Country Programme Action Plan Between

UNFPA

And the Government of Sudan

(2013 – 2016)

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List of Acronyms and Abbreviations

AIDS	Acquired Immune Deficiency Syndrome
AYSRH	Adolescent Youth Sexual Reproductive Health
BCC	Behavior Change Communication
CBS	Central Bureau of Statistics
CCA	Common Country Assessment
CO	Country Office
CMR	Clinical Management of Rape
CP	Country Program
CPAP	Country Program Action Plan
CPD	Country Program Document
CPR	Contraceptive Prevalence Rate
CSOs	Civil Society Organizations
DRA	Darfur Regional Authority
DEX	Direct Execution
EmONC	Emergency Obstetric and Neonatal Care
eMTCT	Eliminate mother to child transmission
FGM/C	Female Genital Mutilation/ Cutting
FP	Family Planning
GCA	Government Coordinating Authority
HACT	Harmonized Approach Cache Transfer system
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
ICPD	International Conference on Population and Development
IP	Implementing Partner
LMIS	Logistics Management Information System
MARPS	Most At Risk Populations
MISP	Minimal Initial Service Package
MDG	Millennium Development Goal
MDR	Maternal Death Review
M&E	Monitoring and Evaluation
MMR	Maternal Mortality Ratio
MNMR	Maternal Neonatal Mortality Rate
MOGE	Ministry of Guidance and Endowment
MOH	Ministry of Health
MOF	Ministry of Finance
MoWSS	Ministry of Welfare and Social Security
MoYS	Ministry of Youth and Sports
NCCW	National Council for Child Welfare
NEML	National Essential Medical List
NEX	National Execution
NGO	Non-Governmental Organization
NPC	National Population Council
NSDS	National Strategy for the Development of Statistics
NSS	National Statistical System
OF	Obstetric Fistula
P&D	Population and Development
PMTCT	Prevention of HIV from mother to child transmission
PNC	Post Natal Care
PRA	Participatory Rural Appraisal
PRM	Program Result Manager
PRSP	Poverty Reduction Strategy Paper
RH	Reproductive Health
RHC	Reproductive Health Commodity
RR	Reproductive Rights
RRF	Results and Resources Framework

SAI	Supreme Audit Institution
SBA	Skilled Birth Attendant
SP	Strategic Plan
STI	Sexually Transmitted Infection
TFR	Total Fertility Rate
UNDAF	United Nations Development Assistance Framework
UNCT	United Nations Country Team
UNDP	United Nations Development Program
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
VAW	Violence Against Women
VG	Vulnerable Groups
VMW	Village Midwives
WEP	Women Empowerment Policy
Y-Peer	Youth Peer Education Network

The Framework

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

Furthering their mutual agreement and cooperation for the fulfillment of the Program of Action of the International Conference on Population and Development (1994);
Building upon the experience gained and progress made during the implementation of the 5th Country Program and previous Programs of Cooperation between the Government and UNFPA, the priorities identified in the United Nations Development Assistance Framework, the 2012-2016 Five Year National Development Plan and the UNFPA revised Strategic Plan;
Entering into a new period of cooperation as described by the Sixth Country Program 2013-2016;
Declaring that these responsibilities will be fulfilled in a spirit of friendly cooperation and accountability;
Have agreed as follows:

Part I. Basis of Relationship
The standard Basic Agreement (SBAA) between the Government and United Nations Development Program (UNDP), signed on 24th October 1978 and ratified by the Government of Sudan on 2nd January 1980 constitute the legal basis for the relationship between the Government of Sudan and UNFPA.

Part II. Situation Analysis

1. During the past CPAP cycle, Sudan has gone through a **dramatic political change with the separation of South Sudan, ,**and now has a **new socio-demographic profile.**. While the situation in Darfur calmed and allowed for some returns and recovery, **new tensions** in the border areas with South Sudan resulted in significant population displacement and the declaration of South Kordofan and Blue Nile as emergency states.
2. The separation was accompanied by a **severe economic downturn**, jeopardizing many development efforts. Post secession, Sudan lost most of its oil resources – the major income earner – as well as other natural resources.. The country is now left with 25% of forest and 75% of the population[1]. The unemployment rate is at 26%, with 46.5 % of population living below poverty line[2]. In 2011, Sudan ranked 169 out of 187 countries in the 2011 Human Development Index[3].
3. Significan**t population migration** is a tradition in Sudan and intensified during the past cycle; an estimated two million South Sudan returnees transited through White Nile and South Kordofan states and about half a million people were displaced or severely affected by conflicts in the three protocol areas[4]. Meanwhile, 1.7 million internally displaced people (IDP) still reside in camps in the now five states of Darfur[4]. These movements are in addition to the regular migration of the nomadic groups (nearly 10% of the national population) and already heavy seasonal and labour migration.
4. Environmentally, consistent **depletion of natural resources** and urbanization has resulted in increased deforestation rates from 0.7% to 2.2% [5] and desertification continues to affect the northern parts of the country. Seasonal natural disasters such as floods occur in most regions in Sudan.
5. According to the 2008 census, Sudan had a population of 30.9 million. The **population profile** is mostly rural (58%) and young (62% below 25 years and 43% below 14 years of age) with almost an equal gender distribution (51% males and 49% females)[6]. The population growth rate is 2.5% and, if sustained, will double the population by 2037[7].

1 National Forestry Report 2011
2 Sudan National Budget Household Survey 2009
3 UNDP 2011 Human Development Report
4 OCHA 2012
5 National Forestry Report 2011
6 2008 CBS National Census
7 Ibid

6. **Maternal health** is poor in Sudan. The current national maternal mortality ratio of 216 maternal deaths per 100,000 live births has wide interstate variations and is one of the highest rates in the region.. Maternal morbidity and mortality is linked to the weak status of health system building blocks[8] (service delivery, workforce, medical products, health information system, governance and health finance) and socio-cultural factors.
7. **Service delivery:** Reproductive health indicators show that 47% of pregnant women receive four or more ANC visits, but quality of care is inadequate. Less than 60% receive blood pressure measurement, blood or urine investigations. Seventy three percent of deliveries are assisted but most of these are by village midwives. Only 21% of deliveries take place at the health facility level. Only 18% of women who delivered receive postnatal care[9 10]. The quality of service packages is weak; nationally only 19% of primary health-care facilities provide the minimum health-care package and only 66% of rural hospitals can offer basic emergency obstetric and neonatal care[11]. The coverage of health services is not equitable; facilities[12] and health providers are heavily concentrated in urban areas[13]. There are also nomadic groups, which make up 9% of the country's population, have poor access to basic services and the poorest health indicators. Those living in inaccessible geographical area or in conflict zones also cannot access services. Overall, about a quarter of the Sudanese population is unable to access health facilities.
8. **Workforce:** The gap in human resources for health is huge, especially for the nurses, midwives and medical assistants. The National Health Strategic Plan of 2004-2013 estimates a gap of 80,000 nurses, 14,500 midwives and 20,000 medical assistants. The number of midwifery graduates has been on a general decline since 2005 and those who have graduated do not meet the international standards for professional midwives[14]. The 2009 -2011 Maternal Death Review and the 2012 midwifery assessment identified gaps both in facility care and in midwifery education/skills.. A national strategy for raising the midwifery profession up to the international standards is in place but needs effective implementation to address the number and distribution of midwives and the quality of midwifery skills.
9. **Medical products:** The Reproductive Health Commodity Security (RHCS) program faces many challenges. The logistics management and distribution system of commodities such as contraceptives and medications for emergency obstetric care is inadequate, fragmented and not fully linked with the essential drugs logistic system. Sudan is still completely dependent on multilateral and bilateral donors to fulfill its contraceptive needs with UNFPA taking the lead role.
10. There has been modest progress in contraceptive prevalence rates (CPR) from 7.7% to 9%[15], but the unmet need for family planning (23.8%)[16] remains high. The low CPR rate is not only attributed to the weak quality of services and inconsistent commodity availability but also to lack of community knowledge or even negative cultural attitudes towards use of family planning.
11. **The health information system (HIS)** is composed of several vertical information systems, does not include data from the private sector, and is centralized and only weakly established at state and locality levels. Data sources are primarily health facilities, with minimal data on community (socio-cultural determinants). The quality of the HIS is affected by non-regular reporting frequency, low availability of registration books and lack of trained staff. In addition, there is limited dissemination and utilization of the annual statistical reports at the state and locality levels[17]. This has resulted in the dependency on census and surveys for data on major morbidity and mortality trends.
12. **Health system governance:** Sudan has undergone several health system reforms and currently has a three tiered system: the federal level is responsible for policy making, planning, supervision, co-ordination and

8 WHO Health System Framework
9 Sudan Household Survey 2006
10 Sudan Household Survey 2010
11 2011 National Health Service Mapping Survey
12 2012 Sudan Health Equity Report
13 Sudan Household Survey 2010
14 Situational Analysis of Ministry of Health Midwifery Education in Sudan, 2012
15 Sudan Household Survey 2006 and 2010
16 Sudan Household Survey 2010
17 2007 Sudan Health Information Review

standard setting; the state level for planning, policy making and implementation; and the locality level for policy implementation and service delivery. The structures and functions at the locality level are the least developed and suffer high staff turnover due to poor working conditions and also sometimes from the frequent political restructuring in locality subdivisions The current national strategic direction for health (2012-2016) puts emphasis on decentralization and badly needed integration of vertical programs.. In addition, the national Roadmap for Reducing Maternal and Neonatal Mortality provides a very good framework for integrated action for improving maternal and neonatal health. The integration process is in its early phases but evidence shows promising results, as also seen in UNFPA efforts on RH/HIV integration.

13. **Health finance:** The Government's spending on health has increased marginally from 7% to 9% of public expenditure[18] and remains extremely low. Most health care costs are out of pocket costs. Only 2% of the health budget is allocated for Maternal Child Health and 0.3% for Reproductive Health. Advocacy efforts are required to increase government's investment in health overall and in reproductive health, in particular. Initiatives like the International Health Partnership Plus and the Campaign to Accelerate Reduction of Maternal Mortality, of which Sudan is a member, can provide new opportunities to seek additional resources for health.
14. **Socio-cultural determinants** such as poverty, harmful traditional practices (e.g. Female Genital Mutilation/Cutting (FGM/C) and child marriage), and gender inequalities in education and employment contribute to maternal morbidity and mortality in Sudan. There is a limited body of evidence linking sociocultural determinants with maternal health in Sudan. However, existent indicators indicate a wide gender gap[19], which is further exacerbated in conflicts settings. FGM/C rate is still high at 66%, with about half of women (48%) in reproductive age willing to continue this practice[20]. Eighty-nine percent of females and 93% of males confirm the presence of gender-based violence in communities[21]. In comparison to men, women are less likely to be educated (51% versus 39%) and half as likely (55% versus 20%) to be employed[22]. Nevertheless, there are growing efforts from the government and civil society to address gender gap issues such as ratified human rights declarations and frameworks, development of policies (e.g. Women Empowerment Policy), and establishment of structures and mechanisms (Gender and VAW units) within governmental institutions. Child marriage has been on a decreasing trend. This is illustrated by the reduction of marriage rates before the age of 15 years from 12% down to 9.5%[23]. The upcoming expected parliamentary approval for increasing the minimum legal age of marriage may also facilitate a further decrease in child marriage trend.
15. The **HIV epidemic** in Sudan is concentrated among Most at Risk Populations (MARPs); the prevalence is only 0.7%[24] among the general population. However, here is a real danger of HIV transmission cross over into the general population since considerable proportion of MARPs are married. In addition, HIV comprehensive knowledge among most at risk populations is found to be less than 50% with low consistent use of condom (<30%). If no effective preventive measures are made, the HIV epidemic will be generalized by 2015 (1.12%)[25]. Nationally, HIV interventions have been carried out vertically but UNFPA has takena lead role in providing evidence and implementing pilot RH/HIV integrated models in four target states (Khartoum, Kassala, Gedaref and Blue Nile). The challenge now is to strengthen and establish structural mechanisms within ministries of health. Moreover, HIV stigma in Sudan remains high, the 2011 HIV stigma index survey found high levels of stigma among health care providers and within the general population.

