COUNTRY CASE STUDY

# Mid-term evaluation of the Maternal and Newborn Health Thematic Fund

Phase III 2018-2022

**Sudan**

**UNFPA Evaluation Office**

**2022**

## MID-TERM EVALUATION OF THE MATERNAL AND NEWBORN HEALTH THEMATIC FUND PHASE III, 2018-2022

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# FOREWORD

Since 2008, the MHTF has served as the UNFPA flagship programme on maternal and newborn health. Now in Phase III, the MHTF has widened its scope to contribute to the broader sexual and reproductive health and rights agenda impelled by the International Conference on Population and Development's (ICPD) Programme of Action. Joining the momentum built up around the necessity of a greater focus on the newborn period along the continuum of care, and recognizing the indivisible interconnections between maternal and neonatal health (MNH), it changed its name to the Maternal and Newborn Health Thematic Fund in 2018. Its goal is to enable every woman, adolescent girl and newborn to have equitable and accountable access to quality sexual, reproductive, maternal and newborn health and rights by strengthening health systems in countries with a high burden of maternal morbidity and mortality, thus contributing to the global target of having fewer than 70 maternal deaths per 100,000 live births by 2030 (Sustainable Development Goal 3, Target 1).

The mid-term evaluation of the MHTF (Phase III) was conducted as an independent assessment of the performance of the MHTF in providing catalytic support through country-owned and -driven interventions in order to improve maternal and newborn health and rights in 32 high-mortality countries. The evaluation covers the period from 2018 to 2021 and provides learning to feed into the implementation of the MHTF in its current phase. It also informs the reflection on the strategic directions and operating model for the MHTF post 2022.

The evaluation highlights the significant and tangible contributions of the MHTF to country health systems and shows how the MHTF model (a combination of seed funding, links to established global partnerships, and technical support) enables programme countries to access guidance and support to upgrade relevant national approaches in order to meet global standards. In fact, the MHTF brings value across a significant range of technical areas and delivers considerable thrust with a limited package of resources, opening, in countries, specific entry points for health systems strengthening and for the integration of SRHR-MNH services. With the MHTF, UNFPA is a credible partner, taking the lead in midwifery, and is consistently valued for its responsiveness and strategic investments as well as for its knowledge products and technical guidance in maternal, newborn and adolescent health.

However, the MHTF faces a number of challenges that have started to constrain its impact, or will do so in the future. The evaluation points, in particular, at the need to engage with communities to address barriers to access, to overcome delays, to improve accountability and to better ground MHTF investments with affected populations. To fully exercise its catalytic effect, the evaluation also shows how important it is for the MHTF to further engage national leadership for MNH in order to target the resource mobilization needed to take technical advances to scale. This is key to support greater institutionalization of the MHTF systems strengthening investments.

I am confident that the lessons learned and the recommendations highlighted by this mid-term evaluation will help to further enhance the contribution of UNFPA and the MHTF to maternal and newborn health. The evaluation results are also particularly relevant as UNFPA channels its efforts to help health systems recover from the COVID-19 pandemic so that progress continues to be made in advancing sustainable development and promoting the health, rights and well-being of mothers and newborns to ensure that no one is left behind.

**Marco Segone**

Director

UNFPA Evaluation Office

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# ABBREVIATIONS AND ACRONYMS

| | |
|---|---|
| AMDD | Averting Maternal Death and Disability |
| ANC | Antenatal care |
| ASRO | Arab States Regional Office |
| BEmONC | Basic emergency obstetrics and newborn care |
| CAFA | Community Animator Friendly Association |
| CEmONC | Comprehensive emergency obstetrics and newborn care |
| CMR | Clinical management of rape |
| CO | Country office |
| COVID-19 | 2019 novel coronavirus/Corona virus disease/SARS-CoV-2 |
| DHIS | District health information system |
| EHG | Euro Health Group |
| EmONC | Emergency obstetric and newborn care |
| eMTCT | Elimination of mother-to-child transmission |
| EPMM | Ending Preventable Maternal Mortality initiative |
| ERG | Evaluation Reference Group |
| FCDO | Foreign, Commonwealth and Development Office (UK) |
| FGM | Female genital mutilation |
| FIGO | International Federation of Gynaecologists and Obstetricians |
| FMoH | Federal Ministry of Health |
| FTE | Full time equivalent |
| GBV | Gender-based violence |
| GDP | Gross domestic product |
| GFF | Global Financing Facility |
| GIS | Geographic Information System |
| GNI | Gross national income |
| GoS | Government of Sudan |
| H6 | A group comprising six United Nations health agencies (WHO, UNAIDS UNFPA, UNICEF, UN Women, World Bank) |
| HDU | High dependency unit |
| HIV | Human immunodeficiency virus |
| HMIS | Health management information system |
| HQ | Headquarter |
| ICM | International Confederation of Midwives |
| ICU | Intensive care unit |
| iNGO | International non-governmental organization |
| IPC | Infection prevention and control |
| MCH | Maternal and child health |
| mCPR | Contraceptive Prevalence Rate (modern methods) |
| MDG | Millennium Development Goal |
| MDR | Maternal death review |
| MDSR | Maternal death surveillance and response |
| MHTF | Maternal and Newborn Health Thematic Fund |
| MISP | Minimum initial service package for SRH in emergencies |
| MMR | Maternal mortality ratio |
| MNH | Maternal and newborn health |

| | |
|---|---|
| MoH | Ministry of Health |
| MoU | Memorandum of Understanding |
| MPDSR | Maternal and perinatal death surveillance and response |
| MSI | Marie Stopes International |
| NGO | Non-governmental organization |
| NMDRC | National maternal death review committee |
| NMR | Neonatal mortality rate |
| Ob/Gyn | Obstetrics and gynaecology |
| PAC | Post-abortion care |
| PHC | Primary health care |
| PMNCH | Partnership for Maternal, Newborn and Child Health |
| PMTCT | Preventing mother-to-child transmission of HIV |
| PPE | Personal protective equipment |
| QI | Quality improvement |
| RH | Reproductive health |
| SDG | Sustainable Development Goal |
| SGBV | Sexual and gender-based violence |
| SMDRC | State maternal death review committee |
| SMoH | State Ministry of Health |
| SRH | Sexual and reproductive health |
| SRHR | Sexual and reproductive health and rights |
| SRMNAH | Sexual reproductive newborn adolescent health |
| SRMNCAH | Sexual, reproductive, maternal, newborn, child and adolescent health |
| STI | Sexually transmitted infections |
| SuMA | Sudan Midwifery Association |
| The Global Fund | The Global Fund to fight AIDS, Tuberculosis and Malaria |
| TWG | Technical working group |
| UHC | Universal health coverage |
| UN | United Nations |
| UNFPA | United Nations Population Fund |
| UNICEF | United Nations Children's Fund |
| USAID | United States Agency for International Development |
| VIA | Visual inspection of the cervix with acetic acid |
| WHO | World Health Organization |

# GLOSSARY OF TERMS

| Term | Definition | Source |
|---|---|---|
| **Child marriage** | Child marriage is any formal marriage or informal union where one or both of the parties are under 18 years of age. Each year, 12 million girls across the world are married before the age of 18. Complications in pregnancy and childbirth are the leading cause of death in girls aged 15-19 globally. | https://www.girlsnotbrides.org/about-child-marriage/ https://www.girlsnotbrides.org/themes/health/ |
| **EmONC: Emergency obstetric and neonatal care** | A standard of care to manage obstetric complications. EmONC designated facilities must have skilled attendants covering 24 hours a day, seven days a week, assisted by trained support staff. Basic EmONC (BEmONC) includes seven capacities: (1) parenteral treatment of infection (antibiotics); (2) parenteral treatment of post-partum haemorrhage (uterotonic drugs like Oxytocin); (3) parenteral treatment of pre-eclampsia/eclampsia (anticonvulsants like magnesium sulphate); (4) manual removal of the placenta; (5) removal of retained products following miscarriage or abortion; (6) assisted vaginal delivery, preferably with vacuum extractor; and (7) basic neonatal resuscitation care. Comprehensive EmONC (CEmONC) includes these seven capacities plus the provision to conduct a caesarean section/surgery and to administer safe blood transfusions. | https://www.unfpa.org/featured-publication/implementation-manual-developing-national-network-maternity-units |
| **Integrated MNH and SRHR** | This term refers to the integration of maternal and newborn health (MNH) and sexual and reproductive health and rights (SRHR) information and services. Note that the evaluation will not utilise the acronym for reproductive, maternal, newborn, child and adolescent health, as child health is not part of the scope of the evaluation. The MHTF encompasses focus areas related to MNH and SRHR interventions, including family planning, preventing mother-to-child transmission of HIV, prevention of HIV/sexually transmitted infections (STIs), and cervical cancer prevention and screening. A focus on adolescents cuts across all MHTF interventions related to MNH and SRHR. | https://www.unfpa.org/sites/default/files/pub-pdf/UNFPA-MHTF-WEB.pdf |
| **Maternal and Newborn health (MNH)** | Maternal health refers to the health of women during pregnancy, childbirth, and the postnatal period (42 days following birth). Newborn health focuses on improving care around the time of birth and in the first four weeks of life. | https://www.who.int/health-topics/newborn-health#tab=tab_1 https://www.who.int/health-topics/maternal-health#tab=tab_1 Accessed from World Health Organization accessed February 27, 2021 |
| **Maternal and perinatal death surveillance and response (MPDSR)** | MPDSR is a continuous cycle of identification, notification and review of maternal deaths followed by recommendations to improve care. The full cycle also includes follow-up of actions taken to improve quality of care and prevent future deaths. | https://www.who.int/maternal_child_adolescent/epidemiology/maternal-death-surveillance/en/ |

| Term | Definition | Source |
|---|---|---|
| **Maternal mortality ratio** | The number of maternal deaths during a given period per 100,000 live births during the same period. The global maternal mortality target (to reduce maternal deaths to at least as low as 70 per 100,000 live births) was agreed in 2015 in a consensus paper on Ending Preventable Maternal Mortality (EPMM) and adopted as the Sustainable Development Goal (SDG) target (SDG indicator 3.1.1). Maternal mortality is measured less frequently than other indicators (every 3 to 5 years) and evidence would be strengthened where country civil registries and vital statistics systems were strengthened. There is a tendency in many countries to underreport maternal deaths. | Health statistics and information systems: Maternal Mortality Ratio World Health Organization accessed 25 Feb 2021. |
| **Newborns/ neonates** | A newborn or neonate is a baby in its first 28 days of life. About 75 per cent of neonatal deaths occur in the first seven days of life and a third of these on the day of birth. Neonatal deaths are primarily caused by birth injuries and asphyxia, preterm birth, post-partum infections and birth defects. | https://www.who.int/news-room/fact-sheets/detail/newborns-reducing-mortality Ending Preventable Newborn Deaths and Stillbirths, 2020-2025, UNICEF, 2020 |
| **Obstetric fistula** | Obstetric fistula is a serious childbirth injury. It is a hole that has opened between the birth canal and bladder and/or rectum and is caused by prolonged, obstructed labour without access to timely, high-quality medical treatment. It leaves women leaking urine and/or faeces and can lead to chronic medical problems, social isolation and deepening poverty. | https://www.unfpa.org/obstetric-fistula |
| **Perinatal death** | A death that occurs between 28 weeks of completed gestation and the first seven days of life. | |
| **Sexual and gender-based violence (SGBV)** | SGBV refers to harmful acts directed at an individual based on their gender. It is rooted in gender inequality, patriarchal norms and harmful practices.<br>SGBV is a violation of human rights and a life-threatening health and protection issue. It is estimated that one in three women will experience sexual or physical violence in their lifetime. During displacement and times of crisis, the threat of SGBV significantly increases for women and girls. | https://www.unhcr.org/uk/gender-based-violence.html |
| **SRHR** | A comprehensive range of services to enable every person to achieve sexual health and well-being. Services include contraceptive services; maternal and newborn care; prevention and control of STIs, including HIV; comprehensive sexuality education; safe abortion care, including post-abortion care; prevention, detection, and counselling for SGBV; prevention and treatment of infertility and cervical cancer; and counselling and care for sexual health and wellbeing | Guttmacher Lancet Commission on SRHR: https://www.guttmacher.org/guttmacher-lancet-commission/accelerate-progress-executive-summary# This definition was endorsed by WHO and UNFPA: https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)30901-2/fulltext |
| **Stillbirth** | A baby born with no signs of life at or after 28 weeks of gestation. There are different types of stillbirths. More than half of all stillbirths for example occur during labour and birth. The majority are preventable. | Ending Preventable Newborn Deaths and Stillbirths, 2020-2025, UNICEF, 2020 |

| Term | Definition | Source |
|---|---|---|
| **Young people, youth and adolescents** | Child: a person under 18 years of age, as defined by the United Nations.<br>Adolescent: a person aged 10 to 19 years, as defined by the United Nations.<br>Young person: a person between 10 and 24 years old, as defined by WHO.<br>Youth: a person between 15 and 24 years old, as defined by the United Nations. The United Nations uses this age range for statistical purposes but respects national and regional definitions of youth. | UNESCO (2018) *International technical guidance on sexuality education: An evidence-informed approach* |

# EXECUTIVE SUMMARY OF THE OVERALL MID-TERM EVALUATION OF THE MHTF PHASE III (2018-2022)

## PURPOSE AND SCOPE OF THE EVALUATION

Ending preventable maternal deaths is one of three transformative results of United Nations Population Fund (UNFPA) and includes an emphasis on the integration of sexual and reproductive health and rights (SRHR) with maternal and newborn health (MNH) services. The Maternal and Newborn Health Thematic Fund (MHTF) was first established in 2008 and, now in its third phase, is closely associated with this transformative result. Unfortunately, global progress on maternal and newborn mortality reduction is not on track to meet the 2030 Sustainable Development Goal (SDG) targets and has been further affected by the health, social and economic effects of the global COVID-19 pandemic.

The MHTF delivers technical and financial support in 32 high burden countries to create catalytic and accelerated progress in one or more of four priority technical areas: midwifery, emergency obstetric and newborn care (EmONC), maternal and perinatal death surveillance and response (MPDSR) processes, and the prevention and treatment of fistula and other obstetric morbidities. The MHTF also contributes to the UNFPA presence and leadership of maternal health at the global level.

This evaluation assesses the MHTF progress against its 2018-2022 Business Plan and identifies key lessons and challenges to support its future evolution. In particular, the evaluation considers the extent to which the MHTF has contributed to strengthening health systems, improving quality of care, and advancing equity, human rights and accountability to stakeholders in partner countries. The evaluation also assesses the extent to which the MHTF supports the scaled up integration of SRHR-MNH services, reflecting the well-established and critical role of universal access to quality SRHR services as essential to achieving MNH.

## METHODOLOGY

The evaluation identifies the contribution made by UNFPA and applies a theory-based approach in order to analyse the intended results of UNFPA support. It also takes into account the larger health system factors and economic and social determinants affecting MNH. The evaluation team adapted the MHTF theory of change to incorporate all aspects of UNFPA support and developed a series of nine detailed evaluation questions to set out and define the areas of research. Associated with each question, key causal assumptions were tested via indicators using primary and secondary data gathered, analysed and presented by the evaluation team.

Data collection was structured around six country case studies (Benin, Sudan, Uganda, Zambia, Bangladesh and Togo) involving a range of methods and sources including document review, country-focused interviews and group discussions and, where feasible (given COVID-19 legal and public health restrictions), site visits and observation. Data were also collected through key informant interviews with global and regional stakeholders, through a comprehensive review of relevant documents and data sets at the global and regional levels and through an online survey completed by respondents from the MHTF partner countries. The evaluation followed a structured plan for analysis and triangulation of the data to respond to the nine questions.

## MAIN FINDINGS

**As one of the few United Nations funds and programmes supporting midwifery, with the MHTF, UNFPA has succeeded in raising the profile and standing of midwives at the global and country levels.** The UNFPA partnership with the International Confederation of Midwives (ICM) is a key asset that amplifies its credibility with partner governments, supporting the alignment of national policies with international standards. MHTF investments and expertise have led to global policy products and

practical benefits supporting midwifery development in countries beyond the MHTF. Professional development is a long-term process, and the key challenge for the MHTF and its partners remains how to put midwifery policies into action at scale, particularly with limited resources. Furthermore, while UNFPA is ambitious in its aim to eradicate gender disparities, action taken in countries to ensure midwives have a seat at the table to effect policy change is inconsistent. Nonetheless, MNH partners recognize midwifery support as a central pillar of the MHTF and a critical driver of other technical priorities (namely EmONC, fistula and MPDSR) as well as a crucial strategy for effective integration of SRHR and MNH services despite a lack of holistic programming in some contexts.

**The MHTF has championed the development and application of the EmONC network model in selected partner countries using an innovative health systems strengthening approach based on consensus building around standards of care, the rationalization of EmONC facility distribution, and routine facility monitoring.** The phased approach of the EmONC network offers an objectively verifiable model for elaborating service delivery standards that can be adapted to each country context. Viewed by key informants as rigorous and credible, this methodology – and the MHTF application of it - enables a concrete step forward in EmONC and MNH systems strengthening that creates leadership opportunities in partner countries and opens a pathway to improving quality of care. Two limitations affect the long-term sustainability of the MHTF investments in EmONC. The first is the limited consideration given so far to including the community level as a structured part of care networks. The second is the challenge of sustainability through the institutionalization of the monitoring process associated with quality improvement and without which the benefits of the model will be difficult to maintain. An additional challenge for the MHTF, given the range of countries it supports (including many that do not implement the EmONC network approach), is to balance a flexible and country responsive approach to EmONC support while also ensuring sufficient links to larger health system reform processes.

**Sustained MHTF partnership has enabled MPDSR processes to be somewhat embedded across a range of health systems contexts and is valued by country governments and partners.** MHTF technical and financial resources enable countries to develop MPDSR strategies, implement national and subnational committee structures and produce periodic reports. The MHTF has also participated in the development of new indicators for measuring the implementation of MPDSR in countries. While notifications of maternal deaths tend to be increasing, the sustained institutionalization of MPDSR has been difficult to achieve and progress varies depending on country leadership and commitment. Although exceptions can be identified, death audit/review findings are underutilized in most countries, which is indicative of a problem with the process itself rather than with MHTF technical support. The challenges faced in strengthening MPDSR systems stress the importance of demand creation and community engagement for better outcomes from SRHR-MNH integrated service investments as well as the need to maintain systematic action to encourage earlier attendance by women at the health facility and build trust between providers and beneficiaries of care.

**UNFPA has made a clear contribution at both the global and national levels towards increasing the commitment of governments and partners to end fistula.** As lead for the Global Campaign to End Fistula, UNFPA/MHTF effectively coordinates an advocacy and knowledge sharing agenda that has helped to maintain fistula as a global priority. At the national level, the strategic positioning of UNFPA is enhanced by its partnership with governments and its convening role, which has advanced national strategies to end obstetric fistula. Building capacity for fistula treatment and care is the main thrust of programming in countries and tangible progress has been made through strategies linking competent surgeons with clients, with mobile teams, and with service delivery camps. However, in most countries, these services remain donor-dependent and have yet to be mainstreamed into the health system. Efforts to rehabilitate and reintegrate survivors into communities are at early stages overall. The rise in iatrogenic fistula (caused by medical treatment) is an emerging issue globally and

requires renewed attention to safe surgical services and quality of care throughout all components of the MHTF.

