United Nations Population Fund (UNFPA)

Country Programme Mid-term Review 2009-2010

Executive Report

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Acronyms in the text

ACORD	Agency for Cooperation and Research in Development
ADCs	Analysis and Dissemination Committees
ASRH	Adolescent Sexual Reproductive Health
AWP	Annual Work Plan
ANC	Antenatal Care
AUW	Ahfad University for Women
BCC	Behavioural Change Communication
B/CEmONC	Basic/Comprehensive Emergency Obstetric and Neonatal Care
CBO	Community-based Organisation
CBS	Central Bureau of Statistics
CCM	Country Commodity Manager
CHF	Common Humanitarian Fund
CP	Country Programme
CPA	Comprehensive Peace Agreement
CPAP	Country Programme Action Plan
CPR	Contraceptive Prevalence rate
CSO	Civil Society Organisation
DC	Delivery Care
DDR	Disarmament, Demobilisation and Reintegration
DPC	Data Processing Committee
DPTC	Data Processing and Tabulation Committee
EDR	Economic Dependency Rate
FBOs	Faith-based Organisations
FGM/C	Female genital Mutilation/Cutting
FMoH	Federal Ministry of Health
FMoYS	Federal Ministry of Youth and Sport
FP	Family Planning
FSW	Female Sex Worker
GBV	Gender-based Violence
GIS	Geographical Information System
GoNU	Government of National Unity
GoS	Government of Sudan
HIS	Health Information System
HCYS	High Council for Youth and Sport
ICPD	International Conference on Population and Development
IDP	Internally Displaced Person
IEC	Information, Education, Communication
IP	Implementing Partner
JP	Joint Programme
LFQ	Long Form Questionnaire
LMIS	Logistics Management Information System
MARPs	Most at Risk Populations
MDGs	Millennium Development Goals

MDR	Maternal Death Registry
MDTF	Multi Donor Trust Fund
M&E	Monitoring and Evaluation
MISP	Minimum Initial Service Package
MMR	Maternal Mortality Ratio
MNMR	Maternal and Newborn Maternity Reduction
MoE	Ministry of Education
MoF	Ministry of Finance
MoGE	Ministry of Guidance and Endowment
MoSD	Ministry of Social Development
MoWSS	Ministry of Welfare and Social Security
MSDWCA	Ministry of Social Development, Women and Child Affairs
MSM	Men who have sex with Men
MTR	Mid-term Review
MVA	Manual Vacuum Aspiration
MW	Midwife
NCCW	National Council for Child Welfare
NCSP	National Council for Strategic Planning
NGO	Non-governmental Organisation
NPC	National Population Council
NPP	National Population Policy
NYP	National Youth Parliament
PAC	Post-abortion Care
PCCs	Population Census Councils
PCM	Programme Component Manager
PHC	Primary Health Care
PLoA	Plan of Action
PNC	Post-natal care
PoA	Programme of Action
PRSP	Poverty Reduction Strategy Paper
RBM	Results Based Management
RH	Reproductive Health
RHCP	Reproductive Health Care Provider
RHCS	Reproductive Health Commodity Security
RHIS	Reproductive Health Information System
SDP	Service Delivery Point
SHHS	Sudan Health Household Survey
SMART	Specific, Measurable, Attainable, Reliable, Time bounded
SMoSP	State Ministry of Social Planning
SNAP	Sudan National Aids Programme
SOC	Standard Obstetric Care
SPC	State Population Council
SPLM	Sudanese People Liberation Movement
SPN	Sudanese Population Network
SYP	State Youth Parliament
TADC	Tabulation, Analysis and Dissemination Committee

TWG	Technical Working Group
UNDAF	United Nations Development Assistance Framework
UNMIS	United Nations Mission in Sudan
VAW	Violence against women
VCCT	Voluntary Confidential Counselling and Testing
VCT	Voluntary Counselling and Testing
VMWs	Village Midwives
WAAF	Women Associated with Armed Forces
WEP	Women Empowerment Policy

Executive Summary

The purpose of the CPAP Mid-Term Review is to assess the achievement of the programme results, limitations, lessons learned and best practices during the first two years of the Country Program lifetime (2009 – 2010). The MTR is expected to provide credible information on the CP relevance, efficiency, effectiveness and strategic alignment to support decision-making by the programme management and national counterparts for the remaining program period and over the new cycle of assistance

More specifically and as part of the Mid-Term Review of the United Nations Development Assistance Framework (UNDAF), UNFPA has undertaken a Mid-Term review (MTR) of the UNFPA Country Programme for 2009-2012 with the following objectives: (1) review progress toward outputs; (2) assess relevance for peacebuilding in Sudan; (3) identify constraining and facilitating factors; and (4) recommend ways forward in the new Sudanese context.

A team of four independent national consultants carried out the MTR based on a review of programme documents and reports, meetings with UNFPA staff and implementing partners in Khartoum and in the five target states, discussion groups, and monitoring visits to field sites in order to verify information, crosscheck data, and gather qualitative information from beneficiary institutions. The consultants reports were discussed in a consultative meeting with UNFPA and implementing partners as well as in the formal MidTerm Review Meeting held at the Ministry of International Cooperation. It should be noted that the MTR also included a separate review of UNFPA work in Darfur, which was not part of the CP.

The UNFPA Country Programme for 2009-2012 was designed to deliver 8 outputs under three main components, namely Reproductive Health (3), Population and Development (3) and Gender (2). It has been operating under the UNDAF (developed based on priorities identified in the National 5-year Strategy Plan 2007-11) and contributes primarily to thethreeUNDAF outcomes of peace-building, good governance and delivery of basic services at the national level and in the UNFPA target states (White Nile, South Kordofan, Blue Nile, Gadarif and Kassala). During the period of this Mid-Term review, 2009 and 2010, the Programme has been working through 34 main Implementing Partners (government and NGO) with a total investment of US$ 15.4 million (63% from non-core funding). The RH, PD and Gender components have respectively received 59%, 30% and 11% of the Country Programme budget allocations during 2009 and 2010.

The CP has responded to a complex context of both development and and post-conflict recovery through four levels of interventions, namely support to policy formulation/review, strategy formulation/review, programming (establishing systems and standards, developing operational and contingency plans, and delivering capacity building and services), and community outreach. Research and advocacy have been cutting across all intervention areas.

The overall achievement of the CP across all components has been well above average, reaching up to 75% rate of implementation of the agreed Annual Work plans (AWP)'s. Despite the reporting gaps (a notable limitation), the top-10 achievements included:

- more than 60 data/survey reports produced (census, PD specialised research, manuals/guidelines, need assessments and situation analyses);
- the revision of the National RH Policy which decentralised the RH Policy/Strategy by means of integrating new concepts/practices that were non-existent, shifting/delegating tasks to lower level of healthcare providers/professionals, and increasing access to FP services in remote under-served areas;
- 11 sectoral strategies formulated/reviewed;
- 21 operational action and contingency plans developed;
- 25 health facilities (primary to tertiary, including fistula centres) supported (rehabilitation, new establishments, equipment), in addition to introduction of systems of mobile clinics to reach out under-served areas, and provision of 38 local ambulances to VMWs for referral of complicated obstetric cases;
- at least 4,637 persons received training - RH (1,969), PD (887) and Gender (1,781);
- at least 361,627 community members outreached with IEC/BCC materials through open mobilisation campaigns/sessions;
- at least 74,950 MARPs outreached (286,313 male condoms distributed);
- at least 126,202 IEC/BCC materials distributed to communities - RH (91,202) and Gender (35,000) the result of which 39 communities have already declared banning of FGM/C while 224 are similarly expected to do so;
- 5,692 RH-MISP emergency kits and hygiene kits prepositioned.

The activities implemented so far have made significant contributions to peace building and governance in Northern Sudan. The successful completion of the 5th National Census has provided useful disaggregated data to implement the key milestones of the Comprehensive Peace Agreement, which were the national elections and the Southern Sudan Referendum. The process of data analysis and disseminated has created a condusive atmosphere between the CPA partners (the GoS and the SPLM) and so softened process of endorsements of the census data/results. The policies, strategies, action plans, and monitoring mechanisms have set the basisfor accountability and transparency between state and non-state actors. The open and evidence-based dialogue/approach on RH, population, youth and gender issues have peacefully broken the barriers between the duty bearers and rights bearers. The community outreach approach through BCC and IEC materials reduced the tensions with the marginalised and the excluded groups, and so has signalled contribution to equity and better chances for good governance and social peace.

One main conclusion of the MTR is that the Country Programme support has been most instrumental at the level of technical support, particularly in policy and strategy review/formulation and operationalisation, as well as establishing systems, protocols and standards for quality service delivery. As well, it was found that support to states and outreach to communities has generated vivid impact in a relatively short period of time. The CP modalities of management and coordination of partnerships, despite their complicated and “heavy” nature, have facilitated delivery of outputs.

Accordingly, key strategic recommendations of the MTR are (i) gradual scaling-down of service delivery and more focus on advocacy; (ii) more support to state at the level of implementation while focussing on policy/strategy at the national level; (iii) use findings of the Census 2008 and the SHHS to map out the states and localities that should receive direct support, depending on the status of relevant indicators in each state/locality, i.e. establish an 'intervention map' according to evidence-based criteria for selection. This might expand converge to other states, or to localities within the current target states

1. Introduction and Background

1.1. Programme context

During the last decade, Sudan has emerged from a long devastating conflict affecting both the Northern and Southern parts of the country. In particular, the Comprehensive Peace Agreement (CPA) signed in 2005 between the Government of Sudan (GoS) and the Sudanese People Liberation Movement (SPLM) has brought peace to Sudan, formed the Government of National Unity (GoNU), and provided new opportunities for development and recovery. Another peace agreement also ended armed conflict in the Eastern states even as negotiations continue in Darfur.

The UNFPA 5th Country Programme (2009-2012) has been responding to the context in which some of the key milestones enshrined in the signed peace agreements, particularly the CPA, were implemented by the peace processes. The main national priorities during 2009-2010, had been the completion of the 2008 National Census (data, processing, analysis, as well as endorsement and dissemination of results) as a prerequisite for the National Elections in April 2010, and preparation for the Southern Sudan Referendum in January 2011. These priorities had taken the bulk of internal and external political commitments, and had therefore left the other national development agendas and programming priorities with relatively little attention.

Processes associated with these CPA milestones were accompanied by mass population movements between Northern and Southern Sudan, as well as within Northern Sudan, particularly in the border-states (White Nile, Blue Nile and South Kordofan). There are also ongoing processes of disarmament, demobilization and reintegration (DDR), spontaneous displacement and returns in conflict-affected states which the UNFPA has been responding to, within its areas of mandate. The responses include efforts in reducing GBV, addressing gender inequalities, improving awareness on HIV/AIDS, and procuring/distributing emergency RH commodities.

Within this complex national context, UNFPA has to respond to both "normal" development needs and transitional/recovery needs in a two-way holistic programming approach. For example, while a programme is implemented to provide policy and recovery/development support (e.g. rights and access to RH services), it also delivers the RH humanitarian support through emergency preparedness and contingency plans, mostly in collaboration and joint work with other actors.

The UNFPA Country Programmewas designed to respond to contextual challenges in Northern Sudan and the growing unmet needs at the community level that go beyond the available national resources and institutional capacities. The challenges include the following indicators[1]: 50-90% of Sudanese are engulfed in absolute poverty; the Economic Dependency Rate (EDR) is at 87% which means high unemployment rate, especially among the youth population; 75% of the population are not covered by any insurance; there are 4 million IDPs; 70% of returnees are below 30-year old; 1.7 million people and 425 thousands women of reproductive age were expected to return from the North to the South in 2010

[1] These indicators are available both in the Country Programme Action Plan (CPAP) and UN Country Situation Analysis (2007). However, values of some of these indicators might have changed.

by passing through the border states; the prevalence rate of HIV/AIDS is 1.6%; the contraceptive coverage is as low as 8%, and the demand for contraception is low; Maternal Mortality Ratio (MMR) is 638 per 100,000 mothers; 77% of women prefer to give birth at home; only 57% of births are attended by skilled birth attendants; and approximately 37% of girls enter marriage or give births before the age of 18.

In response to these challenges, the Programme has been implementing its programme under the United Nations Development Assistance Framework (UNDAF) through three distinct but interlinked components, namely Reproductive Health and Rights (RH), Population and Development (PD), and Gender Equality. The Agency has allocated reasonable resources and identified key strategic implementing partners at the national and state levels.

1.2. Programme configuration and financial allocations

The UNFPA programme has been implemented through 34 major governmental and non-governmental implementing partners (IPs) at the national level and in the five target states. The total investment in the period of 2009-2010 reached USD 15.4 million, out of which 59% was devoted to the Reproductive Health Component, as the major focus area. The overall rate of spending vis-à-vis the budgeted amounts during this period was 81% (see table).

Component	IPs	Pledges 2009-10 (US$)			
		Budget	Budget share	Spending	Rate of spending
RH	15 IPs, led by Federal Ministry of Health (FMoH)	9,088,823	59%	6,844,374	75%
PD	7 IPs, including Central Bureau of Statistics (CBS), National Population Council (NPC), Federal Ministry of Youth and Sport (FMoYS), High Council for Youth and Sport (HCYS) (Gadaref & Kassala), Sudanese Population Network (SPN), and Turath (NGO in South Kordofan)	4,582,572	30%	4,121,778	90%
Gender	12 IPs, including Ministry of Welfare and Social Security (MoWSS), Ahfad University for Women (AUW), Violence against Women Unit of Ministry of Justice/MoJ (VAW), National Council for Child Welfare (NCCW), Ministry of Health (MoH), Ministry of Guidance and Endowment (MoGE)	1,731,348	11%	1,478,305	85%
All Country Programme (CP)	34 IPs, each with Annual Work Plans (AWPs)	**15,402,743**	**100%**	**12,444,457**	**81%**

The sources of funding are categorized into the 'core fund' of the UNFPA and 'non-core fund' which is mobilised from various donors. The core and non-core funds contributed to the total budget in 2009 and 2010 by 37% and 63% respectively. This indicated UNFPA's success in mobilising additional resources for almost two-third of its overall budget secured for the programme in 2009 and 2010 (see table).

Programme component	Core fund		Non-core fund		Total budget allocations	
	Amount US$	%	Amount US$	%	Amount US$	%
RH	3,448,982	*38%*	5,639,841	62%	9,088,823	*59%*
PD	1,516,339	*33%*	3,066,233	67%	4,582,572	*30%*
Gender	706,729	*41%*	1,024,619	59%	1,731,348	*11%*
All CP	**5,672,050**	***37%***	**9,730,693**	**63%**	**15,402,743**	***100%***

Almost all programme components used resources from the non-core funds for the bulk of their budgetary allocations, i.e. through fundraising with donors. This was possible due to the specific areas of work in the programme components that attracted funding, such as HIV/AIDS activities under the RH, the Sudan 5th National Population Census under the PD and Female Genital Mutilation/Cutting (FGM/C) initiatives under the Gender component.

1.3. Mid-term Review (MTR) objectives

The overall objective of the Country Programme MTR is to assess the programme achievements and their relevance to peace building efforts in Northern Sudan. Specific objectives are:

- To provide information on the *progress* in achieving the Country Programme Outputs, in light of the contextual constraints and opportunities.

- To assess the continued *relevance* of the UNFPA's assistance in contributing to national reproductive health, population and development goals, as well as peace building efforts in Northern Sudan.

- To review the *constraining and facilitating* factors to determine whether original risks and assumptions as articulated in the CPAP have materialised or whether new risks have emerged.

- To recommend the way forward, which include a proposal of performance measures that will specifically capture UNFPA's contribution to the peace building process in Northern Sudan.

