COUNTRY REPORT

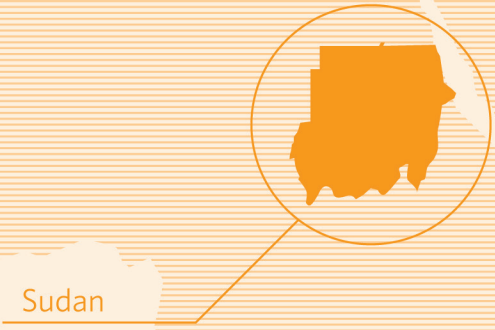
SUDAN

EVALUATION OF UNFPA SUPPORT TO MATERNAL HEALTH

Mid-Term Evaluation of the Maternal Health Thematic Fund

EVALUATION BRANCH
Division for Oversight Services

New York, October 2012



Sudan

UNFPA

Evaluation of UNFPA Support to Maternal Health
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COUNTRY REPORT: SUDAN

Sudan Country Office

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http://www.unfpa.org/public/home/about/Evaluation/EBIER/TE

Layout and design: uPwelling.net

EVALUATION OF UNFPA SUPPORT TO MATERNAL HEALTH

Including the contribution of
the Maternal Health Thematic Fund

EVALUATION BRANCH
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List of Acronyms

AHS	Academy of Health Sciences
AR	Annual report
ARP	African Regional Programme
AUW	Afhad University for Women
AWP	Annual Work Plan
BEmONC	Basic Emergency Obstetric and Newborn Care
CARMMA	Campaign for Accelerated Reduction of Maternal Mortality in Africa
CCA	Common Country Assessment
CEmONC	Comprehensive Emergency Obstetric and Newborn Care
CMA	Country Midwife Advisor
CO	Country Office
COAR	Country Office Annual Report
CP	Country Programme
CPAP	Country Programme Action Plan
CPD	Country Programme Document
CPI	Consumer Price Index
CSO	Civil Society Organizations
CSS	Country Support Strategy
DP	Development partner
EmONC	Emergency Obstetric and Newborn Care
EU	European Union
FG	Focus Group
FGM/C	Female Genital Mutilation/Cutting
GBV	Gender based Violence
GDP	Gross Domestic Product
GNI	Gross National Income
GPRHCS	Global Programme to Enhance Reproductive Health Commodity Security
H4	UNFPA, UNICEF, World Bank, WHO
H4+	UNFPA, UNICEF, World Bank, WHO, UNAIDS
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome
HMIS	Health Management Information System
HQ	Headquarters
HRH	Human Resources for Health
ICM	International Confederation of Midwives

ICMA	International Consortium for Medical Abortion
ICPD	International Conference on Population and Development
IDP	Internally Displaced Person
IEC	Information, Education and Communication
IP	Implementing Partner
IUD	Intrauterine Devices
M&E	Monitoring and Evaluation
MDA	Maternal Death Audits
MDG	Millennium Development Goal
MDR	Maternal Death Review
MHTE	Maternal Health Thematic Evaluation
MHTF	Maternal Health Thematic Fund
MISP	Minimal Initial Service Package
MMR	Maternal Mortality Ratio
MNCH	Maternal, Newborn and Child Health
MNH	Maternal and Neonatal Health
MoH	Ministry of Health
MoUs	Memoranda of Understanding
MT	Metric ton
NGO	Non-governmental organization
PHC	Primary Healthcare Centres
PMTCT	Prevention of mother-to-child HIV transmission
PRSP	Poverty Reduction Strategy Paper
RHCS	Reproductive health commodity security
RHTF	Reproductive health thematic fund
SAG	Sector Advisory Group
SHHS	Sudan Household Health Survey
STI	Sexually transmitted infection
SWAP/SWAp	Sector wide approach
TBA	Traditional birth attendants
TL	Team leader
ToT	Training of trainers
TV	Television
TWG	Technical Working Group
UBW	Unified Budget and Workplan
UN	United Nations

UNDAF	United Nations Development Assistance Framework
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UNV	United Nation Volunteers
US	United States
USD	US-dollar
VMW	Village midwives
WHO	World Health Organization
YFS	Youth-friendly services

1. Purpose and scope of this evaluation

Maternal health remains a major challenge to health systems worldwide. The world is on track to reach some targets of the Millennium Development Goals (MDGs) by 2015, but falling short on others; maternal health is the least likely to meet the 2015 target. A recent analysis found an annual rate of reduction of 1.3 per cent during the period of 1990–2008, well short of the 5.5 per cent needed to attain the MDG target by 2015. At the current rate of decline, it will take more than 188 years to meet the goal of 100 per 100,000 live births.

Given the current lack of sufficient progress in tackling maternal mortality, it is critical that effective interventions are implemented and monitored. Careful evaluation of these interventions is crucial for determining what works and for ensuring that scarce resources are allocated effectively. This is particularly true for developing countries, where maternal mortality is highest and access to maternal health services is poor. For this reason, UNFPA has launched the evaluation of its support to maternal health in the last eleven years and the mid-term evaluation of the Maternal Health Thematic Fund. Following the terms of reference, the evaluation covers the period from 2000 until 2010, and also includes information related to a number of interventions implemented in 2011.

The aim of conducting both evaluations in parallel; i.e. the Maternal Health Thematic Evaluation (MHTE) and the Mid-Term Evaluation of the Maternal Health Thematic Fund (MHTF); is to take advantage of potential synergies in the evaluation portfolio of UNFPA and obtaining deeper and better substantiated insights on the thematic area of maternal and reproductive health as a whole, as well as on the MHTF individually.

1.1 Scope of the Maternal Health Thematic Evaluation (MHTE)

The MHTE is meant to assess to what extent UNFPA support to maternal health has been relevant, effective, efficient and sustainable in contributing to the improvement of maternal health. The evaluation covers all programmatic interventions that have been directly relevant to maternal mortality and morbidity within UNFPA mandate, including all activities financed from core and non-core resources; and those financed through UNFPA Reproductive Health Thematic Funds.[1] MHTE focuses on key elements of reproductive health including family planning, skilled birth attendance and Emergency Obstetric and Newborn Care (EmONC), i.e. the "three pillars" of reducing maternal mortality. The specific thematic scope of the MHTE is defined by a list of twelve evaluation questions (a table with all evaluation questions and related judgment criteria is presented in Annex 6.3).

1. I.e., the Maternal Health Thematic Fund, the Global Programme to enhance Reproductive Health Commodity Security and the joint UNFPA-UNICEF FGM Programme.

1.2 Scope of the Maternal Health Thematic Fund (MHTF) mid-term evaluation

The objectives of the mid-term evaluation of the Maternal Health Thematic Fund (MHTF) are to assess to what extent MHTF support has been relevant, effective, efficient and sustainable in contributing to the improvement of maternal health. The mid-term evaluation focuses on technical areas (midwifery, family planning and emergency obstetric and newborn care) and on the potential of the MHTF to act as a catalyst in these areas. The evaluation also covers the internal coordination and management processes of the MHTF (support to planning, programming and monitoring, coordination and management mechanisms, and the facilitation of the integration and use of synergies). Additionally, aspects of leveraging and visibility are assessed. The temporal scope of the mid-term evaluation covers the period since the launch of the MHTF in 2008.

The strategic framework of the MHTF (i.e., the MHTF business plan) provides a clear reference framework for the mid-term evaluation. The specific thematic scope of the mid-term evaluation of the MHTF is defined by a list of eight evaluation questions (a table with all evaluation questions and related judgment criteria is presented in Annex 6.3)

1.3 Geographical scope of the MHTE and mid-term evaluation of MHTF

The scope is limited to those 55 countries whose maternal mortality ratio in the year 2000 was higher than 300 deaths per 100,000 live births. The main rationale for this delimitation of the scope is to a) include those countries that have or have not made improvements in addressing maternal heath since the year 2000; and b) to focus the analysis on those countries that, relative to others, have experienced the greatest challenges in improving maternal health in accordance with MDG 5.

1.4 Purpose and structure of this country case study report

This country report has been prepared following the completion of the country case study in Sudan and summarizes its findings and conclusions. The findings presented in this country report, together with nine other case studies, inform the final evaluation reports for the MHTE and the mid-term evaluation of the MHTF.[2]

The country report is structured as follows:

- Chapter 2 explains the case study methodology. It discusses:
    - The process and criteria for selecting case study countries overall, and the specific reasons for choosing Sudan as a case study
    - The preparation and conduct of the case study
    - The limitations and constraints experienced by the evaluation team

2. Final evaluation reports for MHTE and MHTF are available on the following web page: http://www.unfpa.org/public/home/about/Evaluation/EBIER/TE/pid/10094.

- Chapter 3 provides a short description of the reproductive health sector in Sudan, and describes the overall approach of UNFPA to supporting maternal health in the country.
- Chapter 4 presents the findings of the country case study.
- Chapter 5 presents the conclusions of the country case study drawing on the findings for each of the evaluation questions. While Chapter 5.1 draws conclusions for UNFPA overall maternal health support in the country, Chapter 5.2 focuses on the added value of the Maternal Health Thematic Fund.
- Chapter 6 presents the annexes of this country report including a list of all documents consulted and a list of people interviewed for this case study. The annexes also contain the methodological instruments utilized for this case study and a list of UNFPA interventions and activities in Sudan.

2. Methodology of the country case study

The methodology for the case study has been developed based on the overall methodology for the MHTE including the mid-term evaluation of the MHTF (see final reports for MHTE and MHTF). The purpose of the country case study is to use the field visit to collect data and information to verify the hypotheses developed during the desk phase of the evaluation and to further inform the answers to the evaluation questions.

2.1 The selection of country case studies

2.1.1 The process and criteria for selecting country case studies

The evaluators carried out a comprehensive staged sampling process to select the countries to be included in the field phase of both evaluations. The first sampling stage resulted in the selection of all 55 UNFPA programme countries with a maternal mortality ratio (MMR) higher than 300 deaths per 100,000 live births in the year 2000. In the second sampling stage, 22 countries out of the initial 55 were selected for inclusion in the extended desk phase. In order to ensure that different types of country contexts were included in the second-stage sample, the countries were grouped and selected according to the following criteria (see Table below).

Criteria used to create a typology of desk phase countries

Selection Criteria
Relative success of programme countries in improving maternal health (to include "high-performing" and "low-performing" countries);
Average income level in the different programme countries (to include countries with different poverty levels as one determinant of maternal health);
Quality of the public administration (to include countries with different administrative capacities to develop and manage maternal health programmes); and
Relative prevalence of HIV (to include programme countries whose maternal health situation was interlinked with a high incidence of HIV).

In the third sampling stage, ten countries out of the group of 22 were selected for in-depth case studies (field phase);[3] eight of these countries were recipients of the MHTF. Case studies were selected so that each type was represented by two cases: One country that had made large improvements; and a similar country (according to the above selection criteria) that only achieved small improvements in reducing maternal mortality. Overall, this systematic approach to selecting countries for the field phase allowed for different types of country contexts to be equally covered by the evaluations.

2.1.2 Justification for selecting Sudan

Within the sample of ten countries selected for the field phase, Sudan is one of four countries that have made little progress in reducing maternal mortality. The maternal mortality ratio (MMR) of 770 deaths per 100,000 live births decreased by only 20 deaths since 2000 until the year 2008. This represents a reduction of 2.6 per cent over a period of eight years and means that Sudan is ranked 49th among all countries with an MMR higher than 300 deaths per 100,000 live births with respect to the progress it made in those years. The other countries selected as case studies that have made little or no progress in reducing maternal mortality are Burkina Faso, Kenya and Zambia.

Another context factor that was considered in selecting Sudan as a case study country was its relatively high per-capita gross national income (GNI) of US$ 2,051.[4] The assumption was that the higher resource availability would influence the ability of the government and society to address bottlenecks in maternal health service provision with its own resources. In turn, this circumstance would affect the demands made on UNFPA to support government efforts in reducing maternal mortality. However, it is clear that in Sudan, this assumption would not hold true, and that the evaluation team would have to take the specific context of Sudan into consideration when assessing the availability of public and private resources for addressing the maternal health challenges of the country.

Sudan scored particularly low in the category of 'quality of public administration'. This was interpreted to mean that the government would not be able to lead the implementation of its health initiatives independently of significant technical and financial input from its development partners, including that of UNFPA.

Lastly, Sudan had a relatively low prevalence of HIV, in particular compared to countries like Zambia or Kenya. This was assumed to make the task of reducing maternal mortality less challenging for the government as well as for UNFPA. It was also assumed to make the integration of HIV related supported with UNFPA sexual reproductive health sub-programme less critical.

3. The sampling criterion has been selected to establish a close ling to the MDG5 indicators. The data have been taken from the H4 report "Trends in Maternal Mortality: 1990-2008" in agreement with UNFPA.
4. This puts Sudan into a group of countries with per capita GNIs higher than US$1,000, along with Cambodia, Ghana, and Lao PDR as countries that have made relative progress in lowering their maternal mortality ratio; and Burkina Faso, Kenya and Zambia that, similar to Sudan itself, have not achieved a significant reduction of maternal mortality.

2.2 Scope of the country case study

This country case study is one of several evaluation components used to collect evidence to answer the global evaluation questions and judgment criteria[5] of the two evaluations.[6] These evaluations draw on a number of different information sources. Consequently, this country case study provides only some of the information required that is required to answer the global evaluation questions comprehensively.[7] The scope of the country case study is defined by the "issues to assess" which are listed at the beginning of the findings-section for each evaluation question, together with the judgment criteria they correspond to.[8] These "issues to assess" were defined after analyzing the global maternal health strategy of UNFPA and its underlying theory of change. Based on this analysis, the evaluation team determined which parts of this theory of change were the most important for the overall success of the UNFPA maternal health strategy. The global list of "issues to assess" was then adapted to the context of the case study country.[9] The country case study focuses on collecting information on these specific issues and the findings presented in this country report do not provide complete answers to the global evaluation questions.[10] Recommendations are not elaborated at this stage, as the overall conclusions to the evaluation questions will only be developed on the level of the final reports to the MHTE/MHTF evaluations.

Since the 20 global evaluation questions of the two evaluations[11] are designed to assess the relevance, efficiency, effectiveness, and sustainability[12] of the support to maternal health provided by UNFPA, the issues to assess that were derived from the evaluation questions are also related to these four DAC standard evaluation criteria.

2.3 Preparation of the country case study

The evaluation team prepared this country visit in cooperation with the UNFPA country office. The evaluation team mapped the relevant stakeholders, selected interviewees, identified data sources and selected data collection approaches to ensure that information on each particular issue would be collected:

1. From different sources, such as from different stakeholders, to reflect potentially differing perspectives; or from different documents (data triangulation).
2. Using complementary data collection methods, i.e., a mix of quantitative and qualitative methods, such as the use of secondary data on maternal health from demographic health surveys; and the use of feedback from key informant interview and focus groups (methodological triangulation).[13]

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5. During the inception phase of this assignment, the focus of each of these global evaluation questions had been sharpened by defining a set of judgment criteria that specified which aspects of UNFPA associated support to maternal health should be at the center of attention for each evaluation question. These judgment criteria define in greater detail the specific conditions of success of UNFPA support in each of the thematic areas covered by the evaluation questions. For a more detailed explanation of judgment criteria, please see the final reports of the MHTE and MHTF evaluations.
6. I.e., the Maternal Health Thematic Evaluation and the MHTF mid-term evaluation; see Chapters 1.1 and 1.2 above.
7. 12 evaluation questions for the Maternal Health Thematic Evaluation and eight evaluation questions for the MHTF mid-term evaluation.
8. A complete list of issues to assess for this country is also contained in Annex 6.3., the data collection results matrix for this country report
9. Issues addressed may vary from one country case study to the other. Only issues which have been addressed in this specific country case study are shown in the tables in front of each evaluation question and in the Annex. This might lead in some occasions to difficulties in linking issues and judgment criteria but this is unavoidable as the methodology has been designed for the overall global evaluations.
10. See also the final reports of the MHTE and MHTF evaluations for more details on the methodological approach.
11. The Maternal Health Thematic Evaluation and the MHTF Mid-Term Evaluation.
12. I.e., four out of the five standard Development Assistance Committee (DAC) evaluation criteria.
13. E.g., semi-structured interviews, focus groups, document reviews.

An overview of the triangulation for each evaluation question is presented in Annex 6.2.

2.4 Data collection and analysis during the country case study Sudan

The evaluation team used the following approaches for collecting data during the country visit to Sudan:

- The evaluators conducted a series of individual interviews, i.e., with staff from UNFPA country office and with UNFPA main partners in the country, including governmental, non-governmental, development, civil society and other implementing partners. In these interviews, the team focused on the collection of qualitative data that would help to provide contextual information on UNFPA interventions, its contributions and roles in partnerships, etc.
- During the country visit, the team collected and reviewed additional documents that either had not been available during the desk phase; or that needed to be revisited to verify particular information that had been received during one of the interviews.[14] Evaluators focused in particular on the following types of documents:
    - Annual work plans (AWPs), in particular those AWPs that had not been available to the evaluation team during the desk phase.
    - Relevant national strategic documents including policies and strategic frameworks for sexual and reproductive health policies, maternal health policies, family planning, EmONC and other relevant topics.
    - Needs assessments and other inputs into the policy-making process that UNFPA had supported or implemented, covering all relevant maternal health topics.
    - Documents that described and defined UNFPA relationship with its partners in the country, such as Memoranda of Understanding (MoUs) with development partners or government.
    - Evaluations or assessments of UNFPA maternal health support in the country that had not been available to the evaluation team during the desk phase of this evaluation.
- The evaluation team traveled to Gadaref and Kassala to visit a selection of intervention sites. The team interviewed UNFPA staff from the respective sub-office, representatives from local authorities, staff from health centers that had received UNFPA support, and implementing partners.
- The evaluation team also traveled to Northern Darfur (El-Fasher) to gain an impression of UNFPA humanitarian support of maternal health.
- Throughout the preparation and conduct of the case study, the evaluators ensured that they differentiated between maternal health support financed by UNFPA core funds, and support financed by the MHTF. The team consulted annual work plans to discern, which activities had been funded with MHTF resources.

At the end of the visit to Sudan, the evaluation team did a preliminary analysis of the findings for each of the evaluation questions. These findings were presented to the UNFPA country office prior to the departure of the team. In addition, the team formulated conclusions on a number of topics that cut across the thematic areas covered by the evaluation questions. These conclusions constitute an assessment of selected aspects of UNFPA support to maternal health in Sudan and on the added value of the MHTF. However, due to the selective nature of the case study, these conclusions do not necessarily form a comprehensive and complete assessment of UNFPA support of sexual and reproductive health in the country, as would have been the case in a country programme evaluation of Sudan. These conclusions are presented in Chapter 5.