**The MHTF has been able to support integration of SRHR and MNH services to some extent and there is tangible evidence of progress in the integration of family planning into maternal health services across the care continuum**. The MHTF supports each country to define the scope of integration between SRHR and MNH services according to their own opportunities and service priorities. However, integration of post-abortion care is inconsistently addressed. Moreover, the MHTF support to integrating both adolescent SRHR and sexual and gender-based violence (SGBV) is at an earlier stage of evolution and this task seems to be considerably harder as it requires midwives with an expanded skillset, more time and space (privacy), and attitudes that are respectful and non-judgemental. At the centre of the integration process, the midwife is a critical lynchpin to expanding access to a full range of SRHR and MNH services for women and girls. Yet, efforts to support midwifery-led integration are obstructed by weak infrastructure and a lack of equipment, two structural health system failures that the MHTF can only partially tackle. An important emerging challenge is the need to balance the opportunity and vision to develop a comprehensive approach to women's health across the life-course without increasing the risk of overburdening midwives and associated health systems.

**The MHTF is oriented towards equality, human rights and values associated with ensuring equitable access to services for all women and girls but with uneven results so far**. MHTF interventions supporting service access (midwifery training, EmONC and fistula) have resulted in expanding service delivery to underserved geographic areas and vulnerable populations, while also maintaining a spotlight on relevant social and economic determinants affecting MNH. However, the MHTF does not have a defined or explicit approach or process for identifying those most at risk or the most vulnerable. The MHTF lacks a framework for defining and operationalizing rights-based principles in programming, which leads to inconsistent application in country-based activities, including, for instance, varying attention to the need for respectful care. Because of limitations in the integration of SRHR and MNH, MHTF activities are less effective in ensuring that adolescent girls and women are empowered to access a full range of SRHR services, especially contraception, post-abortion care and, where legal, safe abortion services.

**The MHTF method of combining technical knowledge, seed funding, and global partnerships in order to support country partners to tackle particular SRHR-MNH technical areas is a strength that positions it well to leverage catalytic results.** The method allows the MHTF to provide high quality support in four critical technical areas and increases UNFPA credibility with country partners. The MHTF has produced an impressive range of global guidance, peer reviewed evidence papers and other policy documents. However, the potential behind many "catalytic" investments is still to be fully realized especially - but not only - given constraints to progress created by the ongoing COVID-19 pandemic (although these should be transient). Other stand-alone innovations and digital adaptations (such as mobile phone apps) have played a role in supporting results but are not, in themselves, necessarily catalytic or sustainable. The MHTF is currently addressing the twin challenge of firstly developing strengthened guidance that clearly defines what being catalytic means and secondly laying out the operational approach countries should take in order to build on and document catalytic effects more systematically.

**The MHTF is benefitting from improved leadership and vision and the recently established Advisory Board supports more structured engagement with partners (including donors).** These developments should help the MHTF address the several challenges it faces. These challenges include: positioning its strategic direction in relation to overarching UNFPA MNH; building SRHR-MNH integration across the life-course; overcoming bureaucratic constraints; and delivering clearer communication of results. Results data collected from countries tend to focus on outputs and build a cumulative picture of the MHTF activities, but they are less effective at helping identify the MHTF contribution to country-specific progress. The consequence is a difficulty in fully capturing the value

of results achieved from the whole of the MHTF, including its strategic partnerships. The lack of community-facing links or investments into building demand for services is a visible gap, as are more systematic interlinkages between the MHTF support to MNH investments and larger health systems strengthening and reforms.

**UNFPA effectively used the MHTF to respond quickly and flexibly to the COVID-19 pandemic through programmatic efforts and reallocation of available resources to ensure continuity of essential SRHR and MNH services while protecting the safety of clients and providers.** UNFPA articulated a response in support of partner countries referencing key lessons learned from the West Africa Ebola outbreak, during which routine services were seriously disrupted causing high levels of preventable mortality, especially for women and children. The UNFPA/MHTF response included the development and dissemination of COVID-19-specific technical guidelines and protocols, the provision of personal protective equipment (PPE), other strategic support, such as transport vouchers for health personnel to get to work safely, and hospital triage support to ensure safe access to essential maternity services.

## CONCLUSIONS

**1. With the MHTF, UNFPA is a partner of choice providing visible and valued support to critical MNH priorities.** The MHTF has evolved into a strong, focused and technically sophisticated tool for supporting MNH in the programme countries, especially in its four priority areas of midwifery, EmONC, MPDSR and fistula. The MHTF delivers support to programmes that are perceived to be of high quality, that address gaps in country health systems and that produce tangible results. At a global level, MHTF staff participate in and/or lead the development of a range of knowledge products whose impact extends beyond the 32 MHTF partner countries. It is a programme that delivers considerable thrust with a limited package of resources.

**2. Midwifery is the anchor of the MHTF and the cornerstone of the UNFPA MNH response.** Identified as the leading partner for midwifery, UNFPA has instigated major steps forward on the definition of midwifery practice (for example, standards of care, capacity and skills, and performance monitoring) that have been complemented by country-focused efforts to upgrade the education, training and deployment of midwives and initiatives to support their professionalization. The role of midwives is critical to promoting SRHR-MNH integration and to overcoming the three delays that lead to maternal mortality (delay in seeking care; in reaching the right level of care; in receiving the right care) particularly in promoting health-seeking behaviour among women and girls. However, the MHTF has not yet fully captured the pernicious effects of gender inequalities and power dynamics that affect health systems in programme countries.

**3. The MHTF delivers value for money, both globally and for individual countries.** Through leveraging global partnerships, deepening policy and technical coherence, and strengthening the quality of programme implementation, the MHTF has developed a programme model that delivers visible results and creates effective entry points for a range of interventions. To maximize these opportunities, the MHTF relies on a set of skills and a vision in the country office that are strong on systems strengthening, coordination, convening, advocacy and partnership building. Achieving optimal effects also relies on the country offices' ability to supplement the MHTF resources with core funds and to raise additional resources through engaging partners locally. At the global level, the MHTF has enabled UNFPA to influence the agenda on MNH and to deliver a wide range of policy and guidance products in all of the four technical areas that will influence MNH programming beyond the MHTF partner country context.

**4. The MHTF is not clearly positioned within a holistic UNFPA MNH strategic framework.** By focusing on four specific technical areas, the MHTF has carved out a defined expertise. However, at a global and organizational level, the MHTF is not aligned with or anchored in a UNFPA maternal health strategy. As the main (but not the only) UNFPA programming vehicle into maternal health, this leaves a policy and strategy gap between the MHTF (as a programme delivering specific inputs) and the UNFPA MNH strategy at the global and organizational level. In turn, this gap makes it difficult to clearly identify the locus of UNFPA policy, strategy, and programming effort in relation to the transformative result of ending preventable maternal deaths. Meanwhile, at the country level, the issue is the agility of the MHTF, and whether it can position its interventions within a holistic SRHR-MNH strategy that is context specific to the programme countries themselves. The challenge for the MHTF is to maintain its technical focus (and well-defined offer of expertise and support), while remaining flexible to assist countries in addressing their priority needs in MNH.

**5. If not addressed, critical gaps will limit the relevance and the sustainability of the MHTF investments.** Investing in the supply of high-quality maternal services is necessary but not sufficient to ensure sustainable results. There is a need to engage with communities to address barriers to access, to overcome delays, to improve accountability and to better ground MHTF investments with affected populations. Furthermore, while the MHTF has helped countries identify and set standards for the supply-side and delivery of quality EmONC and related MNH services and care, it should also actively incorporate the views of women and girls and what they value in relation to SRHR-MNH integrated services, especially in relation to respectful care. While each of the four technical areas of the MHTF aims to influence and strengthen quality of care improvements, the indicators that enable quality of care measurement and tracking (especially including the experience of women who have been through the care of the health services) are insufficient and underutilized.

**6. The MHTF has not yet been fully designed to deliver its "catalytic effect" systematically.** The MHTF leverages its limited financial resources through investments which have, by and large, a catalytic potential and are, at times, catalytic when taken to scale with necessary leadership, sustained national commitment and resources. However, the MHTF is not sufficiently systematic in identifying or creating opportunities to engage national leadership for MNH in order to target the resource mobilization needed to take technical advances to scale. The realization of this catalytic potential depends on the ability of the MHTF to anticipate and prepare for the challenging shift from a relatively low-cost, intense technical process focused on developing a national policy or strategy to a much larger, longer-term, higher-spend, national scale-up of that policy. The absence of a strategy clearly positioned within the engineering of the programme itself and accompanied by a tried and tested toolbox to support the elevation of programme inputs in ways that generate the "catalytic effect" currently reduces the MHTF catalytic achievements.

**7. The MHTF targets gender equality, human rights and equity, especially among adolescents, but does so unevenly.** The MHTF has identified three rights-based principles upon which its strategy is based (accountability, quality of care, and equity in access), but it lacks a framework for defining and operationalizing rights-based principles in MHTF programming, which has led to uneven application of these principles in country-based activities, such as for quality of care. Furthermore, while the MHTF aims to target vulnerable women and girls through the application of the "leave no one behind" principle, it has yet to define or articulate an approach or process for identifying those most at risk or the most vulnerable. MHTF interventions supporting service access (midwifery training, EmONC and fistula) have resulted in expanded service delivery to underserved geographic areas and vulnerable populations. However, because of limitations in the integration of SRHR and MNH, MHTF activities are not as effective in ensuring that adolescent girls and women are empowered to access a full range of SRHR services.

**8. Given its results and successes, the MHTF has considerable unrealized potential.** The MHTF is a programme with a modest profile, whose strengths and accomplishments are not always well-known. Not enough has been done, at UNFPA, to highlight its achievements, drive resource mobilization, position it strategically within a coherent MNH strategy and use the knowledge gained through the MHTF to help better shape the global agenda. This is also the consequence of a monitoring system that does not emphasize the use of a small number of readily available results indicators, which can be interpreted and presented in a manner that increases visibility for the MHTF in both UNFPA and the global arena. The MHTF image deficit, compounded by monitoring that lacks sufficient qualitative and contextual analysis, may also constitute an impediment to the mobilization of more funding and the pursuit of long-term engagement from partners. Ultimately, this may prevent the MHTF from being valued in relation to its actual contribution to maternal and newborn health, which this evaluation demonstrates is significant and multifaceted.

## RECOMMENDATIONS

### 1 As the key UNFPA vehicle for SRHR-MNH integration and support, continue the MHTF and expand it into a new phase

The MHTF makes a visible contribution to maternal health in the countries where it is working and to the overall UNFPA maternal health response. The MHTF should continue into Phase IV with design adjustments taking into account the strategic and operational recommendations identified in this evaluation. In particular, an expanded theory of change should identify the larger landscape in which the MHTF operates and its specific contribution. Phase IV of the MHTF should serve as an opportunity to clarify the MHTF role and positioning in relation to other UNFPA investments into maternal health as well as the larger, global MNH landscape.

### 2 Position the MHTF within a comprehensive UNFPA maternal health strategy and action plan

The 2022-2025 UNFPA strategic plan is shaped around three transformative results, including ending preventable maternal deaths. In this context, it is not clear whether the MHTF is intended to serve as a limited, catalytic fund, channelling a specific set of technical and financial resources to defined elements of MNH, or is expected to encompass the entire UNFPA MNH programme (with other UNFPA programmes supporting important MNH results). Drawing on the MHTF experience, UNFPA should develop an organisational-level comprehensive maternal health strategy and action plan that clearly situates the MHTF and other UNFPA MNH efforts within a coherent organizational mandate with roles and responsibilities in relation to its objectives in maternal health and its broader remit on integrated SRHR-MNH.

### 3 Champion quality of care at the point of delivery, including respectful care

The MHTF approach to strengthening user-centred quality of care, including respectful care, is still at an early stage. The MHTF should invest in building country experience and global leadership on scaling up quality SRHR-MNH services at the point of implementation (from the user's perspective) and should champion respectful care especially, but not only, among midwives. This includes developing and integrating actionable programming into all MHTF

technical areas and strengthening progress monitoring to enable lesson learning and scale-up of good practices.

**4 Be more systematic about integrating community engagement across all MHTF activities**

Community decisions about whether, when and how to seek care affect MNH outcomes. Currently, the main thrust of the MHTF has been focused on the supply of services. While the MHTF does not necessarily need to invest extensively in demand creation and community engagement itself, it should integrate and promote a more structured approach to community engagement as part of a broader strategy to generate increased demand for timely and accessible MNH services. This adjusted orientation should focus on increasing the timeliness and efficacy of decisions to seek care, to access family planning and SRHR services, to elect to deliver in a health facility, to build the interface of the midwife with the community, and to participate in death audits/reviews. It will require developing and deepening partnerships with others and investing in country office staff capacity and advocacy skills.

**5 Engage partners, especially donors, more actively in the MHTF progress**

The recently created Advisory Board is in the early stages of carving out its role and has been welcomed by partners. Donor engagement in the work of the MHTF, including as part of the Advisory Board, will foster visibility and support, as well as create potential opportunities in specific countries or settings. Over time, the MHTF should invest in the role and functioning of the Advisory Board in order to strengthen its accountability to funding partners, to increase its participation in shaping strategic direction and to support improved communication of results and performance.

**6 Improve the strategic coherence and responsiveness of the MHTF**

A key strength of the MHTF is its programme model, which offers countries access to strategic global partnerships, technical expertise and financial resources to seed-fund investments. The four technical areas promoted by the MHTF are insufficiently coordinated with each other however, and are not all equally well supported at the country level. In addition, as priorities evolve, the MHTF will achieve more traction with more flexibility in its programme model to respond to country priorities. It should thus aim to clarify and streamline the linkages and coherence among the four current technical areas. It should also consider options to selectively include other technical areas without sacrificing its well-defined programme model. The development of the MHTF Phase IV and associated theory of change creates an ideal opportunity to include these critical aspects.

**7 Embed the focus on midwifery and the health workforce environment across the MHTF**

As a key entry point and “gateway” to women’s health across the life course, midwives and the larger health workforce environment in which they operate constitute tangible health systems strengthening investments. The experience of women and girls highlights the role that skilled health personnel play in their perception of what quality care is. The MHTF progress and leadership on midwifery and the health workforce environment continue to create a key entry point for MNH. This should be further developed in Phase IV by investing more in embedding midwifery into community and primary care, integrating more focus on respectful care, and investing in health systems reforms, including the EmONC network expansion.

**8 Invest more in MHTF core added values: SRHR-MNH integration and promoting catalytic results**

The MHTF has two core element features that add value. The first is the fact that it is uniquely focused on integrating SRHR and MNH services and has made good progress in this area. The second is that the emphasis on driving catalytic results is integral to its delivery model and a cornerstone of the MHTF approach. In both these areas, the MHTF has made visible but inconsistent and insufficiently documented progress. In Phase IV, the MHTF should develop detailed and actionable guidance for country offices to support design, partnership development, and implementation. This should include promoting, documenting and communicating on SRHR-MNH integration and the MHTF catalytic role.

**9 Refine results monitoring to improve understanding and communication about the MHTF added value in different contexts**

Although detailed, the current results-oriented monitoring (ROM) system does not easily enable the MHTF to identify and communicate its results and contribution as a United Nations programme working in an often crowded field. The MHTF should adapt its current approach to track fewer, more immediately relevant results that can support a clear narrative about the MHTF contribution and value-added in varied settings. The results-oriented monitoring system should have a greater focus on perceptions of change among stakeholders by supplementing a shorter indicator framework with reporting that makes use of qualitative information on the MHTF contribution to, and progress toward, outcomes. This would support increased understanding about what is working, where and why.

**10 Invest in innovative funding approaches to attract an expanded donor base**

The MHTF should develop a comprehensive funding model and financing plan to support Phase IV. The plan should be linked to its new programme of work and be well situated within a UNFPA maternal health strategy in order to enable the MHTF to address (and reverse) declining commitments, as well as the negative effects of onerous financial management processes. The plan should also foresee innovative funding options to generate country engagement and commitment to SRHR-MNH integration, for example through matching arrangements. Innovative funding modalities could extend the value of MHTF resources, leverage additional funds from core and other partner sources, and help open up additional programme priorities.

Read the **evaluation report** of the Mid-term evaluation of the MHTF Phase III, 2018-2022 here

# 1 INTRODUCTION OF THE CASE STUDY

## 1.1 Mid-term evaluation of the MHTF Phase III, 2018-2022

The purpose of the mid-term evaluation is to assess the performance of the Maternal and Newborn Health Thematic Fund (MHTF) in providing catalytic support through country-owned and driven interventions to improve maternal and newborn health and rights in 32 high-mortality countries.[1] It will assess the contribution of the MHTF to strengthen health systems through its focus on:

- Four components of health systems: workforce, service delivery, health information systems, leadership and governance
- Four integrated technical areas: midwifery, emergency obstetric and newborn care (EmONC), maternal and perinatal death surveillance and response (MPDSR), obstetric fistula and other morbidities.

It will also assess the MHTF contribution to:

- Increased equity in access to sexual reproductive health and rights (SRHR) information and services, including for those furthest behind
- Improved quality of care
- Higher accountability
- The promotion of gender equality and human rights in the context of maternal and newborn health (MNH).

The evaluation has two principal objectives:

1. **Analyse how and to what extent** UNFPA support to MNH has been guided by the theory of change and results framework as set out in the MHTF Phase III Business Plan (2018-2022)[2] and assess the progress made thus far in the implementation of the MHTF strategic interventions in the four overlapping and mutually reinforcing MHTF outcomes.
2. **Facilitate learning and capture good practices** from the MHTF across its components and areas of health system strengthening to inform the implementation of the MHTF current phase, other ongoing programmes with a link to MNH, as well as UNFPA future programmatic interventions in support of MNH and broader SRHR.

While the results of the mid-term evaluation are expected to feed into the implementation of the MHTF through the end of its current phase, they will also inform the reflection on strategic directions, programmatic scope as well as the operating model for the MHTF post 2022.

**Temporal and geographical scope**

The evaluation will cover the period since 2018 under the current MHTF Business Plan (2018-2022). Its geographical scope includes all 32 countries in the five UNFPA regions of operation where MHTF interventions are currently being undertaken: Western and Central Africa; Eastern and Southern Africa, Asia and the Pacific, Arab States, and Latin America and the Caribbean.

### 1.1.1 Evaluation questions

The evaluation examines nine evaluation questions.

[1] The global midwifery programme works in over 100 countries & the global Campaign to End Fistula supports 55+ countries (including all 32 MHTF countries). This expanded remit beyond the MHTF partner countries will be explored further in the evaluation.