1.4. MTR Methodology

A team of four national consultants was recruited to carry out the review at the national level and in the five target states. The consultancy commenced on 6th March through 15th April with a two weeks extension to the team leader for the write-up and compilation of the report. The review team received exhaustive inductions by the UNFPA Country Office, as well as orientations from the Programme Officer of each component. The team was also introduced to representatives from key line Ministries, and was involved in a one-day conceptual session on peace-building presented by a the UNDP Sudan Peace-building Advisors. The consultancy team had various preparation meetings and have accordingly:

- Reviewed the key programme documents – e.g. CPAP
- Reviewed the annual programme progress reports for 2009 and 2010; and the Sudan Country Office Annual Reports for the same years.
- Held consultative meetings with the Component Programme Officers.

- Held review meetings with the IPs at national level (in Khartoum), including the Government and Civil Society Organizations (CSOs).
- Carried out field visits to meet with the staff from UNFPA field offices and IPs in the 5 target states, as well as some of the institutions that have benefited from the UNFPA's support (see list in the Annex). The objective of the visits was to collect state-based information and interview partners to check the accuracy of information related to the programme performance.

Findings from the desk and field reviews were analysed, written up and presented into separate Component Review Reports by the individual consultants, namely:

1. Ibrahim M. G. Sahl (M.Sc. Economics), consultant for the PD component and Team Leader
2. Abdelrahman M. Mubarak (M.Sc. Econ.; M.Sc. Population Communication), consultant for the RH component.
3. Mustafa EL Nimeiri (Associate Prof. of Community Medicine), consultant for the RH component
4. Limiaa Abdelghafar (PhD in Sociology and Social Policy), consultant for the Gender component

The Component Review Reports, thereafter, were used as the sole references and synthesised into an Executive Review Report. It should be noted that this MTR is not intended as an evaluation but rather a review of the programme performance in relation to the agreed Annual Work Plans with the IPs in 2009 and 2010. Furthermore, much of the emphasis has been placed on progress in each programme output and key achievements in relation to the preset indicators.

Limitations

The MTR faced the following limitations:

- The poor reporting and documentation of achievements by the program implementing partners took much of the consultants' time to verify the accuracy of information through additional interviews.
- The relatively large number of IPs at national and state levels was also a limiting factor for timely conduct of the MTR.
- The unavailability of baseline data for identified targets limited the team ability to report on progress at the output level using the identified indicators.
- The methodology did not include the interview of beneficiaries
- The lack of a comparable state for the assessment process limited the extent to which the findings could be applied.

2. Review of the RH and Rights Component

The goal of the RH component is to promote equitable access to, utilisation of, and demand for quality basic health services/commodities and reproductive health information, including HIV/AIDS, by individuals and communities, particularly women, youths, children and vulnerable groups in conflict-affected settings. The component activities have been implemented at the federal level and in 5 selected states (White Nile, Blue Nile, Gadarif, Kassala and South Kordofan)[2]. Although the programme specifically focuses on providing support to those 5 states, it also aims to provide support for the rest of the Northern States regarding RHCS including Family Planning, RH policy development, review and development of national curriculum etc. (FP). The RH component has been delivering activities to achieve the following 3 outputs:

Output 1: An essential and integrated reproductive health package and reproductive health commodities are available at service delivery points in the selected states.
Output 2: The technical and institutional capacity to provide basic and comprehensive emergency obstetric and neonatal care and to prevent obstetric fistula is strengthened, including in post-conflict situations.
Output 3: Increased awareness of reproductive health information and improved knowledge of preventing HIV/AIDS, especially among out-of-school youths.

2.1. Progress in Output 1: … on integrated RH service package/commodities …

The overall objective of Output 1 is to strengthen the health system with special emphasis on the issues of capacity building for better health systemgovernance/management, RHCS including Logistics Management Information System (LMIS), Health Information System (HIS) for decision-making (service-related data), specific action-oriented research, and service delivery. Activities implemented under this output included (i) support for advocacy and policy dialogue to integrate RH activities into annual health sector plans (national and state); (ii) availing integrated basic package of reproductive health services at primary healthcare points in the selected states; (iii) capacity building on RHC-LMIS at the national and state levels; (iv) competency building and clinical skills for RH/FP service providers at the state level, including in the area of youth-friendly services; (vi) increasing state competencies on RH contingency planning and emergency preparedness through the Minimum Initial Service Package (MISP) critical to RH and GBV prevention and response. The following is the review summary of key activities and achievements during 2009 and 2010.

RH policy advocacy and research:
The technical expertise provided through the programme has facilitated the review of the National RH Policy in 2009-2010. The revised policy has integrated new concepts/practices which were non-existent previously, such as distribution of oral contraceptive pills and male condoms by Village Midwives (VMWs) and community-based healthcare providers, permission for healthcare providers to use Manual

[2] The selection of these states was made according to the findings of the SHHS 2006 which showed that, apart from Darfur States, those locations were found to be at the top-5 of states in Northern Sudan with the worst RH indicators (e.g. MMR, Contraceptive Prevalence Rate (CPR)). In addition, some of these states have recently emerged from the long conflict in Sudan and are therefore the focused areas for the development and recovery agenda enshrined in the signed peace agreements, particularly the CPA.

Vacuum Aspiration (MVA) for post-abortion care, and provision of magnesium sulphate for the management of eclampsia at the primary healthcare level. In addition, the programme has also supported the development of the National RH Communication Strategy. This was seen as a critical step towards task shifting and delegation of responsibilities from tertiary level to lower level healthcare providers/professionals in managing life-threatening conditions in remote areas. This approach was also critical for increasing access to FP services, i.e. by supporting decentralisation of the RH policy and strategy. The direct impact was evident in the creation of a better policy environment and information to support the prioritisation and provision of the integrated RH/FP services package at the primary healthcare level.

For better targeting, identification of priorities and decision-making for RH services at all levels, the programme has supported some operational researches, such as the socio-cultural study on barriers to FP at the community level, and RH situational analysis in the 5 target states. UNFPA has also provided technical and financial contribution for the Sudan Health Household Survey (SHHS 2009). The survey report is yet to be endorsed by the FMoH.

Capacity building for health system:
All planned RH training activities on Antenatal Care P (ANC/P)[3], Antenatal Care Family Planning (ANC/FP), HIS, /Country Commodity Manager (CHANNEL/CCM, −RHCS software) and LMIS have been implemented. Using the standard training packages by the FMoH, UNFPA has trained 518 participants representing medical doctors, medical assistants, health visitors, assistant health visitors, and VMWs. The objective of those trainings was to improve the delivery of the integrated RH package at the primary healthcare level, strengthen the RHIS, improve community-based reporting on RH services, and develop states' capacity in LMIS particularly related to tracking/forecasting of RH commodities. The review findings indicate an improvement in the HIS as a result of gradual involvement trained VMWs in data collection at the community level.

Although it is premature to assess the impact of the capacity building activities for health system at the state level, the next phase of the CPAP nevertheless needs to focus on ensuring the quality of the RH data and HIS in general. Gadarif's experience in training the RHCPs and statisticians on HIS is considered as a good practice, which has supported for improving the quality of RH database. It should also be noted that those trainings have faced constraints, such as the lack of accredited trainers, high turn-over at the state level, insufficient in-class training modality, lack of follow-up mechanisms, and illiteracy of most VMWs.

RH/FP Service delivery:
Activities in this area include (i) rehabilitation of and provision of equipment for FP/health centres to ensure quality service delivery; (ii) establishment of new FP service delivery centres; (iii) direct provision of FP commodities; and (iv) implementation of innovative ways in expanding outreaches and access to RH services in underserved and remote rural areas.

Out of 37 targeted centres in 4 states, UNFPA has managed to rehabilitate and equip 12 centres (32.4% of the target). This is because some of these refurbishments were unfunded activities right from the beginning but still captured into the AWPs. This strategy was adopted by UNFPA in 2010 as a need-

[3] Except for the ANC/P for Medical Doctors in Kassala State

driven plan, apart from the financial commitments. Those identified funding gaps in the AWPs were to be used later as a guide for resource mobilisation.

UNFPA has also established 2 FP units in Kadugli and Dilling Hospitals (South Kordofan State). The function of one of the 2 units is still pending the Government's official launching. In comparison with the other states, South Kordofan has a good number of health visitors and assistants (i.e. 60 personnel). If this critical mass is fully mobilised, the outreach of and access to FP services can be expanded, particularly in the areas where no hospitals with exist and have only secondary health facilities. This means that the future UNFPA's work should take this factor into consideration, including the possibility for introducing mobile clinics.

The technical support provided through the programme has further facilitated the development of the National Addendum RHCS Operational Plan (2008), based on which the programme later integrated the 5-year RHCS Plans into the Maternal and Newborn Maternity Reduction (MNMR) Roadmap. Within this process, the states have also prepared their plans[4] and developed a community-based distribution modality to increase utilisation of FP services. A series of training for RH providers and VMWs were conducted alongside the comprehensive community mobilisation and awareness raising campaigns. UNFPA procured the required FP contraceptives for the 5 target states. However, those efforts have been affected by shortages in the supply of FP contraceptives for all states, particularly in 2009. Due to the FMoH's decision to distribute the FP commodities equally to all 15 northern states, instead of the 5 programme's target states experienced nation- wide commodity stock outs and limited commodity coverage, thus resulting in a relatively low level of utilisation of FP services and delivery of comprehensive RH services.

The need assessment carried out in the states has resulted in the mapping of RH needs, particularly in remote areas uncovered by formal primary healthcare system. To widen access and expand outreach, UNFPA piloted rural mobile clinics in the underserved areas of the White Nile State. This initiative was new, and therefore in the next Programme Phase 2011-12 and in collaboration with the local health authorities, UNFPA needs to undertake further evaluation of the innovation in relation to its effectiveness, sustainability and feasibility, in order to replicate for other similar areas.

RH emergency preparedness:

UNFPA has responded to some emergencies including the flood in Kassala and White Nile State, spontaneous displacement and returns in South Kordofan State, as well as population movements from Northern to Southern Sudan and within Gadarif and Blue Nile State (e.g. returnees). Such emergency occurrences had contributed to RH risks and gender inequalities in those locations. The UNFPA Programme has been tasked to respond to emergency RH needs in the 5 target states through provision of MISP packages critical for RH and prevention and response to GBV. To this end, UNFPA has (i) trained 25 RH coordinators and health managers on emergency preparedness; (ii) conducted intensive MISP Training of Trainers (ToT), leading to the formation of a national core team of 22 trainers (10 trainers from the 5 target states who extended similar trainings to the other 78 RH-MISP personnel); (iii) developed the Annual Contingency Plan for each state; (iv) procured and prepositioned emergency RH equipment, supplies and medicines in the 5 states and provided stocks in the State Ministry of Health (SMoH); (v) trained 160 health providers on Clinical Management of Rape (CMR) for survivors; and

[4] Gadarif and Blue Nile States are yet to produce their plans.

(vi) distributed 342 RH emergency kits and 4,500 hygiene/dignity kits to the border states (White Nile, South Kordofan and Blue Nile) in preparation for the Sudan Referendum (for a period of 3-6 months).

In addition to the 5 target states, UNFPA (in conjunction with the Referendum) also extended emergency support to Sinnar and North Kordofan State through training of 80 RH personnel and distribution of emergency RH kits for health facilities.

Experiences and lessons learned from the emergency preparedness programme in 2009-2010 enabled UNFPA to develop a comprehensive Contingency Plan to respond to the expected mass population movements and any possible conflict during the post-referendum period and following the formal announcement of Southern Sudan in July 2011.

Governance and management of health service system:
UNFPA has facilitated the establishment of the National Reproductive Health Partners' Forum led by the FMoH and aimed to improve coordination between development actors at the national level. Similar forums were also established in the five target states. These forums have been supporting the health planning, decision-making, policy advocacy and dialogue with Government and partners, thus providing UNFPA with the opportunity to pursue the RH advocacies and policy agendas. This system has also facilitated reviews of existing policies and operational plans, as well as formulation of the new ones at the national and state level.

Overall, the following Table provides a summary of the achievements under Output 1 with respect to the preset indicators[5].

Indicator	Achievement 2009-2010
% of health delivery points providing the integrated basic reproductive health package	The required RH Policies, strategies and plans produced (normal and emergency), HIS strengthened, staff trained and facilities increased (i.e. 14 additional facilities). There was a marked increase in services availability and access due to the increase in number of service providers at facility level. All PHCs in the 5 target states have followed standards and guidelines for RH service package despite the insufficient RH commodity stocks due to distribution of the pre-positioned RH commodities across 15 rather than the initially planned 5 target states, resulting in RH commodity stock outs.
Implementation of the RHCS Plans	The National Addendum RHCS Plan available and operational; the state-specific plans operational in White Nile and South Kordofan , and approved for operation in 2011 in Kassala. No plans so far in Gadarif & Blue Nile.
Availability of operational emergency preparedness and response plans	The Operational RH Contingency Plans, including MISP, available in Blue Nile, White Nile and South Kordofan. In Kassala, Annual Flood Emergency Plan is operational. The implementation of the contingency plan in South Kordofan for the spontaneous displacement and returns is ongoing.
Emergency RH kits available for humanitarian needs	5,692 RH kits of various types, composed of 1,192 RH-MISP (cartons) and 4,500 hygiene/dignity kits, pre-positioned in the 5 target states

[5] In preparation for the End-phase Programme Review, UNFPA needs to conduct a small baseline indictors survey on the existing situation. This applies for all outputs so as to provide basis for accuracy in measuring the progress.

2.2. Progress in Output 2: … on Emergency Obstetric and Neonatal Care (EmONC) services …

The overall objective of Output 2 is to support the implementation of the Government MNMR Strategy aiming at reducing the maternal and newborn mortality. Activities implemented and technical support provided through the programme contributed to the (i) development of the MNMR strategy and operational plans; (ii) basic training for midwives; (iii) in-service training for midwives and other cadres on critical life-saving skills (i.e. EmONC, Standard Obstetric Care (SOC) and Post-abortion Care (PAC)); (v) review of the existing midwifery curricula; (iv) capacity of the midwifery schools; and (v) obstetric fistula prevention, treatment and social reintegration.

Development of MNMR strategies, plans and service standards:
The technical and financial support extended by UNFPA to the Government has resulted in the: (1) development of the national MNMR Roadmap with the overall objective of reducing the maternal and newborn deaths, thus furthering the strategic guidance to reduce unwanted pregnancies and unsafe abortions; (2) development of state-specific MNMR Roadmap implementation plans; (3) facilitation of development and implementation of the National Midwifery Strategy aiming at increasing the coverage of professional midwives, thus eventually increasing the use of skilled birth attendants during pregnancy and childbirth; and (4) development of the EmONC guidelines and protocols, namely the training manual for facilitators and participants, management protocol, and post-abortion care management protocol, in order to improve the quality of the EmONC service provision. Those four key achievements have helped in laying the foundation, producing plans and fixing necessary standards for service provision. The next for the programme support, therefore, is to primarily focus on the costing of the national MNMR Roadmap and to support the implementation of the action plans.

Institutional capacities and mechanisms building for service delivery:
Main areas of the programme focus were on emergency obstetric and neonatal care services EmONC services and referral service system. The EmONC related activities ranged from clinical skills training to rehabilitation of health facilities and provision of essential obstetric equipments. The status of the comprehensive EmONC service in the target states in 2008 showed that Blue Nile had one tertiary hospital, South Kordofan had 2 tertiary hospitals covering about 40% of the state's population, and the rest of the states had adequate number of tertiary hospitals in in relation to the population size. UNFPA has upgraded 2 rural hospitals (Hawata and Doka) in the southern Gadarif and equipped the hospitals with blood transfusion facilities. Yet, although the number of tertiary facilities in the Gadarif State is adequate, the upgraded rural hospitals are in areas that are off limits during rainy season with high maternal deaths. The Agency has also equipped 2 hospitals' operation theatres in South Kordofan (Kadugli and Delling). In White Nile, 3 tertiary hospitals were equipped with basic medical equipments including CS sets and blood transfusion kits. However, due to funding shortage, UNFPA was not able to support the 2 state hospitals in Kassala.