14. A comprehensive list of interviewees and short records of focus groups conducted is presented in Annex 6.5 and 6.6.

2.5 Limitations and restrictions

During the country visit, the evaluators encountered the following challenges or constraints:

Table 1:Challenges or constraints encountered throughout the field phase and reactions

Challenges/constraints encountered	Reactions
Constraints in scheduling the country visit to Sudan made it necessary to begin the visit to the country in the week after Eid Al-Adhha (Eid of Sacrifice). This meant that many government offices were closed during the first week of the country visit; and that also many of UNFPA partners were not available for interviews during the first week.	The team spent the first week primarily conducting interviews with the UNFPA country office and with a few available UNFPA partners. Other interviews could be held at the end of the country visit in Sudan. Other interviews had to be dropped from the schedule and the evaluation team instead attempted to obtain relevant information from UNFPA or other documents.
There had been high rate of staff turnover in the UNFPA country office, with nearly all staff positions being replaced in the one to two years prior to the country visit by the evaluation team. As a result, very few staff members were available to provide information on UNFPA work before 2008/2009.	UNFPA staff made considerable effort to provide documents from 2000-2008. The evaluation team used these documents to assemble information for the earlier period of UNFPA maternal health support. Also, some IPs were able to provide information on for the 2000-2008 period. However, country office staff turnover did adversely affect the depth of information that the evaluation team was able to obtain for these years.
Unforeseen changes in the UNHAS flight schedule limited the time available to the evaluation team in Darfur to only a few hours. As result, very few interviews could be held, which were not sufficient to provide a sufficiently broad basis for reliable findings on UNFPA humanitarian maternal health support in Darfur	The evaluation team used information from the few interviews that could be held, in combination with evidence from documents, to assemble an approximate picture of UNFPA humanitarian maternal health support in Darfur. Nevertheless, information on UNFPA work in Darfur remained scarce. Therefore, this country case study primarily covers UNFPA support (both development and humanitarian) in its five focal states outside of Darfur.
United Nations Children's Fund (UNICEF), one of the most important partners of UNFPA in Sudan, was not available for interviews during the country visit as all UNICEF staff were attending an organizational retreat outside of Khartoum.	The evaluation team attempted to obtain information about the UNICEF role in maternal health support from various documents. However, the absence of UNICEF staff meant that the evaluation team could not obtain detailed feedback on the UNICEF-UNFPA cooperation in maternal health in Sudan. Time constraints prevented follow-up phone interviews after the country visit to Sudan.

3. Short description of the reproductive health sector

3.1 Country Background

The Republic of Sudan declared independence in 1956 and since then the country experienced decades of conflict. A major trigger for conflict has been political, socio-cultural and economic differences between the mainly Muslim and Arab north and the predominantly Christian non-Arab south. Civil wars between both regions broke out in 1972 and 1983. A Comprehensive Peace Agreement was signed between the two regions in 2005 but ongoing disagreements and inequalities could not be resolved. In January 2011 the southern population voted for separation, dividing the country into north and south. Ten of the 25 original federal states gained independence and the independent state of South Sudan was formed in July 2011.

Since 2003 there has been conflict in Darfur in Western Sudan, which was described as the 'world's greatest humanitarian crisis' by the UN Resident and Humanitarian Coordinator for Sudan. Compared with the rest of Sudan, Darfur still receives the majority of support from international and national donors in terms of humanitarian and emergency assistance as well as financial resources.

Due to continuing instability in the Horn of Africa, Sudan continues to face a significant influx of refugees from Eritrea, Ethiopia and Chad.

Table 2: Key economic data Sudan

Total Population Sudan (2009)	42,272,000
GDP[15] (2009)	55,19 billion US$
GDP/per capita (2009)	1,305 US$

Source: UN Statistical Service UNData.

Despite its history of conflict, Sudan was able to achieve significant economic growth of more than ten per cent prior to the global financial crisis and approximately four to six per cent after 2006/07. This is attributable to the large oil reserves in the country and increasing oil prices. In 2010, the composition of the gross domestic product was: agriculture 44.6 per cent; industry 45.3 per cent and services 10.2 per cent. Most oil reserves are located in southern Sudan and it is not known what impact the independence of South Sudan will have on the Sudanese economy in the next few years. This will also have implications for the Sudanese population in terms of health and development spending and strategies.

15. Gross Domestic Product.

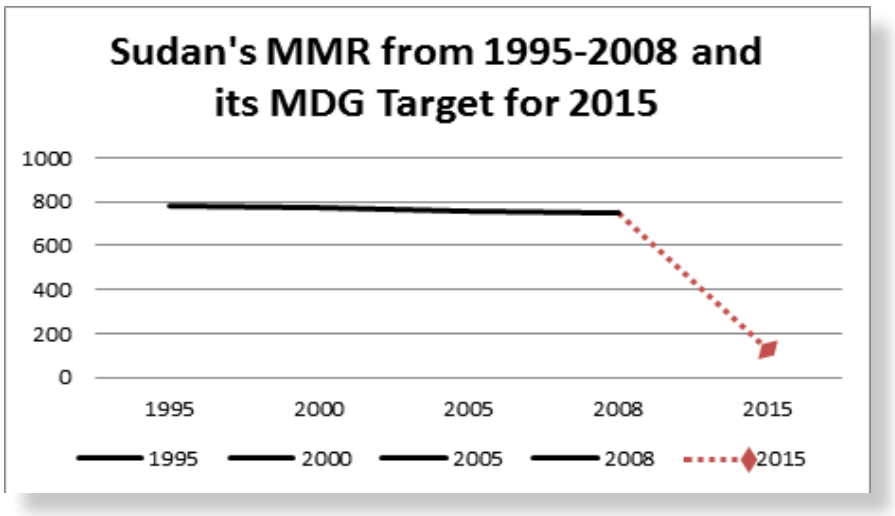
3.2 Sudan Health Sector

The Sudanese health system is decentralized and administered by the Ministry of Health at the federal and state level. Service delivery is undertaken by the Ministry of Health, the private sector and non-governmental organizations (NGOs). The reproductive health programme is based on the "four pillars" of safe motherhood: 1) family planning; 2) focused antenatal care; 3) skilled birth attendance including essential commodities, drugs and equipment, and 4) emergency obstetric care and neonatal care. There is commitment to reach national maternal health and MDG targets. However, limited health spending as well as limited donor support for regions except Darfur constitutes a serious constraint. Major challenges also result from the unstable security situation as it leads to large population movements within the country. There are also problems of availability of human resources as Sudan records an oversupply of medical doctors but a serious lack of qualified nurses and midwives. Steps taken to address the shortage of midwives include providing basic training to community-level midwives in order to bridge the gap until an adequate number of fully-skilled midwives and nurses can be provided in line with international standards. Nonetheless, limited resources, poor training capacities and socio-economic challenges will present an obstacle for meeting these targets in the foreseeable future.

3.3 Health Indicators

At the beginning of the evaluation period, the maternal mortality ratio (MMR) in Sudan was at 770 deaths per 100,000 live births.[16] As shown in figure 1 there has been little improvement in reducing the MMR, which remained at 750 in 2008.

Figure 1: Maternal Mortality Ratio Sudan (1995-2008) and 2015 MDG 5 target



Source: WHO Global Health Observatory Data Repository

The adolescent fertility rate dropped from 77 births of women between 15 and 49 years of age to 56 births in 2009. The contraceptive prevalence rate remained stable at seven per cent over this time period. Data for other indicators was not available. According to estimate from the UN and other international organizations, it will be challenging for Sudan to meet the MDG5 target by 2015.[17]

16. Trends in Maternal Mortality Report 1990-2008, H4
17. See Sudan Millennium Development Goals Progress Report 2010, Ministry of Welfare & Social Security, National Population Council General Secretariat (NPC/GS), Khartoum.

Table 3: Status of MDG5 indicators in Sudan in 2010, MDG5

Indicators	Northern Sudan	2015 Target	Southern Sudan	2015 Target
Maternal mortality ratio (per 100,000 live births)	638	134	1,989	1680
Birth attended by skilled health staff	57%	90%	10.2%	-
Contraceptive prevalence rate (current use)	7.6%	-	4.7%	-
Adolescent birth rate (12-14) years	-	-	204/1000	-
Antenatal care coverage (at least one visit and at least four visits)	70%	-	16%	-

Source: United Nations Development Programme (UNDP), 2010

There are significant discrepancies between data from international sources and information from the Sudan Household Health Survey (SHHS) from 2010 which reports dramatic improvements in terms of maternal health since the last SHHS in 2006 and the census data published in 2008. Considering the low level of government spending on health and the low level of change in all other maternal health-related indicators, the results presented in the 2010 SHHS can be questioned.[18]

18. Reproductive Health Commodity Security (RHCS) Assessment, 2011.

Table 4: Maternal Health Indicators. Sudan Household Health Survey SHHS 2006[19]

Maternal mortality ratio	1,107
MDG target for maternal mortality rate[20]	134
% HIV prevalence rates (aged 15-49)	1.6[21]
% Current use of contraception (all methods)	7.6
% Antenatal care coverage, at least one visit	69.6
% of Births attended by health personnel	49.2
% Unmet need for family planning (total)	5.7

Source: Sudan Household Health Survey (SHHS) - 2006

19. More recent studies not available.
20. UN Data.
21. Not available from SHHS, thus UNDP data: http://www.sd.undp.org/projects/hiv3.htm.

3.4 UNFPA response to maternal health in the country

Geographic coverage of UNFPA support:	The following five states were identified as focal regions[22]
	Kassala (est. population in 2010: 1,909,534[23]),
	Al Gedarif (est. population in 2010: 1,494,704),
	Blue Nile (est. population in 2010: 882,337),
	White Nile (est. population in 2010: 1,866,734)
	South Kordofan (est. population in 2010: 1,649,443)
Population covered by UNFPA support	7,802,752
% of total population covered by UNFPA support	17, 32 %
Total spending regular sources 2004-2010	33.509.196 US$
Total spending regular sources per capita (focus regions only)	4,29 US$
Total spending other sources 2004-2010[25]	38.359.737 US$
Total spending other sources per capita	4,91 US$
Planned spending other funds CPAP 2009-2012	Total: 33.000.000 U$ Regular sources: 20.000.000US$ Other sources: 13.000.000 US$ Reproductive health component: 22.000.000US$ Population and development component: 5.000.000US$ Gender component: 5.200.000 US$ Coordination and assistance: 800.000 US$
Total spending MHTF (since 2009)	2009 Budget: 260,100 US$ Expenditure: 87.827,54 US$ 2010 Budget: 200,000 US$ Expenditure: 210.260,33 US$

Source: Calculation by evaluation team based on UNFPA sources

22. Darfur is not included as it has been covered by a separate country programme.
23. All population estimates per region from the Sudan Central Bureau of Statistics: The Total Projected Population of States for the Period 2009 to 2018.
24. ATLAS data.
25. ATLAS data.

Under the fourth country programme (2002-2006) UNFPA supported reproductive health services, advocacy for reproductive rights, and focused in particular on policy and strategy development. Among the policies UNFPA helped to draft were the National Reproductive Health Policy, Sudan's Population Policy (2002) and the Women Empowerment Policy (2007). Additional efforts were aimed at strengthening technical capacities for National Population Council in Northern Sudan to support the integration of population, gender and reproductive health.

In 2005, the UNFPA country programme shifted focus due to the conflict in Darfur and the signing of two peace agreements between the North and Southern Sudan and North and Eastern Sudan. UNFPA pledged to focus on addressing the emerging needs of women and families who had been displaced because of internal conflict, and to focus on Southern Sudan in programme support and delivery. UNFPA also used resources from the Common Humanitarian Fund to finance maternal health services as part of the humanitarian response in Sudan and supported the development of protocols and guidelines for gender based violence (GBV), post exposure prophylaxis to HIV/AIDS, provision of reproductive health supplies, equipment and disposables, reproductive health kits, and capacity development for NGO and Ministry of Health (MoH) staff in emergency situations.

From 2007-2008, the two-year interim period when there was no formal country programme, UNFPA supported a number of initiatives in relation to reproductive health commodity security, including a reproductive health commodity security needs assessment and the establishment of a reproductive health commodity security (RHCS) coordination committee. During this period, UNFPA also financed and supported the implementation of two large-scale surveys; the nationwide Sudan Health and Household Survey, and the 2008 census. UNFPA also supported specific efforts to eradicate female genital mutilation (FGM) through a UNFPA-UNICEF joint programme.

In its fifth country programme (2009 – 2012), UNFPA changed focus to the state level by identifying and directly supporting maternal health issues in five focal states: Kassala, Gadarif, Blue Nile, White Nile and South Kordofan, as well as humanitarian support for the three Darfur States. The country programme intended to: help build the capacity of national and state managers in prioritizing reproductive health activities in the national and state planning process; strengthen the ability to provide technical assistance to states on quality and standards for comprehensive reproductive health, and; develop skills in monitoring, supervision and reporting on reproductive health-related initiatives. The country programme identified the need to support midwifery training, increase access to EmONC and family planning services, as well as provide support for improved capacity for fistula prevention and repair in its five focal states. Four of the focal states were prone to flooding[26] and UNFPA provided support for contingency planning and emergency preparedness through the prepositioning of basic supplies and the training of state MoH and NGO staff on emergency reproductive health.

In cooperation with the federal Ministry of Health, UNFPA aimed to support the mobilization of both internal and external resources for sexual and reproductive health to help the implementation of health sector annual plans both at national and state levels. UNFPA also planned to provide technical assistance for the development of a reproductive health logistics management information system in the federal MoH in order to support the needs-based distribution, storage, procurement of and reporting on reproductive health commodities. In addition, UNFPA financed a full-time international reproductive health specialist to assist with the co-ordination of UNFPA assistance to federal MoH. Finally, the fifth UNFPA country programme also integrated HIV/AIDS awareness-raising efforts into its reproductive health response along with the dissemination of reproductive health-relevant information.

26. Kassalla, Gadarif, South Kordofan and Blue Nile.

4. Findings of the country case study

The following section presents the findings of the country case study.

4.1 Findings related to the MHTE

4.1.1 Evaluation question 1: Relevance/Coherence

Evaluation question 1

To what extent is the maternal health support of UNFPA adequately focused on addressing the reproductive and maternal health needs of the vulnerable groups among countries and within countries?

Judgment criteria[27]	Issues to address (field phase)
1.2. (Increased) availability of accurate and sufficiently disaggregated data for targeting most disadvantaged/ vulnerable groups	Has UNFPA identified and targeted "vulnerable groups" for Maternal and Neonatal Health (MNH) support beyond the extent that is described in situation analysis/ problem analysis Country Programme Action Plans (CPAPs)?
	To what extent do UNFPA/Implementing Partner (IP) monitoring tools include indicators to capture the specific situation of the most vulnerable?
	To what extent have UNFPA country offices (COs) utilized information from needs assessments other than the Common Country Assessments (CCAs)?
1.3. Needs orientation of planning and design of UNFPA supported interventions	To what extent have country offices used alternative means for needs-oriented planning and the identification of the most vulnerable groups?

27. For indicators associated with the judgment criteria, please see the final reports of the MHTE and MHTF evaluations.

Judgment criterion 1.2

- (Increased) availability of accurate and sufficiently disaggregated data for targeting most disadvantaged/ vulnerable groups

and

Judgment criterion 1.3

- Needs orientation of planning and design of UNFPA supported interventions

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UNFPA has helped to increase the availability of data for planning and targeting maternal health support (and support in other sectors), both through the studies and surveys implemented under its reproductive health sub-programme and also through support of macro-level surveys, such as the census or the Sudan Household Health Survey (SHHS).

In Sudan, UNFPA has not operationalized the term "most vulnerable" with respect to particular demographic groups. Targeting is instead done geographically, concentrating on the five UNFPA focal states. Within those states, UNFPA has provided maternal health support without focus on particular demographic groups. Geographic targeting is in line with the national reproductive health programme's focus on "red zones for women's health", and the monitoring systems of UNFPA have not specifically focused on the maternal health situation of specific demographic groups.[28] However the UNFPA country office is specifically supporting internally-displaced persons and returnees with maternal health services.

In order to ensure needs-oriented planning, the UNFPA country office has financed and conducted a large number of needs assessments and ex-ante studies of maternal and reproductive health and specific issues such as EmONC, family planning and reproductive health commodity security (RHCS).[29] This has created a relatively robust evidence base for programming, especially for a data-scarce environment such as Sudan.[30]

28. Interviews at UNFPA country office.
29. Note: In midwifery, UNFPA documents mention an assessment of the "midwifery status in the country" (reportedly financed by MHTF), however, the evaluators were not able to obtain the corresponding document during the country visit.
30. Document review and UNFPA country office interviews.

4.1.2 Evaluation question 2: Harmonization and coordination of maternal health support and partnerships

Evaluation question 2

To what extent has UNFPA successfully contributed to the harmonization of efforts to improve maternal health, in particular through its participation in strategic and multi-sectoral partnerships at global, regional and national level?

Judgment criteria	Issues to address
2.1. Harmonization in maternal health partnerships between UNFPA UN organizations and World Bank (including H4+[31]) at global; regional and country level	To what extent do functioning mechanisms for coordination and harmonization of planning and implementation in UN joint programmes exist? What is the extent of use of pooled funding in UN joint programmes?
	What is the significance of H4+ country teams for country level maternal health harmonization and coordination?
2.2. Harmonization of maternal health support through partnerships at country and South-South/regional	Does the donor community consider the national maternal health Road Maps to be viable components of a national health policy that allows them to use it as a focal point for aligning their support with government structures and mechanisms?
	Is UNFPA financing activities that are geared at facilitating the adoption and implementation of maternal health Road Maps, i.e. activities that identify and address existing bottlenecks in maternal health Road Map operationalization and implementation at country level?
2.3. UNFPA participation in partnerships for producing evidence for policy debates and definition; prioritization of coordinated operational maternal health research agenda	What kind of evidence-related deliverables that were meant for adaptation at country level have UNFPA-supported partnerships for evidence creation produced?
	How has this UNFPA-generated evidence on MNH (stemming from "research partnerships) been used in policy formation?

31. UNFPA, UNICEF, World Bank (World Bank), World Health Organization (WHO), UNAIDS.

Judgment criterion 2.1

- Harmonization in maternal health partnerships between UNFPA and UN organizations and World Bank (including H4+) at global; regional and country level

Harmonization between UNFPA and other development partners that support maternal health in Sudan has been relatively weak due to the fact that UNFPA has only identified a small number of opportunities to coordinate its support with other development partners. The Sudanese government leads the donor groups that support maternal health and the government expects to be involved in most if not all exchanges between development partners. This factor, together with staffing bottlenecks in the UNFPA country office, limits the opportunities for UNFPA to engage with the other agencies to elaborate a harmonized and coordinated approach in Sudan. The H4+ initiative, which had been introduced by WHO only relatively recently, has not yet changed this dynamic.

