



**Country Programme Action Plan
Between
The Government of Sudan and UNFPA**

Seventh Programme Cycle

2018 – 2021

List of Acronyms and Abbreviations

AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Care
ART	Antiretroviral Therapy
AYSRH	Adolescent and Youth Sexual and Reproductive Health
AWP	Annual Work Plan
BCC	Behaviour Change Communication
CBS	Central Bureau of Statistics
CBO	Community-Based Organization
CCA	Common Country Assessment
CO	Country Office
CMR	Clinical Management of Rape
CMW	Community Midwife
CP	Country Program
CPAP	Country Program Action Plan
CPD	Country Program Document
CPR	Contraceptive Prevalence Rate
CSO	Civil Society Organization
EmONC	Emergency Obstetric and Neonatal Care
FGM/C	Female Genital Mutilation/Cutting
FP	Family Planning
GBV	Gender-Based Violence
GBVIMS	Gender-Based Violence Information Management System
HACT	Harmonized Approach to Cash Transfers
HCP	Health Care Provider
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
ICM	International Confederation of Midwives
ICPD	International Conference on Population and Development
IEC	Information, Education and Communication
IPRS	Interim Poverty Reduction Strategy
KAP	Knowledge, Attitudes and Practices
K&VP	Key and Vulnerable Populations
LMIS	Logistics Management Information System
LTA	Long-Term Agreement
MCH	Maternal and Child Health
MIC	Ministry of International Cooperation
MISP	Minimal Initial Service Package
MDG	Millennium Development Goals
MDSR	Maternal Death Surveillance and Response system
M&E	Monitoring and Evaluation
MMR	Maternal Mortality Ratio
MNMR	Maternal and Neonatal Mortality Rate
MOH	Ministry of Health
MOF	Ministry of Finance
NCCW	National Council for Child Welfare
NGO	Non-Governmental Organization
NPC	National Population Council
NSDS	National Strategy for the Development of Statistics
OF	Obstetric Fistula
PAC	Post Abortion Care

PEP	Post-Exposure Prophylaxis
PHC	Primary Health Care
PHK	Personal Hygiene Kit
PLHIV	People Living with HIV
PMTCT	Prevention of Mother to Child Transmission (HIV)
RH	Reproductive Health
RHC	Reproductive Health Commodity (ies)
RHCS	Reproductive Health Commodity Security
SAI	Supreme Audit Institution
SBA	Skilled Birth Attendant
SDG	Sustainable Development Goals
SOP	Standard Operating Procedures
SP	Strategic Plan
SRH	Sexual and Reproductive Health
SRHR	Sexual and Reproductive Health and Rights
STI	Sexually Transmitted Infection
TFR	Total Fertility Rate
UNDAF	United Nations Development Assistance Framework
UNCT	United Nations Country Team
UNDP	United Nations Development Program
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
VAW	Violence Against Women
VCT	Voluntary Counselling and Testing
VMW	Village Midwives
WEP	Women Empowerment Policy
Y-PEER	Youth Peer Education Network

The Framework

In mutual agreement to the content of this document and their responsibilities in the implementation of the country programme, the Government of Sudan (hereinafter referred to as the Government) and the United Nations Population Fund (hereinafter referred to as UNFPA)

Furthering their mutual agreement and cooperation for the fulfilment of the International Conference on Population and Development Programme of Action;

Building upon the experience gained and progress made during the implementation of the previous Programme of Cooperation;

Entering into a new period of cooperation;

Declaring that these responsibilities will be fulfilled in a spirit of friendly cooperation;

Have agreed as follows:

Part I. Basis of Relationship

The Basic Agreement concluded between the Government and the United Nations Development Programme on 24 October 1978 (the “Basic Agreement”) mutatis mutandis applies to the activities and personnel of UNFPA in Sudan. This CPAP together with any work plan concluded hereunder, which shall form part of this CPAP and is incorporated herein by reference, constitutes the project document as referred to in the Basic Agreement. References in the Basic Agreement to “Executing Agency” shall be deemed to refer to “Implementing Partner” as such term is defined in the Financial Regulations of UNFPA and used in this CPAP and any work plans concluded hereunder.

Part II. Situation Analysis

Sudan has suffered from prolonged years of conflict, volatile security situation, political transition, unsustainable debt burden, economic and financial sanctions and fragile relations with the international community, all of which have severely constrained the country’s broad-based growth prospects and poverty reduction efforts. In spite of Sudan rising to lower middle income status in the last decade due to oil wealth, the country has high poverty and inequality.¹ The current context drains the country’s resources, affects investment in all social sectors and contributes to inequalities between and within states. The projected population for 2017 is 40.8 million with two-thirds of the population living in rural areas. Annual population growth rate is 2.5 per cent, total fertility rate is 5.2 (5.6 rural, 4.4 urban) and 62 per cent of the population is under the age of 25.² This demographic profile indicates that Sudan is in its pre-dividend stage. Sudan continues to experience population movements reflected in rural-urban migration, internal displacement, influx of refugees and emigration of highly skilled workers.³

Sudan’s poverty rate is estimated at 36 per cent, while One in four Sudanese falls below the extreme poverty line (25 per cent). The poverty rate varies markedly across states, from 12.2 per cent in Northern state to 67 per cent in Central Darfur and South Kordofan States.⁴ Public resources allocated to the Interim Poverty Reduction Strategy (IPRS) pillars with the view of targeting the poor have grown since 2012, signalling the Government’s commitment to poverty reduction. The growth in pro-poor spending has occurred despite the decline in total expenditures and the difficult economic situation following South Sudan’s secession, limited access to external financing for development due to Sudan’s external debt, and challenges of the sanctions. Public expenditures on health stand at 1 per cent of GDP and 8 per cent of total public expenditures. Around 87 per cent of the health expenditures occur at the state level. A major concern is the extremely low level of development/investment spending in the health sector, with about 75 per cent going for current expenditure. Improved service delivery to the poor in the longer term will require larger investment in health infrastructure.⁵

¹ The Sudan Interim Poverty Reduction Strategy Paper Status Report, WB and MoF, 2016

² Census 2008

³ HNO, 2017

⁴ Sudan Household budget and Poverty Survey, 2017

⁵ The Sudan Interim Poverty Reduction Strategy Paper Status Report, WB and MoF, 2016

Sudan is a highly indebted country that has accumulated sizable arrears and the external debt burden weighs heavily on Sudan's development. As of end-2014, its public and publicly-guaranteed debt stood at US\$45 billion.⁶

Currently, the unemployment rate is 19 per cent on average and 34 per cent among youth.⁷

Sudan has made progress in a number of Millennium Development Goal (MDG) indicators, particularly those related to health and education. Available evidence suggests that education, health, gender equity, social protection and standards of living have expanded in spite of the numerous challenges facing Sudan both internally and externally. However, progress has been slowed by the eruption of violent conflict and the resulting impact on institutional stability and social capital.⁸

The Government is working towards aligning its Five-Year Plan of 2017 - 2021 with SDGs as part of the Strategic Development Plan priorities of the country. The President formed an Inter-Ministerial High Mechanism on SDGs and is chaired by Vice President, the mechanism includes in its membership all line ministers. Through support from the UN system in Sudan; MIC has embarked in wide consultations and advocacy processes on SDGs targeting policy-makers at national and state levels; to enhance their understanding and their roles vis-à-vis SDGs, and agree on operational steps to effectively implement SDGs. Sudan SDGs roadmap has been launched in November 2017 during SDGs Conference organized by government of Sudan with support and wide participation of the UN System in the country.

Sudan has made significant progress in its maternal and child health indicators, great momentum has been built towards achieving substantial reductions in maternal and child mortality. A great step taken by the government of Sudan in the journey of ending maternal and child mortality was the financing of four major projects that play a key role in improving maternal and child health, initiated through Presidential decrees: the PHC Expansion Project, the Free Under-five Drugs Scheme, and later followed by an Antenatal Care Scale-up Program and lastly the Maternal Mortality Reduction Initiative. Great effort has been exerted towards achieving universal health coverage during the first and second years of implementation of the MCH Acceleration Plan. Village midwifery coverage reached 72 per cent and access to essential MCH services has increased from 42 per cent to 75 per cent through the five key intervention areas that were initially identified.⁹

One-quarter of the population has no access to health facilities, while only 19 per cent of primary health care facilities provide the minimum health care package. Two-thirds of rural hospitals offer basic emergency obstetric and neonatal care and less than half provide comprehensive emergency obstetric and neonatal care. Obstetric fistula is complicated by lack of timely emergency obstetric care for obstructed deliveries and high adolescent birth rate (87 births per 1,000 women aged 15-19).¹⁰

The official national maternal mortality ratio is 216 deaths per 100,000 live births,¹¹ while recent international estimates put the ratio at 311 deaths per 100,000 live births.¹² Skilled personnel-attended deliveries is 78 per cent (only 19 per cent by medical doctors), and 28 per cent of deliveries take place in health facilities. Antenatal care coverage is 51 per cent (four visits), and postnatal care coverage is 27 per cent.¹³

Contraceptive prevalence rate is 11.7 per cent (19 per cent urban, 8.7 per cent rural) and unmet need for family planning is 26.6 per cent.¹⁴ Poor supply chain management results in commodity stock-out in 38 per cent of health facilities.¹⁵ Socio-cultural barriers create low demand and utilisation of reproductive health commodities (RHC).