In the meantime, the status of the BEmONC in the target states in 2008 showed that Blue Nile had 2 out of the required 8 facilities, Gadarif had adequate number of facilities, Kassala had 10 out of the required 16 facilities, South Kordofan had 8 facilities covering only 40% of the state's population[6], and White Nile had adequate number of facilities. Except South Kordofan State, the Programme rehabilitated 1 facility in each of Blue Nile, Gadarif[7], and Kassala. In addition to these rehabilitation efforts, the Programme in White Nilehas also conducted in-service training for medical doctors and standard obstetric care training for VMWs in White Nile. The efforts made so far have resulted in the overall service coverage reaching 72% (see table), which was however still below the national coverage in Northern Sudan in 2008 (80%). This was due to the fact that the activities in South Kordofan were still to be implemented. Therefore this figure has not reflected the overall improvement. The coverage in White Nile, Gadarif and Kassala was however above the national coverage. To this end, with regards to the 4 states in which UNFPA's support has taken place, the overall coverage of 80% was similar to the national coverage in Northern Sudan in 2008. This means that the next programme phase 2011-2012 should maintain the status quo and work towards further improvement of the service coverage so it will surpass the national status in 2008, with special focus on South Kordofan and Blue Nile State, accordingly.

State	Number and type of EmONC service facilities available to 500,000 populations				Service coverage 2010
	2008 (base)		2010 (MTR)		
	CEmONC	BEmONC	CEmONC	BEmONC	
White Nile	4	14	4	16	83%
Blue Nile	1	2	1	3	54.3%
Gadarif	3	14	5	14	100%
Kassala	3	10	3	11	83.8%
S.Kordofan	2	8	2	8	40%
Overall	***13***	***48***	***15***	***52***	***72%***
Overall coverage excluding South Kordofan					80%

In order to strengthen the referral system/service in remote and inaccessible areas, UNFPA has also engineered the idea of donkey-driven carts as a form of ambulance. In Gadarif and Kassala, respectively 20 and 18 such ambulances have been provided to VMWs to facilitate the referral for complicated obstetric cases. Although there is still a need to assess the effectiveness of such innovation, the initiatives have started showing immediate impact, such as the saving of women's lives at affordable cost and extra income for VMWs which has further retained them within their communities.

However, despite all of these efforts, there is still a need to advocate for additional government and development partners' commitments to address the following gaps: limited human resources, shortage of essential obstetric equipments, inadequate basic supplies and limited budgets for maintenance and running cost. Those gaps need to be addressed to ensure the delivery of quality obstetric services in the target states.

Capacity of the midwifery schools

[6] This limited coverage in South Kordofan State was further aggravated by the geographical distribution of BEmONC facilities, chronic shortages of healthcare providers in rural areas, and insecurity.
[7] Original plan was to rehabilitate 3 facilities.

UNFPA has equipped the Omdurman Midwifery School, the country's lead midwifery training institution, with skill labs necessary to provide quality midwifery training. The ToTs were also extended to the schools and states' midwifery tutors and health visitors. Through the implementation of the programme UNFPA has further (i) rehabilitated and equipped 2 midwifery schools in White Nile, with annual intake of 120 VMW candidates and with the objective of increasing the coverage of community-based midwifery services; (ii) rehabilitated 1 village midwifery school in Blue Nile, but yet to be equipped; and (iii) rehabilitated Gadarif Midwifery School to provide basic trainings for VMWs and MW technicians. The rehabilitation activities in Kassala are planned to be undertaken by the MDTF.

Review and implementation of midwifery strategy and curricula

UNFPA has supported the formulation of the National Midwifery Strategy which includes transitional and long term plans. The ultimate objective of this strategy is to reinstitute professional midwives (to the level of diploma and B.Sc) into the health system through gradual replacement of VMWs. The VMWs will be kept at the community level or upgraded depending on their educational level.

UNFPA has also extended its financial and technical support for the review of curricula for different levels of midwifery cadres (2-year curriculum for technicians, 3-year curriculum for diploma, and 4-year curriculum for B.Sc.). While funds have already been provided in 2010 and the trainings for midwifery technicians have already started, the B.Sc. and Diploma trainings are planned for 2011.

Since the pre-requisite for admission to the training of professional midwives is possession of a secondary school certificate, this might limit the chances for candidates from rural areas who most likely do not meet such a criterion for admission. The alternative strategy in the short-run, therefore, should be a gradual phase-out approach while replacing VMWs. In the long-run, the health and education authorities need to work together towards ensuring that all villages have female secondary school graduates who will be eligible for admission.

Training of midwives: basic and in-service trainings on critical life-saving skills

It was observed that the prevailing distribution pattern of midwives in all states is urban-based, which makes coverage of the rural underserved areas remain low. For this reason, UNFPA has provided considerable support for basic trainings of VMWs. This role is expected to be taken over by the Government in the future.

In 2009, 190 VMWs received 1-year training and delivery kits, and are currently providing midwifery services to their communities. Additional 120 VMWs have also been enrolled and will be graduated. For the 2-year midwifery technician training, a total number of 150 midwives in White Nile, Gadarif and Kassala were enrolled in 2010 and are yet to complete their diplomas. In addition to this, the in-service trainings delivered to VMWs on life-saving skills covering ANC, Delivery Care (DC), PN, and early referrals, have greatly contributed to the improvement of community-based midwifery services in the target states.

Findings from the MTR revealed an improvement in service coverage of VMW/skilled birth attendants in the communities (see table). The highest improvement has taken place in Blue Nile (almost doubled) due to the appropriate selection criteria. The advocacies carried out in Blue Nile, Gadarif, and White Nile States have resulted in the Government's recruitment of VMW graduates, thus further increasing the coverage of the under-served rural areas in these states. The overall coverage in the target states has improved by almost 31% relative to the situation in 2008. As new midwifery graduates are expected to join the service in 2011, the improvement is expected to further escalate. Despite this, however, the scattered nature of villages in some states is still a constraint which limits the service coverage. Addressing this challenge requires the local health authorities' decisions on distribution of services and coverage.

Midwifery service coverage in the communities with 2,000 populations		
State	**2008**	**2010**
White Nile	50.6%	54%
Blue Nile	25%	47%
Gadarif	44%	53%
Kassala	29.5%	44.5%
South Kordofan	50%	62%
Overall coverage	***40%***	***52%***
Coverage improvement	***31%***	

Maternal Death Review/Audit

The Maternal Death Review (MDR) provides information on the causes and contributing factors to mothers' deaths, in an attempt to inform the HIS and take actions accordingly. The process involves notification, investigation and reporting. UNFPA's support in this include the (i) establishment of MDR Secretariat Offices at national and state level (through provision of equipments, management costs for the national office, and costs for the review meetings); (ii) development of the standards for registration and reporting (guidelines and formats); and (iii) advocacy sessions to disseminate findings. The result was the implementation of the MDR system that yet to be institutionalised into the HIS across the country.

Obstetric fistula prevention, treatment and social reintegration

Activities in this area were done in collaboration with the Abbo Fistula Treatment Centre in Khartoum. UNFPA has (i) rehabilitated and equipped the Abbo Centre; (ii) established the section for treating cases within the Abbo Centre; (iii) established additional fistula satellite treatment centres in Kassala and Nyala; (iv) trained specialist doctors and general practitioners from the Kassala Fistula Centre and other tertiary hospitals on diagnosis and management of obstetric fistula; (v) led outreach campaigns for treatment of fistula in periphery hospitals; and (vi) drafted the National Fistula Management Protocol and Guidelines, which is expected to be finalised in 2011.

The table below summarises key achievements and progress under Output 2:

Indicator	Progress 2009-2010
Need is met for emergency obstetric and neonatal care .	The number of CEmONC and BEmONC facilities has increased by 15% and 8%, respectively. This means an overall increase in number of EmONC facilities by 10%. Needs for CEmONC were addressed through staff trainings on B/CEmONC and provision of equipment and caesarean section sets. The accomplishments in this area were confirmed in the 5 states.
% of caesarean section as a proportion of all births.	There is no data can be referred to assess changes, since the Sudan Health Household Survey (SHHS) Report is not yet released. However, the

Indicator	Progress 2009-2010
	EmONC support for the target states is expected to pledge improvement.
% of communities with a population of 500,000 that have at least one CEmONC and four BEmONC centres.	With the exception of Blue Nile and South Kordofan, the EmONC coverage in the target states has exceeded the national average in Northern Sudan (which was 80% in 2008)The EmONC coverage in White Nile has reached 100%.
% of communities with a population of 2,000 inhabitants covered by a village midwife or skilled birth attendant.	Midwifery service coverage has increased from 40% in 2008 to 52% in 2010, with 31% improvement in the coverage. The remarkable increase found in Blue Nile which showed increase from 25% to 47% in 2010, with 88% improvement in the coverage. As the new midwifery graduates, who are still enrolled in midwifery schools, are expected to join the service in 2011, further improvement is expected.

2.3. Progress in Output 3: … on awareness on RH and HIV/AIDS …

In 2009 and 2010, UNFPA received a generous financial support amounting USD 2.5 million from the Global Fund, the biggest multilateral funder for the health-related MDG initiatives worldwide. This support aimed at improving the knowledge and practice related to HIV/AIDS and STIs among the Most at Risk Populations (MARPs) groups, and providing technical support for the implementation of Behavioural Change Communication (BCC) across the 15 Northern States. UNFPA has combined the Global Fund with its core resources in order to achieve the objectives of the National HIV/AIDS Strategic Plan under the Reproductive Health Output 3.

The objectives envisaged under the Output 3 were (i) to support initiatives in establishing links between the RH and HIV/AIDS prevention, leading to the integration strategy of RH, Gender, ASRH, and RH-BCC[8]; (ii) to facilitate community mobilisation to raise awareness and to increase demand for RH services and information; (iii) to provide technical assistance and secure commodities for a comprehensive condom programming (supply chain, quality assurance, and condom utilisation through cultural sensitive approaches); and (iv) to support initiatives targeting MARPs, including out-of-schools youths and women. To this end, UNFPA has been delivering support under the following activity clusters.

HIV/AIDS sensitization and integration in the federal RH system:

Findings from the MTR indicate that RH and HIV/AIDS activities have been implemented in isolation even though the targets, workers and activities are the same. The UNFPA's justifications on this include the fact that the two areas are managed separately within the national health structures by the HR Directorates and Sudan National Aids Programme (SNAP). Moreover, the HIV/AIDS programme has different funding mechanisms and potentials compared to the RH programme, which is generally under-funded. Although the *systematic* and *operational* linkages between RH and HIV/AIDS are still far, integration related processes are ongoing.

In response to those realities, UNFPA has put some efforts at the federal level towards strengthening the HIV/AIDS interventions and sensitising the RH system to integrate HIV/AIDS (both *systematic* and *operational*). The technical and financial supports provided in this area include:

[8] Has already been addressed in the National RH Communication Strategy referred to in Output 1 above

1. Support of HIV/AIDS interventions, which yielded the (i) establishment of the MARPs Units at the national and state level; (ii) capacity building of the Government and NGOs staff on planning, reporting and fund raising skills; and (iii) development of 5 MARPs' service packages (i.e. female sex worker (FSW), men who have sex with men (MSM), tea sellers, out-of-school youths, and prisoners)

2. Support for SNAP to conduct (i) a comprehensive review of available literatures on HIV/AIDS stigma in Sudan, which was used in developing the suitable service packages to address occupational stigma among health cadres and stigma in schools in the communities and various settings; and (ii) operational researches on stigma and mapping of MARPS in Gadarif and Blue Nile (e.g. the Bio-behavioural Surveillance Survey among FSW and MSM).

3. Collaborations with SNAP on the (i) development of the new National Strategy on HIV/AIDS; and (ii) advocacy of the strategy to policy makers and opinion leaders with the emphasis to target the MARPs in Sinnar, White Nile, South Kordofan, River Nile, Northern, North Darfur and Red Sea State.

Related to strengthening the integration of HIV/AIDS into the RH the programme supported the following interventions:

4. UNFPA's financial support through the Health Alliance International for undertaking a study on the health system (at national and grassroots level) to identify opportunities for RH-HIV/AIDS *systematic* integrations. The findings from this study have informed UNFPA strategic entry points for integration to be prioritized in its next programme phase.

5. The Programme advocated and supported the establishment of the Technical Working Group (TWG) on the RH-HIV/AIDS integration, whose memberships includes SNAP, RH Directorates and relevant UN agencies. The objectives of the TWG are to (i) coordinate the common work between RH and HIV/AIDS in order to avoid duplication and maximise the use of resources; (ii) facilitate and expedite process of integration (in the short and long term); and (iii) strengthen the overall health system. So far, there have been progresses with regard to harmonisation of work and collaboration of resources between RH and HIV/AIDS, which are made possible by the similaries in partners' activities, targets and workers at the community level.

Communication and awareness-raising at the community level:

UNFPA has been focusing on establishing strategic partnerships and networks with the local NGOs that have the capacity to reach out to communities in all 15 Northern States. The agency has also taken advantage of every opportunity to integrate the HIV/AIDS messages into broader RH related issues through available channels of communication and IEC materials. The collaborations with local NGO partners have resulted in the following activities and achievements at the community level in the 5 target states:

1. In White Nile: the establishment of 48 committees in 240 villages who act as agents in facilitating the community mobilisation on maternal health issues. This effort resulted in the appointment of 89 VMWs for formal vacancies.

2. In Blue Nile: the implementation of awareness raising sessions, peer educations, advocacies with community leaders, mobile VCT services and training activities on HIV/AIDS and RH.

3. In Gadarif: the implementation of IEC activities on RH issues through mass media sessions targeting 22 communities in three localities. In addition, the mobile theatre was used to deliver RH messages to 10 communities. The training activities on IEC were extended to strategic target groups, such the teachers, mass media personnel and the youths. The cultural-sensitive approach adopted by UNFPA has smoothly facilitated the dissemination of IEC messages and the distribution of condoms at the community level.

4. In Kassala: the implementation of awareness raising sessions and HIV/AIDS prevention activities, including training of 50 healthcare providers, 85 volunteers, 331 MARPS and 180 community leaders. UNFPA has further mobilised 433 persons for voluntary HIV/AIDS counselling and testing. The agency has also distributed condoms and disseminated IEC materials. The condom distribution was seriously affected by out-of-stocks incidence in 2010. Dissemination of IEC messages was done in 6 residential areas in Kassala town, targeting the military barracks, prison, households and female sex workers. The IEC dissemination methods used included home visits, group discussions and lectures. It was noted that most of the activities were confined to Kassala town with little outreach to rural areas, which should be improved in the next programme phase.

5. In South Kordofan: the implementation of activities covering about 150 communities. UNFPA has trained 60 persons in Kadugli and Dilling through peer-education on the HIV/AIDS prevention. Training on RH issues also targeted community leaders, healthcare providers and volunteers. Coordination meetings with the SMoH and locality authorities were regularly held to facilitate and update on the progress of implementation.