Overall, coordination of development support for maternal health has been minimal in Sudan. The main reasons for this weak coordination have been partly political. The Sudanese government is seen as the overall coordinator and prefers to participate only in those meetings that it has organised. In practical terms this means that joint meetings have only been convened by UN agencies when they were chaired by the government. An additional reason for the weak coordination is that UNFPA felt it had insufficient staff resources to devote to donor coordination activities. It should be noted that coordination has been significantly stronger for the humanitarian component of the UNFPA country programme in Sudan. For this component, inter-agency coordination has been able to utilize standard coordination and implementation arrangements that have been established in humanitarian settings, such as the cluster approach, and the related coordination bodies and forums.

At the time of the country visit, the practical significance of the H4 group in Sudan was low. The organization of the group, led by WHO, had only taken place a few months prior to the country visit and had not yet translated into any concrete joint interventions or other joint initiatives.

Judgment criterion 2.2

- Harmonization of maternal health support through partnerships at country and South-South/regional

The Maputo process and the corresponding Sudanese Maternal and Newborn Health Road Map have great potential to significantly increase the degree of aid harmonization in Sudan. The main limiting contextual factor is the low presence of international donors in the country and the corresponding low availability of donor resources, with US$118 million of external resources required.

The process of developing the Maternal and Newborn Health Road Map in Sudan was a process that extended over several years. A draft Road Map was produced in 2005/06, but was not finalized. In 2010/11, UNFPA supported the appointment of a maternal health expert to the MoH who was assigned responsibility by the Director of the National Reproductive Health Programme to finalize the Road Map. The Road Map has been costed with UNFPA support, to help attract funding, and different development agencies have been informed about the Road Map. However securing financing from external sources for the US$ 118 million projected costs will be difficult given the low presence of development donors in Sudan.

Judgment criterion 2.3

- UNFPA participation in partnerships for producing evidence for policy debates and definition; prioritization of coordinated operational maternal health research agenda

The country office has actively participated in research-based partnerships for the creation of evidence on maternal health in Sudan. The evidence has been used to generate information on maternal health-related issues, such as FGM, or maternal health-related guidance documents. However, equally important as providing evidence to inform the policy process was the ability of UNFPA to create good working relationships with governmental counterparts that were willing to use this evidence in the policy process.

UNFPA country office has established relationships with various research institutions and universities, including a long-standing relationship with Ahfad University for Women (AUW) that has been in place since 1972. UNFPA has supported the development of the teaching and research capacity of the university, which has conducted operational research on maternal health and gender issues and has also been involved in project implementation. Other research cooperation has been established with the University of Delling (South Kordofan) and the University of Kassala.[32]

UNFPA research partnerships have produced a range of results. For example, the partnership with AUW had produced a maternal health quality of care assessment (2001) that subsequently was translated into a maternal health quality of care manual.[33] Another research project implemented with the University in Omdurman on FGM became the basis for information material on FGM and sexual reproductive health for communities. At the time of the evaluation, AUW was also implementing a pilot project in Kassala state on strengthening primary healthcare centres (PHC) in emergency obstetric and newborn care (EmONC) and maternal health service provision. The project aimed to generate lessons learned that could be adapted to similar projects.[34]

UNFPA has also supported evidence creation in maternal health through technical assistance and needs assessments. These needs assessments partly provided the evidence base for the Maternal and Newborn Health Road Map. However, the main challenge for UNFPA in influencing policy is not the lack of evidence but establishing close relationships with the most relevant governmental institutions, and to use these relations to ensure that available evidence is used for policy formation, programming or, ultimately, implementation.[35] This notwithstanding, UNFPA has made important progress in maternal health-related advocacy, for example by establishing working relationships with the Ministry of Social Welfare and Gender and the Ministry of Justice.

4.1.3 Evaluation question 3: Community involvement/demand orientation and civil society organizations (CSO) partnerships

Evaluation question 3

To what extent has UNFPA support contributed to a stronger involvement of communities that has helped increase current levels of demand and utilization of services, in particular through its partnerships with Civil Society?

Judgment criteria	Issues to address
3.1. Governments commitment to involve communities translated in sexual reproductive health and maternal health strategies through UNFPA support	Can civil society organizations (CSO)/community participation in policy/programme formulation (if occurring) be linked to greater awareness, and demand for MNH services?
3.2. Civil society organization (CSO) involvement in sensitization on maternal health issues and facilitating community based initiatives to address these issues supported by UNFPA	Examples of UNFPA coordination among implementing partnerships to bring together governments and civil society organizations especially at local level to intensify community participation.

32. Interviews with UNFPA, implementing partners.
33. Interviews with implementing partners.
34. Document review, interviews with implementing partners and UNFPA.
35. Interviews with UNFPA implementing partners.

Judgment criterion 3.1

- Governments commitment to involve communities translated in sexual reproductive health and maternal health strategies through UNFPA support

In Sudan, the significance of civil society organizations as implementing partners is relatively small. Nonetheless, UNFPA has supported the awareness-raising work of individual NGOs such as ZENAP, which has been working with communities on changing attitudes towards female genital mutilation (FGM). According to feedback collected by the organization itself, communities are changing their attitudes, albeit slowly.[36]

Judgment criterion 3.2

- CSOs involvement in sensitization on maternal health issues and facilitating community based initiatives to address these issues supported by UNFPA

UNFPA regularly supports initiatives to raise awareness about maternal and newborn health in Sudan. However, the country office primarily carries out these campaigns in cooperation with the federal and state health ministries, and not with civil society organizations.

Awareness-raising about reproductive, maternal and newborn health is a regular component of UNFPA support in Sudan at the federal level as well as in the five focal states. These activities are mostly implemented through federal and state MoH representatives, and not with civil society organizations (with the exception of certain NGOs and academic organizations, such as ZENAP in Gadaref or the Afhad Women's University). In Kassala State, for example, staff from the state MoH Reproductive Health Programme participated in a training of trainers (ToT) for media representatives (staff from local newspapers and community radio stations) that had been organized and financed by UNFPA.

36. Interviews with implementing partners, UNFPA, beneficiaries (project visits).

4.1.4 Evaluation question 4: Capacity Development - human resources for health

Evaluation question 4

To what extent has UNFPA contributed to the strengthening of human resources for health planning and human resource availability for maternal health?

Judgment criteria	Issues to address
4.1. Development/strengthening of national human resources for health (HRH) policies, plans and frameworks (with UNFPA support)	What mechanisms had UNFPA applied to ensure that policy makers include reproductive health in national human resource plans?
	What was the UNFPA approach to support human resources for health in countries where the political environment was adverse to external support to policy development? (i.e. Sudan; Ethiopia)
	To what extent was UNFPA involved in country needs assessments to inform policy makers for human resources for health planning (outside of MHTF countries or prior to MHTF launch)?
	To what extent was UNFPA involved in supporting the development of regulatory frameworks for reproductive health cadres in the human resources for health plans?
4.2. Strengthened competencies of health workers in HIV/AIDS, family planning, obstetric fistula, skilled birth attendance and EmONC to respond to sexual reproductive health/maternal health needs	Which mechanisms did UNFPA utilize to ensure applicability and usability of training?

Judgment criterion 4.1

- Development/strengthening of national human resources for health policies, plans and frameworks (with UNFPA support)

UNFPA has helped to expand the policy framework for human resources for health issues in Sudan by assisting the Ministry of Health to finalise a number of high-level policy documents. It is unclear, however, to what extent these policy documents will become the basis for government-driven implementation of corresponding human resources for health activities given the political context in the country, the low level of donor support, and the weak capacity of the Ministry of Health itself. The policy framework for midwifery was also strengthened with UNFPA support but did not bring required qualifications and curricula in line with international standards.[37]

In 2009-2010, the main mechanism used by UNFPA to ensure inclusion of human resources for health into health policy frameworks was the posting of a UNFPA-funded reproductive health programme advisor to the reproductive health programme of the federal Ministry of Health. MoH tasked this advisor to finalize a number of human resources for health-related policy documents that had not been completed for several years.[38] These included: i) the reproductive health

37. It should be noted that midwifery had been a neglected discipline in Sudan for several decades, so that any efforts to build up a midwifery cadre start from a very low level.
38. Among these documents were the Federal Reproductive Health Policy, the National Strategy Document for Scaling-Up Midwifery in the Republic of the Sudan and the MNH Road Map (see above; interviews with MoH, UNFPA).

policy, authored largely by the UNFPA-financed long-term technical assistant, that stresses the importance of "health workforce development", i.e., in particular on strengthening the role of village midwifes;[39] ii) the national strategy document for scaling-up midwifery, that asserts the importance of establishing a cadre of professionally trained midwifes in adherence with international definitions; and of integrating village midwifes into the health system,[40] and; iii) the Maternal and Newborn Health Road Map that was developed to include a cost component,[41] and deals with the expansion of the coverage of midwifery services.[42] The UNFPA approach of supporting human resources for health issues at the policy level in Sudan was in many ways similar to the approach used by UNFPA in other countries with less challenging political environments. In the particular context of Sudan, however, it is not clear to what extent these policy development efforts will translate into the effective implementation of corresponding activities by the partner government.[43]

In order to support needs-based planning of midwifery support activities, UNFPA conducted the updated mapping of village midwifes that guided the development of the national strategic plan for scaling up midwifery services. The new "National Strategy Document for Scaling-up Midwifery in the Republic of Sudan" foresees support for training of professional midwifes beyond the existing pool of village midwifes. In this way, UNFPA has helped to move the midwifery agenda forward in the Sudan. UNFPA also supported the development of a new two-year midwifery training curriculum and the curriculum for training of village midwifes. However, none of these curricula is meeting the international standards of the International Confederation of Midwives (ICM). Furthermore, progress in ensuring improved regulation of reproductive health cadres, in particular midwifes, is inhibited by weak capacity of human resources for health system and the midwifery sub-system in Sudan. Sudan still lacks a functioning midwifery association, and does not have an accepted "standardized practice code" for midwives. The Sudanese health system also lacks a budget for the supervision of midwifery services and an adequate cadre of supervisors.[44]

Judgment criterion 4.2

- Strengthened competencies of health workers in HIV/AIDS, family planning, obstetric fistula, skilled birth attendance and EmONC to respond to sexual reproductive health/maternal health needs

UNFPA has helped to improve the competencies of health workers in Sudan in disciplines relevant to maternal health. However, the weaknesses of the human resources for health system in Sudan have impeded more systematic and comprehensive progress. Trainings of health workers have been carried out on an ad-hoc basis and on a relatively small scale.

The main challenge in Sudan is to ensure that the midwifery training system becomes operational and adheres to accepted standards, i.e. the six ICM standards for midwifery education and training. By providing technical support through the Country Midwifery Advisor and policy support through the long-term technical assistance to the MoH, UNFPA has supported the professional midwifery programme in Sudan and has helped to put in place certain pre-requisites for improving midwifery training. However, the remaining challenges, including lack of knowledge of global standards in MoH, lack of teaching staff and qualified supervisors, lack of managerial staff and the absence of teaching materials that meet accepted standards, are so severe that it is unlikely that UNFPA alone can offer sufficient support, given the limited amount of resources UNFPA can invest in midwifery in Sudan. Trainings of h ealth workers have been carried out but on an ad-hoc basis and on a scale that has been too small to meet the large-scale needs in Sudan due to UNFPA resource constraints UNFPA and the ongoing out-migration of skilled health workers from Sudan.

39. Review of the MNH road map.
40. National Strategy Document for Scaling-up Midwifery in the Republic of Sudan
41. US$ 26.7 million out of US$ 198,7 million.
42. Document review, i.e., of the costed roadmap.
43. See evaluation question 9.
44. Strengthening midwifery is subject to a number of challenges that are linked to the particular context of the country. The challenges include, among other things, the limited literacy at community level and the previous elimination of a midwifery training programme that met international criteria (Interviews with UNFPA and development partners).

4.1.5 Evaluation question 5: Maternal health in humanitarian contexts (relief, emergency/crisis, post-emergency/crisis)

Evaluation question 5

To what extent has UNFPA anticipated and responded to reproductive health threats in the context of humanitarian emergencies?

Judgment criteria	Issues to assess
5.1. Inclusion of sexual reproductive health in emergency preparedness, response and recovery plans	Does the health cluster response plan include sexual reproductive health based on UNFPAs intervention?
5.2. Accessibility of quality EmONC, family planning and reproductive health/HIV services in emergency and conflict situations	To what extent are humanitarian maternal and newborn health interventions covered by UNFPA mandate?
	To what extent do UNFPA mechanisms/procedures facilitate timely/flexible response to maternal and newborn health needs in humanitarian situations

Judgment Criterion 5.1

- Inclusion of sexual reproductive health in emergency preparedness, response and recovery plans

UNFPA has worked towards the inclusion of sexual and reproductive health in emergency preparedness, response and recovery plans in cooperation with the state ministries of health in the five focal states. In addition, UNFPA has also supported these states by ensuring the pre-positioning of health supplies and commodities, and training government staff and civil society organizations on the delivery of the Minimal Initial Service Package (MISPs) during emergencies.

UNFPA has worked with state ministries of health in its five focal states on pre-positioning basic supplies, such as reproductive health kits and personal hygiene kits (the Minimal Initial Service Packages) that are critical for the implementation of emergency reproductive health interventions. UNFPA also trained government staff and staff from civil society organizations in the delivery of the MISPs and ensured that sexual and reproductive health was reflected in state-level emergency preparedness plans.[45]

Judgment Criterion 5.2

- Accessibility of quality EmONC, family planning and reproductive health/HIV services in emergency and conflict situations

UNFPA has helped to improve the accessibility of quality EmONC and family planning services in response to the Sudanese context which has the characteristics of both a prolonged emergency and a development context. However, UNFPA global standard procedures have not been appropriate for this context and have hindered the work of the country office.

UNFPA has not focused on immediate emergency situations but instead focused on the wider context by ensuring that reproductive health is included in state-level preparations for emergencies, providing and pre-positioning basic supplies and commodities, and training government and civil society organization staff in the delivery of MISPs. However, the global

45. Interviews with UNFPA.

standard procedures of UNFPA have not been appropriate for the specific context in Sudan as the logistical and financial infrastructure and other prerequisites for project management and financing are often not in place. Development concerns and humanitarian concerns often need to be addressed in parallel as the social, political and security situations are often in flux and change from a development situation to an emergency situation relatively quickly. Specific challenges include the procurement of supplies, which has been made more difficult due to trade embargoes against Sudan.[46] Also, UNFPA financial accountability requirements that foresee quarterly advances and limit the possibility of the roll-over of funds from one quarter to the next are not appropriate for a situation in Sudan where financial transfers from UNFPA to implementing partners in the focal states can take up to two quarters, and where the volatile political context makes implementation delays unavoidable.[47]

4.1.6 Evaluation question 6: Sexual and reproductive health services – family planning

Evaluation question 6

To what extent has the UNFPA contributed to the scaling up and increased utilization of and demand for family planning?

Judgment criteria	Issues to assess
6.1. Increased capacity within health system for provision of quality family planning services in UNFPA programme countries	Are national reproductive health strategies geared towards integration of family planning services in all service delivery points?
	Are the capacity development interventions designed strategically i.e. taking into account national strategies and orientations, supervisory mechanisms, potential for replication?
	Are the capacity development interventions accompanied by interventions ensuring an environment where trained health care providers can practice their newly acquired skills once they are back in their health facilities (equipment, material, and infrastructure)?
6.2. Increased demand for and utilization of family planning services in UNFPA programme countries, particularly among vulnerable groups[48]	To what extent communication initiatives aimed at increasing demand for family planning (undertaken with UNFPA support) are based upon evidence?
	How is UNFPA supported community-based distribution of family planning translated into sustainable national strategies?
	Are UNFPA supported initiatives contributing to the increase of family planning utilization among vulnerable groups?
6.3. Improved access to contraceptives (commodity security)	What are the mechanisms in place to sustain actual achievements and governments' commitment to reproductive health commodity security?

46. Interview with UNFPA.
47. Interviews with UNFPA and implementing partners.
48. Approximation of "increased demand", which is difficult to capture.

Judgment criterion 6.1

- Increased capacity within health system for provision of quality family planning services in UNFPA programme countries

and

Judgment criterion 6.2

- Increased demand for and utilization of family planning services in UNFPA programme countries, particularly among vulnerable groups

UNFPA has been able to incorporate family planning into a number of high-level policy documents, such as the current reproductive health policy of Sudan and the Maternal and Newborn Health Road Map. However, this progress at the policy level has not been translated into strengthened capacity for the provision of family planning services in Sudan overall. The main bottlenecks are funding to implement the aforementioned policy commitments, social resistance to family planning in some parts of Sudan including its political class, and the weakness of the health system overall. UNFPA has organized and financed individual training workshops on family planning for state MoH and health staff; however, in the absence of a supportive and enabling social, political and cultural environment, these efforts were too fragmented to make a lasting difference to the capacity of the Sudanese health system to provide quality family planning services.

UNFPA has supported the drafting of the current reproductive health policy of Sudan and the Maternal and Newborn Health Road Map, both of which formally commit the Sudanese government to promote increased access to family planning services as part of its reproductive health and maternal health approach. In particular the Maternal and Newborn Health Road Map foresees a number of activities for ensuring the availability of family planning services across Sudan.[49]

However, it is not certain if these formal commitments will lead to appropriate government efforts to make family planning services available in most, if not all, service delivery points. Similar policy commitments in the past have not always been honored or acted upon by the government. Furthermore, financing for the provision of family planning services is not secure. This also includes the financing for the implementation of the Maternal and Newborn Health Road Map, where the projected implementation costs significantly exceed the amount that is currently spent on reproductive health by the Sudanese government.[50] This means that funds from external sources, including development partners, are required to fill an annual funding gap of approximately US$39.8 million to implement the Road Map, and family planning support in particular. The Sudanese government currently does not have a viable strategy for addressing the shortfalls in family planning services that could not be supported by UNFPA.

In the absence of a viable national strategy and the overall sensitivity of, and even resistance to, family planning in Sudan,[51] UNFPA has only had limited options for ensuring its family planning support aligns with national strategies and mechanisms (see above; issue on national strategies). Although UNFPA has channeled family planning support (e.g., support for training health care providers in family planning approaches) through the federal and state level ministries of health, the capacity weaknesses at these levels have prevented a comprehensive and strategic approach.[52]

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49. See chapter 4.1, judgment criterion 6.2.
50. The estimated amount spent on reproductive health annually is US$236,000, or 0.3 per cent of the annual health budget of Sudan of approximately US$ 79 million, according to estimates of the Health Economics Department of the federal MoH (UNFPA, 2011).
51. Feedback in interviews with UNFPA suggested that the practice of family planning is often maligned in some of Sudan newspapers and the resistance to family planning is expressed in other forums as well. Also, anecdotal evidence from interviews at project sites suggested that the choice of women for different contraceptives was often limited and that the choice was even at times made by male doctors on behalf of women.
52. Interview with UNFPA.