⁶ Ibid

⁷ Labour Force survey, 2011

⁸ CCA 2016

⁹ RMNCHA Strategic Plan 2016- 2020

¹⁰ MICS 2014

¹¹ SHHS 2010

¹² UN Statistics Division, MDG Indicators Data, mdgs.un.org/unsd/mdg/Data.aspx.

¹³ MICS 2014

¹⁴ MICS 2014

¹⁵ HF based RHCS survey 2016

HIV prevalence in Sudan is 0.24 per cent. The prevalence among most-at-risk population groups ranges from 3.1 per cent to 7.7 per cent. About 80 per cent of new HIV cases are detected amongst most-at-risk population groups. Due to stigma and discrimination, access to preventative services is limited.

Over the years, Sudan exerted huge efforts to combating harmful practices that resulted in improving the work environment, putting coordination systems in place, adopting policies and laws and engaging various stakeholders at national, state and community levels. Extensive advocacy efforts resulted to adoption of policies, strategies, and legal frameworks leading to an enabling political and social friendly environment, such as Women Empowerment Policy, GBV strategy, National Strategy on Child Marriage, States laws banning FGC, In addition, efforts have led to building capacity of stakeholders and facilitated community engagement.

Gender-based violence (GBV) manifests itself through female genital mutilation/cutting (FGM/C), child marriage, domestic and sexual violence and trafficking. The prevalence of FGM/C in 2014 was 87 per cent among women aged 15-49 and 32 per cent among girls aged 0-14. Although there is a decrease in the younger cohort, about 40 per cent of women report that they still have the intention to cut their daughters. Twelve per cent of women were first married before age 15 and 38 per cent before age 18, which leads to early childbearing. Twenty-two per cent of married women had at least one live birth before the age of 18. These practices are upheld by rooted social norms, religious misinterpretations, gaps in policies and legislations, poverty, illiteracy and the consequences of conflicts.

Humanitarian needs in Sudan are considerable in scope. These are predominantly caused by conflict, which, in turn, drives displacement and food insecurity. Humanitarian challenges are not limited to conflict areas, and needs are also driven by poverty, underdevelopment, and climatic factors.¹⁶

Although there is a National Strategy for the Development of Statistics (NSDS) and its associated protocols, the capacity to produce, analyse and disseminate population data is limited. The health information system is not well-functioning. Though improving, use of data on population dynamics to inform planning, policy formulation, implementation and monitoring of programmes remains low both at national and state levels.

Major efforts are needed to strengthen states' capacity to deliver basic services. The capacity for data collection and information management within the decentralized framework of service delivery remains weak. The weak capacity leads to incomplete reporting/monitoring of expenditure and inadequate evaluation of related results at these levels. This challenges evidence-based planning and targeted service delivery.¹⁷

Part III. Past Cooperation and Lessons Learned

The sixth country programme made contributions to improving sexual and reproductive health (SRH) in focus states by increasing coverage of basic emergency obstetric and neonatal care (EmONC) from 35 to 65 per cent, comprehensive obstetric and neonatal care from 27 to 53 per cent, antenatal care (ANC) from 61 to 78 per cent: at least one visit, midwifery by 14 per cent and use of contraceptives to 17 per cent of first-time users. The programme contributed to establishing a basis for the Government to launch a nation-wide Primary Healthcare Expansion Programme, and for the President to sign up to the UN-SG Global Strategy for Women's, Children's and Adolescents' Health (2016-2030), pledging political and financial commitments. This has led to the development of Maternal, Neonatal, Child and Adolescents Health Strategy (2016-2020).

There were quite a number of challenges and gaps, such as inadequate integration and co-ordination across programme components, high staff turn-over among key health service providers, inadequate supply chain management for reproductive health commodities, stigma associated with HIV and the target group, ineffective implementation of policies and laws, limited evidence on GBV, and the fact that the programme was ambitious vis-à-vis the estimated financial resources and annual targets given the changes in funding landscape.

¹⁶ CCA 2016

¹⁷ The Sudan Interim Poverty Reduction Strategy Paper Status Report, WB and MoF, 2016

Lessons learned included: (a) community-based interventions proved to be effective in promoting awareness and creating demand for services; (b) integration of the management of family planning commodities into the national supply chain proved to be effective in stock management, distribution and reporting; (c) the adoption of a context-specific HIV prevention package helped detect new cases; (d) in-depth analysis of existing data is needed for better planning and targeting; and (e) advocacy with parliamentarians, media, and religious and community leaders was instrumental in leveraging resources and developing policy frameworks to address persistent socio-cultural determinants.

Part IV. Proposed Programme

The overall goal of the proposed programme (2018-2021) is to contribute to the reduction of maternal deaths and disabilities through an integrated approach to SRH, family planning (FP), and prevention and response to GBV. The programme is aligned with the national development priorities, the United Nations Development Assistance Framework (UNDAF) 2018-2021, and builds on recommendations from the sixth country programme evaluation.

The programme is designed to contribute to the UNFPA Strategic Plan Goal (2018-2021) to achieve universal access to SRH, realize reproductive rights, and reduce maternal mortality. Specifically, outputs 1 and 2 will contribute to the first outcome of the UNFPA strategic plan (utilization of SRH services), output 3 will contribute to the 3rd outcome of gender equality and advancing reproductive rights, and output 4 will contribute to the 4th outcome (Everyone, everywhere, is counted, and accounted for).

The programme will directly address national priorities identified in national strategic plans, national policies and strategies and the results to be achieved will be aligned with the national strategic plans: (a) the Twenty-Five Year National Strategy 2007-2030, (b) the Sudan Reproductive, Maternal and Child Health Strategic Plan 2016-2020, (c) the Ten Year National Action Plan for the Promotion and Protection of Human Rights in Sudan 2013-2023, (d) the National Policy on Violence Against Women 2016-2031, and (e) the National Policy for Abandonment of FGM (2008 – 2018); f) the National Strategy for Development of Statistics.

The programme outputs 1, 2 and 3 will contribute to the UNDAF outcome 3: “By 2021, populations in vulnerable situations have improved health, nutrition, education, water and sanitation, and social protection outcomes”, while outputs 3 and 4 will contribute to the UNDAF outcome 4: “By 2021, national, state and local institutions are more effective to carry out their mandates including strengthened normative frameworks that respect human rights and fundamental freedoms and ensure effective service delivery”. The programme outputs 1, 2 and 3 will contribute to the UNDAF outcome 5: “By 2021, community security and stabilization of people affected by conflict is improved through utilization of effective conflict management mechanisms, peace dividends and support to peace infrastructures and durable solutions that augment peaceful coexistence and social cohesion”.

The programme’s main beneficiary groups are women and youth, particularly those most in need, including poor, rural communities, key populations, conflict-affected groups, refugees and victims of trafficking. The programme will focus on policy formulation, knowledge management and strategic guidance at national level and service delivery and capacity development at state level.

Due to resource limitation, the programme will focus on five high priority states using an index of technical indicators and results generated by the latest MICS and National Poverty Surveys; these indicators are: maternal mortality ratio (MMR), contraceptive prevalence rate (CPR) and prevalence of FGM and child marriage,. Using this index, the order of high priority states will be: Central Darfur, East Darfur, West Darfur, South Darfur, and North Darfur. In addition to the five high priority states, the programme will support selected interventions in other priority states for consolidation of previous UNFPA support, namely: Kassala, Gadarif, North Kordufan, White Nile and Blue Nile States. The expansion of the interventions and presence in additional states will be determined based on needs and availability of resources, while humanitarian assistance will be provided as and when needed. Integrated community-based interventions will be implemented in a phased approach, starting with one locality in each state. Upon successful implementation, the program will be expanded to more localities. The selection of localities will depend on several criteria, such as poor maternal health outcomes, high

proportion of underserved populations, availability of systems in place for the comprehensive multi-sector humanitarian response, accessibility, security, political commitment, and availability of national NGOs.