Youth mobilisation and awareness-raising:

In White Nile, local NGOs partners have carried out peer-education, and designed IEC messages and distributed the IEC materials on RH and HIV/AIDS related issues to the secondary and university students and to the communities through the State Radio and TV. The use of formal media and the high capacity of local implementing partners have contributed to widen the coverage and outreach. These efforts have also increased demand for commodities and created a favourable environment for distributing condoms to IDPs in Kosti which was done through 30 volunteers.

In Blue Nile, UNFPA targeted the youth leaders, but the methodology and materials used for community mobilisation were not very effective. However, the interventions through mobilization of the staffs of the State Radio and TV in delivering the RH messages in the local dialects were proved to be attractive for the target audience.

In Kassala, the Agency for Cooperation and Research in Development (ACORD) has implemented some HIV/AIDS awareness-raising activities targeting the MARPs, including peer education, education sessions on condom usage, 20 campaigns with VCT services, dissemination of RH-IEC messages, and distribution of condoms, which was also affected by out-of-stocks in 2010. ACORD also supported the referral of the HIV positive persons to the VCT centres and payment of the treatment for the HIV positive persons. .

In South Kordofan, 50 community volunteers received youth peer-education training on RH rights, RH services and FP benefits.

The following table provides, to the extent possible, summary of the number[9] of community members and MARPs reached, as well as IEC materials and condoms distributed to MARPs as the result of various training sessions as well as mobilisation and awareness activities targeting the communities and youths.

	2009-2010			
State	**Community members reached**	**MARPs reached**	**IEC materials distributed**	**Male condoms distributed**
White Nile	68,443	1,200	1,250	8,934
Blue Nile	23,561	17,129	21,000	25,160
Gadarif	39,358	2,750	1,200	38,824
Kassala	35,458	1,817	18,260	29238
South Kordofan	31,400	9,700	1,350	2,600
Khartoum	33,037	17,201	16,235	116,581
Red Sea	5,190	2,473	11,000	24,560
Sinnar	33,209	7,890	11,000	9,850
Northern	15,650	560	550	0
Gazira	25,256	9,700	268	21,450
River Nile	33,155	2,050	3,229	2,116
Northern Kordofan	11,450	1,300	3,860	7,000
South Darfur	1,605	580	700	TBC
West Darfur	TBC	TBC	TBC	TBC
North Darfur	4,000	600	1,300	TBC
All Northern States	**360,772**	**74,950**	**91,202**	**286,313**

RH-HIV/AIDS services for population of humanitarian concerns:

In White Nile, UNFPA provided health services in the area of clinical management of rape, health education, and awareness/capacity building of returnees passing the state to the South. Support also included distribution of hygiene kits, clean delivery assistance for women (1,500 in year 2010), essential drugs including ARV, HIV screening and condoms distribution for the IDPs in Kosti town.

Although it was difficult to identify local partners in Blue Nile State, in 2010 the Islamic Relief Agency (ISRA) was selected by UNFPA to train the healthcare providers on clinical management of rape. ISRA also conducted training for the community health promoters and facilitated the advocacy with policy-makers at the state level. Furthermore, UNFPA has been implementing the Social Reintegration component of Disarmament Demobilization and Reintegration (DDR) Programme[10] on HIV, RH and GBV in 4 localities[11] with considerable number of ex-combatants and Women Associated with Armed Forces (WAAF). The project so far has completed the assessment of all VCCT and health centres in all 4 localities, training of DDR caseworkers, distribution of IEC materials, and capacity building of healthcare providers on clinical management of rape. The challenges faced by UNFPA include weak

[9] These are the identified numbers; however, it seems that the achievements by far exceed the reported numbers.

[10] This project is implemented alongside the UNFPA's Humanitarian Response Branch DDR project which has almost similar activities in Damazine and Kurmuk localities, with the exception of HIV/AIDS initiatives.

[11] Rosareis, Geissan, Tadamon, and Baw

coordination with the IPs on the ground and low capacity of the IPs. The key lesson learned from those challenges was that the coordination with the DDR Technical Reintegration Committees in the state is critical to the success of the DDR project.

In South Kordofan, the DDR programme was built on the existing efforts and infrastructures for provision of HIV/RH/GBV services during the demobilisation phase of ex-combatants, in partnerships with the Government and local NGOs. Training was conducted on key messages related to the services for the DDR Case Workers and Counsellors. Community based interventions such as BCC and awareness through the ex-combatant peer educators, in addition to efforts for enhancing delivery of relevant services (STI management, basic RH/GBV services), were implemented in four selected reintegration localities (Buram, Habila, Reif El Sharghi and El Quz). In these locations, 10 ex-combatant midwives were supported with 1-year revolving small loans linked with RH literacy sessions and HIV/GBV prevention education.

Indicator	Achievement 2009-2010
Criteria and protocols for the provision of youth friendly health services	Youth freidndly manual available at the federal level but has yet to be endorsed. UNFPA is still rehabilitating the youth-friendly service centre in Kadugli which is expected to be functional in 2011.
Percentage of clinics providing an essential service package for young people	There is no clinic providing such service identified in the 5 states.
Numbers of condoms distributed through free distribution/public sector.	104,756 condoms distributed in the target states, however, the situation could have been better if supplies were secured
Numbers of MARPs reached through BCC/Counselling	32,596 MARPs reached in the target states.
Percentage of women, men, and vulnerable groups whose knowledge improved in identifying three modern contraceptive methods.	There is no information available but it is expected that the activities related to IEC on RH issues implemented in the 5 target states will improve knowledge of the women, men and vulnerable groups of the FP methods

3. Review of the PD Component

The objectives of the PD Component are to (i) avail disaggregated population data and information for planning and policy-making; (ii) integrate population issues and/or dynamics and their inter-linkages with gender equality, HIV/AIDS and reproductive health into sector-based planning processes; and (iii) incorporate youth rights and multi-sectoral needs into public priority policies, strategies and plans. Three outputs have been identified under this Component:

Output 1: Improved national and state-level capacities to collect, analyse, disseminate, and utilise quantitative and qualitative data (disaggregated by age, sex, socio-economic status, and administrative) taking into consideration emergency settings.
Output 2: Enhanced capacity to integrate population dynamics, reproductive health and gender equality concerns into development planning and monitoring processes at national and state levels.
Output 3: Promotion of young people's participation and empowerment in development.

3.1. Progress in Output 1: … on availing disaggregated population data…

UNFPA was in the CPA as the UN partner of the GoNU in conducting the 5th National Population and Housing Census in 2008. The agency has successfully completed the population counting in 2008. In collaboration with the CBS during 2009-2010, UNFPA supported data processing/analysis and dissemination of census results (basic and Long Form Questionnaire (LFQ)). In order to produce a unified credible and acceptable census according to the national and international standards, UNFPA implemented the following activities:

Technical, facilitation and operational support:
UNFPA provided its expertise through the recruitment of 10 national and international experts in management of census, Geographical Information System (GIS), sampling, data consistency editing, data processing, demographic analysis and writing up of the analytical reports. The supports have resulted in the completion of census priority and LFQ, which were uploaded in the CBS website (www.cbs.gov.sd) for public and private use.

UNFPA also facilitated coordination and monitoring mechanisms and joint work between the Northern and Southern Population Census Councils (PCCs). Mechanisms established included the TWG (forum for the North/South National Statistical Centres), Data Processing and Tabulation Committee (DPTC), Analysis and Dissemination Committees (ADCs), and Scientific Committee. These mechanisms and joint meetings provided opportunities for interactions between national and international stakeholders to discuss the technical issues and agree on processes, plans and budgets. The role played by the UNFPA and involvement of technical/international expertise have reduced tensions among TWG members and smoothened process of releasing census results to the public. The ultimate outcome has been the endorsement of the Priority Results by the President in May 2009, and approval of the merged and tabulated LFQ data.

UNFPA continued its support for the CBS personnel (top ups and rentals for transportation), in addition to the provision of office rentals to the Data Processing Centre and rehabilitation of the premises for CBS data processing. The agency has also supported procurement and supplies of data processing equipments and materials (e.g. GIS Lab). This support has allowed the completion of the remaining data

processing activities, such as coding, merging of data sets (North and South), consistency editing, and tabulations.

Production, dissemination and utilisation of census results:
UNFPA has upgraded the CBS Website; printed and disseminated 7,000 State Priority Results' booklets; and prepared 16 National/State Analytical Reports (to be printed and disseminated in 2011).

In addition to the national census information by the CBS, the NPC also completed 3 socio-cultural studies on the Maternal Mortality, Fertility and Migration, which started in 2008. The reports of the studies have been prepared but not yet printed nor disseminated. Using the census data, the NPC also carried out studies (2010) on the same issues. However, due to delay in the release of census data (LFQ), the reports will only be printed in 2011. Now the question is how different are the studies carried out by the NPC from those conducted by the CBS in its Analytical Reports, if all discussed issues of maternal mortality and fertility as the focused thematic areas. It seems that the NPC should focus instead on the population policies using information/indicators generated by the CBS and other line Ministries (e.g. MoH).

Capacity building and census advocacy:
UNFPA has trained 58 personnel from the state statistical offices on data analysis; 3 CBS staff on advocacy (2 persons in Cairo, 1 person in Abuja); and 45 researchers from the states on ToT for analytical reports writing. To raise awareness on the importance and use of the census data, the NPC has organised (i) a workshop on utilisation of census data for tracking the Millennium Development Goals (MDGs) and International Conference on Population and Development Programme of Action (ICPD-PoA); (ii) 3 policy advocacy sessions for the state senior planners, as an advocacy tool on the utilisation of census data for local-level sectoral planning and service delivery; and (iii) advocacy materials on population dynamics, integration and M&E indicators based on the census data –which were not yet printed.

The findings from the review indicate the key achievements/progress during 2009-2010, measured against the CPAP's indicators, as shown in the table below.

Output 1 key achievements against indicators 2009-2010	
Indicators	**Achievements 2009-2010**
Operational set of indicators at national & state level to monitor population & gender programmes, & MDGs available	Census Priority Results released (hard copies available and information uploaded in CBS website); 6 studies conducted (3 socio-cultural, 3 census-based) on mortality, fertility & migration issues; the National Population Reports published (2010) and prepared (2009); LFQ Census Results officially released (through CBS website); and 16 National and State Analytical Reports produced
Percentage increase in the use of population data in programme design and service delivery.	Government used census data in the national elections, national budgeting, service distribution and financial allocations for the states (States' Support Fund). The census data were also used by researchers, NGOs, UN, and private sector. CBS offices continue receiving demand for data.

The MTR has also attempted to draw some initial impacts in relation to the stipulated indicators. The followings are some of the examples:

- The census process has provided the CBS with an exposure to technical knowledge, internal/external interactions, and trust/relations with public and private bodies, particularly the media. Furthermore, the momentum created by the census process (training, processing, analysis, etc.) has generated awareness about the importance of the statistical information for evidence-based planning.

- The state CBS offices (e.g. in Kassala), have already started a series of statistical analysis training to increase awareness and produce qualified cadres of statisticians at the state level. Due to the increasing demand, the next plan is to expand the outreach to the locality level. This plan however needs financial support (as one of the potential areas for the CPAP).

- In Kassala, the census data is being used by the police in crime control and the Water Corporation for its 'Water Strategy 2007-2016'. It is also used in the preparation of the State Statistical Encyclopaedia. Additionally, the GPS equipments are used by the Department of Epidemiology of the SMoH. In Gadarif State, the census results are being used by all government bodies, universities, Zakat Chamber, and civil society (particularly on women and youth related issues). Data is particularly used in the distribution of wealth between localities, mapping exercise for control of smuggling by the economic security authorities, mapping for crisis prevention by the UNDP, etc.

3.2. Progress in Output 2: … on integration of population issues …

The progress made under this Output has laid down the ground work for the integration of population issues. The progress includes capacity building, advocacy on the importance of integration, establishment of structures (steering committees), conceptual framework for the integration (roadmap and generic manual), and development of operational plans for sectoral integration. Main activities and achievements are:

Capacity building for integration:
UNFPA has (1) organised 4 training workshops on SPECTRUM (a software for planning and projection) using the 2008 census data, targeting the agency's partners from the line ministries, NGOs and other relevant institutions; (2) trained 9 NPC staff (outside Sudan) on policy analysis for integration, who in turns trained 15 other staff and partners; (3) trained 30 staff from partner organizations on M&E; and (4) procured a vehicle for the NPC to facilitate its field visits to the states. All of these efforts aimed at equipping partners with the necessary skills on projections and ways to integrate populations issues into sectoral plans, as well as monitoring of the integration plans. The efforts were expected to ultimately create a common institutional vision between relevant institutions in addressing population and development issues.

Generating information/system for integration:
The Programme support to the NCP has resulted in the (1) production of 2 National Reports which were presented in the Africa meeting in Addis Ababa (on ICPD-PoA) and the Arab meeting in Sharam EL Sheikh (on ICPD-MDGs); (2) establishment of an operational M&E system, identification of population indicators, and collection of data from the line ministries and through questionnaires; (3) publishing and

dissemination of the Sudan Population Reports (2009 and 2010); and (4) completion of 6 studies on maternal mortality, fertility and migration (using both socio-cultural surveys and 2008 census data).

Advocacy for integration:
To create awareness on the importance of integration, secure commitments of institutions working on population issues, educate the civil society on the ICPD@15, and expand outreach to the public through media and advocacy materials, UNFPA has supported the (1) organisation of 4 NGO quarterly issue/theme-focussed forums on ICPD@15 (60 NGOs participated in each forum); (2) production of 4 pamphlets on population dynamics, and M&E with indicators from the Sudan Population Report, demographic indicators from SHHS, ICPD goals and targets, and ICPD@15 National Report; (3) production and dissemination of 10 display stands on the NPC and ICCP@15 report; (4) distribution of demographic indicators and 8 periodical newsletters to all partners and relevant organisations; (5) organisation of 3 media forums to increase awareness on population issues – each forum was attended by about 50 journalists and 10 reporters from the Radio, TV and relevant institutions; (6) organisation of two national thematic seminars related to the ICPD@15; and (7) agency's participations in the international population forums, including (i) the High Level Meeting on MDGs in New York, (ii) the Annual Meeting of Arab State Population Councils and Committees, (iii) the UN Summit in New York, (iv) the Africa meeting in Addis Ababa (on ICPD-PoA), and (v) the Arab meeting in Sharam EL Sheikh (on ICPD-MDG).

Facilitation and coordination of the integration:
As an important milestone, efforts made so far have yielded the production of a generic manual and development of 5 operational plans on sectoral integration for the Ministries of Health, General Education, Labour, Youth, and Agriculture, Which was an important milestone.

However, despite those reasonable efforts, the process of integration seems to still lag behind. Key issues identified are the needs for (i) the in-the-job training on SPECTRUM; (ii) the retainment of the Government's and partners' commitment (action-taking) and ownership of the process; (iii) a clear strategy and/or roadmap (with key milestones) for the integration process, as well as an M&E system to track out progress; (iv) the link up and alignment of the integration process with the NPP and its Programme of Action; (v) more focus at the state level; (vi) an independent assessment of the generic manual for integration prepared by the NPC; (vii) contextualisation of the generic manual for integration; and (viii) crosscheck on how the manual is being used by the target line ministries.

The following table summarises the key achievements against the CPAP's indicators under Output 2 of the PD Component.

Output 2 key achievements against indicators 2009-2010	
Indicators	**Achievements 2009-2010**
Number of national & sectoral annual plans (by GoNU) for integrating population, reproductive health & gender	Preparatory work for the integration done; generic manual for the integration prepared; and 5 operational sectoral plans for the integration developed.
% increase in (availability of) access to information and services across local areas by all population groups	Materials and indicators on population issues are made available and being used (although it is still immature to assess the impact).

