages were given on FGM. This is because the manuals produced by the "Gender, Reproductive Health Rights Resource Centre -AUW (GRACe)" are not used for training the facilitators.

Some political parties and religious groups, including Christians, educated on maternal health and GBV issues, are engaged in the advocacy for FGM abandonment. This is an initiative of GRACe to reach important groups not targeted by most UNFPA implementing partners and to address political and religious diversity.

GRACe is functioning effectively, conducting research, designing training manuals, undertaking training of trainers, and managing a consortium including seven of UNFPA implementing partners. This implementation modality is innovative, challenging and rewarding to the consortium members, who participate in capacity building, coordination and monitoring educational sessions organized by GRACe.

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UNFPA support to GRACe resulted in the production of training manuals[58], which were used for training of 24 core teams of trainers (each team composed of 2 people), at the states level. The manuals were provided to the partner NGOs and consultants. A review of some of these manuals by the evaluators showed their comprehensiveness and user-friendliness making them vital for promoting trainers' skills, standardizing the delivered messages, and for ensuring the quality of the conducted trainings. However, the trainers are neither recognized nor engaged by the implementing partners in the states. In addition, their training does not include the "Mawada and Rahma" messages.

GRACe contributed to the evidence-based interventions through the provision of research results for the planners and actors. The 2014 survey on the '*youth knowledge, perception and attitude about maternal health, early marriage and gender based violence*', conducted among students in three Sudanese universities (Ahfad University for Women, Kassala University and University of Science and Technology), provided significant results for planners. According to the survey, 86 % do not know

[57] Interview with FGM Coordinator, National Council for Child Welfare, 19 September; Almawada and Rahma Campaign, Communication Strategy.

[58]Some of the training manuals are: intergenerational dialogue; community mobilization on GBV; and gender and reproductive rights.

about maternal mortality, 93% do not know the relationship between CM and education, and 62% have no knowledge on the legal age of marriage in Sudan. The study, titled, *'exploring the stakeholders and activists perspectives on effective interventions for combating child marriage: what works and what does not work*', conducted by GRACe in 2014, gave important recommendations such as a) the need for advocacy efforts to mobilize government commitment and role in enacting and enforcing legislations; b) the use of multiple and comprehensive approaches to address the factors and reasons behind the practice specially use of media; and the enactment of a law to define the child age. UNFPA supported interventions are addressing these recommendations.

Similarly, the findings of the research on *'discussing and debating on FGM: decision making processes within families of different backgrounds: experiences and positions in Khartoum State*' showed that pro-FGM campaigns were not as strong as anti-FGM campaigns. In addition, the research concluded that the mothers and grandmothers were the main decision makers. It is evident that UNFPA implementing partners are targeting the main decision makers for the practice. This is more evident in the interventions in Tuti Island, in Khartoum State. The *baseline indicators* research is a good guide for the GRACe consortium's members to monitor the progress and results of their interventions.

Trained midwives and community leaders are leading the campaigns for FGM and CM abandonment at the community level. The GRACe community midwife curricula contributed to the enhancement of the midwives' community engagement. The "watchdog" groups, formed and trained by the National Council for Child Welfare (NCCW) and the other implementing partners, consolidate the community leaders' role.

The nineteen CBOs (women, grandmothers and youth protection groups), established at the communities reached by UNFPA implementing partners, are engaged effectively in community education on RH, MM, gender and GBV as well as in monitoring of the commitment to the abandonment of FGM and CM. Nine of these CBOs, are financially supported and trained through UNFPA 6th CP. They are efficiently managing the safe motherhood fund and are functioning as community- based referral mechanisms. A member of a CBO, from the Gedaref State, said: "the CBOs referral work is recognized by the community, and the women are paying monthly contributions to ensure the continuity of its support. As FGM is not inherent in our culture, but adapted from other groups, we are working to declare our villages "free of FGM by 2015".

The UNFPA support enabled the General Directorate of Women and Family to engage the sectoral ministries for the formulation of a multi-sectorial plan for the reduction of MM. The advocacy for the plan by the Higher Technical Committee for MM Reduction succeeded in securing local funds for each sector to contribute towards the implementation of the plan. Five ministries acquired the needed knowledge and skills for mainstreaming gender and socio-economic determinants of MM into their sectoral plans.

In eight UNFPA supported states[59], 240 media professionals acquired knowledge on gender issues, and the socio-economic determinants of maternal mortality. They contributed in enhancing the media in developing and airing related messages. For example, the Gedaref Radio State Corporation presented the information, conveyed in the sensitization workshops, through radio programs, to people in remote areas.

The communities and the Y-Peer groups in four states, (Khartoum, Gedaref, Blue Nile, and Kassala), got messages on socio-economic determinants of MM through dialogue sessions and mobile theatre. Some communities demanded more information and interaction on the issues. Other communities formed CBOs to continue spreading the messages. However, specific results for these activities are unclear as in most cases no follow-up was done and when done it is not adequate.

[59]The 8 UNFPA supported states are: South Kordofan, White Nile, Blue Nile, Kassala, Gadaref, North Darfur, West Darfur, and South Darfur.

Cumulatively, 178 directors of planning from line ministries, Khartoum State ministries, the National Strategic Planning Council, and Khartoum State Legislative Council were trained on gender- sensitive policy analysis, monitoring and evaluation. According to the activity report[60], the results of the training are the identification of gaps in the gender policies of the states and its alignment with sectoral policies. However, no plan of action was developed for the directors to follow up on the results noted.

The politicians, community and religious leaders in Gedaref (Dokka) State, Blue Nile and Khartoum states were oriented on the gender issues, RH, MM, FGM and CM abandonment from "Al Mawada Wa Rahma" perspectives by the Directorate of Women and Family (DoWF). Activity report[61] noted that the methodology included the presentation and discussion of scientific papers. The relevance of such a methodology for the village communities is questionable. Similar activities are undertaken by most UNFPA partners in these states. The added value of the engagement of the Directorate from the federal level is not clear. This orientation was done from the federal level directly to the community while some of the UNFPA implementing partners at the state level, such in Gedaref State, confirmed that they are not aware of the 'Al Mawada Wa Rahma' discourse and are not using it.

With support from UNFPA, the DoWFA trained 103 participants from three localities in three states, Kassala, Khartoum and Blue Nile. They acquired skills on the community dialogue tool for the abandonment of FGM and CM. The presentation and discussion of scientific papers is not adequate for skills building at the level of these participants. Also the activity reports do not explain how these skills were applied.

- **The 6th cycle Country Programme supported the formulation of policies, strategies and drafting of laws in support of banning FGM, CM and sexual violence with limited results in terms of law adoption at the national level and law enforcement.**

UNFPA's support for advocacy sessions conducted by NCCW and Women Human Rights Center, at the state level was fruitful. Politicians, parliamentarians, lawyers, judges, police, and media in 5 states voiced their commitment for law reform or enactment, and their support for the FGM and CM abandonment[62]. For states with such laws in place, the engagement with decision makers and law enforcement personnel was important to start a debate on review and amendment of laws. For Gedaref, the engagement of the Ministry of Health with the Gedaref Legislative Assembly, supported by UNFPA, consolidated the voiced commitment of the state's parliament for review and update of the existing FGM abandonment law. For states with no law, the engagement was important for building the political will of the newly elected legislative assemblies. The Blue Nile State Legislative Assembly, which has no law, was very receptive to the arguments for importance of laws for FGM abandonment.

The NCCW was successful in drafting a national law for banning FGM. The draft law took into consideration articles from the criminal and family laws. In addition, a proposal to amend the criminal law articles related to FGM was also drafted and is currently being submitted to the National Legislative Assembly. The likelihood for the law to be passed by the parliament is great, since some of the influencing women who led FGM law are currently in parliament. With the support of UNFPA, a National Strategy and a Communication Plan for CM abandonment were formulated and presented for endorsement by the National Committee established at NCCW. The strategy was a result of processes of debates, dialogues on the studies on CM from religious, health, social and human rights perspectives.

Also with the support of UNFPA, the Combating of Violence against Women Unit, drafted the National Policy for Combating VAW, 2015-2030. The policy has a broad definition of violence including the deprivation from education and work. The EVAW Unit 2012 survey showed that marital violence is high including the intentional deprivation of a wife from sexual relations. This is an important issue related

[60] General Directorate of Women and Family Affairs, 2013, Annual Progress Report.
[61] General Directorate of Women and Family Affairs, 2014, Annual Progress Report, p 6.
[62] Interview with the Director of Women Human Rights, MoWSS, 6 august, 2015; and Activity reports, 2014.

to the sexual rights of women. The policy would be the national framework for the on-going interventions. The dialogue sessions organized by the Unit on the child age[63], and the criminal responsibilities of children in criminal law enhanced understanding of judges, prosecutors, lawyers and police officers to complications and injustices related to children and their criminal responsibilities. The EVAW Unit was also engaged in advocacy for 'Al Mawada and Rahma'.

Still, UNFPA support for studies, advocacy, debates and trainings for amendment/drafting of laws addressing FGM abandonment and child marriage issues had limited results as the laws that were formulated for FGM abandonment are not yet enforced; and the national FGM abandonment law and CM abandonment strategy are still not yet submitted to the parliament for approval.

➲ CP contributed to increased awareness on the GBV and improved institutional capacities and response to the needs of GBV survivors, in emergency situations.

UNFPA supported interventions contributed to improving awareness and response to GBV through programming and capacity development. UNFPA-support targeted a wide range of governmental and non-governmental stakeholders**.** Community leaders, (youth, men and women), paralegals, CBOs (women and youth protection groups) are effectively engaged in the education of their communities on GBV issues and protection as well as in providing support to GBV survivors such as in South and East Darfur States.

A total of 422 midwives, medical assistants, social workers and doctors were trained on referral pathways and Clinical Management of Rape[64]. Acquired skills were put to use in the provision of care for GBV survivors such as in South Darfur. Assistance and services are provided through the health centers specifically in IDP camps.

Women centers established at the community level through UNFPA's support, such as in South Darfur State, have become "safe social spaces" for providing GBV survivors with the first line of assistance in raising awareness and building the skills of women; and for social engagement of women and sometimes youth groups. Such centers are addressing the needs of all women not only GBV survivors, and thus, such institutions are contributing to the transition from humanitarian to recovery.

The UNFPA's support for reduction of GBV in the South Sudan refugee camps in the White Nile is effective in provision of needed services. Community leaders, service providers, and trained social workers are working on case identification, and provision of all needed support. Those trained from within host communities in the White Nile State are also active in the protection and provision of care for GBV survivors. The support of UNFPA is extended to the Ethiopian refugees in Khartoum[65].

UNFPA's lead role for the GBV working groups in the humanitarian settings is commended by interviewed participants. The challenge to coordination- as noted in South Darfur - is the security situation, the change in UNAMID mandate, and turnover of staff of agencies and international organizations. These challenges entail the review of the terms of reference, and the membership of the coordinating groups.

There are however, some shortcomings in the GBV activities, particularly the fact that "Almawada and Rahma" messages and Saleema discourse (a UNICEF led initiative for abandonment of FGM) are not aligned or coherent. The "Al Mawada and Rahma " messages are not yet used at state level; follow-up to the activities of CBOs and protection groups established at community level is not adequate; and there are no clear strategies and plans to follow up on the declarations for the FGM abandonment. In addition, several government institutions including the DoWFA, the National Council for the Child Welfare, the Combating Violence against Women Unit, the Ministry of Guidance and Endowment, the

[63] Child age in criminal law is marked by puberty.
[64] UNFPA Country Programme Review, 2014, p 48.
[65] UNFPA Country Programme Review, 2014

Ministry of Health and the states ministries of Social Welfare are dealing with advocacy, raising awareness and implementation of the laws related to gender based violence, FGM and CM. This multiplicity of government actors created challenges in terms of division of roles and responsibilities between the various governmental actors.

4.3 EFFICIENCY

EQ7: *To what extent did the intervention mechanisms (funds, expertise and timing) foster or hinders the achievement of the programme outputs?*

SUMMARY

UNFPA Sudan Country Office was generally efficient in mobilizing financial resources for the Country Programme. Despite a general non-conducive country environment in regards to dwindling donor interest and decrease in overall development assistance, the country office managed to raise 75 percent of its planned budget for 2013 and 92 percent for 2014.

UNFPA programme support managed to prompt an increase in government allocations to some government directorates (Health & Youth) but did not yet elicit a direct cost share for UNFPA programme interventions.

UNFPA Country Office was relatively efficient in disbursing annual programme budgets to support the implementation of Annual Work Plans (AWPs) - through contracts with Implementing Partners as well as Direct Execution (DEX) modality. Programme Annual Review Reports stated a 99 percent and 82 percent implementation rate of available cash for the years 2013 and 2014 respectively.

CP implementation model through partnerships with government, non-government partners and umbrella organizations, dual procurement modality (NeX and DeX) as well as improved integration of some programme activities was efficient in implementing programme work plans.

At the time of the evaluation, in the middle of the programme life span, most of the programme midterm targets were already achieved or overachieved except in cases of 'fistula repair' and 'policy related plans and article of laws'.

- **Resource Mobilization Efficiency: UNFPA Sudan Country Office was generally efficient in mobilizing financial resources for the Country Programme.**

Three fold budget increase from the 5th CP: UNFPA Sudan office managed to raise required resources for its 6th cycle programme despite challenges of a threefold budget increase when compared to the 5th cycle programme and a general decrease in development assistance to Sudan. Whereas the previous country programme had planned US$33 million for the four years, the current programme has a US$ 91 million budget for 4 years of implementation. This increase in financial requirement is also coupled with a geographic expansion of the programme coverage area from five to nine states in addition to the national level.

Table 5: Country Programme Planned versus Actual Budget

	Planned Budget Resources CPAP - 2013		Actual Resources Raised for 2013		Planned Budget Resources CPAP - 2014		Actual Resources Raised for 2014	
	$	%	$	%	$	%	$	%
Core resources	5,000,000	22%	5,338,654	32%	5,000,000	22%	3,944,327	19%
Co-financing – non-	17,400,000	78%	11,313,120	68%	17,700,000	78%	16,973,696	81%

core resources								
	22,400,000	100%	16,651,774	100%	22,700,000	100%	20,918,023	100%
			75% of Budget Plan				**92% of Budget Plan**	

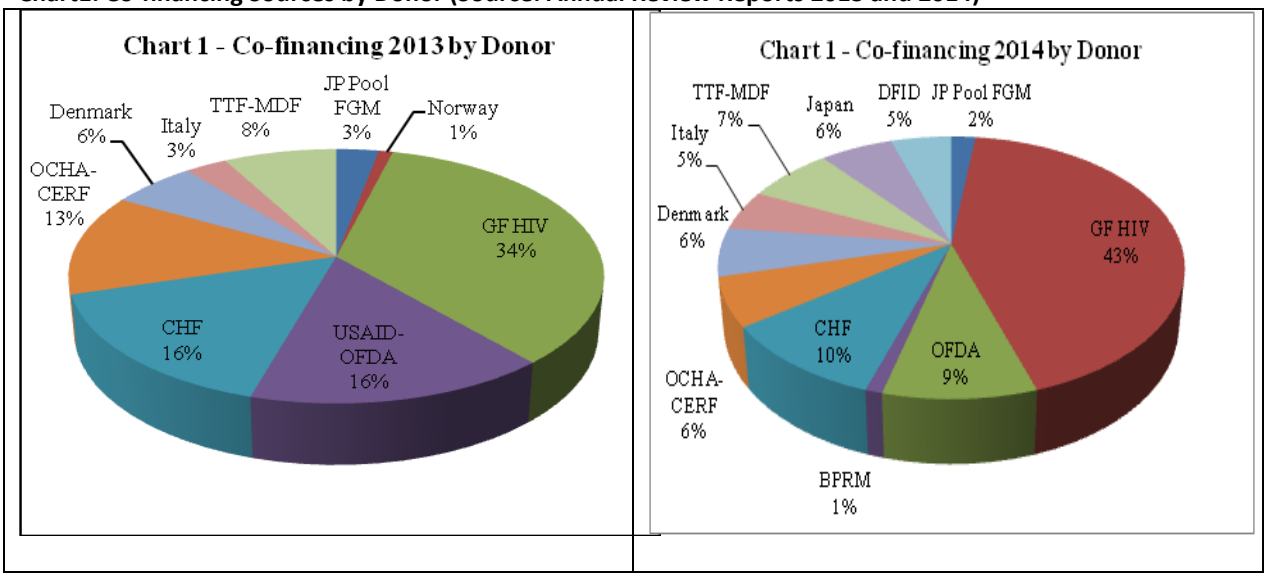
Despite a general non-conducive country environment in regards to dwindling donor interest[66] and decrease in overall development assistance, the country office managed to raise 75 percent of its planned budget in 2013 and 92 percent in 2014. Table 5 above provides a comparative analysis of planned versus actually raised budgets for the past two years 2013 and 2014 of the current programme cycle.

Relative increase in non-core resources and access to new donors: We note from table 5 above that in 2013 and 2014, UNFPA Sudan had planned for a 22 percent financing from core resources versus 78 percent through co-financing modalities. While in 2013 the core resources reached 32%, in 2014, it dropped to 19 percent, indicating an increase in non-core resources raised (81%). Notwithstanding a decrease in the amount of core resources in 2014, from US$5 million to slightly less than US$4 million, the country office still managed to raise 92 percent of its total programme 2014 budget.

Table 6: Co-financing Sources by Donor

Donors -Co-financing Sources	Year 2013 – US$	Year 2014 – US$
JP Pool FGM - HQs	307,548	285,217
Norway	71,630	0
Global Fund	3,994,552	7,236,182
USAID OFDA	1,755,826	1,513,957
USA BPRM	0	250,000
UNDP - MPTF (CHF)	1,798,912	1,716,822
OCHA (CERF)	1,415,103	1,057,679
Denmark	712,385	1,098,574
Italy	329,487	817,939
TTFMDF	425,000 + 457,789	425,000 +730,864
UNDP NSDS	44,888	39,300
Japan*		1,000,000
DFID (JP thru UNICEF)*		802,161
Total US$	**11,313,120**	**16,973,695**

Chart1: Co-financing Sources by Donor (Source: Annual Review Reports 2013 and 2014)

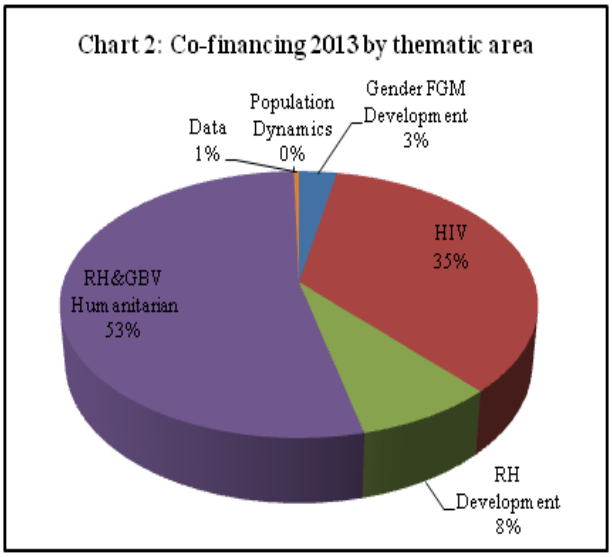


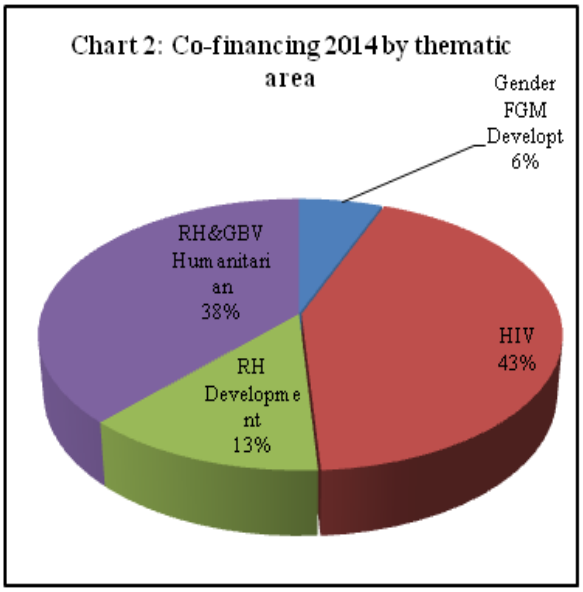
Moreover, an overview of the co-financing amounts and donors (table 6 and charts 1 above) show an increase of more than $5.5 million from the year 2013 to 2014 in the amounts raised through co-

[66] It was noted in the Coordination section that core resources decreased from an estimated $ 5 million a year for the four year cycle to a confirmed amount of $2.9 million.

financing. This amount is mainly due to two new donors on the list for 2014 -Japan and DFID- and an increase in the Global Fund financing for UNFPA HIV/AIDS.

Charts 2: Co-financing by Thematic Area (Source: Annual Review Reports 2013 and 2014)





Outputs 1 & 6-Population Dynamics and Data financed almost exclusively from core resources: Though the CO managed overall to raise the total financing needed to implement its planned CP, it is important to note however that, as shown in chart 2 above, Outputs 1 and 6 – Population Dynamics and Data did not attract any significant financing from non-core resources (1% in 2013 and 0% in 2014). Additionally, the thematic areas which attracted the largest amount of co-financing are HIV/AIDS prevention and humanitarian assistance for Gender and GBV.

Resource Mobilization Strategy: To support its fund raising efforts, UNFPA Sudan Country Office developed a 'Resource Mobilization Strategy' (RMS) intended "to inform and guide UNFPA Sudan efforts towards sustainable financing of its 6th cycle country programme[67]." UNFPA Sudan RMS has analyzed previous years co-financing trends, challenges of the country context and current UNFPA donors. Following this analysis, the RMS document proposed a fund raising strategy and action plan that highlights mainly the need to: (1) Continuously scan the donors' environment; (2) maintain and nurture relationships with current donors; (3) seek private sector funding and emerging non-traditional donors; and (4) maintain and continuously update donors' information. To note that UNFPA CO has been mostly successful in mobilizing co-financing resources to cover its yearly budget plans for the years 2013, 2014 and 2015 and, though efforts have been exerted as recommended in the RMS, UNFPA Sudan did not break through yet to the non-traditional donors' pool and private sector resources.

- **UNFPA programme support managed to prompt an increase in government allocations to some government directorates (Health & Youth) but did not yet elicit a direct cost share for UNFPA programme interventions.**

Leveraging financial resources from the government to buttress UNFPA's supported interventions through cost sharing is a development approach that enhances impact and sustainability of the assistance support. We note from the evaluation document review, interviews and the preceding financial analysis that UNFPA did not yet elicit government financial contribution through cost share.

[67]UNFPA Sudan Country Office, Resource Mobilization Strategy, 2013-2016, 2014 Version, August.

However there are cases where the government has supported UNFPA interventions through in-kind contributions such as office space and human resources

Despite lack of government direct cost share, during interviews with government officials, signs of government positive re-enforcement of UNFPA supported thematic areas through increased government budget allocations to the relevant ministries and directorates was noted. This is specifically the case for the Reproductive Health and Youth interventions.