UNFPA has several competitive advantages to implement the programme, including (a) UNFPA has technical expertise at field, country office (CO), regional and HQ levels on sexual and reproductive health and rights (SRHR), HIV, youth, GBV, population and environmental issues in both development and humanitarian settings. (b) UNFPA has wide field presence and ability to rapidly scale up operations on need basis. (c) UNFPA has established networks of partners (government, civil society and community groups – youth, women, etc.), with growing organizational and technical capacity that will facilitate efforts to improve the quality of interventions. (d) The strengthened capacity of different national partners achieved in previous cycles will be further enhanced in this cycle. This is a key strategy that promotes national self-sustainability and facilitates UNFPA's programmatic exit strategy.

The programme has four interlinked and inter-related outputs designed to reinforce each other and contribute to the overall goal of contributing to reduction of maternal deaths and disabilities:

Output 1: Strengthened capacities of health ministries and civil society partners at federal and priority states level to ensure access to high-quality sexual and reproductive health services, including in humanitarian settings.

This output has 13 strategic interventions that will strengthen the national capacity to improve access to SRH services.

Strategic intervention 1(a) advocating for political and financial commitments to sexual and reproductive health: Evidence for advocacy will be generated through in-depth analysis of existing data, e.g. the Maternal Death Surveillance and Response system (MDSR) reports, regular programme reports, joint annual review reports, and by conducting small scale/operational research and contributing to focused surveys, such as knowledge, attitudes and practices (KAP) surveys. In addition, the programme will contribute to strengthening the health information system for evidence generation and will support the inclusion of SRH key indicators into national surveys, like the Multiple Indicator Cluster Survey (MICS) and Sudan Household Health Survey (SHHS). Advocacy interventions will include development and dissemination of focused advocacy materials and messages such as policy briefs, factsheets and other types of advocacy materials. It will also include supporting celebrations of international days related to SRH and supporting the participation of key government officials in regional and international meetings and conferences. Mass media will be utilised to deliver certain advocacy messages. The key target audiences for this strategic intervention will include senior government officials, parliamentarians, decision makers at different levels and religious and community leaders. Managers of the educational institutions, non-government actors and other sectors will also be targeted, specifically to take actions on MDSR recommendations. Abandonment of FGM/C and ending child marriage will be integrated into the activities under this strategic intervention.

Strategic intervention 1(b) strengthening the maternal death surveillance and response system: The programme will focus on improving the MDSR system through fulfilling the maternal death investigation function by verbal autopsies at community level, maternal death reviews at facility level, and maternal death confidential enquiries at federal level. Support will also be provided to strengthen the electronic system. The purpose is to identify obstacles to and enablers of the use of MDSR findings for quality of care improvements. Notification and investigation of maternal death at both facility and community levels will be strengthened to improve the timeliness and completeness of reporting. Operational support (e.g. equipment and furniture) will be provided for the regular MDSR committees meeting on a quarterly basis at national and state levels. New members from other sectors will be invited to the existing MDSR committees, such as civil society organisations (CSO), media, religious and community leaders. National annual MDSR reports will be developed and disseminated at federal and state levels. Follow up on findings, recommendations and responses of MDSR reports will be ensured through conducting follow up meetings and field visits at different levels. Mechanisms at community level to analyse the social bottlenecks related to maternal death will also be supported.

Strategic intervention 1(c) upgrading of midwifery training and improving quality of midwifery services: This intervention will include upgrading of midwifery schools and institutions in terms of

infrastructure and staffing to accommodate the International Confederation of Midwives (ICM) standards for the pre-service training of midwives at diploma level. Equipment, supplies, and renovation of midwifery training sites will be provided where required. It will also include the development and update of standardised curricula that meet the ICM standards and training of tutors on the implementation of the new/updated curricula. In addition, technical and operational support to midwifery teaching institutions in order to increase the production of professional/skilled birth attendants (SBA) will be provided. Performance and accountability management of midwives will be reinforced. Continuous professional development of active midwives, including community midwives (CMW) and other health personnel, on specific midwifery skills based on real needs will be supported, including renewal of midwifery kits and consumables as needed. Midwifery cadres and other SRH care providers will be supported to provide integrated SRH services. Necessary tools, such as protocols and guidelines in maternal care, neonatal care, FP and prevention of maternal morbidities, including for mobile clinics, will be developed/updated, printed and distributed. To regulate the practice, a framework and scope of practice will be developed, including the implementation of the accountability framework. Policy dialogues will be conducted to allow midwives to provide a wider range of services. State midwifery associations will be supported to serve as advocates for midwifery in their states, to empower midwives and to increase their contribution to improving the quality of midwifery services. Clean delivery kits and other supplies will be availed to midwives working in humanitarian settings and for underserved populations.

Strategic intervention 1(d) creating demand for utilization of sexual and reproductive health services: Evidence will be generated on the specific gaps in the knowledge about SRH among the target populations and will be used to design appropriate messages for each target population. Mass media activities will be supported (TV, radio, etc...) at federal and state levels in addition to developing printed educational materials. At community level, the community-based referral mechanisms as well as local community mediators and youth groups will be the main mechanisms for community mobilization and awareness raising. Those groups will act as community mobilizers after providing them with the necessary training and sensitization to provide information and formulate the appropriate links between the community members and health care providers. Local media channels will be used to disseminate information on SRH at community level, including use of social media where appropriate. Awareness raising in infertility management will also be included. **This intervention is closely linked to strategic interventions 1(g) and 1(i).**

Strategic intervention 1(e) improving the capacity of health care providers to detect and manage emergency obstetric and neonatal complications and fistula: The investment in improving the EmONC, both basic and comprehensive, will be based on the results of the EmONC needs assessment survey (2017). The results, which will include standards of health facilities providing EmONC, and mapping of facilities and referral pathways at national and state levels, will be used to upgrade the identified health facilities according to the map. A service upgrade plan will be developed based on the survey results and capacity building interventions for the care providers in the selected facilities will be implemented. This will include the adoption of more advanced methodologies of skill-based training and strengthening of the monitoring and evaluation (M&E) system for EmONC facilities in terms of creation of a system for facility-based data utilization. This will be implemented in partnership with experienced institutions. In addition, support will be provided to expand the coverage and the quality of post-abortion care (PAC) services. Updating of the EmONC services availability map/ network will be conducted together with the M&E activities, including in humanitarian settings. Obstetric fistula (OF) treatment and prevention activities will also be supported under this strategic intervention. The established fistula national task-force will be supported to undertake advocacy, develop guidelines and protocols, create a fistula registry and contribute to mobilizing resources. Advocacy activities will be conducted aiming at increasing government financial contribution to fistula prevention and treatment. Capacity building of medical teams, including surgeons, to improve the clinical outcomes and OF diagnosis and management will also be carried out in selected states. This includes supporting participation of OF surgeons, managers and advocates in international conferences, meetings and training workshops. Existing OF centres in the states will be rehabilitated and equipped as needed, including procurement of fistula repair kits. Awareness raising activities will be supported by engaging community committees, volunteers,

youth groups and community-based organizations (CBOs) to identify, register and refer more cases and further increase the utilization of the available treatment services. Treatment of registered cases will be supported within the routine medical and surgical services for gynaecological cases; however, fistula treatment campaigns will be conducted when there is a pressing need. Furthermore, and in close partnership with CSOs, resources will be mobilized to support social reintegration and life-skills training for OF patients.

Strategic intervention 1(f) rehabilitating health facilities in priority states to provide maternal and neonatal health services: Prioritization exercises will be conducted at state and locality levels to ensure better accessibility and utilization of services. Prioritized health facilities providing maternal and neonatal health services will be rehabilitated and equipped. This will include renovation of health facilities to provide integrated SRH and FP services, including prevention of uterine and cervical cancer, breast cancer and infertility care.

Strategic intervention 1(g) establishing community-based obstetric referral mechanisms in priority states: The community-based obstetric referral mechanisms will be scaled-up to promote and increase the utilization of SRH services, especially EmONC, to contribute to decreasing the first and second delays, and to empower women. Communities will be selected based on the state MDSR reports and findings. In each selected community, a committee led by midwives and/or women activists will be elected/established and will include prominent community leaders and youth. Locality authorities and local community leaders will be involved in the selection and facilitation of the work of those groups. Each committee will be supported with seed money to establish a community revolving fund to be used for referral of emergency obstetric cases to the health facilities. Committees will be provided with training, tools and supportive supervision to ensure proper management of the fund and for awareness raising activities. The committees will also be responsible for supporting pregnant women to develop delivery plans and will keep close contact with health care providers in the area to link women with them. The committees will be linked to the MDSR system in order to contribute to the identification of the social barriers.

The committees will be supported by youth groups, to be established in each selected community, which will be responsible for providing information on SRH using different approaches and methods, such as discussions in social gatherings, use of social media, theatre performance and dissemination of printed educational materials.