UNFPA has supported training of health care providers in family planning as well as other complementary activities, such as the provision of commodities. UNFPA also has supported media-based awareness-raising campaigns that took into account the findings of a UNFPA-supported survey on the use and access barriers for family planning services conducted in 2009. However, UNFPA has not supported activities in areas where stock outs of reproductive health commodities have been a significant problem (which has been a problem in many areas of Sudan recently).

Judgment criterion 6.3

- Improved access to contraceptives (commodity security)

UNFPA support has helped to make a minimum supply of family planning commodities available to the Sudanese population. The total demand for contraceptives, however, has far exceeded the amount UNFPA has been able to supply. Contraceptives procured by UNFPA have been distributed using a UNFPA system that it has had to maintain due to the persistent weakness of the national commodity security system of Sudan.

Sudan has a fragmented, non-functional commodity procurement and supply system that has not allowed UNFPA to systematically build capacity for commodity management in the government. Although the Ministry of Health has been willing to work towards improving this situation, the weaknesses of the system have been so great that sustainability is not feasible; UNFPA support has had to rely on mechanisms and infrastructure that were owned and provided by UNFPA itself.

UNFPA is the only major donor that has offered support to increase access to reproductive health commodities in Sudan. [53]However, UNFPA support has been insufficient to meet the significant level of need. Utilizing government-owned systems and systematically developing them has been limited to a few initiatives at the state level.[54] In addition to the weak government system, lack of harmonization with other donor-supported programmes, including the Global Fund for HIV, TB and Malaria, contributed to a fragmented commodity procurement, storage and distribution system with several parallel structures.[55]

53. UNFPA has been providing family planning commodities for its 5 focal states. However, the government has been distributing these commodities among all of the 15 states, since no other donor is providing similar support.
54. Document review and interview UNFPA and state MoH.
55. Interview with UNFPA.

4.1.7 Evaluation question 7: Sexual and reproductive health services – EmONC

Evaluation question 7

To what extent has UNFPA contributed to the scaling up and utilization of skilled attendance during pregnancy and childbirth and EmONC services in programme countries?

Judgment criteria	Issues to assess
7.1.Increased access to EmONC services	What elements in UNFPA EmONC support were meant to ensure sustained commitment of the MoH to integrate EmONC services in the national planning and budgeting?
	Which mechanisms has UNFPA applied to ensure most efficient use of resources of support to EmONC providing facilities?
	How has UNFPA supported functioning referral systems from home to tertiary care?
	Has UNFPA support improved the equitable distribution of EmONC facilities (affected the planning process for placement of EmONC facilities)
7.2.Increased utilization of EmONC services	What mechanisms is UNFPA utilizing to mobilize the communities to support women in accessing EmONC?
	To what extent does UNFPA support research to evaluate barriers to EmONC?

Judgment criterion 7.1

- Increased access to EmONC services

UNFPA has helped to put in place a number of important pre-requisites for expanding access to EmONC services for Sudanese women: by incorporating EmONC into a number of key high-level policy documents; by providing evidence on the existing gaps in EmONC coverage in Sudan, and; by organizing and financing individual EmONC training workshops for doctors, nurses, midwifes and traditional birth attendants on obstetric first aid and referral-related skills. However, large distances, poor transport infrastructure and weaknesses in the overall health system seriously curtail the extent to which individual UNFPA initiatives can create synergies and produce lasting improvements in access to EmONC services.

To lobby for increased support for EmONC UNFPA has used research and data to describe the extent of the shortfall in access to EmONC services in Sudan, both at national level, and more specifically in its five focal states and in Darfur. Examples include a national EmONC assessment that was conducted and published in 2005, and a situation analysis on the availability of sexual reproductive health services including EmONC services, as well as a number of other studies. According to UNFPA, the EmONC survey in 2005 particularly helped to increase government attention on the poor state of emergency obstetric services. Later assessments also then helped to influence strategy development (e.g. Maternal and Newborn Health Road Map) and planning at the state level. UNFPA staff in its five focal states used the data to inform the EmONC planning process conducted with its partner state ministries of health.[56]

56. Interviews in focal states, UNFPA, document review.

UNFPA support for the production of data on the EmONC situation in its focal states has also provided a basis for directing investments to improve the referral system. For example, the above-mentioned reproductive health situation analyses provided information on referral-relevant indicators.[57] The need to strengthen the weak referral system in Sudan is also reflected in the relevant policy and strategy documents that UNFPA has helped to draft, in particular the Maternal and Newborn Health Road Map and also the reproductive health policy, in which the Sudanese government commits itself to addressing, among other things, the second and third delays: delay in transporting women to an appropriate referral facility and delay in receiving 'optimal care promptly at the facility'.[58] However, the significance of these policy-level commitments is dependent on the likelihood of their implementation.[59]

In addition, UNFPA has been addressing the issue of referral by supporting in-service trainings of midwifes and traditional birth attendants (TBAs). For example, a hospital that had received long-term support from UNFPA to provide training for midwives, anesthetists and doctors on EmONC services has also been working with TBAs and midwives on increasing their skills and knowledge about initiating referrals. This is particularly important as late referral is one of the main causes of maternal deaths in Sudan.[60]

Overall, however, improvements in referral systems are hampered by the challenging context: large distances, poor transport infrastructure (i.e., absence of paved roads, which makes use of motorized ambulances difficult, especially during the rainy season) and the overall weak health system limit the extent to which individual UNFPA initiatives can create synergies and produce sustainable results.[61]

Judgment criterion 7.2

- Increased utilization of EmONC services

By helping to institute maternal death audits in Sudan, UNFPA has helped to increase the awareness of practitioners and policy makers of the specific causes of maternal deaths. In-service trainings of village midwives and traditional birth attendants have increased their knowledge of potential warning signs for complications during pregnancy.

UNFPA has been supporting in-service training of village midwives (VMW) and traditional birth attendants to help build knowledge about the warning signs for complications during pregnancy. UNFPA has also worked with media personnel on communication campaigns about maternal health. Outside of these activities, however, UNFPA has provided limited support to community-based activities to raise awareness on EmONC.

UNFPA has also helped to institute protocols for maternal death audits (MDA) in its five focal states by organizing training sessions on MDA, developing and disseminating forms to be used in maternal death audits, and providing an office for coordination of the maternal death review in Gadaref state. In addition, midwife trainings conducted by UNFPA-supported hospitals include case studies on maternal deaths. Overall, these activities have helped to generate data and raise awareness on one the main causes of maternal death, the late referral of pregnant women with complications.

57. Such as "percentage of ambulances in good condition"; "percentage of referral services with paved road" and other indicators that capture the range of EmONC services available at different types of health facilities in each state.
58. Review of the reproductive health policy.
59. See evaluation question 9, among other things.
60. See chapter 4.1, judgment criterion 7.1.
61. UNFPA interviews, interviews with implementing partners in focal states.

4.1.8 Evaluation question 8: Results/evidence orientation of UNFPA maternal health support

Evaluation question 8

To what extent has UNFPA use of internal and external evidence in strategy development, programming and implementation contributed to the improvement of maternal health in its programme countries?

Judgment criteria[62]	Issues to assess
8.3. Results- and evidence based management of individual interventions throughout their life	What were main factors that contributed to weak monitoring of most country offices?
	To what extent did UNFPA take into account capacity gaps in monitoring and evaluation (M&E) among its implementing partners and its own staff when developing its M&E calendars?

Judgment criterion 8.3

- Results- and evidence based management of individual interventions throughout intervention life

The lack of monitoring data and the absence of systematic analysis by the UNFPA country office in Sudan have severely limited opportunities for the results-based and evidence-based management of UNFPA projects. Factors that have contributed to these shortcomings include the weak design of UNFPA monitoring frameworks, the weak monitoring and evaluation capacity of implementing partners, and the insufficient analysis of existing monitoring data by the country office.

The main factors that have contributed to weak monitoring by the UNFPA country office include the poor quality design of the current monitoring systems, including the design of indicators. Indicators used by UNFPA have typically captured activities but not the agreed outputs and outcomes[63] of UNFPA support.[64] As a result, progress towards achieving these outputs is generally not monitored. In addition, both UNFPA implementing partners and, to a lesser extent, the UNFPA country office have demonstrated variable capacity to analyze available monitoring data for the purpose of drawing lessons for future programming or for the continuation of an existing project. In particular, efforts to assess the existence of a logical link between the monitored activities and the higher-level "output" results data have been insufficient.[65]

It has been standard practice for UNFPA to conduct assessments of the monitoring and evaluation (M&E) capacity of implementing partners (IPs) but this has primarily resulted in information on "the way they are reporting"[66]. It is unclear to what extent UNFPA has adjusted its M&E requirements in response to the actual M&E capacities of its implementing partners. Implementing partners were offered the opportunity to attend standardized courses on M&E relevant topics, such as a course on results-based management that was offered by the regional office/headquarters, which were appreciated by the implementing partners.[67]

62. The previous judgment criteria 8.3 was deleted; the assessment of the operationalization of UNFPA support in an nual work plans was put together with the development of UNFPA country strategies (country programme document/country programme action plan).
63. It has to be noted that the country office interpretation of outputs in CPD, CPAP and AWP is not in line with the commonly accepted definition of the Development Assistance Committee (DAC) of the OECD that defines outputs to be the (direct and tangible) "products, capital goods and services which result from a development intervention". "Outcomes" are defined as "[t]he likely or achieved short-term and medium-term effects of an intervention's outputs". (OECD/DAC (2002): Glossary of key terms in evaluation and results-based management, Paris).
64. According to UNFPA information, this has been changed for more recent AWP, i.e. for the period 2010 – 2012.
65. Interview with UNFPA, review of protocols of quarterly review meetings, etc.
66. Interview with UNFPA.
67. Interviews with implementing partners.

4.1.9 Evaluation question 9: Integrating maternal health into national policies and development frameworks

Evaluation question 9

To what extent has UNFPA helped to ensure that maternal health and sexual and reproductive health are appropriately integrated into national development instruments and sector policy frameworks in its programme countries?

Judgment criteria	Issues to assess
9.1. UNFPA support improved comprehensiveness of analysis of causes for poor maternal health and of effectiveness of past maternal health policies/strategies	To what extent have relevant policy frameworks referenced maternal health-relevant disaggregated data (i.e. from UNFPA-supported censuses or other data collection exercises)?
9.2. Maternal health and sexual reproductive health integration into policy frameworks and development instruments based on (UNFPA supported) transparent and participatory consultative process	What are the principal mechanisms by which UNFPA advocacy and awareness raising campaigns contribute to the development/revision/integration of maternal health issues into national policies?
9.3. Monitoring and evaluation of implementation of sexual reproductive health/maternal health components of national policy framework and development instruments	To what extent are maternal health indicators included in the monitoring (and evaluation) systems of national policies?

Judgment criterion 9.1

- UNFPA support improved comprehensiveness of analysis of causes for poor maternal health and of effectiveness of past maternal health policies/strategies

UNFPA has improved the analysis of the causes for poor maternal health and maternal deaths, which is now more comprehensive. However, no analyses have been supported on the effectiveness of past maternal health policies or strategies.

The majority of policy frameworks relevant to maternal health in Sudan (reproductive health policy, Maternal and Newborn Health Road Map, National Strategy Document for Scaling-up Midwifery in the Republic of Sudan) have been drafted with UNFPA support. These policies make reference to the evidence created by the various studies and reports that have been produced with UNFPA support in recent years, such as the census (2008), reproductive health situation analyses (2009) and other relevant assessments. However, the likelihood of policy-level commitments resulting in corresponding actions by the Sudanese government is low based on past results (see evaluation question 2). UNFPA has not supported any specific analyses to gauge the effectiveness of past maternal health policies or strategies.

Judgment criterion 9.2

- Maternal health and sexual reproductive health integration into policy frameworks and development instruments based on (UNFPA supported) transparent and participatory consultative process

UNFPA has established working relationships with a relatively diverse group of stakeholders, including a number of government ministries and other bodies. In spite of this, raising awareness about maternal health has remained a difficult and contentious activity in Sudan that has required UNFPA to take a cautious approach when advocating for issues including family planning.

UNFPA has supported advocacy activities to address issues of gender-based violence, female genital mutilation (FGM) and early marriage. Among the mechanisms used to encourage legal or policy changes have been awareness-raising campaigns directed at parliamentarians. In addition, UNFPA has established close relationships with a number of policy-focused organizations, such as the National Population Council, the Ministry of Social Welfare and Gender and the Ministry of Guidance, in addition to its relationship with the Ministry of Health. These relationships have also been used to discuss policy-relevant issues and to promote policy changes on the above topics.[68]

Judgment criterion 9.3

- Monitoring and evaluation of implementation of sexual reproductive health/maternal health components of national policy framework and development instruments

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UNFPA has helped to develop appropriate maternal health indicators for a number of relevant national policies. However, the policies neither identify the data sources these indicators will draw on nor explain how the Sudanese government will collect the required data. Weaknesses in the monitoring and evaluation system in the Sudanese health system are also likely to affect data collection for these policies.

Maternal health specific indicators were included in the recently expired Five-Year Health Strategy of Sudan (2007 – 2011); however, there is no indication of the level of UNFPA involvement in drafting the strategy or in ensuring that appropriate indicators were included.[69] The recent Maternal and Newborn Health Road Map that was developed with significant technical and financial support from UNFPA also included a comprehensive set of maternal health indicators that consider maternal (and newborn) health from different perspectives.[70] The Road Map states that most of these indicators are also included in the Sudan Household Health Survey and the Sudan health management information system (HMIS); however, the Road Map does not include an assessment of the feasibility of collecting data on these numerous indicators, nor has it assigned responsibilities for data collection to specific stakeholders

68. Based on information from UNFPA, the country office has advocated in particular on the issues of female genital mutilation, e.g., with the Ministry of Guidance.
69. I.e., the Strategy is neither mentioned in COAR or in the relevant UNFPA programme evaluation; nor is UNFPA acknowledged in the Five Year Strategy itself.
70. E.g., the community perspective, different aspects of maternal health, such as family planning, political will in the government, etc.

4.1.10 Evaluation question 10: Coherence of sexual reproductive health/maternal health support with gender and population and development support

Evaluation question 10

To what extent have UNFPA maternal health programming and implementation adequately used synergies between UNFPA sexual and reproductive health portfolio and its support in other programme areas?[71]

Judgment criteria	Issues to assess
10.1.Linkages established between programmes reproductive health with gender and population and development established in intervention design	What elements in UNFPA EmONC support were meant to ensure sustained commitment of the MoH to integrate EmONC services in the national planning and budgeting?
	How have these gender constraints been addressed in UNFPA programming? How have annual work plans currently integrated gender constraint findings into the reproductive health component?
	How has UNFPA addressed gender-related maternal health constraints in its programming?

Judgment criterion 10.1

- Linkages established between programmes (reproductive health with gender and population and development) established in intervention design

Apart from a small number of opportunities to address maternal health and gender in an integrated way that UNFPA has created for implementing partners, UNFPA has not established a clear organizational culture and structure that promotes gender-integrated maternal health programming. Programmatic linkages between sub-programmes have been established with help from committed implementing partners with an established track record and experience in integrated programming.[72]

UNFPA has created a number of new, small-scale, opportunities for a stronger integration of medical concerns about maternal health with social considerations regarding the role and position of women in Sudanese society. It has established partnerships with important stakeholders in the government such as the Ministry of Social Welfare which is responsible for setting policies, plans and programmes on social insurance, population, maternity and childhood, social consolidation and development.[73] UNFPA has also been involved in awareness-raising on issues including female genital mutilation and early marriage and a review of corresponding legislation that proposes to increase the age of marriage from 10 years to 15-16 years.

71. Gender (including female genital mutilation/cutting (FGM/C), gender-based violence (GBV)), HIV-PMTCT (Prevention of mother-to-child HIV transmission); Population and development, Global Programme to Enhance Reproductive Health Commodity Security (GPRHCS)).
72. It should be noted that a number of UNFPA staff members from outside the sexual reproductive health sub-programme have emphasized the importance of a stronger integration of sexual and reproductive health issues and gender issues in the response of UNFPA.
73. According to UNFPA information, the Ministry had been aware of the issues of maternal mortality prior to UNFPA engagement, but had not begun to conduct independent research into the issue.

UNFPA staff members are aware that cultural and religious attitudes towards women have been a contributing cause to poor maternal health alongside medical issues.[74] UNFPA considers that these factors directly affect the health of women and mothers, and also restricts their access to maternal health services. At the time of the evaluation, there was an ongoing debate in the country office as to whether UNFPA programming has sufficiently addressed these cultural barriers to maternal health or was too focused on maternal health as a medical issue.

However, only a small proportion of UNFPA annual work plans (AWP) have specifically integrated reproductive health and gender into one project. The majority of AWP, including the most recent from 2009 and 2010, contained little explicit integration of gender into reproductive health work plans. Although these projects were formulated in a way that would allow the integration of medical and cultural barriers with maternal health, the AWP did not specify a clear requirement for addressing maternal health from a medical as well as a gender perspective. The extent to which a gender perspective was actually integrated into these projects therefore would have depended on the capacity and commitment of the implementing partners.[75]

UNFPA planning and administrative structures have provided relatively few "push" factors to ensure that gender and reproductive health are addressed in this integrated way. The examples of AWP that did explicitly integrate reproductive health and gender issues were drafted and implemented by partners that had prior experience of working in an integrated way to improve maternal health.[76] Furthermore, the current vertical differentiation of the gender and reproductive health sub-programmes presented an obstacle for implementing partners who wished to implement these types of integrated projects: integration would have required working with three different UNFPA officers to implement one integrated project.

The main challenge for integrating gender, population and development and reproductive health has therefore been as much organizational as conceptual. The country office had experienced a number of internal challenges to integrating programming, including UNFPA procedures and processes, but also external challenges related to finding appropriate implementing partners and other partners to carry out integrated programmes and projects. One important constraint faced by UNFPA in Sudan has been the lack of time to devise country-specific procedures and projects to facilitate an integrated approach. In addition, UNFPA had become highly focused on financial accountability[77] in a country where managing money flows and accountability through quarterly reporting is particularly difficult. These constraints have consumed additional resources that otherwise could have been used for conceptual work, such as developing Sudan-specific initiatives to integrate gender, population and development and reproductive health programming.

74. Main issues that were mentioned were gender-based violence (GBV) including rape and female genital mutilation (FGM), attitudes toward family planning that limits the access of women to contraceptives, early marriage, the persisting pressure to have multiple children against any medical indications of risks for the women, as well as the low social status of women and the resulting low self-esteem of women overall (Interview with UNFPA).
75. The extent of integration between maternal health and gender was stronger in UNFPA humanitarian programme in Darfur. The concentration of beneficiaries in camps, and the more regular presence of humanitarian personnel allowed UNFPA and its partners to roll out more closely knit communication efforts on gender and maternal health.
76. One of these projects was designed to specifically contribute to the population & development sub-programme of the UNFPA country programme, as well as the reproductive health sub-programme (Note: gender was not a separate sub-programme in UNFPA country programme when this project was carried out), and addressed the social and economic position of women, e.g., through income-generating activities, as well as the awareness of gender and reproductive health issues among communities and leaders. Another project had used UNFPA funding to conduct awareness-raising campaigns against female genital mutilation, for which they organized workshops and open forums for men and women together and approached doctors, religious and community leaders. The IP for this project also had an already established profile outside of the medical field.
77. "UNFPA staff members here in Sudan have become 'compliance officers'" (UNFPA interview).