➲ **Implementation Efficiency: Relatively good budget utilization reflecting UNFPA Country Office implementation capacity**

Table 7: Country Programme Implementation Rate

Implementation Year	Cash Available	Budget Utilisation	Implementation Rate
Year 2013	$ 16,651,774	$ 16,462,342	99%
Year 2014	$ 20,918,023	$ 17,230,614	82%

Desk review of UNFPA country programme documents and interviews with Implementing Partners (IPs) undertaken in the course of this evaluation revealed the following:

- UNFPA Country Office was relatively efficient in disbursing annual programme budgets to support implementation of Annual Work Plans (AWPs) -contracts with Implementing Partners- and Direct Execution (DEX) modality. Preceding table 7 reports a 99 percent and 82 percent implementation rate of available cash for the years 2013 and 2014 respectively.

- The lower budget utilization rate of 82 percent in 2014 is most likely due to delays in processing AWPs to implementing partners and transfer of quarterly budgets. Almost all interviewed implementing partners voiced complaints of delay in funds transfer to finance AWPs' activities. This delay potentially affected partners' capacity for timely implementation of AWP planned activities. Delay in quarterly funds transfer to some IPs is also partly due to IPs non-conformity with all of UNFPA financial and reporting procedures. According to UNFPA management procedures, IPs need to provide progress reports and financial documentation to evidence at least 75 percent disbursement of the previous quarter budget before the next quarter budget can be transferred. Hence delays when IPs supporting documentation are not in conformity with UNFPA management and financial procedures.

➲ **Improved implementation efficiency through partnerships, procurement modalities (NeX, DeX), integration approach and umbrella organizations**

Table 8: Breakdown of UNFPA Implementing Partners

Implementing Partners	Government Ministries & Institutions	Non Governmental Organizations (NGOs)	Total
2013	36	36	**72**
2014	37	50	**87**

Partnership Implementation Modality: UNFPA Sudan programme interventions are executed primarily through implementing partners: Ministries, government institutions and non-governmental organizations. UNFPA has engaged with each IP on the basis of this IP organizational mandate, technical expertise, action plans, capacity, access and / or outreach. UNFPA engaged with 72 and 87 IPs in 2013 and 2014 respectively.

This model of partnership with national and local organizations, federal government ministries and state ministries, umbrella organizations and local NGOs facilitated greater efficiency in (1) disbursing

larger budgets; (2) accessing wider geographic areas; (3) outreach to challenging locations such as IDP camps and (4) access to hard to reach target groups such as MSW, FSW and PLWHA. In addition to improved efficiency, this partnership model facilitates a better management of risk as the responsibility of implementation is spread over a number of partners and not just a few.

Care should be noted however, that this approach/modality though efficient has also its negative aspects as (1) it requires building capacity of partners in certain technical and management aspects hence incurring time and costs and (2) cost of monitoring and validating data specifically IPs projects' information and beneficiary data.

Procurement Modalities: Another country programme feature which enhances implementation efficiency is the two procurement modalities of NEX and DEX. National Execution (NEX) modality is applicable with implementing partners / line government ministries, institutions and NGOs. It entails transfer of funds to IPs through Annual Work Plans and IP execution of the planned activities and disbursement of funds against progress and financial reports. Direct Execution (DEX) is used when there is lack of national capacity to implement and thus this function is directly implemented by UNFPA. This dual procurement modality is flexible and thus enhances CO implementation capacity and programme efficiency.

Integration: As recommended in the 5th cycle end of programme evaluation, the present country programme made strides towards integration of some programmatic activities specifically in Health. Details of the integration process and results have been covered in an earlier section under 'Effectiveness'. Sufficient over here to note that integration, and to the extent that it is successful, had a positive impact on implementation efficiency, effective use of resources and synergies such as when expanding the role of the midwife to carry also family planning kits and HIV/AIDS prevention information.

- **Resources and Results: At the time of the evaluation most of the programme midterm targets were already achieved or overachieved except in cases of 'fistula repair' and 'policy related plans and article of laws'**.

Linking resources with results, the evaluation analysed the extent to which the 6th CP was able to achieve results as planned in the Results and Resources Framework (RRF). Desk review of the programme performance monitoring plans and interviews with IPs undertaken in the course of this evaluation resulted in the following:

- Overall, interviewed IPs confirmed that financial resources allocated through AWPs were sufficient for the achievement of planned results. Some IPs, most specifically at states level, complained that allocated funds local value made it difficult for them to implement their plans and achieve expected results because of the inflation of prices and relative increase in costs of commodities.

Table 9: CP Planned and Achieved Indicators up till December 2014

CP OUTPUT 1: Strengthened national capacity to incorporate population dynamics, including its linkages with sexual and reproductive health, into relevant policies and development plans, with special attention to the needs of young people and women.		
Budget Utilized over two years: $ 472,869.11+ 348,646.38 = **$ 821,515.49**		
CP Indicator	**Achieved - 2 years**	**Net Target - 4 years**
Number of studies on population dynamics conducted, with the findings incorporated into policies, strategies and plans at national and ... state levels;	1	6
Number of UNFPA-supported localities with youth coordination mechanisms established and operational;	4	12
CP OUTPUT 2: Increased demand for information and services related to reproductive, maternal and new-born health and HIV prevention.		
Budget Utilized over two years: $ 6,034,610.00 + 7,701,764.33= **$13,736374.33**		
Number of civil society organizations engaged in behaviour change	26	60

communication on gender, reproductive health, early marriage and HIV/AIDS ... community level		
Number of community-based obstetric referral mechanisms established and functional at the local level	29	48
Number of individuals from MARPs and VGs reached by BCC outreach activities	42,021	49,796
Number of MARPs benefitted from IGAs	306	500
Comprehensive condom programming approach adopted; (SP indicator);	285,120 (condom distributed)	Not defined
CP Output 3: Increased availability of high-quality information and services for maternal and new-born health and HIV prevention, especially for underserved populations and people with special needs		
Budget Utilized over two years: $ 5,239,724.95 + 3,967,018.04 = **$9,206,742.99**		
Number of fistula repair surgeries	228	1,000
Percentage of health facilities providing Basic Emergency Obstetric and Neonatal Care (EmONC) services.	+30%	+45%
Percentage of health facilities providing Comprehensive Emergency Obstetric and Neonatal Care (EmONC) services.	+26%	+ 36%
Number of primary health-care facilities providing integrated services on sexual and reproductive health, HIV and sexually transmitted infections.	37	46
Number of village midwives trained in selected states.	343	653
Number of people from vulnerable groups and populations that are most at risk who have received counselling, testing and management services /UNFPA support.	13,409	9,000
Number of peer educators trained* (*not a CPAP Indicator)	915	No end target
Maternal death surveillance system established and functional in the UNFPA supported states	YES in 7 states	
CP Output 4: National systems for reproductive health commodity security and for the provision of family planning services are strengthened		
Budget Utilized over two years: 1,024,871.45 + 920,487.24= **$1,945,358.69**		
Number of service providers trained in family planning	1,267	3,000
Percentage of national commodity requests satisfied	+61%	+80%
Percentage of facilities having no stock-outs of contraceptives in past six months in UNFPA supported states(UNFPA achieved 100% while plans were for 74%)	+83%	+70%
CP Output 5: Strengthened national, state and community capacity to promote gender equality and to prevent and respond to early marriage, sexual violence and female genital mutilation		
Budget Utilized over two years: $ 2,322,379.00 + 2,896,656.57= **$5,219,035.57**		
Number of UNFPA supported villages and urban communities that have abandoned FGM/C	48	100
Number of localities in UNFPA-supported states with functional gender-based violence referral pathways that include at least three multi-sectoral services	22	31
Number of health-care providers trained in clinical management of rape;	880	1440
Number of identified articles within family laws and the penal code revised and endorsed, advancing gender equality and equity;	1	10
CP Output 6: Strengthened national and state capacity to produce, analyze and disseminate high-quality disaggregated population data for evidence-informed planning and monitoring, with a focus on maternal health		
Budget Utilized over two years: $ 418,865.61+ 436,181.37 = **$855,046.98**		
Nationally agreed standardized protocols for data collection and analysis in place	Yes	Yes
National- and state-level statistical coordination mechanisms for data suppliers and users established and functional	Yes / Yes partially	Yes / Yes

- On the overall programme level, table 9 presents a comparative analysis of CP planned end of project (4 years) performance indicators for each of the CP six outputs/indicators versus total results achieved by mid point i.e. for two years. We note from the table analysis that the CP was able to achieve midpoint on the majority of the results indicators and overachieve midpoints for some other results indicators. The only results lagging behind are for Output 1 – Population

Dynamics "Number of studies on population dynamics conducted, with the findings incorporated into policies, strategies and plans" where the programme has so far supported only 1 study versus 6 planned; Output 3 indicator for "Number of fistula repair surgeries" with plans to reach 1,000 cases and so far reached only 231 cases; and Output 5-Gender, indicator for "Number of identified articles within family laws and the penal code revised and endorsed, advancing gender equality and equity" with programme plans for reviewing 10 articles of law and so far only 1 article of the law reviewed.

4.4 SUSTAINABILITY

EQ8: *To what extent has UNFPA been able to support its partners and the beneficiaries in developing capacities and establishing mechanisms to ensure ownership and the durability of effects?*

SUMMARY

Programme approach of participatory needs assessment, intensive consultations with stakeholders and joint programme planning with implementing partners helped develop a sense of ownership of programme interventions and goals. This ownership and IPs implementation of programme interventions has built IPs capacities and enhanced likelihood of sustainability, provided IPs are able to maintain acquired results technically, institutionally and raise needed financial resources.

Likelihood of sustainability and durability of effects varied across programme outputs, implementing partners and types of interventions. Likelihood of sustainability is higher in thematic areas where UNFPA strategic interventions have gained traction, government endorsement and community acceptance such as in SRH and Youth. Where UNFPA strategic interventions are still mostly at the level of advocacy to break the cultural taboos, such in GBV and FGM, the potential of sustainability is still weak.

Sustainability is challenged by more than the mere availability of financial resources or risks of staff turnover. Factors that enhanced likelihood of sustainability are political commitment and involvement of the community leaders and community members.

Sustainability assessment refers to the extent to which supported programme activities are likely to continue without UNFPA's support; or the willingness and capacity of implementing partners to maintain provision of these services without further programme technical and financial support. Assessment of the sustainability of UNFPA supported interventions has been determined based on the capacity and willingness of UNFPA implementing partners to sustain programme benefits and continue provision of services whether from own resources or from other sources for financial support.

- **Participatory needs assessment and planning with IPs created programme ownership; sustainability is still challenged by staff turnover and limited financial resources**

Programme approach of participatory needs assessment, intensive consultations with stakeholders and joint programme planning with implementing partners helped develop a sense of ownership of programme interventions and goals. Furthermore, this ownership and a direct implementation of UNFPA supported interventions has built IPs capacities and enhanced likelihood of sustainability, provided IPs are able to maintain acquired results technically, institutionally and raise needed financial resources.

Commitment of UNFPA implementing partners in planning and implementing UNFPA-supported interventions, especially at the state level, has effectively contributed to scaling up the capacity of

those partners. However, as reported by many government' IPs[68], staff turnover and limited budgets are always a challenge for increased levels of sustainability. Factors that can enhance likelihood of UNFPA-supported interventions' sustainability are political commitment and involvement of the community leaders and community members in the implementation of the projects / activities in UNFPA-supported states.

- **Sustainability assessment results varied across programme outputs, implementing partners and types of interventions.**

Sustainability assessment results varied across the programme outputs, implementing partners and types of interventions. To note that sustainability is challenged by more than the mere availability of financial resources to maintain the provision of services and or maintain the durability of effects acquired through the programme. In thematic areas where UNFPA strategic interventions gained traction, government endorsement and some levels of community acceptance, such as in Sexual and Reproductive Health and Youth, we note that sustainability potentialities have improved. In other thematic areas where UNFPA strategic interventions are still mostly at the level of advocacy to break the cultural taboos, such in gender based violence and female genital mutilations, sustainability potentialities are still weak.

Reproductive Health (Output 2, 3 & 4): UNFPA programme support in capacity building that targeted trainees at the local level, such as health care providers, volunteers, community leaders and others, is likely to be sustainable as it focused capacity building on stakeholders who are more likely to be stable at the state level and less subjected to staff turnover. Moreover, interviewed implementing partners noted that the sustainability issues were discussed with the UNFPA CO during the planning and implementation phases of the AWPs. This means early engagement of the implementing partners as well as the commitment towards creating effective approaches towards sustainability.

The RH government partners at both the federal and state levels noted that the training of the community village midwives and the in-service training of the other midwifery cadres can be sustained-should UNFPA support phase out-as they are currently in the process of securing funds till 2017, from the Expanded Primary Health Care project. The community-based obstetric referral mechanisms are likely to continue as they have developed their own revolving funds and this fund can support their activities without need for further UNFPA support. However, according to interviewed stakeholders, activities such as advocacy & Information, Education and Communication (IEC) sessions, fistula repair, and midwifery supervisory system and family planning supplies are unlikely to be sustained without UNFPA or other donors support.

P&D: From the evaluation interviews, it was noted that the CBS may continue using the statistical system, supported by UNFPA, for data collection and production, but would not be able to update these systems as needed without external support. The implementation of the PoA for NPP would most likely be put on hold without support from UNFPA and other partner UN Agencies.

Youth: Trained youth would continue managing UNFPA-rehabilitated youth centers and disseminating educational messages on maternal health, but the community mobilization and trainings would be discontinued if not supported. Despite poor infrastructure and limited facilities, many of the youth centres have been in use at the time of the evaluation site visits. The rehabilitation of these centres by UNFPA encouraged the youth to continue operating in them. Moreover, interviewed youth confirmed that they will continue the activities that can be supported from their limited sources, as they used to do for decades. They are likely to keep some awareness raising activities, since the messages on maternal health, gender and HIV/AIDS are integrated in their songs and drama, which will continue, but with less frequency if external support is discontinued.

[68] Limited budgets were reported as a constraint to sustainability during interviews with CBS, state ministries of youth, state ministries of health and NPC.

Gender Equality: *Most* UNFPA-supported interventions and services in the field of gender equality, empowerment of women and GBV responses are unlikely to be maintained without UNFPA support. UNFPA IPs, government institutions and NGOs, would continue implementation of some of the activities that are funded by other agencies and donors such as advocacy, awareness raising and law enactment/reform related to FGM, and CM. But all the capacity building activities related to gender, maternal health, and research are unlikely to be sustained without UNFPA support.

It is most likely that GRACe will continue functioning as it is hosted and operated by Ahfad University for Women. Ahfad University has the capacity to maintain some of GRACe's activities with its own resources. The university's ability to raise funds to support research and capacity building activities is well recognized. However, the focus on reproductive health issues may not continue with the same impetus without UNFPA's financial support for these interventions.

NGOs confirmed that they would be able to keep the contact and engagement with the CBOs, and participate on a limited scale in community education. However, they made it clear that the community mobilization will not be maintained due NGOs limited access to funds without UNFPA's to support for these interventions.

Humanitarian assistance: Interventions in humanitarian settings cannot be sustained without UNFPA continuous support. UNFPA programme' interventions in humanitarian contexts are dependent on UNFPA's ability to raise resources from donors/humanitarian funds. This limitation is due to the fact that no UNFPA core resources are committed to support assistance in humanitarian settings.

4.5 COORDINATION

EQ9. To what extent were the programme coordination and monitoring mechanisms effective to boost the programme implementation and achieve better results;

EQ10. To what extent did UNFPA contribute to the existing coordination mechanisms within the UN system in Sudan?

SUMMARY

UNFPA participates in, is a member of, and at times is leading in multi layered coordination structures with UN agencies, federal and state government institutions in development and humanitarian contexts. Each of these coordination structures has a defined objective, lead and participant organizations and regular and ad hoc coordination meetings. Whereas government coordination seek *mainly* to coordinate the interventions of the various development assistance actors on the ground, the UN coordination mechanisms aim beyond this level to joint planning, joint programming, resource mobilization, assignment of implementation mandates, lobbying and advocacy of the government, and at times joint action as in campaigns.

Coordination mechanisms proved mostly effective in joint planning, complementary interventions and information sharing in coordination meetings. UN Agency coordination was less effective in joint implementation and advocacy.

Reportedly, coordination mechanisms that entailed active participation of the donor organization had stronger leverage in: (1) Assigning clear and complementary roles to participating agencies to avoid overlap and improve efficiency; (2) strengthening agencies to come up with a unified position to support policy change; and (3) making use of the conventional inter-agency competition to drive for achievements as participating UN agencies compete for larger share of resources. UNFPA Sudan managed to substantially increase funding level from the CCM/Global Fund for its HIV/AIDS

prevention programme through achieving and sometimes exceeding expected results.

Constraints to Coordination Effectiveness: Competition over Resources and Leadership. Limited access to funding resources has increased levels of inter-agency competition and negatively impacted 'coordination'. In the absence of a strong leadership or in case of conflict between leaderships or conflicting interests, coordination within the UN system for joint action is difficult.

- **UNFPA membership in various multi-layered coordination mechanisms with UN Agencies, Federal and State Governments.**

UNFPA Sudan is active in the UN coordination system and engages in coordination mechanisms of the government at federal and state levels as relevant to its technical thematic areas. UNFPA contributes as well in other interim coordination groups such as joint programmes and timely events.

UN Coordination Mechanisms: Within the UN system framework, UNFPA participates in:

(1) The **UNCT** which includes representatives of the United Nations Operations and Programmes, specialized Agencies and other United Nations entities accredited to Sudan. Under the leadership of the UN Resident Coordinator, UNCT is responsible for the effective coordination of the United Nations System especially in cases where resources can be combined. The UN assistance to Sudan is coordinated through the United Nations Development Assistance Framework (UNDAF). The UNDAF process and document provides the basis for collaboration, coherence and effectiveness of the United Nations System initiatives and support.

(2) UNFPA is a member of the inter-Agency Programme Management Team (**PMT) and** Operation Management Team (**OMT)** and **chairs the M&E Working Group**. The UNCT oversees the PMT and the OMT. The PMT comprises Heads of Programmes from all United Nations Agencies and/or Deputy Heads of Office. The PMT provides strategic and technical leadership for the implementation of the UNDAF and is responsible for overseeing the work of UNDAF Pillar Groups and UNDAF M&E Group to ensure effective coordination and timely achievement of UNDAF results. The Operation Management Team (OMT) comprises senior operations managers of UN agencies in Sudan and aims to ensure a more efficient, streamlined and coordinated administrative management system amongst UN agencies. Additionally, the UNCT has established a UN Monitoring and Evaluation (M&E) Group to enhance United Nations inter-Agency coordination and collaboration in monitoring and evaluation and to provide technical assistance to the Pillar Groups in programme monitoring and performance progress measurement towards achieving UNDAF Outcomes.

(3) UNDAF-Outcome Level Coordination: UNDAF results are clustered under four Pillars with a total of eight Outcomes. Pillar Groups, comprising representatives of United Nations Agencies and the Government serve as the main mechanisms for implementing the UNDAF. Several UN agencies contribute through their programmes for the achievement of UNDAF outcome level results. Outcome leads in the Coordination bodies have been designated to lead, manage and coordinate the interventions of contributing UN Agencies under their specific outcomes. *UNFPA programme contributes to UNDAF Pillar One - Outcome 1* "People in Sudan, with special attention to youth, women and populations in need, have improved opportunities for decent work and sustainable livelihoods and are better protected from external shocks, thereby reducing poverty" and participates in coordination meetings of the four Pillar groups.

(4) Thematic Areas: In addition to UNFPA membership in the above mentioned UNDAF strategic level coordination mechanisms, UNFPA participate in coordination mechanisms by thematic areas and or cross cutting issues such as Gender and HIV/AIDS whereby UNFPA participate under the leadership of UN Women in the Gender Thematic Group and coordinates its HIV/AIDS programme with UNAIDS.

(5) Coordination in Humanitarian Contexts - GBV sub-sector lead: A separate UN Pillar/Sector coordination structure is applied in humanitarian settings. Under the leadership of UNHCR, UN Agencies lead – coordinate sectors and sub-sectors working groups in areas critical to prevention and response in accordance with each Agency's mandate and technical expertise. In 2004, UNFPA was designated as the lead agency for the coordination of the Gender Based Violence (GBV) sub-sector group (with other UN agencies UNICEF, UNHCR and UNAMID) under the main Protection Cluster.

(6) Joint Programmes: Other coordination structures are also established through joint programmes with other UN Agencies. UNFPA is currently involved in coordination for the implementation of four joint programmes: 2 joint programmes for the abandonment of Female Genital Mutilation / Cutting (FGM/C) with UNICEF and WHO with co-financing from DFID, Norway, Italy, Germany and the Netherlands; Joint Initiation Plan (JIP) to support the implementation of the Sudan National Strategy for the Development of Statistics (NSDS) with UNDP (core financing); and HIV/AIDS Prevention with financing from the Global Fund and in coordination with other UN agencies -WHO and UNICEF.

(7) Finally, issue specific coordination mechanisms are also established for events and campaigns such as for the celebrations of International Women's Day under the lead of UN Women.

Government Led Coordination

On the government level, federal and the state ministries assume leadership for the coordination of international donors, international organizations, NGOs and CBOs assistance support. On the federal level, UNFPA interventions in Sudan are coordinated with the following ministries and programmes:

- Federal Ministry of Health: National Reproductive Health Directorate; Sudan National AIDS Control Programme (SNAP now integrated under the National Institute for Communicable Diseases).
- Ministry of Welfare and Social Security: National Council for Child Welfare; Combating of Violence Against Women Unit; General Directorate of Women and Family.
- Federal Ministry of Youth and Sport
- Ministry of Guidance and Endowments
- National Population Council (NPC)
- The Central Bureau of Statistics.

At state level, coordination is managed by state ministries, institutions and local councils based on their geographic and technical mandate. Local state institutions lead coordination mechanisms for donors, international organizations, NGOs and CBOs who are intervening in the technical area under their mandate and geographic jurisdiction.

Programme Coordination with Implementing Partners

Coordination is also part of the UNFPA internal programme monitoring and evaluation arrangements. Programme M&E plans indicate organisation of Quarterly Review Meetings at both national and state levels under the leadership of the F/SMoHs (co-ordinating authorities) for all Implementing Partners to discuss projects' progress against signed Annual Work Plans (AWPs), to identify implementation challenges and to devise mitigating measures. Annual Planning and Review Meeting was also conducted in 2014 under the lead of Ministry of Finance - as Government Coordinating Authority - bringing all stakeholders together to review the stock of achievement and highlight areas for 2015 planning. The meeting concluded with strategic and programmatic recommendations and action plan to ensure its implementation.