[2] https://www.unfpa.org/pcm/node/18565

**Table 1: Evaluation questions by area of investigation**

| Evaluation Questions |
|---|
| **Area of Investigation 1: Midwifery** |
| **Evaluation Question:** To what extent has the MHTF contributed to ensuring the education, training, and deployment of an adequately skilled/competent, motivated, and sustainable midwifery workforce? |
| **Area of Investigation 2: Emergency obstetric and newborn care** |
| **Evaluation Question:** To what extent has MHTF supported ministries of health (MoH) to design, strengthen and scale-up a national network of referral maternity facilities capable of providing quality SRHR services and MNH care, including EmONC? |
| **Area of Investigation 3: Maternal and perinatal death surveillance and response** |
| **Evaluation Question**: To what extent has the MHTF contributed to firmly establish the main components of the MPDSR programme; to support its implementation at national scale; and to increase the notifications of maternal deaths and strengthen the quality of maternal death reviews (MDRs) and implementation of the "response" component? |
| **Area of Investigation 4: Obstetric fistula and other obstetric morbidities** |
| **Evaluation Question:** To what extent has the MHTF contributed to the capacity of governments to develop, implement and monitor national strategies for ending fistula cases that are founded on: prevention, access to quality treatment of fistula cases and other obstetric morbidities, and social reintegration of obstetric fistula survivors? |
| **Area of Investigation 5: Integrated MNH and SRHR** |
| **Evaluation Question:** To what extent has the MHTF contributed to a strengthened integration between maternal health and SRHR with a view to achieving quality service delivery, increasing client satisfaction, and stimulating greater public demand for SRHR services? |
| **Area of investigation 6: Equitable and accountable access** |
| **Evaluation Question:** To what extent has the MHTF contributed to strengthening the availability and quality of health service delivery and health information system to meet the diverse and differentiated needs of the women, newborns, and adolescent girls including in the lowest wealth quintiles, living in hard-to-reach areas, facing discrimination (based on identity, ethnicity, and/or faith) and living with disabilities? |
| **Area of investigation 7: A catalytic role** |
| **Evaluation Question:** To what extent has the MHTF fulfilled its catalytic role enabling UNFPA to 'punch above its weight' in support of MNH outcomes and integration with SRHR? |
| **Area of investigation 8: MHTF governance and management** |
| **Evaluation Question:** To what extent have MHTF management mechanisms and internal coordination processes contributed to the overall performance of the programme. Specifically, how have these facilitated: (i) resource mobilization for the MHTF; (ii) efficient and effective collaboration with other UNFPA programmes; (iii) the integration of MNH within country programmes; and (iv) an effective oversight and guidance by the MHTF Advisory Committee? |
| **Area of investigation 9: COVID-19** |
| **Evaluation Question:** To what extent has the MHTF been able to respond to emerging and evolving needs of national health authorities and other stakeholders at national and sub-national level due to the COVID-19 pandemic? |

### 1.1.2 Country case studies

The evaluation is structured around a series of country case studies, augmented by global and regional data collection. A case study-centred approach allows for the exploration of the MHTF in

widely differing contexts and settings. The MHTF takes different shapes or paths depending on UNFPA interaction with other health actors and formulates responses to opportunities and barriers in different ways depending on a range of variables that are country specific.

The specific purpose of the case studies is to investigate the design and implementation of interventions under Phase III of the MHTF, and to assess the results achieved within the specific context of programme countries. The evaluation encompasses four field-based country case studies (Benin, Sudan, Uganda and Zambia) and two desk-based country case studies (Bangladesh and Togo) mapped in Figure 1. The case studies are not intended to present a statistically valid sample, nor are they representative of the entire population of programme countries.

**Figure 1: Map of field and desk-based country case studies**


*The designations employed and the presentation of material on the map do not imply the expression of any opinion whatsoever on the part of UNFPA concerning the legal status of any country, territory, city or area or its authorities, or concerning the delimitation of its frontiers or boundaries.*

Countries were selected for the field and desk studies to provide a set of variable examples of MHTF support in different regions and with varying MNH indicators. For example, some countries had high maternal mortality ratio (MMR) and/or neonatal mortality ratios (NMR) despite declining fertility. Some countries also offer a mix of conflict and humanitarian contexts, differing access to development assistance for health, or other factors that added nuance or complexity.

## 1.2 Objectives of the field country case studies

The field-based country case studies aim to provide insights into the evaluation questions and a comprehensive nuanced picture of programme actions and their results. They allow the evaluation to explore the evaluation questions in greater depth than would be possible in desk studies. The country case studies are not individual programme evaluations at country level. Their objectives are to:

- Provide input for answering the evaluation questions and causal assumptions
- Triangulate data collected from other sources and respondents with qualitative and quantitative information collected in country
- Identify lessons learned.

## 1.3 Approach and methodology

Each field country case study uses a theory-based evaluation approach based on the theory of change and causal assumptions developed for UNFPA activities related to MNH. The theory of change is described in detail in the Section 1.4 below. The causal assumptions form the basis of the evaluation matrix (Annex I) and enable the evaluation to determine the contribution of UNFPA to MNH outcomes in the theory of change.

The data collection methods used in each field country case study are:

- Identification and review of core documents at country level, including country programme documents and annual workplans, programme review and evaluation documents, monitoring and progress reports, national plans and programmes, minutes of coordination meetings and documents produced by other bilateral and multilateral agencies supporting MNH
- Review of financial data regarding programme investments
- Key informant interviews with a wide range of stakeholders at national level (Annex 2)
- Visits to programme and service delivery sites, including interviews with service providers, managers and community members
- Interviews and, where possible, group discussions with individuals accessing SRHR and/or MNH services
- A debriefing workshop with participation by UNFPA country staff. This allowed the evaluation team to present preliminary observations and receive feedback on any gaps in the collected data, factual errors or misrepresentation.

The evaluation also uses other methods, including an online survey of key stakeholders, interviews undertaken at global and regional level and a comprehensive global document and data review to ensure coverage of all elements of the MHTF.

The resulting evaluation data was analysed and interpreted jointly by the evaluation team. Each element of evidence was recorded in the evaluation matrix (Annex 1) in relation to relevant evaluation questions and causal assumptions. This allowed the evaluation team to triangulate evidence from different sources and to develop the findings presented in Section 3.

## 1.4 MHTF overall theory of change

This section presents the overall theory of change for the MHTF as developed during the inception phase, updated during data collection, and refined during the analysis and reporting stages of the evaluation. The theory of change presented here attempts to capture all the different ways in which the MHTF provided catalytic support through country-owned and driven interventions to improve maternal and newborn health and rights in vastly differing contexts and at different levels (global, regional and national).

In this sense, nowhere has the evaluation team seen this theory of change implemented in its entirety. In fact, the theory of change encompasses a wide range of activities and a multi-layered chain of results, which are difficult to implement effectively and to sustain given the current staffing and financial resources available to UNFPA in the different MHTF programme countries.

The MHTF theory of change (Figure 2) should be ‘read’ from the bottom to the top and from left to right. The MHTF specific inputs, activities, outputs, and outcomes are presented within a larger landscape, while the chain of effects is clearly demarcated within a blue-lined box. Expected COVID-19 effects are laid out in purple and describe how the UNFPA strategy and programmatic guidance on responding to COVID-19 is expected to impact specific areas of the MHTF. These identify the

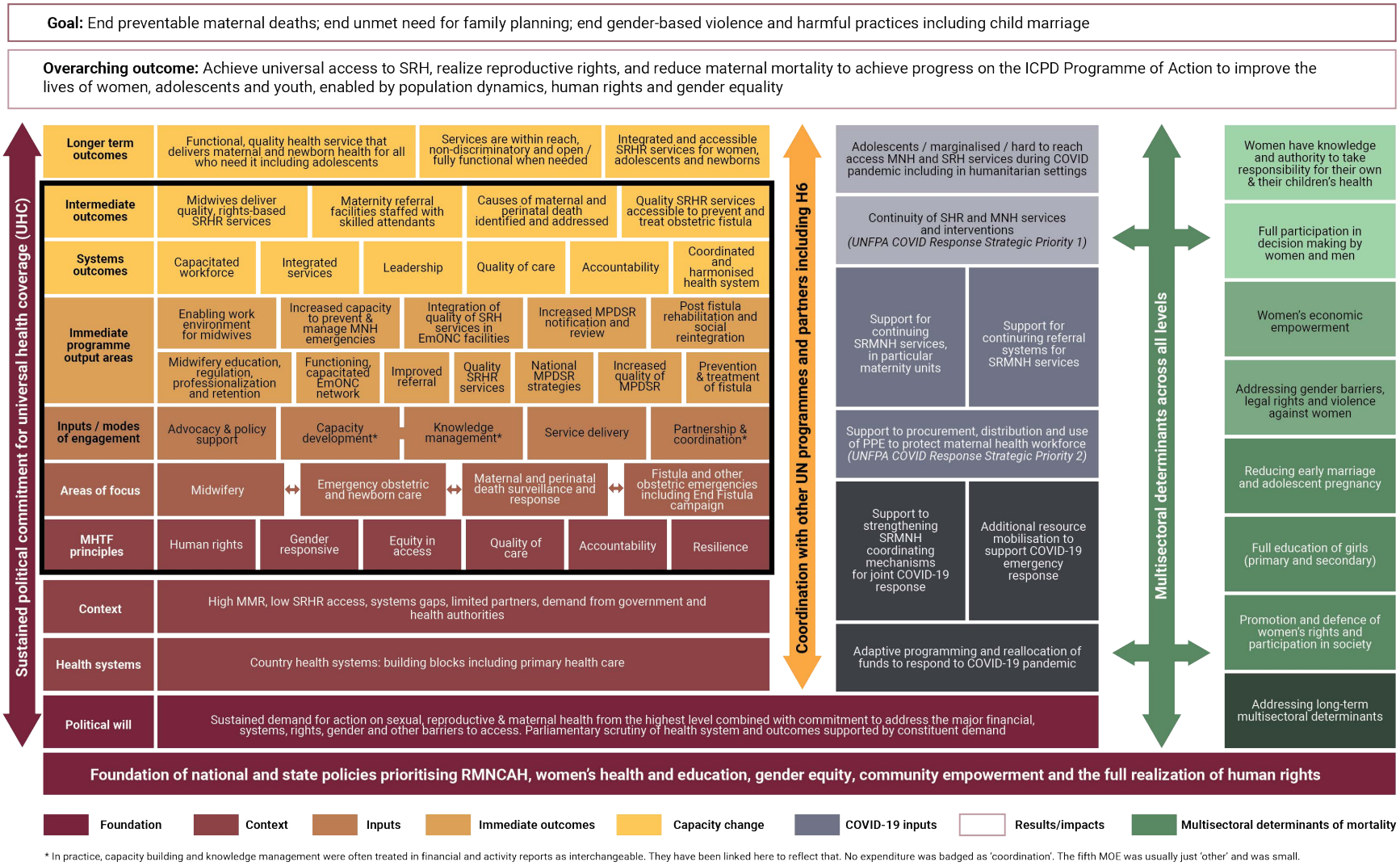
relevant UNFPA policies, the activities undertaken, and the outputs and outcomes expected. The broader social and economic determinants that affect MNH outcomes (and which the evaluation does not assess) are laid out in green on the right-hand side. The vertical arrows identify three critical cross cutting dimensions: political will, coordination across all stakeholders, and multisectoral determinants. The specific chain of effects is explained in Table 2.

Following the MHTF theory of change (Figure 2), the specific segments of the theory of change to be evaluated have been extracted and are magnified in Figure 3 in order to map the placement of the evaluation questions and corresponding assumptions thus linking the theory of change directly to the evaluation matrix available in Annex 1.

**Table 2: A key to help read the refined MHTF theory of change**

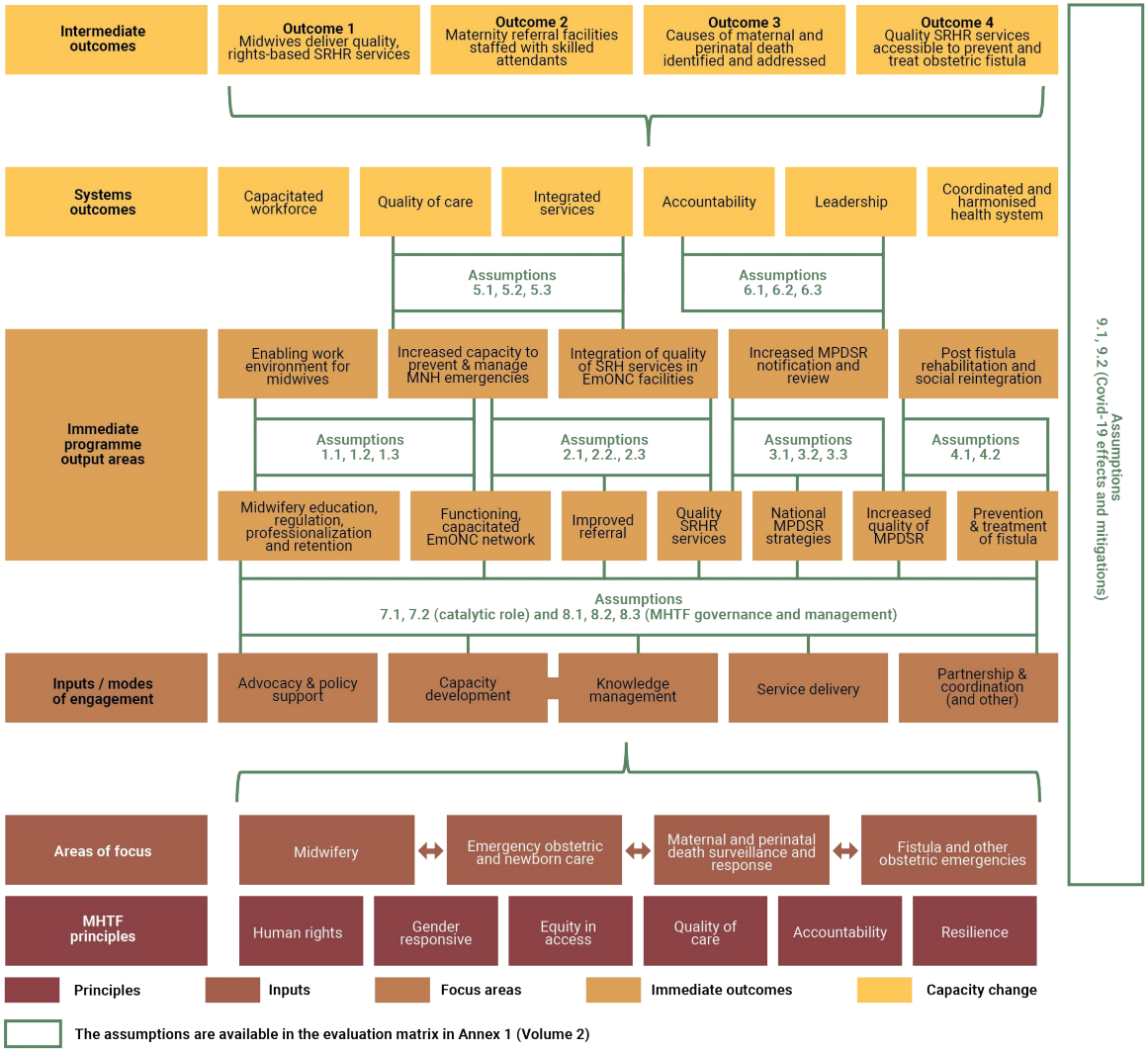
| Line of the theory of change (from the bottom) | Explanation |
|---|---|
| **Foundation** | The institutional setting, range of laws, and public policies that are the foundation of every country's approach to governance, health and welfare. |
| **Political Will** | The presumption that countries are invested in SRHR and maternal health and have the will to engage across political levels to improve outcomes. |
| **Health Systems** | A recognition of the health system that will be in place in all countries at national and sub-national levels. The MHTF will engage in some elements of some health systems building blocks but largely its efforts are based on what is already in place. |
| **Context** | The specific context that MHTF partner countries share. |
| **MHTF Principles** | The principles that shape the approach taken by the MHTF in developing and implementing its activities and support. |
| **Areas of Focus** | The four major and inter-related areas of engagement around which the MHTF focuses its work. |
| **Inputs/Modes of Engagement** | The five modes of engagement which together define the main vehicles for the types of support and specific inputs provided by the MHTF. |
| **Immediate Programme Output Areas** | These are the expected direct outputs from MHTF inputs and a critical chain of effect to make visible and assess. |
| **Systems Outcomes** | The broader outcomes expected to result from programme outputs and which MHTF will aim to shape and contribute towards. |
| **Intermediate Outcomes** | The outcomes linked to the four areas of focus identified in the MHTF Business Plan. |
| **Longer-term Outcomes** | The strategic outcomes towards which the MHTF is contributing. |
| **Over-arching Outcomes** | The long-range outcomes identified in the MHTF Business Plan change model. |
| **Goal** | UNFPA organizational goals laid out in the UNFPA strategic plan, 2018-2021. |

**Figure 2: Overall theory of change for UNFPA support to maternal and newborn health**




* In practice, capacity building and knowledge management were often treated in financial and activity reports as interchangeable. They have been linked here to reflect that. No expenditure was badged as 'coordination'. The fifth MOE was usually just 'other' and was small.

**Figure 3: Focused MHTF theory of change with evaluation assumptions mapped out**




| Summary of assumptions |
|---|
| 1. Technically sound and relevant support to midwives |
| 2. Support to EmONC networks an appropriate strategy |
| 3. Support prioritizes quality, credible MPDSR systems |
| 4. Support engages health systems and communities in obstetric fistula prevention, treatment and social reintegration |
| 5. UNFPA uses MHTF as a platform for integration |
| 6. Use of MHTF as a platform to advocate for needs of women, girls and newborns |
| 7. MHTF processes suited to catalyzing MNH investments, knowledge and innovation |
| 8. Management and governance enables MHTF to influence UNFPA strategy in MNH and SRHR |
| 9. MHTF structure and process sufficiently agile to respond to COVID-19 |

## 1.5 Carrying out the field-based case study in Sudan

### 1.5.1 Data collection activities

The Sudan country case study mission was carried out by a team composed of one international consultant and one national consultant. Data collection was undertaken between 30 May and 17 June 2021. The case study mission was preceded by a review of documents provided by the Sudan UNFPA country office. These were supplemented by documents gathered from key informants during the field mission where relevant (see Annex 4).

The evaluation team carried out a wide range of interviews with key stakeholders for UNFPA activities and support to MNH, notably:

- The UNFPA Sudan staff including the deputy representative and programme and technical specialists in MNH, family planning, adolescent SRHR, primary health care (PHC), finance and monitoring and evaluation
- Senior policy makers and managers at the Federal Ministry of Health (FMoH), Sudan
- Technical specialist and programme supervisors and focal points for sexual reproductive health (SRH), midwifery, elimination of fistula, reproductive health related cancer, EmONC, MPDSR, and sexual and gender-based violence (SGBV)
- The director of the Academy of Health Sciences
- Civil society organizations working on or adjacent to MNH
- Staff of the United Nations H6[3] group including the World Health Organization (WHO) and the United Nations Children's Fund (UNICEF)
- Staff of the most active development partners engaged in supporting MNH in Sudan and/or supporting UNFPA
- The evaluation team also carried out interviews with service providers and a small number of community members.

Additionally, the evaluation team conducted visits to hospitals and health centres delivering maternal and newborn services. The sites visited were located in (i) Khartoum State: The Academy of Health Sciences, in Khartoum City, the Omdurman Maternity Hospital, and Hay Alzohor Primary Health Centre; and (ii) Blue Nile State: Damazin Hospital, in Ad-Damazin, the state health authorities, a local PHC site, WHO and Community Animator Friendly Association (CAFA), a national non-governmental implementing partner.

During the site visits in Omdurman and the Blue Nile State region, the evaluation team conducted interviews with members of the state and local health services management teams, local non-governmental organizations (NGOs), service users and health workers (see Annex 2). The visited sites were chosen to:

- Provide the evaluation access to hospitals and health centres that would most likely reflect the investments made by UNFPA with MHTF resources in support of MNH including one or more of the four focus areas: midwifery, EmONC, MPDSR and fistula.
- Ensure that sites were visited in both urban and rural settings and include multiple sites across more than one state.