18 National Health Account Survey
19 UNDP 2011 Human Development Report
20 Sudan Household Survey 2010
21 2009 Violence Against Women Survey
22 2008-2009 UNDP Human Development Report
23 2006 and 2008 Sudan Household Survey
24 2012 EPP Estimated Projections
25 2012 EPP Estimated Projections

16. The **youth**[26] in Sudan make up a significant proportion of the population. The15-35 and 10-35 age groups make up 34% and 46% of the total population respectively[27]. The youth reproductive needs, rights and civic/social participations have not been prioritized. About half of adolescents (48% of 12-19 age bracket) are married and 95% have no access to family planning. About a quarter of adolescents do not receive ANC visits and 18-26% of them are reported to have used traditional birth attendants during delivery[28]. All these factors increase youth's risks of early pregnancy and related morbidities e.g. obstetric fistula (OF) and maternal mortality. The 2010 RH Adolescent Survey found that 52% of adolescents experience gender-based violence, 11% are sexually active and only a quarter (26%) knows that HIV can be transmitted sexually. Poverty status of youth difference is wide in urban settings (25%) compared to rural settings (50%)[29]. There is limited data on social and civic participation; available data shows that 47-57%[30] of youth in Kassala and Gedaref states participate in social activities. The revised 2010 National Youth Strategy has identified several priority areas, but unfortunately its plan has not been fully implemented because of funding problems.
17. In summary, the Government has taken **positive steps to address development challenges** in the Interim Poverty Reduction Strategy Paper (PRSP) (2011) and the National Development Plan (2012-2016). The evolving situation in Darfur has also led to an increased emphasis by national and international actors on promoting early recovery, durable solutions and transition from relief to development, alongside continued humanitarian assistances where needed. The signing of the Doha Darfur Peace Document (DDPD) on 14 July 2011 and the establishment of the Darfur Regional Authority (DRA) in February 2012 have provided further impetus to step up recovery and durable solutions in the region.
18. Despite these favorable developments, the humanitarian situation in Sudan remains unstable due to recurrent conflict and natural disasters, creating new, on-going vulnerabilities and humanitarian need. There is a continuous interface between humanitarian and development phases underscoring the need to achieve a smooth transition from humanitarian phase, to recovery and long-term development. Furthermore, developing the capacity of the Government to generate quality data through a more unified database, data analysis and use for policy making, planning and programming will be crucial for making development plans effective.

Part III. Past Cooperation and Lessons Learned

19. The fifth UNFPA Country Program (CP) (2009-2012) had a total budget of $33 million and interventions based on the Common Country Assessment (CCA-2008), UNDAF (2009-2012) and UNFPA Strategic Plan (2008-2011). The CP consisted of three distinctive components; 1) Reproductive Health and Rights; 2) Population and Development; and 3) Gender, with crosscutting issues such as human rights based approach, gender mainstreaming, and emergencies and humanitarian response. Program activities were mainly implemented in five focus states namely Kassala, Gedaref, South Kordofan, White Nile and Blue Nile but a large humanitarian programme was also carried out in Darfur.
20. The final evaluation of the fifth CP indicated a high rate of achievement for all components. Some of the programmatic **achievements** and **best practices** were: (a) **Reproductive Health** – The revision of the Reproductive Health Policy; development of the National Strategy for Scaling up Midwifery and the initiation of professional midwifery trainings; the launch of the 2010-2015 Roadmap for Reducing Maternal and New-born Mortality, and the RHCS Strategic Plan. Bio-behavioral and operational research supported provided evidence-based planning and technical assistance within the RH and HIV directorates as well as to the midwifery education program at federal and state levels. The umbrella partnership modality for the implementation of HIV programmatic activities was found to be a best practice for inclusiveness and expansion of existing partnerships. In addition, work with civil society organizations on issues related to gender-based violence, early marriage and HIV/AIDS proved to be a self-sustaining strategy for the community outreach. (b) **Gender** – The development of a national plan to combat gender-

26 Youth African Chart definition
27 Sudan National Budget Household Survey 2009
28 Sudan Household Survey 2006
29 2009 NBHS
30 2008 Elias et al

based violence; the criminalization of female genital mutilation in four states and its abandonment in a number of communities; and the establishment of VAW units and gender focal points (GFP) were all accomplished.. The VAW units and GFP have brought gender issues to the forefront of national development plans in different sectors. In Darfur, the Wali Advisors on Women and Children were significant in raising awareness of GBV issues there and establishing services. Two best gender practices were identified: 1) partnerships with religious and community leaders were instrumental for effecting change in gender based violence issues within communities; and 2) partnership with academic institutions on researches was found to be a cost effective way to generate data on population, RH and gender issues (c) **Population Development** – The adoption of 2007-2031 National Youth Strategy, establishment of youth networks and the analysis and availability of census data from all 15 states are a few of achievements in the past cycle. In addition, the national population policy was revised. (d) **Emergency preparedness**– Given the regularity of natural disasters and conflict displacement in the country, the strengthening of government and NGOs' capacity for reproductive health emergency preparedness in 11 states and legalization of the immediate delivery of medical services to survivors of sexual violence were also significant accomplishments. .

21. There were several **challenges** faced in the development and implementation of the fifth CP. Eruption of conflict and inaccessibility of many areas impeded programme interventions and also sometimes dampened donors' commitment/funding and reduced the number of implementing partners. In addition, because of the unique context of Sudan during the past CP cycle, the coordination of development interventions faced many challenges. Frequent restructuring of governmental institutions at all levels and high turnover of staff within various ministries have reduced the government's implementation capacity and pace in some activities. The integration of population dynamics into development planning processes was poor because of the obsolete population data, conflicting multiple data sources, and weak institutional capacity of partners. There was limited ownership and buy in for RH and HIV integrated activities at federal, state and locality levels. Finally, the limited youth's capacity in planning, implementation and management of their activities hindered full ownership of the National Youth Strategy. Because of the weak HMIS, paucity of data and absence of UNFPA baseline indicator survey, the M&E component of the past CP was not able to include all baseline indicators for program outputs and targets, making it difficult to monitor and attribute results to CP activities.
22. There were several **lessons learnt** from the overall programming and from each program component throughout the past cycle. The overall program design and its implementation modality were not well-coordinated and integrated as activities from the three program components did not support each other as much as they could have. in an effective manner. In the regular programme, resources were spread too thin over a wide geographical coverage of implementation to effectively yield tangible results. In addition, the lack of coordination between development and humanitarian activities made it difficult to directly attribute interventions to program outcomes. Capacity building activities through training were found inadequate and required more actual practice and on-the-job mentoring to consolidate the theoretical skills.
23. This proposed CP will have an integrated top-down and bottom-up approach that will synergistically bring together reproductive health and rights, population and development, gender, HIV, RH contingency planning and preparedness in one package. Programmatic activities will be based on best practices, lessons learnt and countering some challenges faced from the last cycle.

Part IV. Proposed Program

24. This proposed program **design and content** take into consideration the country context and existing national priorities and strategies, as well as the achievements/best practices, challenges faced and lessons learnt from the past fifth country program detailed in Part II and III respectively. The guiding principles in this program development are equity promotion, human rights, and population development, with capacity building being an essential cross cutting component.
25. The **overall objective** of this program is to contribute to UNFPA 2011-2013 strategy's goal of **achieving universal access to sexual and reproductive health, promoting reproductive health rights, reducing maternal mortality and accelerating progress on the ICPD agenda and MDG 5** (A and B) of women and youth.
26. The proposed CP for the 6th cycle will address both **development and humanitarian integrated interventions in a tiered manner**. The focus at the national level will remain the same; that is supporting the development and implementation of policies, strategies and advocacy on RH, HIV and gender issues; procurement of RHCs; and HIV interventions targeting most at risk populations (top-down approach).

While at the state level, support to Emergency Obstetric and Neonatal Care (EmoNC), OF, FP and midwifery education will continue. The focus at the locality/community level will be the implementation of an integrated package of RH/HIV and Gender services, and for generating data and model approaches that feed into advocacies, policies, strategies, and planning and programming (bottom-up approach).

27. Reproductive health and rights, population and development, gender, HIV, and emergency contingency planning and preparedness are all addressed synergistically in the six interrelated program outputs. These programmatic outputs are all linked to the seven outcomes of the national development plan; four focus areas of the interim PRSP, six outcomes of the UNFPA strategic plan, and seven UNDAF outcomes. Kindly refer to Annex 1 and 2.
28. **Target population:** Priority intervention areas on maternal health and gender will focus particularly on women, youth and vulnerable populations (the poor, rural communities, nomads, conflict-affected and internally displaced people, ex-combatants, disabled, most at risk populations for HIV, and people living with HIV/AIDS).
29. **Geographical coverage:** UNFPA will establish its interventions and presence in ten states as an initial phase for the CPAP implementation, namely the five Darfur states, Blue Nile, White Nile, South Kordofan, Kassala and Gadarif. The selection of the ten states was based on UNFPA geographical coverage in the 5th CP cycle. These states were identified as the most vulnerable and in need of integrated interventions to bring about the desired change. The expansion of the interventions and presence in additional states will be determined based on needs and availability of resources. Integrated community program activities will be implemented in a phased approach, starting with six localities namely Rural Gedarif, Rural Kassala, Gabalain, Kass, Genaina and Rural Elfasher". Upon successful implementation, the program will be expanded to more localities. The selection of localities is based on several criteria, such as poor maternal health outcomes, high proportion of underserved populations, availability of systems in place needed for the comprehensive multi-sector humanitarian response, accessibility, security, political commitment, and availability of national NGOs.
30. **UNFPA** has several **competitive advantages** to implement the 6th Country Program. Firstly, it has technical expertise at field, CO, regional and HQ levels on reproductive health/rights, HIV, women, youth, gender (including GBV), population and environmental issues in both development and humanitarian settings. Secondly, the availability of comprehensive data generated from previous cycles (e.g. Population Census 2008, Sudan Household and Health Survey 2010, Integrated Bio-behavioral Survey (IBBS) 2011). Documentation of best practices as detailed in Part III will be enhanced further through South-South Cooperation in this cycle to promote the efficient implementation of activities. Thirdly, UNFPA has wide field presence and ability to rapidly scale up operations on need basis. Fourthly, the established networks of partners (government, civil society and community groups –youth, women, etc.), with growing organizational and technical capacity, will facilitate efforts to improve the quality of interventions. Finally, the strengthened capacity of different national partners achieved in previous cycles will be further enhanced in this cycle. This is a key strategy that promotes national self-sustainability and facilitates UNFPA's programmatic exit strategy.
31. **Program Outputs and Strategic Interventions/Activities:** This program has six outputs which address the health system building blocks and socio-cultural factors affecting the reproductive health of women, youth and vulnerable populations, including most at risk populations for HIV and people living with HIV/AIDS. Three of the outputs (**2, 3 and 4**) focus on **increasing demand and use of/access to information and services related to reproductive, maternal and newborn health, HIV prevention, and family planning.** Because of the emerging humanitarian crisis and increasing poverty and its expected results in **gender inequities** (e.g. child marriage, gender-based violence, etc.), output (**5**) is specifically earmarked for this area. However, this does not preclude its inter-relation between other outputs. Finally, the two remaining outputs (**1,6**) focus on capacity building to incorporate **population dynamics, including its linkages with RH, into policies and development plans,** with special attention to the needs of **young people and women** in order to **generate and utilize quality data** on maternal health.
32. **Capacity building** is a pivotal element in all outputs. The type of capacity development interventions is based on findings from the past experience and planned assessments of implementing partners. The interventions target all levels, i.e. national, state and locality levels. Activities include formal trainings, on-the-job mentoring, experience sharing through field visits, review meetings or conferences at local, regional and international levels, and provision of

technical assistance and operational support. Due to high staff turnover and institutional changes of national partners, rapid assessments are planned to take place during the life cycle of this program in order to monitor changes and to allow interventions in a timely manner.