➲ **Coordination mechanisms were effective in facilitating planning of interventions, sharing of information and less in joint implementation.**

In general, coordination groups have been effective in programme joint design and planning. On the UNDAF level, intensive consultations take place at the planning stage to design and develop the

UNDAF document with clear objectives, lead and participating organizations by outcome and a result based monitoring and evaluation framework. A midterm evaluation of the UNDAF is currently taking place. Several comments made during interviews suggest limited effectiveness of the UNDAF in delivering expected results beyond the planning stage. For example, an interviewee from a sister UN organization said they spend endless time working on the UNDAF document, hail and celebrate when it's finished and then it is seemingly shelved with no further use. It is noteworthy to mention that the position of the Resident Coordinator who leads the UNDAF process has been vacant since January 2015[69].

A comparatively similar joint planning process takes place in joint programmes where two to three (or more) UN Agencies get together for intensive planning to design and develop a joint programme in thematic areas overlapping the participating UN Agencies mandate. The design of a joint programme usually involves a clear delineation of intervention area for each of the partner organizations, related budget share and plans for joint monitoring and reporting. Minding notable exceptions, coordination of these projects do not go beyond a division of tasks and resources as well as reporting on progress in coordination meetings and joint narrative reports to donors. Such is the example of the anti-FGM programme jointly implemented by UNICEF through Saleema and UNFPA through Al Mawada Wal Rahma campaigns where each agency is implementing a different strategic approach to abandonment of FGM.

UNFPA programme interventions at the federal and state levels were coordinated with the federal and state governments through intensive consultations to jointly identify needs and priorities following which plans for UNFPA support to the federal and state ministries was determined and endorsed by the federal ministries. Federal ministries' involvement in the states projects does not go beyond this stage. Apart from the quarterly review meetings organized by UNFPA with its implementing partners to discuss projects' progress, federal ministries are not engaged in the states' projects monitoring, reporting or evaluation.

At state levels, regular coordination meetings are convened by the relevant state level ministries and institutions. These meetings bring together UN agencies, international organizations and NGOs active in the development assistance sector. In general these meetings are effective as their objective is simply to coordinate the different actors' project assistance by sharing information on the progress of activities, success and constraints encountered during implementation. The aim is to inform and avoid duplication rather than to mobilize resources or lobby the government and from this perspective they were deemed effective.

> UNDP/ Principal Recipient of the Global Fund "UNFPA is the only sub-recipient that was able to absorb all the funds and was able to achieve their indicators."

As noted earlier, there are notable examples suggesting that coordination mechanisms were effective in facilitating achievement of improved programme results. Such is the case of UNFPA HIV/AIDS programme where coordination with the National AIDS Control programme at national and state levels and implementing partners (NGOs and CBOs) facilitated outreach to a large number of key stakeholders and increased programme coverage at the national level. Another instance where coordination facilitated achievement of programme targets can be noted in the mobilization for drafting, advocacy and approval of anti-FGM/C legislations and public declarations for abandonment of FGM.

- **Coordination is more effective in supporting achievement of programmatic results when donor is involved in the coordination mechanism**

Reportedly, coordination mechanisms that entailed active participation of the donor organization had stronger leverage in: (1) Assigning clear and complementary roles to participating agencies thus

[69]The RC was told to leave the country by the relevant Sudanese government authorities. A new RC has been recently appointed.

avoiding overlap and improving resource efficiency; (2) strengthening agencies to present a unified position in case of advocacy with communities or the government in support for policy change; and (3) making use of the conventional inter-agency competition to drive for achievements as participating UN agencies' share of the funding pool is based on 'performance results'. The Global Fund supported programs can be cited as an example where a donor organization is actively participating in coordination meetings, supporting implementing agencies in negotiations with the government and supporting coordination for improved programmatic results. As a result of its 'good performance', UNFPA Sudan managed to substantially increase funding level from the CCM/Global Fund for its HIV/AIDS prevention programme through achieving and sometimes exceeding expected results: "UNFPA is the only sub-recipient that was able to absorb all the funds and was able to achieve their indicators" CCM/Global Fund.

- **Constraints to Coordination Effectiveness: Competition over Resources and an Effective Leadership**.

It was reported in meetings with UN Agencies and some federal government ministries that the overall level of development assistance allocated by international and bilateral donors to Sudan has dropped significantly in the past couple of years. This drop is especially felt in the 'development interventions' as the country is transitioning from humanitarian assistance to a more sustained development. Limited access to funding resources has thus increased levels of inter-agency competition and negatively impacted coordination. For example UNFPA core resources have dropped from an estimated and budgeted level of US$ 5 million per year to slightly less than US$ 3 million in the year 2014. This decrease in financial resources has created pressure on the organization to seek funding from non-core resources in support of its planned country programme.

Furthermore, effective coordination within the UN System is highly dependent on the effectiveness of the leadership in charge of the coordination mechanism. As noted earlier, the Resident Coordinator, the highest UN System position in Sudan with regard to the Sudan government, and the previous UNFPA Country Representative, became 'Persona No Grata' and were requested to leave the country. This created a gap in UN leadership at the highest levels and potentially affected UN Agencies coordination on the UNDAF. As the UN coordination mechanism is structured by 'Outcome lead', it thus puts the burden of responsibility on the lead agency for effective coordination. In the absence of leadership or in case of conflict between leaderships or conflicting interests, coordination for joint action is difficult.

4.6 ADDED VALUE

EQ11. What are the main comparative strengths of UNFPA in Sudan – particularly in comparison to other UN agencies in the Country?

SUMMARY

Interviewed stakeholders, specifically donors and other UN Agencies, confirmed that UNFPA comparative advantage is through programme strategic positioning in the states and direct service delivery / interventions at the locality and for communities where the needs are the greatest. In addition to facilitating implementation efficiency, this local positioning offer a comparative advantage vis-à-vis other UN agencies who lacks at present this access and outreach capability.

There is an overall agreement among stakeholders on UNFPA historical comparative strengths and technical expertise in Gender, Reproductive Rights and combating GBV.

Country Programme achievements and notable results in the thematic area of HIV/AIDS prevention in Sudan has placed UNFPA and the programme at a comparative advantage with respect to the government and other organizations active in this thematic area.

The evaluation findings related to value added and strategic positioning[70] of UNFPA in Sudan and within the UN system suggest the following strengths areas:

- **Value added through strategic positioning and interventions at the state-locality level.**

UNFPA country office in Sudan has sub-offices in three Darfur states and presence in 5 states through one technical officer and administrative/finance personnel accommodated by the State Ministries of Health. Additionally, the6thCP introduced the notion of direct service delivery to communities in the selected states. As confirmed by interviewed stakeholders and specifically donors and other UN Agencies, the presence of UNFPA in the states enabled the programme to reach the local communities and intervene in localities where the needs are the greatest. In addition to facilitating implementation efficiency, this local positioning offers a comparative advantage vis-à-vis other UN agencies such as UN Women who lacks presence and outreach capability.

- **Overall agreement on UNFPA comparative strengths and technical expertise historically in Gender, Reproductive Rights and combating GBV.**

UNFPA historical competitive advantage and technical knowhow in Gender, Reproductive Rights and combating Gender Based Violence is widely acknowledged by other UN agencies and the government. UNFPA in Sudan has had long standing presence and relatively well accepted interventions in the areas of RH, Gender and Combating Violence against Women despite the cultural sensitivities and taboos related to some of these topics. UNFPA' technical expertise, presence and strategic field positioning in the country, is well recognized by both government partners and UN agencies and puts UNFPA in a competitive advantage over other organizations to deliver on the UNFPA mandate.

UNFPA technical strength and comparative advantage is formally accredited with UNFPA designation in 2004 as the lead agency for the coordination of the Gender Based Violence (GBV) sub-sector group (with other UN agencies UNICEF, UNHCR and UNAMID) under the main Protection Cluster in Darfur[71].

- **Comparative strengths – programme achievements in the thematic area of HIV/AIDS prevention.**

Country Programme achievements and notable results in the thematic area of HIV/AIDS prevention in Sudan has placed UNFPA and the programme at a comparative advantage with respect to the government and other organizations active in this thematic area. UNFPA coordination with the National AIDS Control programme at national and state levels and implementing partners (NGOs and CBOs) facilitated outreach and increased programme coverage to the national level. As a result, UNFPA Sudan managed to substantially increase funding from the Global Fund for its HIV/AIDS prevention programme as confirmed in meeting with UNDP/Global Fund.

[70]The strategic positioning of UNFPA within the UN system was presented at length under the 'coordination' mechanism section

[71] Sudan Protection Sector Strategy 2013 – 2014

5 ANALYSIS OF THE COUNTRY PROGRAMME M&E FRAMEWORK

Overview of UNFPA Programme M&E Framework: UNFPA Sudan 6th Cycle Country Programme designed a "Monitoring and Evaluation System" (October 2012) to provide the basis for CP Monitoring and Evaluation and to guide all programme M&E activities. The 'Monitoring and Evaluation System' document incorporated a Result and Resource Framework (RRF) that aligned the Country Programme Outputs with UNFPA Strategic Outcomes and identified a set of 'Strategic Interventions' and 'performance indicators' for each of the CP six Output areas.

UNFPA programme (old[72]) intervention logic - 'effect diagram' was designed, with the exception of Outputs 2 and 3, as a 'single Output–Outcome relationship' with one CP Output contributing to the achievement of one Strategic Plan (SP) Outcome. Only Output 2 (demand for information and services) and 3 (availability of information and services) were to contribute jointly to the achievement of SP Outcome of "increased access to and utilization of quality maternal and new-born health services".

UNFPA 6th CP Result and Resource Framework defined a set of performance indicators with corresponding baselines, end of programme targets and Means of Verification (MoV). Programme RRF incorporated a series of 'milestones' for each of the six CP Outputs to monitor progress towards achievements of planned results. The CO has been reporting on programme progress and achievements mainly through the following yearly reports: 'Country Office Annual Report' and 'Programme Review Report'. Monitoring of programme performance data and indicators is reported also yearly in the 'Performance Monitoring Plans' that tracks progress on each CP Output indicators' achievements versus planned yearly targets.

In 2014, UNFPA Sudan programme intervention logic and results framework had to be aligned to the new UNFPA Strategic Plan 2014 – 2017. This alignment mainly involved clustering of more than one CP Output to contribute to a strategic level outcome e.g. CP outputs 2, 3 and 4 will now be contributing jointly to the achievement of SP Outcome 1 "Increased availability and use of integrated sexual and reproductive health services (including family planning, maternal health and HIV) that are gender-responsive and meet human rights standards for quality of care and equity in access." Additionally, CP output 1 (Population Dynamics) and 6 (Data) will now jointly contribute to the achievement of SP Outcome 4 "Strengthened national policies and international development agendas through integration of evidence-based analysis on population dynamics and their links to sustainable development, sexual and reproductive health and reproductive rights, HIV and gender equality." Only CP Output 5 on Gender **"**Strengthened national, state and community capacity to promote gender equality and to prevent and respond to early marriage, sexual violence and female genital mutilation" still remain as a 'single output-outcome effect relationship' with SP Outcome3 "Advanced gender equality, women's and girls' empowerment, and reproductive rights, including for the most vulnerable and marginalized women, adolescents and youth."

UNFPA indicators system had also to be re-aligned to follow the new CP Outputs / SP Outcomes relationship with minor changes mainly in terms of addition of new indicators on the outcome/ strategic country-level.

- **UNFPA Sudan programme M&E system-intervention logic (SP Outcomes, CP Outputs and indicators), *with the exception of youth interventions,* are well aligned with a direct Output/Outcome effect relationship and appropriate indicative measures.**

[72]Noted in the following paragraphs that the CP M&E framework – Intervention Logic aligned in 2014 with UNFPA new strategic plan

Analysis of the programme re-aligned intervention logic following the theory of change reveals that the CP outputs, when achieved, will likely contribute to the strategic level outcome. The CP outputs are phrased as results and are in direct effect relationship with the expected change on the higher strategic level outcome. An example would be SP Outcome 1 "Increased availability and use of integrated sexual and reproductive health services…"and the direct effect relationship with CP Output 2 that create demand for these services, CP Output 3 that support the supply of these services and CP Output four which is concerned with RH and FP commodity security.

UNFPA programme indicator plan consists of a total of 25 Indicators for the six output areas with the maximum of 9 indicators for CP Output 3 (sexual and reproductive health services) and the minimum of 2 indicators each for CP Outputs 1 and 6. Overall, the indicators present a good measure of the Output, are well defined and in direct indicative relationship to the expected result under each CP Output such as the example that follows.

CP Output 6: Strengthened national and state capacity to produce, analyze and disseminate high-quality disaggregated population data for evidence-informed planning and monitoring, with a focus on maternal health.	**Indicator:** Nationally agreed standardized protocols for data collection and analysis in place.
	Indicator: National- and state-level statistical coordination mechanisms for data suppliers and users established and functional.

Programme youth interventions are the only thematic area where the result/output/objective of UNFPA programme support to youth is not clearly identified or defined in the Output terminology "CP output 1 "Strengthened national capacity to incorporate population dynamics, including its linkages with sexual and reproductive health, into relevant policies and development plans, with special attention to the needs of young people and women." UNFPA Programme youth interventions under this output involve institutional capacity building and support to youth serving institutions and centers; capacity building for policy dialogue, youth participation, community mobilization and training in life and vocational skills for employability; technical, financial and management support to the National Y Peer Network. These interventions and ensuing results are not *captured* in the output terminology nor are they really reflected in the related indicator.

CP OUTPUT 1: Strengthened national capacity to incorporate population dynamics, including its linkages with sexual and reproductive health, into relevant policies and development plans, with special attention to the needs of young people and women.	**Indicator:** Number of studies on population dynamics conducted, with the findings incorporated into policies, strategies and plans at national and UNFPA-supported state levels. (*direct relationship to CP output)*
	Indicator: Number of UNFPA-supported localities with youth coordination mechanisms established and operational. (No obvious effect relationship on the CP Output; does not it indicate the depth of interventions' results under this output.)

In short, programme interventions in youth are not clearly spelled out in CP output 1 in terms of intended achievements and the relevant indicator *does not indicate – cover the extent* of UNFPA intervention results in terms of capacity building of youth institutions, support to youth services and youth empowerment trainings. This gap unavoidably results in a loss of highlight specifically on the Output level in terms of UNFPA interventions and achievements in youth.

- **Language of Strategic Interventions lacks precision to help develop action plans - activities and their inter-linkages in the achievement of the Output.**

These Strategic Interventions are supposed to specify the 'interim results' to be achieved in order to reach the CP Output level result under each thematic area. Strategic Interventions should basically guide the design/development of a set of complementary or interlinked activities the implementation

of which would assumedly realize each Strategic Intervention area. Reviewing UNFPA programme 'Strategic Interventions', we note that these statements are more general than specific and hence lacks explicit guidance and directions on what activities are needed to achieve them. Programme Strategic Interventions such as "addressing the stigma associated with gender based violence" or "strengthening the management of the reproductive health programme " do not provide a clear strategy on what activities or action plans are to be implemented to 'strengthen the management…' or to 'address the stigma…' Additionally, the complementarity or inter-linkages between the different Strategic Interventions clustered under some of the CP outputs is not always obvious.

- **UNFPA M&E System – Result Framework would benefit from interim result level indicators to capture activity results**

Overall, the 'type' of CPAP indicators is high level indicative of 'Output level' planned results rather than indicative of strategic intervention level type planned achievements. Many activities or 'Strategic Interventions' needs to be implemented to effect change on the CP Output level. We note over here that the CPAP result framework did not plan for such measurements of interim results or activity effectiveness. UNFPA Programme management covers some of these gaps with reporting on IP progress results in the yearly review reports and by conducting ad hoc interim assessment of specific issues such as the midwifery training. In fact, there are no indicators to capture the results of these activities and appraise the extent of their contributory effect on the CP Output. These indicators and framework are important in terms of appraising what works and what does not work and lessons learned for future interventions.

This gap in indicative measures (indicators) is mostly felt in training and institutional capacity building[73]. UNFPA invest large resources in the technical and institutional capacity building of its governmental and non-governmental IPs. The current result framework lacks measures to indicate what changed in terms of institutional capacity after training, what is the baseline and end line of UNFPA interventions in specific capacity building trainings, and when would the UNFPA supported institutional' service becomes sustainable at least on the technical and institutional side.

[73] The CO is managing an e-database system which tracks, among others, the investment in training, awareness raising, south-south cooperation and partners' travel to attend regional and international workshops /training / conferences. This system is annually updated.

6 CONCLUSIONS

6.1 STRATEGIC LEVEL CONCLUSIONS

CONCLUSION 1 (C1) – RELEVANCE
UNFPA Country Programme 2013 and 2014 interventions are relevant to the context, priorities and dynamics and have adequately addressed the needs of population as identified in the development plans and through the participatory needs assessments and consultation with partners.
➢ **ORIGIN:** EQ1 ➢ **ASSOCIATED RECOMMENDATION:** R1

The interventions for the Population and Development component took account of the gaps identified by assessment of institutional and human resources of the CBS and NPC. The interventions focused on addressing gaps identified in capacities for collection and analysis of data related to maternal health.

CP interventions targeted the young population. It addressed the social and economic priorities identified in the National Youth Strategy and created a momentum for youth engagement which will be used to cover reproductive health needs of young people, including adolescents.

The UNFPA has good practice of participatory consultation with partners, on the priorities of programme interventions. The UNFPA consultation succeeded in improving the focus of the Ministry of Youth and Sports at the federal and state levels from sports to the civic engagement and participation.

The strategic approach of focusing on the population needs tallying with the country policies and strategies has enabled UNFPA to target the vulnerable groups especially women in reproductive age.
The practice of base-line needs assessment and surveys especially for maternal health has facilitated the availability of information for UNFPA to develop evidence-based country programme.

The gender component focused on awareness with maternal health issues specifically harmful practices, and responded to the needs of women, men and girls among the underserved population.

CONCLUSION 2 (C2) – RESPONSIVENESS TO EMERGING NEEDS
UNFPA adequately responded to the needs of the internally displaced population in the conflict-affected areas, and the refugee groups. In the humanitarian field, UNFPA successfully led the GBV coordination groups, and contributed to the complementarity of interventions of the UN agencies, and international organizations**.** The UNFPA CO has demonstrated adequate response capacity to the needs of the refugees from South Sudan and the IDPs in the war-affected states and flood-affected localities through strengthening the RH services, technical support and necessary supplies.
➢ **ORIGIN:** EQ2 ➢ **ASSOCIATED RECOMMENDATION**: R2

UNFPA Country Office participated in the interagency needs assessments in the humanitarian settings, and was able to respond quickly and adequately to the needs of population, specifically, women, girls and GBV survivors in the displaced camps, and their host communities in the different regions of Sudan. UNFPA was able to reach the large influx of refugees from neighbouring countries with gender-based interventions. UNFPA also responded to the emerging needs, such as dignity kits, in humanitarian settings.

The UNFPA role in coordinating GBV/SRH with the state authorities, NGOs, and among the international actors active in humanitarian settings, is recognized and appreciated by all partners.

The UNFPA CO has responded rapidly to the needs of the refugees and IDPs in the affected states manifested as strengthening the RH services. The response included capacity building of the human resources, logistics and supplies, mobile clinics with renovation of the health facilities outside the camps. The strengthened RH health services have served both the refugees, IDPs within the camps and the hosted communities in the affected localities.

UNFPA technical support and timely updating of the State Emergency Preparedness and Response Plans (EPRPs) have served dual actions of early response before the crises and improved capacity of the concerned partners at the state level.

CONCLUSION 3 (C3) – EFFICIENCY

In spite of dwindling donor interest, UNFPA CO managed to raise financing for its country programme, to increase financing levels from non-core resources and to access new donors. Still, UNFPA did not manage to raise significant levels of financing for Population Dynamics and Data; to access financing from non-traditional sources and to attract more financing for development interventions in comparison with humanitarian assistance.

- **ORIGIN:** EQ7; CPD; UNDAF
- **ASSOCIATED RECOMMENDATION**: R3

Despite dwindling donor interest and a general decrease in development assistance to Sudan, UNFPA was relatively efficient in raising financing for its Country Programme and increasing levels of co-financing from non-core resources. Three points to be noted though: UNFPA did not manage yet to access private sector funding and to break into the non-traditional donors' pool; co-financing amount for CP Outputs 1 and 6 is negligible; and humanitarian funding still relatively higher than development funding. The last two facts are important in light of UNFPA's Sudan commitment to transition to development assistance, and the upcoming population census in the year 2018 and the role that UNFPA will play in this endeavor.

UNFPA business model of implementing through government and non government partners, NEX and DEX implementation modalities and programme integration approaches enhanced implementation efficiency and enabled UNFPA to reach most of its mid cycle CP performance indicators. Delays in funds transfer to partners indicate need to improve internal management processes and with partners.

Partnership with government and non-government organizations enabled UNFPA to expand programme implementation capacity and outreach but this implementation modality through IPs require greater attention to be devoted to building partners capacity for future sustainability of programmatic interventions and greater attention to be devoted to monitoring and validating IP performance and data.

CONCLUSION 4 (C4) – SUSTAINABILITY

Sustainability assessment results varied across the programme outputs, implementing partners and types of interventions. In thematic areas where UNFPA strategic interventions are still *mostly* at the level of advocacy to break the cultural taboos, such in gender based violence and female genital mutilations, sustainability potentialities are weak.
Sustainability is challenged by more than the mere availability of financial resources to maintain the provision of services and or to maintain the durability of effects acquired through the programme. Joint assessment and planning, in addition to interventions at the local level and with local actors improve potential for future sustainability.

- **ORIGIN:** EQ8, EQ1
- **ASSOCIATED RECOMMENDATION:** R4

Sustainability assessment refers to the extent to which programme results are likely to continue after programme' support is completed and / or the willingness and capacity of implementing partners to maintain provision of these services without further programme technical and financial support.

Sustainability is challenged by more than the mere availability of financial resources to maintain the provision of services and or maintain the durability of effects acquired through the programme. Sustainability of programme support is also highly dependent on the continued stability of the human resources whose capacities have been built by the programme, adequacy of the institutional capacities and management systems 'for the provision of the service' *and willingness* of the institution to continue provision of the UNFPA-supported service.

From those analysis perspectives, sustainability assessment results varied across the programme outputs, implementing partners and types of interventions. In thematic areas where UNFPA strategic interventions gained traction, government endorsement and some levels of community acceptance, such as in Sexual and Reproductive Health and Youth, we note that sustainability potentialities have improved. In other thematic areas where UNFPA strategic interventions are still mostly at the level of advocacy to break the cultural taboos, such in gender based violence and female genital mutilations, sustainability potentialities are still weak.

Programme approach of participatory needs assessment, intensive consultations with stakeholders and joint programme planning with implementing partners, *in addition to* interventions at the local level and with local state and non-governmental stakeholders, helped develop a sense of ownership, improved chances of trained resources stability, and have thus increased chances for future sustainability of UNFPA interventions

CONCLUSION 5 (C5) – COORDINATION

Coordination mechanisms proved mostly effective in combining agencies technical resources in joint projects, planning and ensuing complementary interventions by competitive advantage of each agency and finally sharing of information on projects' progress and achievements in coordination meetings. Coordination mechanisms, specifically UN Agency coordination mechanisms, were less effective in joint implementation and advocacy.