3.3. Progress in Output 3 Youth empowerment

The objectives under this Output include to (i) provide evidence-based support to policy dialogues and advocacies for prioritising the youth development needs in the national and state plans; (ii) review and implement the National Youth Strategy; (iii) establish/strengthen the national/state youth parliaments, centres, organisations and/or committees; (iv) strengthen partnerships between the Government, NGOs and CSOs; and (v) empower youth to participate in planning and monitoring processes and mechanisms. These following are the activities and achievements by the Programme 2009-2010.

Youth information:
In order to identify youth development needs and institutional constraints to their participation, 3 studies (1 at national level and 2 in Kassala and Gadarif State) and the youth training needs assessment in Kassala have been conducted. Findings and indicators from these reports were important and validated to inform UNFPA on youth empowerment activities. Examples of particular important indicators from these studies were that: (i) youth represents above 40% of Sudan's total population; (ii) 60% of young people are unemployed; (iii) 60-66% of employed young people are dissatisfied with their current jobs; (iv) over 80% of the surveyed youth are unmarried; (v) 43% of the youth in Kassala and 79% of this population in Gadarif are suffering from depression; (vi) over 80% of the youth have leisure time; and (vii) there is prevalence of some worrisome negative attitudes among the surveyed youth, e.g. 15-35% (in Gadarif and Kassala) support the FGM, and 24-28% (in Gadarif and Kassala) oppose the idea for women to work. Reports/findings from these studies should be further consolidated, translated into Arabic and disseminated to partners.

The National Youth Strategy:
Prior to UNFPA's interventions, there was no written national strategy for the youth but only work plans. The programme has enabled the FMoYS to carry out 5 meetings for the Technical Working Group (TWG)formed by the Ministerial Decree and consisting of various youth organisations (Sudanese National Youth Union, Sudanese Students Union), relevant ministries (health, social affairs, higher education), and the National Council for Strategic Planning (NCSP). The TWG reviewed the FMoYS 5-year Strategic Plan (2007-2011), and supported the process of producing and endorsement of the National Youth Strategy (NYS). The Action Plans for 2009-2011 were produced in consultation with the youth groups, TWG and relevant ministerial bodies. It was noted that the FMoYS has started developing a better understanding and consciousness on the importance of the strategic planning and partnership in this area. Based on the NYS, the FMoYS has launched new national projects and started implementation, such as the creation of opportunities for youth employment which was a joint initiative with 10 UN agencies and 8 line Ministries. So far, the project has started training the youths at state level and opened up ways for small-scale financing. Another project was the youth development project, which was politically supported at the presidency level and still at the identification (surveys) stage.

Establishment of Youth Parliaments:
Although the support from UNFPA was limited to the preparatory workshop for launching the process of establishing the National Youth Parliament, it has inspired the FMoYS to further provide political as well financial support to the process. Efforts made by the FMoYS have resulted in the establishment of 15 State Youth Parliaments (SYPs) and the National Youth Parliament which are all operational. Both the NYP and the SYPs have been availed premises and the right to attend sessions of the National

Assembly and State Legislative Councils although without the right to vote. The mandate of the youth parliaments is to act as a 'pressure group' advocating for youth issues to ensure that they are taken into consideration by the legislators and policy-makers.

However, the MTR has raised a question with FMoYS and HCYSs, namely, how can a youth parliament established by the government hold it accountable? The response was that these youth parliaments were directly elected by the youth themselves while the government was no more than a facilitator. Another response was that these parliaments include youths from different political affiliations. From the discussions with the staff of the HCYS in Gadarif, they think that the youths have exhibited independency in thinking and actions. Furthermore, youth have credibility at grassroots level and legitimacy and so youth parliaments are expected to play critical roles in future. The envisaged future prospects for the youth parliaments include (i) the opportunity for the generation of young leaders with experience in parliamentarian work to rally in the next elections; (ii) the opportunity to influence the Election Law to secure a quota for the youth in the national parliament and state legislative councils.

Youth leaders training:

More than 360 young people have been trained on leadership, management, advocacy through Y Peer at national, state and locality level (Kassala and Gadarif). Additional issues discussed in those workshops included substance abuse, HIV/AIDS, reproductive health, adult-youth partnership, and state statistical information and indicators. Even though there were no follow-up plans or post-training monitoring, the observation indicated that the trainings have started to show some change including, e.g. the youths from various areas/background have gotten together and therefore were exposed to their peer's experiences. The youth organisations have also put plans in place, but are still awaiting ToT and budgets. Moreover, 10 of the trained youth leaders are now the staff members of the Gadarif HCYS, which is a newly established body.

Dialogue and advocacy for integrating youth issues in planning:

Six working papers were prepared in consultation with the youth organisations, as part of the groundwork for the First Youth Conference. The FMoYS continued to broadcast messages through national Radio and TV, in addition to 'illuminated public address screens', to expand outreach and disseminate the Youth National Strategy. The advocacy and awareness messages were also extended through state and community Radios and TVs in Arabic and local dialects (in Kassala and Gadarif) in order to draw attention to youth issues and the Youth strategy.

At the state and locality level, the HCYSs led the process of 'youth cultural momentums and/or movements' using popular media, such as community drama, open thematic sessions, music and sport competitions, open cultural/promotional evenings, and youth symposiums. The youth issues discussed included the youth problems, population issues, poverty, unemployment, marriage, and reproductive health and diseases, such as HIV/AIDS.

Most of the policy debates and symposiums were hosted at the youth centres and attended by officials who presented their papers and participated in discussions. The processes generated a set of priority issues that have been already put into plans of the HCYSs. UNFPA supported the HCYS in Gadarif in formulating its plan for 2010 and the plan for the National Youth Union, according to which, 2,400

youths received vocational training[12] on carpentry, wielding, and general electricity, as an effort for the youth economic empowerment.

Some success stories were noted as the result of the various youth competitions. For example, the Gymnast Union in Kassala participated in the national competition and was awarded the cup of championship and some medals. Another story showed 2 youths from Gadarif who were selected to participate in the national music contest - a TV programme called 'future stars'.

Support to youth offices and centres:
UNFPA procured audio-visual equipment and facilities (multimedia projector, digital camera, laptop) to support the FMoYS, and renovated and equipped the project office with tables, chairs, cabinet, computer, and stationeries. The HCYS in Kassala was also supported with one motorcycle. Nine youth centres (6 in Kassala and 3 in Gadarif) have been supported with multimedia projectors, TVs, cameras, tables, chairs, cabinets, sport uniforms, etc. The observation of one of the youth centres in Kassala showed that there is a need to put standard procurement in place. It was also observed that some of the locally produced furniture (e.g. tables) are more durable than imported ones. This finding suggests that it will be better to procure the locally made furniture because of its durability, and because it will support the local producers. The youths met at these centres requested for support such as multimedia projectors and sound systems (for entertainment purposes and income-generating activities to sustain these centres). The youths and officials interviewed at the centres pointed out that the centres which have received support are now more attractive to the wide community and have become the main gathering and mobilisation points for youth activities.

Youth economic empowerment:
Though equally important, this activity received less attention, hence less allocation in the UNFPA programme budget. In Kassala, only 110 female youths (47 from localities) were trained on food processing and household economy, and 22 male youths from New Halfa locality received vocational training on general electricity. There is no evidence of post-training follow-up to assess the impact.

Sensitization of youths in conflict-affected settings:
UNFPA has provided support to South Kordofan State (Kadugli and Dilling) in 2010 through the local NGO, Turath. All planned activities have been successfully implemented which include (i) 4 community mobilisation workshops for 100 participants in Kadugli and Dilling (2 workshops in each locality) on adolescent RH including issues of FPand HIV/AIDS; (ii) 2 training workshops for 50 peer educators on adolescent RH messages in Kadugli and Dilling; and (iii) 2 BCC workshops for 50 participants on adolescent RH in Kadugli and Dilling, including IEC sessions on behavioural change in. For sustainability and in order to expand the outreach to rural areas (villages and nomads), Turath has formed a local Association for Reproductive Health and Gender-based Violence, which consists of 100 members who have received the training mentioned above and has assigned this association with office space within its premises and access to use its training hall. Through collaboration with UNMIS, the Association received ToT (on RH and GBV) and access to transportation facilities to reach the rural areas. The Association is currently functional and has a work plan.

Based on the above findings and analysis, it is quite clear that activities under Output 3 have made quite a good progress despite the relatively small budget allocations. This is because (i) the area of youth

[12] Training activities were funded by the State Government.

empowerment is a new focus for the Government planners; (ii) the Government has provided resources to most of UNFPA's unfunded programme activities; and (iii) most of the activities were implemented at the state level where there is a real need.

Output 3 key achievements against indicators 2009-2010	
Indicators	**Achievements 2009-2010**
Evidence-based national dialogue on investing in youths	(1) Information provided through surveys and census results, and an active dialogue started at the national, state and locality level; and (2) the National and State Youth Parliaments established and operational
The National Strategy on young people submitted for approval	(1) the National Youth Strategy approved; and (2) national and sub-national plans and projects designed and started being implemented

4. Review of the Gender Component

This component was built on the previous programme support, particularly the operationalization of the National Women Empowerment (WEP) Policy, which was officially endorsed by the President in 2007. The overall objective of the Gender Component is to contribute to gender equality and women empowerment through "enabled institutional and socio-cultural environment to ensure human rights and eliminate GBV in the 5 target states"[13]. To this end, UNFPA has designated two main outputs:

Output 1: Strengthened technical and institutional capacity for gender analysis, mainstreaming and budgeting at national and state levels.
Output 2: Responses to GBV, including FGM, domestic and sexual violence, early marriage and to HIV/AIDS stigma are strengthened through improved policies, security and protection systems, and community mobilisation, including in emergency and post-emergency situations[14].

Progress in Output 1: … on technical and institutional capacity …

UNFPA's support has been primarily focusing to make the WEP Plan of Action operational. The work has been done in collaboration with the MoWSS and Ahfad University for Women. Activities implemented in the period 2009-2010 include:

Institutional assessment and support:
UNFPA supported the MoWSS to carry out 2 Need Assessment Surveys on: (1) assessing the capacity gaps for the gender focal points in the federal line Ministries; and (2) assessing training needs of gender focal points in the 5 target states. These studies confirmed the strategic role of the gender focal points and the need for strengthening technical expertise on gender mainstreaming and budgeting. In addition, Ahfad University has also carried out 2 surveys to (3) map out the existing NGOs, CBOs, FBOs working on gender issues in the five target states; and (4) undertake capacity assessment of these organisations, which showed that there were existing and capable networks at the community level for the advocacy and awareness raising on gender related issues. Most of these institutions need capacity building and need to be engaged in the policy dialogues at national, state and community level.

To further strengthen the institutional performance of the Women and Family Directorates (SMoSA) in the 5 target states,(White Nile, Blue Nile, Gadarif, Kassala, North Kordofan[15]) UNFPA has furnished the offices with computers, printers and office furniture for the establishment of M and E units.

Institutional and human capacity building:
The core objective of the capacity building efforts are to strengthen the institutional and human capacities of the Government and non-governmental stakeholders, in order to make the WEP operational and to institutionalise the gender-sensitive planning and budgeting at national, state and local level.

[13] In addition, Gender Component also extended support to the 3 Darfur states through the UNFPA Humanitarian Response Unit Project outside the regular Country Programme
[14] Some of the responses have also been addressed under RH Output 3, which shows the programme internal links.
[15] The FMoWSS has been targeting North rather than south kordofan. UNFPA needs to revisit this.

Based on the findings from the 4 surveys mentioned-above, a series of training packages on gender analysis, mainstreaming, and budgeting have been delivered to (1) 59 participants from all federal line ministries and 173 from line ministries and NGO's in the target states(including M and E) (2) 23 policymakers drawn from 15 federal Ministries; (3) Policy advocy with Ministries of Finance (national and State level) to increase financial allocation for the implementation of WEP-PoA (4) 93 activists/supporters from political parties and NGOs. In addition to this, 2 training courses on Visionary Leadership and Gender-sensitive Project Design have also been delivered to various NGOs in 4 of the target states (Kassala, Gadaref, Khartoum, South Kordofan) to approximately 80 participaticipant.

Development of training and sensitisation materials:
In order to manage the consistency and quality of information, Ahfad University has developed and reprinted IEC materials and training manuals to be used in seminars, training workshops and sensitisation sessions on gender analysis, mainstreaming and budgeting.

Strengthening of institutional coordination:
Because the activities related to the WEP-PoA fall under the mandates of different governmental and non-governmental stakeholders, UNFPA has initiated and supported the establishment of coordination forums led by the government. The forums include (1) the bi-annual coordination forums for the state gender focal points, line Ministries and NGOs; (2) the annual co-ordination forums for donors, Government, NGOs and UN agencies; and (3) the quarterly review meetings for the UNFPA bprogramme implementing partners. The forums have facilitated work relationships and information exchanges between various stakeholders, and also provided the MoWSS with an opportunity to better coordinate and manage the implementation of the WEP.

Overall, key achievements against indicators in the period of 2009-2010 are summarised in the following table:

Indicators	Achievements 2009-2010
% increase in gender focal points and units trained at national and state levels.	All GFPs at national level and 5 state levels trained, in addition to 3 GFP from Darfur states. (
% increase in budget to strengthen the state gender focal points (GFPs)	No information available . However in 2009 MoSWW received SDG 1.5 out of the 4.6 million approved budget (33%)
Number of sectoral plans integrating gender concerns	3 national sectoral plans (education, health and agriculture) have integrated gender concerns
Percentage increase in project funding to support women's empowerment	No information available

4.1. Progress in Output 2Responses to GBV

UNFPA's responses to GBV have been influenced by previous programme surveys, lessons learned from Darfur, and partners' best practices. Efforts made so far have included support to initiatives addressing the various aspects of GBV both in normal and post-conflict settings. In addition, support was also extended to policy formulation, strengthening of the existing legal and social protective systems, and the ensuing social dictates contributing to GBV.

In achieving these targets, UNFPA has collaborated with the Violence Against Women Unit of the Ministry of Justice and Ahfad University. In a joint programme with UNICEF, UNFPA has also extended support to the National Council of Child Welfare, the Ministry of Welfare and Social Security,, the Ministry of Guidance and Endowment,, Khartoum SMoH, Khartoum SMoSD, University of Gadarif, Sudanese Obstetrics and Gynaecology Society, Teeba Press, and SEEMA Centre, with support fromthe South Kordofan-Joint Programme, MDG-F Spain, and Common Humanitarian Fund (CHF). The joint programme was primarily aiming at supporting the community-led process for abandoning FGM/C. The following is the summary of the key interventions and achievements by UNFPA in the period of 2009-2010.

Surveying opinions on GBV:
This survey was a national rapid assessment on the understanding and definition of GBV by various stakeholders. Another baseline survey was carried out in White Nile (Gazira Aba town), as one of the programme target areas, on FGM/C and early marriage. Findings from the assessments have accordingly informed the process of formulating the National Strategy on GBV, and guided the community-based interventions. Findings are also envisaged to be uploaded in the national AUW's website on the FGM/C abandonment.

National Strategy Development:
UNFPA has supported the VAW Unit of the MOJ in formulating the National GBV Strategy. The Strategy has included a provision for combating FGM/C. Although it is still pending the government ratification, the VAW Units at the national and state level have produced the Strategy's operational work plans.

Support for the revision of laws/legislation
To date, all attempts to retain the Article 13th, which incriminates FGM/C within the ratified Child Act have failed. UNFPA, therefore, has aligned its efforts at the national level to support the advocacy agendas of the parliamentarian's advocacy group, journalists, media, health personnel, and civil society campaigns (82 CSOs) to minimise the resultant implications.