33. **Partnerships** with the government, non-governmental organizations and UN agencies are an essential component of this program and will be continued, either strengthened or initiated at all levels as detailed in Part V. Effective coordination mechanisms for the planning and implementation, such as regular review meetings, are planned for.
34. **CPD Output 1** has five strategic interventions and aims to **strengthen the national capacity to incorporate population dynamics, including its linkages with reproductive health, into relevant policies and development plans, with special attention to the needs of young people and women.**
35. *Strategic intervention 1 (a) Building capacity in population analysis and the use of data in planning:* Activities of this intervention are based on the past experience and planned assessments on institutional and human capacities in population analysis, data use, and level of incorporation of population dynamics and environmental issues into national/state policies and strategies. Based on findings, support will be provided in the form of either funding, systems strengthening, provision of expertise or equipment, or organization of/participation in population conferences.
36. Decision makers, civil society organizations and community will be sensitized on population and environmental issues through the repackaging and production of policy briefs, population education, and advocacy activities.
37. Trainings in demographic and priority areas of population, policy analysis, population projection (SPECTRUM), statistical analysis (SPSS), population and gender-sensitive planning will be offered to partners (data producers and users).
38. *Strategic Intervention 1(b) Strengthening the management and advocacy capacity of youth-serving organizations:* UNFPA will assist the establishment of organizational structures and systems of youth-serving organizations and institutions by supporting its infrastructure and functionality. This will be achieved through human resource capacity building and the provision of necessary supplies/equipment. Training and on job mentoring on leadership, management, advocacy, communication/social media, peer education and community mobilization/sensitization skills will be offered.
39. *Strategic Intervention 1(c) Supporting the coordination and networking among youth organizations and women's organizations:* A mapping and classification exercise of existing nation-wide youth and women organizations will be carried out. UNFPA will support periodic forums and meetings to facilitate information exchanges, thematic activities, and trainings in networking and communication/social media skills.
40. *Strategic Intervention 1(d) Supporting livelihood and life-skills training for young people addressing employability, gender and reproductive health concerns:* Strategic partnerships will be built with potential partners, e.g. UNICEF and ILO for joint youth programming. Studies will be undertaken to identify young people needs and marketable skills, and to build a youth-friendly market information system. Context-sensitive, integrated training packages, such as life skills and "know about business" (KAB) vocational trainings and career counseling, will be developed and implemented. Enrollment of targeted youth groups in training institutes (e.g. vocational training centers) for livelihood skills will also be supported. In addition, support will be provided to innovative youth-led initiatives.
41. Finally, youth center facilities will be supported so that the centers become an attractive space for gathering, learning (employability, gender, RH concerns), counseling, and receiving integrated services and information. This activity synergizes with outputs 3(h), 3(i), 3 (j) and 5 (all of its strategic interventions).
42. *Strategic Intervention 1 (e) Promoting civic participation and social responsibility:* At the national level, UNFPA will support the development and productions of materials that promote civic education, and disseminate publications through seminars and forums. Civic and citizenship education will be advocated for its integration into the school formal and extracurricular activities.
43. Skills training on social peace and dialogue, youth-adult partnership, social exclusion analysis, social action programming/planning, community mobilization, rights-based approach, peer education, voluntary/humanitarian work, civic education, and RH/HIV will be provided to youth leaders and institutions (including youth centers and school clubs). Support will be provided to youth initiatives and interventions that promote civic participation and social responsibility such as youth camps, cultural events and competitions/quizzes. Finally, a joint program on outreach built on Y-PEER methodology will be established to sensitize communities, particularly on gender issues and socio-cultural determinants of maternal health.

44. **CPD Output 2:** This output has five strategic interventions that will **increase demand for information and services related to reproductive, maternal and newborn health, and HIV.**

45. *Strategic intervention 2 (a) Implementing a strategic Communication for behavior change and development:* An overall review of the RH communication strategic plan (2008-2011) will be carried out. To ensure an integrated communication approach that encompasses RH, HIV, Humanitarian and Gender issues, revisions will also focus on its alignment with other related strategies/policies, e.g. Women Empowerment Policy, HIV strategy, FGM/C strategy, Gender strategy, etc. In addition, the utilization and effectiveness of currently available strategic communication for behavior change materials targeting all beneficiaries/users will also be evaluated and/or revised based on needs assessments carried out in the previous cycle.

46. Integrated communication packages that address RH, HIV, gender, youth and population issues will be developed for different types of target audience at all levels. Beneficiaries will include religious leaders, decision-makers, public figures, law enforcers, community leaders, youth, health care providers, MARPs, vulnerable populations and the general population. Different research and evaluation methodologies will be carried out to assess newly developed integrated packages and to identify any additional needs of the targeted populations and make necessary modifications.

47. Capacity building activities targeting different implementing partners like government counterparts, religious leaders, media, CSOs, youth groups, associations and CBOs will be carried out in areas such as advocacy, communication skills, and Behavior Change Communication program design in the context of an overall “enabling environment” that caters for political and economic factors, religion, traditions, norms, values, attitudes, etc.

48. Finally, media and advocacy activities will be expanded at all levels, for example, regular update of electronic web sites, and development, printing and distribution of BCC materials, etc.

49. *Strategic intervention 2(b) Addressing the stigma associated with gender-based violence (GBV), obstetric fistula (OF) and HIV:* Religious dialogue fora will be held to discuss varied religious interpretations of all forms of GBV (including FGM/C and child marriage) and their consequences such as OF; as well as issues of HIV prevention interventions (e.g. condom programming) and stigma in the community. This will not only raise awareness on the diversity of negative attitudes towards these issues but will also provide an opportunity to reach a consensus, reduce associated stigma among religious leaders, and influence law revision/endorsement, policy making/implementation and community attitudes and practices.

50. Advocacy skills strengthening will be used to build on outcomes of strategic intervention 2 (a) targeting religious leaders, decision makers, public figures, law enforcers, community leaders, health care providers and the community. The aim is to develop a critical mass of advocates (against GBV and de-stigmatization of OF and HIV) who are active at the community level.

51. Support for the re-integration of GBV survivors/ex-combatants, people living with HIV/AIDS and OF patients into the community will also be provided.

52. *Strategic intervention 2(c) Strengthening knowledge regarding sociocultural determinants to guide reproductive health interventions:* The current maternal mortality reduction council/committee will be adapted and expanded to include socio-cultural and economic determinants on maternal health at federal, state and community levels.

53. A review of the past and current RH/HIV/GBV interventions relevance and effectiveness on socio-cultural determinants will be carried out. Utilization of existing or additional research on sociocultural determinants on RH/HIV/GBV services to improve on current services or develop new ones.

54. Media campaigns on socio-cultural determinants and their linkages with maternal health, gender and HIV mortality —such as health seeking behavior, birth planning, FGM/C, child marriage, will target populations like decision makers and implementers (health providers, media, NGO, CBOs). Different media messages and communication methods will be used, for example, films, open days, cultural bands, mobile youth RH drums, songs, role plays, local radio).

55. *Strategic intervention 2 (d) Enhancing community mobilization to address gender-based violence and create gender-responsive referral mechanisms to promote reproductive health and prevent HIV:* The community role is instrumental for the sustainability of this activity. Therefore, much focus will be put into community empowerment and women groups. This will include strengthening community participation (e.g. community-based committee) and management of community based referral mechanisms.

56. Youth (Y-peer), community leaders, midwives and law enforcers will also be engaged in the creation of an integrated GBV/RH/HIV/OF) responsive referral mechanism. This will include mechanisms such as the GBV satellite trauma centers at locality level, Safe Motherhood for Youth, and GBV community forums

and CBOs and their linkages to law enforcers, etc. Community participatory monitoring systems will also be established. The organizational and functional capacity to address GBV and referral systems will be strengthened at federal (Ministries of Justice, Interior and Security/Social welfare) and state levels.

57. *Strategic intervention 2(e) Supporting advocacy and policy dialogue to implement policies regarding reproductive health and HIV:* Joint mechanisms to support regular coordination, monitoring and evaluation meetings will be held with concerned line ministries, NGOs, CBOs, and other partners at national and state levels.
58. At national level, support for the review and dissemination of policies and strategies will be provided to decision makers, parliamentarians, members of state legislative councils, and communities/general population. A few examples of policies and strategies include the Women Empowerment Policy, recruitment of midwives, health fee subsidies, and roll out of the "HIV test opt-out" approach for women of reproductive age.
59. At national, state and locality levels, skills on leadership, lobbying/advocacy and policy communication will be built for partners such as the Sudan Midwives Association, etc. While at community level, generation of data and use of evidence, data or stories will be supported to inform and guide evidence based policy dialogue (– bottom-up approach).
60. **CPD Output 3:** This output has ten strategic interventions that aim to **increase availability of high quality information and services for maternal and newborn health and HIV prevention, especially for underserved populations and people with special needs.**
61. *Strategic intervention 3 (a) Strengthening the management of the reproductive health program:* The MNMR road map will be reviewed and regularly monitored to assess progress, update/modify where necessary, and develop annual operational plans at national and state levels.
62. Skills building activities targeting RH/HIV partners at national and state levels will be carried out on program management areas such as; a) Result Based Management, b) Documentation and report writing, c) Proposal writing and fund raising, d) Program monitoring and evaluation, e) Research methodology, f) Quality of care and g) Development and updating of systems. These skills will enable them to effectively and efficiently mobilize and manage resources. In addition, institutional and operational support will be provided to RH and HIV partners.
63. To promote and support RH/HIV integration at national and state levels, a mapping exercise will be carried out. Coordination between RH and HIV Partners (old and new) will be enhanced through regular fora and meetings. In addition, UNFPA will serve as a model for management of integrated activities, and will support its partners on lessons learnt and best practices through onsite visits, mentoring and trainings.
64. *Strategic intervention 3 (b) Supporting interventions to increase the coverage of skilled birth attendance:* Findings from the 2012 situational analysis of midwifery education in Sudan indicated a limited production of professional midwives/skilled birth attendants, weaknesses in midwifery institutional infrastructures and staffing, and non-standardized curricula that do not meet international standards. This strategic intervention aims to accelerate the implementation of midwifery scale-up program and to address the gaps found in the situational analysis.
65. At the national level, UNFPA will provide technical support to establish and update Sudan midwifery education standards, including curricula, midwifery practice regulation, and operationalization of the midwifery association. In addition, it will provide technical and operational support to midwifery teaching institutions in order to increase the production of professional/skilled birth attendants.
66. Innovative initiatives to strengthen the quality of midwifery training and service delivery will be supported. Continuous professional development of midwives and other skilled birth attendants on midwifery skills, RH/ HIV/GBV integration issues, and field supervision and performance management will be supported.
67. Necessary tools, such as protocols and guidelines in antenatal care, delivery care, postnatal care and neonatal care for static and mobile clinics, will be developed/adapted, printed and distributed. Equipment, supplies, and renovation of midwifery schools and training sites will be provided where required.
68. Finally, more evidence will be generated on factors associated with the distribution of skilled birth attendants, and necessary interventions will applied to improve the coverage of skilled birth attendants.
69. *Strategic intervention 3(c) Supporting evidence-based advocacy efforts to mobilize resources to implement the maternal health road map:* This intervention will be achieved through the development and implementation of an evidence based resource mobilization plan for RH/ HIV at both national and state levels.
70. *Strategic intervention 3(d) Expanding community-based maternal health interventions:* At national level, community-based maternal health protocols and guidelines for static and mobile clinics will be

developed/updated, printed and distributed. While at community level, RH/HIV activities will be integrated into NGO/CBO's programs in development and humanitarian settings. Health care providers will also receive refresher trainings on community based maternal health services. This strategic intervention will synergize with strategic interventions 2 (b) and 2 (d).

71. *Strategic intervention 3 (e) Strengthening the provision of emergency obstetric and neonatal services, including supporting the critical rehabilitation and renovation of health facilities:* Basic and Comprehensive Emergency Obstetric Neonatal Care (EmONC) protocols and standards will be developed/updated, printed and distributed. Based on the findings of the 2011 National Health Service mapping survey, EmNOC rehabilitation, equipment and supplies will be provided. In addition, support will be provided to expand the number and quality of post-abortion care services. UNFPA will also continue to support professional development of health providers related to the Basic and Comprehensive EmONC skills.
72. *Strategic Intervention 3 (f) Supporting the capacity for the repair of obstetric fistula and the social reintegration of fistula patients:* Both the curative and preventive activities of Obstetric fistula (OF) will be addressed in this intervention. At national level, OF management protocols and guidelines will be developed/updated, printed and distributed. Regular meetings of the OF surgeons at the national level will be held to collect data and share experiences, providing a rich educational forum. Obstetric Fistula management campaigns will also be carried out in selected states.
73. At state level, existing OF centers will be rehabilitated and equipped. Continuous professional development will be offered to OF management teams with the aim of increasing the quality of service to improve clinical outcomes and use of services. This activity will be in synergy with the OF anti-stigma activities covered under the strategic intervention 2 (b), aiming to further increase the use of these facilities.
74. At community level, UNFPA will provide support to OF prevention through awareness raising programs by engaging community committees, Y-peer and CBOs. Research on gender inequalities and other sociocultural factors associated with OF (in line with the strategic intervention 2(c))) will be carried out with a view to developing a comprehensive OF prevention package. Finally, psychosocial support to OF patients and their families will be provided in the form of pre- and post-operative interventions. In close partnership with CSOs, social reintegration support will provide, for instance, income generating activities and life skills trainings.
75. *Strategic Intervention 3 (g) Implementing the Minimum Initial Service Package (MISP) in humanitarian settings:* This strategic intervention will be implemented through provision of support to rapid response and comprehensive programs on maternal health, sexual violence, and STIs and HIV/AIDS within the Health and Protection clusters in humanitarian settings. This will include the development of a strategic plan to prevent excess maternal and newborn morbidity and mortality at clinic and referral hospital levels in humanitarian settings and developmental phase transitions. This plan will support integration of RH/HIV/GBV activities and will strengthen the coordination between development and humanitarian actors. UNFPA will continue the procurement and distribution of RH/HIV emergency supplies and equipment.
76. Because of the unstable political situation and seasonal environmental disasters as detailed in Part II, the technical capacity of MoH program managers and service providers at all levels needs to be further strengthened on emergency preparedness and contingency planning and planning during the transition period from MISP to comprehensive RH programs. In addition, decision makers, women and communities need to be sensitized on MISP to help spread and utilize these services.
77. *Strategic intervention 3 (h) Ensuring youth-focused peer counseling and peer education:* To ensure wider coverage and sustainability, the Adolescent Youth Sexual Reproductive Health (AYSRH) services will be integrated into several outlets such as youth recreation centers and health facilities. There will be a focus on capacity building of peer educators and peer counselors. In addition, referral mechanisms between services will be strengthened. AYSRH manuals, guidelines and information packages will be developed/revised, printed and distributed. In addition, UNFPA will support the procurement of commodities for AYSRH services. Where required, youth centers and youth friendly health facilities will be rehabilitated and equipped. The skills of AYSRH peer educators will also be strengthened at national and state levels.
78. *Strategic Intervention 3 (i) Strengthening the elimination of mother-to-child HIV transmission (eMTCT):* UNFPA will focus its interventions on Prong 1 (primary prevention of HIV among women of childbearing age) and Prong 2 (prevention of unintended pregnancies among women living with HIV) of four pronged strategy for elimination of mother-to-child transmission (eMTCT). UNFPA will provide the support to strengthen the technical and management capacity of partners at federal, state and locality levels.