- **ORIGIN:** EQ 9, EQ10; UNDAF
- **ASSOCIATED RECOMMENDATION**: R5

UNFPA participates in, is a member of, and at times is leading in multi layered coordination structures with UN agencies, federal and state government institutions in development and humanitarian contexts. Each of these coordination structures has a defined objective, lead and participant organizations and regular and ad hoc coordination meetings. Whereas government coordination seek *mainly* to coordinate the interventions of the various development assistance actors on the ground, the UN coordination mechanisms aim beyond this level to joint planning, joint programming, resource mobilization, lobbying and advocacy.

UN coordination mechanisms proved mostly effective in combining agencies technical resources in joint projects, planning and ensuing complementary interventions by competitive advantage of each agency. Government coordination structures are mostly effective for programme planning and information sharing on projects' progress. Effective coordination is challenged by dearth of financial resources and weak leadership.

CONCLUSION 6 (C6) - VALUE ADDED

In addition to UNFPA technical mandate and value added in Sexual and Reproductive Health rights and services, UNFPA Sudan positioning at the states/community/locality level proved to be a competitive advantage as compared to other organizations.
➢ **ORIGIN:** EQ11 ➢ **ASSOCIATED RECOMMENDATION**: R6

UNFPA's technical mandate in sexual and reproductive health already positions UNFPA at a comparative advantage in those thematic areas with regards to other organizations of the UN System. In addition to this competitive positioning, UNFPA offered through the current CP, technical expertise, extensive experience and programmatic achievements in RH, HIV/AIDS, GBV and gender.

Besides its technical mandate and strengths areas, UNFPA managed to strategically position itself at the states, communities and locality levels. This geographic expansion provided opportunities to extend support to the states ministries and to deliver services, technical support and advocacy where the need is the greatest. 'Local positioning' offered UNFPA another strength and competitive advantage over other organizations in terms of established relationships and capacities to implement in the states and at the local level.

CONCLUSION 7 (C7) – TRANSITION TO DEVELOPMENT
UNFPA attempts at transitioning from humanitarian to development assistance is challenged by a general lack of donors' interest in supporting development interventions owing to Sudan political and other country specific limitations.
➢ **ORIGIN:** EQ7,CPD, CPAP, UNDAF ➢ **ASSOCIATED RECOMMENDATION**: R7

The UNFPA country office has been planning, following UNDAF strategy, to transition from humanitarian and emergency assistance to a more development oriented strategic interventions. As noted in the efficiency analysis, the country office efficiency in attracting donor resources for development programmes and for the thematic area of population dynamics were less successful than the other programme areas due to a general lack of donors' interest in the country development owing to political and other country specific limitations.

These facts created challenges for UNFPA to address and implement its strategic development mandate and to raise funds for its commitments in population dynamics and data. This issue is especially critical due to UNFPA's commitments specifically its mandate and assigned contributions to the UNDAF.

6.2 PROGRAMMATIC LEVEL CONCLUSIONS

CONCLUSION 8 (C8) - RH
The RH interventions were relevant and effective to deliver RH services in the UNFPA-targeted states. Some interventions such as integrating the management and prevention of STIs & HIV into RH service outlets and management of the RH programme showed limited coverage.
➢ **ORIGIN:** EQ3 ➢ **ASSOCIATED RECOMMENDATION:** R8

The current RH interventions have been effective to deliver information and services in the UNFPA-targeted states. These interventions need adjustments and modifications to ensure quality and standards of the delivered RH services and information to the vulnerable groups including women in the reproductive age, youth & adolescents, IDPs and refugees etc.

CONCLUSION 9 (C9) – FP
The CP has contributed to initiation of community-based family planning services. The delivered services are constrained with irregular supply of commodities.
➢ **ORIGIN:** EQ3 ➢ **ASSOCIATED RECOMMENDATION:** R9

The RHCS is effectively functioning up to the locality level. The village midwives were trained to deliver the community-based family planning to the clients. The village midwives have faced constraints of delivering the supplies to the community level especially in the remote rural areas.

CONCLUSION 10 (C10) – HIV/AIDS
The CP has supported MARPs and PLWHA with IGAs/life skills with the ultimate goal of reducing risky behaviour of FSW and MSM, stigma reduction and improving nutritional status of PLWHA. A recent UNFPA-supported evaluation of the IGA activities for sex workers indicated the sustainability of the activities with emphasis on quality improvements instead of scaling up the programme. Still, available information is inadequate to assess the effectiveness of UNFPA interventions to achieve the stated goal.
➢ **ORIGIN:** EQ3 ➢ **ASSOCIATED RECOMMENDATION:** R10

The rationale of addressing the intervention of IGAs/life skills for the MARPs and PLWHA is apparently logic and sensible. The approach needs evidence to support further expansion among the target groups. This is important considering the surrounding social, cultural and economical circumstances of the MARPs and PLWHA that may adversely affect the desired results.

CONCLUSION 11 (C11) – P&D
The integration of the population dynamics into the development of sectoral policies and plans is slowly progressing because it is challenged by the limited capacities of the states' population councils, the limited understanding of the population dynamics in the sectoral ministries and by the gaps in capacities for demographic research.
➢ **ORIGIN:** EQ4 ➢ **ASSOCIATED RECOMMENDATION:** R11

The NPP/PoA was an important step in identifying the population dynamics priorities that should enhance the integration process. The challenge for NPC leading the process is to ensure effective coordination with the relevant ministries, for the review of its development plan for the integration of population dynamics, and for ensuring the commitment for the implementation of plans.

Although the state population offices were engaged in the preparation of POA and ICPD advocacy reviewed report, many are not able to operate at the state level due to the limited support and limitation of population dynamics.

The capacities for demographic research, specifically for qualitative research, are limited and challenged by the shortage of demographers.

CONCLUSION 12 (C12) – P&D

Despite that the advocacy for ICPD 2014, and Beyond 2015 Development Agenda, was recognized by some decision makers, the engagement of the government and CSOs in promoting the sustainable development goals remains a challenge.

- **ORIGIN:** EQ4, EQ9, EQ10
- **ASSOCIATED RECOMMENDATION**: R11

The UNFPA support for advocacy and engagement of decision makers and media in ICPD 2014 and beyond 2014 Agenda is a strategic country initiative, and a timely start for ensuring responses to the Sustainable Development Goals. The challenge is how to coordinate with other UN Agencies to continue advocacy at the national and state levels, and build the commitment to sustainable development goals targets.

CONCLUSION 13 (C13) - Youth

UNFPA support succeeded in strengthening the youth structures, building their capacity for employability, civic engagement, networking, and social responsibilities. As well as community education on gender, RH, MM, FGM and CM abandonment. This is a process of economic, and social empowerment of youth, which will most likely encourage the youth to raise issues related to their RH needs.

- **ORIGIN:** EQ6
- **ASSOCIATED RECOMMENDATION**: R13

UNFPA-support promoted the role of youth centres, from isolated institutions used by few youth for sports and cultural events, to social institutions recognized by youth communities. The changing role of the youth centre, gave young women in some UNFPA target states an opportunity to engage with each other, and participate in the community activities.

The UNFPA support was successful in creating agents for change, (youth groups and Y-Peer NGOs) active in educating others on maternal and gender related issues. However, the youth have no standard messages on gender and still many are not aware of “Al Mawada Wa Rahma” initiative. Moreover, there are cultural sensitivities related to consideration of the reproductive health issues of youth and adolescents.

CONCLUSION 14 (C14) – Data

The support to the development of the statistical systems contributed to the production and availability of data related to gender and maternal heath indicators which were used for planning, monitoring and advocacy. However, still there are gaps in data disaggregated by the locality and administrative levels, and limitations in the capacities for writing reports. Though the upgraded CBS website provided some statistical data to users, accessibility would remain limited without the operationalization of the National Data Users Committee.

- **ORIGIN:** EQ4
- **ASSOCIATED RECOMMENDATION**: R12

The implementation of the National Strategy for Development of Statistics and the capacity plan of action contributed to the improvement of quality, standards, and techniques for the collection of the population data. The implementation of states and sectorial strategies for statistics development would enhance the coordination with the data producers at the federal and state level.

As a result of UNFPA support, CBS has built capacities for qualitative data collection which is needed for assessing needs in humanitarian settings.

CONCLUSION 15 (C15) – Gender

Efforts for advocacy and community education on gender issues and socio-economic determinants of maternal mortality at the national and locality level is a new initiative to link maternal mortality to gender inequalities.

Advocacy and raising awareness with regard to maternal health issues, gender issues, child marriage and FGM reached men, women, school boys and girls, and youth at the state, locality and village levels, creating community structures, (CBOs and protection groups) that respond to the safe motherhood needs, and follow up the commitment to FGM and CM abandonment. The challenges to such efforts are related to limitations in "Al Mawada Wa Rahma" approach, inadequate monitoring of the groups created at the community levels, and the commitment to declarations.

- **ORIGIN:** EQ5
- **ASSOCIATED RECOMMENDATION**: R13

The engagement of the task forces for reduction of maternal mortality at state level was successful in reaching communities with information on socio-economic determinants of MM. While the advocacy, led by the Directorate of Women and Family, to decision makers enhanced the decision makers at sectoral ministries for formation of multi-sectoral plan for which some funds were allocated. These efforts are likely to enhance the processes of maternal death prevention and reporting. This initiative also contributes to enhancement of awareness for giving information to researchers and data collectors on sensitive issues related to maternal health. The initiative complements other advocacy efforts, as it empowers women and men to address maternal health risks. The establishment of the FGM state task force and locality teams in some states is a step forward for improving coordination. But still these structures are not familiar with the mechanisms' terms of reference. The follow- up to the CBOs and declarations is not adequate.

The UNFPA interventions' approach for the community mobilization and education has contributed to the declarations for abandonment of FGM and FGM, establishment of structures to follow the commitment. However, there are challenges of confusing messages and contradictory religious discourses and the 'Al Mawada Wa Rahma' discourse is not yet articulated. In addition, the core team of trainers trained on maternal health, gender, reproductive rights and GBV issues by GRACe, are not yet recognized and engaged in training at the state level to improve the quality of training.

CONCLUSION 16 (C16) – Gender

UNFPA interventions were successful in addressing GBV issues in humanitarian settings with a package including advocacy for prevention, raising awareness for referral pathways, capacity building for service providers and provision of service at the community and health service institutions, in coordination with all relevant actors. However, still no information on any cases of violence reported. The efforts for law adoption and enforcement for FGM and CM abandonment yielded limited results.

- **ORIGIN:** EQ5
- **ASSOCIATED RECOMMENDATION**: R14

The GBV interventions succeeded in raising concerns among government institutions, youth and national NGOs for GBV reduction, specifically in Darfur. Although the service providers confirmed the prevalence of violence and the utilization of the services, yet there is reluctance to give data. The women centres, established with UNFPA support, have enhanced the social engagement of different groups of women, and sometimes men, of the community, and contributed to the empowerment of women, specifically the GBV survivors.

The support to law reform promoted the engagement in advocacy, debates, with parliamentarian, justice sector experts and NGOs. The capacity building in relation to GBV created interest among the law enforcement personnel, specifically in Darfur states, to engage in the training, and cooperating with the service providers. A national law for FGM abandonment is drafted, and discussed with

parliamentarians to ensure their ownership of the law. The studies undertaken demonstrate that state laws for FGM abandonment are not enforced. The law reform activities are scattered among several government institutions with limited coordination.

CONCLUSION 17 (C17) – M&E
UNFPA M&E System is well aligned with a direct Output- Outcome relationship and adequate indicative measures. Overall, the indicator plan does not fully capture the results of Youth interventions nor does it include indicators for capacity building and sustainability of UNFPA Sudan interventions in institutional capacity development of partners.
➢ **ORIGIN:** M&E Framework ➢ **ASSOCIATED RECOMMENDATION**: R15

UNFPA Sudan programme M&E system-intervention logic (SP Outcomes, CP Outputs and indicators), *with the exception of youth interventions,* are well aligned with a direct Output/Outcome effect relationship and appropriate indicative measures. Programme interventions in youth are not clearly spelled out in CP output 1 in terms of intended achievements and the relevant indicator *does not indicate – cover the extent* of UNFPA intervention results in terms of capacity building of youth institutions, support to youth services and youth empowerment trainings.

Strategic Interventions phrasing lack precision to help identify action plans - activities and their inter-linkages in the achievement of the Output. UNFPA M&E System – Result Framework would benefit from a more focused identification of the 'Strategic Interventions' and addition of interim result level indicators to capture activity results. This gap in indicative measures (indicators) is mostly felt in training and institutional capacity building. The current result framework lacks measures to indicate what changed in terms of institutional capacity after training, what is the baseline and end line of UNFPA interventions in specific capacity building trainings, and when would the UNFPA supported institutional' service becomes sustainable at least on the technical and institutional side.

7 RECOMMENDATIONS

7.1. STRATEGIC LEVEL RECOMMENDATIONS

RECOMMENDATION 1 (R1) – RELEVANCE
UNFPA should continue the good practice of basing programme interventions on research and needs assessments, national strategies and plans, participatory consultations with stakeholders and implementing partners and mapping of existing interventions of other organizations to insure complementarity and UNFPA coverage of priority gaps.
➢ **PRIORITY LEVEL:** Medium ➢ **ADDRESSEE:** UNFPA Country Office and Components' Lead ➢ **ORIGIN:** C1

Operational Implications

- UNFPA to maintain its strategic approach of evidence based planning and joint consultations with partners at state and national level for the development of future programme interventions.
- UNFPA to maintain its strategic approach of programme planning based on national sectorial strategies and Plans of Actions developed for specific sectors or issues such as National Population Policy Action Plan and others.
- UNFPA to support the development of Plans of Action to operationalize national strategies and new research such as a plan of action for the implementation of the National Policy for Combating Violence against Women, 2015-2031, (currently in the process of endorsement).

- UNFPA to strive to improve needs assessment and evidence approach practices to avail quality information for formulation/updating of future CP interventions.
- UNFPA to continue support for research, assessments and evaluations to provide the basis for targeted and focused programme interventions based on performance results.
- UNFPA future programme interventions to be based on a thorough mapping of existing actors and programmes to insure planning of programme interventions that are coherent or in complementarity with other actors' interventions in the same geographic and technical area.

RECOMMENDATION 2 (R2) - RESPONSIVENESS TO EMERGING NEEDS
UNFPA to maintain its emergency response readiness to enable appropriate responsiveness to emerging humanitarian needs (manmade or natural) while also strengthening coordination and collaboration with relevant stakeholders for the identification and planning of programme interventions that respond to the priority needs, within UNPA mandate, of vulnerable groups in the conflict-affected areas, and among refugees' communities.
➢ **PRIORITY LEVEL:** Medium ➢ **ADDRESSEE:** UNFPA Country Office, HRU and GBV Sub-sector Lead ➢ **ORIGIN:** C2

Operational Implications

- To increase collaboration with UN Agencies and local actors in mapping and needs assessment of the vulnerable people in conflict affected areas and among refugees.
- UNFPA to maintain and increase efforts in leading, strengthening its lead coordination role of the GBV sub-sector coordination group in humanitarian context.
- Continuous updating of the UNFPA strategic response to RH needs of the vulnerable populations is advised to overcome the emerging challenges and ensure proper coverage.
- UNFPA being the sole agency providing the MISP package will give it the leading role in RH in emergency settings. This role should be institutionalized through extending the appropriate interventions among the vulnerable groups in the war- affected states.

RECOMMENDATION 3 (R3) - EFFICIENCY
UNFPA CO to focus efforts towards accessing financing resources for the thematic areas that were least funded in the past couple of years i.e. Population dynamics and development interventions. Owing to the general lack of interest of traditional donors in these areas, UNFPA ought to target as well non-traditional donors and the private sector.
➢ **PRIORITY LEVEL:** Medium ➢ **ADDRESSEE:** UNFPA Country Office, component lead, regional office. ➢ **ORIGIN:** C3

Operational Implications

- Maintain efforts to seek access to and funding from non traditional sources and the private sector, as proposed in the RMS, specifically for the under financed thematic areas and for development interventions.
- UNFPA might consider to devote specialized staff for fund raising and to support proposal writing efforts and to follow up on maintaining relationships with existing donors.
- UNFPA to review its management and administrative procedures with a view to improve timely transfer of funds to partners.
- UNFPA to continue training of IPs on its administrative and financial procedures to improve IPs' conformity with UNFPA reporting and financial requirements.

RECOMMENDATION 4 (R4) - SUSTAINABILITY
Sustainability is a challenging issue for some of the culturally sensitive intervention areas of UNFPA's work and when UNFPA interventions are more humanitarian then development oriented. Still, UNFPA should strive in the upcoming 7th CP to discuss and include in its programming with implementing partners' measures of sustainability especially as it concerns technical support and organizational capacity building.
➢ **PRIORITY LEVEL:** High ➢ **ADDRESSEE:** UNFPA Country Office, component lead, implementing partners. ➢ **ORIGIN:** C4

Operational Implications

- UNFPA to include, in future programme interventions, plans to improve degrees of sustainability, specifically for institutional /organizational capacity building and for culturally sensitive thematic interventions such as GBV and FGM/C.
- Sustainability issues ought to be discussed with implementing partners at the time of drafting the AWPs to clarify expectations and to gain IPs' support to work towards improving sustainability of UNFPA supported interventions.
- UNFPA to plan for training and capacity building of IPs with clear goals on expected achievements in terms of capacity building and sustainability.

RECOMMENDATION 5 (R5) - COORDINATION
Despite inherent challenges of coordination, UNFPA should continue and enhance its efforts to improve coordination with other partner UN Agencies for joint advocacy of the government and in the implementation of joint programmes specifically for Gender, GBV and FGM/C programmes.
➢ **PRIORITY LEVEL:** High ➢ **ADDRESSEE:** UNFPA Country Office, relevant component lead ➢ **ORIGIN:** C5, C17

Operational Implications

- To discuss with UNICEF on how to unify messages and integrate programme approaches for combating GBV and FGM and early child marriage.
- To discuss with UN Women on common strategies for Gender advocacy with the government.

RECOMMENDATION 6 (R6) - VALUE ADDED
UNFPA to maintain its value added in RH, HIV Prevention and Gender and expand on its strategic positioning at the state level and with local actors.
➢ **PRIORITY LEVEL:** Medium ➢ **ADDRESSEE:** UNFPA Country Office, relevant component lead ➢ **ORIGIN:** C6, C4

Operational Implications

- Maintain in future programmes UNFPA three tiered approach of interventions at national, state and community levels.
- Maintain direct service delivery to the states level and expand to other states and localities when resources become available.
- Continue building capacities for service delivery, advocacy and community mobilization of local actors.

RECOMMENDATION 7 (R7) - TRANSITION TO DEVELOPMENT
UNFPA to exert additional efforts in coordination with UN RC-UN Agencies to seek funding and design programmes to transition to a more development oriented intervention assistance to Sudan.
➢ **PRIORITY LEVEL:** High ➢ **ADDRESSEE:** UNFPA Country Office, UNCT ➢ **ORIGIN:** C6

7.2 PROGRAMMATIC LEVEL RECOMMENDATIONS

RECOMMENDATION 8 (R8) – RH
The UNFPA needs to promote and tune the RH interventions to accommodate the anticipated expansion to the underserved localities to deliver better quality RH services and information to vulnerable groups.
➢ **PRIORITY LEVEL:** High ➢ **ADDRESSEE:** UNFPA Country Office ➢ **ORIGIN:** C8

Operational Implications

- The UNFPA needs to conduct regular review of the current RH interventions through evidence-based approaches to improve the delivery of the RH services and information.
- Development of national RH service standards to reinforce the quality RH services delivered within the primary health care services.
- Strengthening of the referral and midwifery supervisory systems to improve the overall performance especially at the PHC level.

RECOMMENDATION 9 (R9) – FP
UNFPA needs to support the community-based family planning services through adoption of effective approaches to strengthen the delivery, monitoring and reporting of the FP commodities to ensure availability at the community level towards improving the quality of the provided services.
➢ **PRIORITY LEVEL:** Medium ➢ **ADDRESSEE:** Component Lead ➢ **ORIGIN:** C9

Operational Implications

- Extra support is needed to strengthen the delivery of the FP commodities at the community level.
- Improve the reporting system on the distribution of the family planning commodities to enable estimating the unmet needs at the community level.
- Strengthening of the midwifery supervisory system can serve to improve the quality of the community-based FP services.

RECOMMENDATION 10 (R10) – HIV/AIDS
It is necessary to conduct operational research to find out if the intervention of IGAs/life skills for MARPs and PLWHA is effective to empower the target groups and to yield concrete evidence for further expansion.
➢ **PRIORITY LEVEL:** Medium ➢ **ADDRESSEE:** UNFPA CO & Component Lead ➢ **ORIGIN:** C10

Operational Implications

- To identify the objectively verifiable indicators to measure the actual improvement attained or the drawbacks if they are any.
- The IGAs/life skills outcomes need to be explicitly displayed to show their effectiveness and efficiency as an introduced intervention.

RECOMMENDATION 11 (R11) – P&D
UNFPA should support the advocacy and coordination for the implementation of NPP/PoA, for ICPD 2014 and Sustainable Development Goals
➢ **PRIORITY LEVEL:** High ➢ **ADDRESSEE:** UNFPA CO & Component Lead ➢ **ORIGIN:** C11 & 12

Operational Implications

- UNFPA should continue to support NPC for: (1) Advocating for NPP/POA and coordinating with line Ministries for the commitment, and integration of population dynamics into the sectorial development plans; (2) Providing the needed technical support to some sectors for the integration of population dynamics, starting with education, health and women; and (3) Strengthening the capacities of the NPC for coordination with and monitoring the state councils.
- UNFPA should continue to strengthen the operationalization of the state population councils by: (1) Supporting the advocacy at the state level, to promote the understanding for the population dynamics, and enhance the commitment of states' authorities for the support to the population councils; (2) Supporting the needs assessment of the state population councils, starting with the UNFPA target states, and the capacity building (specifically on advocacy and coordination), as needed; and (3) Providing technical assistance and financial support for the states' population councils (starting with 3 of the UNFPA target states),for plans of action for the implementation of NPP/POA at state level.
- UNFPA should help in reducing the limitations in research by: (1) Supporting the establishment of a research demographers' center, within one of the universities that have the capacities, and the commitment to maintain it; (2) Providing the technical and financial support for the center, to function as a training and research institution; (3) Supporting the center to form a core team of researchers (including demographers), recruited from different state universities; and (4) Support a regular forum for disseminating research results.
- UNFPA should coordinate with other UN Agencies and international organizations for orientations on ICPD 2014 and targets of Sustainable Development Goals at the national and state levels. It should also encourage the use of both, as frameworks, in formulation of policies and plans.

RECOMMENDATION 12 (R12) – Data
UNFPA should intensify the support for the production of an improved quality of data related to population dynamics and reproductive health.
➢ **PRIORITY LEVEL:** High ➢ **ADDRESSEE:** UNFPA CO & Component Lead ➢ **ORIGIN:** C14

Operational Implications

- UNFPA should continue supporting the implementation of the National, State and Sectorial strategies for the Development of Statistics to strengthen the data production at state level and that may address gaps in data from locality and administrative units' levels.