Monitoring mechanisms will be established for those groups including reporting and supervision to track the progress such as the rates of referral to services.

Strategic intervention 1(h) strengthening the capacity of youth-serving organizations to provide training for young people and address their sexual and reproductive health concerns: This strategic intervention will be achieved through the revision and update of the standards and curricula on adolescent and youth sexual and reproductive health (AYSRH) service provision that has already been developed. The update will include life-skills and youth empowerment approaches within the standard peer education and service provision curricula. This will require advocacy interventions to secure the endorsement of such curricula and standards; sensitization, consultative meetings, and training workshops will be carried out to bring different actors on board and strengthen the coordination between different stakeholders like ministries, UN agencies, and NGOs. New (non-traditional) SRH service providers will be approached and their capacities will be built to provide SRH in their settings; this includes schools and youth clubs, through the related ministries, and religious institutions like *Khalwa* and churches. The coordination between these institutions can be materialized through the establishment or activation of the adolescent and youth health technical working group. Trainings for health care providers and peer educators will also be carried out on the provision of youth-friendly health services. Innovative and creative approaches will be used to scale-up the Y-PEER network to continue to reach out more young people. Awareness raising and capacity building for youth organizations on SRH/GBV/STIs/HIV will be supported.

Strategic intervention 1(i) mobilizing young people for community outreach and education on maternal health, family planning and HIV prevention: This intervention aims at achieving more engagement and participation of youth in community mobilization, and creation of demand for SRH/FP and HIV services. Support will be provided to youth leaders in rural areas, and IDP and refugee camps,

for the establishment of community-based youth groups and to build their capacities on SRH as well as link them with the existing community mechanisms to strengthen referral services. Since youth are usually interested in the new technology and innovative approaches, the programme will support the development of a user-friendly website and phone application to respond to the youth SRH needs and concerns. This website and application will enhance accessibility of SRH/FP/HIV-related information in a timely and easy-to-use manner while also creating a platform for young people to share their experiences and practices in SRH. Music, theatre and sports will be used for the mobilization of communities and youth groups, which can result in helping the youth and communities in appreciating their cultures and the adoption of healthy lifestyles through sport and recreation. An essential part of this intervention will be ensuring youth participation in the planning, implementation, monitoring and evaluation of the SRH programmes in their communities. **This intervention is closely linked to intervention 1(g).**

Strategic intervention 1(j) implementing the minimum initial service package for reproductive health in humanitarian settings: Support will be provided for strengthening the SRH sub-sector coordination mechanism at national and state levels. The development/updating of national protocols on reproductive health (RH) and sexual violence during emergencies as well as training of health managers will be supported. Special attention will be given to the mapping of the available services in SRH, FP, GBV and referral systems in humanitarian settings. The results of the mapping will be disseminated to the relevant stakeholders, including the affected and vulnerable populations. Training on data collection and analysis of SRH in humanitarian settings will be provided. The programme will also provide capacity building through training of humanitarian workers and key counterparts on the minimum initial service package (MISP), assessment techniques and basic issues related to managing programmes in areas affected by humanitarian crises. Health care providers (HCP) and SRH managers will be trained on SGBV programme management including CMR, psychosocial support, and integration of GBV prevention and response into SRH programmes in humanitarian settings, with a focus on opening confidential spaces for GBV case management. The programme will support the provision of basic EmONC services in IDP and refugee camps, and ensure safe blood transfusion in comprehensive EmONC facilities by renovating and equipping blood banks. In addition, UNFPA will work with the affected communities, health ministries and UN agencies to strengthen the referral, transport and management of emergency obstetric cases. Support will be provided for HIV and sexually transmitted infection (STI) prevention services, targeting the people of humanitarian needs through dissemination of HIV information and services using awareness campaigns, mobile voluntary counselling and testing (VCT) in addition to provision of post-exposure prophylaxis (PEP) kits for rape cases and referral of HIV positive cases to antiretroviral therapy (ART) centres.

Strategic intervention 1(k) supporting national capacity for emergency preparedness and response: The programme will provide training and capacity building for SRH managers and relevant ministries on contingency planning and emergency preparedness and response, including the prepositioning of emergency RH kits and supplies. It will also support the development/updating of national and state level emergency preparedness plans related to SRH and GBV, where different scenarios will be discussed. Follow up and supportive supervision will be conducted at different levels, in addition to documentation and dissemination of good practices.

Strategic intervention 1(l) supporting HIV prevention among key populations and addressing HIV-associated stigma: Support will be provided for evidence-based advocacy to address HIV and STI stigma, with a special focus on key and vulnerable population groups (K&VP), and to target policy and decision makers at the national and state levels. Advocacy and sensitization efforts will also be a key part of HIV interventions within key populations. The active engagement of key stakeholders during the planning, implementation and monitoring of interventions will facilitate the creation of an enabling environment for programme delivery. National NGOs and health care providers will be supported and capacitated to provide HIV prevention services to the target groups (K&VP), including HIV risk reduction counselling through outreach services. The programme will support socio-economic impact mitigation for PLHIV through conducting stigma reduction interventions, sensitization and advocacy. Support will be provided to review and design the most appropriate and effective stigma reduction packages targeting the health care providers.

Strategic intervention 1(m) integrating HIV and sexual and reproductive health services for increased coverage: At the national level, support will be provided to ensure functioning coordination mechanisms between different departments and facilitate operationalizing the existing strategies and guidelines for SRH/HIV integration. A qualitative assessment of SRH needs for people living with HIV (PLHIV) and key populations will be conducted to inform priority services to be integrated. Attention will be given to the provision of SRH services for K&VP and PLHIV, including: condom provision as dual protection for FP and prevention of STIs, management of STIs, screening and treatment for syphilis and cervical cancer, linkage of HIV positive cases of women and children to treatment centres, and comprehensive condom programming. The concerned departments will ensure provision of integrated awareness messages at facility and community levels, including outreach activities. The SRH care providers will be trained on VCT and HIV testing kits will be provided. Provision of prevention of mother to child transmission (PMTCT) services will be supported targeting all pregnant women attending ANC. The PMTCT service will include counselling and testing, FP and referral of HIV positive women to ART centres.

Output 2: Strengthened capacities of health ministries and civil society partners at federal and priority states level for better access to high quality family planning services, including in humanitarian settings.

This output will be implemented through eight strategic interventions:

Strategic intervention 2(a) generating evidence for advocacy to scale up family planning services: Evidence will be generated through specialized studies and research on the social and economic development benefits of FP. The evidence generated will be disseminated through a series of seminars targeting all relevant government sectors and development partners, as well as production and dissemination of policy briefs and fact sheets. The programme will support regular dialogue forums bringing religious leaders and medical doctors together to address socio-cultural determinants of FP. The evidence generated will also be used to support mobilizing public, private and donors' commitment towards reproductive health commodity security (RHCS). New partners/actors other than the Ministry of Health will be approached to lead the advocacy campaigns on FP. The programme will support the inclusion of key FP indicators into national surveys, e.g. MICS.

Strategic intervention 2(b) introducing innovative community outreach strategies to create demand for family planning services:

Qualitative studies on FP will be conducted, guided by results from the maternal and child health (MCH) KAP survey 2015 and the RHCS annual survey reports, aiming to analyse the key barriers of FP service usage, with a special focus on the most disadvantaged and underserved population groups. Awareness messages on FP will be developed and disseminated. A national media campaign for awareness raising will be conducted. The communication and awareness activities under this strategic intervention will be closely linked to similar interventions under the first output, and FP will be included in the integrated communication package, i.e. the use of youth groups, community volunteers and other community based structures for demand creation. This strategic intervention will include support of innovative service delivery approaches to underserved populations in order to increase access to FP services. Men will also be targeted to play a positive role in supporting the utilization of FP services.

Strategic intervention 2(c) establishing effective coordination mechanisms for family planning and reproductive health commodity security: An effective FP and commodities coordination mechanism will be established; it will include all relevant government, private sector, development and humanitarian partners. Technical and financial support will be provided to the coordination forum for development of a FP national strategy and costed implementation plan. A national FP task force will be formulated and supported to follow up on the implementation of the FP strategy and to mobilize financial resources and increase the political commitment. Support will be provided for study tours to countries with successful experiences in FP and addressing FP barriers in similar contexts, targeting key decision makers from the Government. The FP task force and the coordination mechanisms will maintain the integration of FP services in other primary health care (PHC) services, like nutrition and immunization.