Meanwhile, at facility level, support will be provided to improve the quality of care in infection control and STI services through the rehabilitation and provision of equipment and supplies.

79. At community level, interventions for community awareness on eMTCT will be expanded and will target women of reproductive age, youth and men, compared to the previous limited coverage of only women attending ANC. Civil society organizations and associations of people living with HIV/AIDS will be trained to implement and deliver comprehensive integrated community awareness packages. In order to strengthen referral mechanisms between RH and HIV specialized services for HIV positive patients, UNFPA will also provide support for the operational cost (transport and communication).

80. *Strategic intervention 3(j) Integrating the management and prevention of sexually transmitted infections and HIV into reproductive health service outlets, including outlets that have services for young people:* This strategic intervention will build on the intervention (3i). Financial and technical support will be provided to support the integration of the vertically delivered STI and HIV services into reproductive health outlets at policy and system levels. Integrated RH/HIV/STI service packages for women at reproductive age, PLWHA, youth and MARPs will be developed/updated, printed and distributed. Orientation and training of these comprehensive packages will be carried out to decision makers, program managers and health care providers. Supportive supervision of outlets providing integrated packages will be carried out to monitor and improve the quality of services. In addition, operational research and impact evaluation will be carried out to inform programming and improve the quality of services.

81. **CPD Output 4:** Comprises of three strategic interventions that aim to **strengthen national systems for reproductive health commodity security and for the provision of family planning services.**

82. *Strategic Intervention 4 (a) Strengthening the health information and logistics system:* Reproductive Health information will be reviewed to include HIV and sociocultural determinants indicators. The comprehensive health information will be regularly updated and will have monitoring procedures in place to ensure that national standards are met. Capacity building activities on skills such as accurate collection, reporting and use of data, targeting RH/HIV health care providers and managers, will be carried out.

83. Research (studies, surveys and operational research) on Reproductive Health Commodities (RHCs) barriers that include, among others, social, regulatory, operational, financial and cultural factors will be supported to inform planning and decision-making. Finally, UNFPA will assist in the provision of IT equipment and supplies for the health information system.

84. With regard to the logistic system, UNFPA will provide technical and operational support. This will include support for the coordinated forecasting of RHCs, including contraceptives method-mix, as well as for the procurement of contraceptives and other RHCs and IT equipment and software for the logistics management. The storage and distribution infrastructure of RHCs will be supported to ensure continuous supply of RH/HIV commodities to Health facilities and other outlets. Data collection, reporting and use will be strengthened through training of RH/HIV managers and staff on forecasting/quantification, supply chain management and logistics management of RHCs.

85. *Strategic Intervention 4 (b) Advocating reproductive health commodity security, including the prevention of HIV/AIDS prevention:* UNFPA will provide support to for advocacy efforts for to including a government budget item line item for RHCs in the government budget and to advocate for the inclusion of RH/HIV essential drugs within the National Essential Medical List (NEML). UNFPA will also assist in the mobilization of public, private and donor support to for the RH commodity security. Evidence generation on for RHC sustainability initiatives, e.g. revenue generation and cost recovery schemes, will be carried out to examine the feasibility, best practices and alternatives for to donor funding.

86. *Strategic 4 (c) Enhancing the capacity of health-care providers to deliver high-quality family planning services:* Family Planning (FP) services are not offered routinely for women attending ANC and PNC visits. The public and private sectors do not tally in providing FP services, and therefore, mechanisms should be developed to ensure that the capacity of health care providers in the two sectors meet the national standards. Family Planning guidelines, protocols and other professional support will be integrated into RH/HIV/GBV service packages, which will be printed and distributed. As part of the comprehensive training package, health care providers will be trained to provide quality FP services. The quality of the service will be monitored through activity reports, supervision, and quick surveys on the client's satisfaction. This strategic intervention will also be supported through Output 2, aiming at increasing demand for family planning in health facilities.

87. **CPD Output 5:** In effort to promote gender equality and to prevent inequalities and violence in humanitarian and poverty settings, this output aims to **strengthen the national, state and community**

capacity to promote gender equality and to prevent and respond to early marriage, sexual violence and female genital mutilation.

88. _Strategic intervention 5(a) Supporting the implementation of the national legislation that supports gender equality and youth empowerment:_ This strategic intervention is closely linked with the intervention 2 (e). A multi-sectoral approach to implement national legislations on gender equality and youth empowerment will be emphasized in all RH/HIV and FGM/C strategies. For instance, the abandonment of all types of FGM/C (both primary and secondary cuts) will involve Ministries of Health, religious leaders, youth, judiciary and others. Tools required for the implementation of this multi-sectoral approach, such as advocacy kits and BCC materials on gender issues and youth, will be developed and distributed.
89. The function and training of national and state task force committees will be supported. This includes activities for raising awareness around policies, revising policies, and reviewing laws and proposals to amend laws. The policy analytical skills of the government counterparts/sectors and civil society members, as well as linkages between policy and national legislations will also be strengthened.
90. Relevant indicators in Gender (e.g. Gender Equality, Women Empowerment, Violence against Women, Child Marriage, Women Friendly Law), Reproductive Health and Rights (maternal health, HIV, OF), and Youth (Employment, Reproductive Health and Rights, HIV, OF) will be closely monitored. Accordingly, UNFPA will support interventions at national and state levels aiming to advocate for polices and law reforms (e.g. incorporation of FGM/C and Child Marriage into the Child Act). UNFPA, where applicable, will assist the strategies and plans development, law reforms, and policies development or revisions. Research activities promoting law reform will be supported (e.g. research on medical, theological and socio-cultural determinants of child marriage). Researches promoting gender equality and youth empowerment will also be encouraged (e.g. understanding the needs of young women to create female friendly youth centers.
91. At community level, UNFPA will provide support for people-centered advocacy to address gender issues related to maternal health, such as child marriage, OF, FGM/C and maternal morbidity. Activities will also include the establishment or reactivation of an independent watchdog to monitor the implementation of legislations at the community level.
92. _Strategic intervention 5(b) Building the capacity to prevent and respond to gender inequalities affecting maternal health, including gender-based violence:_ This strategic intervention is linked to all strategic interventions of CPD Output 2 and to Outputs 3 (b) and 3 (d), through several activities. Different capacity building methodologies will be utilized in this intervention, including trainings by a core group of trainers; in-service and onsite mentoring, various events at state, national and international levels (e.g. conferences/meetings/fora); development of work related systems (e.g. Standard Operating Procedures, manuals, guidelines, BCC materials); and provision of equipment and supplies.
93. Line Ministries will be trained on results based management, planning techniques, and gender mainstreaming. UNFPA will also provide technical and operational support to the M&E units of Women Empowerment Policy at the federal, state and, particularly, locality level.
94. Health care providers, police, prosecutor, lawyers, paralegal and legal staff will be trained on legal, sociocultural, and health aspects of child marriage, sexual violence and FGM/C. NGOs, women and youth CBOs, religious leaders and politicians will be trained specifically on determinants of women's health and GBV, Reproductive Health and Rights management, community mobilization and communication, and leadership and advocacy skills. UNFPA will also provide support to existing religious groups and forum/platform to address child marriage, sexual violence and FGM/C issues through the Affection and Mercy Campaign (AMC).
95. Because of the high incidence of FGM/C medicalization by midwives in Sudan, this group of health provider needs a special attention. The integration of education on the risks and complications of FGM/C, re-infibulation and de-infibulation into midwifery curricula, as well as in-service trainings, will be supported. Midwives will also be encouraged to make public declarations against FGM/C.
96. BCC materials on issues of child marriage, sexual violence and FGM/C will be specifically developed for use by religious leaders as well as targeting youth, women and other vulnerable groups. In addition, media personnel will be trained on the design of culture-sensitive messages on VAW, child marriage, Obstetric Fistula, gender equality, women's rights, women friendly laws etc.
97. Manuals, guidelines, SOPs that prevent and respond to gender inequalities affecting maternal health, including GBV, will be reviewed, adapted, printed and distributed. Activities may include, for example, development of manual on "Increasing Community response to GBV"; guidelines for religious leaders on

Child Marriage, Sexual Violence and FGM/C; and SOPs of "training packages development" for partners in order to unify, strengthen and standardize the development and implementation of quality trainings.

98. *Strategic Intervention 5 (c) Strengthening the provision of comprehensive services for gender-based violence survivors:* The National Council for Child Welfare, Federal Ministry of Health, and Ministry of Welfare and Social Security will all be supported to influence the integration of FGM/C (specifically de-infibulation and re-infibulation) and GBV issues, and Women Empowerment Policy strategy into strategies and annual plans of other relevant ministries at all levels of implementation. An integrated comprehensive counseling and communication skills package for midwives, health personnel and paralegals will be developed. All of these activities are closely linked to the strategic intervention 2 (a). Family and Child Protection Units will also be upgraded to include women's services.
99. Referral mechanisms for GBV survivors at the national, state and locality level will be strengthened. For example, support will be provided for the central trauma center as a training hub and for centers' coverage at the community level.
100. *Strategic Intervention 5 (d) Strengthening strategies to increase the involvement of young men and boys in efforts to improve women's health:* The involvement of young men and boys is important in improving women's health, given that the patriarchal system of the Sudanese culture influences community's practices in health seeking, utilization of family planning methods, child marriage, and gender-based violence (FGM/C, physical and sexual violence). At national level, communication strategies on RH/HIV, Women Empowerment Policy and gender (see also 2 (a)) will be reviewed to engage young men and boys. Social media materials will also be developed to improve young men and boys' involvement in priority RH/HIV/GBV issues.
101. There is a shortage in data and evidences needed to replace the anecdotal evidences and assumptions for developing effective interventions for young men and boys. Research activities will be encouraged and supported to enhance young men and boys' friendly initiatives in maternal and child health services for RH, including PMTCT, STIs, FP, and GBV. In addition, young men and boys will be supported in developing groups and organizations that promote access to maternal health as well as eradication of FGM/C, child marriage and sexual violence.
102. **CPD Output 6:** this output has four strategic interventions which aim to **strengthen the national and state capacity to produce, analyze and disseminate high-quality sex disaggregated population data for evidence-informed planning and monitoring, with a focus on maternal health.**
103. *Strategic Intervention 6 (a) Improving quality standards and techniques for the collection of population data:* UNFPA will support the development and compilation of standardized statistical protocols and guidelines, gender-sensitive checklists, and concepts/definitions/classifications and methodologies for the preparation of upcoming census/surveys. Support will be provided for the establishment and operationalization of M&E unit within the Central Bureau of Statistics (CBS). A database on Violence against Women (VAW) will be developed in linkage with the VAW units and Ministry of Health at the national and state level. UNFPA will ensure that data collection is disaggregated at sub-levels (locality and administrative units). In addition, support will be provided for statistical audits of major statistical collections every other year in order to monitor the quality of data. Funding will be provided for the implementation of National Strategy for the Development of Statistics (NSDS). This includes human resources capacity building activities such as training programs in NSDS, support for participation in regional or international training programs, and facilitation of meetings/conferences at the national level (e.g. quarterly/semiannually meetings to discuss the progress of statistical activities). In addition, UNFPA will support line ministries/institutions to contribute to the National Statistical System (NSS) of the CBS.
104. *Strategic Intervention 6 (b) Establishing national indicators related to population development and maternal health:* The national statistical system will be supported through the adaptation of Sudan-info as a national database. Data banks will be designed to capture all relevant maternal health indicators in RH, gender, HIV, social-culture and environment. Regular updating and maintenance of the NSS website will be supported. In addition, human resources and institutional capacities will be enhanced through trainings on administrative and user interfaces.
105. *Strategic Intervention 6 (c) Strengthening the capacity for qualitative data collection, analysis and dissemination, including in humanitarian settings:* Operational support in the printing of statistical products and dissemination of findings through different media will be provided. Partners and institutions will be trained on the qualitative data collection (e.g. Participatory Rural Appraisal -PRA) in development and humanitarian settings.