- Special efforts may be needed to raise the awareness on the importance of statistical data for planning and monitoring population developments. Specific efforts are needed to address the cultural sensitivity of providing information on maternal health.
- The support for the disseminations of MICS results related to GBV issues may help evidence based advocacy, planning and raising awareness.
- There is a need to strengthen the capacities for report writing, through technical assistance, and to target younger generations utilizing the proposed research center.
- The activation of the national Data Users Committee is essential to enhance interaction and coordination of the data producers and users.
- Support to the operationalization of the Emergency Statistics Unit in data collection from humanitarian settings is needed to help in the application of the skills for qualitative data collection and analysis. The research on GBV issues would come with more detailed information if qualitative methodologies are used.

RECOMMENDATION 13 (R13) – Youth
UNFPA should continue supporting youth empowerment and engagement in the community education, on reproductive health and related issues, while advocating for identification of the youth/adolescents SRH needs.
➢ **PRIORITY LEVEL:** High ➢ **ADDRESSEE:** UNFPA CO & Component Lead ➢ **ORIGIN:** C13,15

Operational Implications

- The UNFPA needs to continue supporting the rehabilitation of youth centers, and strengthening their capacities to manage, and promote the centers' role as social spaces for engagement of young women and men.
- The engagement of youth in intergenerational dialogue, may draw attention to the youth's social and cultural issues, and address the cultural sensitivity related to the youth's health and RH issues.
- A youth situational analysis in Sudan is important for advocacy for the RH needs of the youth. This may entail discussing the possibility of having a separate output for youth, or integrate it with the gender equality output.

RECOMMENDATION 14 (R14) – Gender
UNFPA should intensify community mobilization and advocacy for maternal health and GBV including to law adoption and law enforcement efforts for reducing FGM and CM for promoting gender justice.
➢ **PRIORITY LEVEL:** Medium ➢ **ADDRESSEE:** UNFPA CO & Component Lead ➢ **ORIGIN:** C16

Operational Implications

- The UNFPA should ensure engagement of its technical relevant staff to help in the finalization of the 'Al Mawada Wa Rahma' as a comprehensive discourse integrated with Saleema, and should provide it to all the implementing partners and other actors.
- UNFPA to support the development of education materials and production of research.
- UNFPA should continue the establishment of women centres, to allow women to engage in providing support for GBV survivors, raising awareness in issues such as fistula, maternal health risks, FGM and CM abandonment.
- UNFPA should support the CVAW unit for coordinating the law reform interventions.

- There is a need for a plan of action for law reform, for the enforcement of the states' laws, for FGM abandonment.

RECOMMENDATION 15 (R15) – M&E
For future programmes, UNFPA to improve strategic interventions design and indicator plan to better capture mid level and intermediary activity results.
➢ **PRIORITY LEVEL:** Medium ➢ **ADDRESSEE:** UNFPA CO ➢ **ORIGIN:** C17

Operational Implications

- Planning of future UNFPA programmes to identify and improve phrasing of complementary sets of strategic interventions with direct interrelationship and contributing linkages to the expected output and outcomes.
- UNFPA to review indicator system to better reflect youth interventions and expand with new intermediary level indicators to objectively assess activity results specifically as it concerns capacity building and sustainability.

ANNEXES TO

COUNTRY PROGRAMME EVALUATION REPORT

UNFPA SUDAN

6th Cycle Programme
2013-2016

September 2015

LIST OF ANNEXES

Annex 1: Terms of Reference
Annex 2: List of People Interviewed – Organizations
Annex 3: List of Documents Consulted
Annex 4: The Evaluation Matrix
Annex 5: Data Collection Tools

Terms of Reference for Evaluation of the 6th Country Programme (2013 – 2016)

1. CONTEXT

The Republic of Sudan has an estimated population of about 31 million[1], with a surface area of approximately 1.9 million KM^2. 9% of the overall population is nomadic, about 29% live in urban areas and 63% in scattered rural localities. Population under 15 years of age constitutes 46% of the total population signifying a built-in growth momentum. Women in reproductive age constitute 42% of the total population. The annual population growth rate is high at 2.6%. Total fertility rate is around 5.6 (census 2008), which accounts for expanding population growth. The civil unrest in Darfur region has resulted in the displacement of over 2 million people with 200,000 refugees sheltering in Chad. The recent conflict in South Sudan has also resulted in 205,000 refugees most of them temporarily reside in White Nile and Khartoum States.

The health sector in Sudan is heavily skewed towards tertiary level of care. The health infrastructure in most areas of the country, particularly in the rural areas, is characterized by sub-standard quality of services, limited coverage of health facilities vis-à-vis number of population and unequal distribution. Infant mortality rate is 70 per 1,000 live births and U-5 mortality rate is 120 per 10,000 live births. Different sources of official data at different time intervals estimate maternal mortality ratio (MMR) at 428[2] and 216[3] deaths per 100,000 live births with wide variations between and within states. The high MMR levels are linked to poor access to quality reproductive health services, including family planning. The percentage of deliveries attended by skilled health personnel is 23%. According to latest statistics (SHHS 2010), contraceptive prevalence rate is low, at 9%. Fistula is a priority for national programs and majority of cases are found in the remote rural areas of Darfur and Kordofan States. However, there are no prevention programs and repair is not adequately available even in many secondary and tertiary health facilities. HIV/AIDS prevalence is 0.4% among the general population according to an estimated projection in 2013; HIV prevalence is 1.5% among the FSWs and 2.6% among the MSM based on integrated bio-behavioral surveillance conducted in 2012.

The state of women empowerment in Sudan varies across regions and poses a major concern to policy makers and NGOs/CSOs. Female-headed households account for 11.7%, and 60% among the IDPs. Average age at first marriage increased from 19 years in 1999 to 20 in 2010 respectively though it varies across the country, from 17 years in Southern Darfur to 21 years in Khartoum. Literacy rate is 49% with much variation between and within the states. Gender literacy rates are 71% and 52% for males and females respectively. The forms of gender-based violence in different regions of Sudan also differ. The FGM prevalence rate decreased from 90% in 1999 (SMH) to 64% in 2010 (SHHS/2). Poverty among women[4] is 55% compared to 46% national average based on the national poverty line. Recent constitutional developments resulted in 25% representation for women in the national parliament and state legislative councils. Actual seats occupied by women in the national parliament exceed the quota, at 28%.

2. BACKGROUND:

UNFPA Sudan is currently implementing its sixth Country Programme starting 2013 through 2016. The CP has been developed on the basis of a comprehensive Country Population

[1] Census, 2008
[2] Census, 2008
[3] SHHS, 2010
[4] National HH Baseline Survey, 2009

Analysis (CPA) in 2012 which addresses the national needs and priorities within the mandate and comparative advantage of UNFPA's strategic plan 2008 - 2011 and its extension 2012-2013. It encompasses and covers the 4 outcomes namely: 1) increased access to and utilization of quality maternal and neo-born health services; 2) Increased access to and utilization of quality family planning services; 3) Gender equality and reproductive rights advanced; 4) Population dynamics and incorporation of their linkages into national development plans and strategies. The same document, together with others commissioned by partner UN agencies, constituted the framework for developing the UNDAF.

The CP implementation uses a tiered approach (National, State and Community) with specific set of strategies/interventions for each layer. The programme consists of six outputs (integrated) on RH, FP, HIV/AIDS, Gender, Data Production and Population Dynamics and covers nine states (five of which are in Darfur region) in humanitarian and development contexts. The CP introduced -and for the first time- the notion of direct service delivery to communities in the selected states. To that end, one locality from each state has been identified for implementation of pilot interventions mainly advocacy and awareness promotion for demand creation. Replication to other localities is subject to resource availability and the success achieved.

Estimated resources for the four years' cycle are $ 91 million, 78% of which are resources (non-core) to be mobilized through different co-financing modalities. The CP is managed by: the main office in Khartoum, sub-offices in three Darfur states and UNFPA presence in 5 states through one technical officer and administrative/finance personnel accommodated by the States' Ministries of Health.

3. EVALUATION PURPOSE AND SCOPE

Purpose

The purpose of this evaluation is to conduct an end of programme cycle evaluation to assess the achievement of the 6th country programme, the factors that facilitated or hindered achievements, and to compile lessons learned in respect of each of the programme stages to inform development of the next country programme cycle (7th country programme).

The specific objectives of the independent evaluation of the UNFPA 6th country programme for Sudan are to:

a) Examine the soundness of the programme in terms of addressing national needs and gaps vis a vis the UNFPA mandate and comparative advantage;
b) Draw key lessons from past and current cooperation and provide actionable and strategic recommendations for future programming;
c) Assess the extent to which the programme has contributed to the on-going humanitarian and development efforts and provide an analysis of how UNFPA Sudan has positioned itself within the development community and national partners with a view to adding value to the country development results

Scope

Time Period: The CPE will cover activities implemented from 2013 to March 2015.

Geographic coverage: All the nine states (namely Gedarif, Kassala, White Nile, Blue Nile and the five Darfur states) will be targeted, as well as ministries/institutions of the the federal government (national level) involved in the CP implementation..

Programme aspects: The CPE will cover 4 outcomes and 6 outputs of the CPD 2013-2016. The focus will be on both developmental and humanitarian programmes.

4. EVALUATION CRITERIA AND EVALUATION QUESTIONS

Evaluation criteria: The evaluation will be informed by the Evaluation Handbook "How to design and conduct a CPE at UNFPA" and will follow the four OECD/DAC criteria: Relevance, Effectiveness, Efficiency and Sustainability as well as on questions related to strategic positioning: Coordination with UNCT and Added Value.

Evaluation questions: The evaluation team will put together a list of evaluation questions (to be approved by the Evaluation Manager, in consultation with the ERG) addressing the following topics/issues:

Relevance

1. To what extent the Country Programme addressed national priorities and needs of population vis-à-vis the UNFPA mandate and comparative advantage?
2. To what extent has the country office been able to respond to changes in the national development context and, in particular in relation to the humanitarian crisis in Darfur

Effectiveness

3. To what extent has the country programme contributed to improving quality and affordability of RH services particularly the management of delivery and its complications including the surgical repair of obstetrical fistula?
4. To what extent have UNFPA supported interventions contributed (or likely to contribute) to a sustained increase in use of demographic and socio-economic information and data in the evidence-based development and implementation of plans, programs and policies to (improve access to Reproductive Health Services including in areas associated with gender equality, population dynamics and HIV/AIDS)
5. Has the UNFPA support in the area of gender equality contributed to women empowerment and reduction of some forms of gender based violence especially in war-affected settings?
6. To what extent has UNFPA ensured that the needs of young people have been taken into account in the planning and implementation of UNFPA-supported interventions under the country programme?

Efficiency

7. To what extent did the intervention mechanisms (funds, expertise and timing) foster or hinder the achievement of the programme outputs?

Sustainability

8. To what extent has UNFPA been able to support its partners and the beneficiaries in developing capacities and establishing mechanisms to ensure ownership and the durability of effects?

Coordination

9. To what extent were the programme coordination mechanisms effective to boost the programme implementation and achieve better results;
10. To what extent did UNFPA contribute to the existing coordination mechanisms in the UN system in Sudan?

Added Value

11. What are the main comparative strengths of UNFPA in Sudan – particularly in comparison to other UN agencies in the Country?

5. EVALUATION METHODOLOGY

Data collection

The evaluation will consider both secondary and primary sources for data collection. Secondary sources are desk review primarily focusing on programme annual reviews, progress and monitoring frameworks/reports as well as facility records/registers. Thematic evaluations reports and findings of assessments conducted during the current CP shall also be considered. As for the primary sources, semi-structured interviews with key informants at national and state levels as well as focus group discussions with beneficiaries and field visits observations shall be conducted as appropriate.

Validation mechanisms

To ensure the validity of the data collected, the Evaluation Team will use a variety of methods. Besides a systematic triangulation of data sources and data collection methods and tools, the validation of data will be sought through regular exchanges with the CO programme managers; technical officers at national and field levels and members of the evaluation reference group.

Stakeholders' participation

The Evaluation Team will consider the participation of partners and stakeholders in the evaluation process. This includes direct and indirect partners (government, NGOs and CBOs) and the programme beneficiaries at national and sub-national levels. This inclusive approach is important to generate diverse views on the programme performance and expected outcomes.

6. EVALUATION PROCESS

The evaluation process can be categorized under five stages as follows:

Preparatory phase

This phase will include:

- the nomination of the evaluation manager by the CO
- the constitution of the ERG

- the drafting of terms of reference for the evaluation;
- the gathering of initial documentation regarding the country programme (including a list of Atlas projects);
- the selection and recruitment of the evaluation team

Design phase

- *Documentary review*: all relevant documents (listed in annex 1) shall be made available to the evaluation team for review;
- *Stakeholders mapping: Identification of partners and stakeholders* to be visited for the purpose of the evaluation;
- *Configuration of the programme* based on the intervention logic and theory of change; are the planned activities relevant to intended results to be achieved?
- *Identification of key performance measures* and its effectiveness to guide the judgment on the programme performance;
- *Development of the evaluation questions* based on the evaluation purpose and criteria;
- *Identification of appropriate methods and tools* for data collection and the development of a concrete work plan for the field phase.

Field work phase

During this phase the Evaluation Team will collect data from relevant sources based on the pre-set evaluation questions. Following this, the team is expected to provide a debriefing report which is comprised of preliminary findings and results as well as tentative conclusions and recommendations.

Analysis and report writing phase

In this phase, additional inputs from the debriefing together with other information coming from the analysis of collected data are expected to feed into the development of a first draft of the final evaluation report. This draft will be submitted to the ERG for review and comments which will then allow the Evaluation Team to make the second final draft.

The second draft of the final evaluation report will be disseminated in a workshop attended by the CO staff and stakeholders including the key national partners. Inputs and comments arising from the discussion shall form the basis for making the final report.

Dissemination and follow-up phase

During this phase, the country and regional offices as well as relevant divisions at UNFPA headquarters will be informed of the results of the evaluation. The evaluation report, accompanied by a document listing all recommendations will be communicated to all relevant units within UNFPA, with an invitation to submit their response. Once filled, this document will become the management response to the evaluation (cf. Annex 3).

The evaluation report, along with the management response, will be published in the UNFPA evaluation database. The evaluation report will also be made available to the UNFPA Executive Board and will be widely distributed within and outside the organization.

7. INDICATIVE TIMEFRAME

Phases/deliverables	Dates
1. Preparatory phase ▪ *The nomination of the evaluation manager by the CO* ▪ *the constitution of the ERG* ▪ *the drafting of terms of reference for the evaluation;* ▪ *the gathering of initial documentation regarding the country programme (including a list of Atlas projects);* ▪ *the selection and recruitment of the external evaluator*	November 2014 – March 2015
2. Design phase *Submission of the design report*	April 2015
3. Field Phase	April – May 2015
4. Reporting phase - *1st draft final report - 2nd draft final report - Stakeholder workshop - Final report*	June – August 2015
5. Dissemination phase	September 2015

8. EVALUATIOIN DELIVERABLES

The evaluation team will submit the following deliverables:

Design report — a design report (a maximum of 30 pages) will be prepared by the evaluators before going into the evaluation exercise. It is intended to reflect why and how each evaluation question will be answered by way of: proposed methods, sources of data, and data collection procedures. The report should include a proposed schedule of tasks, activities and deliverables. The report enables the Evaluation Reference Group (ERG) and Evaluation Manager to have common understanding about the evaluation objective, expected results and methodology as well as spelling out the division of labor among the Evaluation Team.

Draft final evaluation report — the draft report should be submitted within four weeks after submission of the inception report. The EMC, ERG and UNFPA CO staff will review the draft report to ensure that the evaluation meets the required quality standards as per UNFPA evaluation guidelines.

Dissemination workshop — an evaluation brief on key findings, conclusion and recommendations shall be presented to stakeholders and partners in a one day workshop to be arranged by the UNFPA Sudan CO.

Final report (50 – 70 pages) – the required layout/structure is found under annex 3. The final evaluation report (electronic version) is required one week following the dissemination workshop and approval of the draft report by the ERG.

All deliverables will be drafted in English. The power point presentation for the dissemination seminar will be translated into Arabic language. Final CPE (electronic version) will be disseminated to all partners after submission by the evaluation team.

DELIVERABLE	CONTENT	TIMING	RESPONSIBILITIES
Design Report	Evaluator provides clarifications on methodology, tools, work schedule	April 2015	Team leader with support from technical experts
Debriefing workshop	Initial Findings	June 2015	Evaluator needs to carry out a validation session for UNFPA Sudan's partners and Programme staff immediately after the field data collection and before leaving the country.
Draft of the Final Report[5]	Full report	July 2015	Evaluators send the draft of the final report to the UNFPA Sudan. The Evaluation Manager shares the draft report with the Evaluation Reference Group for comments.
Final Report	Revised report	August 2015	The Evaluator submits a final report incorporating UNFPA staff and implementing partners comments
Power point presentation summarizing the key findings, conclusions and recommendations	Not more than 20 slides, to be submitted together with the final report and to be used for dissemination workshop.	September 2015	Evaluation manager

[5] the evaluation report **should not** be shared outside of UNFPA before it is **final**

9. Management of the Evaluation

The CPE management structure includes an evaluation manager; an evaluation reference group and the evaluation team. Their roles and responsibilities are:

9.1. Evaluation Manager

Under the overall guidance of the UNFPA Representative for Sudan, the M&E Analyst will act as the evaluation manager to oversee the entire process of the CPE. He will receive technical support and guidance from the regional M&E adviser to:

- Prepare the Terms of Reference (ToR) for the evaluation
- Identify potential evaluators and submit them to the Evaluation Office for pre-qualification
- Compile a preliminary list of background information and documentation on both the country context and the UNFPA country programme;
- Constitute an evaluation reference group
- Prepare a first stakeholders mapping of the main partners relevant for the CPE and the Atlas project list.

9.2. Evaluation Reference Group (ERG)

As per the UNFPA's evaluation handbook, an ERG will be put in place and tasked to provide guidance and constructive guidance and feedback on implementation and products of the evaluation, hence contributing to both the quality and compliance of the exercise. Throughout the process of the evaluation, the ERG will be regularly invited to discuss and comment on notes and reports produced by the evaluation team.

Members of the ERG are also expected to facilitate the evaluation team's access to information sources and documentation on the activities under evaluation. They will specifically:

- Provide input to the ToR;
- Contribute to the selection of the evaluation questions
- Provide comments on the design report;
- Facilitate access of evaluation team to information sources (documents and interviewees) to support data collection;
- Provide comments on the main deliverables of the evaluation including the draft and final report;
- Advise on the quality of the work done by the evaluation team;
- Ensure that quality standards are reflected in the final evaluation draft;
- Assist in feedback of the findings, conclusions and recommendations from the evaluation into future programme design and implementation.

9.3. Evaluation Team

The Evaluation Team will consist of 3 technical experts as described below:

Evaluation Team Leader (International), with overall responsibility of providing guidance and leadership in: preparation of evaluation design, schedule and methodology, inception, draft and final reports as well as brief summary for presentation to the dissemination workshop. Due to lack of appropriate national expertise in the area of Population and

Development (PD), the team leader is also requested to collect, analyze data and report on UNFPA support to the PD under two Country Programme Outputs (Population Dynamics and Data Generation).

Reproductive health expert (consultant) will provide expertise in reproductive and maternal health (including family planning, emergency obstetric and newborn care). He/she will be responsible for collection and compilation of data pertaining to RH/FP and HIV/AIDS from both primary and secondary sources. She/he will be responsible for drafting key parts of the design report and of the final evaluation report, including (but not limited to) sections relating to reproductive health and rights.

Gender expert (consultant) to support the team leader and provide expertise on gender equality issues (women and adolescents reproductive rights, prevention of discrimination and violence against women, etc.). Besides her/his technical expertise, the gender expert should have a good knowledge of the context and be fluent in Arabic. She/he will take part in the data collection and analysis work during the design and field phases. She/he will act as a facilitator for the organization and implementation of the field work. She/he will also assist other evaluation team members in the analysis of the documentation in Arabic. She/he will be responsible for drafting key parts of the design report and the final evaluation report, including (but not limited to) sections relating to the national context and gender equality.

Competencies for the Team Leader

- Extensive experience in population and development
- Excellent analytical, writing and communication skills
- Leadership and good management skills
- Ability to work with a multi-disciplinary team of experts
- Excellent problem identification and solving skills
- Excellent written and spoken English Language skills. Knowledge of Arabic is an asset*.

Qualifications and experience of Team Leader

- Minimum of Master's Degree in social sciences, development studies or a related field
- Minimum of 10 year experience in conducting/managing programme evaluations
- Experience in mainstreaming and management of cross cutting themes
- Experience in conducting evaluations in population and development issues;
- Familiarity with the UNFPA work will be an added advantage

Roles and responsibilities of the Team Leader

- Provide overall leadership to the evaluation team;
- Responsible of the assessment of one thematic programme area
- Provide the inputs for quality aspects of the overall process
- Evaluate the UNFPA contribution to population and development as envisaged by the country programme

- Compile the design report with the inputs from national consultants
- Compile draft and final reports including his inputs on population and development and deliver them on time, considering the quality assurance aspects. The team leader will have primary responsibility for the timely completion of a high-quality evaluation that addresses all the items required in this TOR.
- Responsible for debriefing the findings when required
- Liaise with Evaluation Manager particularly on issues related to the evaluation design, field work and reporting;

Competencies for the thematic consultants

- Excellent analytical, writing and communication skills
- Ability to work with a multi-disciplinary team of experts
- Excellent problem identification and solving skills
- Excellent written and spoken English Language skills. Knowledge of Arabic is an asset*.
- Should be able to provide deliverables on time

Qualifications and experience of thematic consultants

- Two thematic consultants one for Reproductive Health and HIV/AIDS and another one for Gender and Gender-Based Violence. Each should be an expert in the relevant thematic area.
- Each consultant should have a minimum of five years of experience in conducting evaluations
- Each consultant should have an experience in conducting evaluations in the relevant thematic area.

Roles and responsibilities of the thematic consultants

- Prepare the design report in accordance with the UNFPA standards
- Evaluate the UNFPA's contribution to the relevant thematic areas of the country programme
- Participate in debriefing meetings
- Deliver quality reports on time

** If none of the team members has Arabic language skills, UNFPA CO will hire gender balanced interpreters with suitable qualifications/backgrounds to accompany the team during the field work.*

Quality Assurance:

AT each step of the evaluation, data collected and reported will go through a rigorous quality assurance mechanism for validation as follows:

- **Design phase**: The design report will be approved by the evaluation manager after contribution from the regional M&E adviser, the EO's evaluation adviser and the ERG as appropriate.
- **Field phase:** During the field phase the evaluation manager will be responsible to ensure that the data collection is in accordance with the approved design report. He

will also ensure that the data collection and recording are consistent across the different evaluators and evaluation components.