4.1.11 Evaluation question 11: Coherence between country, regional, global programmes

Evaluation question 11

To what extent has UNFPA been able to complement maternal health programming and implementation at country level with related interventions, initiatives and resources from the regional and global level to maximize its contribution to maternal health?

Judgment criteria	Issues to assess
11.1. Clarity of division of labor and delineation of responsibilities between UNFPA global, regional and country offices	To what extent has staff in country offices have had a clear idea what kind of support they were able to expect from regional offices and UNFPA globally?
11.3. Enhancement/improvement of UNFPA country level programming and interventions through technical and programmatic support from global and regional level	To what extent has global programme guidance for maternal health service up-scaling; midwifery up-scaling been applied at country level/was relevant for programming/implementation support at country level?

Judgment criterion 11.1

- Clarity of division of labor and delineation of responsibilities between UNFPA global, regional and country offices

Until 2010, the division of labor between the global, regional and country offices had not been clearly communicated to the country office in Sudan, which hindered the extent to which the country office could request targeted assistance from the regional level.

Country office staff and implementing partners expressed that the role of the regional office was not sufficiently clear and therefore could not be used as a consistent source of support for their work. Cooperation between the country office and the regional office has also been prevented by difficulties contacting UNFPA staff in regional offices, and obtaining feedback on specific topics. Implementing partners who had worked with the country support team prior to the formation of the regional office stated that the support from the regional level had not increased since the regional offices had been established.

Judgment criterion 11.3

- Enhancement/improvement of UNFPA country level programming and interventions through technical and programmatic support from global and regional level

The "National Strategy Document for Scaling-up Midwifery in the Republic of Sudan" was developed by adapting a corresponding framework for scaling-up midwifery that had been developed during the First International Form on Scaling-Up Midwifery (held in Tunisia, in 2006). The Sudanese midwifery strategy contains many of the same issues and key topics laid out in this global framework for scaling up midwifery.

4.1.12 Evaluation question 12: Visibility

Evaluation question 12

To what extent did UNFPA maternal health support contribute to UNFPA visibility in global, regional and national maternal health initiatives and help the organization to increase financial commitments to maternal health at national level?

Judgment criteria	Issues to assess
12.2. UNFPA leadership of maternal health advocacy campaigns at national level	What mechanisms or approaches has UNFPA used to advance its mission vis-à-vis the government and public?
12.3. Increased financial commitments of partner Governments to sexual reproductive health and maternal health	What are the tools, information and evidence provided by UNFPA country office that has been utilized (in the last three years) in reproductive health/maternal health resource mobilization (non-cash) and fundraising (cash) by partner governments?
	In what way did these tools improve the ability of governments to raise additional funds for maternal health; or the willingness of governments themselves to devote more funds to maternal health?

Judgment criterion 12.2

- UNFPA leadership of maternal health advocacy campaigns at national level

UNFPA has supported a number of advocacy causes that were related to maternal health, but has maintained a low profile as an organization on this issue.

The country office has worked to raise awareness on issues related to gender-based violence (GBV), including female genital mutilation (FGM)[78] and early marriage, safe motherhood, and HIV. Mechanisms included media campaigns and working in partnership with state level media, support for youth networks, and awareness-raising campaigns directed at parliamentarians. UNFPA has been working with and supporting a "Religious Leaders Platform on Reproductive Health". In addition, UNFPA has established close relationships with a number of policy-relevant organizations, such as the National Population Council, the Ministry of Social Welfare and Gender, and the Ministry of Guidance (in addition to its relationship with the Ministry of Health). UNFPA has also worked with local media and has supported the development of programmes on maternal health-related topics.

However, UNFPA has maintained a low profile in advocacy and awareness-raising campaigns in light of sensitivities about an international organization addressing sensitive national cultural, religious or political issues.

Judgment criterion 12.3

- Increased financial commitments of partner governments to sexual reproductive health and maternal health

UNFPA-supported advocacy campaigns have not translated into the commitment of additional funds to improve maternal health in Sudan.

78. Including the UNFPA-UNICEF Joint Programme on Female Genital Mutilation/Cutting (FGM/C): Accelerating Change

The Maternal and Newborn Health Road Map that was developed largely with UNFPA technical assistance was intended as a tool to leverage additional funding for improving maternal and newborn health in Sudan. So far, however, neither the government nor UNFPA itself has been able to raise any of the funds required for its implementation.[79] As mentioned above, the projected costs to implement this Road Map significantly exceed the amount that is currently spent on reproductive health by the Sudanese government. This means that funds from external sources, including development partners and others, are required to fill an annual funding gap of approximately US$ 39.8 million to support the implementation of the Road Map overall, and the family planning component in particular.

Moreover, there has not been a direct link between public awareness of maternal health, formal government commitments to maternal health, and increased funding for maternal health. Maternal health is a relatively visible public issue in Sudan, as demonstrated by some public events being attended by the President, for example on midwifery. However, this symbolic support for maternal health has not translated into increased levels of funding. Even though staff in the Ministry of Health are generally committed to these issues, their options for ensuring increased funding for health overall, and maternal health in particular, are limited by the budgeting process in Sudan.[80]

4.2 Findings related to the mid-term evaluation of MHTF

4.2.1 Evaluation question 1: Relevance

Evaluation question 1

To what extent is MHTF support adequately focused on addressing the reproductive and maternal health needs of the vulnerable groups among countries and within countries?

Judgment criteria	Issues to assess
1.1. MHTF countries selection processes support the role of MHTF as strategic instrument to improve maternal health among the most vulnerable populations	How/to what extent has the global agreement on the division of responsibilities among the H4+ partners been translated into concrete cooperation agreements among the agencies at country level?
1.2. MHTF supported national assessments yield sufficient and disaggregated data for needs orientation planning, programming and monitoring targeting the most vulnerable groups (including underserved groups)	To what extent are MHTF supported needs assessments (see output 2 of the MHTF business plan) sufficiently "owned" by national governments to guide the subsequent planning and implementation of national maternal health support?
	To what extent do the MHTF supported needs assessments consider the needs of the most vulnerable groups in the programme countries; and identify the gaps that have prevented the addressing of their needs to that point?
1.3. National policies and sub national level sexual reproductive health/maternal health planning and programming priorities the most vulnerable groups and underserved areas	To what extent is the subsequent MHTF support targeted to address the identified gaps and needs of the most vulnerable?

79. Judgment criterion 6.2
80. Interview with UNFPA.

Judgment criterion 1.1

- MHTF countries selection processes support the role of MHTF as strategic instrument to improve maternal health among the most vulnerable populations

The H4+ concept has not yet translated into any concrete cooperation between the global H4+ partners, as the concept has been introduced into Sudan only recently, promoted in particular by WHO.[81]

Judgment criterion 1.2

- MHTF supported national assessments yield sufficient and disaggregated data for needs orientation planning, programming and monitoring targeting the most vulnerable groups (including underserved groups)

The MHTF in Sudan has not supported needs assessments. A number of relevant needs assessments had already been carried out before the MHTF was launched in Sudan.[82]

Judgment Criteria 1.3

- National policies and sub national level sexual reproductive health/maternal health planning and programming prioritize the most vulnerable groups and underserved areas

The availability of MHTF resources have neither changed the UNFPA approach for addressing the maternal health needs of vulnerable populations in Sudan, nor have the funds been used to advocate for a more targeted reproductive health policy framework to address their maternal health needs. Instead, the country office has used the MHTF as supplementary funding for its core reproductive health package.

The availability of MHTF resources has not resulted in a significant change to the thematic focus of UNFPA support in Sudan, and has not changed the UNFPA approach for addressing vulnerable groups or advocating for their needs at policy level. Instead, the country office has used the MHTF to supplement the financing of the existing UNFPA reproductive health package. MHTF resources have been used to supplement financing for refurbishing schools, purchasing lab equipment, pre-service village midwifery trainings, and in-service family planning trainings on counseling for care providers (health visitors, nurses, medical assistants and medical doctors). MHTF has also been used to complement core funds to deliver EmONC support through in-service trainings, equipment and supplies, and refurbishing of operating theatres, and supported the development of obstetric fistula repair capacity through the training of physicians and construction of operating theatres and wards.[83]

As obstetric fistula is often a cause for stigmatization and exclusion from families and communities, MHTF has helped to address the maternal health needs of some of the most vulnerable women in Sudan. The MHTF has also financed the position of the International Country Midwifery Advisor (ICMA).

81. For more information, see evaluation question 2 on the Maternal Health Thematic Evaluation.
82. Document review and interviews with UNFPA; Also, UNFPA office defines vulnerable groups broadly as women of reproductive age, between 15 and 49 years, and has targeted these age groups within the 5 focus states and three Darfur regions.
83. Other activities that have been supported by the MHTF are noted below under evaluation question 2.

4.2.2 Evaluation question 2: Capacity Development - human resources for health

Evaluation question 2

To what extent has the MHTF contributed towards strengthening human resources planning and availability (particularly midwives) for maternal health?

Judgment criteria	Issues to assess
2.1. Programme countries midwifery education upgraded based upon ICM (International Confederation of midwives essential competencies through MHTF support	How does the MHTF support mechanisms for long term national midwifery education funding, country wide integration of new curricula and monitoring of effective uptake of new knowledge/training?
	What follow up mechanisms are instituted by the MHTF to assess the relevance of the training content, the trainers' capacities and the appropriate utilization of the training equipment?
2.2. Strategies and policies developed to ensure the quality of midwifery services provision in programme countries through MHTF support	To what extent does the MHTF support the relevant national institutions to address deployment, motivation and retention policies for health care workers?
	How does MHTF support partner counties to define the most urgent needs/priorities of midwifery scaling-up within the financial and political constraints?
2.3. Midwifery associations able to advocate and support scaling up of midwifery services through MHTF support	What approaches is the MHTF considering to enabling midwives' associations, to take on the role envisioned in the programme?
Additional issues:	Is the skill mix of the MHTF Country Midwifery Advisors optimal to best support countries?
	What other strategies should be used to strengthen HRH in the MHTF supported countries?

Judgment criterion 2.1

- Partner countries midwifery education upgraded based upon ICM essential competencies through MHTF support

As in other technical areas, MHTF support for midwifery complemented projects that had been launched primarily with UNFPA core funds. Although the complementary funding had been used to improve the training of technical health cadres, the corresponding curricula and trainings were not upgraded sufficiently to meet the International Confederation of Midwives (ICM) standards for midwives or skilled birth attendants. At the time of the evaluation, the recently posted International Country Midwifery Advisor (ICMA) had not yet been able to make a substantive contribution to help upgrade midwifery education in Sudan.

MHTF funds have been used to complement UNFPA core funding by supporting individual budget items for projects financed through the core funds. Therefore the added value of the MHTF relates to the additional resources it has made available, i.e., funding midwifery support that had started prior to the launch of the MHTF in Sudan. For example, MHTF funds had been used to complement UNFPA core funding directed at developing and implementing a 2 year training curricula for midwifery technicians. These technicians were considered to be skilled birth attendants (SBAs) by the Sudanese government, despite the fact that their training did not meet the corresponding global ICM definitions.[84]

84. The education level of the trainees also did not allow a more comprehensive training than the one offered (document review and interviews with UNFPA).

At the time of the evaluation, the MHTF had not funded the development of any follow-up mechanisms to assess the relevance of training content, trainers' capacities or the appropriate utilization of training equipment for the training of midwives. Although the MHTF-funded ICMA was posted at the Academy of Health Sciences (AHS),[85] the agency in charge of the curriculum review process, the ICMA had not yet been allowed to play an active role in this process.[86] However, the post-holder had begun to advocate for a stronger role for herself and the other (unpaid) midwifery staff member of the AHS.[87] At the time of the evaluation, the ICMA was also in the process of drafting a proposal for recruiting United Nations volunteers (UNV) as midwife tutors and midwife supervisors in hospitals.[88]

Judgment criterion 2.2

- Strategies and policies developed to ensure the quality of midwifery services provision in programme countries through MHTF support

At the time of the evaluation, the MHTF had not yet made a significant contribution to the development of strategies and policies to ensure the quality of midwifery service provision in Sudan. Initiatives by the newly-posted ICMA that were intended to make a contribution were still in the planning stages.

Prior to the evaluation, MHTF-financed organizational support had been relatively limited. As the MHTF-funded ICMA was appointed only four-six months prior to the evaluation, it was too early to observe any concrete results to address deployment, motivation and retention of health care workers/midwives. The ICMA had begun to establish a cooperative relationship with the National Midwives Association of Sudan, specifically to organize a group of midwives to discuss the issue of gender and maternal health; and to potentially use this group to advocate for quality maternal health services. [89]However, this initiative was still in the planning stage at the time of the country visit.

As mentioned above, UNFPA had been supporting the Sudanese government in midwifery, and in particular in redefining national priorities, before the introduction of MHTF Sudan. This earlier support included a national study on the status of midwifery which became the basis for the development of the "National Strategy for Scaling-Up Midwifery in the Republic of Sudan".[90] In contrast, MHTF-specific initiatives, promoted in particular by the ICMA, were still in their infancy at the time of the country visit. They include a concept paper for short-, medium and long-term actions to strengthen midwifery education; and also the proposal to use UN Volunteers as midwifery tutors to ensure a certain quality of training and service delivery.[91]

85. The Academy of Health Sciences is the Sudanese government agency in charge of overseeing and regulating the training of midwives and at the time of the evaluation was formally leading the curriculum review process on behalf of the government.
86. Reasons that contributed to this situation include the low standing of midwifery as a profession in Sudan, which added to the difficulties of the ICMA, as a non-Sudanese professional from Sub-Saharan Africa, to advocate for midwifes in the challenging social and political context of Sudan.
87. Interviews with UNFPA.
88. Interviews with UNFPA.
89. UNFPA interviews.
90. Document review.
91. Interviews with UNFPA.

Judgment criterion 2.3

- Midwifery associations able to advocate and support scaling up of midwifery services through MHTF support

The MHTF, through the ICMA, has helped to make some initial steps toward the official creation of a midwifery association. However, at the time of the evaluation, the association had not been officially registered yet and was not yet operational.

The MHTF has been supporting the organizational consolidation of the Sudanese Midwifery Association at national level through some technical and logistical support. It is also promoting the creation of local chapters of the association at the level of the states.[92] However, at the time of the evaluation, the association was still in its infancy and was not yet officially registered at national level, although it already had elected some of its officers. The ICMA has also been supporting the Council for Allied Health Professions (which includes midwives).[93]

The additional staff position of the ICMA is appreciated by the country office. However, it has been challenging for the post-holder to promote midwifery as a discipline in Sudan as the awareness of the importance of midwives has decreased and women are marginalized socially, politically and in the workplace.[94]

Overall, many of the activities that represent the core MHTF mandate have been affected by the same challenges that also have affected other maternal health support activities by UNFPA, in particular the need for capacity development at both federal and state levels. The MoH reproductive health department has been challenged by: i) the low motivation and high turnover of staff; ii) the lack of political will and commitment which has delayed the endorsement of the registration of the Sudanese Midwifery Association as well as the establishment of a midwifery council, despite the ongoing policy advocacy efforts, and; iii) the lack of interested candidates (associated with cultural barriers) which has hampered the availability of suitable candidates for the midwifery technician basic training. In addition, delays in disbursement of MHTF resources and in the recruitment of the ICMA have delayed effective implementation of activities under the MHTF AWP.[95]

92. Review of annual work plans, annual reports and interviews at UNFPA.
93. Interview with UNFPA.
94. UNFPA interviews.
95. Interviews with IPs, UNFPA, document review.

4.2.3 Evaluation question 3: Sexual and reproductive health services – family planning

MHTF resources had not been used to finance family planning support in Sudan.

4.2.4 Evaluation question 4: Sexual and reproductive health services – EmONC

Evaluation question 4

To what extent has the MHTF contributed towards scaling up and utilization of EmONC services in priority countries?

Judgment criteria	Issues to assess
4.1. Creation of enabling environment that facilitates scale-up of EmONC services through MHTF support	What mechanisms does the MHTF apply to motivate and sustain the commitment of the Ministry of Health to respond to the bottleneck identified during EmONC needs assessment (including maternal death audits)?
	What mechanisms does the MHTF support to provide continuous EmONC education in remote areas?
4.2. Utilization and access of EmONC services improved through MHTF support	What are the mechanisms in place to explore the barriers to EmONC services in countries supported by the MHTF?
	What are the mechanisms MHTF utilizes to address the identified barriers and to increase demand of quality EmONC services?

Judgment criterion 4.1

- Creation of enabling environment that facilitates scale-up of EmONC services through MHTF support

and

Judgment criterion 4.2

- Utilization and access of EmONC services improved through MHTF support

MHTF resources have been used to complement core funding of EmONC support projects, including repair of obstetric fistula. No additional initiatives were launched that were linked exclusively to the MHTF.

As in other technical areas, MHTF funds have been used to complement UNFPA core funds to support EmONC projects that pre-date the launch of MHTF in Sudan. Activities include the prevention and management of obstetric fistula, including the development of capacity in obstetric fistula repair through training of physicians and construction of operating theatres and wards.[96] With regard to supporting the MoH to maintain its commitment to EmONC, MHTF resources were used as complementary funding to finance relevant country office activities, such as the costing of the Maternal and Newborn Health Road Map, which includes a component on EmONC services.

96. Review of annual work plans, other documents, interviews with UNFPA.

The country office has used MHTF resources to support obstetric fistula campaigns in Khartoum, Kassala state and Nyala, Darfur. Campaigns include community mobilization activities to identify affected women, training of physicians, and refurbishing or building of centers.[97]

No specific projects on identifying barriers to EmONC or fistula prevention activities had been financed with MHTF funds.[98,99]

4.2.5 Evaluation question 5: Support to health planning, programming and monitoring

Evaluation question 5

To what extent has the MHTF contributed to improve planning, programming and monitoring to ensure that maternal and reproductive health are priority areas in programme countries?

Judgment criteria	Issues to assess
5.1. Improved positioning of maternal and reproductive health in national strategies and policies through MHTF support	How have the advocacy campaigns supported by the MHTF been translated into national policies (including family planning, skilled care in pregnancy and childbirth, emergency obstetric and neonatal care, obstetric fistula and sexual reproductive health and reproductive health/HIV linkage)?
	Does sexual reproductive health coordination bodies established in countries provide a coordinated framework to address sexual reproductive health/MNH issues? Do the MoH have a strong ownership about sexual reproductive health/MNH coordination?
5.2. National plans consider sustainable funding mechanisms for sexual reproductive health/maternal health through MHTF support	To what extent allow institutional capacities which have been developed through MHTF support systematic and sound costing and budgeting of sexual reproductive health/maternal health interventions?