106. *Strategic Intervention 6 (d) Strengthening the quality of maternal and reproductive health data collection, including data on HIV:* An assessment on methodologies (tools and indicators) and M&E systems in humanitarian settings will be carried out, and interventions will be made accordingly. Data systems will also be developed to ensure data disaggregation at locality and administrative unit levels.
107. The Maternal Death Review (MDR) system will be supported to generate and utilize data through several activities, including regular MDR Committees meetings at national and state levels; development of administrative records and registers; training and coordination of data recorders; and operational support (e.g. equipment, furniture, etc.).
108. Partners and institutions will be trained on quantitative data collection and statistical audits every other year to improve the quality of statistical production across the NSS.
109. Finally, in effort of promoting the integration of RH, HIV/STI and GBV, UNFPA will provide financial and technical support for the inclusion of relevant indicators in data collection at all levels. See also strategic interventions under outputs 3 (g and j) and 4 (a) that build on this activity.
110. *Strategic Intervention (e) Building national capacity in preparation for the 2018 population census:* A comprehensive and holistic census program will be developed to capture all the required data in a coordinated manner. Development of Geographic Information System (GIS) standards/protocols to digitalize enumeration areas and mapping will be supported. In addition, a framework of field activities e.g. logistics and administration preparation, and public awareness raising will be developed. Support will also be provided for operational activities, such as the procurement of equipment (PCs, laptops, printers, network equipment, and software package).

    Finally, the census process (format, data collection and analysis) will include gender and comprehensive maternal health indicators, as well as socio-cultural and economic variables. Capacity building will be provided for the census teams on additional indicators, and disaggregated data collection and analysis.
111. *Strategic Intervention (f) Supporting research on the linkages between population and development*: The establishment of micro data warehouse and data sharing network will be supported to facilitate easy access for research. UNFPA in collaboration with academic institutions will build the capacity of implementing partners through short- and long-term training courses and fellowships on population and development issues as well as communication skills. Finally, support will be provided to research activities on population linkages (migration, urbanization, fertility, mortality) and maternal health (RH, HIV, Gender, youth's priorities) to inform policy and planning.

Part V. Partnership Strategy

112. The CPAP was developed through a comprehensive consultative process with all Government and civil society partners and in close collaboration with UN agencies and donors to ensure alignment with national priorities and synergy with other partners. The Ministry of Finance and National Economy will assume the overall role of the Government Coordinating Authority, while the Ministry of Welfare and Social Security will act as the main government technical counterpart. At the national level, UNFPA will partner with the Ministry of Welfare and Social Security, Federal Ministry of Health, Federal Ministry of Youth and Sports, National Population Council, and Central Bureau of Statistics to ensure a conducive policy environment and will enhance their capacity in strategic guidance, and monitoring and support of state level entities and counterparts for the implementation of planned interventions. UNFPA will also work closely with CSOs at the national level to ensure their full participation and involvement in the policy advocacy agenda in line with the UNFPA mandates. In particular, UNFPA will partner with the Sudan Family Planning Association for the provision of Family Planning services where possible.
113. At state level, UNFPA will partner with the State Ministries and CSOs to enhance their capacity for service delivery and to assist in creating a conducive environment for implementation. For the Darfur Region, UNFPA will work closely with the Darfur Regional Authority (DRA) and related structures of DRA at the state level to enhance their capacity and ensure their optimal support for partners delivering services and interventions. While at the locality level, UNFPA will partner with technical governmental and nongovernmental counterparts.
114. The partnership with academic and research institutions is very crucial at both national and state levels. Academia will be engaged to support capacity building efforts for all partners through existing technical capacity. They will also be involved in supporting research and generation of evidence to guide programming efforts. Partnership with media and work with policy makers and legislators will also be a crucial component of this CPAP.

115. The CPAP has a very strong focus on communities and community-based interventions. This will entail UNFPA's partnerships with communities and CBOs to ensure their full involvement in implementation and monitoring. As well as building their capacity in management of community based initiatives addressing socio-cultural barriers affecting maternal health and harmful traditional practices.
116. While government institutions will serve as the main implementing partners, UNFPA will also build on lessons learned from the previous CP cycle in order to promote the partnership and enhance the implementation capacity of NGOs through the umbrella NGO approach. This approach will also strengthen the partnership between Government, CSOs and academic/research institutions, and will help achieve the capacity building elements of the CSOs.
117. UNFPA will work closely with WHO, UNICEF, UNDP, ILO and UNIDO to enhance coordination and synergy as well as engagement in joint programming in the areas of Maternal Mortality Reduction, abandonment of FGM/C, HIV/AIDS and youth empowerment.

Part VI. Program Management

118. The Country Program fully recognizes the interface between humanitarian and development interventions and, therefore, the CP outputs are aligned with the humanitarian, early recovery and development needs of the target populations. The CPAP document will strategically support key principles of the national priorities as depicted in the 5-year Development Plan (2012-2016). There will be a particular focus on institutional and human capacity strengthening; promotion of civil society and NGOs participation in the implementation of development programs; and sustainable initiatives with stronger monitoring and reporting mechanisms. National ownership, and human rights based and culturally sensitive approaches are the underlying principles of UNFPA collaboration with the government.
119. The management structure of CPAP will have a tiered approach, involving a Steering Committee, Program Result Manager and state output committees. The Ministry of Finance and National Economy has the overall responsibility for the development and coordination of the UNDAF. In this capacity, the Ministry also assumes the role of the Government Coordinating Authority (GCA) for the UNFPA CP, with the main responsibility in overseeing the program development and evaluation. The GCA is also responsible for convening and chairing the Annual Review Meeting at the national level
120. The Ministry of Welfare and Social Security, in its role as the Program Result Manager (PRM), will chair the Steering Committee consisting of one key partner from each CP output and a member from Ministry of Finance. The Steering Committee is mandated to meet biannually at the national level to provide policy advice and strategic direction on program implementation, management and evaluation.
121. To provide emphasis on the Women Reproductive Health Cluster, the MoH will chair the RH Steering committee which is mandated to meet biannually at the national level to provide overall policy and strategic guidance on program issues related to RH.
122. Output Managers and Implementing Partners responsible for delivering outputs/projects at the national level will organize quarterly review meetings; while the Director Generals of the State Ministries of Health will convene and chair quarterly meetings of the State Output Committees, engaging all implementing partners, including government technical counterparts, at state and locality levels. The objective of these activities is to review the progress and status of implementation, identify constraints, and propose recommendations for the way forward. Findings of the meetings will be recorded and communicated to national technical counterparts and Output Managers at the national level for their information and follow-up. These findings will also be used as the basis of reviews in the Steering Committee meetings and the Annual Review at the national level.
123. National Execution (NEX), through advances, direct payments or reimbursement of Implementing Partners' expenditures by UNFPA, will be the implementation modality for the Country Program. Subject to the outcome of Implementing Partner assessments and in cases where the capacity for NEX does not exist, the program will be implemented through Direct Execution (DEX).
124. Each Implementing Partner, in close cooperation with UNFPA program/operation staff, will develop the Annual Work Plans (AWPs) detailing interventions at national, state and locality levels, responsible implementing institutions, and timeframe and planned inputs with clear baselines and targets. All cash transfers to an Implementing Partner are based on the Annual Work Plans agreed between the Implementing Partner and UNFPA.
125. Cash transfers for activities detailed in AWPs can be made by a UN agency using the following modalities:
1) Cash transferred directly to the Implementing Partner:
a) Prior to the start of activities (direct cash transfer), or

b) After activities have been completed (reimbursement);
2) Direct payment to vendors or third parties for obligations incurred by the Implementing Partners on the basis of requests signed by the designated official of the Implementing Partner;
3) Direct payments to vendors or third parties for obligations incurred by UN agencies in support of activities agreed with Implementing Partners.

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

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

128. Cash transfer modalities, the size of disbursements, and the scope and frequency of assurance activities may depend on the findings of a review of the public financial management capacity in the case of a Government Implementing Partner, and of an assessment of the financial management capacity of the non-UN31 Implementing Partner. A qualified consultant, such as a public accounting firm, selected by UNFPA may conduct such an assessment, in which the Implementing Partner shall participate. (Where Government wishes, add: The Implementing Partner may participate in the selection of the consultant.)

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

130. **Resource Mobilization:** Despite the serious economic situation in Sudan, including large fiscal and external financial debt as the result of the loss of oil revenues following the separation of South Sudan, UNFPA will advocate with the Government for expanding public resources to address development gaps. UNFPA will further mobilize additional resources from traditional donors as well as UNFPA thematic funds, humanitarian funds, Global Funds and other donors, including contributions from the private sector. UNFPA will put strong efforts into attracting new donors for the program. It will also mobilize resources through joint programming with UN agencies, with a special focus on the reduction of maternal mortality, HIV prevention, abandonment of FGM/C, elimination of GBV, and youth programming.

131. **Human Resources:** The UNFPA Country Office will undergo a staff restructuring to facilitate smooth implementation of the CPAP. UNFPA Management and Development resources will be used to cover the posts of Representative, Deputy Representative, International Operation Manager, Finance Associate, Personal Assistant to the Representative, ICT Assistant, Administration Associate and Driver. Resources from core and non-core program budget will be used to ensure adequate technical and operations staffing to provide support for the management, implementation and monitoring of program. These staff posts will include International Emergency Coordinator, International Program Specialists, International Technical Advisors, Assistant Representatives, National Program Officers, Program Associates, Program Assistants, Finance Associates, Administrative Associates, Administrative Clerks and Drivers.

Part VII. Monitoring and Evaluation

132. Monitoring and evaluation is an integral component of result-based management for improved strategic planning, learning and accountability. It is also a mechanism to assess the extent to which efficiency and effectiveness are built into the program in order to achieve its objectives. The primary purpose of the M&E system is, therefore, to generate evidence-based results for learning, appraisal and decision-making.

133. The M&E system of the Country Office will be developed based on the CPAP Results and Resource Framework, and the Monitoring and Evaluation Planning Matrix. Annual Monitoring and Evaluation Plans will be developed to track the AWPs' indicators and targets. The plan will consist of building blocks with measurable and achievable milestones that could be monitored over the course of the program period. Given the adopted integrated program approach, there will be a well-coordinated monitoring and evaluation mechanisms/activities at national, state and locality/community levels, in accordance with UNFPA procedures and guidelines.

134. Individual and joint field monitoring visits will be conducted to monitor the progress of implemented activities on a regular basis. In addition, partners will be oriented on associated M&E methodological issues as well as the reporting template to ensure the quality monitoring information. Findings of monitoring visits will be communicated to relevant stakeholders for information sharing and development

of recommendations where necessary, and will be presented in the regular review meetings as part of the progress review and reporting.