- **The final evaluation report** will be reviewed by the regional M&E adviser, the EO's evaluation adviser and the ERG to ensure the reliability of the data collected and reported as well as the overall credibility of the evaluation findings, the soundness of conclusions, and the alignment of the recommendations to the findings and conclusions as well as their feasibility.

10. Evaluation Audience

Findings, lessons learned and recommendations of the CPE shall be used to assess the achievements of the 6th CP and to inform the development of the next Country Program. For transparency and accountability purposes, the CPE report shall be communicated to all stakeholders including national and state level partner governments and civil society organizations and donors. Most of the program partners especially the government are part of the evaluation process either as sources of data (primary/secondary) or through their
representation in the ERG.

11. REMUNERATION AND DURATION OF CONTRACT:

	LoE of team members (in days)		
Evaluation phases	**Technical expert 1 and Team leader*** **(PD)**	**Technical expert 2 (MNCH & RH)**	**Technical expert 3 (Gender)**
Design report	4	4	3
Data collection (fieldwork)	14	21	10
Analyses and report writing	8	10	7
Final report	3	3	2
Dissemination workshop	1	1	1
Total	**30**	**39**	**23**

*: In addition to the number of days required for its technical thematic area, 10 days will be added to the team leader to allow proper coordination of the team of evaluators, ensure quality, finalisation and submission
of all deliverables.

Remuneration timeframes	
- Approval of the design report	20%
- Approval of the draft report	50%
- Approval of the final report	30%

12. EVALUATION ETHICS

The work of the evaluation team will be guided by the Norms and Standards established by the United Nations Evaluation Group (UNEG) available at www.unevaluation.org/ethicalguidelines. Team members will adhere to the Ethical Guidelines for Evaluators in the UN system and the Code of Conduct, also established by UNEG. The evaluators will be requested to sign the Code of Conduct prior to engaging in the evaluation exercise.

Annex 1: LIST OF DOCUMENTATION FOR REVIEW BY THE EVALUATION TEAM

- CP Document 2013 - 2016
- CPAP Document and CPAP Results and Resource Framework 2013 – 2016
- Performance Monitoring Frameworks 2013 & 2014
- COAR 2013 and 2014
- OMP 2013 and 2014
- Resource Mobilization Strategy 2013-2016
- CP Reviews 2013 and 2014
- Outputs Progress Reports 2013 and 2014
- Programme Annual Review Meeting Minutes 2014
- Facility based RHCS Report 2014
- Underlying causes of Fertility Decline in Eastern Sudan
- Annual Budget and Expenditure Reports (2013 - 2016)
- Monitoring reports

Annex 2: DESIGN REPORT OUTLINE — Number of pages

- The design report should use the following template:

CHAPTER 1: Introduction — 1-2 pages max

- 1.1 Purpose and objectives of the Country Programme Evaluation
- 1.2 Scope of the evaluation
- 1.3 Purpose of the design report

CHAPTER 2: Country context — 4-6 pages max

- 2.1 Development challenges and national strategies
- 2.2 The role of external assistance

CHAPTER 3: UNFPA strategic response and programme — 5-7 pages max

- 3.1 UNFPA strategic response
- 3.2 UNFPA response through the country programme
- 3.2.1 The country programme
- 3.2.2 The country programme financial structure

CHAPTER 4: Evaluation methodology and approach — 7-10 pages max

- 4.1 Evaluation criteria and evaluation questions
- 4.2 Methods for data collection and analysis
- 4.3 Selection of the sample of stakeholders
- 4.4 Evaluability assessment, limitations and risks

CHAPTER 5: Evaluation process 3-5 pages max

- 5.1 Process overview
- 5.2 Team composition and distribution of tasks
- 5.3 Resource requirements and logistic support
- 5.4 Work plan
- (Total number of pages) 20-30 pages max

Annexes to the design report outline

- Annex 1 Terms of Reference
- Annex 2 Evaluation matrix
- Annex 3 Interview guides
- Annex 4 List of atlas projects
- Annex 5 Stakeholder map
- Annex 6 CPE agenda
- Annex 7 Documents consulted

Annex 3: **EVALUATION REPORT OUTLINE**

- UNFPA evaluation report should use the following template: **Number of pages**
- EXECUTIVE SUMMARY 3-4 pages max

CHAPTER 1: Introduction 5-7 pages max

- 1.1 Purpose and objectives or the Country Programme Evaluation
- 1.2 Scope of the evaluation
- 1.3 Methodology and process

CHAPTER 2: Country context 5-6 pages max

- 2.1 Development challenges and national strategies
- 2.2 The role of external assistance

CHAPTER 3: UN / UNFPA response and programme strategies 5-7 pages max

- 3.1 UN and UNFPA response
- 3.2 UNFPA response through the country programme
- 3.2.1 Brief description of UNFPA previous cycle strategy, goals and achievements
- 3.2.2 Current UNFPA country programme
- 3.2.3 The financial structure of the programme

CHAPTER 4: Findings: answers to the evaluation questions 25-35 pages max

- 4.1 Answer to evaluation question 1
- 4.2 Answer to evaluation question 2
- 4.3 Answer to evaluation question 3
- 4.4 Answer to evaluation question X

CHAPTER 5: Conclusions 6 pages max

- 5.1 Strategic level
- 5.2 Programmatic level
- CHAPTER 6: Recommendations 4-5 pages max
- Recommendation #1, #2, #3
- (Total number of pages) 50-70 pages

Annexes to the evaluation report

- Annex 1 Terms of Reference
- Annex 2 List of persons/institutions met
- Annex 3 List of documents consulted
- Annex 4 the Evaluation Matrix

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ANNEX 3: List of Documents Consulted

Programme Documents	
	Country Programme Document for Sudan (2012)
	Country Programme Action Plan (2013-2016)
	Country Programme Review (2013)
	Country Programme Review (2014)
	Country Office Annual Report (2013)
	Country Office Annual Report (2014)
	Performance Monitoring Plan (2013)
	Performance Monitoring Plan (2014)
	Annual Work Plans (AWPs) 2013
	Annual Work Plans (AWPs) 2014
	Annual Budget and Expenditure Reports (ATLAS) 2013
	Annual Budget and Expenditure Reports (ATLAS) 2014
	Monitoring and Evaluation System – 6th Country Program (2013 - 2016)
	Country Programme Mid-term Review (2009-2010) Executive Report
	Evaluation of UNFPA 5th Cycle Country Program Report (February 2012)
Country Office Documents	
	Resource Mobilization Strategy 2013 – 2016 (August 2014)
UN Documents	
	United Nations Development Assistance Framework for the Republic of Sudan (May 31, 2012)
	UNFPA Sudan Aligning to the Strategic Plan 2014 – 2017 (October 2014)
Programme Related Reports	
	Multi-Indicators Cluster Survey (MICS) Results 2014
	Sudan Household Survey, 2010; MICS result
Health Related Report s	
	FMOH-RH Directorate-Multi-sector Maternal Mortality Reduction Plan 2013.
	FMOH-RH Directorate-MCH Acceleration Plan (2013-2015).
	FMOH Road Map for Reducing Maternal & Neonatal Mortality in Sudan 2009.
	FMOH-National Health Sector Strategic Plan 2012 – 2016.
	Reproductive Health Strategic plans of the state RH Directorates.
	FMOH-SNAP-National HIV/AIDS Strategic Plan (2015-2017).
	FMOH-RH-Directorate- Communication Strategic Plan for Reproductive Health 2010-2015.
	FMOH- The National Reproductive Health Policy 2010.

	PHC Service in Sudan towards Universal Coverage 2012-2016.
	The Republic of Sudan -Ministry of Welfare & Social Security -National Population Council General Secretariat - Sudan Millennium Development Goals Progress Report 2010.
	FMOH & UNFPA Sudan Facility Based Assessment for Maternal Health Commodities and Services 2014.
	FMOH-PHC mapping 2011
	Sudan, FMOH, 2006, Sudan Household Health Survey, 2006.
	Sudan, FMOH, 2010, Sudan Household Health Survey, 2010.
	Mohamed, Nasr Abdalla, 2015, Research study on fertility in the eastern region of Sudan: trends, rates and determinants. Technical Report. General Secretariat National Population Council, Department of researches.
	Gender
	Abu Al Yaman, S.H., 2009, Final Analysis for Data of National Survey on Violence against Women and Children. Sudan: Ministry of Justice, Unit of Ending Violence against Women and Children.
	Alnadeef, E, 2013, A study on impact of implantation of FGM abandonment Laws in Gadaref, South Darfur and South Kordofan. Women Human Rights Center, Ministry of Welfare and Social Security. (Research supported by UNFPA).
	Badri, Balghis, Gindeel, R. and Bushra, H. Baseline Study to Develop Indicators for FGM abandonment. AUW, GRACe and UNFPA.
	Badri, etal, 2009, Survey of Women's Political Participation in Eastern Sudan (Red Sea, Kasala Gadanf). Report submitted to UN Women and Partners in Development Services, Khartoum, Sudan.
	Sudan, Combating Violence against Women Unit, (nd) Draft of national policy for combating violence against women.
	Badri, Nafisa and Hussein, Tibyan , 2014, Exploring stakeholders and activists perspectives on effective interventions for combating child marriage : What works and What does work. AUW, GRACe and UNFPA.
	Gamal El Deen, Ahmed and Hussein, Faiza, 2014, Discussing and deciding on FGM/C: Decision making Processes within families of differently backgrounds experiences and Positions in Khartoum State. Sudan: AUW, GRACe and UNFPA.
	Grace and UNFPA, 2014, Small Scale Survey on Youth Knowledge Perceptions and Attitude about Maternal Health, Early Marriage and Gender Based Violence. GRACE Research Brief N 3.
	Grace and UNFPA, 2014, To DO it or not to Do it: decision- making process on Female Genital Mutilation among Sudanese Women. GRACe Research Brief No 1.
	GRACe, 2014, Training manual on gender and reproductive Rights. Grace, AUW, and UNFPA.
	Population Dynamics
	Central Bureau of Statistics, 2009, Sudan National Budget Household Survey, 2009.
	Central Bureau of Statistics, National Baseline Household Survey 2009, Northern Sudan: Key Findings.
	Sudan: Central Bureau of Statistics, 2008, Fifth National Population Census, 2008.
	Mahmoud, M.M, 2009, Population growth and the state of labour Force in Northern Sudan. Data Dissemination Conference; The Fifth National Population Census. Sudan: Ministry of Cabinet, Central Bureau of Statistics.

	Ministry of Welfare and Social Security, 2010, National Population Council general Secretariat, Sudan Millennium Development Goals Progress Report.
	National Population Council, General Secretariat, 2013, Sudan Position on ICPD beyond 2014.
	Sudan, Ministry of Welfare and Social Security, UNDP and University of Gezira, 2012, Sudan national human development report 2012: geography of peace: putting human development at the center of peace in Sudan. New York: UNDP
	Sudan, Ministry of Human Resources and Labor, 2011, Labor Force Survey, 2011.
	National Population Council, 2013, Sudan position paper on ICPD beyond, 2014.
	See the IMF, 2013, Sudan interim poverty reduction strategy paper, IMF, Country Paper, 13/318
	EL Nagar, Samia, 2014, Youth in Khartoum State. Unpublished memo
	El Nagar, Samia, El Tigani, Limya and Abdel Atti, Hassan, 2011. Population Situational Analysis, Report submitted to UNFPA.
	Sudan: Central Bureau of Statistics, 2009, Key Findings: National Baseline Household survey 2009, Northern Sudan. Sudan: Ministry of Council of Ministers, Central Bureau of Statistics and Ministry of Finance.
	UNDP, 2014, Human Development Report, 2014: Sustaining Human Progress: sustaining vulnerabilities and building resilience. New York: UNDP
	Youth
	Elias, A.H., 2008 (a), Research Report on Youth Issues and Needs in the Sudan (Case Study: Kasala state). Sudan: UNFPA.
	Elias, A.H., 2008 (b) Research Report on: Youth Issues and Needs in the Sudan (Case Study Gadaref State). Sudan: UNFPA.
	General Directorate of Youth, Five-year Plan. 2012-2016 Khartoum: Ministry of Youth and Sports.
	Sudan: Ministry of Youth and Sports, 2011, the National Youth Strategy 2007-2031
	Sudanese Population Network, 2012, Report of assessment of the training program for youth institutions, organizations, centers focusing on leadership, management and advocacy. White Nile, Gadaref and Kassala States.(The Sudanese Network, UYNFPA and Higher Council of Youth and Sports).

ANNEX 4: CPE Evaluation Matrix

<table>
<tr><th colspan="4">RELEVANCE
EQ1: To what extent the Country Programme addressed national priorities and needs of population vis-à-vis the UNFPA mandate and comparative advantage?</th></tr>
<tr><th>Assumptions to be assessed</th><th>Indicators</th><th>Sources of Information</th><th>Methods and Tools for data collection</th></tr>
<tr>
<td>Within the framework of UNFPA mandate, the Country Program Document addresses national priorities and needs of population especially those ‘most at risk’.

AWPs effectively translate CPD into activities that addressed national priorities and needs of target population.</td>
<td>o Evidence of a wide consultative process inclusive of federal, state, civil society/community level stakeholders by thematic area.
o Evidence that UNFPA thematic support was designed based on needs assessments of government, partners and population surveys prior to the programming
o The selected target groups for UNFPA supported interventions were addressed as national priority groups.
o Extent to which interventions planned in AWPs accurately reflect interventions identified in CPD.</td>
<td>o CPD, CPAP and AWPs
o National RH policy/National RH strategic plan, Sudan National HIV/AIDS Control Policy, Multi-sector Maternal Mortality Reduction Plan 2013.
o Needs assessment studies
o Stakeholders’ feedback</td>
<td>o Documentary review (program documents and related research and surveys)
o Interviews with UNFPA CO staff
o Interviews and group discussions with implementing partners (gov and ngos)
o Focus groups with trainees’ beneficiaries.</td>
</tr>
<tr><td colspan="4"><u>FINDINGS:</u>
- The UNFPA CP 2013-2016 is relevant to the national policies and strategies, and takes into consideration the priority needs of the population and institutions identified in the planning process.
Population Dynamics: UNFPA interventions are aligned to the national policies and plans such as the National Population Policy, reviewed 2012, and the Strategy for Development of Statistics.
The component is based on the lessons learned from the UNFPA support to the 2008 National Census.
UNFPA interventions in Youth take account of the National Youth Strategy.
The planned activities were identified by intensive consultation with the youth- serving institutions, at the federal and state levels.

- Sexual and Reproductive Health: The Country Programme addressed the national and state SRH priorities and needs of the population.
UNFPA interventions were preceded with baseline surveys and assessments of needs, and institutional capacity assessment of implementing partners both at the federal and state levels.
Information-based programme which tallied with the national needs and priorities as developed in: Sudan National Health Sector Strategic Plan 2012-2016; MCH Acceleration Plan 2013-2015; PHC Service in Sudan towards Universal Coverage 2012-2016; Reproductive health strategy (RH Strategy 2009) and policy (RH Policy 2010); Costed Road map for reduction of maternal and newborn mortality 2010-2015); Multi-sector Maternal Mortality Reduction Plan 2013 and Reproductive Health Strategic Plans of the State RH Directorates.</td></tr>
</table>

CP relevant and addressed the needs and priorities of the vulnerable groups such as PLWHA, MARPs, refugees, IDPs, women in the reproductive age, youth and adolescents in the underserved localities.
Some RH needs were inadequately addressed in the current CP such as infertility, post-menopausal care, and Ca cervix and other reproductive organ cancers mainly because of lack of solid information while others are newly arising issues.

Gender Equality: UNFPA programme interventions take account of the National Women Empowerment Policy, 2007, and its plan of action, the FGM Abandonment Strategy, 2008-2018, and the National Plan of Action for Combating Violence against Women, 2012-2016.
The Gender component took into consideration the Women Movement's concerns for child marriage and FGM abandonment and law reform for promoting gender justice.

RELEVANCE

EQ2:To what extent has the country office been able to respond to changes in the national development context and, in particular in relation to the humanitarian crisis in Darfur

Assumptions to be assessed	Indicators	Sources of Information	Methods and Tools for data collection
UNFPA Country Office was responsive to *emerging needs* of humanitarian nature and national development issues.	○ Evidence of humanitarian assistance extended to war affected and displaced populations specifically in Darfur. ○ Extent to which the response was adapted to emerging needs, demands and national priorities of government counterparts and implementing partners. ○ Emergency preparedness response plans and commodities.	○ Emergency Preparedness and Response Plans (EPRPs). ○ AWPs ○ APRs ○ UNFPA staff (central and state) ○ Government counterparts, State ministries and civil society implementing partners.	○ Documentary review ○ Interviews with UNFPA staff and government counterparts ○ Interviews and group discussions with implementing partners in Darfur and other war-affected localities (camps) ○ Site visits/observation

FINDINGS:

- Adequacy of the UNFPA Country Programme response to the emergency needs of IDPs and refugees in the war affected states and other states affected by natural disasters such as the floods which occurred during the current CP cycle.

UNFPA program interventions in the humanitarian settings are based on the needs assessment undertaken by the international community in collaboration with the government.
Project director from South Darfur: "whenever we have new influx of displaced people, the UNFPA office responds quickly to the needs, specifically the supply of dignity kits".
UNFPA is the lead agency for the GBV working groups in Darfur states.
UNFPA adequately responded to the emerging needs of IDPs and refugees specifically for GBV survivors and refugees from neighbouring countries such as South Sudan and Ethiopia.
The UNFPA country office has adequately responded to emerging RH issues in the war affected states and other states affected with natural disasters i.e. floods during the current cycle.

MSIP training of RH partners
Emergency Preparedness and Response Plan (EPRP) for each State.
Prepositioning and storage of RH Emergency Kits.
The UNFPA CO response to RH emerging issues was hindered by continuous re-location of the refugees' camps.

EFFECTIVENESS II: Extent or Likelihood of Output contribution to UNFPA programme outcomes

Q3. To what extent has the country programme outputs contributed to improving quality and affordability of RH SERVICES particularly the management of delivery and its complications including the surgical repair of obstetrical fistula?

Assumptions to be assessed	Indicators	Sources of Information	Methods and Tools for data collection
Comprehensive, gender-sensitive, high-quality reproductive health services are available and accessible in underserved areas with a focus on young people and vulnerable groups.	○ Inclusion of RH services within the annual plans of Federal & targeted State Ministries of Health ○ Integration of Essential reproductive health services package (including Emergency obstetric and neonatal care, and post unsafe abortion care) within PHC services. ○ Evidence of capacity building of RH program management at both the federal and state level. ○ Gender sensitive outreach services training are developed and institutionalized. ○ Services providers' capacity is developed in conducting gender sensitive outreach services.	○ Federal and state reproductive health plans. ○ Federal and state PHC plans. ○ Training modules and reports. ○ Field visits to PHC, RH centers and tertiary hospitals ○ Monitoring reports	○ Documentary review ○ Meetings with PHC, RH concerned bodies at the federal and state levels. ○ Interviews with health care providers at the primary and tertiary levels. ○ Focus group discussions with RH service providers, users and cases of obstetrical fistula.
The national systems for reproductive health commodity security and for the provision of family planning services have been strengthened and adequately functioning.	○ The national system for RH commodity security system has been strengthened and adequately functioning. ○ Strengthening and standardization of the logistics management information system. ○ Capacity building of the health cadres & statisticians RHCS and LMIS at both the federal and state	○ CPRs ○ Monitoring reports ○ Training reports on RHCS and LMIS ○ Field visits.	○ Documentary analysis ○ Meetings with RH concerned bodies at the federal and state levels. ○ Interviews with health care providers at the RH centers. ○ Interviews with FP users

	level.		

FINDINGS:

CP Output 2

- The CP was effective in contributing towards increased demand for information and service-related to RH, maternal and newborn health and HIV.

Advocacy and Community Dialogue: Increased political commitment of the government is reflected in the incorporation of maternal health services within the Primary Health Care Expansion Project and mobilization of additional resources at both federal and state levels.

The Government of Sudan has committed budgets for $9 million in 2014 and $40 million in 2015 for the Primary Health Care Project and to support the midwifery profession (basic training, kits, equipment to schools, emergencies), EmONC (rehabilitation of rural hospitals), and ANC services.

The Government has pledged its political commitment to include the graduated community/village midwives on the government payroll and the Presidency advised state governments to account for this commitment in their yearly budget plans.

Community Sensitization, Mobilization and Behavioral Change Communication: The distribution of condoms among the FSW and MSM has markedly increased and this is indicative of increased demand but no grantee for the condom use.

Interviewed partners in the UNFPA-targeted states have confirmed increased responsiveness to HIV-related BCC messages delivered to the target vulnerable groups and their peers.

Initially trained MSM and FSW refer their clients and peers for counselling and testing.

The NGOs and civil society organizations engaged in behavioural change communication at the community level on gender, RH, early marriage and HIV/AIDS prevention is 60 exceeding the CP end of programme indicator target of 26.

The training was competency-based with application of innovative methods like real life demonstration, case studies, group discussions, role play, and interactive discussion between the trainees and trainers

The number of IGA/life skills projects to MARPS in year 2013 and 2014 amounted to 492 while the number of IGA/life skills projects to PLWHA amounted to 306

CP Output 3

UNFPA programme support has effectively improved the delivery of integrated RH, EmONC and fistula repair services in the UNFPA-targeted states. Case finding for fistula is still a challenge.

Integrated RH services: At the federal ministerial level, the CO managed to bring together the Federal Ministry of Health (FMoH) and Ministry of Welfare and Social Security (MoWSS) to work jointly on maternal mortality reduction and FGM, which was a key policy breakthrough for establishing inter-sectoral work within the Government systems.

Country Programme support led to an increase in the number of PHC facilities providing integrated services on sexual, RH, HIV and STIs to 37 PHC facilities.

High costs of operating the mobile clinics might jeopardize future continuity of these services if support is not continued.

EmONC Services: Country Programme rehabilitation of the BEmONC facilities resulted in an increase of 30 percent and the rehabilitation of the CEmONC facilities resulted in an increase of 26 percent in the UNFPA-targeted states.

Midwifery Services: The midwifery curricula and manuals on Basic Obstetric Care (BoC - participants and facilitators) were updated, tested, validated, endorsed, printed and disseminated and used for in-service training of the midwifery cadres.

UNFPA support included 10 midwifery skill laboratories. Field visits and field observation confirmed that the visited skill laboratories were functional.

Three hundred and forty three midwifery candidates were fully supported during the current country programme and mostly returned to their villages to provide community-based services.

UNFPA support resulted in the establishment of community-based structures and new referral pathways to service delivery points for GBV survivors, fistula and complicated emergency obstetric cases.

Fistula Repair Services: The CP has supported the repair of a total of 231 cases of fistula which amount to 23.1 percent only of the CP end of programme indicator target of 1000.

CP Output 4

Country Programme support has effectively improved the logistics management information system for RH commodity security at the state and locality levels, utilization of facility-based family planning services and initiation of community-based family planning distribution.