Since the states have the rights to formulate their own Child Act, UNFPA has extended support to the state-led processes of reviewing, drafting and ratification of the law. The results of this support include (i) the Child Act in South Kordofan ratified with an article banning FGM/C; (ii) the Child Acts in Gadarif and River Nile which are pending ratification; (iii) the Child Acts in Red Sea and North Kordofan with an article banning FGM, and are still being reviewed; (iv) the State Child Act recently drafted in South Darfur includs the banning of FGM/C; and (v) support provided to the SMoH in Khartoum State to draft the RH Law that clearly bans FGM/C.

Building capacities in GBV related expertise:
Through the VAW Unit, UNFPA supported training of 30 women police officers and investigators at national level on the International Conventions of Human Rights and GBV concepts necessary for an appropriate response in managing the GBV issues. In addition, the agency also provided technical assistance for the development of the GBV training manual, and conducted the (i) 182 community volunteers in integrating FGM/C and early marriage and human rights into RH, (ii) 215 members of NGO's, CBO's, NCCW, SMoH (Kosti) received training in M and E and advocacy skills, (iii) 80

community group members in child rights protection; (iv) orientation and advocacy for 95 participants from formal and popular media, together with CRPGs and SCCW's; (v) 750 women received 1-year diploma training in community development (Gadarif University)

Special efforts have been made to focus on strengthening the expertise on (i) advocacy and mobilization for law enactment and enforcement; (ii) networking for legal reform; and (iii) the role of legislators and parliamentarians in child protection.

In order to improve response of the health sector to manage rape survivors in post-conflict settings in South Kordofan, UNFPA has trained service providers on the Clinical Management of Rape (CMR) and prevention and response to GBV with a special focus on sexual gender-based violence.

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Setting up institutional mechanisms for GBV/FGM implementation:
To support the government mechanism, UNFPA has established 3 VAW Units in White Nile, Kassala, and Gadarif State. While the VAW Units in White Nile and Gadarif are affiliated to the Governor's Advisory Office on Women and Child Affairs, it is put under the Directorate of Women and Family of the SMoSA in Kassala. Each VAW Unit has a GBV coordinating committee with memberships from relevant governmental and non-governmental stakeholders, who are expected to implement the State GBV Work Plans. The VAW unit in Blue Nile is not yet approved by the state Governor and for South Kordofan it was not yet established.

To support the state/community-based mechanisms, UNFPA has (i) facilitated the formation of a network of CBOs working on FGM/C and early marriage in Gazira Aba (White Nile State) to organise for community mobilisations and develop the awareness-raising strategy; (ii) established the voluntary Child Rights Protection Group (20 youths) in White Nile working as the monitors for FGM/C, early marriage, and maternal health advocacies; (iii) trained 1-year diploma programme on Community Development in the Gadarif University, who later formed 14 CBOs at in their respective communities in order to support the initiatives on banning FGM/C; and (iv) established the Gender Coordination Forum in South Kordofan, chaired by the MSDWCA-VAW, to co-ordinate GBV related activities at the state level; (V) organised regular meetings for the CRPG's; (vi) organised exchange visits for 9 members of the CRPG to relevant institutions in Khartoum and Blue Nile states..

Advocacy and communication:
A website on FGM/C has been designed and agreed by all implementing partners except the VAW Unit. The NCCW has been assigned as the website administrator. UNFPA has succeeded in engaging 220 imams (religious leaders) through collaboration with the MoGE, and secured their commitment to deliver preaches that support the abandonment of FGM. Advocacy and awareness-raising efforts were further supported by the production and distribution of 35,000 IEC/BCC and advocacy materials (including leaflets, caps, t-shirts, school bags, student exersize book notes, CDs, Calenders, stickers, puzzle, games etc.) with different messages on FGM/C early marriage to the target local communities.

In South Kordofan, the CMR national guidelines, and GBV T-Shirts and posters have been printed and distributed.

The programme supported 10open community conversation sessions attended by 250 community members and religious leaders, as well as arrangement of 2 sport events attended by 600 students and community members. To further expand outreach to all primary , secondary and passive advocacy constituencies, the programme also organised 6 orientation and advocacy workshops for the media (TV, radio), which resulted in developiong and broadcasting of various awareness materials on FGM/C, early marriage, GBV, and other forma of violence against women.

Efforts made so far have resulted in 39 communities declaring the banning of the FGM/C practice (2 communities in Khartoum, 18 in Gadarif, 6 in North Kordofan, 6 in South Kordofan and 7 in Kassala). Similar declarations are expected in 224 other communities who have been introduced to collective abandonment of FGM/C.

Improvement of the institutional performance:

To strengthen their performance and work follow-ups, VAW Units at the state levels have been provided with office equipments, computers, printers, and faxes. The Ahfad University for Women has also been supported with 2 computers, a laptop, accessories, multimedia projector, video camera, digital photography camera, and construction of 2 office spaces.

The following are are summaries of the key achievements against indicators:

Indicators	Achievements 2009-2010
The National GBV Strategy submitted for approval and operationalization	The National GBV Strategy developed.
Number of sectroal plans addressing GBV	4 sectors have addressed GBV
GBV information and M&E system in place	7 protection units enhanced on GBV
National policy on the appropriate age at marriage developed	No activity done

5. Review of programme relevance and quality

5.1. Programme relevance

Peace building

UNFPA has been actively serving communities that have recently emerged from conflict and those that are still in transitional situations, such as displaced, returnees, ex-combatants, survivors of GBV, and women associated with armed forces. The agency has been providing both development/recovery reproductive health services and humanitarian support in urban and remote under-served areas, utilizing a pro=poor approach.. The efforts translated human rights into these policies/strategies and integrated such rights into the operational systems, capacity building and direct service delivery. Direct impact was evident in the improvement of access to RH and FP services and raised awareness at the community level. This has contributed to breaking the barriers between duty bearers and rights holders, as well as healthcare providers at the different levels using an evidence-based approach, BCC and IEC materials. UNFPA's special focus on programme interventions targeting the marginalised and excluded groups has clearly contributed to improved equity and therefore better chances for securing social peace.

UNFPA has also contributed to the successful completion of the 5th National Population and Housing Census through support for counting, data processing, data analysis and dissemination of results for wider public and private use. Although it was a complicated process, the coordination, facilitation and technical support from UNFPA have contributed to reducing the tensions between the census population councils and committees from Southern and Northern Sudan. This had ultimately led to the acceptance, endorsement and release of unified census results.

The census was one of the key milestone and requirement for the CPA implementation. The disaggregated census data was a key input for the national elections (April 2010) to prepare the eligible voters' registry, and identify the number of constituencies and their geographical distribution, as well as women quota. At the later stage, the census was used in the preparatory stages for the Southern Sudan Referendum. This achievement was a significant contribution to peace in Sudan.

UNFPA has also addressed the issues of women and youth empowerment and brought them to the attention of the Government and relevant stakeholders. Efforts made in these two areas have contributed to reducing social exclusion and inequalities in the social and political systems. Currently, the youth have their national and state parliaments and are present at the legislative and executive level as a 'pressure group' to peacefully protect and promote youth rights. Interactions between the youth and officials, and proactive use of youth energies represented a step towards peaceful pursuance of rights, using evidence-base dialogue, advocacy and lobbying.

The adult-youth partnerships and the youths' cultural initiatives (sport, music, drama, etc) at the state and locality levels have created sentimental and social solidarity among various ethnic groups on one hand, and between youth and other community members on the other. This is evident in the community's engagements with youth centres, thus contributing to peace building and further reinforcing the social fabric.

UNFPA's support for the development of the National GBV Strategy aimed at protecting women against all forms of violence (including domestic, sexual) and human rights violations. Likewise, the support in banning the FGM/C and early marriage will contribute to eliminating discrimination against women and girls, which is a seed for promoting positive social changes. The accompanying RH services, awareness activities and psychosocial support/counselling have set the foundation for the formation of GBV Working Groups/Networks as responses by the civil society in the target states to take up responsibilities in protecting women against violence.

Good governance

UNFPA's contribution to formulation/review of policies, strategies, systems and building of strategic partnerships under the three components (RH, PD and Gender) is a critical step towards building good governance and accountability at the state and civil society level. For instance, the technical and financial support to advocacy, data generation, and research carried out so far has provided disaggregated data for evidence-based planning, resource allocation, decision-making and service delivery.

Census data is now being used in planning and projects design at the national, state and locality level. At the national level, data is used for budgeting, distribution of services, distribution of financial pledges to states according to population weights, etc. At the state level census data is also being used for planning by public, private sector, researchers/students and NGOs/UN. In particular, the data is being used in mapping for crises prevention, smuggling control in Gadarif, and state statistical encyclopaedia in Kassala.

Interactive discussions on youth and population issues break boundaries between duty bearers and right holders, thus making strategic planning more sensitive to and encompassing these issues. There are currently social movements (e.g. CSOs, steering committees, media and youth parliaments, centres and groups) who have received training on population issues, projections, leadership, management and advocacy to support process of planning. In fact, the Government officials are now more acquainted with the youth and populations issues though plans are still emerging.

The advocacies and researches done on population issues, particularly the ICDP@15 and MDGs, together with the civic education through media outreach, have created awareness about the importance of integrating these issues into planning, and have started to secure commitments by relevant governmental and non-governmental institutions. Sudan has produced national reports (on ICDP@15 and MDGs), participated in regional, Arab and international summits, and started developing monitoring mechanisms to track progress of the MDGs and related population issues.

The data sets and information generated have been helpful in putting directions towards integrating women's empowerment and population issues into sector plans at the federal and state level. The planning processes supported by UNFPA have been preceded by wide range of institutional and human capacity building which was aimed to establish the mechanisms that support good governance and accountability at the federal and state level.

5.2. Lessons learned

- Working through the local IPs (e.g. NGOs, CSOs, and CBOs) with direct connections and access to grassroots communities has been effective in facilitating the outreach and implementation of activities (especially in terms of knowledge of the context and local dialects, particularly when the base IEC materials are written in Arabic or English, which may not be understood), and reducing operational and management costs. It also contributed to rebuilding the trust in these organisations because UNFPA funding support has provided them with chances for visibility at the grassroots level , thus creating better chances for sustainability.

- Involvement of the youth organizations, using the peer education strategy, proved to be a successful strategy to target young people through advocacy and IEC messages. However, despite of the publicity campaigns, the youth continue to be a vulnerable group at high risk of not only STIs and unwanted pregnancies but also HIV/ AIDS.

- Production of IEC materials and execution of community related sensitisation seminars indicated some progress towards the integration between HIV/AIDS and RH. The weaknesses in managing HIV/AIDS related initiatives are resolvable through adoption of a systematic approach for the integration.

- Partnership with community-based organisations for RH-HIV/AIDS awareness-raising using local dialects was effective in achieving greater coverage and identification of VMW's for training.

- UNFPA used the advantage of its strategic partnerships to take the lead in mobilising resources and advocating for additional support to the RH related activities. One direct result, for instance, is that the other actors have already joined the area of basic training/equipping of midwives.

- The mainstreaming of gender issues across the UNFPA programme components, together with a separate Gender component with projects addressing specific gender gaps, has been strategically successful and should be enhanced.

- The MoWSS effective coordination on the WEP with the line Ministries, particularly FMoH and NPC (Gender Unit) was instrumental in linking up UNFPA Gender Component with other programme components. However, the unclear division of roles among Gender component IPs has been negatively affecting the delivery of programme outputs.

5.3. Programme quality

Based on the MTR findings, there is a need to pay attention to some areas that are crucial for improving the programme quality, such as:

Annual Work Plans (AWPs)

One positive aspect of the AWPs is that they are detailed enough to identify activities and guide the implementation. However, the activities are only detailed lists with less internal consistency and thematic-based clustering. Most of the AWPs do not have monitoring and evaluation calendar, as well as baseline information on indicators necessary to monitor the progress.

Monitoring and Evaluation (M&E)

The programme management is not result-based but rather financially-driven at the expense of the programme quality and monitoring of impact. The indicators in the CPAP planning and tracking tool[16] are difficult to measure partially because there is a lack of baseline data and that outputs are less SMART. However, it was found that the IPs' practice of M&E was no more than a follow-up when it exists, and that the objectives and formats used were for the internal use rather than tracking progress.

The absence of a programme master M&E operational plan has affected the quality and comprehensiveness of reports (progress, annual). In addition, reports on regular (CPAP) and non-regular programmes (joint and separate) are not compiled to capture the actual achievements. This is partially due to IPs limited capacities to follow the reporting format and the reporting requirements by the non-regular programmes.

Reporting and documentation

It was been observed across programme components that the good work on the ground has been defeated at the level of reporting. This is either due to lack of technical support from the Programme Officers in-charge, defect in reporting format or weak IPs' reporting capacities. The current reports do not sufficiently convey the necessary information on the process, achievements, and status of activities beyond simplying saying activies were implemented.

Furthermore, some of the activities implemented were not fully captured in the annual progress reports and there was hardly any technical activity-based report, e.g. workshops. UNFPA has not established standards for delivering workshops and writing up of reports. The current practice assigns the reporting responsibility to the component lead-IPs with less quality control and hands-on involvement of UNFPA.

Coordination and internal programme links

Coordination and communication should start internally at the UNFPA level, and the different components should be better coordinated to achieve synergies. This would require improved communication across component areas. Again, this is the responsibility of the officers-in-charge and the component lead IPs.

It was observed that the PD and Gender components are managed from the UNFPA Country Office in Khartoum while the NPPPs in the states are mandated to primarily focus on the RH component. The NPPPs are not kept in communication about Gender and the PD components' IPs at the state levels, and therefore have no information on what is going on. (Recruitment of programming personnel with social science background (1 staff for both Kassala and Gadarif for example) might help resolve issues of programming quality, accountability and reporting with regard to the PD and Gender components.) Consequently, the 3 components are practically implemented in isolation while they are very much interlinked and have common activities, workers and target population. While the awareness-raising issues and mobilisation activities, for example, are focussing on RH, HIV/AIDS and GBV in the three components, yet they are not coordinated.

[16] This MTR used the CPAP's indicators identified in 2009 which the Programme is currently reviewing them

5.4. Facilitating and constraining factors:

Facilitating factors:

- The existence of signed peace agreements, and government policies and strategies (RH, PD and Gender) has supported partnerships building and provided UNFPA's programme with legitimacy and favourable work environment, both at the national and state level.

- The presence of capable community-based structures (i.e. CBO's and NGO's) in most of the target states was instrumental in extending the outreach and nurturing efforts towards awareness-raising and social change. It was observed that the CBOs had better acceptance because they had relatively strong connections with the communities.

- The existence of national and state mechanisms which makes the WEP and GBV strategy operational, such as VAW units, GFPs and Walis' Advisory Offices on Women and Child Affairs at the state level, are strategic entry points for promoting and integrating gender issues into development processes.

- UNFPA's ability to mobilise significant additional non-core funding, as well as and donors' interest to support the programme proposed thematic interventions.

- Increasing interest in capacity building activities by the IPs and other stakeholders.

- Transparent consultation between UNFPA and its partners on programming issues, and flexibility of AWPs to accommodate the IPs' plans.

Constraining factors:

- The emphasis during the period 2009-2010 which prioritised the CPA's political commitments (census, national elections and referendum) has resulted in less attention to other aspects of the development agenda.

- At the federal level, the main constraints to the RH component are related to limitations in institutional support, capacity and resources. For example, the limited institutional capacity of the Academy of Health Science together with the lack of recognition of midwifery as a profession have hampered UNFPA initiatives in institutionalising the midwifery programme and structures, such as the establishment of the Sudan Midwifery Association and Sudan National Midwifery Council, and in making the Midwifery Strategy operational. This is further aggravated by the limited financial resources to support the high-cost but high-return investments for RH related activities, such as the RHCS, rehabilitation of health facilities, improvement of the referral system, and provision of supplies and essential equipment.