Judgment criterion 5.1

- Improved positioning of maternal and reproductive health in national strategies and policies through MHTF support

At the country level, MHTF had only made a small contribution to improving the positioning of maternal and reproductive health in national strategies and policies. The only related activity was the preparation and implementation of the International Day of the Midwife.

97. Interviews with implementing partners in focal states, UNFPA; document review.
98. Apart from a planned project to undertake operational research on the "Obstetric fistula caseload in the three national obstetric fistula centres and five tertiary hospitals" (planned for 2011, but not yet implemented at the time of the evaluation).
99. Challenges that UNFPA was faced with in the training of health staff on EmONC was the turnover of staff and outmigration of physicians who previously had been trained by UNFPA.

The Maputo Plan of Action, one of the most prominent regional campaigns and which is supported by MHTF globally and regionally, has translated into the development of a Maternal and Newborn Health Road Map in Sudan, albeit without MHTF funding at the country level. Having remained in draft form for several years, the Road Map was finalized under the leadership of a UNFPA-funded technical assistant and is now available as a costed strategy.[100] However, questions remain regarding the feasibility of raising the required funds.[101] Other advocacy events financed with MHTF funds have been limited to the International Day of the Midwife, whilst other campaigns are being planned for the future.[102]

The MoH intends to establish a coordination committee for midwifery; however at the time of the evaluation, this committee did not yet exist. UNFPA intends to support its formation, partly funded by MHTF resources.[103]

Judgment criterion 5.2

- National plans consider sustainable funding mechanisms for sexual reproductive health/maternal health through MHTF support

MHTF funds have been used to help finance the costing of the Maternal and Newborn Health Road Map at federal and state level.

The MHTF has, in part, supported the costing of the Maternal and Newborn Health Road Map for Sudan. UNFPA has also supported a costing exercise in its five focal states. Support included training of MoH staff, and recruitment of a consultant to support the costing exercise and to work with a team of national colleagues from five target states. MHTF also provided support for MoH staff in the five focal states to attend a related training outside of Sudan.

4.2.6 Evaluation question 6: Management of MHTF

Evaluation question 6

To what extent have the MHTF management mechanisms and internal coordination processes at all levels (global, regional and countries) contributed to the overall performance of the MHTF in fulfilling its mission?

Judgment criteria	Issues to assess
6.2. Instruments and mechanisms developed by the MHTF to strengthen country office capacities to manage the fund at global and regional level	To what extent country offices MHTF/Reproductive Health Thematic Fund (RHTF) planning process is facilitated by the tools provided at global level?
	What are the outcomes of South-South collaboration for technical assistance?
Additional issues:	Has the actual MHTF set up (particularly as far as human resources are concerned) at country, regional and global level allowed MHTF to achieve expected results? What are the constraints?

100. For more details, see evaluation questions 2 and 9 of the Maternal Health Thematic Evaluation.
101. See evaluation question 2 of the Maternal Health Thematic Evaluation for more details.
102. Review of documents and interviews with implementing partners, UNFPA.
103. Interview with UNFPA.

Judgment criterion 6.2

- Instruments and mechanisms developed by the MHTF to strengthen country office capacities to manage the fund at global and regional level

Apart from providing funds for an additional staff position, the International Country Midwifery Advisor (ICMA), the MHTF has not contributed to strengthening the capacity of the UNFPA country office in Sudan. Moreover, the reporting requirements and conditions attached to MHTF resources have placed an additional administrative burden on country office staff that exceeds the administrative burden associated with the same amount of core funds.

The country office had made little use of planning tools provided by MHTF at the global level, partially because MHTF funds were used to co-finance projects that had been planned independently of the MHTF and had been part of the country office annual planning process. [104]

Since the launch of the MHTF, the country office has supported a number of events to foster South-South cooperation. For example, the MHTF supported a visit by the ICMA to South Sudan which may contribute to the successful development of a proposal to use UN Volunteers as midwifery tutors in Sudan. The ICMA was able to observe the operations of UNV midwives in South Sudan and to learn lessons to apply in developing a funding proposal.[105] However, as this occurred relatively recently, it is difficult to determine any contribution to specific outcomes.

Although the MHTF has provided additional resources which have been beneficial for country office activities, the various requirements and conditions attached to the funds have reduced the net-benefit for the country office. In addition, UNFPA has funding needs particular to the Sudanese context that could not be met by the MHTF, such as resources for building renovations, or additional resources for addressing the cultural barriers that prevent women from seeking medical care during pregnancy. In at least one instance, MHTF funding had to be returned to UNFPA headquarters because the country office was unable to use it within the specified time.[106]

Additional issues

MHTF has added value by improving communication with UNFPA headquarters. Since the regionalization process in UNFPA took place and country support teams were ended, it had become difficult for the country office to access technical support from the regional level. The current regional office often only refers the country office to a consultant when assistance is requested. The MHTF structure, however, does allow the country office to access UNFPA staff in the Technical Division in UNFPA headquarters.[107]

104. Interview with UNFPA.
105. Interview with UNFPA.
106. Interviews with UNFPA.
107. Interview with UNFPA staff.

4.2.7 Evaluation question 7: Coordination/coherence

Evaluation question 7

To what extent has the MHTF enhanced and taken advantage of synergies with other UNFPA Thematic Funds e.g. the Global Programme on Reproductive Health Commodity Security, the Campaign to End Fistula and the UNFPA-ICM Midwives Programme and HIV/Prevention of Mother-to-Child HIV Transmission (PMTCT) in order to support maternal health improvements?

Judgment criteria	Issues to assess
7.1. Integration of the components of the Campaign to End Fistula into maternal health programmes after the integration in MHTF	Do MHTF supported countries include obstetric fistula in their advocacy campaign for sexual reproductive health/ maternal health?
	To what extent does MHTF support in promoting sexual reproductive health/maternal health policies, strategies and plans including M&E plans (with specific indicators) allow to integrate obstetric fistula?
7.2. Joint and coordinated planning at country level with Global Programme to Enhance Reproductive Health Commodity Security (GPRHCS)	Not relevant - RHCS Funds became available in Sudan for the first time in 2011.
7.3. Integration of Midwife programme strategic directions in MHTF plans in countries	What is the role of ICM regional advisor in supporting country offices?
	Is partnership with ICM sufficient to boost midwifery in programme countries? Are there other potential partners that can contribute to this aim?

Judgment criterion 7.1

- Integration of the components of the Campaign to End Fistula into maternal health programmes after the integration in MHTF

Since the launch of MHTF in Sudan, MHTF funds have been used to co-finance various fistula-related activities.

MHTF funds have been used to complement core UNFPA funding for fistula repair and fistula campaigns. Apart from supporting the costing of the Maternal and Newborn Health Road Map, the MHTF has not been involved in promoting maternal and newborn health policies. However, the MHTF has provided complementary funding for a number of other fistula-related activities related to the development of fistula treatment protocols,[108] the training of surgeons in fistula repair in Sudan and abroad, renovations of buildings[109] and the establishment of additional satellite fistula centers. MHTF and core funds have helped to build a cooperative long-term relationship with the Abbo Fistula Management Centre.

108. E.g., in cooperation with the Abbo Fistula Management Centre.
109. E.g., of the Abbo Fistula Management Centre.

Judgment criterion 7.3

- Integration of Midwife Programme strategic directions in MHTF plans in countries

The International Country Midwifery Advisor (ICMA) has utilized International Confederation of Midwives (ICM) tools and standards that are available on the ICM website. High-level advocacy for midwifery is needed as the midwifery profession is currently not well-respected in Sudan. This is beyond the scope of the current ICMA, especially in the context of Sudan, but no such support has been received from the ICM.

4.2.8 Evaluation question 8: Leveraging and visibility

Evaluation question 8

To what extent did the MHTF increase the visibility of UNFPA sexual reproductive health/maternal health support and help the organization to leverage additional resources for maternal health at global, regional and national level?

Judgment criteria	Issues to assess
8.1. (MHTF-facilitated) presence of UNFPA in global and regional maternal health initiatives	To what extent are the various MHTF supported advocacy and communication efforts translated into higher visibility and additional resources for maternal health?
	To what extent benefit programme countries from regional maternal health related initiatives (conferences, workshops) supported by MHTF?
8.2. Effect of MHTF on (increased) external financial commitments to UNFPA/MHTF for maternal health support (at global, regional, country level)	To what extent contributed the MHTF support to an increase in the share of external financial commitments earmarked to support maternal health at country level?
	What kind of mechanisms are in place to support programme countries to increase their efforts to leveraging additional resources with external donors?

Judgment criterion 8.1

- (MHTF-facilitated) presence of UNFPA in global and regional maternal health initiatives

and

Judgment criterion 8.2

- Effect of MHTF on (increased) external financial commitments to UNFPA/MHTF for maternal health support (at global, regional, country level)

As previously mentioned, at the time of the evaluation, the MHTF-funded International Country Midwifery Advisor (ICMA) was preparing a proposal to recruit international midwives as UN Volunteer tutors in midwifery schools in Sudan. This was being marketed to various donors at the time of the country visit. The country office has also used MHTF funds to finance the costing of the Maternal and Newborn Health Road Map, both at state and federal levels. However, at the time of the evaluation, it was not clear if this will lead to the commitment of additional resources for maternal health. Overall, therefore, the MHTF had not yet triggered any commitments of additional funds for maternal health in Sudan at the time of the evaluation.

5. Conclusions[110]

Based on the findings on the issues to assess for each of the evaluation questions, the country evaluation team has drawn some cross-cutting conclusions which are presented below. These are country-specific conclusions and are not to be confused with the conclusions of the MHTE/MHTF final reports. The conclusions presented in this section are based on the selective analysis of UNFPA maternal health support in Sudan only, and as such do not provide a judgment on the quality of UNFPA country programme in Sudan overall, which would only be provided by a comprehensive country programme evaluation. The conclusions cover the overall maternal health interventions of UNFPA in Sudan and also the specific added value of MHTF in the country.

5.1 Conclusions on overall maternal health support in Sudan

1. The UNFPA country office has performed reasonably well, in spite of very difficult circumstances[111]

    - UNFPA has been able to establish relatively good relationships with a number of important governmental agencies and bodies. It has been able to use these relationships to conduct issue-based advocacy with important governmental stakeholders (Ministry of Guidance, etc.) on sensitive issues, such as female genital mutilation and early marriage.
    - UNFPA has provided relevant support to midwifery in Sudan, especially considering the decline of the midwifery profession in Sudan since the early 20th century. The country office had identified midwifery as an issue prior to the launch of the MHTF. Although progress is slow, it has been integrating its efforts of creating a cadre of professional midwives with the priorities of the government to build-up the cadre of so-called "Village Midwives" as a parallel group of community-based health care providers.
    - UNFPA also has been able to contribute some important pre-requisites for needs-based planning in maternal health and other areas through supporting various studies and survey. These activities have been particularly relevant in an environment like Sudan where reliable data are generally scarce.

2. UNFPA approach for systems strengthening and capacity development related to maternal health[112] has not sufficiently addressed the low capacity of the administrative health system and the absence of complementary resources from other development partners to achieve lasting improvements in Sudan[113]

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110. Recommendations are not elaborated at this stage, as the overall conclusions to the evaluation questions will only be developed on the level of the final reports to the MHTE/MHTF evaluations.
111. The findings in Sections 4.1 and 4.2 are based primarily on documentation and feedback that refer to the period from 2007 (approximately) to 2010/11. Therefore, the performance of UNFPA in Sudan could only really be assessed for these recent years. Based on evaluation Questions 4 (capacity development), evaluation question 6 (family planning), evaluation question 7 (EmONC), evaluation question 9 (maternal health and policy frameworks).
112. Based on a combination of technical assistance and logistical support for policy development, advocacy, training of health staff in different technical disciplines.
113. Based on evaluations questions 2 (harmonization & coordination of support), evaluation question 4 (HRH), evaluation question 6 (family planning), evaluation question 7 (EmONC), evaluation question 9 (maternal health and policy frameworks).

- In many ways, the activities that UNFPA has implemented in Sudan have been similar to those that the organization might have carried out also in other, more stable, country contexts. For example, UNFPA has invested in drafting relevant policies on behalf of the Sudanese government (MoH), but has not clearly factored the weak implementation capacity and the low access to financial resources of the Ministry of Health and the Sudanese government overall into its approach.
- The same caveat exists for UNFPA support of the finalization of the Maternal and Newborn Health Road Map. Although UNFPA successfully helped the Ministry of Health to develop a costed document, neither of the partners anticipated a viable strategy to finance the implementation of the strategy. Sudan has seen very small investments in health overall and in maternal health in particular, and it is now very uncertain if the necessary funding can be mobilized to implement the Road Map.
- The above observations also suggest that the absence of a group of resource-rich development agencies to complement UNFPA support of sexual and reproductive health issues with more comprehensive assistance for the Sudan health sector has been challenging.[114] In other countries, UNFPA can work in concert with other development partners and focus on sexual reproductive health issues, while its partners address health system issues more broadly. This option largely did not exist in Sudan.

3. Training of reproductive health staff under the conditions of high staff turn-over, out-migration of trained staff, and the overall weakness of government capacity in the health sector rendered UNFPA human resources for health support too fragmented to achieve lasting results

- The effectiveness of UNFPA support to human resources for health development in different technical disciplines (family planning, EmONC, midwifery) suffered from difficult context conditions (high staff turnover, out-migration, overall weakness of government capacity in the health sector).
- UNFPA alone has not been able to address these difficult context conditions. For example, it has not been able to put in place an incentive scheme for retaining health workers, at least in part due to internal limitations of using UNFPA resources for temporarily topping-up the low salaries of health cadres. Overall, however, UNFPA resources would have been too limited to systematically address the issue of staff deployment and retention. Without a clear commitment of the Sudanese government to address these issues, support from other donors would have been needed to advocate in these areas and to provide additional technical and financial resources.
- As a result, UNFPA has been able to transfer skills to other health workers in Sudan (doctors, midwives, nurses, community health workers), but was not able to ensure that these remained in their positions after the trainings, that they found work conditions that allowed them to apply their new skills, or that the individual trainings were accompanied by other initiatives to strengthen the health system overall.

5.2 Conclusions on the added value of MHTF in Sudan

4. MHTF had not yet acted as a catalyst for maternal health support and systems strengthening in Sudan [115]

- The MHTF Business Plan 2008 – 2011 acknowledges that MHTF resources only represent two per cent of the globally required resources to meet MDG 5, and that therefore, MHTF will need to act catalytically in recipient countries, i.e., by leveraging additional funds and by strengthening the capacity of the programme country's own health systems to pursue the improvement of maternal health conditions. As stated above in the general conclusions, UNFPA has been challenged to achieve either systems strengthening or the leveraging of additional funds in Sudan on its own.

114. This observation applies in particular to development assistance for the 12 States of Sudan outside of Darfur.
115. Based on MHTF evaluation Questions 1 (relevance), evaluation question2 (HRH), evaluation question 3 (family planning), evaluation question4 (EmONC), evaluation question7 (coordination/coherence), evaluation question 8 (leveraging/visibility)

- Prior to the country visit, the MHTF had not improved UNFPA prospects for achieving either systems strengthening or leveraging additional funds for maternal health. Most of the strategic initiatives that could lead to such a catalytic effect (e.g., Maternal and Newborn Health Road Map, EmONC assessment and National Strategy for Scaling-Up Midwifery in the Republic of Sudan) were already underway when the MHTF was launched in Sudan.

5. MHTF has added value to maternal health programming in Sudan primarily by providing additional resources for the implementation of the sexual reproductive health sub-programme,[116] but has not influenced the programmatic direction of the sexual reproductive health/maternal health sub-programme itself.[117]

- The main tenets of UNFPA support to midwifery had already been defined before the launch of the MHTF in Sudan. Neither the ICM/UNFPA midwifery programme nor any other global and regional resources and guidelines have indicated the need to change UNFPA midwifery support in Sudan.
- The same principle applies to UNFPA support for EmONC. Although MHTF funds have been used to financially complement the implementation of the UNFPA sexual reproductive health sub-programme, the MHTF has not influenced the strategic direction of UNFPA in these areas.
- In essence, the MHTF funds have therefore been functionally equivalent to 'topping-up' core funds for the sexual reproductive health sub-programme, albeit associated with considerably higher transaction and overhead costs than regular core funds.

6. Global/regional initiatives that have been supported by MHTF have not yet translated into viable approaches in Sudan [118]
   - The ICM/UNFPA midwifery programme[119] has so far produced little or no added value in Sudan. Although the International Country Midwifery Advisor has been using ICM standards tools and guidelines to inform their work, the programme has helped to make available customized technical support for UNFPA in Sudan.
   - The Maputo Plan of Action has been translated into a national Maternal and Newborn Health Road Map with the help of UNFPA, and has been costed with the help of MHTF. However, it is unclear if the Road Map will be able to guide the implementation of maternal and newborn health support in Sudan, in large part due to the lack of national and external resources to finance its implementation.
   - Although the H4+ concept has been formally adopted, the Sudanese context poses significant challenges for making this concept operational. The Sudanese government is wary of donors and development partners who coordinate independently of the government. The legacy of weak coordination among UN partners in Sudan is an additional challenge.

116. I.e., the sexual reproductive health component of UNFPA country programme.
117. Based on findings from evaluation question 1 (relevance/coherence), evaluation question 2 (HRH), evaluation question 3 (family planning), evaluation question 4 (EmONC), evaluation question 7 (coordination/coherence), evaluation question 8 (leveraging/visibility).
118. Based on findings from evaluation question 1 (relevance/coherence), evaluation question 5 (health planning, programming, monitoring), evaluation question 6 (Management of MHTF), evaluation question 8 (leveraging/visibility)
119. Funded with MHTF resources at regional and global level.