[3] A group comprising six United Nations health agencies (WHO, UNAIDS UNFPA, UNICEF, UN Women, World Bank)

The figure below provides an overview of administrative regions in Sudan and the sites visited by the evaluation team.

**Figure 4: Administrative regions of Sudan**


▲ = sites visited by the evaluation team

### 1.5.2 Limitations

The Sudan case study was undertaken during an exceptional time and the COVID-19 pandemic continued to make most aspects of travel and in-person meetings very difficult. As a result of this situation, three important limitations in the evaluation approach and methodology are noted with mitigating factors.

Firstly, as the evaluation took place during the second year of the COVID-19 pandemic, a number of challenges and restrictions remained in place. The international consultant was unable to travel to Sudan, which meant that the national consultant undertook the site visits alone. Internet connectivity and Zoom links had an effect on the ability of the evaluation team – especially the international consultant to connect with the MoH and other stakeholders during the data collection period. Some interviews were conducted in Arabic rather than English. Furthermore, mobility was limited in the country and some health facilities were not fully functioning.

Secondly, the sample of site visits was small and not as representative of service provision in maternal, newborn or SRHR care throughout the country as would normally be the case in this type of evaluation; two states not three were visited for example. This is particularly so given the decentralised system pursued in Sudan and its federal administration. In addition, restrictions on access to some regions and time constraints made internal travel more difficult.

Thirdly, the main focus of data collection for the Sudan case study has been key informants working in government services and its partners on MNH in relation to the four priority thematic areas. Due to the limitations explained above, the evaluation team had limited contact with individual users of

the services. However, given the nature of the interventions supported by the MHTF, it is unlikely that service users would identify the contribution of UNFPA which are mainly directed to policy makers, and this is not considered a serious limitation.

In mitigation, the international and national consultant were in constant communication and on some occasions, interviews were conducted twice (covering similar and different questions). Furthermore, increased efforts were made to triangulate data from a wide range of sources. Photographs and videos were also collected to verify findings and additional follow-up was conducted when needed.

Overall, despite the limitations identified, the evaluation team is confident that the data collected supports the validity of the findings reported in Section 3. The data and information collected are presented in the evaluation matrix in Annex 1.

# 2 NATIONAL MATERNAL AND NEWBORN HEALTH CONTEXT AND PROGRAMME RESPONSE

## 2.1 Sudan: Context and health setting

Sudan is a large, geographically diverse country with an estimated population of just under 45 million growing at 2.4 per cent each year. It has a relatively youthful population and about 40 per cent are under the age of 15[4] and 60 per cent under the age of 25. More than two thirds live in rural areas, and many are nomadic. Sudan hosts a large and distributed population of refugees from South Sudan, Chad, Central African Republic, and recently from Ethiopia.[5] Forty-five per cent of the economy is derived from agriculture.

In August 2019, after 30 years of government led by Omar al-Bashir, a new governance arrangement in Sudan was agreed but negotiations around long-term government arrangements are still in progress. For MHTF and UNFPA partners and stakeholders, the backdrop to the 2018-2020 programming period has been this evolution in the country, a process that continues to unfold and could have implications for every aspect of health as well as huge potential to reframe human rights and opportunities in the future.

At the same time, however, the economic woes that affect Sudan have continued to grow and gross national income (GNI) has steadily declined (to USD 650 per capita in 2020). The economy has been shrinking over a period of several years partly because of weak resource mobilisation, but also as a result of stagnant growth exacerbated by an unaffordable public debt burden and ongoing fuel and other subsidies. Adjustment in the coming years will be painful according to the International Monetary Fund (IMF) analysis,[6] which reports that "fiscal and external imbalances are large, inflation is high, the currency is overvalued, and competitiveness is weak"[7].

Gender imbalances and inequality remains a challenge across all aspects of national life in Sudan. Although only 52 per cent of all women over the age of 15 are literate, this rises to 73 per cent in the

[4] World Bank data bank: https://data.worldbank.org/indicator/SP.POP.0014.TO.ZS downloaded on 2 August 2021.

[5] According to the UN High Commission for Refugees, Sudan currently hosts 1.1 million refugees, 30% of whom are settled in camps, and 2.5 million internally displaced persons, https://data2.unhcr.org/en/country/sdn downloaded 2 August 2021.

[6] https://www.imf.org/en/Publications/CR/Issues/2020/03/10/Sudan-2019-Article-IV-Consultation-Press-Release-Staff-Report-and-Statement-by-the-Executive-49254

7 https://www.imf.org/en/Publications/CR/Issues/2020/03/10/Sudan-2019-Article-IV-Consultation-Press-Release-Staff-Report-and-Statement-by-the-Executive-49254

15-to-24-year age bracket indicating a rising education trend among younger women.[8] Limited opportunities have resulted in high unemployment however, and 40 per cent of all young people in urban areas are unemployed. The situation for women is worse despite improving education outcomes and most are "highly marginalised from the labour market in general".[9] Only 33 per cent of women participated in the labour market compared to 76 per cent of men. Furthermore, a recent analysis of women's status found that Sudanese women have "less than a third of the legal rights men have in key dimensions related to access to economic opportunities"[10], placing Sudan near the bottom of the Global Women, Business, and the Law 2021 index.

## 2.2 Social and economic determinants of maternal health

Under the new transitional governance arrangement, Sudan has already undertaken a number of steps to improve the status of women and girls, including adopting legislation to criminalize female genital mutilation (FGM), repealing so-called "morality" laws that restrict women's freedom and movement, and adopting the first national standard operating procedures to prevent and respond to gender-based violence (GBV).[11] These are necessary but not sufficient reforms to guide the longer-term social change needed to ensure women's equality and empowerment. Early marriage, lack of autonomy, low education outcomes among many marginalised women and girls – especially rural, nomadic, disabled and the poor – and restrictive social norms continue to limit women's access to life opportunities, social services and employment. Sudan was ranked 138 out of 162 in the 2020 Gender Inequality Index of the Human Development Report[12].

Critical barriers to accessing essential health care have been identified in Sudan that, taken together, undermine MNH. Among myriad factors, a preference for home births, the age of first births, quality of care in health facilities and access to services stand out. Four out of five babies are still delivered at home, many with the assistance of community midwives but many without birth attendants of any kind. Relatively few women attend a hospital to deliver. Women in Sudan start having babies when they are still young – often in their adolescence – and often continue throughout their reproductive years. A third of young women report they were in a union before the age of 18.

## 2.3 Brief outline of the Sudan health system

An updated national health sector plan is under development. The health sector in Sudan is a devolved system largely decentralised to the 18 states. The health sector is arranged across four levels of care: tertiary, secondary, primary and community level. The number of PHC facilities varies by state reflecting inequities in access, utilization and health outcomes. For example, in the five Darfur states, more than 20 per cent of people live more than five kilometres from a health facility[13]. Facilities are not all operational, 24 per cent do not offer the main components of the PHC package (SRH, immunization, nutrition, prevention and treatment of common diseases and essential drugs). Despite a growing private sector, particularly in urban areas, the health sector in Sudan is dominated by government-owned and operated services although there are also services delivered through

[8] World Bank data bank: https://data.worldbank.org/indicator/SE.ADT.LITR.FE.ZS and https://data.worldbank.org/indicator/SE.ADT.LITR.FE.ZS downloaded on 2 August 2021.

[9] World Bank social deprivation: https://blogs.worldbank.org/africacan/sudans-women-and-youth-are-severely-economically-deprived-study-sudanese-market-trends

[10] World Bank social deprivation: https://blogs.worldbank.org/africacan/sudans-women-and-youth-are-severely-economically-deprived-study-sudanese-market-trends

[11] https://www.unfpa.org/news/sudan-sees-expanded-life-saving-reproductive-health-services-women-helm

[12] http://hdr.undp.org/sites/default/files/hdr2020.pdf

[13] Sudan National Health Plan II 2012-2016, Federal Ministry of Health, Sudan p.v https://extranet.who.int/countryplanningcycles/sites/default/files/planning_cycle_repository/sudan/sudan_national_health_sector_strategic_plan_nhssp_2012-2016.pdf

military medical services, police, universities, and the private sector. As in many environments, staffing is constrained in a range of ways. In Sudan, for example, salaries are very low. The doctor to nurse ratio was 1:2.5 in 2013[14] making the consolidated number of medical doctors, nurses and midwives 1.23 per 1000 population[15]. This is well below the WHO recommended number of 2.28 health care professionals per 1000 population. Although low in absolute terms, the ratio is unusually skewed towards doctors at 4.1 per 10,000 population rather than nurses and midwives (8.1 per 10,000 population). As public sector salaries continue to fall, staff turnover is high and, as noted in the draft National Health Strategy 2021-2025 and other documents, doctors in particular often seek employment outside the country.

As noted recently, the United Nations' latest Humanitarian Needs Overview for Sudan[16] identified the extent that health facilities are failing to deliver. Essential medicines are available in only 43 per cent of health facilities, "while only 33 per cent of health facilities can provide all main components of primary care, with services particularly limited in conflict zones such as Darfur, South Kordofan, and Blue Nile.[17]" Disease outbreaks continue alongside COVID-19 and over the last few years include dysentery, typhoid, cholera, chikungunya virus, rift valley fever, malaria and dengue.

## 2.4 Overview of the maternal and newborn health in Sudan

### 2.4.1 Maternal and newborn data and trends

Many of the indicators commonly used to track maternal and newborn mortality show a similarly improving trend.[18] Progress on reducing maternal mortality, while somewhat slowed in recent years, continues to decline and, with a ratio of 295 maternal deaths per 100,000 births in 2017, is half its 2000 level. Under five mortality was 58 per 1000 births in 2019, down from 104 in 2000. However, newborn mortality has been less amenable to rapid change. In 2019, neonatal mortality was 27 per 1000 live births, down from 37 in 2000 and 29 in 2015, a decline of just 7 per cent. Almost half of all under five deaths occur in the neonatal period.[19]

Fertility among women in Sudan continues to be high at 4.2 babies per woman and the use of modern methods of contraception, while increasing, continues to be low at 11 per cent. The trend is edging upwards however, bearing in mind that the modern contraceptive prevalence rate (mCPR) in Sudan had been stagnant at seven to nine per cent before 2015. Recently, growth has started to pick up and although modest, now reaches 16 per cent of married women.[20] Almost one in five women aged 15-49 (18 per cent) has an unmet need for family planning but this rises to 28 per cent among married women[21]. Demand satisfied at 34 per cent thus remains a fraction of need although the proportion is on an upward trend.

The main causes of maternal death in Sudan (Figure 5) are post-partum haemorrhage (24 per cent), sepsis (11 per cent), hypertension (11 per cent), hepatitis (15 per cent), anaemia (seven per cent) and indirect causes (24 per cent)[22]. Among newborns, complications related to preterm births account for

[14] Ebrahim MAE, Ghebrehiwot L, Abdalgfar T, Juni MH, 2017, Health Care System in Sudan: Review and Analysis of Strength, Weakness, Opportunity, and Threats (SWOT Analysis) *Sudan Journal of Medical Sciences 2017,* DOI: 10.18502/sjms.v12i3.924

[15] Joint External Evaluation of IHR Core Capacities of the Republic of the Sudan. Geneva: World Health Organization; 2017, p. 4.

[16] https://reliefweb.int/sites/reliefweb.int/files/resources/Sudan_2020_HNO.pdf

[17] https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(19)32974-5/fulltext

[18] This section draws on data reported in the Sudan Country Profile (Annex 3) unless footnoted otherwise.

[19] https://profiles.countdown2030.org/#/ds/SDN

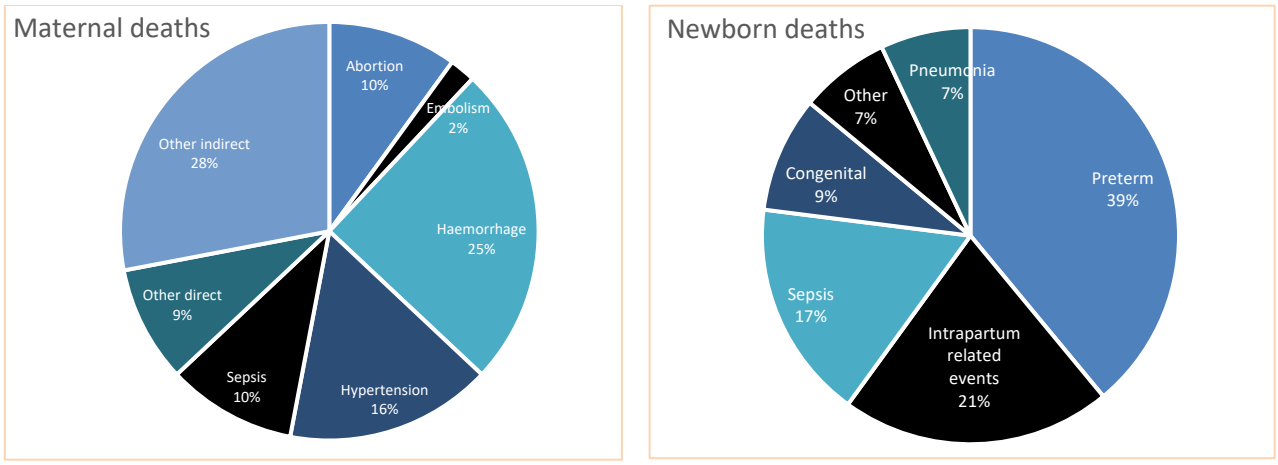
[20] UNFPA data: https://www.unfpa.org/data/world-population/SD downloaded on 2 August 2021.

[21] UNFPA data: https://www.unfpa.org/data/world-population/SD downloaded on 2 August 2021.

[22] Data are captured from the Sudan Country Profile, Countdown to 2030: https://profiles.countdown2030.org/#/ds/SDN

almost 40 per cent of all newborn deaths, followed by intrapartum-related events (21 per cent). These are babies who died as a result of their birth experience (lack of oxygen, for example), but not before their birth. Newborn deaths exclude stillborn deaths which in Sudan are estimated at 22.6 per 1000 births,[23] a high toll that reflects the complex context of poor access to quality health services, weak empowerment of women, lack of trust in health providers and a preference for home births.

**Figure 5: Causes of maternal deaths and newborn deaths in Sudan (2014)**




Source: https://profiles.countdown2030.org/#/ds/SDN
Source: https://profiles.countdown2030.org/#/ds/SDN

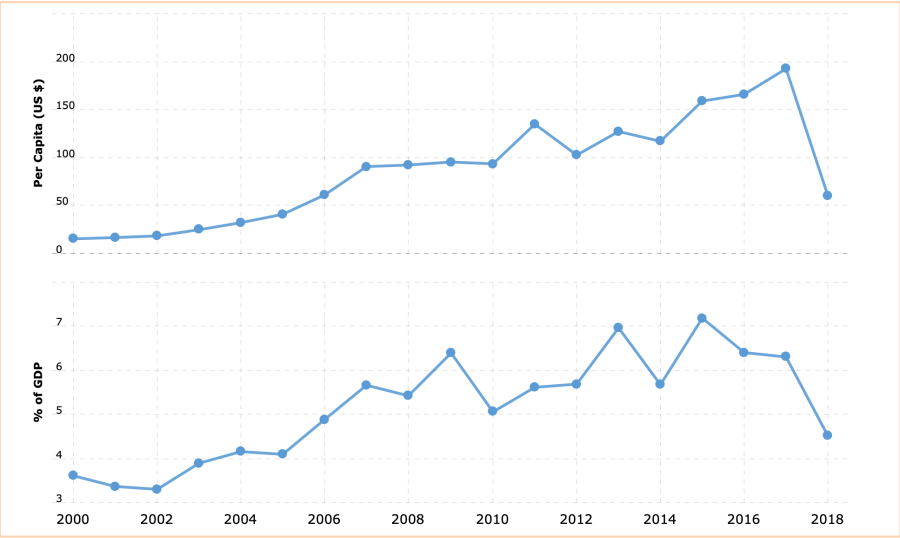
### 2.4.2 Financing maternal and newborn health in Sudan

Government spending on health in Sudan has been declining for some years reflecting the economic crisis (Figure 6) and by 2018 accounted for 23 per cent of total health expenditure.[24] Out-of-pocket spending as a share of total health expenditure has increased proportionately to 66 per cent and risk of impoverishment as a result of health expenditure is high. Although external funding quadrupled as a share of total health expenditure from two to eight per cent between 2015 and 2018, the relatively small share reflects the marginal role of foreign aid in the Sudan health budget.

[23] Stillbirths are those that occur after 28 weeks of gestation up to and during birth. According to the first global report on stillbirths, almost two million occur every year across the world, 40 per cent during labour. In Sudan, the high rate of stillbirth reflects low access to health services, anaemia, illness and malnutrition in mothers, and low-quality care. The global Every Newborn Action Plan target for stillbirths by 2030 is 12 per 1000 live births. https://thedocs.worldbank.org/en/doc/845141602114822604-0090022020/original/AneglectedtragedystillbirthsIGMEreportEnglish2020.pdf

[24] Unless otherwise stated, the data in this section draw on the Sudan Country Profile in Annex 3.

**Figure 6: Government spending on health in Sudan**




Source: Based on World Bank Data Bank analysis https://www.macrotrends.net/countries/SDN/sudan/healthcare-spending

## 2.5 UNFPA maternal and newborn health programme priorities in Sudan

### 2.5.1 Strategic orientation and programmatic approach

In 2018, UNFPA was supporting a range of development, humanitarian and recovery programmes in Sudan. The overarching goal of the Sudan programme was to "reduce maternal mortality through improved and equitable access to basic reproductive health services and information" including through youth and women's empowerment and targeted support to other vulnerable groups including rural, poor and displaced communities. By the start of the 2018-2021 programme cycle, the Sudan programme was defined more explicitly around promoting the increased availability and use of integrated SRH services (including family planning, maternal health and HIV) that are "gender-responsive and meet human rights standards for quality of care and equity in access".[25] Policies centred on inclusion of marginalised groups and the integration of SRH and MNH services. Over the last few years, in addition to its long-standing focus on SRH services and maternal health, UNFPA has expanded its focus on services to prevent and respond to GBV as well as cervical cancer screening, detection and referral.

In 2020, the UNFPA Sudan budget was just over USD 20 million of which 55 per cent was spent on "integrated SRH services", largely related to COVID-19 and humanitarian inputs, followed by 40 per cent on gender equality programmes. UNFPA was the largest implementer (about 60 per cent) followed by contracted NGOs and the Government of Sudan (GoS) at about 20 per cent each. Across these programmes, UNFPA identifies a range of results including 56,299 people reached with dignity kits, 73,064 UNFPA-assisted deliveries, and 143,665 women reached with SRH services. These 'results' tend to be framed as outputs or activities. The evidence about impact especially over time is not as visible in UNFPA reports.

### 2.5.2 UNFPA Sudan budgets and expenditure

UNFPA Sudan has been growing year-on-year in this review period, primarily through its programme budget and as a result of attracting funds to support the UNFPA response to multiple humanitarian crises. The core funding budget (resources allocated from UNFPA headquarter) has remained stable in real terms, although its contribution to the overall budget has declined as programme funding

[25] UNFPA website: https://www.unfpa.org/data/sowmy/SD accessed on 2 September 2021

increased. Across the programmatic areas, integrated SRHR services accounts for almost 60 per cent of all UNFPA Sudan expenditure (Table 3) followed closely by gender equality investments.