- High staff turnover and absence of a clear retention strategy within government institutions were common constraints to the implementation of all programme components. It was particularly noted that the high turnover of the trained C/BEmONC healthcare providers remains as a common threat to the quality of service delivery at the state level.

- The minimal consultative planning between IPs at the national and state levels has generated reservations on the planned activities, target areas, target groups and strategies of implementation. This is further affecting ownership of the process and commitment to the programme deliverables.

- Although the programme components support each other in terms of implementation, inadequate co-ordination nevertheless reduces chances to maintain a better synergy and multiplier effect.

- Delay in releasing the LFQ advanced census results (LFQ) and the SHHS Report (2010) has affected the implementation of other associated programme activities

- Inadequate IPs' programming capacities (e.g. project design, monitoring, report writing), as well as lack of common vision on the CPAP and the role of each other.

- Delays in the approval of the 2010 AWPs had affected the overall rate of implementation

5.5. Recommendations for programming:

SHORT-TERM (PROGRAMMATIC):

<u>All Programme Components</u>

- Working towards aligning the 3 components by forming a joint 'Programme Task Group' and bringing the officers-in-charge together with the Senior Management Team on programming. This is important in order to create internal synergies, to avoid overlapping, and to maximise the resource use. The approach might also require structural financial decisions, such as creating 'internal pool fund' for the components with similar activities.

- Training of programme stakeholders on PCM (particularly the Results Based Management (RBM)), M&E, and reporting writing. The project progress reports should use the standardised formats; review of existing formats is needed.

- Execution of retrospective baseline survey on indicators (CPAP) to establish baseline data (with 2008 as the base year).

- Strengthening of the M&E system. UNFPA should emphasise monitoring and evaluation both internally within the UNFPA and externally within IPs. There is a need to inject a budget line within the AWPs for monitoring (currently put as monitoring visits).

- UNFPA, with the IPs, should institute stronger quality control measures, e.g. standards for workshops, reports, drafting Terms of References (ToRs) and selection of consultants/training facilitators.

- UNFPA should require quality assessment of research/survey reports and manuals by an independent expert before they are published or disseminated

- UNFPA and IPs should participate in the upcoming 5-year strategic plan and PRSP processes to ensure that population concerns are mainstreamed

RH

- Prioritization of rehabilitation of health facilities in Blue Nile and South Kordofan, as the areas with low population coverage according to the MTR findings

- Assessment and documentation of the experience of the use of local ambulances by the VMWs in Gadarif and Kassala in order to find out the effectiveness and to scale up.

- Strengthening of the national/state RHCS operational plans, including development of national training guidelines, establishment of national and state level master trainers, and capacity building on supply-chain management.

- Integration of RH and HIV/AIDS internally within UNFPA in terms of planning, coordination, implementation, monitoring and evaluation.

PD:

- Revisit of the strategy on integration for better alignment. It is recommended for UNFPA to develop a direct strategic partnership with the NCSP which is much more close to decision making cycles at the national level, while the NPC continues its technical support for the integration in line with the NPP and PoA.

- Scaling up of support to the youth sub-component, particularly the youth centres, and capacities building of the state HCYSs

Gender

- Execution of a thorough independent joint assessment of the institutional capacity on the WEP implementation and coordination mechanisms at federal/state level

SHORT-TERM (POLICY ADVOCACY & DIALOGUE):

RH

- Policy and advocacy prioritization on mobilisation of resources for the midwifery training and supportive supervision (e.g. certified trainers, kits), and support to formal recruitment of the VMW

- Capitalization of strategic and diverse partnerships by involving faith based organisations, NGOs, CBO's, media, parliamentarians and professional associations to create demand for and utilisation of Maternal new born Health/family planning services

- Focus on the following national policy dialogue agenda with government while capitalising on existing efforts in the establishment of RH partnership forum, a) institutionalisation of the RHCS; b) resource mobilisation for implementation of the MNMR roadmap; c) support for the formation of structures to support the midwifery intake for the establishment of regulatory standards, increase in political commitment to midwifery and representation in policy dialogue; d) strengthening of the Government and national NGO expertise to respond to national disasters or conflict as part of regular programming; e) human resources for health to address high staff turn-over rates, incentive packages to work in under-served areas, and other related staff retention issues; and f) facilitation of

deliveries in SDPs that are closer to the community. This should ultimately ensure scaling-up of essential RH interventions beyond the current target 5 states.

Gender

- Advocacy for the evaluation of the status of the WEP implementation, with regard to the priorities, by identifying institutional opportunities and bottle necks from federal to state/locality level.

LONG-TERM (PROGRAMMATIC):

All Programme Components

- Utilize findings from the Census 2008 and the SHHS by the next CP to map out the states and localities that should receive direct support, depending on the status of relevant indicators in each state/locality, i.e. establish an 'intervention map' according to evidence-based criteria for selection

- More focus on UNFPA's support to the state where there is real need and potential for immediate impact. While IPs at the national level should work at the policy/strategy level, the state-based IPs should be assigned at the programmatic level (activities).

- Identification of additional strategic partners and assessment of capacities of current partners.

RH

- Mainstream of RHCS into the National Health Commodity Supply System
- The expansion of UNFPA's support to the states and localities instead of limited focus of support to the national partners. While the national focus should be at the policy/strategy level, the state focus should be at the programmatic level (activities).

LONG-TERM (ADVOCACY)

- Scale-down of service delivery and expansion of advocacy work in line with the use of the inevitable service delivery as an entry point for advocacy work with communities (i.e. people-centred advocacy). This is done jointly with other similar partners and through the existing forums.

- Advocacy for the Government support to basic training for professional midwives and establishment of structures, such as the Sudan Midwifery Association and Sudan National Midwifery Council, and advocacy for making the National Midwifery Strategy operational.

Annexes:

Annex 1: Programme financial matrix by source of funding 2009-10

Programme components by output	Funding source	2009 (US$)		2010 (US$)		Total (US$)	
		Budget	**Expenses**	**Budget**	**Expenses**	**Budget**	**Expenses**
RH I	Core	1,120,489	1,128,480	827,004	741,877	1,947,494	1,870,357
	Non-Core	255,657	233,457	235,528	187,309	491,184	420,766
	Total	**1,376,146**	**1,361,937**	**1,062,532**	**929,186**	**2,438,678**	**2,291,123**
RH II	Core	268,139	212,810	466,774	402,141	734,912	614,952
	Non-Core	852,370	171,953	401,844	369,580	1,254,214	541,532
	Total	**1,120,509**	**384,763**	**868,618**	**771,721**	**1,989,127**	**1,156,484**
RH III	Core	505,468	476,703	261,108	241,754	766,576	718,457
	Non-Core	1,933,356	1,488,066	1,961,086	1,190,243	3,894,442	2,678,309
	Total	**2,438,824**	**1,964,769**	**2,222,194**	**1,431,997**	**4,661,018**	**3,396,767**
Total RH	Core	1,894,096	1,817,993	1,554,886	1,385,773	3,448,982	3,203,766
	Non-Core	3,041,383	1,893,476	2,598,458	1,747,132	5,639,841	3,640,608
	Total	**4,935,479**	**3,711,469**	**4,153,344**	**3,132,905**	**9,088,823**	**6,844,374**
PD I	Core	667,305	624,869	349,652	338,960	1,016,958	963,828
	Non-Core	2,996,233	2,685,553	-	-	2,996,233	2,685,553
	Total	**3,663,538**	**3,310,421**	**349,652**	**338,960**	**4,013,191**	**3,649,381**
PD II	Core	210,293	200,792	54,916	50,805	265,209	251,596
	Non-Core	-	-	-	-	-	-
	Total	**210,293**	**200,792**	**54,916**	**50,805**	**265,209**	**251,596**
PD III	Core	153,440	140,373	80,733	53,538	234,173	193,911
	Non-Core	-	-	70,000	26,890	70,000	26,890
	Total	**153,440**	**140,373**	**150,733**	**80,427**	**304,173**	**220,801**
Total PD	Core	1,031,038	966,034	485,301	443,302	1,516,339	1,409,336
	Non-Core	2,996,233	2,685,553	70,000	26,890	3,066,233	2,712,443
	Total	**4,027,271**	**3,651,586**	**555,301**	**470,192**	**4,582,572**	**4,121,778**
Gender I	Core	195,000	190,166	119,169	118,145	314,169	308,311
	Non-Core	-	-	-	-	-	-
	Total	**195,000**	**190,166**	**119,169**	**118,145**	**314,169**	**308,311**
Gender II	Core	260,000	232,534	132,560	134,736	392,560	367,270
	Non-Core	472,236	358,789	552,383	443,936	1,024,619	802,724
	Total	**732,236**	**591,323**	**684,943**	**578,672**	**1,417,179**	**1,169,994**
Total Gender	Core	455,000	422,700	251,729	252,881	706,729	675,580
	Non-Core	472,236	358,789	552,383	443,936	1,024,619	802,724
	Total	**927,236**	**781,488**	**804,112**	**696,816**	**1,731,348**	**1,478,305**
Total Country Program	Core	3,380,135	3,206,726	2,291,916	2,081,956	5,672,050	5,288,682
	Non-Core	6,509,852	4,937,817	3,220,841	2,217,957	9,730,693	7,155,775
	Total	**9,889,987**	**8,144,544**	**5,512,757**	**4,299,913**	**15,402,743**	**12,444,457**

Annex 2: List of persons/institutions met/visited by state & component

RH: Component:

1. Dr. Omer El-farouk, UNFPA – NPPP, White Nile State
2. Dr. Siddig El-tayib, Deputy Director General, SMOH, White Nile State
3. Dr. Abdelmoneim Mustafa, SNAP Coordinator, White Nile State
4. Ms. Amina Badi (NMW), RH Director, White Nile State
5. Ms. Safa'a Ahmed El-Mustafa, Sudanese Society for Environment Protection,
6. Ms. Gihan Bagadi, Sudanese Society for Environment Protection,
7. Mr. Elhadi Sabah El-Kheir, Sudanese Red Crescent,
8. Mr. Eltayib Abdelati Osman, Sudanese Red Crescent,
9. Sudanese Society for Environment Protection, White Nile State
10. Dr. Mohamed Ali Momahed El-Haseen, UNFPA – NPPP, Blue Nile State
11. Ms. Faiza Mirghani Abdelrahim, UNFPA Finance/Admin, Blue Nile State.
12. Dr. Amir El-Sheikh, DG, SMOH, Blue Nile State
13. Dr. Asim Mohamed Ahmed Ali, RH Coordinator, Blue Nile State
14. Dr. Nasreddin Mohamed Ahmed, Psychologist/Counselor - SNAP, Blue Nile State
15. Dr. Mohamed Abdelkarim, MDR Focal Point, Blue Nile State
16. Dr. Mustaf Gabr-eddar, Dean of Academy for Health Science, Blue Nile State
17. Mr. Gasim Mohamed Mohamed Ahmed, Director, Community Radio, Blue Nile State
18. Mr. Shaseddin babiker, TV Director, Blue Nile State
19. Mr. Zikrayat Hyder, Programme Director, State Radio, Blue Nile State
20. Mr. Hani Abdelgaffar Abdelrahim, Communication Officer, SMOH, Blue Nile State
21. Mr. Abbas fadlalla, Programme Manager, Islamic Relief Agency, Blue Nile State
22. Mr. Mohamed H. Kabbashi, Programme Coord., Islamic Relief Agency, Blue Nile State
23. Mr. El-fatih Hussein, Islamic Relief Worldwide, Blue Nile State
24. Dr. Hisham Hasab El-rasoul, UNFPA – NPPP, Gadarif State
25. Dr. Abdelrahman O. El-Imam, Dean of the Academy for Health Science, Gadarif State
26. Mr. Gibriel Mohamed Ibrahim, Statistician, RH Directorate, Gadarif State
27. Ms. Amira Mohamed Obaidalla, RH Directorate, Gadarif State
28. Mr. Mohamed Ali, SNAP, Coordinator, Gadarif State
29. Mr. Ahmed Mustafa and Ms. Zeinab, Women & Develop. Organization, Gadarif State
30. Mr. Mustafa Mohamed, Sudanese Red Crescent, Gadarif State
31. Representative of the Community Health Dept., University of Gadarif, Gadarif State
32. Dr. Samah Ahmed Awad, UNFPA NPPP, Kassala State
33. Dr. Ali Adam Mohamed Ahmed, RH Director-SMOH, Kassala State
34. Mr. Abdelazim El-Tahir, JASMAR, Kassala State
35. Mr. Motaz Abdallah, JASMAR, Kassala State
36. Ms. Nahid Hamza, ACORD, Kassala State
37. Mr. Taha Ja'afar, Sudanese Red Crescent, Kassala State
38. Dr. Maria Emauel, UNFPA Team Leader, South Kordofan State
39. Dr. Gorashi Musa El-Nour, UNFPA NPPP, South Kordofan State
40. Ms. Khadiga Osman Abdelkarim, UNFPA - GBV Officer, South Kordofan State
41. Nahid Julie Arguf, UNFPA Admin/Assist., South Kordofan State
42. Mr. Omer Mohamed Hamid, Mubadiroon (NGO), South Kordofan State

43. Mr. Sabir Farah Bakheit, Programme Coordinator, Mubadiroon, South Kordofan State
44. Mr. Miraiha El-daw Miraiha, Sudanese Red Crescent, South Kordofan State
45. Mr. Alsadig Mohamed Osman, PANCARE, South Kordofan State
46. The Midwifery School, White Nile State
47. SNPA Office, Blue Nile State
48. The Midwifery School, Blue Nile State
49. To the Youth Vocational Training Center, Blue Nile State
50. The Midwifery Schools, Gadarif State
51. Clubs in residential areas (sites for HIV/AIDS awareness campaigns, Kassala State

PD Component:

52. Ms. Rasha Osman El Mahdi, National Project Director, NPC, Khartoum
53. Wisal Hussein Abdalla, Integration Focal Point, NCP, Khartoum
54. Hanadi Hassan Mahgoub, National Project Director, NCP, Khartoum
55. Mr. Murtada Abdulmottalib Hussein, Project Co-ordinator, FMYS, Khartoum
56. Mr. Ali Abbas, Secretary General, SPN, Khartoum
57. Mr. Mohamed Osman Hamid, Communication and Information Oficer, SPN, Khartoum
58. Mr. Elsir Hassan Abbass, Manager to the Office of the CBS Director General, CBS, Khartoum
59. Mr. Ibrahim Abbas Seif En-nassr, Census Project Director, Khartoum
60. Mr. Mustafa Hassan Ali, Statistical Co-ordination and Fieldwork Manager, CBS, Khartoum
61. Dr Hisham, NPPP, UNFPA Gadarif State
62. Mr. Sabir Sa'ad Hassan, HCYS Director General & Youth Empowerment Project Manager, Gadarif
63. Ayman Ahmed Adam, Youth Empowerment Project Co-ordinator, HCYS, Gadarif State
64. Mr. Mohamed Ahmed Al-Abhari, Director General, SPC, Gadarif State
65. Mr. Yassir Mohamed El Hadi, Journalist, SPC, Gadarif State
66. Ms. Naila Adam Ahmed, Researcher, SPC, Gadarif State
67. Mr. Ali Suleiman Ali, Director, CBS, Gadarif State
68. Dr. Samah, NPP, UNFPA Kassala State
69. Ms. Nour Ahmed Zarroug, Director General, SPC, Kassala State
70. Mr. Hashim Abdalla Elfaki, Director General of Youth Directorate, HCYS, Kassala State
71. Mr. Kamal Mohamed Hassan, Director of Youth Centres Directorate, HCYS, Kassala State
72. Mr. Hassan Mohamed Hassan, Youth Empowerment Project Co-ordinator, HCYS, Kassala State
73. Mr. Yousif Hassan Abdelmageed, Director, CBS, Kassala State
74. Halanga Youth Centre, Kassala State