6. Annexes

6.1 Key data of Sudan

SUDAN (including South Sudan)		
Summary statistics		
Region	2000	Northern Africa
Currency	2008	Sudanese Pound (SDG)
Surface area (square kilometers)	2008	2505813
Population (estimated, 000)	2008	41348
Population density (per square kilometer)	2008	16.5
Largest urban agglomeration (population, 000)	2007	Khartoum (4754)
Economic indicators		
GDP: Gross domestic product (million current US$)	2008	70276
GDP: Gross domestic product (million current US$)	2005	33153
GDP: Growth rate at constant 1990 prices (annual %)	2008	7.6
GDP per capita (current US$)	2008	1699.6
GNI: Gross national income per capita (current US$)	2008	1662.4
Gross fixed capital formation (% of GDP)	2008	17.5
Exchange rates (national currency per US$)	2008	2.18
Balance of payments, current account (million US$)	2008	-1314

Agricultural production index (1999-2001=100)	2007	124
Food production index (1999-2001=100)	2007	124
Labor force participation, adult female pop. (%)	2008	31.6
Labor force participation, adult male pop. (%)	2008	71.5
Tourist arrivals at national borders (000)	2008	436 (incl. nationals residing abroad)
Energy production, primary (000 MT oil equivalent)	2008	23525
Telephone subscribers, total (per 100 inhabitants)	2008	27.9
Internet users (per 100 inhabitants)	2008	9.2
Exports (million US$)	2008	9500.9
Imports (million US$)	2008	16416.7
Major trading partners (% of exports)	2008	China (79.5), Japan (7.3), United Arab Emirates (2.3)
Major trading partners (% of imports)	2008	Saudi Arabia (25.0), China (7.9), United Kingdom (6.6)
Social indicators		
Population growth rate (avg. annual %)	2005-2010	2.2
Urban population (%)	2007	42.6
Population aged 0-14 years (%)	2009	39.1
Population aged 60+ years (women and men, % of total)	2009	6.1/5.3
Sex ratio (men per 100 women)	2009	101.4
Life expectancy at birth (women and men, years)	2005-2010	59.5/56.5
Infant mortality rate (per 1 000 live births)	2005-2010	69.1

Fertility rate, total (live births per woman)	2005-2010	4.2
Contraceptive prevalence (ages 15-49, %)	2006-2009	7.6
International migrant stock (000 and % of total population)	mid-2010	753.5/1.7
Refugees and others of concern to UNHCR	end-2008	1499683
Education: Primary-secondary gross enrolment ratio (w/m per 100)	2005-2008	55.2/61.7
Education: Female third-level students (% of total)	2005-2008	47.2
Seats held by women in national parliaments (%)	2009	18.1
Economic indicators		
Threatened species	2009	109
Forested area (% of land area)	2007	27.9
CO2 emission estimates (000 metric tons and metric tons per capita)	2006	10805/0.3
Energy consumption per capita (kilograms oil equivalent)	2007	98.0

Source: UN World Statistics Pocketbook

Figure 2: Map of Sudan

6.2 Data Triangulation

Table 5: Data and methodological triangulation – Maternal Health Thematic Evaluation

Evaluation Question - Maternal Health Thematic Evaluation	Country Office	Nat. Government (MoH)	Sub-national Government	Civil Society	Development Partners	Implementing Partners[120]	Beneficiaries	Data collection methods
1. Relevance	▲ O	▲ O	▲			▲		Document analysis (strategic and planning documents), interviews
2. Harmonization, coordination, partnerships	▲ O	▲			▲ O	▲		Document analysis (e.g. joint programmes, documentation of coordination structure), interviews
3. Community involvement and demand orientation	▲ O	▲ O	▲ O	▲	▲	▲	▲	Document analysis (e.g., gov. strategies), interviews capital, field visit (focus groups, interviews)
4. Capacity development – Human Resources in Health (HRH)	▲ O	▲ O	▲ O		▲ O	▲	▲	Data and document analysis (strategic documents, needs analyses), interviews, field visits (focus groups, interviews)
5. maternal health in humanitarian contexts	▲ O	▲			▲			Data and document analysis, interviews
6. Sexual and reproductive health services – family planning	▲ O	▲ O	▲	▲	▲	▲	▲	Data and document analysis, interviews, field visits (focus groups, interviews)
7. Sexual and reproductive health services – EmONC	▲ O	▲ O	▲		▲ O		▲	Data and document analysis (e.g., scale up plan, Annual Work Plans (AWPs)), interviews, field visit (interviews, focus groups)
8. Results/evidence orientation	▲ O	▲	▲			▲		Document analysis (monitoring reports, tools), interviews
9. Integrating maternal health in national policies and frameworks	▲ O	▲ O		▲	▲			Document analysis (policies and frameworks), interviews
10. Coherence of maternal health support with Gender and Population and Development	▲ O	▲			▲	▲ O		Document analysis (review of AWPs, Country Programme Document (CPD)), interviews
11. Coherence between country, regional, global programmes	▲ O	▲				▲		Document analysis (technical documents, AWPs), interviews
12. Visibility	▲ O	▲	▲	▲	▲	▲		Interviews, document analysis (visibility tools and strategies)

▲= Primary Sources (Interviews, Focus Groups), O = Secondary Sources (Evaluations, project/intervention reports, planning documents, etc.)

120. Other than national government (in particular the Ministry of Health (MoH)) or sub-national governments.

Table 6: Data and methodological triangulation – Mid-Term Evaluation of the MHTF

Evaluation Question - Maternal Health Thematic Evaluation	Country Office	Nat. Government (MoH)	Sub-national Government	Civil Society	Development Partners	Implementing Partners[121]	Beneficiaries	Data collection methods
1. Relevance	▲O	▲O			▲	▲		Document analysis (strategic and planning documents), interviews
2. Capacity Development – HRH	▲O	▲O			▲	▲		Document analysis (e.g., curricula, strategic documents), interviews
3. Sexual and reproductive health services – family planning	▲O	▲					▲	Document analysis, interviews capital, field visit (focus groups)
4. Sexual and reproductive health services - EmONC	▲O	▲O	▲			▲		Document analysis, interviews, field visits (interviews)
5. Health planning, programming and monitoring	▲O	▲O		▲	▲	▲O		Data and document analysis, interviews
6. Management of MHTF	▲O					▲		Document analysis, interviews
7. Coordination and Coherence	▲O					▲		Document analysis, interviews
8. Leveraging and Visibility	▲O	▲		▲	▲	▲		Document analysis, interviews

▲= Primary Sources (Interviews, Focus Groups), O = Secondary Sources (Evaluations, project/intervention reports, planning documents, etc.)

121. Other than national government (in particular MoH) or sub-national governments.

6.3 Data collection result matrix

Overview evaluation questions MHTE	
Evaluation question 1 To what extent is UNFPA maternal health support adequately focused on addressing the reproductive and maternal health needs of the vulnerable groups among countries and within countries?	
Judgment criteria	1.2. (Increased) availability of accurate and sufficiently disaggregated data for targeting most disadvantaged/vulnerable groups
	1.3. Needs orientation of planning and design of UNFPA supported interventions
Evaluation question 2 To what extent has UNFPA successfully contributed to the harmonization of efforts to improve maternal health, in particular through its participation in strategic and multi-sectoral partnerships at global, regional and national level?	
Judgment criteria	2.1. Harmonization in maternal health partnerships between UNFPA and United Nations (UN) organizations and World Bank (including H4+[122]) at global, regional and country level
	2.2. Harmonization of maternal health support through partnerships at country and South-South/regional
	2.3. UNFPA participation in partnerships for producing evidence for policy debates and definition and prioritization of coordinated operational maternal health research agenda

122. UNFPA, UNICEF, World Bank, World Health Organization (WHO), UNAIDS.

Evaluation question 3 To what extent has UNFPA support contributed to a stronger involvement of communities that has helped to increase current levels of demand and utilization of services, in particular through its partnerships with civil society?	
Judgment criteria	3.1. Government commitment to involve communities translated in sexual and reproductive health and maternal health strategies through UNFPA support
	3.2. Civil society organization (CSO) involvement in sensitization on maternal health issues and facilitating community-based initiatives to address these issues supported by UNFPA
Evaluation question 4 To what extent has UNFPA contributed to the strengthening of human resources for health planning and human resource availability for maternal health?	
Judgment criteria	4.1. Development strengthening of national human resources for health (HRH) policies, plans and frameworks (with UNFPA support)
	4.2. Strengthened competencies of health workers in HIV/AIDS, family planning, obstetric fistula, skilled birth attendance and EmONC to respond to sexual and reproductive health/ maternal health needs
Evaluation question 5 To what extent has UNFPA anticipated and responded to reproductive health threats in the context of humanitarian emergencies?	
Judgment criteria	5.1. Inclusion of sexual and reproductive health in emergency preparedness, response and recovery plans
	5.2. Accessibility of quality EmONC, family planning and reproductive health/HIV services in emergency and conflict situations

Evaluation question 6 To what extent has the UNFPA contributed to the scaling up and increased utilization of and demand for family planning?	
Judgment criteria	6.1.Increased capacity within health system for provision of quality family planning services in UNFPA programme countries
	6.2 Increased demand for and utilization of family planning services in UNFPA partner countries, particularly among vulnerable groups.
	6.3. Improved access to contraceptives (commodity security)
Evaluation question 7 To what extent has UNFPA contributed to the scaling up and utilization of skilled attendance during pregnancy and childbirth and EmONC services in programme countries?	
Judgment criteria	7.1. Increased access to EmONC services
	7.2. Increased utilization of EmONC services
Evaluation question 8 To what extent has UNFPA use of internal and external evidence in strategy development, programming and implementation contributed to the improvement of maternal health in its programme countries?	
Judgment criteria	8.3. Results- and evidence based management of individual interventions throughout project life

Evaluation question 9 To what extent has UNFPA helped to ensure that maternal health and sexual and reproductive health are appropriately integrated into national development instruments and sector policy frameworks in its programme countries?	
Judgment criteria	9.1. UNFPA support improved comprehensiveness of analysis of causes for poor maternal health and of effectiveness of past maternal health policies/strategies
	9.2. Maternal health and sexual reproductive health integration into policy frameworks and development instruments based on (UNFPA supported) transparent and participatory consultative process
	9.3. Monitoring and evaluation of implementation of sexual and reproductive/maternal health components of national policy framework and development instruments
Evaluation question 10 To what extent have UNFPA maternal health programming and implementation adequately used synergies between UNFPA sexual and reproductive health portfolio and its support in other programme areas?[123]	
Judgment criteria	10.1. Linkages established between programmes (reproductive health with gender and population and development) in intervention design

123. Gender (including female genital mutilation/cutting, gender-based violence, HIV-PMTCT (prevention of mother-to-child HIV transmission), population and development.

Evaluation question 11 To what extent has UNFPA been able to complement maternal health programming and implementation at country level with related interventions, initiatives and resources from the regional and global level to maximize its contribution to maternal health?	
Judgment criteria	11.1. Clarity of division of labor and delineation of responsibilities between UNFPA global, regional and country offices
	11.3. Enhancement/improvement of UNFPA country level programming and interventions through technical and programmatic support from global and regional level
Evaluation question 12 To what extent did UNFPA maternal health support contribute to the visibility of UNFPA in global, regional and national maternal health initiatives and help the organization to increase financial commitments to maternal health at national level?	
Judgment criteria	12.2. UNFPA leadership of maternal health advocacy campaigns at national level
	12.3. Increased financial commitments of partner governments to sexual reproductive health and maternal health

Overview evaluation questions MHTF	
Evaluation question 1 To what extent is MHTF support adequately focused on addressing the reproductive and maternal health needs of the vulnerable groups among countries and within countries?	
Judgment criteria	1.1. MHTF countries selection processes support the role of MHTF as strategic instrument to improve maternal health among the most vulnerable populations
	1.2. MHTF supported national assessments yield sufficient and disaggregated data for needs orientation planning, programming and monitoring targeting the most vulnerable groups (including underserved groups)
	1.3. National policies and sub national level sexual reproductive health (SRH)/maternal health planning and programming priorities the most vulnerable groups and underserved areas
Evaluation question 2 To what extent has the MHTF contributed towards strengthening human resources planning and availability (particularly midwives) for maternal health and newborn health?	
Judgment criteria	2.1. Partner countries midwifery education upgraded based upon International Confederation of Midwives (ICM) essential competencies through MHTF support
	2.2. Strategies and policies developed to ensure the quality of midwifery services provision in partner countries through MHTF support
	2.3. Midwifery associations able to advocate and support scaling up of midwifery services through MHTF support

Evaluation question 4 To what extent has the MHTF contributed towards scaling-up and utilization of EmONC services in priority countries?	
Judgment criteria	4.1. Creation of enabling environment that facilitates scale-up of EmONC services through MHTF support
	4.2. Utilization and access of EmONC services improved through MHTF support
Evaluation question 5 To what extent has the MHTF contributed to improve planning, programming and monitoring to ensure that maternal and reproductive health are priority areas in partner countries?	
Judgment criteria	5.1. Improved positioning of maternal and reproductive health in national strategies and policies through MHTF support
	5.2. National plans consider sustainable funding mechanisms for sexual and reproductive health/maternal health through MHTF support
Evaluation question 6 To what extent have the MHTF management mechanisms and internal coordination processes at all levels (global, regional and countries) contributed to the overall performance of the MHTF in fulfilling its mission?	
Judgment criteria	6.2. Instruments and mechanisms developed by the MHTF to strengthen country office capacities to manage the fund at global and regional level

Evaluation question 7 To what extent has the MHTF enhanced and taken advantage of synergies with other UNFPA thematic funds e.g. the Global Programme on Reproductive Health Commodity Security (GPRHCS), the Campaign to End Fistula, the UNFPA-ICM[124] Midwives Programme and HIV-PMTCT[125] in order to support maternal health improvements?	
Judgment criteria	7.1. Integration of the components of the Campaign to End Fistula into maternal health programmes after the integration in MHTF
	7.2. Joint and coordinated planning at country level with GPRHCS
	7.3.Integration of Midwives Programme strategic directions in MHTF plans in countries
Evaluation question 8 To what extent did the MHTF increase the visibility of UNFPA sexual and reproductive health/maternal health support and help the organization to leverage additional resources for maternal health at global, regional and national level?	
Judgment criteria	8.2. Effect of MHTF on (increased) external financial commitments to UNFPA/MHTF for maternal health support (at global, regional, country level)
	8.3. Effect of MHTF on (increased) financial commitments of partner governments to sexual and reproductive health/maternal health

124. International Confederation of Midwives.
125. Preventing Mother-to-Child Transmission.

6.4 Focus Group report template

FOCUS GROUP	**Evaluation team member**		**Date**
	Topic/issues to be addressed	**Place**	
Participants (type, number, etc.)			
Issues discussed			
Findings			
Other Observations by evaluator			

6.5 List of documents consulted

TITLE	YEAR	TYPE OF DOCUMENT
ACP/EC/UNFPA: Monitoring Visit to Assess the Status of Implementation of the National RHCS Action Plan in Sudan under the "Joint ACP/EC/UNFPA Programme of Assistance to ACP Countries in Achieving RHCS ".	2009	Report
African Medical Research Foundation/UNFPA: Rapid Needs Assessment for Midwifery and Reproductive Health Training in South Sudan	2005	Assessment Report
Ahfad University: Maternal Health Initiative	2010	Report
Department for International Development/UNFPA: Gender Based Violence Protection in Darfur	2006	Report
Draft Report on Barriers for family planning,	2010	Report
ECHO: Darfur Emergency Reproductive Health Project	2007	Project Report
ECHO: The Evaluation of UNFPA Darfur Reproductive Health Project	2006	Evaluation Report
Gadaref State: Situation analysis of EmONC indicators in Gadaref state Hospitals/Gadaref state 2009	2009	Report
GoS/MoH/ICM: Transitional Action Plan for Midwifery Development in Sudan 2009 – 2010	2010	Planning Document
GoS/MoH: National Reproductive Health Policy	2010	Planning Document
GoS/MoH: National Strategy Document For Scaling-up Midwifery in the Republic of the Sudan 2010	2010	Planning Document

GoS/MoH: Roadmap for Reducing Maternal and Newborn Mortality in Sudan 2010-2015	2009	Planning Document
GoS/MoH/UNFPA: Reproductive Health Commodity Security Situation Analysis for the Northern States	2007	Analysis
GoS/MoH: five-year Health Sector Strategy: Investing in Health and Achieving the MDGs 2007-2011	2007	Planning Documents
GoS/MoH: National Health Policy	2007	Planning Document
GoS/MoH: Sudan Household Health Survey	2007	Report
GoS/MoH: Draft Maternal and Reproductive Health Policy for Southern Sudan	2006	Planning Document
GoS/MoH: The National Strategy for Reproductive Health 2006-2010	2006	Planning Document
GoS/MoH/UNFPA: Reproductive Health Services Map	2005	Report
GoS/UN: Interim Poverty Reduction Strategy Paper 2004-2006	2004	Planning Document
GoS: Interim Poverty Reduction Strategy Paper 2004-2006	2004	Planning Document
GoS/MoH/Central Bureau of Statistics/UNFPA: Safe Motherhood Survey National Report	1999	Report
HAI: Progress Report for Health Alliance International March-April 2011	2011	Report
HAI: Progress Report for Health Alliance International September – December 2010	2010	Report

HAI: Strengthening Health Systems – Annual Report	2010	Report
HAI: Role of Condoms in HIV Prevention Policy and Programming in Sudan	2007	Report
Health Alliance International (HAI)– Profile	2011	Report
International Health Partnership: Joint Assessment of National Health Strategies and Plans	2009	Assessment Report
MoH/EC/UNFPA: Reproductive Health Commodity Security Situation Analysis for the Northern States – Draft Report	2007	Report
MoH/UNFPA: Reproductive Health Component Review Report	2010	Report
MoH/UNFPA: Standard Progress Report reproductive health Component	2010	Report
MoH: National EmONC Needs Assessment	2005	Report
National Human Resources for Health Observatory/Sudan (NHRHO): Human Resources for Health. Strategic Workplan for Sudan 2008-2012	2007	Planning Document
National Population Council, Ministry of Social Affairs and Welfare: population and development Component Report	2010	Report
National Population Council: population and development Component Report 2009-2012	2009	Report
PENHA: Socio-Economic Baseline Survey for Women in Eastern Sudan, Kassala State	2009	Report
Population Council West Asia and North Africa Regional Office: A Situation Analysis of Reproductive Health Services and Utilization Patterns in Gadarif State, Sudan	2009	Situation Analysis

Population Council West Asia and North Africa Regional Office: A Situation Analysis of Reproductive Health Services and Utilization Patterns in Gezira State, Sudan	2009	Situation Analysis
Population Council West Asia and North Africa Regional Office: A Situation Analysis of Reproductive Health Services and Utilization Patterns in Kassala State, Sudan	2009	Situation Analysis
Population Council West Asia and North Africa Regional Office: A Situation Analysis of Reproductive Health Services and Utilization Patterns in South Kordofan State, Sudan	2009	Situation Analysis
Rahma: Reproductive Health KAP Survey among Communities Affected by Conflict in Darfur	2009	Report
SNAP: Desk Review of Literature on Stigma and Discrimination among HIV at Risk and Vulnerable Populations in Sudan	2009	Report
SPRINT: Training Report MISP	2010	Report
Sudanese Household Survey – Data used	2007	Statistics
UNFPA: Country Office Annual Report (COAR)	2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010	Management Report
UNFPA: Annual Work Plans with Implementing Partners	2005, 2006, 2007, 2010, 2011	Planning Documents
UNFPA/Italian Fund: Improving Maternal Health in Kassala: Strengthening Primary Health Care to Support Assisted Deliveries	2011	Report
UNFPA North Sudan Contingency Planning for Humanitarian Emergency Response	2011	Report
UNFPA: Revised MTR for UNFPA Country Programme	2011	Report
UNFPA: Darfur MTR: Darfur Humanitarian Program	2011	Report