**Table 3: Distribution of UNFPA Sudan expenditure across all programmes and divided by core and all sources of programme funding, 2018-2020, USD**

| Sudan Programme Priority | USD 2018 | % | USD 2019 | % | USD 2020 | % | Total USD 2018-2020 | % |
|---|---|---|---|---|---|---|---|---|
| Integrated SRHR Services | 6,329,867 | 62 | 7,101,075 | 59 | 11,092,469 | 55 | 24,523,411 | 58 |
| Adolescents and Youth | 228,397 | 2 | 390,603 | 3 | 487,355 | 2 | 1,106,355 | 3 |
| Gender Equality | 2,988,977 | 29 | 3,959,375 | 33 | 7,984,785 | 40 | 14,933,137 | 35 |
| Organizational effectiveness | 12,671 | 0 | 77,953 | 1 | (184) | 0 | 90,440 | 0 |
| Population Dynamics | 607,958 | 6 | 595,278 | 5 | 459,278 | 2 | 1,662,514 | 4 |
| **Total** | **10,167,870** | | **12,124,284** | | **20,023,703** | | **42,315,857** | |
| Of which, UNFPA Core Funding | 3,474,024 | 34 | 3,284,338 | 27 | 3,245,799 | 16 | 10,004,161 | 24 |

Total UNFPA Sudan expenditure draws on a wide range of resources beyond MHTF funding to fund its five programme priorities. In 2020, UNFPA Sudan received significant additional funding from bilateral donors and from United Nations emergency funding channels to respond to flooding in the country and to COVID-19.

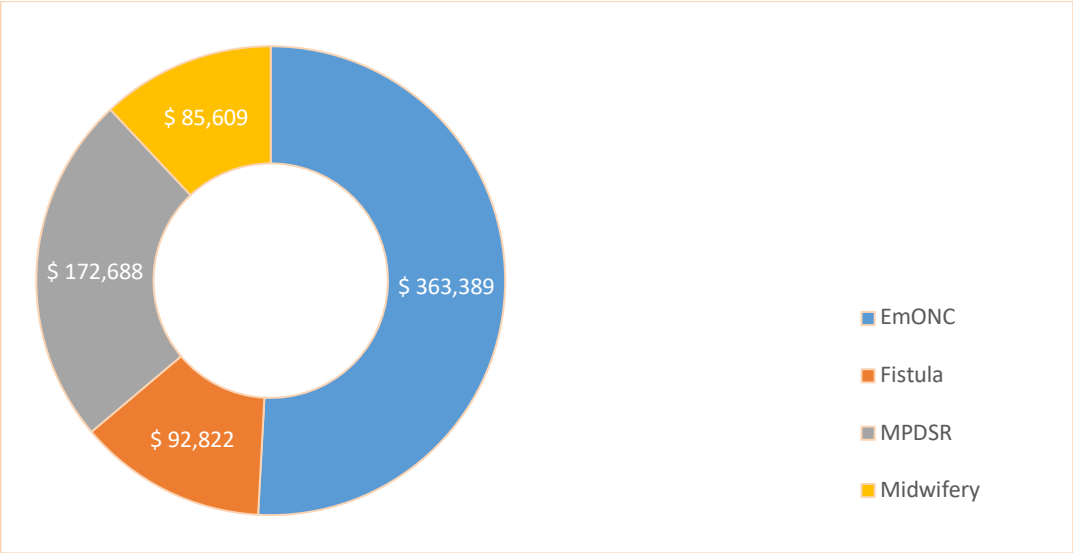
As Table 4 shows, MHTF financial resources as a proportion of all UNFPA Sudan expenditure by year amount to a small percentage of total funds and highlighting the extent to which both core and programme funding from other sources is also crucial to financing UNFPA work in Sudan. Furthermore, even in relation to its area of focus, integrated SRHR programme spending draws on a range of sources of funding.

**Table 4: UNFPA Sudan total and MHTF expenditure by year 2018-2020, USD**

| Year | Total UNFPA expenditure USD | MHTF expenditure USD (%) |
|---|---|---|
| **2018** | **10,167,870** | 246,209 (2.4%) |
| **2019** | **12,124,284** | 229,205 (1.9%) |
| **2020** | **20,023,703** | 243,168 (1.2%) |
| **Total** | **42,315,857** | 719582 (1.7%) |

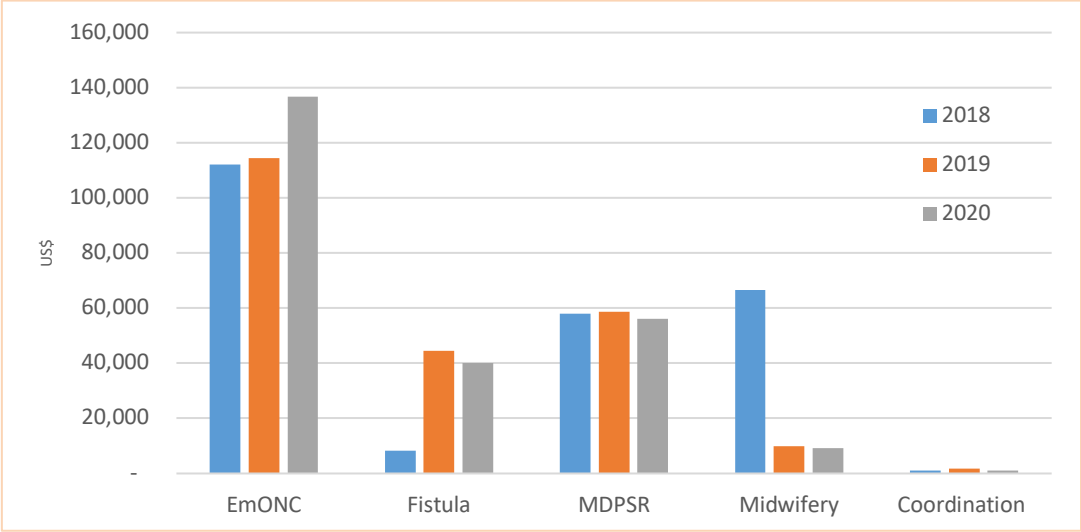
Within the scope of its funding, Figure 7 shows the distribution of resources across the four main technical areas of the MHTF in Sudan. The EmONC investment accounts for about half of the investment during these three years.

**Figure 7: Total MHTF programme expenditure across the four MHTF technical focus areas (2018-2020), USD**



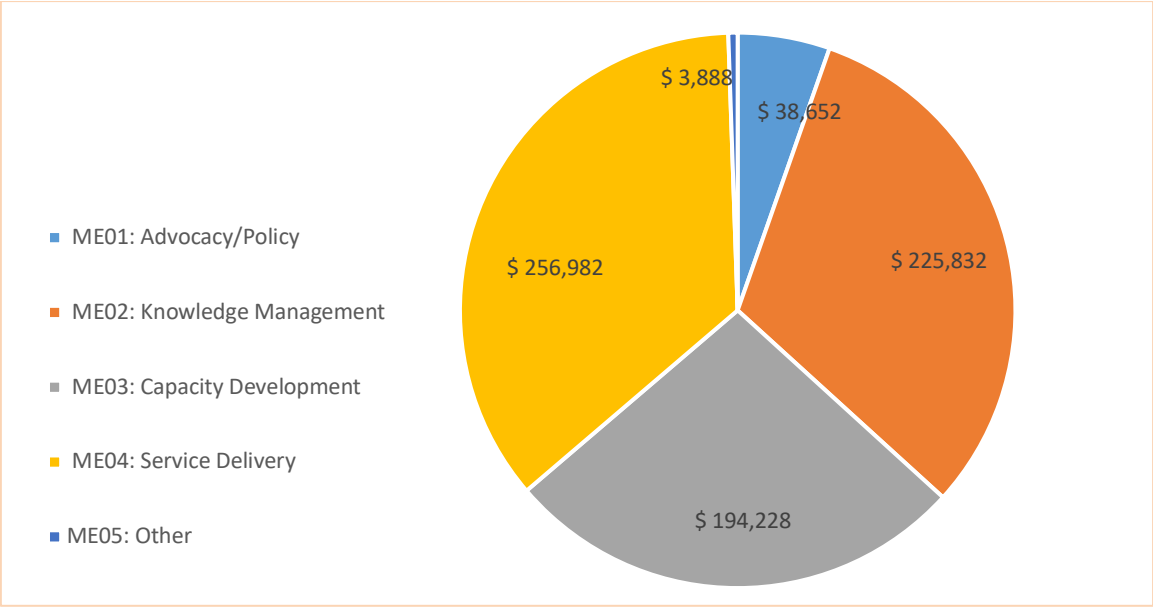

Distributed by year, the funding demonstrates variable expenditure including a significant drop in midwifery expenditure (discussed in Section 3). The MPDSR was funded over the review period in a stable fashion while other areas have shown more variability (Figure 8).

**Figure 8: Disbursed MHTF funds across the four technical focus areas by year, USD**



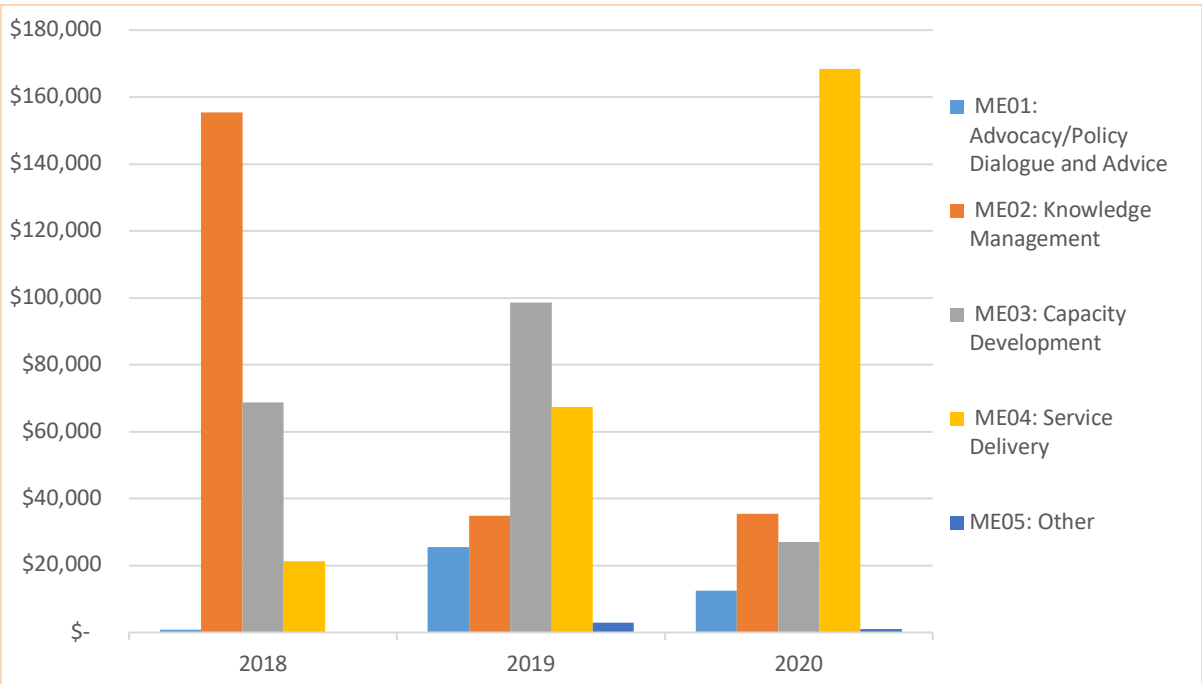

UNFPA delivers across five modes of engagement. These require different kinds of inputs and effort. While financial spending is not always a reflection of time, effort, importance or scale of result, it can be indicative of focus of UNFPA in country. Figure 9 showing the distribution of total MHTF spending over three years suggests that service delivery and knowledge management are seen as most important to MHTF results, followed closely by capacity development. UNFPA Sudan engages less in advocacy and policy dialogue activities within the framework of the MHTF.

**Figure 9: The cumulative distribution of investments across the modes of engagement (2018-2020), USD**




Breaking this down by year highlights the way that programmes evolve and how UNFPA efforts are likely to shift year on year. The bulk of midwifery investments were knowledge management for example, and the spending in 2018 reflects that (Figure 10). Midwifery programming decreased in 2019 and 2020 as key milestones were achieved and government decisions on the next steps continue to be awaited (Section 3.1). On the other hand, investments in service delivery increased as COVID-19 hit the country (Section 3.9) and capacity development investments reflected the EmONC training investments and support to fistula repair skills training (Sections 3.2 and 3.4).

**Figure 10: The distribution of MHTF investments across the five modes of engagement (2018-2020), USD**




### 2.5.3 Key coordination and implementing partners

Sudan is notable for its relative isolation in terms of development partners and external financing assistance. While most United Nations agencies are present, few bilateral agencies have a large

health footprint in the country with some exceptions. Table 5 highlights some of the main MHTF partners in maternal health in Sudan.

**Table 5: Key MNH partners in Sudan**

| Partner organization | Main roles and functions in MNH | Main areas of UNFPA engagement |
|---|---|---|
| **WHO** | Normative guidance | Sits on technical committees for **MPDSR** and **fistula**; participates in **midwifery** development. |
| **UNICEF** | Support to newborn health and leads on all elements of developing standards of care for newborns; works at national and state level | Cooperation on the **MPDSR** process. UNICEF participates in the national technical committee; support to the **EmONC** norms and standards development; participation in **midwifery** care for **newborns** training and policy development |
| **International Confederation of Midwives (ICM)** | Norms and standards for midwifery training and professionalisation | Global technical partner for the **midwifery** development programme. |
| **Community Animator Friendly Association (CAFA)** | Delivering training programmes and community engagement | **Infection Prevention and Control** (IPC) training during **COVID-19**; Support to **HIV and cervical cancer** related services training and community engagement |
| **Sweden/Italy** | Support to health and in particular MNH, gender empowerment and rights | Support to **EmONC** services to marginalised populations and among refugee and displaced communities |
| **Global Fund to fight AIDS, TB and Malaria (the Global Fund)** | Works on HIV, TB and Malaria | UNFPA provides **condoms** for the Global Fund programmes; **HIV, TB and malaria** are all major indirect causes of maternal mortality |
| **Gavi** | Vaccinations | **Human papilloma virus** (HPV) rollout and co-working on **cervical cancer** and **COVID-19** inputs. |
| **World Bank** | Infrastructure, roads and economy support | Limited engagement as the World Bank health programme in Sudan is minimal |

# 3 CASE STUDY FINDINGS

## 3.1 Midwifery

Over several years of sustained support to midwifery development in Sudan, UNFPA has used the MHTF technical and financial resources to progress results through all its modes of engagement: capacity-building, leadership support, knowledge and information management, advocacy and policy dialogue. UNFPA has pursued a logical approach to midwifery expansion and development building on its strong partnership with the FMoH. It has sought to optimise opportunities to establish meaningful cooperation around several aspects of midwifery development, including pre-service training, professionalisation, skills and retention. The UNFPA-MHTF global partnership with the ICM enabled UNFPA Sudan to orchestrate technical support that was cost-effective, highly relevant to needs and valued by the FMoH. The Midwifery Situation and Gap Analysis process undertaken by the FMoH with ICM and UNFPA support in 2017 kick-started the logical and methodical rollout of a succession of low cost, high impact strategy, capacity, training, and professionalisation processes including a new midwifery degree and a national professional midwifery association. Although fully ready to launch in 2019, these developments are still pending as a result of delayed decision-making by the relevant Sudan national authorities. Exogenous factors due to the political change together with the high turnover of health and other government staff have exacerbated the impact of delays. Although the programme can still be considered just about on track, a continuing decline in unskilled birth attendants at the community level makes the introduction of the new diploma urgent. The midwifery course is founded on

a gender-sensitive approach to integrated reproductive and maternal health services delivery that mainstreams key determinants such as FGM and the recently enacted law to raise the age of marriage.

For details of the evidence supporting findings in Section 3.1, see Annex 1: Assumptions 1.1, 1.2 and 1.3

**Strengthening midwifery as a means to improving maternal health**

In Sudan, midwifery workers have been largely made up of a cadre of "community midwives", a health worker group with pre-service training that does not meet the standards set by the ICM. With a limited range of skills, no professional association or formal role in health facilities, the community midwife has nonetheless been the main birth attendant supporting women across Sudan. At the hospital level, some nurses have trained midwifery qualifications although it is common for doctors to oversee deliveries especially in larger hospitals. Despite this, across most communities, there has been and continues to be a preference for homebirths. In 2015, amplifying and strengthening the role of midwives was identified by the FmoH as one of the ten key priorities needed to advance health systems and services (Ten in Five Strategy 2016-2020).[26]

Working with the FmoH, UNFPA leveraged the MHTF to identify and build consensus around the importance of midwifery as a cadre, the role midwives could play in the Sudan health sector, and the steps needed to ensure that Sudan met international standards in midwifery. The aim of the FMoH was to strengthen the profession within the formal health structures over the medium to long-term in order to build more effective and efficient services, improve quality of care, and save lives. It identified UNFPA as its United Nations partner of choice on maternal health, capable of offering a combination of technical, policy and financing support. UNFPA also brought with it an established partnership with the ICM, the global standard setting organization that had in place proven tools and a clear pathway to better outcomes. At that time (2016 and 2017) no other partner was reportedly working in this area anyway. The case for developing a midwifery cadre in relation to the benefits for improved health and reduced preventable deaths in women and girls more than outweighed the costs.

**A complex long-term policy and systems strengthening process**

Creating a new cadre of health worker in any health system is a major policy, financing and systems development process with long-term consequences in terms of financial commitment to public sector salaries, health systems reorganization, and regulatory and legal changes. Such a major expansion would also bring with it opportunities including cultural adaptations in demand for health services and shifts in utilisation of care not to mention, for women generally and midwives in particular, a host of gender-related adaptations, and education and career opportunities. Initially, between October 2017 and August 2018, UNFPA supported the FMoH to convene a series of high-level, multistakeholder meetings needed to build consensus, validate the findings of MHTF-funded and supported assessments, endorse the shift to a more formally trained midwifery cadre, and then agree the pathway and timetable for reforms.

As part of the gap analysis process, UNFPA funded the team to visit Morocco on a study tour in February 2018 to learn and shape its ideas. Sudan has a largely physician-centred hospital system and neither the role of midwives nor of nurses are optimised within the system. Analysis of the health worker structure suggests that Sudan needs more nurses and midwives and to use them more effectively. Furthermore, increasing the corps of nurses and midwives (through the introduction of a new midwifery cadre) and broadening their role and skills would create scope to do more community engagement and outreach, focus on prevention and strengthen health promotion.

**MHTF global partnership with the ICM strengthened UNFPA credibility to deliver midwifery reform**

[26] https://scalingupnutrition.org/news/sudan-launches-a-5-year-strategy-for-the-health-of-women-children-and-adolescents/

The result of the process was the presentation and discussion of a gap analysis in August 2018 with a proposal for a new midwife cadre working across the SRH-MNH services, trained through the delivery of a higher degree and rooted within the formal health worker structure. This was a major policy process in terms of evolving human resources for health and beginning to shift the balance in skilled health personnel. UNFPA was the main driver of this complex process and co-led the development of key components of policy, advocacy and partnership needed to deliver the result.