135. At national and state levels, quarterly review meetings will be organized and chaired by the Program Results Manager and State Ministries of Health, engaging Output Managers and their respective Implementing Partners, with the aim of assessing the progress, and identifying challenges and lessons learned. These meetings will also generate key recommendations for ongoing and future interventions. The data generated from the quarterly review meetings will feed into the bi-annual steering committee (see details in Part VI) and annual review meetings at the national level.
136. Annual review meetings will be organized by the Government Coordinating Authority (Ministry of Finance) and will be attended by all Output Managers and Implementing Partners, with the objective of assessing the overall progress towards achieving the outputs' annual targets. The annual review is an accountability platform, which examines the implementation rates, best practices, and status recommendations from the last year's annual review. Annual Progress Reports presented in this event will be based on indicators, taking into account what has been achieved against the AWPs' baselines and targets.
137. Field monitoring visits conducted during the year and the cumulative progress in the quarterly reviews will feed into the development of the annual project/output progress reports and the Country Office Annual Report (COAR).
138. In line with the recommendation from the fifth CP evaluation, a baseline survey will be conducted prior to the launch of the CP in order to sett up baseline indicators and targets for the interventions at state and community levels. The baseline will capture situations at the output level, while the outcome and impact will be assessed as part of the periodic Sudan Household and Health Surveys.
139. Thematic evaluations and operation researches are also part of the monitoring and evaluation plan. Thematic evaluations/Knowledge Attitude and Practice surveys (in RH, Family Planning, HIV/AIDS, and Youth) will be conducted to measure results, and identify and document best/bad practices and success stories. The pilot model of the integrated program approach implemented at the locality/community level will be evaluated in the middle of the second year of the CP, with the objective of learning and demonstrating results.
140. UNFPA will also assess the capacity of all potential partners of the 6th CP using the capacity assessment tool. Results of the assessment will feed into the development of a capacity building plan aimed to address various capacity gaps for the implementation in close collaboration with Implementing Partners.
141. Implementing partners agree to cooperate with UNFPA for monitoring of all programmatic activities supported by cash transfers and will facilitate access to relevant financial records and personnel responsible for the administration of cash provided by UNFPA. To that effect, Implementing Partners agree to the following:
    - Periodic review of their financial records by UNFPA or its representatives, following UNFPA's standards and guidance,
    - Periodic review and monitoring of their programmatic activities following UNFPA's standards and guidance,
    - Special or scheduled audits: UNFPA, in collaboration with other United Nations agencies (where so desired: and in consultation with the [coordinating Ministry] GCA) will establish an annual audit plan, giving priority to audits of Implementing Partners with large amounts of cash assistance provided by UNFPA, and those whose financial management capacity needs strengthening.
142. To facilitate assurance activities, Implementing Partners and the United Nations agency may agree to use a program monitoring and financial control tool allowing data sharing and analysis.
143. Where no assessment of the Public Financial Management Capacity has been conducted, or such an assessment identified weaknesses in the capacity of the Supreme
Audit Institution, audits shall be conducted by auditors designated by UNFPA.
144. For effective tracking of CP progress and performance, the Country Office has designed and operationalized an electronic program database system which includes, among other parameters, interfaces for the CP outcomes and outputs, capacity development interventions, and field monitoring visits. It is a user-friendly system that allows data entry and reports generation in tabular and graphic presentations forms.
145. The final program evaluation will be conducted in the penultimate year of the program cycle. It will examine program design and its relevance, efficiency, effectiveness and sustainability. Program

management will also be evaluated. Lessons learned and strategic recommendations will be generated for the development of the subsequent CP.

146. UNFPA will take part in the UNDAF annual reviews organized by UN agencies in collaboration with the Government Coordinating Authority and other stakeholders. An update on the progress of relevant UNDAF outputs will be made for all the thematic pillars/outcomes. UN agencies, line government ministries/institutions, civil society organizations and private sector will participate in the review process. At the end of the UNDAF lifetime, an independent comprehensive evaluation will be jointly conducted to assess the overall progress and achievement against the targets. UNFPA will follow up and update on the implementation of activities planned in the UNDAF Monitoring and Evaluation Calendar.

Part VIII. Commitments of UNFPA

147. The Country Program Document requests the UNFPA executive Board for a total commitment of US $ 91 million that includes $ 20.0 million of regular resources and $ 71 million from the co-financing and Global/Regional programming modalities, subject to availability of funds.
148. UNFPA will develop a resource mobilization plan to mobilize a total of $ 71 million as stipulated in the CPD, depending on donor interests. Learning from experiences during the 5th CP cycle, and given the limited interest of donors to support development initiatives in Sudan in general and in areas specifically related to UNFPA mandates, the resource mobilization strategy will consider mobilizing funds through joint programming with other UN agencies, focusing on the reduction of maternal mortality, HIV prevention, abandonment of FGM/C, elimination of GBV, and youth programming. The resources mobilized through this approach do not include funding specifically mobilized in response to emergency appeals.
149. Technical and financial support will be provided to national counterparts, including civil society organizations, as agreed within the framework of the AWPs. Disbursement of funds will be subjected to the satisfactory implementation of planned annual activities, in accordance with UNFPA guidelines and financial procedures.
150. In case of direct cash transfer or reimbursement, UNFPA shall notify the Implementing Partner of the amount approved by UNFPA and shall disburse funds to the Implementing Partner within fifteen days after receiving a request for the respective payment.
151. In case of direct payment to vendors or third parties for obligations incurred by the Implementing Partners on the basis of requests signed by the designated official of the Implementing Partner; or to vendors or third parties for obligations incurred by UNFPA in support of activities agreed with Implementing Partners, UNFPA shall proceed with the payment within fifteen days after receiving a request for the respective payment.
152. UNFPA shall not have any direct liability under the contractual arrangements concluded between the Implementing Partner and a third party vendor. Where more than one United Nations agency provides cash to the same Implementing Partner, program monitoring, financial monitoring and auditing will be undertaken jointly or coordinated with those United Nations agencies.

Part IX. Commitments of the Government

153. The Government of Sudan will continue to provide annual financial contribution to UNFPA. In addition, the Government will commit to counterpart funding to the program and will also be committed to support UNFPA in its efforts to mobilize additional resources as may be required.
154. UNFPA shall be exempted from Value Added Tax or any other forms of taxation in respect to procurement of supplies and services to support the implementation of this CPAP. The Government will also ensure that UNFPA staff, performing services on its behalf, has access to the geographic areas where CPAP is being implemented, in order to monitor and provide technical support when needed.
155. The Government Coordinating Authority and the Program Results Manager will convene program review meetings, UNDAF annual reviews and Steering Committee meetings, as described in Part VI and VII of this document, in order to facilitate the coordination and participation of donors and NGOs.
156. A standard Fund Authorization and Certificate of Expenditures (FACE) report, reflecting the activity lines of the Annual Work Plan (AWP), will be used by Implementing Partners to request the release of funds, or to secure the agreement that UNFPA will reimburse or directly pay for planned expenditure. The Implementing Partners will use the FACE to report on the utilization of cash received. The Implementing

Partner shall identify the designated official(s) authorized to provide the account details, request and certify the use of cash. The designated official(s) of the Implementing Partner will certify the FACE.

157. Cash transferred to Implementing Partners should be spent for the purpose of activities as agreed in the AWPs only. Cash received by the Government and national NGO Implementing Partners shall be used in accordance with established national regulations, policies and procedures consistent with international standards, in particular ensuring that cash is expended for activities as agreed in the AWPs, and ensuring that reports on the full utilization of all received cash are submitted to UNFPA within six months after receipt of the funds. Where any of the national regulations, policies and procedures is not consistent with international standards, the United Nations agency regulations, policies and procedures will apply.
158. In the case of international NGO and IGO Implementing Partners cash received shall be used in accordance with international standards in particular ensuring that cash is expended for activities as agreed in the AWPs, and ensuring that reports on the full utilization of all received cash are submitted to UNFPA within six months after receipt of the funds.
159. To facilitate scheduled and special audits, each Implementing Partner receiving cash from UNFPA will provide United Nations Agency or its representative with timely access to:

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

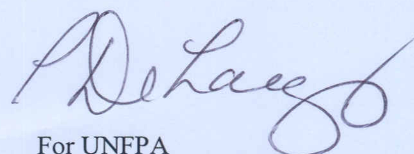
Part X. Other Provisions

160. This CPAP supersedes any previously signed CPAP and may be modified by mutual consent of both parties.

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

IN WITNESS THEREOF the undersigned, being duly authorized, have signed this Country Program Action Plan on this day [22 April 2013] *in* [Khartoum, Sudan].

For the government of Sudan
Undersecretary, Ministry of Finance and National Economy



For UNFPA
Pamela Delargy, UNFPA Representative

UNFPA Sudan CO
CPAP Results and Resources Framework 2013 - 2016

UNDAF Outcome # 1(Extract from UNDAF) UNDAF indicators, baselines and targets to which the CP outputs contribute									
UNFPA Strategic Plan Outcome	**Country programme output(s)**	**Output indicators and means of verification**	**Implementing Partners**	**Risks and assumptions**	**Indicative resources by output per annum (Thousands USD)**				
					Yr. 1	**Yr. 2**	**Yr. 3**	**Yr. 4**	**Total**
Outcome 1: Population dynamics and its inter-linkages with the needs of young people (including adolescents), SRH (including family planning), gender equality and poverty reduction addressed in national sectoral development plans and strategies **INDICATORS** • Population dynamics and its interlinkages are incorporated into national development plans and poverty reduction strategy papers. **Baseline:** **minimal** / **Target:** **Fully integrated** • Reproductive health services are integrated into national health policies and plans **Baseline:** **Partial** / **Target:** **Fully integrated**	**Output 1:** Strengthened national capacity to incorporate population dynamics, including its linkages with sexual and reproductive health, into relevant policies and development plans, w ith special attention to the needs of young people and women **MILESTONES:** -Population dynamics issues identified and studies conducted **(2013)** -Existing national policies/strategies and development plans vis-à-vis population dynamics and their linkages with RH/SRH reviewed **(2014)** -Youth structures and institutions at state and locality level identified; their capacities assessed and terms and conditions of coordination agreed **(2013-14-15-16)**	**1.** Number of studies on population dynamics conducted, with the findings incorporated into policies, strategies and plans at national and UNFPA-supported state levels **Baseline:** **4** / **Target:** **10** **MoV:** Studies' reports **2.** Number of UNFPA-supported localities with youth coordination mechanisms established and operational **Baseline:** **0** / **Target:** **12** **MoV:** Progress and FMV reports, coordination meetings' minutes	National Population Council, Central Bureau of Statistics, Ministry of Youth National Council for Strategic Planning; High Councils for Youth and Sports at states level; Sudanese Population Network; CSOs; ILO, UNICEF, UNIDO, UNDP, WHO; Youth Serving Organizations; Y-Peer Networks	**ASSUMPTIONS:** Commitment and political will of national and state governments Available resources to support the program implementation National Council for Strategic Planning considers population dynamics priority issues in national development planning.	**Regular Resources** 400	400	400	300	**1,500**
					Other Resources 400	400	400	300	**1,500**

UNDAF Outcome # 1(Extract from UNDAF) UNDAF indicators, baselines and targets to which the CP outputs contribute									
UNFPA Strategic Plan Outcome	**Country programme output(s)**	**Output indicators and means of verification**	**Implementing Partners**	**Risks and assumptions**	**Indicative resources by output per annum (Thousands USD)**				
					Yr. 1	**Yr. 2**	**Yr. 3**	**Yr. 4**	**Total**
Outcome 2: Increased access to and utilization of quality maternal and new-born health services **<u>INDICATORS</u>** • Births attended by skilled health personnel **Baseline** | **Target** **23%** | **30%** • Number of states with Caesarean section rates below 5% **Baseline** | **Target** **9** | **4**	**<u>Output 2.1:</u>** Increased demand for information and services related to reproductive, maternal and new-born health and HIV prevention **<u>MILESTONES:</u>** -Partnership agreements with CSOs to provide information and services at community level signed **(2013)** -Capacity of existing obstetric community-based referral mechanisms assessed **(2013)** -New communities for establishing obstetric referral mechanisms identified in collaboration with state/local authorities **(2013-2014)** -Condom programming strategy endorsed and operationalized **(2013)** -BCC strategy for HIV/RH including in humanitarian settings updated/developed **(2014 – 2015)** -Y-Peer educators' networks scaled up **(2013-2014)**	**1.** Number of civil society organizations engaged in behaviour change communication on gender, reproductive health, early marriage and HIV/AIDS at the community level; **Baseline** | **Target** **0** | **60** **MoV:** Partnership agreements **2.** Number of community-based obstetric referral mechanisms established and functional at the local level **Baseline** | **Target** **8** | **19** **MoV:** Progress and FMV rep. **3.** Number of individuals from MARPs and VGs reached by BCC outreach activities **Baseline** | **Target** **130,413** | **180,209** **4.** Number of MARPs benefitted from IGAs **Baseline** | **Target** **140** | **640** **MoV:** assessments and progress reports	Federal and state Ministries of Health; civil society organizations; UNAIDS, WHO, UNICEF, UNDP; Sudanese Family Planning Association; Sudan National AIDS Control Program; Blue Nile Institute; University of Gezira, JASMAR, SRCS; People Living with HIV/AIDS Association; Ahfad University for Women	**<u>ASSUMPTIONS:</u>** Resources available to support the program implementation Potential partner NGOs operating in selected states continue providing services throughout the program lifetime Commitment and political will of national and state governments Stable political context : easy access to program beneficiaries especially in humanitarian settings Communities are receptive and engaged in the different programming processes Strong partnerships and effective coordination mechanisms in place; **<u>RISKS</u>** Turn-over of service providers Negative role of some influential groups (parliamentarians, religious leaders, media) on the policy environment International financial crisis and shift of donor interest	Regular Resources				
					925	925	925	925	**3,700**
					Other Resources				
					5,000	5,200	5,600	5,200	**21,000**

<table>
<tr><td colspan="10">UNDAF Outcome # 1(Extract from UNDAF)
UNDAF indicators, baselines and targets to which the CP outputs contribute</td></tr>
<tr><td rowspan="2">UNFPA Strategic Plan Outcome</td><td rowspan="2">Country programme output(s)</td><td rowspan="2">Output indicators and means of verification</td><td rowspan="2">Implementing Partners</td><td rowspan="2">Risks and assumptions</td><td colspan="5">Indicative resources by output per annum (Thousands USD)</td></tr>
<tr><td>Yr. 1</td><td>Yr. 2</td><td>Yr. 3</td><td>Yr. 4</td><td>Total</td></tr>
<tr>
<td rowspan="4">Outcome 2: Increased access to and utilization of quality maternal and new-born health services