Strategic intervention 2(d) strengthening the supply chain management system at all levels, including adoption of the most appropriate technologies in the logistics management information system: This strategic intervention includes procurement of FP commodities, life-saving drugs, micronutrients and other RH commodities, in coordination with the public and private sectors. A mapping of all actors in the national supply chain will be conducted. This will be followed by advocacy for developing a forum to bring all actors together. The programme will advocate for and support an assessment of the gaps in the national supply chain, to be done jointly with the national supply chain actors. In response to this gap analysis, joint interventions to fill the gaps in the supply chain will be developed to respond to the national supply chain strategy needs. Technical and financial support will be provided for shifting from a manual to an electronic LMIS. Support will be provided for the coordinated forecasting of RHCs, including contraceptives method-mix, as well as for the procurement of contraceptives and other RHCs and IT equipment and software for the logistics and health management information system (HMIS). Integration of RHCs into existing national systems will be adopted as a key strategy to strengthen the supply chain management of RH commodities. On the job training of HCPs, health managers and supervisors at all levels of the health system will be provided.

Strategic intervention 2(e) developing the capacity of health care providers to deliver quality family planning services: HCPs in service delivery points will be trained on FP services, including long acting methods and service protocols according to the national health facility standards and care providers' qualifications. The new WHO guidelines on FP ("Selected practice recommendations for contraceptive use - Third edition" 2016) will be adopted. Educational materials for HCPs will be developed and printed and will be disseminated after training. HCPs working in model FP centres will be supported to participate in international as well as national training courses on quality of care in FP service provision. The programme will advocate for and support the task shifting among HCPs of FP services to improve accessibility to the service. Standardized follow up and supportive supervision after training will be adopted.

Strategic intervention 2(f) rehabilitating and equipping family planning model centres in priority states to promote an appropriate method mix including long-acting family planning methods: Support will be provided for development and dissemination of standard operating procedures (SOPs) for FP model centres. Based on accessibility and utilization of FP services, selected centres will be rehabilitated and equipped. Care providers working in these centres will be targeted with the most updated training on FP service provision, with follow up after the training. The FP model centres will be supported with a strong monitoring system that includes regular reporting and frequent standardized field visits. These centres will also be supported to provide integrated SRH/HIV services, which will include screening for reproductive cancers, PAC services and fertility care services. The programme will support implementation of all elements of FP quality of care in these health facilities. In humanitarian settings, the integration the FP services into existing SRH and PHC services will be ensured through working closely with active and present relevant humanitarian partners in the affected communities.

Strategic intervention 2(g) increasing access to culturally sensitive, age-appropriate and relevant family planning information and services: This intervention is closely linked to strategic intervention 2(b) and to demand creation intervention under the first output, in which an integrated package of community awareness will be developed and delivered. The youth groups working closely with community committees will facilitate access to youth and deliver appropriate messages on FP via a culturally sensitive and acceptable approach. Youth-friendly health services will be supported. This strategic intervention will also be linked to HIV programme interventions.

Strategic intervention 2(h) providing emergency reproductive health kits and family planning commodities in humanitarian settings: This intervention is closely linked to strategic intervention 1(j). Prepositioning of emergency RH kits is critical for timely RH response in resource constrained settings and especially during emergencies. The programme will ensure forecasting, procurement and distribution of RH emergency kits to humanitarian settings in Sudan, including ensuring adequate buffer stock of RH kits. Assessments of the kits will be conducted if needed, based on follow up and evaluation reports. Assessment and mapping of RH emergency services will be conducted and training on supplies and RH kits will be provided, based on the results of the mapping.

Output 3: Strengthened capacity of government and civil society institutions to prevent and respond to gender-based violence, with a special focus on women and young girls, including in humanitarian settings.

This output has seven strategic interventions.

Strategic intervention 3(a) implementing behavioural change communication interventions, engaging community and religious leaders to address rooted socio-cultural norms and religious misinterpretations that uphold gender-based violence: Institutional capacity building as well as technical support to, and capacity building of, key actors (religious leaders, NGOs, CSOs, school teachers, academic institutions, local leaders, and media groups) on gender equality, GBV (including FGM/C and child marriage) and SRH, leadership, programme management, community engagement approaches, and policy communication. Stakeholders and implementing partners are to understand the concepts and implement their work plans and activities with quality and efficiency. Capacity building of all stakeholders is required because the social norms change won't be realized with one-actor interventions. As it has been shown to be effective on social norms and behavioural change, the *Almawada wa Alrahma* approach will be utilised to influence policy and decision makers and community at national, state and locality levels. *Wa man Ahyaha* and community networking as a joint programme for the Ministry of Security and Social Development and the Ministry of Health to engage key community actors and religious leaders will also be supported. Media will be further engaged to speed up the process of behavioural change through wide dissemination of messages via a variety of channels, including print, TV and radio.

Strategic intervention 3(b) developing capacity for community-based protection and co-ordination mechanisms on gender-based violence at national and local levels:

There are functional protection and coordination mechanisms across the country: national and state level task forces on FGM/C; high technical committee on maternal mortality; health technical committee for FGM/C and child marriage; GBV sub-sector working groups; and community-based protection systems/mechanisms. These mechanisms will be supported at national, state, and locality levels and new mechanisms/structures will be established where protection/coordination mechanisms are most needed and not yet in place. Existing women's centres will be supported, and activities that strengthen women's self-reliance and protection from GBV and provide an entry point for GBV survivors, such as livelihoods programmes, skills development, and literacy programmes, will be implemented; new women's centres will be established and supported.

Strategic intervention 3(c) supporting line ministries and civil society organisations to provide comprehensive services for gender-based violence survivors: Service providers (midwives, medical doctors, other health personnel and social workers) will be supported to provide psychosocial support including counselling, referral pathways, and clinical management of rape (CMR) to survivors of GBV where applicable. HCPs and institutions providing GBV medical treatment, personal hygiene kits (PHK), psychosocial and paralegal support for survivors will also be supported to upgrade their engagements in the programme. This includes formulation and implementation of a multi-sectoral institutional framework and programmes that ensure coordinated provision of services to prevent GBV and respond to survivors' needs.

Strategic intervention 3(d) supporting youth-serving organizations to provide training for youth: This intervention is closely linked to strategic interventions 1(h), 1(i) and 2(g), where the existing youth networks, including YPEER and the Youth Against FGM national network, will be supported to scale up the networks and integrate peer education packages and awareness raising activities on SRH, GBV, and HIV to a broader range of youth. Following the successes made in active social movements and youth engagement in social norms and behavioural change, a diversity of youth organisations, associations and networks will be established and trained in intergenerational dialogue and other approaches to social norms change in order to strengthen knowledge and awareness of RH and GBV issues. Young men and boys will be supported to better understand and advocate for women's health. Youth will be encouraged to participate in culturally sensitive dialogues around issues related to gender equality and women's health and to actively participate in social norms change and youth movements.

Strategic intervention 3(e) establishing a pilot gender-based violence information management system in selected states: the programme aims to establish a gender-based violence information management system (GBVIMS), an international standardized system for the collection, management and sharing of GBV-related data as a crucial tool to inform the humanitarian response. GBVIMS data is used to improve programming, advocacy efforts and for resource mobilization through the harmonization of data collection on GBV in humanitarian settings, and the safe and ethical sharing of reported GBV incident data among partners. A GBVIMS will be piloted in selected UNFPA focus states to avail data for programming and engagement purposes in both humanitarian and development settings.

Strategic intervention 3(f) implementing research on female genital mutilation/cutting and child marriage: Efficient M&E structures and evidence generation are essential for improving the programme design, implementation and for measuring results. Data synthesis and dissemination are part of the programme advancement, therefore, support will be directed to carry out research, studies and surveys, to disseminate evidence on FGM/C, CM, and GBV, and to produce and disseminate information, education and communication (IEC) products, training and advocacy materials on RH and GBV issues. Programme achievements, best practices, lessons learned and success stories will be showcased for all stakeholders, including donor agencies. All implementing partners will be encouraged to contribute different research and evidence products that demonstrate convincing results. Effective M&E systems will lead to greater programmatic impact through generation of knowledge products and deep analysis of evidence.

Strategic intervention 3(g) advocating for the endorsement and enforcement of policies and laws incriminating gender-based violence: Advocacy for the endorsement and enforcement of strategies, policies and laws incriminating GBV, including FGM/C and CM, is essential for creating an enabling environment for change. The existence of legal frameworks promoting and advancing gender equality and equity is fundamental for progress in gender programming. This will be implemented through a number of activities: orientation and advocacy sessions with relevant partners to support the endorsement of the law banning FGM; sensitization and training of law enforcement bodies on Articles, Acts, and SOPs relevant to family and criminal laws and women's protection; sensitization sessions on laws criminalizing FGM, CM and GBV, with a focus on the legal procedures of Form 8 and Circular No. 2 for service providers; community outreach to raise awareness on relevant laws and Articles supporting women's and girls' protection; technical and financial backing for the implementation of the national Women Empowerment Policy (WEP), GBV policy, child marriage strategy, and other gender-related laws; and support of women's empowerment programmes, including female political participation at national and state level and engendering of the 2018 national census.