Validation by a wide range of partners across the sector (including potential detractors such as doctors, other nurses or untrained midwives who might not be supported to upgrade their skills) was a critical step to making progress. A high-level, multi-day event that took place 5-9 August 2018 to agree a four-year strategic plan (2019-2022) to strengthen midwifery in Sudan. Dissemination of the plan was done in November 2018. The plan included the formation of a Sudan-based technical team to lead the development and validation of a new midwifery degree, including the curriculum, the examination process, a guide for teachers and a student manual. The national team was supported by the ICM using MHTF funds, working under the leadership of the Academy of Health Sciences and managed by a high-level steering committee jointly overseen by the FMoH and the UNFPA country office (CO).

A new curriculum and associated elements (e.g., teachers' guide, examination standards, student handbook) are the prerequisites for the establishment of a new cadre in the health sector as part of the process of identifying competencies and standards of care but are insufficient. Additional support therefore included the development of a regulatory framework including legal and regulatory elements outlining the scope of practice, a code of conduct for accredited midwives, the accreditation process, performance standards and continuous assessment. It was also critical to ensure broad support for the curriculum and the midwifery cadre from other health stakeholders including the Sudan Medical Specialisations Board, other health professional associations, and the FMoH and State Ministries of Health (SMoH). The curriculum and its associated elements were finalised by February 2019 and sent to the Ministry of Higher Education in March 2019 where, at the time of this evaluation, the formation of the new accredited midwifery degree continues to await approval. Progress was steady and consistent on the development of the new degree and professionalisation processes, which were completed in 2018 and submitted for approval in 2019. However, the revolution in 2019 and the COVID-19 outbreak in 2020, has stalled the advancement of the process. The leadership in the Ministry of Higher Education has been replaced four times.

**Meeting the need for better midwifery training**

Based on the UNFPA and ICM-led, MHTF-funded midwifery gap analysis, which measured midwifery against global standards, Sudan took a decision to stop training community midwives and, instead, to establish a higher degree qualification in midwifery. The ICM assessment identified low standards, failures, gaps, and insufficient quality that, based on their entrance criteria, training methods, role and responsibilities did not meet global standards. The lack of midwives in health facilities was also considered an important underlying factor that led many women to prefer to deliver at home. Women were reinforced in this decision because of the perception of low quality of care they received at the health centre and the lack of respect for patients, which is an acknowledged problem in Sudan.

UNFPA was prepared to support additional in-service training for midwives while the new diploma started up, but the government took a decision to suspend community midwifery training and in-service refresher courses. Just prior to suspension, in 2017and 2018, all community midwives were reached with a short refresher course.

**Opportunity to expand gender-sensitive policies**

The midwifery course is founded on a gender-sensitive approach to integrated reproductive and maternal health services delivery that mainstreams key determinants of health for women and girls.

The course curriculum identifies the midwife as an agent of change. Critical among structural determinants are the abandonment of FGM which UNFPA has integrated across all its programmes (Section 3.6). A post-revolution 2019 law raising the age of marriage to 18 aims to address a second structural barrier to MNH by strengthening women's autonomy and ability to choose when to marry. This is reportedly facing more resistance from community and religious leaders. The midwifery role, as a new facility-based health cadre in Sudan, is identified as an opportunity and an important vehicle to help address gender equity in the longer-term and to challenge and reduce the harmful practices that undermine women's health. Midwives will need high quality training, management and professionalisation to acquire and deploy the skills needed to achieve this role. This begins with challenging their own personal views and understanding their role in relation to human rights, equality and the law.

**Basic community midwife training halted**

Until 2019, UNFPA did support the training of community midwives who make up the huge majority of midwives in the Sudan health system. Following ICM advice (and WHO global guidance), community midwifery training was terminated to make way for the degree course. At the end of 2018, community midwifery training schools were thus closed, and most pre- and in-service training of community midwives ended.[27] This has happened in other countries as well and is not unique to Sudan. Prior to ending the community midwife programme, all community midwives were given in-service training at some point in 2017 or 2018 to upgrade their skills using MHTF and other funds.

In its support to community midwifery training up to the end of 2018, UNFPA routed some of its MHTF assistance to support a retention package for midwifery tutors, including an obstetrician and eight nurse-trainers at the Academy of Health Science in Khartoum and others located in some of the state midwifery schools. Salaries were low in Sudan prior to the protracted economic crisis that started in 2019 and led to inflation and a huge rise in the cost of living. A small retention package to nurse-trainers (USD 55 per month) was affordable and good value for money. However, once the schools were closed in 2018, combined with the economic crash, the monthly retention payment was insufficient to hold onto the trainers while they waited for the new midwifery degree to launch. From 2020, the retention package was no longer paid in any event. It is unclear as yet where the funding for trainers/tutors will come from when the new degree launches.

**The long gap in midwifery training will have lasting impact**

The paralysis in midwifery education has lasted three years (from the end of 2018 to at least the end of 2021) due to unforeseen external events including the political upheaval, rapid and multiple changes in government, and the COVID-19 pandemic. The result is that little midwifery education has happened in Sudan since 2018 outside of the Bachelor of Nursing degree programme, and even that has been affected by COVID-19 suspension. The new diploma degree requires students to have secondary education and Arabic language skills for admission to the course. Many girls, especially outside Khartoum, are not educated to this level as a matter of course. As a result, it will take time to fill the classrooms with midwifery students. In addition, it will be three years before the first graduates are deployed into the health system (2025 at the earliest if there is an intake in 2022). The expenditure pattern of the MHTF funds in Sudan confirms the limited UNFPA engagement in midwifery during the last two years of the review period. MHTF expenditure on midwifery declined in 2019 and 2020 to one sixth of the level spent in 2018 reflecting the paralysis in the delivery of the midwifery strategic plan while awaiting approval from the government for the degree programme to start.

**Aiming for a global standard in the professionalisation of midwifery**

[27] For the sake of completeness, it would be important to note that some additional training was delivered to some midwives after the onset of COVID-19 on infection prevention control. However, this was *ad hoc* and not related to routine skills development.

The Sudan Midwifery Association (SuMA) was established in 2019 with support from the FMoH and regulatory authorities and funded by UNFPA. SuMA is currently awaiting accreditation by the ICM and there are plans to develop state branches in due course. UNFPA provides technical expertise and small grants to support convening, advocacy, knowledge management, and communication at the national level as well as in some states. SuMA is expected to have an important role in professionalising the midwife within the Sudan health system and improving the quality of care provided by midwives. This is a long-term plan but crucial to the sustainability of midwifery as a professional cadre.

**Much has been done but concrete results are still elusive**

Since 2017, MHTF resources have been leveraged by the UNFPA country office to advance the development and implementation of a strategy to expand and strengthen midwifery in Sudan. The work undertaken in 2017 and 2018 to conduct the gap analysis, build consensus around the need to develop the new cadre together with the formulation of a whole new degree course for midwives in 2019 represent significant steps forward. The MHTF provided technical, policy and financial support to the whole process, from the problem definition and gap analysis in 2017-2018, to the design of solutions in 2018, including the new curriculum and the establishment of a professional midwifery association, as well as the health systems reforms needed to make room for a new cadre. The process has had multiple stages and has required a sustained level of engagement and commitment, as well as the approval or support of a wide range of partners and stakeholders. Much has been accomplished. However, at this stage, other than the Bachelor of Nursing programme, midwifery education has been largely suspended since 2018 and as the new curriculum is still awaiting validation, the situation for midwifery in Sudan is at a precarious stage. With an economic crisis constraining public spending, securing long-term government commitment to expanding the health wage bill to cover the salaries of midwives – and of trainers and their managers – remains unsecured.

## 3.2 The emergency obstetric and newborn care network

In Sudan, the identification of an EmONC network has enabled the establishment of an objective, consensus-based and realistic pathway to building a health facility network that meets basic needs and minimum quality standards. MHTF supported the UNFPA country office to work in partnership with the FMoH by providing technical and financial support, and channelling specialist mapping skills from global partners to interventions based on the application of a defined set of tools and processes. The MHTF – UNFPA country office – FMoH partnership in Sudan has so far completed stages one and two of the four stage EmONC network development process. Although still incomplete, the work on the EmONC network has already led to examples of better resource targeting and creates opportunities for improving value for money from infrastructure investments, quality enhancement, and priority setting. As a limitation, however, the EmONC network aims to increase quality of care for those women already in the health system, but in Sudan, most (77 per cent of women) do not attend health facilities for delivery. Therefore, the EmONC network is a necessary but not sufficient condition to improving quality of maternal and newborn care. Upgrading facilities and the skills of health personnel in targeted basic and comprehensive health centres is the next, as yet unrealised step.

For details of the evidence supporting findings in Section 3.2, see Annex 1: Assumptions 2.1, 2.2 and 2.3

**Relevance and impact of EmONC Network Guidelines and Standards for Sudan**

In 2017, at the start of the EmONC network development process, Sudan was assessed to have a 68 per cent gap in EmONC availability. The United Nations guidelines recommend a minimum of five EmONC facilities for every 500,000 population. Accordingly, Sudan requires 396 functional EmONC facilities. Of those already identified, only 127 were fully functioning as EmONC facilities reflecting 32

per cent of the need, leaving a gap of 275 EmONC facilities to be identified and upgraded.[28] Network standards also include the consideration of access to facilities and defined levels of care. At the primary level, all women should be within two hours travel time to reach a basic care facility (BEmONC site) and then two hours travel time from any BEmONC site to reach a comprehensive (CEmONC) site where more complex care is available. These are referred to as 'links' and they are assessed as red, amber, or green to indicate functionality. A total of 89 links between and among BEmONC and CEmONC facilities create the required network in Sudan. As of 2019, 54 per cent of these links were green meaning they were functional and could generate a meaningful referral.

The biggest gap was in basic EmONC (BEmONC) availability where there was 95 per cent shortfall while at the same time, there were too many CEmONC facilities for need. Across Sudan, the large desert area means that most of the population does live reasonably near a health facility. The large 'red zone' where there are few or no health facilities are desert with very low, often nomadic populations. An initial assessment identified that Blue Nile state had the lowest access to BEmONC sites and only 48 per cent of the population lived within two hours of a health facility. In developing a functional network then, the priority in Sudan was to right-size and upgrade its existing network of facilities to create the optimal network of BEmONC sites and then ensure CEmONC quality was achieved and maintained.

**The EmONC network facilities meet the needs of the minority of women and girls who can access them**

The identification and upgrading of the EmONC network guides the allocation of resources in a rational way to boost quality, improve equitable access, and support integration of essential services. These are important goals. However, the EmONC network assessment (2018) found that only 23 per cent of expected births took place in health facilities. When looking only at EmONC network facilities, this proportion drops down to 13 per cent of expected deliveries, and the met need for responding to obstetric complications is very low (three per cent in EmONC network facilities)[29]. These are the rates denominated on actual facility-based deliveries rather than expected births. In the beginning, therefore, strengthening the EmONC network improves health outcomes and results for the women already in the care of the health network. Over time, it is presumed that improved quality and reliability should build confidence among communities and attract more women to the health facilities for delivery.

**UNFPA supported the EmONC network development process with a combination of data tools**

MHTF sponsored and supported the rollout and delivery of a specific methodology to develop the EmONC network. This approach includes four phases of development from: (i) initial analysis and network needs assessment; (ii) design the network by mapping and selecting facilities and developing norms and standards appropriate for national needs; (iii) monitoring and performance assessment against the national norms, and (iv) upgrading and maintenance especially in support of referral. The third and fourth stages are where most of the infrastructure investments and service upgrades are required, and the one that carries the highest costs. Stages one and two, on the other hand, are largely based on technical analysis, policy discussions, consensus building, and mapping. The MHTF offers countries clear guidelines as well as technical support from the team in New York and, through established global partnerships (for example, with the University of Geneva to apply the Geographic Information Systems (GIS) mapping tool), a process to deliver a structured, definable outcome and products. These are: an initial analysis, a mapping to guide decision-making, a process to develop norms and standards, and guidance based on experience elsewhere.

[28] In terms of creating the EmONC network, a range of factors were considered including physical barriers and transport routes, to reflect real movement of people and boost relevance and reality of accessing different health facilities

[29] Worth noting however, that caesarean delivery rates as a proportion of expected births was within the UN recommended range (eight per cent in all facilities and five per cent in EmONC facilities).

Best practice around the application of the mapping and network development tools used in phases one and two suggested that, as with midwifery development, the process itself created an important capacity building, advocacy and leadership development opportunity in Sudan. As such, the EmONC network development was centred on and led by national and state level stakeholders with MHTF-UNFPA support and aimed to build consensus around what the network should look like, its standard of care and what it should offer in the Sudan context, and its role in the Sudan health system. Predictably, this process consumed significant time and effort throughout 2018 and 2019. By 2020, Sudan was at the point of training teams to assess the identified EmONC facilities against agreed national norms. The path to strengthening the health system is clear and so is the rationale enabling the FMoH and state health authorities to concentrate resources on specific facilities and services. However, the COVID-19 pandemic of 2020-21 has delayed state team training to date (Section 3.9).

It is worth noting that there are other factors that are much more difficult to overcome in building access to essential health services, such as impassable roads in the rainy season. Other barriers are social and economic, for example, around the availability and cost of transportation or the long-standing ambivalence of women to attend facilities for delivery. UNFPA reported that in 2019 they supported the formation of links between the FMoH and the police to help address transport barriers for women facing obstetric emergencies.

**Scale of need is great, yet resources are limited**

The number of facilities requiring upgrading is substantial. The midwifery cadre is anticipated as well and as noted in Section 3.1, has not yet started training new midwives. As Sudan advances through the phases of the EmONC network development process, the needs for national and state-based technical and supervisory support will increase. Whereas a skilled but relatively small team was able to do the mapping and decision-making processes working with SMoH teams, the business of assessing facilities against normative standards, and then planning and implementing needed upgrades, and monitoring standards of care require active, trained and managed teams in each state. Creating, training, and supervising the work of these teams has been significantly disrupted by COVID-19 (Section 3.9). UNFPA planned to use the MHTF and other core resources to train state teams throughout 2020. MHTF resources are also channelled to FMoH to support the costs of retaining and deploying such teams.

There are much lower expectations in relation to the MHTF or even broader UNFPA support for the final phase of the network development (upgrading of facilities to meet service delivery norms). The need is beyond the resources UNFPA could normally mobilise. Nonetheless, UNFPA has found and applied resources to support physical infrastructure works in many of the facilities. For example, UNFPA supported the renovation of the emergency unit building, the family planning clinic, the fistula centre and the GBV response centre in Ad Damazin Hospital in Blue Nile State in 2018. Other examples are given in Sections 3.7 and 3.9.

**National leadership and guidance to support EmONC development and expansion**

The FMoH leads the EmONC process. UNFPA has funded the process largely drawing on the MHTF technical and financial resources. UNFPA country office staff worked in close partnership with a FMoH counterpart leading and delivering the first two stages of the EmONC Network development from 2017 to July 2020. In fact, there was high-level endorsement of the network in 2018 but due to the revolution in 2019, the work stopped. In July 2020, UNFPA signed a new accord with the FMoH to start the EmONC Network development process again.

Results of the EmONC needs assessment were presented in a high-level meeting convened by the UNFPA country office in collaboration with the FMoH in August 2018. The Minister of Health was in attendance as well as 80 participants including the major civil society and professional stakeholders in maternal health care across the spectrum. The combination of broad-based, inclusive participation, senior leadership from national authorities, a technically sound and credible process as

well as sufficient time for discussion and consultation, all contributed to ensuring the process was credible and led to an inclusive policy process that resulted in commonly agreed decisions.

**Quality of services a major focus of investment and the priority of the next phase**

The FMoH has identified quality of care in the health system as a high priority. Speaking in June 2021, senior FMoH leaders spoke publicly as well as during interviews about quality of care and a patient-centred ethic as both currently lacking and most urgently needed. The third phase of EmONC network development could help contribute to this quality goal and MHTF funds are used to contribute to training of and support to retain state teams. Each team will be assessing facilities against agreed EmONC norms. When developing the norms, a strategic focus enabled the identification of "almost there" facilities, which are those where a small investment could disproportionately boost service standards and expand access based on better quality of care. The issues raised concerning the barriers to quality in MNH include:

- The lack of midwifery skills (Section 3.1).
- Poor quality of care: the preference for homebirths creates a circular problem linked to perceptions about quality of care and trust, but compounded by low access, the lack of midwives and low empowerment of women (Section 3.6).
- Data systems were identified repeatedly as a major shortcoming, in particular in relation to complications, maternal and newborn deaths, referrals and so on.
- The health management information system (HMIS) was the target of investment and support but there is a large gap to fill, and it is too complex a challenge to address without a comprehensive plan and the support and cooperation of all partners.
- There was a lack of evidence about the use of the partogram or any similar tool to support timely referral, a critical dimension for saving maternal and newborn lives, preventing fistula and other obstetric morbidities and building demand for quality CEmONC care.
- Intensive care unit and high dependency unit facilities seen during this evaluation were of very mixed quality due to high staff turnover, poor maintenance of equipment, and a shortage of supplies. The capacity to manage intensive care for mothers or babies in Blue Nile state hospital for example, one of the least accessible areas in Sudan, was limited.

**EmONC network is an opportunity for integration**

UNFPA advocates for the inclusion of cervical cancer, SGBV services, family planning and reproductive health services and others (Section 3.5). The introduction of cervical cancer screening services has been targeted to EmONC network facilities as well as the expansion of SGBV services, including post-rape counselling and treatment. SRH services are theoretically available across all health facilities and family planning is included in post-natal care. UNFPA has already invested in upgrading family planning units in selected CEmONCs.

## 3.3 Maternal and perinatal death surveillance and response

MPDSR has been supported by UNFPA in one form or another since 2009. MPDSR continues, however, to be framed and delivered as a pilot programme in the sense that it is still not fully embedded into institutional arrangements in the health system. Instead, it is largely health facility focused, undertaken by doctors, and does not have sight of the full spectrum of MNH, particularly community-level experience and delays. Neither is the MPDSR fully integrated into the national HMIS. UNFPA support has kept the MPDSR functional for more than a decade, especially at the national level, through a grant to the FMoH and financial and technical support for periodic reviews. The FMoH leads the technical committee that oversees the programme but, without a legal and regulatory framework, the MPDSR has limited scope to require a meaningful institutional response from the health system. As a result, accountability remains weak despite more than 700notified deaths up to the end of 2020. Deaths that take place in the community are excluded. In addition, as the

MPDSR process does not formally cover all three delays, family and community members are themselves excluded while the participation of community midwives and nurses is limited. Death audits will thus rarely, if ever, take proper account of the factors that contribute to the first of the three main delays (taking the decision to seek care). UNFPA and FMoH report that there are plans under development to link the MPDSR to the functional levels of health care (primary, secondary and tertiary) and to integrate the process with the HMIS so that maternal and perinatal deaths can be included along with recommended actions for improvements.

For details of the evidence supporting findings in Section 3.3, see Annex 1: Assumptions 3.1, 3.2 and 3.3

**UNFPA has maintained a long-standing focus on maternal death review in Sudan**

In Sudan, MDR began in 2009 and has been primarily focused on identifying the major causes of maternal deaths. It has expanded since then in a number of ways. The first of these is from national to state level, whereby in 2020 every state had some form of MDR process. Secondly, it has evolved well beyond surveillance to include surveillance and a health services response (becoming the MDS*R* process). Finally, as of 2018-19, the MPDSR started to include perinatal deaths (becoming the MPDSR process).