Capacity building of the facility-based and community-based health care providers has contributed to improve the availability and accessibility of quality family planning services. The number of health care providers trained on family planning amounted to 1,267 which is 42.2 percent of the indicator target of 3000.

The logistics management information system for RH commodity security is functioning effectively. The supplies from the federal level were regular and continuous.

Gedaref State has achieved no significant increase in the number of new users of family planning methods, either due to problems associated with the reporting system or an insufficient level of CP interventions.

The delivery of services to the end beneficiaries has been constrained with difficult transport of the village midwives to receive FP commodities from the locality level.

Integration of Programme Support: the current CP has made strides to integrate health related activities and programme support with the aim to improve programme assistance efficiency.

EFFECTIVENESS II: - Extent or Likelihood of Output contribution to UNFPA programme outcomes

EQ4.To what extent have UNFPA supported interventions contributed (or likely to contribute) to a sustained increase in use of demographic and socio-economic information and data in the evidence-based development and implementation of plans, programs and policies to (improve access to Reproductive Health Services including in areas associated with gender equality, population dynamics and HIV/AIDS).

Assumptions to be assessed	Indicators	Sources of Information	Methods and Tools for data collection
UNFPA programme contributed to development of a functional integrated information system for formulation, monitoring and evaluation of national and sectorial policies UNFPA contributed to the integration of population dynamics, reproductive health and gender-equality into development planning at national, sectorial and local levels	○ Policy frameworks and protocols for production and integration of population dynamics, reproductive health and gender in development planning are in place and operational. ○ Extent of implementation of plan for capacity building; ○ Extent of implementation of Plan of Action for National Population Policy; ○ Formulation and operationalization of Strategy for Development of Statistics at national and state level; ○ Difference in contributions of professionals and units trained to	○ AWPs ○ UNFPA reports ○ Sectoral Plans ○ Multi-Indicator cluster Survey report ○ Annual reports from NPC and CBS ○ Need assessment, evaluation and monitoring reports ○ CBS Staff and Publications ○ National Population Council staff and publication Council ○ Relevant Stakeholders	○ Documentary review and analysis ○ Interviews with UNFPA CO and P &D officers ○ Interviews and focus group discussions with federal, state IPs and NGOs. ○ Focus group with staff trained

	apply integration methods and tools; o Gender disaggregated data produced, analyzed and utilized at national and sectorial levels; o In-depth, policy-oriented studies released o Large-scale population surveys conducted, disseminated and results utilized for planning; o Database for planning and monitoring established at national and state levels; o Number of national and sectorial plans incorporating population, reproductive health and gender issues; o Inter-linkages between data producers and data users operational		

FINDINGS:

CP contributed to improving national and state capacities for integrating population dynamics through the revised National Population Policy and its Plan of Action.

The technical support provided by UNFPA, enabled the National Population Council (NPC) to formulate the Plan of Action (PoA) for the revised National Population Policy (NPP).

The NPC further succeeded in leading the integration of the population dynamics in the National Strategic Development Plan and in facilitating the alignment of the visions, mission and policies of some sectorial ministries to the revised NPP.

The production of the Sudan National Population Situation Report, 2013, is an achievement as it availed data on important indicators needed for planning and monitoring.

There are some hindering factors, such as the limited capacities of middle level cadre in the NPC; the limited understanding at the state level for the significance of the population dynamics to development, and the limited support to states' population councils.

CP support through advocacy, policy dialogue and population education has improved understanding of the importance of population issues/dynamics.

Production of policy briefs (on youth, environment, maternal mortality and fertility), as advocacy tools. The tools are not yet used to identify specific results.

Advocacy, orientation sessions and policy dialogue on population issues, the MDGs and the ICPD Beyond 2014, improved understanding of the importance of population dynamics for policy makers, parliamentarians, religious leaders and media figures at national and state levels.

UNFPA support enabled the NPC to respond to the international ICPD 2014 survey, to prepare the position paper and the Sudan ICPD review report.

Country Programme contributed to the improvement of data quality, production and availability through enhancement of human resources capacities, development of tools, techniques and strategies for the collection of population data.

A National Strategy for Development of Statistics (NSDS) and the statistical protocols (National Statistics Act, National Compendium) were developed and used.

Capacity building of 208 statistics personnel enabled CBS to collect and produce quality data for the production of the National Baseline Household Survey 2014, and support data collection for UNICEF Child Friendly Village survey.
The study tours enhanced the knowledge of the statisticians trained, and promoted the confidence for applying the skills acquired.
The National Users Committee was formed with clear terms of reference, but it is not yet operational.
CBS has developed the capacity to collect and analyze qualitative data in humanitarian settings.
Collection and availability of data from locality and administrative levels remains a challenge.

EFFECTIVENESS II: Extent or Likelihood of Output contribution to UNFPA programme outcomes

EQ5. Has the UNFPA support in the area of GENDER equality contributed to women empowerment and reduction of some forms of gender based violence especially in war-affected settings?

Assumptions to be assessed	Indicators	Sources of Information	Methods and Tools for data collection
Technical capacity of national institutions and NGOs related to women empowerment and gender equality is increased. Policies, strategies and laws that are gender sensitive and responsive are endorsed and or institutionalized Improved institutional capacity to prevent and respond to needs of women and girls affected by GBV, in particular in emergency situation	○ Difference (new initiatives) contributed by trained staff in government institutions, NGOs and universities ○ Extent of application of Plan of Action for ending VAW ○ Increased number of and impact of public Declarations for FGM abandonment ○ Increased involvement of religious leaders in FGM abandonment media campaign ○ Extent of implementation of EVAW Action Plan ○ Number of new laws discussed or adopted at concerned ministries and parliamentarian committees ○ Progress in design of child marriage strategy ○ The national women's empowerment strategy is reviewed, updated, and operational ○ Capacities of the national institutions and NGOs in GBV prevention are developed ○ Tools and guidelines for rehabilitation and reintegration	○ Laws related FGM, family law and GBV ○ Work plan for execution of the National Women Empowerment Plan ○ AWP and annual reports ○ Mid-term review reports ○ IPs (government, NGOs, and universities) ○ UNFPA/ CO staff ○ Gender related stakeholders	○ Documentary review ○ Review and analysis of recent legislation ○ Review of recent relevant ministry policies and strategies ○ Interviews with concerned Ministry project coordinators other relevant staff ○ Group meeting with UNFPA related projects managers and project teams ○ Focus Group Discussion with trained men and women of support groups ○ Interviews with NGO activists ○ Review of developed materials (tools, manuals, strategies, action plans, and guidelines) ○ Field visit to GBV centers and meeting with service providers(men and women) ○ Field visit to women centers (in IDPS camps Darfur and in Gadaref) and meeting with targeted women and men benefiting from the programme ○ Interview and group discussion with universities' project coordinators,

	interventions of GBV survivors developed, tested and disseminated o Difference in type and numbers of advocacy activities supporting GBV conducted by different concerned parties o Gender considerations of support groups and social health providers of GBV survivors. o New initiatives of GBV and community protection and watch dog' groups o Extent of integration of gender in RH interventions (midwifery curricula, trainees understanding of gender)		trainers and partner NGOs o Group discussion with GBV support group

FINDINGS:

CP support was effective in raising awareness on the need for gender mainstreaming in national plans. Coordination with relevant ministries is still needed to effectively actualize this integration.

UNFPA support to the General Directorate of Women and Family raised the awareness of planning directors at the line ministries for gender sensitive plans,

Interventions started an important momentum for promoting gender equality, and plans for follow-up activities were put with the ministries reached but the activities were later discontinued.

Activities are not well-coordinated with the relevant sectors to address maternal health issues properly.

CP contributed to enhanced awareness and commitment for abandonment of FGM and early child marriage. Al Mawada Wa Rahma initiative needs additional support to improve implementation coherence and follow up strategies on community declarations for abandonment.

The National Task Force (NTF) for FGM and CM abandonment is operational.

More than 399 trained religious leaders are engaged in raising awareness on FGM and CM abandonment, specifically through mosques, and half of them made public declarations delinking FGM from Islam.

The community mobilization and education resulted in 48 community declarations for FGM and CM abandonment. The challenge is in how the mobilization for declaration is implemented. A religious scholar supporter of abandonment noted: "when mobilization is done quickly in a few days, the declaration for abandonment is unlikely to be effective and it is voiced for pleasing actors/initiators of the intervention, but if intensive awareness raising is done, the declaration can become a real commitment".

GRACe is functioning effectively, conducting research, designing training manuals, undertaking training of trainers, and managing a consortium including seven of UNFPA implementing partners. Still GRACe trainers are not recognized or engaged by the implementing partners at the states and their training does not include the "Mawada and Rahma" messages.

Trained midwives and community leaders are leading the campaigns for FGM and CM abandonment at the community level.

19 CBOs (women, grandmothers and youth protection groups),established at the communities reached by implementing partners, are engaged effectively in community education on RH, MM, gender and GBV and in monitoring of the commitment to the abandonment of FGM and CM.

Politicians, community and religious leaders in Gedaref (Dokka) State, Blue Nile and Khartoum states were oriented by the DoWF on the gender issues, RH, MM, FGM and CM abandonment from "Al Mawada Wa Rahma" perspective. This orientation was done from the federal level directly to the community.
Some of the UNFPA implementing partners at the state level, such in Gedaref State, confirmed that they are not aware of the 'Al Mawada Wa Rahma' discourse and are not using it.
The UNFPA support enabled the General Directorate of Women and Family to engage the sectoral ministries for the formulation of a multi-sectorial plan for the reduction of MM.
The methodology of training (the presentation of papers), is not adequate for skill building, and the activities' report does not explain how these skills are applied.

Country Programme supported the formulation of policies, strategies and drafting of laws in support of banning FGM, CM and sexual violence with limited results in terms of law adoption at the national level and law enforcement.
Politicians, parliamentarians, lawyers, judges, police, and media in 5 states voiced their commitment for law reform or enactment, and their support for the FGM and CM abandonment.
The NCCW was successful in drafting a national law for banning FGM.
The Combating of Violence against Women Unit drafted the National Policy for Combating VAW, 2015-2030.
UNFPA support for studies, advocacy, debates and trainings for reform/drafting of laws addressing FGM and child marriage has limited results as the laws that were formulated for FGM abandonment are not yet enforced; and the national FGM abandonment law and CM abandonment strategy are still in the form of drafts.

CP contributed to increased awareness on the GBV and improved institutional capacities and response to the needs of GBV survivors, in emergency situations.
UNFPA-support targeted a wide range of stakeholders, governmental and non-governmental**, c**ommunity leaders, (youth, men and women), paralegals, CBOs women and youth protection groups.
Assistance and services for GBV survivors such as in South Darfur are provided through the health centers specifically in IDP camps.
Women centers established at the community level have become' safe social spaces' for providing GBV survivors with the first line of assistance.
In White Nile State, service providers, community leaders, and trained social workers are working on case identification and provision of care and protection for GBV survivors.

- Hindering factors for the GBV activities: "Almawada and Rahma" messages are not integrated with Saleema discourse; the messages of "Al Mawada and Rahma " are not yet used at state level; follow-up to the activities of CBOs and protection groups established at community level is not adequate; there are no clear strategies and plans to follow up on the declarations for the FGM abandonment; multiple government institutions concerned in the advocacy, raising awareness and implementation of the laws related to gender based violence, FGM and CM which creates confusion as to roles and responsibilities.

EFFECTIVENESS II: Extent or Likelihood of Output contribution to UNFPA programme outcomes
EQ6. To what extent has UNFPA ensured that the relevant needs of YOUNG PEOPLE have been taken into account in the planning and implementation of UNFPA-supported interventions under the country programme?

Assumptions to be assessed	Indicators	Sources of Information	Methods and Tools for data collection
Improved knowledge, information and services for young people, with a	○ Life skills RH curriculum are developed and used	○ Youth National Strategy doc ○ AWPs and annual reports	○ Documentary review ○ Interviews with UNFPA CO

focus on societal and community mobilization and evidence-based advocacy and policy dialogue	○ Increase in youth and Y-Peer centres and new initiatives for engagement of youth (dialogues, forums) ○ Extent to which youth centres are functional ○ Extent to which youth are engaged in management of youth institutions ○ Extent to which young people are engaged in training and advocacy for RH, HIV/AIDS and gender equality	○ Mid-term Review Reports ○ UNFPA CO staff ○ IPs (government, NGOs, and universities) ○ Youth Centres Management at States	○ Interviews and group discussion with IPs ○ Focus group discussions with trainees. ○ Site visits / observation - youth centres

FINDINGS:

UNFPA CP has contributed to youth empowerment and engagement of youth in community education on maternal health and gender specifically GBV related issues.

22 youth centers rehabilitated with UNFPA support have become 'social spaces' for male and female youth engagement, hosting dialogue sessions, youth forums, community educational sessions, and cultural events such as the case of Salamnat Albeih Youth Center in Gadaref.

UNFPA support helped well- established youth organizations, such as Community-Friendly Association (CAFA), and Friends of Peace and Development Organization (FPDO) to strengthen their engagement at the community level.

Training on 'life skills' and 'know about your business' contributed to the employability of some of the trained youth, 20 percent of those trained are self-employed.

Trained female and male youth have engaged with other youth at the localities and villages level in sports, youth day celebrations, music and theatre events.

Y- Peer groups in 5 UNFPA- targeted states, (Gedara, West Darfur, White Nile, South Darfur, and Kassala) succeeded in registering themselves as NGOs, and are actively engaged in mobilizing and educating youth and their communities.

Federal level interventions focus their training only on the youth groups affiliated with the Ministry of Youth and Sports.

It was not clear what gender inequality issues were considered in the educational messages and how these are related to maternal health.

The training of youth created demand for visionary leadership training.

Interview with youth: "some of the youth who participated in the 'camp', volunteered to complete the rehabilitation of the youth center."

EFFICIENCY

Q7. To what extent did the intervention mechanisms (funds, expertise and timing) foster or hinder the achievement of the programme outputs?

Assumptions to be assessed	Indicators	Sources of Information	Methods and Tools for data collection
UNFPA implementing partners received planned support and resources to the level foreseen and in	○ The planned resources were received to the foreseen level in AWPs	○ UNFPA (including finance / administrative departments) ○ IPs: Government counterparts /	○ IPs progress reports ○ Interviews with IPs / beneficiary of UNFPA support

a timely manner.	○ The resources were received in a timely manner	federal ministries, state ministries and NGOs	○ Interviews with UNFPA program staff
Program strategic approaches, business model, administrative and financial procedures and mix of implementation modalities fostered achievement of programme' outputs.	○ Appropriateness of UNFPA strategic business model	○ UNFPA CO staff ○ IPs: Government counterparts / federal ministries, state ministries and NGOs	○ Documentary review ○ Interview with UNFPA staff ○ Interviews with IPs / beneficiary of UNFPA support
UNFPA resource mobilization has leveraged appropriate resources to support implementation of country program document.	○ Resource mobilization strategy document ○ Evidence of resources leveraged from donors and UN partner agencies ○ Leveraged resources appropriate to planned program outputs	○ UNFPA leadership and CO staff, administrative departments ○ Program financial reports	○ Documentary review ○ Interview with UNFPA staff ○ Financial progress reports

FINDINGS:

Resource Mobilization Efficiency: UNFPA Sudan Country Office was generally efficient in mobilizing financial resources for the Country Programme.

Three fold budget increase from the 5th CP

The country office managed to raise 75 percent of its planned budget for the year 2013 and 92 percent for the year 2014.

Relative increase in non-core resources and access to new donors.

Outputs 1 & 6-Population Dynamics and Data financed almost exclusively from core resources.

The thematic areas which attracted the largest amount of co-financing are HIV/AIDS prevention and humanitarian assistance for Gender and GBV.

Resource Mobilization Strategy: UNFPA CO has been mostly successful in mobilizing co-financing resources to cover its yearly budget plans for the years 2013, 2014 and 2015 and, though efforts have been exerted as recommended in the RMS, UNFPA Sudan did not break through yet to the non-traditional donors' pool and private sector resources.

UNFPA and donors' interventions managed to prompt an increase in government allocations to some government directorates (Health & Youth) but no direct leverage of government resources.

There are cases where the government has supported UNFPA interventions through in-kind contributions such as office space.

Implementation Efficiency: Relatively good budget utilization reflecting UNFPA Country Office implementation capacity.

A 99 percent and 82 percent implementation rate of available cash for the years 2013 and 2014 respectively.

The lower budget utilization rate of 82 percent in 2014 is most likely due to delays in processing AWPs to implementing partners and transfer of quarterly budgets.

Delay in funds transfer to IPs potentially affected partners' capacity for timely implementation of AWP planned activities.

Delays are also partly due to IPs non-conformity with all of UNFPA financial and reporting procedures.

Improved implementation efficiency with business model, implementation modalities (NeX, DeX), integration approach and umbrella organizations.

Business Model: UNFPA Sudan programme interventions are executed primarily through implementing partners: Ministries, government institutions and non-governmental organizations. UNFPA has engaged with 72 and 87 IPs in 2013 and 2014 respectively.

Procurement Modalities: 2 procurement modalities of NEX and DEX.
National Execution (NEX) modality is applicable with implementing partners / line government ministries, institutions and NGOs.
Direct Execution (DEX) is used when there is lack of national capacity to implement and thus this function is directly implemented by UNFPA.

Integration: To the extent that it is successful, had a positive impact on implementation efficiency, effective use of resources and synergies.

Resources and Results: UNFPA achieved programme planned targets for most indicators and overachieved for some other indicators except in cases of 'fistula repair' and 'policy related plans and article of laws'.

Overall, interviewed IPs confirmed that financial resources allocated through AWPs were sufficient for the achievement of projects' planned results.
Inflation of prices and relative increase in costs, made it difficult for some IPs to implement AWP plans.
Only results lagging behind are for: Output 1 – Population Dynamics "Number of studies on population dynamics conducted…"; programme actually so far implemented 1 study versus programme planned 6 studies;
Output 3 indicator for "Number of fistula repair surgeries" with plans to reach 1,000 cases and so far reached only 231 cases;
Output 5-Gender, indicator for "Number of identified articles within family laws…" with programme plans for reviewing 10 articles of law and so far only 1 article of the law reviewed.

SUSTAINABILITY

Q8. To what extent has UNFPA been able to support its partners and the beneficiaries in developing capacities and establishing mechanisms to ensure ownership and the durability of effects?

Assumptions to be assessed	Indicators	Sources of Information	Methods and Tools for data collection
UNFPA support for the implementing partners and beneficiaries is adequate to build capacity to ensure sustainability. UNFPA support for the implementing partners and beneficiaries can ensure ownership and durability. The institutional capacities for population data production and analysis strengthened by UNFPA programme are likely to be sustained after end of programme	○ Evidence of addressing sustainability at the planning phase. ○ Capacity building covered broad spectrum of partners' needs. ○ RH care providers acquired necessary competencies to deliver quality services. ○ Evidence of commitment of the implementing partners in support of UNFPA supported interventions ○ Allocation of funds from national sources to maintain equipment, and continue updating information. ○ Commitment of Federal and State	○ UNFPA implementing partners	○ Documentary review ○ Interviews with implementing partners ○ Interviews with health care providers ○ Site visits / observation

Youth institutions and engagement achieved by the UNFPA programme is likely to continue after program terminates its activities. The results of UNFPA supported initiatives for promoting gender equality, women empowerment and for GBV reduction/prevention are likely to be sustained after end of Programme	governments to allocate resources for strengthening results related to gender equality and women empowerment. o Commitment of Federal and State government for application of laws policies and strategies related to GBV. o Extent of ownership of NGOs and universities for UNFPA programme results related to gender equality and GBV prevention. o Evidence for capacities of NGOs and universities for continuing training and engagement with communities addressing gender equality and GBV issues.		

FINDINGS:

Participatory needs assessment and planning with IPs created programme ownership; sustainability is still challenged by staff turnover and limited financial resources.

Factors that can enhance likelihood of UNFPA-supported interventions' sustainability are political commitment and involvement of the community leaders and community members in the implementation of the projects / activities in UNFPA-supported states.

Sustainability assessment results varied across programme outputs, implementing partners and types of interventions.

In thematic areas where UNFPA strategic interventions gained traction, government endorsement and some levels of community acceptance, such as in Sexual and Reproductive Health and Youth, we note that sustainability potentialities have improved.

UNFPA programme support in capacity building that targeted trainees at the local level, such as health care providers, volunteers, community leaders and others, is likely to be sustainable as it focused capacity building on stakeholders who are more likely to be stable at the state level and less subjected to staff turnover.

The community-based obstetric referral mechanisms are likely to continue as they have developed their own revolving funds.

CBS would not be able to update the systems without UNFPA support.

Trained youth would continue managing UNFPA-rehabilitated youth centers and disseminating educational messages on maternal health, but the community mobilization and trainings would be discontinued if not supported by UNFPA.

The implementation of the PoA for NPP would most likely be put on hold without support from UNFPA and other partner UN Agencies.

Most UNFPA-supported interventions and services in the field of gender equality, empowerment of women and GBV responses are unlikely to be maintained without UNFPA support.

Humanitarian assistance: Interventions in humanitarian settings cannot be sustained without UNFPA continuous support.

COORDINATION **Q9. To what extent were the programme coordination and monitoring mechanisms effective to boost the programme implementation and achieve better results**			
Assumptions to be assessed	**Indicators**	**Sources of Information**	**Methods and Tools for data collection**
UNFPA program monitoring and coordination mechanisms are effective in supporting achievement of program results.	○ Program monitoring systems in place and functional. ○ Program coordination mechanisms with UN agencies, federal counterparts, national and state level IPs are established and functional.	○ Program monitoring and reporting documents ○ Coordination modalities with UN, federal and state stakeholders. ○ Implementing partners; UN agencies.	○ Documentary review ○ Interviews with UNFPA CO and technical staff ○ Interviews with other UN agencies relevant staff
COORDINATION **Q10. To what extent did UNFPA contribute to the existing coordination mechanisms in the UN system in Sudan?**			
Assumptions to be assessed	**Indicators**	**Sources of Information**	**Methods and Tools for data collection**
UNFPA is participating / leading coordination working groups in its thematic areas of interest.	○ Evidence of active participation in UN working groups ○ Evidence of the leading role played by UNFPA in working groups relevant to its mandate ○ Evidence of joint implementation of programmes where relevant.	○ Minutes of UNCT working groups ○ Joint initiatives. ○ Monitoring / evaluation reports of joint initiatives. ○ Relevant UN agencies	○ Documentary review ○ Interviews with UNFPA CO staff ○ Interviews with other UN agencies relevant staff

FINDINGS:

UNFPA membership in various multi-layered coordination mechanisms with UN Agencies, Federal and State Governments.
UN Coordination Mechanisms: UNFPA is member of the UNCT, PMT, OMT and also chairs the M&E Working Group.
UNDAF-Outcome Level Coordination: UNFPA programme contributes to UNDAF Pillar One - Outcome 1 "People in Sudan, with special attention to youth, women and populations in need..."
Thematic Areas: UNFPA participate in coordination mechanisms by thematic areas and or cross cutting issues such as Gender and HIV/AIDS.
Coordination in Humanitarian Contexts - GBV sub-sector lead.
Joint Programmes: Other coordination structures are also established through joint programmes with other UN Agencies.
Issue specific coordination mechanisms are also established for events and campaigns such as for the celebrations of International Women's Day under the lead of UN Women.