<u>INDICATORS</u>
• Births attended by skilled health personnel<table><tr><td>Baseline</td><td>Target</td></tr><tr><td>23%</td><td>30%</td></tr></table>
• Number of states with Caesarean section rates below 5%<table><tr><td>Baseline</td><td>Target</td></tr><tr><td>9%</td><td>4%</td></tr></table></td>
<td rowspan="4"><u>Output 2.2:</u> Increased availability of high-quality information and services for maternal and new-born health and HIV prevention, especially for underserved populations and people with special needs

<u>MILESTONES:</u>
-HFs renovated and provided with supplies and equipment necessary for service provision (delivery theatres, drugs, supplies) (2013-2014-2015)

-Service providers trained on EmOC, HIV, RH/SRH and OF (2013-14-15-16)

-EmOC treatment protocols available at service delivery points (2013)

-Midwifery curricula updated and midwifery schools rehabilitated and equipped to lodge midwifery education in the selected states (2013-2014)

-Guidelines for integrated HIV/SRH services developed and operationalized (2013-2014)

-VCT centres mapped and supported to provide HIV counselling and testing for MARPs (2013-14-15-16)</td>
<td rowspan="4">1. Number of fistula cases repaired<table><tr><td>Baseline</td><td>Target</td></tr><tr><td>659</td><td>1,000</td></tr></table>MoV: Health facility records & progress reports
2. Percentage of health facilities providing basic and comprehensive emergency obstetric and neonatal care services in the selected states.<table><tr><td>Baseline</td><td>Target</td></tr><tr><td>B: 19%</td><td>B: 70%</td></tr><tr><td>C: 17%</td><td>C: 60%</td></tr></table>MoV: Health facility records & progress reports
3. Number of primary health-care facilities providing integrated services on sexual and reproductive health, HIV and sexually transmitted infections.<table><tr><td>Baseline</td><td>Target</td></tr><tr><td>65</td><td>111</td></tr></table>MoV: Health facility records & progress reports
4. Number of village midwives trained in selected states<table><tr><td>Baseline</td><td>Target</td></tr><tr><td>5,721</td><td>7,021</td></tr></table>MoV: Progress reports
5. Number of people from vulnerable groups and populations that are most at risk who have received counselling, testing and management services through UNFPA support<table><tr><td>Baseline</td><td>Target</td></tr><tr><td>1,118</td><td>9,756</td></tr></table>MoV: VCT records, progress reports</td>
<td rowspan="4">Federal and state Ministries of Health; academic institutions; civil society organizations; UNAIDS, WHO, UNICEF, UNDP, JAICA; Sudan Academy for Health Sciences;</td>
<td rowspan="4"><u>ASSUMPTIONS:</u>
Available resources to support the program implementation

Commitment of national and state governments

- Stable political context and easy access to program beneficiaries especially in humanitarian areas

<u>RISKS:</u>
Resumption of conflict in the recovery areas and its escalation in the humanitarian settings

Turn-over of service providers (VMWs, medical doctors, HVs …)

International financial crisis and shift of donor interest</td>
<td colspan="5">Regular Resources</td></tr>
<tr><td>1,450</td><td>1,450</td><td>1,450</td><td>1,450</td><td>5,800</td></tr>
<tr><td colspan="5">Other Resources</td></tr>
<tr><td>5,250</td><td>5,250</td><td>5,250</td><td>5,250</td><td>21,000</td></tr>
</table>

<table>
<tr><td colspan="10">UNDAF Outcome # 1(Extract from UNDAF)
UNDAF indicators, baselines and targets to which the CP outputs contribute</td></tr>
<tr><td rowspan="2">UNFPA Strategic Plan Outcome</td><td rowspan="2">Country programme output(s)</td><td rowspan="2">Output indicators and means of verification</td><td rowspan="2">Implementing Partners</td><td rowspan="2">Risks and assumptions</td><td colspan="5">Indicative resources by output per annum (Thousands USD)</td></tr>
<tr><td>Yr. 1</td><td>Yr. 2</td><td>Yr. 3</td><td>Yr. 4</td><td>Total</td></tr>
<tr><td rowspan="4">Outcome 4: Increased access to and utilization of quality family planning services for individuals and couples according to reproductive intentions

<u>INDICATORS</u>
• Contraceptive prevalence rate<table><tr><td>Baseline</td><td>Target</td></tr><tr><td>9%</td><td>15%</td></tr></table>• Unmet need for family planning<table><tr><td>Baseline</td><td>Target</td></tr><tr><td>23.8%</td><td>18%</td></tr></table>• Percentage of service delivery points offering at least three modern methods of contraception<table><tr><td>Baseline</td><td>Target</td></tr><tr><td>10%</td><td>30%</td></tr></table></td><td rowspan="4">Output 4: National systems for reproductive health commodity security and for the provision of family planning services are strengthened

<u>MILESTONES:</u>
-Training Plans prepared and service providers to be trained identified (2013-14-15-16)

-Procurement and distribution plans of FP commodities (by method) developed as per projection/needs of health facilities; (2013-14-15-16)

-Gaps in logistics/supply and reporting systems identified and action plan prepared accordingly (2013)</td><td rowspan="4">1. Number of service providers trained in family planning<table><tr><td>Baseline</td><td>Target</td></tr><tr><td>1,564</td><td>2,564</td></tr></table>MoV: Training and progress reports

2. Percentage of national commodity requests satisfied<table><tr><td>Baseline</td><td>Target</td></tr><tr><td>20%</td><td>80%</td></tr></table>MoV: HFs records and progress reports

3. Percentage of facilities having no stock-outs of contraceptives in past six months in UNFPA-supported states<table><tr><td>Baseline</td><td>Target</td></tr><tr><td>15%</td><td>70%</td></tr></table>MoV: Health facility records and progress reports</td><td rowspan="4">Federal and state Ministries of Health; central medical supply; Sudanese Family Planning Association, UNDP, Central Medical Supply Corporation, Sudanese Fertility Care Association; Private sector</td><td rowspan="4"><u>ASSUMPTIONS:</u>
Available resources to support the program implementation: GPRHCS

Commitment from national and state governments

<u>RISKS:</u>
Negative role of some influential groups (parliamentarians, religious leaders, media) on the policy environment</td><td colspan="5">Regular resources</td></tr>
<tr><td>600</td><td>690</td><td>810</td><td>900</td><td>3,000</td></tr>
<tr><td colspan="5">Other resources</td></tr>
<tr><td>4,000</td><td>4,000</td><td>4,000</td><td>4,000</td><td>16,000</td></tr>
</table>

<table>
<tr><td colspan="10">UNDAF Outcome # 1(Extract from UNDAF)
UNDAF indicators, baselines and targets to which the CP outputs contribute</td></tr>
<tr><td rowspan="2">UNFPA Strategic Plan Outcome</td><td rowspan="2">Country programme output(s)</td><td rowspan="2">Output indicators and means of verification</td><td rowspan="2">Implementing Partners</td><td rowspan="2">Risks and assumptions</td><td colspan="5">Indicative resources by output per annum (Thousands USD)</td></tr>
<tr><td>Yr. 1</td><td>Yr. 2</td><td>Yr. 3</td><td>Yr. 4</td><td>Total</td></tr>
<tr>
<td rowspan="4">Outcome 5: Gender equality and reproductive rights advanced particularly through advocacy and implementation of laws and policy

<u>INDICATORS</u>
• Percentage of women aged 20-24 who were married or in union before age 18
<table><tr><td>Baseline</td><td>Target</td></tr><tr><td>37.6%</td><td>35%</td></tr></table>
• Number of states with established coordination mechanisms in place to track the implementation of laws and policies advancing gender equality and reproductive rights
<table><tr><td>Baseline</td><td>Target</td></tr><tr><td>5</td><td>9</td></tr></table><u>Joint Program output indicators</u>
7. % of HFs providing a comprehensive package of FGC abandonment services
8. Status of midwifery curriculum to include abandonment of FGC
9. Number of communities with leaders (religious, tribal) and community health promoters actively involved in FGC abandonment</td>
<td rowspan="4">Output 5: Strengthened national, state and community capacity to promote gender equality and to prevent and respond to early marriage, sexual violence and female genital mutilation

<u>MILESTONES:</u>
-Partnerships with community/religious leaders and youth serving organizations at state, locality and village levels-built and they are involved in awareness raising and outreach activities (2013-14-15-16)

-Existing women and child protection units received institutional and technical support for referral pathways (2013-14-15-16)

-Annual media strategy on EM and FGM developed (2013-14-15-16)

-Community watchdogs for CM and FGM formed (2013-2014)

-Partnerships with universities, policy makers, legislators and media at national and state levels for evidence-based planning and proper targeting is established; (2013-14-15-16)</td>
<td rowspan="4">1. Number of UNFPA-supported villages and urban communities that have abandoned FGM/C
<table><tr><td>Baseline</td><td>Target</td></tr><tr><td>86</td><td>186</td></tr></table>MoV: Progress reports, KAP study report
2. Number of localities in UNFPA-supported states with functional gender-based violence referral pathways that include at least three multi-sectoral services.
<table><tr><td>Baseline</td><td>Target</td></tr><tr><td>19</td><td>50</td></tr></table>MoV: progress and FMV
3. Number of health-care providers trained in clinical management of rape
<table><tr><td>Baseline</td><td>Target</td></tr><tr><td>432</td><td>1,432</td></tr></table>MoV: training reports
4. Number of identified articles within family laws and the penal code revised and endorsed, advancing gender equality and equity.
<table><tr><td>Baseline</td><td>Target</td></tr><tr><td>2</td><td>12</td></tr></table>MoV: circular on the Revised Family Law
<u>Joint Program output indicators</u>
5. Status of National Task Force to coordinate FGC activities
6. Regular monitoring meetings/events at national and state levels organized and reports disseminated</td>
<td rowspan="4">Ministries of: Education; Health; and Social Welfare; State Committees to Combat Violence Against Women; civil society organizations; WHO, UNICEF, UN Women; Ahfad University for Women; National Council for Child Welfare, Gedarif University, Women Parliamentarian Caucus, Ministry of Guidance and Endowment, Ministry of Labour, Ministry of Agriculture, Ministry of Finance</td>
<td rowspan="4"><u>ASSUMPTIONS:</u>
Available resources to support the program implementation

Positive response from local leaders and target communities

Enabling environment for program implementation

Strong partnerships and effective coordination mechanisms

Stable political context: easy access to program beneficiaries especially in humanitarian areas

<u>RISKS:</u>
Negative role of some influential groups (parliamentarians, religious leaders, media) on the policy environment

International financial crisis and shift of donor interest</td>
<td colspan="5">Regular resources</td></tr>
<tr><td>500</td><td>500</td><td>500</td><td>500</td><td>2,000</td></tr>
<tr><td colspan="5">Other resources</td></tr>
<tr><td>2,000</td><td>2,000</td><td>2,000</td><td>2,000</td><td>8,000</td></tr>
</table>

UNDAF Outcome # 1(Extract from UNDAF)
UNDAF indicators, baselines and targets to which the CP outputs contribute

UNFPA Strategic Plan Outcome	Country programme output(s)	Output indicators and means of verification	Implementing Partners	Risks and assumptions	Indicative resources by output per annum (Thousands USD)				
					Yr. 1	Yr. 2	Yr. 3	Yr. 4	Total
Outcome 7: Improved data availability and analysis around population dynamics SRH (including family planning and gender equality) **INDICATORS** • National household health survey conducted during the next three years **Baseline:** 0 / **Target:** **SHHS conducted**	Output: Strengthened national and state capacity to produce, analyse and disseminate high-quality disaggregated population data for evidence-informed planning and monitoring, with a focus on maternal health **MILESTONES:** -Expertise identified and consultants recruited in support to establishing national statistical system **(2013-2014)** -ToR for statistical coordination mechanism (at national and state levels) developed **(2013)** -Details of required statistical publications identified and agreed **(2013)** -Preparatory work for SHHS3 (2015) and Census (2018) initiated in 2014 and 2016 respectively. **(2014, 2016)**	**1.** Nationally agreed standardized protocols for data collection and analysis in place. **Baseline:** 0 / **Target:** **Protocols and gui in place** **MoV:** consultancy report **2.** Number of national- and state-level statistical coordination mechanisms for data suppliers and users established and functional **Baseline:** 0/0 / **Target:** **1/10** **MoV:** Coordination meetings' minutes, progress reports **3.** Number of statistical publications at national and state levels prepared in line with international standards and with data disaggregated by sex and age. **Baseline:** 0 / **Target:** **12** **MoV:** Statistical publications, progress reports	Central Bureau of Statistics, Academic institutions, UNDP, OCHA, NPC	**ASSUMPTIONS:** Available resources to support the program implementation Commitment and political will of national and state governments Stable macro context: easy access to humanitarian areas **RISKS:** Resumption/escalation of conflict in the recovery and emergency settings	Regular resources				
					450	500	650	900	**2,500**
					Other resources				
					750	850	900	1,000	**3,500**