Output 4: Increased national capacities for the production, analysis, and use of disaggregated data to inform policy formulation, developmental planning and evidence-based advocacy.

The outcome for this component by 2021 is to have improved systems in place for generating, analysing and disseminating disaggregated population and related data, with a focus on improving the monitoring of the International Conference on Population and Development (ICPD)-based Sustainable Development Goal (SDG) indicators at national and state levels in order to inform policy and programmatic interventions. Through supporting the National Population Council (NPC), Central Bureau of Statistics (CBS) and planning departments at national and state levels, the programme will continue building national capacities to help in the production and dissemination of quality disaggregated data on population and development issues that allow for mapping of demographic disparities and socio-economic inequalities, and for programming including in humanitarian settings. The programme will assist in advocacy efforts for FP, the SDGs and demographic dividend work in Sudan.

The programme will provide support to further preparations for the Sixth National Population and Housing Census planned for 2018.

This output will be achieved through six strategic interventions and associated activities:

Strategic intervention 4(a) developing the analytical statistics capacity at national and priority state level for policy and programming: Training of staff at CBS and planning departments at national and state levels on data analysis techniques to facilitate evidence-based planning will be provided. This will include supporting the generation of data for evidence-based policy and programme development at

national, state and locality levels, through assisting sectors and governments to establish or improve databases as sources of information for planning. At state level, the focus will be to develop state and district specific databases that will provide data and information up to administrative unit level to facilitate bottom up planning and resource allocation. The programme will provide technical assistance to the government on the SDG monitoring framework, reflecting ICPD issues prioritized by UNFPA. The framework will be used for monitoring performance against ICPD-based SDG indicators, the National Population Policy Plan of Action (NPP/PoA), and the Demographic Dividend Roadmap; it will be linked to the national framework for monitoring the SDGs. Technical support will be provided to the CBS for developing web-based interactive and innovative databases for the analysis and dissemination of the Sixth National Population and Housing Census 2018. Different issues will be identified and data on the issues from the census and relevant surveys will further be analysed and disseminated for use in decision making. This will be coupled with ensuring that data on these issues is updated regularly in “SudanInfo” to ensure that it is accessible by a wide spectrum of data/information users. Technical support will be provided to improve the analysis and dissemination of population data from a range of sources and standardize the reporting of national development indicators, particularly ICPD-based SDGs, and SDG indicators, migration, and urbanization, and through supporting deepened analysis on the policy implications of the issues relevant to Sudan’s priorities. The programme will provide technical assistance to include population and development issues into national plans and policies. The programme will ensure the population variables are incorporated in the national and sub-national planning guides and plans, including technical assistance for improving administrative data of selected states.

Strategic intervention 4(b) providing technical assistance to Central Bureau of Statistics to conduct the Sixth National Population and Housing Census: The programme will provide technical support to the CBS for improved coordination in the design, implementation, analysis, and dissemination of the Sixth National Population and Housing Census 2018, using advanced technology, and other surveys as relevant. In that respect, technical assistance will be provided for the design/preparation, implementation, advocacy and census data dissemination. Assistance will also cover technical support to questionnaire design, monitoring of adherence to schedule of activities and budget, provision of advice on the issues of demography, census management, and introduction of new technology, data processing, data analysis, and results dissemination. This will be guaranteed through the utilization of independent national and international expertise on population and development as well as the UNFPA in-house expertise. The programme will advocate, provide technical support for and assist in mobilization of resources for the Sixth National Population & Housing Census 2018. UNFPA will also support the undertaking and acquiring of new technologies for data management and applications for census execution both at national and state levels. Technical support will be provided to the CBS in the utilization and dissemination of existing population data and revised national and state (in selected states) population projection. Support to CBS will also include identifying key data sets and conducting more in-depth analysis of available data from census and other surveys and assessments to make them available for public use. The programme will provide technical support to improve the use of innovative data collection and sharing, including mobile data collection protocols in humanitarian settings, building on past institutional support for data collection. Financial, technical and human resource support will also be provided for CBS to promote transformation to more digitized data collection to ensure high quality, comprehensive and timely collection of data. An assessment to examine the effectiveness of the overall census methodology, in light of the shift from traditional to electronic census in order to propose improvements in future censuses, will be undertaken.

Strategic intervention 4(c) providing technical assistance to the National Population Council to develop a national monitoring framework for ICPD-based sustainable development indicators: The programme will provide technical backstopping to enhance and build institutional and human resource capacity in the use of demographic data for planning and monitoring. Focusing on improving decentralized planning and monitoring in priority states and localities, assistance will target NPC, CBS, the Higher Council for Strategic Planning, and other government partners to improve the planning and monitoring of national flagship programmes by building and strengthening institutional capacities including capabilities of data producers, providers and users for enabling evidence-based planning and

programme management. Support will be provided for sensitization of senior government officers on population dynamics and development of inter-linkages, and for capacity enhancement of district statistical officers in evidence-based planning and monitoring. Technical support will be provided to NPC to advocate for better coordination of quality population data and analysis on a cross-sectoral basis to inform national development policies and programmes. Support will be provided for research and studies on inter-linkages between population, RH/FP, gender and sustainable development related issues. Research institutions, universities and individual consultants will be engaged to identify and conduct research on population and development issues. NPC and other staff as relevant, will be trained on integrating population issues in national development planning tools with particular emphasis on integrating demographic dividend. Research findings will be widely disseminated using various media (fact sheets, flyers, workshops, etc.). The programme will utilize international days, including World Population Day and the State of the World's Population Report, to highlight evidence in progress on ICPD-based SDGs in Sudan. This will support advocacy for strong coordination mechanisms for the implementation of the National Population Policy and the country review of the ICPD Programme of Action. Technical support to strengthen capacities and facilitate analysis of the demographic dividend related issues at national and state levels will be availed.

Strategic intervention 4(d) enhancing the capacity on the use of population data in national development planning processes: The programme will support policy and programmatic research and knowledge sharing on inter-linkages between population, RH, gender and sustainable development. In-depth analyses of census data will be undertaken on thematic areas of work including studies on demographic aspects. For this purpose, the programme will engage academic and research institutions to prepare thematic policy and research papers and monographs and will facilitate their dissemination. Support will further be provided to research and academic institutions in order to integrate issues of economics of demography (demographic dividend) into their postgraduate curricula. The programme will provide technical support for the integration of population factors, RH, and gender issues in the development and budget frameworks at national and sub-national levels. The programme will ensure that population variables are incorporated in the national and sub-national planning guides and plans. The programme will support dissemination of research findings on population and development through publications, seminars, symposia and special events. In this regard, support will be provided to leverage national surveys of the government from its thematic perspectives for generating databases and evidences for policy and programming and also enabling tracking ICPD indicators and SDGs in a wider context.

Strategic intervention 4(e) supporting the development of policy briefs and documentation of good practices for advocacy and decision-making: The programme will identify and nurture champions to advance and further population and demographic dividend issues in particular, and to foster debate in the public domain and to carry out policy, media and champion analysis on the discourse of population dynamics and challenges. This will also involve training the identified champions in advocacy skills and providing them with evidence-based research materials to use in their championing roles. Orientation and sensitization of journalists to strengthen their capacity to competently report on population and development and demographic dividend issues will be supported. Journalists, columnist and media personnel will be introduced to key concepts of population and development as well as demographic dividend issues, as well as their role as watchdogs, to be able to report/write on these issues. Technical support will be provided to the Parliamentary Committee on Population, Health and Environment to strengthen its capacity to advocate for integration of population dynamics in development planning; special trainings will be provided to members of the committee and their participation in global and regional forums will be facilitated. Technical assistance will be provided to organize consultation meetings at national and local levels with parliamentarians and members of legislative assemblies at state levels to advocate for repositioning issues of population dynamics, with a special emphasis on family planning and demographic dividend in Sudan within the context of the SDGs. Technical assistance will be provided to develop policy briefs and fact-sheets and for dissemination of both; these will be used as advocacy tools for UNFPA issues of mandate.