Government Led Coordination

Federal and states' ministries assume leadership for the coordination of international donors', international organizations, NGOs and CBOs assistance support.
On the federal level, UNFPA interventions in Sudan are coordinated with the following ministries and programmes: Federal Ministry of Health: National Reproductive Health Directorate; Sudan National AIDS Control Program; Ministry of Welfare and Social Security: National Council for Child Welfare; Combating of Violence Against Women Unit; General Directorate of Women and Family; Federal Ministry of Youth and Sport; Ministry of Guidance and Endowments; National Population Council (NPC); The Central Bureau of Statistics.
Local states' institutions lead coordination mechanisms for donors, international organizations, NGOs and CBOs who are intervening in the technical area under their mandate and geographic jurisdiction.

Programme Coordination with Implementing Partners
Programme M&E plans indicate organization of Quarterly Review Meetings at both national and state levels under the leadership of the F/SMoHs (co-ordinating authorities) for all Implementing Partners to discuss projects' progress.

Coordination mechanisms were effective in facilitating planning of interventions, sharing of information and less so in joint implementation.
UNDAF level, intensive consultations take place at the planning stage to design and develop the UNDAF document.
Interviews point to limited effectiveness of the UNDAF in delivering expected results beyond the planning stage.
Joint Projects. Minding notable exceptions, coordination of these projects do not go beyond a division of tasks and resources and reporting on progress in coordination meetings and joint narrative reports to donors.
UNFPA programme interventions at the federal and states' level were coordinated with the federal and states governments through intensive consultations.
On the states level, regular coordination meetings are convened by the relevant state level ministries and institutions.
Coordination mechanisms were effective in facilitating achievement of improved programme results such is the case of UNFPA HIV/AIDS programme.

Coordination is more effective in supporting achievement of programmatic results when donor is involved in the coordination mechanism.

The Global fund is cited as an example of a donor organization actively participating in coordination meetings, supporting implementing agencies in negotiations with the government and supporting coordination for improved programmatic results.

Constraints to Coordination Effectiveness: Competition over Resources and an Effective Leadership.
Overall level of development assistance allocated by international donors / foreign governments to Sudan has dropped significantly in the past couple of years.
Limited access to funding resources has thus increased levels of inter-agency competition and negatively impacted 'coordination'.
The Resident Coordinator position is vacant since January 2015.
Last Resident Coordinator was requested by the Sudanese Government to leave the country as PNG.

ADDED VALUE

Q11. What are the main comparative strengths of UNFPA in Sudan – particularly in comparison to other UN agencies in the Country?

Assumptions to be assessed	Indicators	Sources of Information	Methods and Tools for data collection
UNFPA comparative strength is contributing value added particularly in comparison to other UN agencies	○ UN agencies support to UNFPA interventions ○ UNFPA lead of coordination	○ Coordination meetings ○ UNFPA CO Staff ○ Other UN agencies such as	○ Records of coordination meetings ○ Interviews with UNFPA CO staff ○ Interview with other UN agencies.

in Sudan.	meetings specifically at UN level	UNICEF, UN Women, WHO, UNDP.	

FINDINGS

UNFPA CP value added through strategic positioning and interventions at the state-locality level.

There is an overall agreement among stakeholders on UNFPA comparative strengths and technical expertise historically in Gender, Reproductive Rights and combating GBV.

UNFPA notable achievements and comparative strengths in the thematic area of HIV/AIDS prevention at national level.

ANNEX 5: Data Collection Tools

Interview Guide – Reproductive Health Thematic Area (Output 2, 3 & 4)

General Introduction: Introduce self and the purpose of the meeting-external evaluation with the objective of assessing experience and learning of the current program cycle with the view of proposing recommendations for the 7th future program cycle. Assure participants of the confidentiality of information exchange which will serve only for the purpose of analysis.					
Relevance	**Stakeholders**				
EQ1: To what extent the Country Programme addressed national priorities and needs of population vis-à-vis the UNFPA mandate and comparative advantage? **EQ2:** To what extent has the country office been able to respond to changes in the national development context and, in particular in relation to the humanitarian crisis in Darfur	**UNFPA Staff**	**Ministry / Federal**	**Ministry State**	**Other IPs (NGOs or committees)**	**Centers / locality**
To what extent did the country program address the RH needs and priorities of the implementing partners?	x	x	x	x	
Were there any RH needs or priorities of the implementing partners that the country program did not address adequately or at all?	x	x	x	x	
If the answer to question (2) is "Yes": what were these RH needs and priorities?	x	x	x	x	
Why these RH needs and priorities were not addressed in the current country program?	x	x	x	x	
To what extent UNPA CO has been able to respond to RH emerging issues in the war-affected states? "South *Darfur, White Nile, Blue Nile states"?*	x	x	x	x	
To What extent UNPA CO has been able to respond to RH emerging issues upon the heavy floods in year 2013 in Khartoum State?	x	x	x	x	
Influencing Factors: What were the factors that facilitated UNFPA CO response to such RH emerging issues? What were the factors that hindered the UNFPA CO response to such RH emerging issues?	x	x	x	x	
Recommendations: What are your recommendations for improving the UNFPA response to these RH needs and priorities?	x	x	x	x	
Effectiveness	**UNFPA Staff**	**Ministry / Federal**	**Ministry State**	**Other IPs (NGOs or committees)**	**Centers / locality**
Effectiveness: Degree or Level of Achievements of Output - Extent or Likelihood of Output contribution to UNFPA programme outcomes					
Capacity Building					
To what extent country program has contributed to capacity building	x	x	x	x	x

of implementing partners on HIV/AIDS related prevention services? *SNAP, SNAP state units in White Nile, Blue Nile, Kassala and South Darfur states?*					
The capacity building for demand creation for information and service utilization has addressed thematic areas namely: BCC, HIV risk-reduction, counselling for MARPs, Sexual & GBV in Emergency Settings, Project Cycle Management for PLHIV, Peer education for working with MARPs: To what extent was this effective? N.B. The numbers and gender of the participants of each thematic area.	x	x	x	x	
To what extent country program has contributed to capacity building for expanding integrated RH services? How this was effective? N.B. The numbers and gender of the participants of each thematic area.	x	x	x	x	
How the country program supported the RH program management capacity building at both the federal and state level?	x	x	x	x	
How effectively the training on adolescent and youth sexual and RH in addressing the adolescent and youth health at different levels?	x	x	x	x	
To what extent the country program has supported capacity building of health care providers at the state level on EmONC? N.B. The numbers and gender of the participants targeted by EmONC.	x	x	x	x	
To what extent the country program has supported capacity building of health care providers at the state level on fistula repair related activities? N.B. The numbers and gender of the participants targeted by the fistula repair related activities.	x	x	x	x	
To what extent the country program contributed to capacity building of health care providers to deliver quality family planning services for couples and individuals? N. B. The numbers and gender of health care providers targeted at both the federal and state level?	x	x	x	x	
Advocacy and community mobilization	**UNFPA Staff**	**Ministry / Federal**	**Ministry State**	**Other IPs (NGOs or committees)**	**Centers / locality**
To what extent the country program has supported advocacy efforts relevant to demand for creation for RH & HIV-related information and service utilization at both the federal and state level?	x	x	x	x	
Who were the targeted groups with RH & HIV-related advocacy efforts?	x	x	x	x	

How the targeted groups for RH & HIV-related advocacy were identified?	x	x	x	x	
To what extent were the NGOs and civil society organizations were involved in planning and implementation of RH and HIV-related advocacy efforts?	x	x	x	x	
To what extent the results of advocacy efforts were effective in bringing changes at different levels?	x	x	x	x	
What is the extent of effectiveness of advocacy efforts? N.B. the numbers and gender of the targeted participants by advocacy efforts.	x	x	x	x	x
How the advocacy efforts and community-based awareness contributed to community sensitization and mobilization towards increased utilization of family planning services?	x	x	x	x	x
What are the suggestions to improve the advocacy efforts related to RH and HIV related interventions?	x	x	x	x	x
RH services					
In year 2013 CP has accelerated the PMTCT implementation through launching of state-based Community Mobilisation Initiative in collaboration with SNAP to increase testing among pregnant women.	**UNFPA Staff**	**Ministry / Federal**	**Ministry State**	**Other IPs (NGOs or committees)**	**Centers / locality**
To what extent was this effective? How many states were covered? How many pregnant women were targeted and how many were HIV tested? How this intervention has increased the HIV testing among the general population?	x	x	x		x
How the incorporation of RH within the Primary Healthcare Expansion Project has contributed to availability of high quality information and services for maternal and new-born health and HIV prevention?	x	x	x	x	
At the policy level: How the integration of gender and sexual RH services into existing policies contributed to changes at the service level?	x	x	x		
To what extent the RH/HIV service within the renovated integrated service delivery PHC/RH at the state level is effectively delivered and used by the target users?	x	x	x		
To what extent capacity of existing obstetric community-based referral mechanisms were effectively functioning? To what extent community midwives are involved in the referral mechanism?	x	x	x	x	

What about the expansion of the maternal death registry to the state, locality level? How the collected information at different levels are complied and used?	x	x	x		x
How the RH/HIV mobile clinics have contributed to delivery of services to remote underserved areas? How the areas were selected? How such modality is effective on ANC and PNC and VCT service utilization?	x	x	x		x
How the establishment community support groups at the community level was effective to enhance and promote referrals to RH/HIV services? How many referrals per month? How the women groups were supported?	x	x	x		x
To what extent the introduction of mobile phones to be used by the community midwives has contributed to improve maternal death notification? What were the other effects? How support from higher levels is practiced? What are the lessons learned?	x	x	x		x
How many BEmONC & CEmONC facilities were supported and/or rehabilitated? How the support is effective to improve the quality of the provided services? How indicators are changed at the state level?	x	x	x	x	
Blood donation campaigns in White and Blue Nile states: How they were organized and to what extent such experience is supporting EOC care?	x	x	x	x	
How many fistula cases were repaired at the state level? How many of them were subjected to post-repair rehabilitation and re-integration including income generating activities?	x	x	x		x
Midwifery Services – supporting the profession	**UNFPA Staff**	**Ministry / Federal**	**Ministry State**	**Other IPs (NGOs or committees)**	**Centers / locality**
What are the gender issues and socio-cultural aspects that were incorporated in community midwifery curriculum? What about implementation at the state level? How the curriculum is expected to contribute to improve access and quality of the community-based midwifery care?	x	x	x		
How the country program supported the Academy for Health Sciences in UNFPA-targeted states? How such support is effective in scaling up the quality of midwifery training?	x	x	x		
How many basic community midwifery trainees were qualified? What about the selection process? Were they trained through the new	x	x	x		x

curriculum? How they were distributed after graduation? What about the current midwifery coverage at the state level "midwife per village"?					
What is the status of inclusion of the community midwives within the governmental jobs at the state level?		x	x		
How the country program has contributed to the midwifery supportive supervision? How the system is currently functioning?	x	x	x		
What about the Emergency Preparedness and Response Plan (EPRP) for each State? How the plans were implemented, monitored?	x	x	x		
Family planning	**UNFPA Staff**	**Ministry / Federal**	**Ministry State**	**Other IPs (NGOs or committees)**	**Centers / locality**
How the community-based distribution of family planning services is effective to avail the needs of couples? What are the constraints and obstacles?	x	x	x		
How the family methods utilization has improved based on the facility reports? New users	x	x	x		
To what extent the country program has contributed to strengthening the logistics management information system for RHCS? What about the regularity and quality of the collected information?	x	x			
To what extent the country program has contributed to rehabilitation of FP service facilities, and support to warehouses?	x	x	x		
How many health facilities at the state level currently providing at least 3 methods of family planning?	x	x	x		
How many health facilities have reported family planning stock out during the last 6 months?	x	x	x	x	
Coordination	**UNFPA Staff**	**Ministry / Federal**	**Ministry State**	**Other IPs (NGOs or committees)**	**Centers / locality**
What were the mechanisms of coordination between different stakeholders to achieve tangible results of the RH and HIV-related advocacy efforts?	x	x	x		
How the established channels of coordination between Ministry of Health and Ministry of Welfare & Social Security are expected to contribute to reduction of maternal mortality and female genital cutting? What about the coordination at the state level between the two ministries?		x	x	x	

What about the quarterly RH partners forum at both the federal and state level? How contributed to coordination between RH partners?	x	x	x	x	x
Implementation modality	**UNFPA Staff**	**Ministry / Federal**	**Ministry State**	**Other IPs (NGOs or committees)**	**Centers / locality**
The HIV-related interventions coverage was not limited to the UNFPA target states only but the whole country 17 states, which required special implementation arrangements. UNFPA CO developed special 6 six contractual modalities for implementation through 27 AWPs covering 77 government and non-government partners: How these modalities were effective? What are the advantages? What are the disadvantages? What the recommendation to improve the effectiveness of these modalities?	x	x	x		
Sustainability	**UNFPA Staff**	**Ministry / Federal**	**Ministry State**	**Other IPs (NGOs or committees)**	**Centers / locality**
To what extent UNFPA support for capacity building is adequate to ensure sustainability?	x	x	x	x	x
To what extent sustainability issues discussed and addressed during the planning phase?	x	x	x	x	x
After UNFPA phasing out: Which interventions are expected to continue? Why? How?	x	x	x	x	x
After UNPA phasing out: Which interventions are expected to discontinue?	x	x	x	x	x
To what extent the implementing partner has been committed in planning and implementation of UNFPA-supported interventions?	x	x	x	x	x
To what extent potential beneficiaries have been included within UNFPA-supported intervention? Examples	x	x	x	x	x
What are the suggestions to improve sustainability?	x	x	x	x	x

Interview Guide –Population and Development (Output 1, 6)

General Introduction: Introduce self and the purpose of the meeting-external evaluation with the objective of assessing experience and learning of the current program cycle with the view of proposing recommendations for the 7th future program cycle. Assure participants of the confidentiality of information exchange which will serve only for the purpose of analysis.					
Criteria Relevance	**Stakeholders**				
EQ1: To what extent the Country Programme addressed national priorities and needs of population vis-à-vis the UNFPA mandate and comparative advantage? **EQ2:** To what extent has the country office been able to respond to changes in the national development context and, in particular in relation to the humanitarian crisis in Darfur	**UNFPA Staff**	**Ministry / Federal**	**Ministry State**	**Other IPs (NGOs or committees)**	**Centers / locality**
-Have you participated with UNFPA in consultative meetings or other exercise to help assess needs and priorities?		x	x	x	
-Do you think that the UNFPA Programme interventions (for population and development and youth empowerment) responded to the national/state priorities (institutions, beneficiaries)?		x	x	x	
- How did you identify the needs covered in the activities included in the annual AWP?		x	x	x	x
-What are the priorities that have not been addressed by the UNFPA program and others? And why?		x	x	x	x
Recommendations: What are your suggestions to improve relevance of UNFPA Programme to needs and priorities (for population and development, youth empowerment?) National and state level?		x	x	x	x
Criteria Effectiveness **Degree or Level of Achievements of Output** What is the extent or degree of achievement of each of the country programme six outputs in comparison with planned targets?	**UNFPA Staff**	**Ministry / Federal**	**Ministry State**	**Other IPs (NGOs or committees)**	**Centers / locality**
-Are all activities in signed AWPs implemented timely and effectively?	x	x	x	x	
-What are the activities which have not been implemented and why?	x	x	x	x	
-Overall, what are the main results / achievements of activities undertaken?	x	x	x	x	
-How do you evaluate the results achieved by the Programme (output level) (very effective, effective, or poor)?	x	x	x	x	
Effectiveness II: Extent or Likelihood of Output contribution to UNFPA programme outcomes EQ 4. To what extent have UNFPA supported interventions contributed (or likely to contribute) to a sustained increase in use of demographic and socio-economic information and data in the evidence-based development and implementation of plans, programs and policies	**UNFPA Staff**	**National population Council/CBS**			
What type of capacity building activities undertaken for the institution and their partners?	x	x			
How was the training put in practice? Give examples		x			
-Was the process for PoA for National Population Policy (NPP) participatory?	x	x			

-Is the plan of action for NPP implemented? What are the results? How do you evaluate the results?		x			
-How are states' population councils functioning?		x			
-How many sectoral ministries integrated population dynamics, RH and gender issues in its plans? (Specify)	x	x			
-Were these plans put into practice by the ministries? If yes, what are the results? If no, why?	x	x			
-Why some ministries have not done integration?	x	x			
-What are the results of training for the staff and what improvement to the processes in the institute they contributed to?		x			
-Are research results used in design of national and states' plans? (plz give example)	x	x			
How do you evaluate the effectiveness of the results achieved? (Very effective, effective, poor)					
Influencing Factors: What are the factors that supported the achievements? What are the factors that hindered achievements?	x	x			
Coordination: How are you coordinating with CBS and other line ministries? What are the challenges of coordination?		x			
Sustainability: What is the plan for sustaining the achievements: systems, protocols, research, state population activation etc? Are there funds allocated from government resources or other partners for sustaining achievements?	x	x			
Recommendations: What are your suggestions for improving the functioning of the population councils at national and state level? What are your recommendations for improving role of the population's councils in post 2015 Development Agenda?	x	x			
Lessons Learnt: What are the lessons learnt, best practices, success story?	x	x			
Effectiveness II: Extent or Likelihood of Output contribution to UNFPA programme outcomes EQ 4: To what extent has UNFPA ensured that the needs of young people have been taken into account in the planning and implementation of UNFPA-supported interventions under the country programme?	**UNFPA**	**YOUTH, Ministry, network,**			**Youth Centers**
How did the ministries at national and states levels benefited from training on planning management, monitoring and evaluation?	x	x			x
Have the training been put in practice? Give examples		x			x
Are Youth Empowerment projects established by governments at state level functional?		x			x
How have the youth benefited from training? Give examples		x			x
If youth have not applied to training , why?					x
Are the youth centers established functional? If yes, what are the results? (Example)	x	x			x

If no, why? What have UNFPA done to help in addressing constraints?	x	x			x
Are young women active in the centers? If yes, do they participate in all activities? If no, why?	x	x			x
What are the results of life-skills vocational training?	x	x			x
What are the new opportunities that opened for youth trained?		x			x
How many Y-Peer networks at state/locality level were able to register and do they have a work plan? (Examples)-	x	x			x
Why some were not able to register? How the programme can help them?	x	x			x
How functional are the youth-serving NGOs? What are the results of capacity building interventions implemented by these organizations?	x				x
Integration: What are the results/impacts of the youth civic engagement (intergenerational dialogue, HIV/AIDS, FGM, cultural events, and community outreach)? (Give examples)?	x	x			x
Are messages in outreach activities integrated, (including RH, HIV/AIDS/ gender equality issues)?	x	x			x
Coordination: Is Youth National Coordinating Body functional? How are the watch – dog groups coordinating their work with other youth and women groups? What are the plans for use of the national registry of youth organizations for coordination? How do Y-Peer and Youth centers work together?	x	x			x
Monitoring: What are results of youth 'watch dog ' groups? (Give examples)	x	x			x
Influencing Factors: What are the factors that supported achievements, coordination and monitoring? What are the hindering factors?	x	x			x
Sustainability: What is the plan for sustaining the achievements: youth centers, networks, skills training, outreach activities and civic engagement? Are there resources from government of other donors for maintain the centers, reaching more youth and states with training, civic engagement? Were the Y-Peer networks and registered, able to find support from other donors and local partners? If no why?	x	x			x
Recommendations: What are your suggestions for improvement of youth institutions, training and outreach activates and civic engagement? What are the lessons learned, best practices, success story?	x	x			x

Focus Group Questions Guide

Focus group discussions will be carried out with the stakeholders' group of beneficiaries / trainees' implementing partners staff (Governments and NGOs) that attended – participated in trainings and capacity building events. Focus group discussions will include trainees from the three thematic areas and different topics such as GBV, RH, and Youth.

Overall, the focus group discussions will aim to assess the trainings / capacity building from four perspectives: 1- Relevance of the trainings to the participant work and type of involvement; 2- Quality of the trainings (in terms of information, training delivery and supporting tools); 3- applicability of the trainings to work and type of involvement; 4- what has actually been applied from the trainings and what were the effects – results.

I- INTRODUCTION	
- Facilitator to introduce himself, the objective of the meeting, time allotted, and applicable rules for the discussions. - Assure participants of the confidentiality of information exchange which will serve only for the purpose of analysis. - Introduce the objective of the evaluation / external evaluation with the objective of assessing experience and learning of the current program cycle with the view of proposing recommendations for the 7th future program cycle - Begin the meeting with participants' introduction: Name, work, position, type of involvement with UNFPA interventions / support - Begin the focus group questions	
Focus Group Questions	
1. What is the subject matter of the training that you attended / participated in?	
2. How would you rate the quality of the training in terms of **information** provided during the trainings? (Very good, good, poor) and why?	
3. Was the training competency-based or theoretical-based? If competency-based; which competencies were mainly addressed?	
4. How would you rate the quality of the training in terms of **delivery** (trainer competence, knowledge…) (Very good, good, poor)? and why?	
5. How would you rate the quality of the training in terms of supporting **materials**, tools, manuals…etc. (Very good, good, poor)? and why?	
6. To what extent is the training subject matters related to your work / position/ involvement? Are the training subject matters applicable to your current work? To what extent?	
7. Did you actually apply the learning acquired in the trainings in your current position/ work / involvement? To what extent? Please explain	
8. What were the results / impact of the trainings on (a) your job performance; (b) on the target group of beneficiaries that you are serving?	
Thank you for your valuable time and input	

Interview Guide – UN Agencies, International Donors and Organizations
Active implementers or Supporters of UNFPA thematic Work Areas

General Introduction: Introduce self and the purpose of the meeting-external evaluation with the objective of assessing experience and learning of the current program cycle with the view of proposing recommendations for the 7th future program cycle. Assure participant of the confidentiality of information exchange which will serve only for the purpose of analysis.	
1- Can you please give us an idea/a summary overview of the thematic areas / programs /activities that your organization is currently supporting in Sudan? And the approximate level of funding?	
2- Are you participating / leading any coordination mechanism with other donors? International Organizations? How often do you meet?	
3- Are you participating in any coordination mechanism with UN Agencies? Cluster or thematic group on the national level? On the state level? How often do you meet?	
4- What are the subject matters discussed in these meetings? Exchange of information? Exchange of experiences? Others?	
5- Are you implementing joint programs with other organizations? With UNFPA? From your perspective, what are the advantages and disadvantages of coordination meetings? Of joint programs?	
6- In your opinion, what is the comparative advantage presented by UNFPA in the sector /thematic areas that are common with your organization?	
7- In your opinion, what is the value added of UNFPA in the sector /thematic areas that are common with your organization	
8- Thank you for your valuable time and contribution	