UNFPA Sudan CO

CPAP Planning Matrix for Monitoring and Evaluation

Expected results (outcomes & outputs)	Indicators (with baselines & indicative targets) and other key areas to monitor	M&E event with data collection method	Time or schedule and frequency	Responsibilities	Resources
Outcome 1: Population dynamics and its inter-linkages with the needs of young people (including adolescents), SRH (including family planning), gender equality and poverty reduction addressed in national sectoral development plans and strategies **Output 1:** 1.1. Strengthened national capacity to incorporate population dynamics, including its linkages with sexual and reproductive health, into relevant policies and development plans, with special attention to the needs of young people and women **MILESTONES:** -Population dynamics issues identified and studies conducted **(2013)** -Existing national policies/strategies and development plans vis-à-vis population dynamics and their linkages with RH/SRH reviewed **(2014)** -Youth structures and institutions at state and locality level identified; their capacities assessed and terms and conditions of coordination agreed (**2013-14-15-16)**	**Outcome indicators** 1. Population dynamics and its interlinkages are incorporated into national development plans and poverty reduction strategy papers. **(Baseline: minimal; Target: fully integrated)** 2. Reproductive health services are integrated into national health policies and plans **(Baseline: partial; Target: fully integrated)** **Output indicators** **1.** Number of studies on population dynamics conducted, with the findings incorporated into policies, strategies and plans at national and UNFPA-supported state levels **(Baseline: 4; Target: 10)** **2.** Number of UNFPA-supported localities with youth coordination mechanisms established and operational **(Baseline: 0; Target: 12)**	**Events:** Routine monitoring Country Program Evaluation (CPE) **Methods:** Review national development plans, PRSP Review studies on population dynamics Review national policies, strategies and plans at national and state levels Interviews and FGDs with youth; review reports and meetings' minutes	2015 2015 Quarterly, Annually (2013-14-15-16)	PD/RH/Gender/HIV/AIDS Specialists M&E Officer	55,000 0 50,000

Expected results (outcomes & outputs)	Indicators (with baselines & indicative targets) and other key areas to monitor	M&E event with data collection method	Time or schedule and frequency	Responsibilities	Resources
Outcome 2: Increased access to and utilization of quality maternal and new-born health services **Output 2:** 2.1. Increased demand for information and services related to reproductive, maternal and new-born health and HIV prevention **MILESTONES:** -Partnership agreements with CSOs to provide information and services at community level signed **(2013)** -Capacity of existing obstetric community-based referral mechanisms assessed **(2013)** -New communities for establishing obstetric referral mechanisms identified in collaboration with state/local authorities **(2013-2014)** -Condom programming strategy endorsed and operationalized **(2013)** -BCC strategy for HIV/RH including in humanitarian settings updated/developed (**2014 – 2015)** -Y-Peer educators' networks scaled up **(2013-2014)**	**Outcome indicators** **-** Births attended by skilled health personnel **(Baseline: 23%; Target: 30%)** **-** Number of states with Caesarean section rates below 5**%** **(Baseline: 9; Target: 4)** **Output indicators** **1.** Number of civil society organizations engaged in behaviour change communication on gender, reproductive health, early marriage and HIV/AIDS at the community level **(Baseline: 0; Target: 60)** **2.** Number of community-based obstetric referral mechanisms established and functional at the local level (**Baseline: 8; Target: 19)** **3.** Number of individuals from MARPs and VGs reached by BCC outreach activities **(Baseline: 130,413 ; Target: 180,209)** **4.** Number of MARPs benefitted from IGA sub-projects **(Baseline: 140; Target: 640)**	**Events:** Sudan Household Health Survey **Methods:** Interviews, FGDs **Events:** Monitoring visits, quarterly review meetings, CPE **Methods:** review AWPs, progress reports, review FMV reports, interviews, FGDs	2015 2015 Annually, quarterly (2013-14-15-16)	RH Specialist M&E Officer RH Specialist. HIV/AIDS Officer M&E Officer RH team	50,000 80,000

Expected results (outcomes & outputs)	Indicators (with baselines & indicative targets) and other key areas to monitor	M&E event with data collection method	Time or schedule and frequency	Responsibilities	Resources
Outcome 2: Increased access to and utilization of quality maternal and new-born health services **Output 3:** Increased availability of high-quality information and services for maternal and new-born health and HIV prevention, especially for underserved populations and people with special needs **MILESTONES** - HFs renovated and provided with supplies and equipment necessary for service provision (delivery theatres, drugs, supplies) **(2013-2014-2015)** - Service providers trained on EmOC, HIV, RH/SRH and OF **(2013-14-15-16)** - EmOC treatment protocols available at service delivery points **(2013)** - Midwifery curricula updated and midwifery schools rehabilitated and equipped to lodge midwifery education in the selected states **(2013-2014)** - Guidelines for integrated HIV/SRH services developed and operationalized **(2013-2014)** - VCT centres mapped and supported to provide HIV counselling and testing for MARPs **(2013-14-15-16)**	**Outcome Indicators:** **1.** Births attended by skilled health personnel **(Baseline: 23%; Target: 30%)** **2.** Number of states with Caesarean section rates below 5% **(Baseline: 9; Target: 4)** **Output indicators** **1.** Number of fistula cases repaired **(Baseline: 659; Target: 1,000)** **2.** Number of village midwives trained **(Baseline: 5,721; Target: 7,021)** **3.**Percentage of health facilities providing basic and comprehensive emergency obstetric and neonatal care services in the selected states. **(Baseline: 19%/17%; Target: 70%/60%)** **4.** Number of primary health-care facilities providing integrated services on sexual and reproductive health, HIV and sexually transmitted infections. **(Baseline: 65; Target: 111)** **5.** Number of people from vulnerable groups and populations that are most at risk who have received counselling, testing and management services through UNFPA support **(Baseline: 1,118; Target: 9,756)**	**Events:** Sudan Household Health Survey **Methods:** Interviews, FGDs **Events:** Monitoring visits, **Methods:** Interviews with health service providers, review records and progress reports	2015 Quarterly, annually (2013-14-15-16)	RH Specialist HIV/AIDS Officers M&E Officer RH Specialist HIV/AIDS Officer M&E Officer RH-HIV/AIDS team	50,000 60,000

Expected results (outcomes & outputs)	Indicators (with baselines & indicative targets) and other key areas to monitor	M&E event with data collection method	Time or schedule and frequency	Responsibilities	Resources
Outcome 4: Increased access to and utilization of quality family planning services for individuals and couples according to reproductive intentions	<u>**Outcome indicators**</u> 1. Contraceptive prevalence rate **(Baseline: 9%; Target: 15%)** 2. Unmet need for family planning **(Baseline: 23.8%; Target: 18%)** 3. Percentage of service delivery points offering at least three modern methods of contraception **(Baseline: 23.8%; Target: 18%)**	**Events** Sudan Household Health Survey **Methods:** Interviews, FGDs	2015	RHCS Officer M&E Officer	50,000
Output 4: 3.1. National systems for reproductive health commodity security and for the provision of family planning services are strengthened <u>**MILESTONES:**</u> **-**Training Plans prepared and service providers to be trained identified **(2013-14-15-16)** -Procurement and distribution plans of FP commodities (by method) developed as per projection/needs of health facilities**; (2013-14-15-16)** -Gaps in logistics/supply and reporting systems identified and action plan prepared accordingly **(2013)**	<u>**Output indicators**</u> **1.** Number of service providers trained in family planning **(Baseline: 1,564; Target: 2,564)** **2.** Percentage of national commodity requests satisfied **(Baseline: 20%; Target: 80%)** **3.** Percentage of facilities having no stock-outs of contraceptives in past six months in UNFPA-supported states **(Baseline: 15%; Target: 70%)**	**Events** Monitoring visits, review meetings **Methods:** Review training/progress/FMV reports Interview training beneficiaries	Quarterly, annually (2013-14-15-16)		50,000

Expected results (outcomes & outputs)	Indicators (with baselines & indicative targets) and other key areas to monitor	M&E event with data collection method	Time or schedule and frequency	Responsibilities	Resources
Outcome 5: Gender equality and reproductive rights advanced particularly through advocacy and implementation of laws and policy **Output 5:** Strengthened national, state and community capacity to promote gender equality and to prevent and respond to early marriage, sexual violence and female genital mutilation **Joint Program output indicators** **8.** Status of National Task Force to coordinate FGC activities **9.** Regular monitoring meetings/events at national and state levels organized and reports disseminated **MILESTONES:** -Partnerships with community/religious leaders and youth serving organizations at state, locality and village levels-built and they are involved in awareness raising and outreach activities **(2013-14-15-16)** - Existing women and child protection units received institutional and technical support for referral pathways **(2013-14-15-16)** - Annual media strategy on EM and FGM developed **(2013-14-15-16)** - Community watchdogs for CM and FGM formed **(2013-2014)** - Partnerships with universities, policy makers, legislators and media at national and state levels for evidence-based planning and proper targeting is established; (**2013-14-15-16)**	**Outcome indicators** 1. Percentage of women aged 20-24 who were married or in union before age 18 **(Baseline: 37.6%; Target: 35%)** 2. Number of states with established coordination_mechanisms in place to track the implementation of laws and policies advancing gender equality and reproductive rights **(Baseline: 5; Target: 9)** **Output indicators** **1.** Number of UNFPA-supported villages and urban communities that have abandoned female genital mutilation/cutting. **(Baseline: 86; Target: 186)** **2.** Number of UNFPA-supported localities with functional gender-based violence referral pathways that include at least three multi-sectoral services. **(Baseline: 19; Target: 50)** **3.** Number of health-care providers trained in clinical management of rape for survivors of gender-based violence **(Baseline: 432; Target: 1,432)** **4.** Number of identified articles within family laws and the penal code revised and endorsed, advancing gender equality and equity. **(Baseline: 2; Target: 12)** **Joint Program output indicators** **5.** % of HFs providing a comprehensive package of FGC abandonment services **6.** Status of midwifery curriculum to include abandonment of FGC **7.** Number of communities with leaders (religious, tribal) and community health promoters actively involved in FGC abandonment	**Events:** Sudan Household Health Survey **Methods:** interviews, FGDs Monitoring visits, review meetings, CPE **Events:** Monitoring visits, KAP survey **Methods:** Review training/progress/FMV reports, KAP survey reports	2015 Quarterly, Annually (2013-14-15-16) Quarterly, Annually (2013-14-15-16)	Gender Specialist M&E Officer Gender Specialist M&E Officer Gender Specialist RH Specialist and RH team M&E Officer	50,000 80,000

Expected results (outcomes & outputs)	Indicators (with baselines & indicative targets) and other key areas to monitor	M&E event with data collection method	Time or schedule and frequency	Responsibilities	Resources
Outcome 6: Improved data availability and analysis around population dynamics SRH (including family planning and gender equality) **Output 7:** Strengthened national and state capacity to produce, analyse and disseminate high-quality disaggregated population data for evidence-informed planning and monitoring, with a focus on maternal health **MILESTONES:** -Expertise identified and consultants recruited in support to establishing national statistical system **(2013-2014)** -ToR for statistical coordination mechanism (at national and state levels) developed **(2013)** -Details of required statistical publications identified and agreed **(2013)** -Preparatory work for SHHS3 (2015) and Census (2018) initiated in 2014 and 2016 respectively. **(2014, 2016)**	**Outcome indicators** 1. National household health survey conducted during the next three years **(Baseline: 0; Target: SHHS conducted)** **Output indicators** **1**. Nationally agreed standardized protocols for data collection and analysis in place. **(Baseline: 0; Target: Statistical protocols and guidelines in place)** **2.** Number of national- and state-level statistical coordination mechanisms for data suppliers and users established and functional **(Baseline: 0/0; Target: 1/10)** **3.** Number of statistical publications at national and state levels prepared in line with international standards and with data disaggregated by sex and age. **(Baseline: 0; Target: 12)**	**Event:** SHHS **Method:** Review SHHS report **Events:** FMVs **Methods:** Review of: progress reports, developed protocols, guidelines and materials, FMVs reports, meetings' minutes, interviews	2015 2014 Annually (2014-15-16)	PD/RH/Gender Specialists M&E Officer	0 50,000
TOTAL					**625,000**