Strategic intervention 4(f) supporting the preparation of demographic dividend advocacy instruments and building national partnerships for increased investments in young people: The

programme will support the operationalization of the newly established National Demographic Dividend Technical Working Committee (NDDTWC) by supporting the secretariat and regular functioning/meetings of the NDDTWG as a national mechanism to advance the demographic dividend work in Sudan. It will assist the NPC in mapping demographic dividend related interventions of public, private, UN and NGOs (who is doing what and where) to promote public-private partnership, coordination and complementarity. Support will be provided to NPC to advocate to Sudanese parliamentarians on ICPD issues, in the context of SDGs, including population data and data usage for policy making and promoting an enabling environment for FP programmes/policies. This will include also working with CSOs, to improve their roles and commitment on FP as an entry point for harnessing the demographic dividend of the country. Technical support will also be provided to strengthen capacities and facilitate consensus on the analysis of the demographic dividend at the state level. The programme will support the Government in the development of background studies as the evidence base for the National Development Plan. Support will be provided to selected academic institutions to incorporate in their teaching programme courses on integrating population variables in development and demographic dividend; these institutions will be identified as centres of excellence to support in creating a mass of supporters to the role of population development through demographic dividend. Capacity strengthening will be availed for government ministries and NGOs that deal with youth issues; this will include widening partnerships with public and private sectors to support youth agenda and youth empowerment and employability. The programme will support conducting quantitative and qualitative studies and in-depth analysis regarding youth and youth issues that will provide input for updating the national youth strategy and the development of a youth policy. It will also support the organization of youth forums to promote their participation in national programmes such as the census and their role in the SDGs, including the Y-PEER Network.

- **Capacity development:**

Capacity development is a key strategy for implementing this programme. At national level, the programme will focus on capacity for evidence generation and use of data for evidence-based planning and programming as well as capacity for advocacy and policy reform to create an enabling environment for programming. At state level, the emphasis will be on enhancing capacity for service delivery. At locality and community level, the programme will focus on enhancing community involvement and participation to support sustainability of interventions, and enhancing behavioural interventions aimed at demand creation and social change to adopt safer behaviours.

Part V. Partnership Strategy

UNFPA has developed a partnership plan to guide the programme focus in maintaining working relationships with a variety of partners who have similar mandates and interests to achieve specific objectives. The partnership plan explains the categories of partners, their roles, associated challenges and lessons learned.

UNFPA will leverage capacity to achieve programme results through reinforcing strategic partnerships guided by the office partnership strategy and ensuring synergy with other United Nations agencies. The CO will rely on key strategic partners (government and non-government) to implement the proposed programme and ensure better results. Federal and state ministries of health, social welfare, youth and sports, the National Medical Supplies Fund, National Population Council, National Council for Child Welfare, Combating Violence Against Women Unit, National Council for Strategic Planning, Central Bureau of Statistics, academia, parliament, media, religious sects and donors are all considered as strategic partners. They are strategic by virtue of their influence, mandate and technical expertise which are critical for policy and social norm change. The identified partners have an instrumental role in policy development, knowledge management and capacity development as key strategies for attaining the programme goal. The strategic partners have high levels of influence in creating an enabling environment by swaying both the policy and community-related interventions and approaches.

Partnering with relevant government institutions and ministries is significant for building national ownership and maintaining accountability for results. Government partners are the lead in program

coordination, policy/strategy development/revision, systems building, knowledge management and capacity development, which constitute the enabling framework for UNFPA support in its areas of mandate. NGOs and CBOs are key partners in service delivery and capacity development for service providers and communities at state and locality levels. People-centred advocacy and awareness promotion are key modes of engagement for this category of implementing partners. Partnerships with academic institutions proved to be successful in knowledge management and capacity development. The experience with national and state universities in the areas of gender/GBV, HIV/AIDS and RH is instrumental in building knowledge through community-based service delivery, research and surveys. Partnership with donors is getting more crucial than ever. In light of changes in the funding landscape in the past few years, the CO has to exert more efforts to mobilize the planned resources for achieving the country programme (CP) targets. Diversification of the funding base and exploring innovative approaches for attracting new donors could be the best way to serve the purpose.

Part VI. Programme Management

The Ministry of International Cooperation (MIC) is the overall coordinating authority for the programme. The programme implementation will use national execution modality through government and non-government partners. In situations where there is lack of national capacity, UNFPA may, in consultation with the Government, directly implement the programme. In the event of an emergency, UNFPA may, in consultation with the Government, re-programme activities for emergency response, in line with UNFPA's mandate.

The Ministry of International Cooperation has the overall responsibility for the development and coordination of the UNDAF. In this capacity, the Ministry also assumes the role of the Government Coordinating Authority (GCA) for the UNFPA Country Programme, with the main responsibility in overseeing the program development and evaluation. The program coordination committee chaired by MIC and comprised of key government partners (Ministry of Security and Social Development, National Population Council, Ministry of Health and Central Bureau of Statistics) shall be maintained to monitor and review the program performance through joint field visits, chairing annual review meetings at national level and participation in the Country Program Evaluation.

The Ministry of Security and Social Development, in its role as the Program Result Manager (PRM), will be represented by the National Population Council (NPC). The NPC will chair the Steering Committee consisting of one key partner from each programme output and a member from MIC, Ministry of Finance and Ministry of Foreign Affairs. The Steering Committee is mandated to meet biannually at the national level to provide policy advice and strategic direction on program implementation, management and evaluation.

In collaboration with MIC and sister UN agencies, UNFPA will implement harmonized approach to cash transfer (HACT) procedures to manage and control the risk associated with the programme implementation. This includes conduct of macro and micro-assessments and assurance activities. With the new programme cycle, all partners will be subjected to micro-assessment using a third party service provider through long-term agreements (LTAs). Findings of the micro-assessments will determine the level of risk and gaps in the various assessment areas. Accordingly, UNFPA will develop a capacity building plan to address those gaps during the course of the partnership period.

Spot checks shall be planned and implemented annually, guided by HACT criteria. UNFPA finance staff at CO and state levels will, regularly, carry out spot checks in their respective areas of operation. The CO will continue strengthening capacity of spot-checkers and implementing partners, particularly the field ones, to ensure that resources are utilized in a more efficient way. Implementing partners will be audited as per the eligibility criteria using a third party service provider. Audit recommendations and implementation of corresponding actions will be strictly monitored.

The CO has put in place an oversight and quality assurance mechanism to ensure that the programme support functions and deliverables are results-oriented. The mechanism is comprised of the programme team, including M&E and operations teams, and is mandated to look into issues of programme alignment; application of programme standards, especially in relation to the output-based annual work plans (AWPs);

under-reporting and reporting gaps; resource mobilization and internal allocation of resources; as well as effectiveness of activities/strategic interventions to achieve the output and outcome results. The team also critically analyses business practices in the CO and recommends reviews, adjustments and updates to ensure the smooth flow of work.

The programme will be implemented by staff funded from the institutional budget, core and non-core resources. Given the huge distance of Sudan, the CO has applied decentralization down to the state level to ensure timely operational and technical support for projects' implementation. Three sub-offices have been established in North, West and South Darfur states; each office includes two technical officers for RH and GBV, admin/finance associate and two drivers. The security service has been outsourced to a private security company in Khartoum and Darfur states. UNFPA also has field presence in other focus states through one programme officer, one admin/finance associate and a driver. In its effort to retain staffing, the CO managed to convert many program positions from service contract modality to temporary fixed term.

A resource mobilization plan will guide the country office to raise funds from available donors to secure the planned non-core resources over the programme period. Such donors will include international and bilateral donor organizations. Apart from the resource mobilization plan, UNFPA and MIC will follow up with implementing partners on securing local contribution for activities related to the projects identified in this document – particularly the development-oriented outputs. Work will continue with a limited number of private sector institutions for contribution in areas of interest.

All cash transfers to an implementing partner are based on the AWP's agreed between the implementing partner and UNFPA.

Cash transfers for activities detailed in AWP's can be made by a United Nations agency using the following modalities:

- 1) Cash transferred directly to the implementing partner:
 - a) Prior to the start of activities (direct cash transfer), or
 - b) After activities have been completed (reimbursement);
- 2) Direct payment to vendors or third parties for obligations incurred by the implementing partners on the basis of requests signed by the designated official of the implementing partner;
- 3) Direct payments to vendors or third parties for obligations incurred by United Nations agencies in support of activities agreed with implementing partners.

Direct cash transfers shall be requested and released for programme implementation periods not exceeding three months. Reimbursements of previously authorized expenditures shall be requested and released quarterly or after the completion of activities. UNFPA shall not be obligated to reimburse expenditure made by the implementing partner over and above the authorized amounts.

Following the completion of any activity, any balance of funds shall be reprogrammed by mutual agreement between the implementing partner and UNFPA, or refunded.

Cash transfer modalities, the size of disbursements, and the scope and frequency of assurance activities may depend on the findings of a review of the public financial management capacity in the case of a government implementing partner, and of an assessment of the financial management capacity of the non-United Nations¹⁸ implementing partner. A qualified consultant, such as a public accounting firm, selected by UNFPA may conduct such an assessment, in which the implementing partner shall participate. (Where the Government wishes, add: the implementing partner may participate in the selection of the consultant.)