UNFPA draws on MHTF guidance and financial resources to support MPDSR processes, including notification, investigations at hospital and primary care levels, technical committee meetings, supervision, production of MPDSR annual report and operational support to the MPDSR national registry office. UNFPA also funds technical assistance to the programme through contracted consultants. In practical terms, UNFPA provides a grant to the FMoH which, in turn, appoints contractors to deliver and manage the programme. At the national level, a joint technical committee sets strategic direction and oversees progress. UNFPA sits on the national steering committee with the FMoH. Thus, while UNFPA is a leading partner in the MPDSR programme, it does not have a hands-on role. WHO joined the technical committee in 2017 to advise on technical standards while UNICEF joined in 2018 to lead on the integration of perinatal death surveillance and response.

The MPDSR delivers death notifications but at varying rates and largely linked to hospital deaths. However, despite the COVID-19 disruptions, 703 maternal deaths were notified and investigated up to the end of the third quarter of 2020.

**Challenges around institutionalisation of MPDSR**

The MPDSR linked processes are still funded largely by UNFPA. It has long been treated like a pilot programme and meetings of both national and state technical committees continue to be funded by UNFPA and others (in some of the states). The programme is reported to be more established at national level than at state level. As identified by UNFPA in its recent annual review, in order to institutionalise the MPDSR, several steps are needed:

- The development of a legislative and policy framework
- Formal adoption into the health system plans and processes
- A budget from the public purse
- Agreed indicators that are integrated into the HMIS.

Although a lack of resources is a persistent challenge (and the UNFPA – MHTF grant is not sufficient to cover all needs across the states), the larger challenge appears to be linked to the institutional arrangements for the MPDSR, legitimacy of the process, credibility of the findings and lines of accountability for delivering the right response to the results. Key informants have identified one of the main barriers to progress is the gap between the development of (sound) guidelines and protocols for managing obstetric emergencies and the reality of implementation and adherence on the ground from day to day.

As with other technical processes supported by the MHTF, the MPDSR institutionalisation suffers from high staff turnover, which makes it hard to build up collective knowledge, trust, and establish processes that the whole team can adhere to. Furthermore, the MPDSR is not yet integrated into the HMIS or interoperable with it. Instead, it has been maintained as a separate, parallel, largely doctor-managed process external to health system for over a decade.

**Limited scope of MPDSR**

As identified above, the scope of the MPDSR in practice is largely focused on health facilities and there is a lack of community engagement or follow-up. Conceptually, the MPDSR format and approach lends itself very well to including communities but in practice this is often not seen. Reports of maternal deaths at the community level are not formally or systematically captured and investigations into such community-based deaths amounted to about 15 per cent of reviews in 2020. While MPDSR processes might capture the extent to which referral (including the prompt for referral, communication about referral, and action on referred cases) was a factor in a facility death, it will not be able to fully assess and consider delays or community decision-making. Furthermore, MPDSR reviews are difficult to perform properly, especially in terms of finding the right balance between transparency and self-reflection by health staff with credibility and a meaningful outcome of the process. Those engaged in death audits need to recognise and validate errors made by health staff where applicable (including themselves) but also maintain confidentiality, privacy and active participation. Currently, in Sudan, there continues to be limited follow-up on recommended actions (accountability) or monitoring around policy and practice reforms based on the MPDSR reviews outcomes.

**Priorities for reform of the MPDSR process**

Since the new government took office after the revolution in 2019, a pathway has reportedly opened up to integrate the MPDSR into the HMIS and the routine data collection and management system. UNFPA and the FMoH also report that there are plans to link the MPDSR to functional levels of health care (primary, secondary and tertiary) and conduct reviews within the ambit of the actual health service rather than, as currently, by medics in their professional and more theoretical environment off-site. In addition, integrating the process with the HMIS will allow for maternal and perinatal deaths to be included along with recommended actions for improvements in a more methodical process. However, more needs to be done to move these important reforms forward and the FMoH replaced its contracted programme manager in 2021 to open the door for new ideas and thinking.

The MPDSR technical committee meets every three months and includes representation from a wide range of stakeholders including the Sudan Society of Obstetricians and Gynaecologists, doctors, midwives, national NGOs, United Nations agencies, and the FMoH. The technical committee expects to review MPDSR data in October 2021 with a view to further streamlining the way the MPDSR process works. The working group is also set to review how to integrate the MPDSR better at an operational level with the health system based on levels of care (primary, secondary, tertiary) as well as the district health information system (DHIS). The next progress review by the national technical committee will be in late 2021.

## 3.4 Fistula and other obstetric morbidities

Fistula is a complex, multifaceted health problem with severe social and economic consequences for the survivor. UNFPA has worked mainly to find and repair hundreds of individual fistulas, thus positively improving health and restoring life opportunities for hundreds of women. UNFPA, using MHTF financing and technical support, has also invested in successfully building national (Sudan-based) capacity to do fistula repair. Prevention of fistula is linked to better midwifery capacity, timely referral, and response to delayed first stage labour, as well as improved trust in quality health services. Yet, rehabilitation and reintegration of survivors into communities is almost entirely lacking. Furthermore, case typology, registration, tracking and outcome monitoring is also nascent or has not yet started. Overall, fistula services – which reflect failures in

the health system – have been tackled by UNFPA with MHTF and other support in ways that have been effective (repair) but are still incomplete (prevention, rehabilitation, reintegration). The recent UNFPA investments (that include contributions from the MHTF) to support the FmoH to develop a national fistula strategy are an opportunity to help define the next steps of UNFPA approach to fistula and other obstetric morbidities. Although an important area of UNFPA engagement and support, the MHTF contribution to fistula is almost the lowest in terms of financial resources, reflecting that UNFPA has other funding sources in Sudan.

For details of the evidence supporting findings in Section 3.4, see Annex 1: Assumptions 4.1 and 4.2

**Fistula is an ongoing problem in Sudan**

Fistula continues to occur in Sudan notwithstanding the progress made with regard to the midwifery cadre and the increased focus on EmONC (see Section 3.2), which are both key interventions to achieving fistula elimination. The persistence of fistula is a sign of continuing failure in the health system. A result of delays or poor quality of care (or both), fistula is entirely preventable, but once it occurs, it requires surgical repair, a protracted recovery period, rehabilitation and – usually – additional social services to support reintegration into communities. In Sudan, ending fistula will require a combination of interventions linked to systems strengthening (including the EmONC network), accessible, available services that welcome all women at low or no cost, improved quality of care especially from midwives, more efficient referral, and, crucially, trust by women and their families in the health services. Currently, UNFPA reports that there is a list of women identified in different communities in need of a fistula repair, and there are thought to be many undiagnosed cases still (see also Section 3.6).

**UNFPA support to national leadership for fistula strategy development**

There has been a programme supporting fistula repair since at least 2009 in Sudan. Until 2018, this support was mainly in the form of surgical 'camps' staffed largely by foreign doctors who would visit for short intensive periods of surgeries on women and girls identified in the previous year to be in need. During this programming period (2018-2020), the focus of support has shifted to a strategy-based on elimination through Sudan-based systems strengthening. UNFPA has leveraged MHTF technical assistance (from headquarters primarily) and financing to support the development of a fistula strategy. The strategy includes a situation analysis, response options, priorities for prevention, treatment and reintegration. The strategy development process started in 2019. UNFPA supported a technical review of the draft strategy in 2020. At the time of this evaluation, the strategy was still with the FMoH awaiting approval, now expected in late 2021, according to stakeholders interviewed. Delays have been caused by the COVID-19 pandemic, as well as changes in ministry leadership.

The strategy is expected to help form a basis for raising funds, pooling resources and strengthening systems capacity to target fistula prevention, repair, rehabilitation and recovery. In addition to overseeing the development of the national fistula strategy, the National Fistula Task Force, (established in 2020 by the FMoH and UNFPA), has also identified treatment sites in six states (Blue Nile, Central Darfur, Kassala, North Darfur, South Darfur, West Darfur) to form the basis of a fistula repair network among states where risk is highest. These sites coincide with related EmONC sites reinforcing the concentration of expertise and services on specific health facilities (as already outlined in Section 3.2).

**UNFPA focus until recently has been mainly on fistula repair but is now branching out**

As described above, until 2018, fistula was largely addressed through externally funded and isolated camps held especially for the purpose. Repairing fistula is highly specialised surgery and requires skills and experience normally held separately by gynaecologists, urologists, colorectal and other surgery disciplines. Since 2017, UNFPA has pursued a strategy to shift from holding (and funding) periodic fistula camps to building national surgical capacity integrated into the national health system in ways that make fistula services more routine. This effort has focused primarily on training

and mentoring Sudan-based surgeons to develop the cross-disciplinary skills needed and then to build experience by concentrating fistula repairs on a defined network of health facilities. Training camps initially took place in 2017 and 2018.

Once trained, and in order to make best use of skills, the FMoH created a mobile or a flexible surgical team that began to function in 2018, supported by UNFPA. The team provided fistula repair services where needed in the states where they were individually living and working. The mobile team is an innovation and has increased the use and deployment of fistula repair skills in difficult to access places. For example, in 2020, when the trained surgeon was no longer available to do fistula repairs in Blue Nile State, UNFPA arranged for the fistula surgeon based in AlFashir (North Darfur) to visit Blue Nile State to do fistula repairs.

UNFPA also supports the links between Sudan-based surgeons (and the Sudan Obstetrics and Gynaecology Association) with the International Federation of Gynaecology and Obstetrics (FIGO) to offer a fistula fellowship programme. Thus, across Sudan, a limited number of hospitals now have fistula repair capacity where prior to 2018, they did not. The number varies and it will be necessary to continuously train more surgeons in the future for this capability to be retained. As illustrated above, the surgeon previously trained in Blue Nile State is no longer available. Limitations are also created by theatre availability and poor infrastructure, lack of specialist nursing care capacity and the unavailability of consumables and medicines.

In addition to the costs associated with building and retaining surgical capacity and skills, UNFPA support to fistula repair covers the costs of the surgery (and associated hospital costs), as well as patient costs for protracted treatment, rehabilitation and care. UNFPA has continuously supported repair in a wide range of ways including, for example, 115 fistula repairs in 2020, of which 45 were funded from MHTF funds. In 2020 also, 220 fistula repair kits were distributed and the fistula repair centre in AlFashir was rehabilitated. UNFPA leads support to the FMoH in this area drawing on MHTF and core funds, but other partners are also active and include: the Italian Agency for Development Cooperation, and USAID. Over four years, partners have repaired the fistulas of at least 1259 girls and women.

**Limited progress on case identification, registration, and tracking**

One aspect of systems strengthening for fistula elimination that is so far under-developed is case identification, typology, outcome tracking, and monitoring. The criteria and agreed descriptors needed to identify and type fistula cases (there are various degrees, types and levels of severity) is not yet elaborated, agreed across the health system, nor embedded into the national HMIS. Case identification and typing exists in the literature but still needs to be domesticated. There is no system for case registration and tracking either at state or national level, although this is necessary to better track fistula cases and manage caseload. Indicators to measure the quality of the services and outcomes of care are also lacking and strengthening the reporting system was identified by many informants as a lagging element of the fistula response.

**Expanding beyond repair is essential to eliminating fistula: recovery, rehabilitation and reintegration is still nascent**

As already shown, most direct fistula effort has been levelled at finding cases and ensuring successful repair, training surgical capacity and supporting strategy development. On the other hand, there has been limited investment into other essential components of fistula services. Prevention, supportive recovery, post-surgery rehabilitation, and services to support reintegration into communities are nascent. Most recently, in 2020, efforts to expand social reintegration for fistula survivors was initiated. Reintegration is a multisectoral programme and is reported to be moving slowly. In 2020 and 2021, COVID-19 has prevented active engagement in social reintegration expansion.

Fistula prevention services are beginning and as laid out in the strategy, will rely on three main elements: ending adolescent pregnancies, increasing women's timely attendance at a health facility

for antenatal care (ANC) and for delivery, and improving timely referral and response to delayed first stage labour. These components, together, reflect the larger health systems development agenda in Sudan, the role and availability of qualified midwives, and trust needed between women and the health services especially in rural areas (as well as their ability to access care). Some informants pointed out that, as the midwifery programme comes on-stream (see Section 3.1), the midwife will also need to be oriented towards the communities they serve, being more proactive about community health and reaching out to women and families. This will require outreach services that enable midwives to build the confidence of the community, identify at-risk women early on and support their decision-making to seek care during delivery.

Once fistulas are repaired, recovery takes time and requires rehabilitation for women to recover fully and as quickly as possible. Most fistula survivors in Sudan – as in other countries – are excluded from their families and communities due to the antisocial side-effects of fistula. One experience conveyed by a key informant in Blue Nile State related the direct intervention of the surgeon, who spoke personally with a man, who had already divorced his wife over her fistula. Through his personal intervention, the couple reunited and now have a healthy baby together.

Every fistula survivor needs practical support to re-join their community. Where it is not possible to reintegrate, women need skills and psychosocial support to re-establish their lives. So far social services of this kind are not routinely available in Sudan and there is limited engagement between the health services and the community generally or between health services and other social services.

In Sudan, these aspects of fistula recovery are currently unsupported in any significant way although as mentioned, in 2020 UNFPA started to support reintegration. Although the strategy lays out a plan to expand to recovery and reintegration, there has so far been limited progress. UNFPA indicated that once COVID-19 no longer prevented internal movement, and subject to plan approval and government interest and commitment, it would aim to support FMoH leadership to expand social reintegration for survivors based on multisectoral programming. Although an important area of UNFPA engagement and support, however, the MHTF financial contribution to fistula is almost the lowest of the four MHTF technical priorities. This indicates that UNFPA has other funding sources to work on fistula in Sudan including its own core resources and funds from other bilateral funders such as Sweden.

## 3.5 SRHR and MNH integration

Gender-based inequities, limitations on the rights of girls and women, and the lack of equality in the Sudan society (in law as well as in practice) leads to the curtailment of access to a fully integrated set of essential services across the life course. Despite fairly well-established integration of some MNH and SRH services at the facility level – post-natal clinics offer family planning services for example – impediments to fully integrated care exists through access barriers. For example, while early marriage is still accepted and leads to adolescent pregnancies, unmarried girls find it difficult to access services. Fully meeting the maternal and reproductive needs of women and girls relies on addressing the social and economic determinants underpinning health outcomes, like early marriage and SGBV. Programme integration is valued in the Sudan country office and, following a reorganization in 2020, all related technical advisers consult and work more proactively together, using resources more effectively to meet shared goals.

For details of the evidence supporting findings in Section 3.5, see Annex 1: Assumptions 5.1, 5.2 and 5.3.

**Integration despite a weak health system context**

“Integration is one solution to scarcity” in a context in which there is “not enough of anything”. These are the words of a Sudan-based informant engaged in systems strengthening. Integration allows services to do more with less. The new 2018 midwifery curriculum demonstrates this approach as it anticipates the midwife will support reproductive services provision to women across the life course, not just around birth. In this sense, integration allows for more comprehensive service delivery and more effective (and efficient) use of skilled health workers. Integration also ensures that health workers can more easily respond to patient needs. However, the weakness of the health system in Sudan with a high staff turnover represents a major obstacle to further integration.

On the other hand, the integration around donated health commodities and pharmaceuticals (including those from UNFPA and other partners) is an example of integration that ultimately supports systems strengthening. Commodities have indeed largely been integrated into the national pharmaceutical system. This constitutes a systems angle to integration, which, in practical terms, is essential for service integration since commodities are vital to quality and credibility of care in the eyes of users.

**Sudan already well advanced on some aspects of basic services integration**

In practical terms, midwives in Sudan already work on delivering family planning services including in post-partum clinics. In-service training for existing midwives has started expanding basic skills on clinical management of rape and other areas. Integration of maternal and newborn services is anticipated in the EmONC network and is elaborated in the EmONC manual. The extent to which integrated maternal and newborn services are currently delivered has not been formally measured in states or at the national level as the delays caused by COVID-19 have meant that limited systematic monitoring has been started (Section 3.2). There are no adolescent-specific services in Sudan. However, in 2020, UNFPA worked with the FMoH to initiate a communication campaign on SRH aimed at youth, including through peer networks.

A theme that emerged from the data collected in Sudan regards how gender-based inequities, the limitations on rights of girls and women, and the lack of equality in Sudan society (in law as well as in practice) leads to the curtailment of access to a fully integrated set of essential services across the life course. As noted in Section 3.6, progress on women’s health and MNH outcomes are closely related to progress on addressing the principal determinants: child marriage, FGM, legal autonomy, education, access to the economy and other fundamental rights. **FGM abandonment** is reported to be happening faster than the abandonment of early marriage where progress is slower. Despite the new law passed after the 2019 revolution raising the age of marriage to 18, there is, “not 100 per cent support” yet for that policy particularly from religious authorities.

**Shift integration to focus on comprehensive PHC**

A theme that emerged from stakeholder comments identified a need to integrate SRH and MNH not just with each other but, with all basic services, into PHC. Reproductive health is just one of many essential services and it is more productive to work towards a strong PHC system. Family health is part of PHC. UNFPA in Sudan aims to focus on family health in a context of PHC where 85 per cent of services are delivered to women and children. Within this there should be teams delivering MNH and SRH. The PHC approach also allows for the adoption of a psycho-social health care approach and a wide-ranging perspective. As noted previously, MNH is adversely affected by a range of harmful practices including FGM and early pregnancy, women’s empowerment and lack of education.

UNFPA works across its programme to address FGM in all its activities, for example, by taking a wide view of integration. So, the question of integrating SRH and MNH at the policy, planning and delivery levels should not be at the expense of the larger, more important goal of supporting partner countries to deliver a comprehensive, strong, quality primary health service.

**Integration in UNFPA plans and programmes**

UNFPA supports the FMoH plan to enable the EmONC network to serve as a platform for the delivery of comprehensive and fully integrated sexual reproductive newborn adolescent health (SRMNAH). In turn, these basic services form the core of a sound PHC approach. Integration of basic services in the context of the network creates the pathway, in Sudan, to agreeing where and how to focus efforts in support of health and health systems. The features of integrated SRH and MNH are partially defined by the midwifery curriculum of 2018, terms of service and scope of work, inclusion of a range of health services at EmONC and other health sites. Examples of such inclusion are family planning clinics linked to maternity services, suitable family planning options for breastfeeding mothers, GBV training for midwives, and adolescent-friendly services.

UNFPA articulates integration as an important step for efficiency and effectiveness but, in Sudan, there are obstacles created by the regulatory and social environment. For example, UNFPA outputs for the year 2020 identified specific results that reflect integration goals. Specifically, programme Output 3 references "Strengthened capacities to provide high-quality, integrated information and services for family planning, comprehensive maternal health, STIs and HIV, as well as information and services that are responsive to emergencies and fragile contexts". A question though, relates to understanding what that means in practice and how progress can be measured. The UNFPA programme indicators tend to be focused on counting deliverables and activities rather than measuring capacity which makes it difficult to assess results or to identify incremental gains in this area.

Integration within UNFPA itself has also evolved. In 2019, within the UNFPA country office, related sub-units including MNH, emergencies, reproductive health supplies, MHTF and others were all linked together into a single unit within the country office. The three technical coordinators now work closely on a daily basis, and in closer coordination with one another. This helps manage gaps and maximises opportunities. For example, the country office reported that they use their access to reproductive health kits to ensure that gaps in Sudan are covered to the greatest extent possible and this is facilitated by the new integrated structure in the country office.