UNFPA: GBV Prevention and Response Training Feedback Report	2011	Report
UNFPA: Joint Programme Results Framework with financial information	2011	Report
UNFPA: MHTF 2011 Progress Review including EmONC, Midwifery and Campaign to End Fistula	2011	Report
UNFPA: Reports on costing of Reproductive Health Roadmap for Blue Nile, Gadaref, Kassala, South Kordofan, White Nile	2011	Report
UNFPA: Reproductive Health Commodity Security (RHCS) Status Assessment in Sudan	2011	Report
UNFPA: Sudan Proposal to fight HIV/AIDS – Grant SUD-305-G04-H – Progress Report	2011	Report
UNFPA: Sudan: New Context, Old Problems – A quick look at the programming environment for UNFPA	2011	Presentation
UNFPA: Technical Report of Family Planning Training for GOAL Midwives in Kutum	2011	Report
UNFPA: UNFPA in Darfur: 2011 health priorities and needs for Reproductive Health support	2011	Report
UNFPA: UNFPA Sudan Strategic Planning Meeting 2011 – Presentation of Financial Performance and Operational Issues	2011	Presentation
UNFPA: UNFPA-HRU Sudan CO Reproductive Health/GBV Consultancy Report	2011	Report
UNFPA/Ministry of Social Affairs and Welfare: Progress Report in Gender Component	2010	Report
UNFPA/UNICEF Joint Programme on FGM/C: Accelerating Change – Annual Monitoring and Reporting Tool	2010	Report

UNFPA AWP: The Global Fund to Fight Malaria, HIV/AIDS and Tuberculosis, Northern Sudan SUD-506-G08-H5 – GFATM Round five	2010	Annual Report
UNFPA/UNICEF/Population Council et al: Policy Brief: Maternal and Neonatal Health Services in Sudan: Results of a Situation Analysis	2010	Report
UNFPA: Annex C: Expenditures report for funds allocated by TD under MHTF funds	2010	Report
UNFPA: Health Sector Information required for Mid Year Review of UN and Partners' Sudan Work Plan 2010	2010	Report
UNFPA: MDG Achievement Fund: Joint Programme Monitoring Report: Conflict Prevention and Peace Building	2010	Report
UNFPA: MHTF Results Frameworks, Indicators, Baselines and Targets	2010	Report
UNFPA: MHTF Results Frameworks, Indicators, Baselines and Targets (South Sudan)	2010	Report
UNFPA: Reproductive Health- HIV/AIDS Programme SDN5R43A – Progress Report	2010	Report
UNFPA: Reproductive Health Performance and Key Results of Reproductive Health Assessment – 2010	2010	Presentation
UNFPA: Southern Sudan Integrated MHTF. Report for 2010	2010	Annual Report
UNFPA: Southern Sudan Midwifery Report	2010	Report
UNFPA: Sudan Proposal to fight HIV/AIDS – Grant SUD-305-G04-H – Progress Report	2010	Report
UNFPA: The Maternal Health Thematic Fund (MHTF) – Sudan Proposal	2010	Report

UNFPA: UN Workplan Life-saving, comprehensive, and multi-sectoral prevention and response to GBV survivors in Darfur	2010	Report
UNFPA and Italian Development Cooperation Multi-sectoral Prevention and Response to Gender-Based Violence (GBV) Darfur - Mid-Year Progress Report	2009	Report
UNFPA AWP: SDN5R - FMoH- Output three	2009	Annual Report
UNFPA AWP: SDN5R11A - Blue Nile State MoH - Output one	2009	Annual Report
UNFPA AWP: SDN5R11A - FMoH - Output one	2009	Annual Report
UNFPA AWP: SDN5R11A - Kassala State MoH - output one	2009	Annual Report
UNFPA AWP: SDN5R11A - MoH Kassala - amount 66560-09	2009	Annual Report
UNFPA AWP: SDN5R11A - PG0003 - Output one	2009	Annual Report
UNFPA AWP: SDN5R11A - PG0003 - Output three	2009	Annual Report
UNFPA AWP: SDN5R11A - White Nile State - Output one	2009	Annual Report
UNFPA AWP: SDN5R22A - Kassala State MoH - output 2	2009	Annual Report
UNFPA AWP: SDN5R22A - MoH S. Kordofan - amount 71950	2009	Annual Report
UNFPA AWP: SDN5R22A - UNFPA Midwives Program	2009	Annual Report

UNFPA AWP: SDN5R22B - State Ministry of Health INGOS	2009	Annual Report
UNFPA AWP: SDN5R43A - Blue Nile State MoH - Output three	2009	Annual Report
UNFPA AWP: SDN5R43A - Kassal State MoH - Output three	2009	Annual Report
UNFPA AWP: SDN5R43A - MoH Gadarif - amount 13000	2009	Annual Report
UNFPA AWP: SDN5R43A - MoH S. Kordofan - amount 284315	2009	Annual Report
UNFPA AWP: SDN5R43A - S. Kordofan MoH - Output three	2009	Annual Report
UNFPA AWP: SDN5R43A – SNAP	2009	Annual Report
UNFPA AWP: SDN5R43A - White Nile State - Output three	2009	Annual Report
UNFPA/UNICEF Joint Programme on FGM/C: Accelerating Change – Annual Monitoring and Reporting Tool	2009	Report
UNFPA/IPPF/WHO et al: Rapid Assessment Tool for Sexual and Reproductive Health and HIV Linkages – A Generic Guide	2009	Report
UNFPA: Annual Review Meeting -2009, Gender Component Achievements	2009	Report
UNFPA: Country Annual Joint Reporting for the Thematic Funds, North Sudan	2009	Report
UNFPA: Country Programme Action Plan 2009-2012	2009	Strategic Document

UNFPA: Interim Report on Midwifery in Republic of Sudan	2009	Report
UNFPA: National Strategy Document for Scaling-up Midwifery in the Republic of Sudan	2009	Report
UNFPA: Reproductive Health Progress Report	2009	Report
UNFPA: Reproductive Health Progress Report	2009	Report
UNFPA: Technical Report 9th Fistula Surgery Campaign El Fasher, North Darfur, Sudan	2009	Report
UNFPA: Template for Country Annual Joint Reporting for the Thematic Funds (South Sudan)	2009	Template
UNFPA AWP: FMOH/UNFPA Project -Capacity development to Promote Reproductive Health SDN6R207	2008	Annual Report
UNFPA AWP: SDN6R203 - Gadarif State MoH	2008	Annual Report
UNFPA AWP: SDN6R203 - Gezira State MoH	2008	Annual Report
UNFPA AWP: SDN6R203 - Kassala State MoH	2008	Annual Report
UNFPA AWP: SDN6R203 - S. Kordofan State MoH	2008	Annual Report
UNFPA AWP: SDN6R203 - White Nile State MoH	2008	Annual Report
UNFPA AWP: SDN6R207 - Federal Ministry of Health	2008	Annual Report

UNFPA/GOS: Evaluation of 4th Country Programme 2002-2008	2008	Evaluation Report
UNFPA: Barriers to family planning in Sudan: The Case of White Nile, Kassala and Al Gadarif States 2008	2008	Report
UNFPA: Knowledge, attitudes and practices of Sudanese health care providers towards HIV/AIDS patients in health settings	2008	Report
UNFPA: Reproductive Health Annual Report for 2006. Darfur Emergency Program	2007	Annual Report
UNFPA/AECI: "Prevention and multi-sectoral response to the gender violence in Darfur"	2006	Report
UNFPA: Multi-Sector, Multi-Partner, Multi-Disciplinary Approach to Gender-Based Violence Prevention and Response in Darfur. An Overview	2006	Report
UNFPA: The Effects of Conflict on the Health and Well-being of Women and Girls in Darfur	2006	Report
UNICEF: Assessment of Village Midwives, in five states	2006	Report
UNFPA: Annual Technical Report. El Fasher Sub Office	2005	Annual Report
UNFPA: Annual Technical Report. South Darfur	2005	Annual Report
UNFPA: Annual Technical Report. West Darfur	2005	Annual Report
UNFPA/GOS: Review/Assessment and Realignment of GOS/UNFPA-Funded Component Projects	2003	Review/Assessment Report
UNFPA: Expenditures Report for Activities Against Thematic Trust Funds	2009-2010	Report

UNFPA: MHTF Review Annual Reports 2009/AWP 2010	2009-2010	Review Report
UNFPA/GoS: Country Programme Action Plan (CPAP)	2009-2012	Planning Document
UNFPA/GOS: Country Programme Documents (CPD)	2009-2012	Planning Document
UNFPA/White Nile State: A Situation Analysis of Reproductive Health Services and Utilization Patterns in White Nile State, Sudan	NA	Report

6.6 List of people interviewed

Name	Position	Organization/Unit
Khartoum		
Ibrahim Abdulrahman	Director	Academy of Health Sciences, Gedarif
Ali Daw Al beit	Health and Nutrition Officer	UNICEF – Kassala Branch
Aline Bizimana	Interim Operations Manager	UNFPA
Amira Mohammed	Reproductive Health Statistician	Ministry of Health – Gadaref State
Anas Jabir	Assistant Representative	UNFPA
Asha Ahmed	Assistant Health Visitor	Wad Sharefi Refugee Camp – Hospital, Kassala
Aziza Abd Alrahim	Nurse	Ministry of Health – Gadaref State
Dorithy Temu-Usiri	Program Specialist	UNFPA
Dr Abd Al Azeim Mohammed AbdAllah	Director General	Director General of Al Saudi Teaching Hospital
Dr Abd Al Aziem	Medical Doctor	Doka Hospital
Dr Abd Al Gader Mohammed Osman	Medical Director	OBYGN Hospital Gadaref
Dr. Abd Allh Al Bashier	PHC Director	Ministry of Health – Gadaref State
Dr. Ali Abd Al Rahman	Director General	Ministry of Health - Gadaref State
Dr. Amira Okod	Director	Fistula Center Kassala
Dr. Daffalla Alam Elhuda	Director	Academy of Health Sciences
Dr. Dina Sami	Assistant Professor; Director of Ahfad Project, Kassala	Ahfad University for Women
Dr. Hussien Ameen	MDR Resident Doctor	OBYGN Hospital Gadaref

Dr. Laila Tanions Gergis	Supervisor and Teacher	Academy of Health Sciences, Gadaref
Dr. Moataz Abd Allah Abd Al Hadi	Director General	Ministry of Health – Kassala State
Dr. Nada Yahya Hamza	National Program Officer	WHO
Dr. Nafisa M. Bedri	Associate Professor in Women and Reproductive Health, Director International Relations Office	Ahfad University for Women
Dr. Sami Al Safi	MDR Resident Officer	OBYGN Hospital Gadaref
Dr. Sami Mahmoud Assil	Technical Monitoring Manager	Japan International Cooperation Agency
Dr. Sawsan Eltahir Suleiman	Director of National Reproductive Health Programme	National Ministry of Health
Dr Shah Waliullah Siddiqi	Health Cluster Coordinator	WHO
Dr. Wisal Mustafa Hassan	Country Director	Health Alliance International
Dr. Hanan Abdo	Consultant for Maternal and Child Health	WHO
Dr. Muneer Mohammed Matar	Emergency Humanitarian Action/NGOs Coordinator	General Director State MoH, North Darfur, Officer in Charge
Ekhlas Hassan	Inspector Health Visitor, MW teacher	Ministry of Health – Gadaref State
Elqurashi Musa	Reproductive Health Officer	UNFPA
Gebriel Mohammed Ali	Health Information System Officer, Reproductive Health	Ministry of Health – Gadaref State
Hassina Mohammed Adam	Midwife	Wad Sharefi Refugee Camp – Hospital
Hibat Abbas	Program Assistant	UNFPA
Hisham Mohammed	Reproductive Health Officer	Gedarif
Jehan Hassan	PMTCT Counselor	Wad Sharefi Refugee Camp – Hospital
Juliana Lunguzi	International Country Midwifery Advisor	UNFPA

Khadija Siraj	Midwife	Wad Sharefi Refugee Camp – Hospital
Kidane Ghebrekidan	Reproductive Health Programme Advisor	UNFPA
Kriston Antonson	Health and Nutrition Officer	UNHCR Office East Sudan, Kassala
Lamya Badri	Gender Officer	UNFPA
Mathew Mpitapita	Humanitarian Affairs Officer, North Darfur	OCHA
Moamar Eltalib	Reproductive Health Officer	UNFPA Sub-office, North Darfur
Mohammed Abdalaziz	National Project Professional Personnel – Kassala State	UNPFA
Mohammed Abdulkareem	Reproductive Health Officer	UNFPA
Mohammed Ahmed	NPO	UNFPA
Mohiadin Abubaka	DDR Consultants	UNFPA
Mustafa Khogali	Professor	Ahfad University for Women
N/A	Head of Office	Relief International, North Darfur
Omer Gtayeb	Programme Associate	UNFPA
Pamela Delargy	Acting Representative	UNFPA
Prof. Amna E. Badri	Vice President Academic Affairs	Ahfad University for Women
Sally Ahmed	HIV Programme Officer	UNFPA
Sister Hikma Idris Elbanani	Deputy Reproductive Health Coordinator	SMoH, North Darfur
Zeinab Mohamed Ahmed	Director	Gadaref Midwifery School

6.7 Overview of UNFPA interventions in Sudan (2008-2011)

Annual Work Plans (AWP)

Component of CP	Implementing partner	Project/programme titles	Volume in US$ (contracted) from UNFPA	Year
reproductive health/ population and development	Federal Ministry of Information and communication	Advocacy for Reproductive Health and Population Issues (focus on Capacity development and Legislation)	246,405	2005
reproductive health	FMOH	Capacity development to Promote reproductive health	473,505	2007
reproductive health	FMOH	Capacity development to Promote reproductive health	1,038,200	2006
reproductive health	FMOH	Capacity development to Promote reproductive health	1,018,818	2005
reproductive health	FMOH and States MOH (Kassala, Gadarif, White Nile, Blue Nile, South Kordofan and South Darfur) and Abbo Fistula Center	CD to integrate maternal health (Increased capacity to integrate the full continuum of maternal health care in national health system)	1,046,433	2011
reproductive health	Sudan Fertility Care Association	Hag reproductive health Project (focus on Midwifery and Youth-Friendly Services (YFS)	150,000	2007
		Reproductive Health Activities in total:	**3,973,361**	
population and development	Ahfad University for Women	Integrated reproductive health, Gender, Equity, Equality and Women (focus on Capacity development and YFS)	160,000	2006
		Other	**160,000**	
	Juba Southern Sudan Field Office	(MHTF)	479,000	2011
		(MHTF)	857,043	2011
		(RHTF/MHTF)	1,122,496 (fund balances from 2009: 512,496)	2010

Note: These are not complete expenditures for the mentioned period, but just an indicative overview about the activities within the three components reproductive health, population and development and gender, according to the available Annual Work Plans.

Table 7: UNFPA Interventions in Sudan 2004-2010 (based on ATLAS data)

Time period	Programme name	Sectors/Issues Addressed	Volume in USD (paid in time period)
2007 - 2010	5th Sudan Population and Housing Census	Population, Data	1,4607,052
2010	Access to sexual reproductive health information	sexual reproductive health	178,049
2009 - 2010	Advocacy Women and Girls	Gender, Advocacy	434,800
2004 - 2007	Advocacy	Advocacy	671,091
2007 - 2010	Averting Maternal Death	maternal health/ reproductive health	1,750,135
	BSB Management	Management	3,326,336
2004 - 2009	Capacity development on Reproductive Health	reproductive health, Capacity development	5,952,010
2004 - 2006	Capacity development to End Obstetric Fistula	Capacity development, Fistula	210,227
2007 - 2010	Capacity development to Promote Reproductive Health	reproductive health, Capacity development	1,221,078
2008 - 2009	CD to Integrate Maternal Health	maternal health/ reproductive health	65,529
2008	CD to Scale-up HIV Prevention	HIV/AIDS	0
2004 - 2007, 2009	DAHAP		7,420,116
2007 - 2009	Emergency Reproductive Health Programmes	reproductive health	5,279,668
2009 - 2010	Enhancing Capacity - HIV Prevention	Capacity development, HIV/AIDS	3,218,717

2008	FGM/FGC Programme	FGM	194,475
2004 - 2007	Gadarif Reproductive Health	reproductive health	242,422
2007 - 2010	GBV Prevention and Response	Gender-based Violence	3,096,176
2007 - 2009	Gender and Women Empowerment	Gender, Empowerment	505,285
2009 - 2010	Gender-based Violence Prevention	Gender-based Violence	3,241,770
2004 - 2007	Hag Reproductive Health Project	reproductive health	270,119
2004 - 2009	HIV/AIDS Advocacy Project	HIV/AIDS, Advocacy	287,540
2009 - 2010	Improving Capacity to Collect Data	Capacity development, Data	3,665,060
2009 - 2010	Increasing Utilization of MHS	maternal health/ reproductive health	1,156,483
2009 - 2010	Institutional Capacity on Gender	Capacity development	308,310
2007 - 2010	Integrated Reproductive Health Services	RHS	150,550
2004 - 2007	Kassala Reproductive Health	reproductive health	191,141
2004	Kordufan Integrated Reproductive Health Project	reproductive health	8,010
2007 - 2009	M&E of NPP/POA Implementation	M&E	221,914
2004 - 2007	OPEC HIV/AIDS Prevention	HIV/AIDS	221,572
2004 - 2007, 2009	PDS/Reproductive Health Project	reproductive health	406,783
2004 - 2008	Refugees	Refugees	592,565
2009 - 2010	Reproductive Health	reproductive health	6,231,876

2009 - 2010	Response To Gender Based Violence	Gender- based Violence	367,923
2006 - 2007, 2009	Reproductive Health and GBV Prevention Activities	Gender-based Violence	316,883
2007	Reproductive Health for Young People	reproductive health, Adolescents	38,175
2004	Reproductive Health Project in Khartoum	reproductive health	0
2007	Reproductive Health, Reproductive Rights Policy and M&E	reproductive health Policy, M&E	0
2007	RHCS for ACP Countries	RHCS	14,301
2007 - 2010	Scaling up for HIV/AIDS	HIV/AIDS	1,574,614
2009	Scaling-up HIV/AIDS Services	HIV/AIDS	182,781
2009 - 2010	Securing Integrated Reproductive Health Package	reproductive health	2,291,123
2004 - 2007, 2009	STIS/HIV/AIDS Prevention	STI/HIV/AIDS	1,120,220
2009 - 2010	Strengthening Responses to GBV	Gender-based Violence	367,269
2008	Support for NIIS and Census	Data	0
2008 - 2010	Tools and Guidelines (including RHCS)	Tools, RHCS	15,385
2004 - 2007	Women Empowerment Project	Gender, Empowerment	198,434
		Total	**71,868,934**