Gender Component :

75. Mawahib Mohammed Ahemd, Project Director, MoWSS
76. Nawal Mahmoud Alfakie, Project coordinator, MoWSS
77. Farida Osman, Project accountant, MoWSS
78. Dr. Attiyat Mustafa, Project Director, MoJ, Cabinet of Ministers
79. Nadia Mohammed Salih, Project Coordinator, MoJ, Cabinet of Ministers
80. Dr. Baligees Badri, Project Director, Gender Institute, AUW
81. Dr. Nafissa Badri, Project Director, AUW
82. Suaad Oragee , Project Coordinator, AUW
83. Rasha Osman Almahdi, Gender Unit, NPC
84. Meeting with IPs working on RH programme component, White Nile State
85. Dr. Fatima Mohamed Ali, Wali Advisor and Chief of VAW Unit, White Nile State

86. Ishraga Ahmed, MoSA, White Nile State
87. Director of Woman Department, MoSA, White Nile State
88. Zeinab Edrees, Director of Woman Department and Dean Faculty of Community Development, Kassala State
89. Masha'ar Adam, Head VAW Unit, Kassala State
90. Dr Samah Ahmed, UNFPA's NPPP, Kassala State
91. Dr. Hisham Hasalrasoul UNFPA's NPPP, Gadarif State
92. Sua'ad Deshoul , Wali Advisor on Women and Child Affairs, Gadarif State
93. Samia Albarbri, Dean Faculty of Community Development, Gadaref University
94. Prof. Mohmmed Awad, Chancellor Gadaref University
95. Director of Woman Department, MoSA, Gadarif State
96. VAW Unit Co-ordinating committee (MoSA, SCCW, Gadaref Prison for Women, Women and Child Protection Unit, Harmful Traditional Practices Society, Sudanese Women Union, Foundation of Religion Ulama, Legal activists), Gadarif State
97. 100 women from Women CBOs working on FGM and women empowerment, and Women's Agricultural Organisations, Gadarif State
98. Doka Women Development Centre, Gadarif State
99. PANCARE and MSDWCA, South Kordofan State

Annex 3: MTR –ToRs: UNFPA Sudan CP achievements & relevance (2009-10)

Background: United Nations Development Assistance framework (UNDAF) 2009-2012 articulates UN's joint support to recovery and development processes in Sudan. Key milestones captured in UNDAF will be jointly reviewed and updated during the UNDAF Mid- Term Review Meeting scheduled for June 2011. To this effect, UNFPA Country Program (2009-2012) which is contributing to three UNDAF Outcomes will need to be assessed so as to document program achievements in past two years; and to propose future strategic options for UNFPA support and used as input into the UNDAF MTR meeting.

Thus and consistent with the draft terms of reference of the UNDAF MTR[17] , the UNFPA Mid-Term Review process will undertake the following:

1. Assess country program achievements, and relevance of program priorities particularly to peace building efforts in Northern Sudan;
2. Assess the case for a change in focus in Darfur from a humanitarian response to supporting longer term recovery and development initiative with respect to UNFPA areas of co-operation;

These terms of reference are a guide to undertake items 1. A separate TOR's has been prepared for item 2 which is not within the scope of this consultancy.

Specific Objectives:

In consultation with government and in line with UN programming principles[18], UNFPA will facilitate the undertaking of an independent assessment of the country program performance to document UNFPA's achievements, and relevance of country program priorities (2009-2012) for past two years and to propose strategic options for future engagement. The specific issues that the assessment will respond to include the following:

- ✓ Provide information on progress in achieving country program outputs and their contribution to country program outcomes in light of contextual constraints and opportunities.
- ✓ Assessment of the continued relevance of the UNFPA program of assistance in contributing to national reproductive health, population and development goals as well as to peace building efforts in Northern Sudan;
- ✓ Review of constraining and facilitating factors to determine whether original risks and assumptions as articulated in the CPAP have materialized or new risks have emerged.
- ✓ Recommend the way forward including a proposal of performance measures that will specifically capture UNFPA's contribution to the peace building process in Northern Sudan.

[17] The UNCT decided to conduct an UNDAF MTR in the absence of UNDAF Annual reviews for 2009 and 2010. Hence agencies are requested to do their own specific MTR's to feed into the UNDAF MTR

[18] Guidance note" application of the programming principles to the UNDAF"

Methodology

The assessment team will:

1. Make reference to the country program priorities, and CPAP M and E framework (2009-2010) , to propose and share the methodology and tools of assessing the extent to which UNFPA has achieved country program outputs, contributed to country program outcomes; and to peace building efforts in northern Sudan.
2. Review and analyze UNFPA's quarterly and annual program progress reports for 2009, 2010, Sudan Country Office Annual Reports 2009 & 2010 and UNDAF thematic and annual reports for 2009 to articulate progress in program implementation. Annex A will include a list of materials to be reviewed by consultants.
3. Consult with strategic partners including Government, UN agencies, and CSO's at the national level as part of the data collection process, use various governments led analysis and partner agency program reviews to validate information on UNFPA's performance.
4. Undertake field visits to selected UNFPA focal states to access state based information and to engage with key actors at this level.
5. Synthesise available information to reflect on programme achievements particularly in capacity building and UNFPA's contribution to peace building efforts in Sudan and proposed programmatic and indicator revisions taking into account the revised 2011-2012 CPAP M&E framework as relevant

Management arrangements for CP MTR process:

1) At UNFPA Country office, under the overall guidance of the Representative and supervision of the Deputy Representative. The program specialist will act as UNFPA CP MTR manager who will be responsible for a) coordinating b) securing technical assistance, c) organizing the review meetings and field visits d) coordinating and providing feedback and guidance to consultants. The MTR manger will work very closely with the M and E Analyst.
2) The consultants will periodically brief UNFPA program team and Government lead agencies on their approach, progress and findings.
3) The team will likewise engage with the established UN Inter-agency groups (such as the Program Management Team and Monitoring and Evaluation UN inter-agency group) for consultations and sharing information.
4) In addition to the individual meetings with government, the team will engage with key stakeholders including donors, NGO's and research institutions.
5) UNFPA CO will consult with ASRO and UNFPA Headquarters program division for feedback and quality assurance of the processes and products.
6) Input from the UNFPA MTR will be used to contribute to the UNDAF thematic review and subsequently UNDAF MTR meeting.
7) The team will then make a presentation on the findings at the UNFPA MTR meeting.

Composition of the Team of consultants:

1) The team will be composed of a mix of national consultants. There will be a team leader having at least ten years of professional experience in UNFPA mandate, evaluation methodology and expertise in peace building and sustainable development.
2) A team of four national consultants will be selected having the following skill mix: familiarity of the complex context of Sudan, familiarity with UNFPA program in Sudan, at least ten years professional

expertise in Reproductive Health, Gender Equality, Population and development and knowledge of evaluation methodology.

3) The Team leader in consultation with the MTR manager will develop terms of reference for each of the national consultants indicating specific deliverables and timing.
4) The team leader will consolidate the whole report and present findings at the MTR meeting.

Scope: The assessment will have a regional perspective (5 States in Northern Sudan) as well as national to assess progress and document lessons learned.

Expected Results: An independent assessment of UNFPA Sudan performance for the past two years that reflects relevance to the programming context of Sudan, and proposal for the way forward will be shared – see Annex B.

Timing: UNFPA Program assessment: **Five weeks:** March

ANNEX A to TORs: List of documents:

UNFPA:

- ✓ UNFPA Strategic Plan (2008 – 2013)
- ✓ Application for Programming Principles to the UNDAF 2010
- ✓ UNDG position statement on UN's contribution to capacity development 2006
- ✓ UN transitional strategy guidance note March 2007
- ✓ Joint Guidance note on integrated recovery planning using post conflict needs assessment and transitional results framework. Sep 2007
- ✓ Gender mainstreaming strategic framework (2008)
- ✓ Gender based violence strategic framework (2008)
- ✓ Reproductive Health and Sexual and Reproductive Health Framework (2008)
- ✓ Guidance note- for entry point to peace building and other useful resources
- ✓ MDG framework
- ✓ Guidelines for humanitarian response and early recovery

Country Specific:

- ✓ Sudan Country program (2009-2012) document
- ✓ Country Programme Action Plan (2009-2012) including annexes
- ✓ Sudan MDG report 2010
- ✓ Human Development report 2010
- ✓ National Household poverty Assessment 2010
- ✓ Sudan health household surveys: 2006;
- ✓ Analytical reviews on census data
- ✓ Labor Market survey 2006
- ✓ Education sector review 2009
- ✓ Comprehensive Peace Agreement 2005

- ✓ Beyond Relief Darfur
- ✓ Health sector national accounts report – 2010
- ✓ Country Office Annual reports. 2009; 2010
- ✓ Component Annual Progress reports. 2009;2010
- ✓ Minutes UNFPA Annual review meeting 2009;2010
- ✓ UNDAF 2009-2012;
- ✓ UNDAF Outcome Reviews 2009
- ✓ UN Country Analysis Sudan 2008
- ✓ Public Expenditure Tracking Survey 2009,
- ✓ National Health Account survey 2010,
- ✓ Evaluation of Free Treatment for Under Fives,
- ✓ National Health Facilities Survey,
- ✓ Human Resources for Health surveys

1.1.1. Country Specific UNFPA:

Reproductive:

2. Baseline RH-GBV KAP Survey among the Communities Affected by Conflict in Darfur- 2009
3. Blue Nile Assessment report Submitted - UNFPA 8-2
4. Causal Analysis Note updated 28 Nov Gov RoL Only
5. EMOC Assessment national
6. Gaddarif EMOnC final report
7. Health Five-year-strategy 1 5 2007
8. Midwifery Transitional Strategy Sudan 2nd Draft
9. Northern Sudan RHCS Operational Plan-2009-2010
10. Proposal of AYFC Kosti
11. Review_of_HIV_Epidemic_in_Northern_SudanSeptember11_2009Final
12. RH MAPPING
13. RHCS Situation Analysis for the Northern States - July 2007
14. ROAD MAP FOR REDUCING MATERNAL AND NEWBORN MORTALITY IN SUDAN
15. Situation Analysis of R H Services Utilization Patterns in Blue Nile State 2009
16. Situation Analysis of R H Services Utilization Patterns in Gadarif State 2009
17. Situation Analysis of R H Services Utilization Patterns in Gezira State 2009
18. Situation Analysis of R H Services Utilization Patterns in Kassala State 2009
19. Situation Analysis of R H Services Utilization Patterns in South Kordofan State 2009
20. Situation Analysis of R H Services Utilization Patterns in White Nile State 2009
21. Sudan National Health Policy 11 6 07

22. SUDAN RHCS assessment mission REPORT-FINAL-KABIR

HIV:

23. Desk Review of Literature on Stigma and Discrimination among HIV at Risk and Vulnerable Populations in Sudan_Dec09
24. Final Draft Report from Condom Programming Team 12 Dec 09
25. NGOs Assessment North Sudan SNAP and UNFPA_11-02-2010
26. Review of HIV Epidemic in Northern Sudan September11 2009 Final

PD:

27. SOCIO-ECONOMICDETERMIN ANTS OF MATERNAL MORBIDITY AND MORBIDITY IN SUDAN
28. Level, Trend and Determinants of Fertility in the Sudan 2008
29. Youth Issues and Needs In the Sudan Case Study: Elgadarif State 2008
30. Youth Issues and Needs In the Sudan Case Study Kassala State 2008
31. NATIONAL POPULATION COUNCIL Monitoring and evaluation system 2008
32. National Population Policy
33. Population Dynamics and Linkages to Poverty 2008
34. Research on Youth Issues and Needs in Sudan - Gadarif Case Study - dec 08
35. Research on Youth Issues and Needs in Sudan - Kassala Case Study - dec 08
36. Training Needs Assessment on population data collection and analysis, Kassala
37. NATIONAL STUDY ON YOUTH ISSUES AND CHALLENGES 2009
38. ICPD country Final report
39. Final Progress of MDGs in Sudan Nov 2010

Gender:

40. Crisis Prevention Peace Building Joint Programme Document 2009
41. FINAL Gender inequality and the MDGs
42. Summary Report on the Mapping and Capacity Building Assessment Study 2009
43. Identifying the Opportunities for the Gender Mainstreaming and Women Empowerment National Policy
44. National Policy for Women Empowerment – 2007
45. Second draft of MDGs Gender REPORT
46. UNFPA role given new entity for Women
47. Women Empowerment National Strategy
48. Concept of Violence against Women

ANNEX B to TORs: Format for the Independent Assessment:

Executive Summary: In line with [19]UN programming principles, highlight UNFPA's relevance and contribution to conflict prevention, peace building and capacity development.

Section 1: Introduction: Brief analysis of the context in Sudan. Highlight major shifts in the programming context (political, economical, environmental and population changes); Document the national development planning frameworks to which UNFPA program is responding to.

Section 2: Highlight specific objectives of the assessment

Section 3: Reflect the methodology used to undertake the assessments.

Section 4: Highlight study findings related to progress in achieving results and relevance to peace building and capacity development

Section 5: Articulate best practices, lessons learned and challenges; Reflect study limitations, facilitating and constraining factors to determine whether original risk and assumptions are valid or new ones have emerged..

Section 6: Way forward: Reflect strategic options for UNFPA support for remaining of the program cycle, taking into account the changed environment

Annex: Tools used for data collection; List of persons met

[19] Guidance note: Application of the programming principles to the UNDAF

Annex 4: MTR proposed Guide:

Methodology:

1. Desk review (key documents, studies and progress/technical reports) for crosscheck
2. Discussions with UNFPA core staff and NPPPs
3. Meetings with some selected resource persons (to be identified during the review course)
4. Discussions with the Federal/National IPs (Khartoum)
5. Discussions with IPs, NPPPs and beneficiary groups/institutions (field visits to White Nile, Blue Nile, South Kordofan, Gadaref, and Kassala states)
6. Consultants' visits to states is identified according to nature of interventions in each (i.e. where relevant components is being implemented)

State	RH	PD	Gender
White Nile	X		X
Blue Nile	X		
Gadarif	X	X	X
Kassala	X	X	X
South Kordofan	X		

IPs to be met/visited:

These are the implementing institutions/organizations with which the UNFPA has signed Annual Work Plan at both the national and state levels.

IP	Location	RH	PD	Gender

MTR Focus:

This MTR is result-based and so data collection and analysis focus on the CP's outputs: RH component (3 outputs), PD component (3 outputs) and Gender component (2 outputs). Each consultant ensures that s/he collect information on the output indicators identified in the CP document.

Output	Output indicator	Achievement

Specific issues, as a base for inventory questions with IPs, include:

- Analysis of specific context of operation
- Progress and achievements against AWPs (2009. 2010) by output
- Relevance of activities to CPAP, UNDAF and beneficiaries' priorities
- Progress towards achieving CPAP's outcomes (2009, 2010)

- Based on the above, analysis of the added value (of each component achievements):
  (1) Contribution to policy and planning (national and state)
  (2) Contribution to good governance
  (3) Contribution to peace building
- Constraints and facilitating factors
- Capacity issues (strengths and gaps) – institutional and human
- Programme quality – implementation, co-ordination, monitoring and reporting systems
- Assessment of quality of services delivered
- Assessment of programme internal links and approach - how the different components talk to each other both at the UNFPA and IP levels
- Proposals for the CPAP second phases 2011-2012