¹⁸ For the purposes of these clauses, "the United Nations" includes the International Financial Institutions (IFIs).

Cash transfer modalities, the size of disbursements, and the scope and frequency of assurance activities may be revised in the course of programme implementation based on the findings of programme monitoring, expenditure monitoring and reporting, and audits.

Part VII. Monitoring and Evaluation

The CPAP monitoring shall be guided by the CPAP results and resource framework and the planning matrix for M&E. The monitoring shall consider a mix of activities and mechanisms for tracking the progress towards achievement of the results as envisioned by agreed set of performance measures. Results at the output level and higher constitute the focus of the monitoring process taking into account the key elements of results-based management to ensure effective and quality program delivery.

As a continuous process, monitoring shall include set of planned activities. This includes field visits to projects implemented at national, state and community levels as primary sources for information gathering. Mixed methods including structured and semi-structured interviews, group discussions and meetings shall be applied. Joint visits with implementing partners will be conducted to ensure national ownership and promote the culture of M&E among the program stakeholders.

UNFPA will support the conduct of quarterly thematic reviews and annual programme reviews for assessing the progress towards achievement of annual targets, identifying challenges, drawing lessons and recommendations. National and State Quarterly Thematic Reviews will be coordinated by Federal and State Ministries of Security and Social Development for review of progress and enhancing coordination and integration of UNFPA supported interventions. Annual reviews represented by national and state partners will be called for and facilitated by Ministry of International Cooperation as national coordinating authority.

The CO will invest in the identification and documentation of good practices and human interest stories – arising from implementation of the thematic programmes – for knowledge sharing and as evidence for replication of the successful approaches and pilot interventions.

As partner of the joint FGM/C program funded by DFID, UNFPA actively participates in the annual reviews – with UNICEF, WHO and national partners – and is held accountable to its performance in the respective outputs. UNFPA is a key player in the UNDAF development and review processes both through its membership in the PMT and the UN M&E advisory groups.

For knowledge management and generation of evidence, UNFPA will implement the Country Program Evaluation Plan to inform programming and policy development. KAP studies and thematic evaluations in the areas of SRH and GBV are expected to assess the programme performance at impact and outcome levels and compile lessons learned for future interventions. End of country program evaluation shall also be conducted to assess the soundness of the program, substantive accountability of the investments made, and as a basis for learning in order to improve the relevance and quality of future programmes.

UNFPA will contribute to the UNDAF annual reviews organized by UN agencies in collaboration with the Government Coordinating Authority and other stakeholders. An update on the progress of relevant UNDAF focus areas will be made for all the thematic pillars/outcomes.

Implementing partners agree to cooperate with UNFPA for monitoring of all programmatic activities supported by cash transfers and will facilitate access to relevant financial records and personnel responsible for the administration of cash provided by UNFPA. To that effect, implementing partners agree to the following:

- Periodic review of their financial records by UNFPA or its representatives, following UNFPA's standards and guidance,
- Periodic review and monitoring of their programmatic activities following UNFPA's standards and guidance,
- Special or scheduled audits: UNFPA, in collaboration with other United Nations agencies (where so desired: and in consultation with the Government Coordinating Authority will establish an annual audit plan, giving priority to audits of implementing partners with large

amounts of cash assistance provided by UNFPA, and those whose financial management capacity needs strengthening.

To facilitate assurance activities, implementing partners and the United Nations agency may agree to use a programme monitoring and financial control tool allowing data sharing and analysis.

Where no assessment of the Public Financial Management Capacity has been conducted, or such an assessment identified weaknesses in the capacity of the Supreme Audit Institution, audits shall be conducted by auditors designated by UNFPA.

Assessments and audits of non-government Implementing Partners will be conducted in accordance with the policies and procedures of UNFPA.

Part VIII. Commitments of UNFPA

The seventh country program document (CPD) approved by the UNFPA Executive Board in September 2017 provided a total commitment of US \$40 million that includes \$10 million of regular resources and \$30 million to be mobilized through co-financing and from global/regional programming modalities, subject to availability of funds. UNFPA will develop a resource mobilization plan to mobilize a total of US \$30 million as stipulated in the CPD, depending on donor interests. The resources mobilized through this approach do not include funding specifically mobilized in response to emergency appeals.

Technical and financial support will be provided to national counterparts, including civil society organizations, as agreed within the framework of the signed work plans. Disbursement of funds will be subjected to the satisfactory implementation of planned annual activities, in accordance with UNFPA guidelines and financial procedures.

In case of direct cash transfer or reimbursement, UNFPA shall notify the implementing partner of the amount approved by UNFPA and shall disburse funds to the implementing partner within fifteen days after receiving a request for the respective payment.

In case of direct payment to vendors or third parties for obligations incurred by the implementing partners on the basis of requests signed by the designated official of the implementing partner; or to vendors or third parties for obligations incurred by UNFPA in support of activities agreed with implementing partners, UNFPA shall proceed with the payment within fifteen days after receiving a request for the respective payment..

UNFPA shall not have any direct liability under the contractual arrangements concluded between the implementing partner and a third party vendor.

Where more than one United Nations agency provides cash to the same implementing partner, programme monitoring, financial monitoring and auditing will be undertaken jointly or coordinated with those United Nations agencies.

Part IX. Commitments of the Government

The Government of Sudan will continue to provide an annual financial contribution to UNFPA. In addition, the Government will commit to counterpart funding to the programme and will also be committed to support UNFPA in its efforts to mobilize additional resources as may be required.

UNFPA shall be exempted from Value Added Tax or any other forms of taxation in respect to procurement of supplies and services to support the implementation of this CPAP. The Government will

also ensure that UNFPA staff, performing services on its behalf, has access to the geographic areas where CPAP is being implemented, in order to monitor and provide technical support when needed. The Government Coordinating Authority and the programme results manager will convene programme review meetings, UNDAF annual reviews and steering committee meetings, as described in Part VI and VII of this document, in order to facilitate the coordination and participation of donors and NGOs.

A standard fund authorization and certificate of expenditures (FACE) report, reflecting the activity lines of the AWP, will be used by implementing partners to request the release of funds, or to secure the agreement that UNFPA will reimburse or directly pay for planned expenditure. The implementing partners will use the FACE to report on the utilization of cash received. The implementing partner shall identify the designated official(s) authorized to provide the account details, request and certify the use of cash. The FACE will be certified by the designated official(s) of the implementing partner.

Cash transferred to implementing partners should be spent for the purpose of activities as agreed in the AWP only.

Cash received by the Government and national NGO implementing partners shall be used in accordance with established national regulations, policies and procedures consistent with international standards, in particular ensuring that cash is expended for activities as agreed in the AWP, and ensuring that reports on the full utilization of all received cash are submitted to UNFPA within six months after receipt of the funds. Where any of the national regulations, policies and procedures are not consistent with international standards, the United Nations agency regulations, policies and procedures will apply.

In the case of NGO and INGO implementing partners, cash received shall be used in accordance with international standards in particular ensuring that cash is expended for activities as agreed in the AWP, and ensuring that reports on the full utilization of all received cash are submitted to UNFPA within six months after receipt of the funds.

To facilitate scheduled and special audits, each implementing partner receiving cash from UNFPA will provide United Nations agency or its representative with timely access to:

- All financial records which establish the transactional record of the cash transfers provided by UNFPA;
- All relevant documentation and personnel associated with the functioning of the implementing partner's internal control structure through which the cash transfers have passed.
- The findings of each audit will be reported to the Implementing Partner and UNFPA. Each implementing partner will furthermore receive and review the audit report issued by the auditors.
- Provide a timely statement of the acceptance or rejection of any audit recommendation to UNFPA that provided cash (and where the SAI has been identified to conduct the audits, and to the SAI).
- Undertake timely actions to address the accepted audit recommendations.
- Report on the actions taken to implement accepted recommendations to the UN agencies (and where the SAI has been identified to conduct the audits, and to the SAI), on a quarterly basis (or as locally agreed).

Part X. Other Provisions

This CPAP supersedes any previously signed CPAP and may be modified by mutual consent of UNFPA and the Government of Sudan.

Nothing in this CPAP shall in any way be construed to waive the protection of UNFPA accorded by the contents and substance of the United Nations Convention on Privileges and Immunities to which the Government is a signatory.

IN WITNESS THEREOF the undersigned, being duly authorized, have signed this Country Programme Action Plan on this 21 February, 2018 in Khartoum, Sudan.

For the government of the Republic of the Sudan

For UNFPA

Edris Suleiman
Minister of International Cooperation



Annexes to the CPAP document

- 1. The Results and Resources Framework**
- 2. Monitoring and Evaluation Framework**



Lina Mousa
UNFPA Representative in Sudan