## 3.6 Strengthening access and equity

Sudan has a low standing on the global gender inequality index reflecting the lack of rights, education, services and status for women and girls. The new government has taken some important steps towards improving the role and situation of women but there is much to do. In this context, each of the four technical areas of the MHTF focuses on strengthening access and equity in their individual ways. In the aggregate, the SRH and MNH agenda as delivered by UNFPA, is underpinned by a strong focus on equality and meeting the needs of women and girls. Despite the improving policy and rights environment, change is slow. Stakeholders suggested that UNFPA continues to be in a sensitive position, pushing for change but cautious not to outpace the capacity for reform and social, religious and political capacity for change.

For details of the evidence supporting findings in Section 3.6, see Annex 1: Assumptions 6.1, 6.2 and 6.3.

**Health outcome and access inequality in Sudan is well-documented**

Inequality is evident in outcomes, life opportunities, access to services, and other indicators in Sudan (Annex 3). In 2020, Sudan was at 170 out of 189 countries on the gender inequality index.[30] Access to services is low overall because of both uneven supply and weak demand. Data collected for this evaluation confirms that the majority of women still prefer homebirths, while this tendency is a leading contributor to the high number of maternal deaths and life changing morbidities. For example, in Darfur alone, there are 366 fistula survivors awaiting repair and, according to the FMoH, many cases are probably undiscovered. As described in Section 3.4, fistula survivors are among the most vulnerable women and girls often excluded from their families and communities. The low level of trust in health services creates reluctance to attend for delivery, related in part to perceptions of

[30] http://hdr.undp.org/en/composite/GII

poor quality of care and in the words of one ministry official, an underdeveloped “respect for patient culture”.

Women and girls face a range of barriers to accessing all nature of services including education, legal protection, basic health care and financial services. Unmarried women and girls are not allowed (in principle) to access family planning services and the range of family planning methods available does not include male condoms. The EmONC network development process (Section 3.2) revealed huge inequities in access to emergency care across the states; whereas in River Nile State was found to have 98 per cent of the recommended number of EmONC facilities, East Darfur state had only 9 per cent. The FmoH and UNFPA both referenced the ongoing aftermath of the revolution as an opportunity for greater gender equality and a new era for women and girls. This pathway has not been easy or straightforward partly because the political compact is still in flux (and will be for some time). A range of other challenges have also affected programmes aimed at increasing access and equity, including conflicts, natural disasters and an economic crisis.

Efficient health services rely on parallel progress to reduce the burden of disease and boost prevention, including through acting on the main determinants of health. In Sudan, these include ending FGM and reducing early marriage and adolescent births. Post-revolution, women are demanding change, and the new government expresses a different view of social development. Change that promotes comprehensive access and equity has been slower around reducing early marriage than on ending FGM. There is an ongoing dialogue with stakeholders across Sudan society, including Islamic authorities, around the type and pace of change in Sudan. The rights of women and girls are “not fully granted” yet and one key informant observed that UNFPA has to be sensitive all the time, ensuring it walks on the right side of the line between pushing change too strongly and, on the other hand, respecting national and local social and cultural norms. In addition, high staff turnover, especially at the state level, means that progress slows or reverses, and dialogue has to start again.

**UNFPA support to government commitment to access and equity**

UNFPA is the lead United Nations organisation for the provision of HIV and STI prevention services in Sudan and it fulfils this role working in close coordination with FMoH, supporting sex workers and other vulnerable groups with health care services, condoms and other support. The approach to lesbian, gay, bisexual, and transgender (LGBT) services and needs is sensitive, and UNFPA does approach discussion of needs and is a leading United Nations partner to the FMoH on this. UNFPA is assessed by its in-country partners and funders to take an astute and objective approach to what can be a sensitive issue. In taking the medical view they focus on strengthening the systems to deliver SRH and other health needs of girls and women, and, in the words of one informant, “that sees them through…” the most difficult discussions and enables them to talk openly, frankly and continuously about sensitive issues and services. Partners report their confidence that UNFPA focuses on the most vulnerable women, but services are limited by distance, lack of staff, poor quality and commodity stock-outs especially in rural areas, and “sustained efforts are needed” to make significant, widespread progress. UNFPA may understand the barriers to access but is not always in a position to address these given their social and political pervasiveness. However, some partners identified the focus of the MHTF as being geared to addressing access barriers (especially the work on EmONC and fistula) and equity with the slow, but meaningful, strengthening of midwifery as a means, over the long-term, to extend quality services to more women.

**Adolescent-friendly services do not feature in Sudan**

Adolescents are not targeted with specific services or approaches. This reflects the situation for girls in Sudan who may marry young and who have little access to confidential SRH and other health services unless married. Prohibitions and social mores combined with early marriage and gender-based inequalities make access to the full range of SRH services severely limited for girls and boys.

Reducing early marriage, FGM, and other harmful practice are all important to prioritising the rights of adolescent girls. UNFPA – together with UNICEF and other partners in Sudan including bilateral donors such as Ireland, the USA and Sweden – supports a wide range of programming to address these social and economic determinants of health. Informants from the UNFPA country office suggested that FGM abandonment is taking place at a faster pace than progress reducing early marriage.

**Gap in midwifery training beginning to affect the most vulnerable girls and women**

In Blue Nile State, there are reported to be 42 areas which now rely on local untrained birth attendants as their community midwives have retired or moved away. As the midwifery schools closed in 2018, there is no possibility to train additional community midwives (Section 3.1). This is most likely going to affect the quality of care available through home births in these areas, and, critically, timely referral.

## 3.7 Catalytic support

UNFPA aims to position itself for more active coordination support to the FMoH as opportunity arises in Sudan. Coming out of a long period under a previous government where external partner support to convening was not particularly valued, Sudan is in the midst of a complex and difficult transition. Consultation and coordination appear to be more valued by the current government, recognised as a vital part of creating credible reform processes. However, although it has been very active in its support of specific sub-sector priorities (including those of the MHTF), it is difficult to identify how UNFPA is actively engaged in promoting universal health coverage (UHC) in Sudan and its wider level of advocacy and engagement. This evaluation has looked only at the support of the MHTF to Sudan in the four technical areas under review. There are good examples of the catalytic nature of MHTF-supported activities by UNFPA in Sudan. These include activities supported by UNFPA that have attracted other partners over time (MPDSR), investments that build unexpectedly on previous outcomes (the EmONC network) and those that could ultimately have a potentially profound and significant impact on improving health outcomes in the future if fully realised (midwifery reform).

For details of the evidence supporting findings in Section 3.7, see Annex 1: Assumptions 7.1, 7.2 and 7.3.

**UNFPA as a convenor of SRHR partners**

Reports from key informants suggest that donor coordination was not a high priority under the previous government (prior to 2019). Convening partners and support to the FMoH to lead partners was difficult. Coordination fora have been established over the years but where reliant on a government-convening role and national or state leadership, had largely languished. There were exceptions – around HIV coordination for example – but the coordination of external partners by national health authorities has been patchy. There are relatively few donors in Sudan compared to many other countries at a similar economic development position. Coordination is not a complex process therefore, yet it is under-supported in terms of its external assistance per capita.[31] In the wake of the 2019 revolution, new opportunities are opening up for a more transparent approach to coordination and old coordination structures are being revived. In particular:

- **A sector-wide SRHR group**: UNFPA is working with the FMoH to revitalise the SRHR forum, supporting the government to convene and lead this forum.

[31] Sudan received USD 4.58 per capita of external assistance in 2018 out of a total spend of USD 60 per capita – about 7.6% of its total expenditure on health. GNI (Atlas method) has declined from USD 1540 in 2015 to USD 650 per capita in 2020 reflecting the severe economic crisis. By comparison, other large LMICs in the Africa region have higher contributions to their health expenditure. For example, DRC, Ethiopia, Tanzania and Zambia with GNIs (Atlas method) of USD 550, USD 850, USD 1010, and USD 1190 respectively, receive health assistance, per capita, of USD 6.52, USD 8.71, USD 11.87 and USD 33.86. As the new government – and more open, transparent and civilian governance model – takes shape and stabilises, more resources may become available to Sudan. (https://data.worldbank.org/indicator/SH.XPD.EHEX.PC.CD?locations=SD)

- **SRH platform in the health cluster**: UNFPA has taken on the role of convening the SRH platform within the Health Cluster – the overarching humanitarian coordination structure led by WHO.
- **United Nations-wide SRHR focus**: UNFPA is in the midst of negotiating a memorandum of understanding (MoU) with H6 partners in Sudan, building on a tripartite MoU already agreed among UNFPA, UNICEF and WHO. There is, too, a blueprint for a cross-United Nations focus on sexual, reproductive, maternal, newborn, child, adolescent health (SRMNCAH). Still under discussion, the idea is to ensure that all United Nations endeavour incorporates and takes account of the reproductive and health needs of women, newborns, children and adolescents akin to the previous well integrated focus on HIV.
- **A global link**: The UNFPA Sudan country office has been nominated to be the respondent for the global Ending Preventable Maternal Mortality initiative (EPMM) and this will require convening MNH partners across the sector and building consensus around tracking and monitoring EPMM.

For all partners, these fora will require new ways of working. There is limited evidence of UNFPA convening and coordination support at the sector level in this review period. This is partly because there has been limited scope for broad coordination and priority setting. Partners report that meaningful coordination occurs between individual MoH teams and individual partners, including UNFPA, but not necessarily in broader groups involving all or even multiple partners. Cooperation and communication – fully in evidence through the MoU between UNFPA and UNICEF for example – are features of coordination.

At the sub-sector level, there is more evidence of UNFPA flexing its convening power in support of coordination, programme design and systems strengthening. The most visible example is the work pursued to develop the new midwifery cadre (Section 3.1), which relied on convening and shaping the views of myriad stakeholders. Coordination starts within the MoH itself, and then trickles down through the health sector, including some actors with significant power or scope to frustrate progress. These are doctors, hospital managers, state health authorities, civil society, community and religious groups, and then other informal health workers who have much less power to influence change. MHTF convened groups of stakeholders – or supported the FMoH to do it – at different stages of the process to reach a productive and positive conclusion. In this context, convening constitutes coordination, partnership, advocacy, and leadership.

**UNFPA technical and policy expertise supports FMoH leadership**

UNFPA leads on key areas of technical support to the FMoH and is recognised by the ministry as their leading partner in some areas including SRHR generally, some critical maternal health interventions including midwifery, action against GBV, the fistula response, post-rape care, family planning, the application of the minimum initial service package for SRH in emergencies (MISP), and cervical cancer screening. In this capacity, UNFPA works closely with the FMoH and supports national efforts to develop relevant policy and deliver services. There is evidence that UNFPA technical knowledge and guidance is much relied upon in the development of national policy, for example, in relation to the incorporation of cervical cancer screening into EmONC sites.

However, it has not been possible to fully identify the extent to which UNFPA actively engages on the integration of basic SRHR services into a PHC platform and the larger UHC system. Although the engagement in SRHR is visible, the active linking of SRHR to PHC systems development and a larger UHC system is not. It is important to note then that this evaluation does not seek to suggest that the UNFPA country office is not sufficiently engaged in national processes in this area. With limited resources available through the MHTF (less than USD 1 million over three years) in relation to the overall budget of UNFPA and, naturally, the national health budget, UNFPA appears to be highly focused on delivering its programme and achieving the significant number of outcomes it has committed to in each of its funding streams. However, one stakeholder suggested that although the country office was supporting the FMoH in making some critical MNH gains, UNFPA at the

organisational level (beyond the Sudan country office) needs to "regain control over coordination on issues around maternal health". This, they said, meant thinking more broadly about what drives maternal deaths including social, gender-based, institutional, economic and political drivers of maternal mortality and strengthening country operations in these broader areas, for example in the national health strategy development process. In order to work at the up-stream end of the SRH-MNH agenda, several key informants also suggested that UNFPA should ensure it fully positions its resources "over the full breadth of its mandate" including human rights, family planning policy and gender empowerment in order to make progress on maternal health outcomes.

**Complementarity between the global MHTF and the country office coordination role**

Related to these larger issues of the UNFPA mandate, role, capacity and performance around convening and coordination, some key informants reflected on the importance of national commitment (or political commitment) to shared goals around reducing preventable mortality of women and girls. They pointed out that national commitment to complex and difficult challenges can be strengthened and sustained through global pressure and global policy processes, which service to maintain the collective global health focus on specific issues. Since 2015, focus on maternal and newborn mortality has waned somewhat creating space for other emerging priorities including non-communicable diseases and a global push on UHC. The potential to lose gains made as a result of COVID-19 related setbacks has revived urgency somewhat.

There were questions about the extent to which UNFPA – and MHTF at the headquarter level in particular – was promoting and advocating for the policy and programme needs that underpin the reproductive health of women and girls. The country office staff thought this was probably happening at the global level, but they did not always know. An important area for follow-up in the global element of the evaluation is to identify the role played by the MHTF team at the global level. In Sudan, stakeholders question whether UNFPA at the global level is fully engaged in maternal and newborn mortality reduction in the global dialogue. Advocacy, partnership and coordination, they say, are a triumvirate of interlocking actions that together amount to 'convening'. Key informants in Sudan identified ways that UNFPA often did step forward to promote dialogue around complex policy issues (age of marriage, access to services by adolescents, safe abortion care, family planning services, sexuality education). But many key informants were also able to provide examples of how they thought UNFPA sometimes showed hesitation or could and should further strengthen its messaging as a leader in these areas and around the language of rights and empowerment. It is a fine balance. Given the sensitivity around many of the issues that UNFPA addresses, the ability to speak out or make calculated judgements about tone, content and timing of messages requires individual confidence, encouragement from managers to engage, and a well-defined and strong internal coordination and communication system that develops accessible language around difficult messages.

**UNFPA investments can bring other partners into the tent**

While it is difficult to verify fully, UNFPA support and leadership among partners to some specific priorities has led to the structured and long-term participation of other partners. UNFPA sustained leadership and engagement has nurtured processes to the point where other partners become engaged. A clear example of this is the MPDSR process, which began as the MDR process with UNFPA support only. Over the last decade, WHO, UNICEF and others have become engaged and participate on the national and state technical committees supporting methodological evolution and – to a limited extent – financial needs of the process.

The MPDSR and the EmONC network programmes are two examples of initiatives supported by UNFPA with assistance from the MHTF (in the form of both technical expertise and financial resources) that have both attracted additional partners in the course of gaining traction in country. As mentioned above, there is a very limited range of partners in Sudan. However, even in this context, UNFPA - including those working on MHTF priorities - appeared to have relatively little

coordination or engagement with some of the other major partners in Sudan such as the World Bank or USAID. In addition, the basic coordination between United Nations agencies was not always sufficient to avoid duplication or gaps, for example around training programmes and reportedly in approaches to addressing GBV in 2018-2019.

**UNFPA investments are catalytic in a range of ways**

The EmONC network was a major technical exercise requiring capacity, digital technology, a scientific approach and national and state level decision-making. It also needed coordination across all levels of the health sector to ensure its full value was realised as a systems strengthening investment. The EmONC network has been identified by key informants as a valuable process that paves the way for a range of systems strengthening investments including – but not limited to – MNH. This is a clear example of catalytic investment. The identification of the network has fostered national and state discussions about priority-setting, which led to consensus building about systems strengthening needs and gaps, and then attracted investments from other partners and galvanised energy among national and external partners to improve services in a defined way. For example, following the 2020 floods that devastated a large part of the country, USD 4 million was made available to invest in health infrastructure. UNFPA targeted the resources (granted to support the 'build back better' approach to infrastructure repair following natural and other emergencies) to priority health facilities using the needs identified through the EmONC network development process. In this way, the resources available from the humanitarian response were/will be invested into the ongoing systems strengthening process already underway.

Other catalytic investments that have drawn on MHTF technical and financial support are in evidence, such as the MPDSR approach that has attracted additional partners over time (Section 3.3). The fistula repair "mobile team" is an innovation that has increased the development of in-country surgical skills and, more importantly, the availability and use of those skills in difficult to access places. While the MHTF used to be a majority 'shareholder' in the fistula programme in Sudan, over time, other funding has increased such that only about 30 per cent of fistula repair costs were covered from MHTF in 2020.

**Not everything has catalytic potential**

Conversely, not everything is catalytic, and innovations can solve one problem but create others. The example of using mobile phones to report maternal deaths is a case referenced by partners and still comes up in the maternal health programme development discussions in Sudan. The distribution of mobile phones in remote areas succeeded in increasing the rate of reporting in the short-term. However, the necessary logistic systems, the lack of a larger HMIS and indicator tracking system, the complexities around charging phones where there is no electricity, the pressure to use phones for other purposes and a host of other issues, ultimately led to programme failure. The experience – which predates this evaluation period – is a constant reminder that some advances can only progress as fast as the larger infrastructure does. But it also makes the case – again – for the crucial role of UNFPA at the national level to keep maternal health at the top of the cross-sectoral national development agenda.

In other ways, MHTF-supported efforts need long, sustained efforts. For example, even now, after more than a decade of support and despite the participation of other partners and the commitment of the FMoH, the MPDSR process, while innovative, has still not led to the integration of maternal death audits into the national health system. Furthermore, it clearly remains fragile on an institutional level. In another example of somewhat missed targeting, a number of tuk-tuks designed to aid transportation of women to hospital when needed were gifted in Blue Nile State by UNFPA (not MHTF though), but so far have reportedly remained largely unused for various reasons. One potential problem is suitability for use in the rainy season on Blue Nile terrain. Transportation to hospital was frequently raised as a challenge in rural areas but the motorcycle or tuk-tuk may not be the best solution outside the main urban areas.

## 3.8 Governance and management

The UNFPA country office draws on technical and financial resources from the MHTF to deliver its programme in Sudan. As the MHTF relationship is with the UNFPA country office rather than with the Sudan health authorities directly, the MHTF can influence UNFPA approaches at the country level but clearly does not have direct control over how its support is used or embedded in the wider country programme. UNFPA draws on its available resources in Sudan (from core and programme funds) to support the FMoH to strengthen its delivery of essential health services for women and girls. This relationship aims to foster increased leadership and ownership in the FMoH and is an important factor in the FMoH perception of UNFPA as a flexible, responsive, and supportive partner to them. The MHTF-brokered global technical partnerships are valued in Sudan and have influenced the credibility of UNFPA-supported activities, especially those requiring multiple steps over years of effort, such as the midwifery reform (with the ICM) or the EmONC network (with the University of Geneva). Sudan-based stakeholders have also referenced technical expertise from the MHTF team as making valuable contributions in the technical focus areas. On the other hand, the MHTF headquarters management of resources is such that annual allocations to Sudan are often delayed, sometimes to the second quarter. Some key informants identified the need for UNFPA to be more visible (globally, regionally, in countries) on the MNH agenda and to raise more funds in support of this area of work.

For details of the evidence supporting findings in Section 3.8, see Annex 1: Assumptions 8.1 and 8.2.

**Level of engagement**

UNFPA uses the MHTF resources to support a combination of national level strategy, policy and planning instruments and processes (for example, the midwifery curriculum, the EmONC network criteria and standards, the fistula strategy) as well as implementation support at both national and state levels. The MHTF resources are frequently co-mingled with other country office resources (from core and/or other programme resources from other partners in Sudan). This balance can change over time (for example, in 2019 and 2020, fistula repairs were funded as much through non-MHTF resources).

**UNFPA programme arrangements support government decision-making and management**

The MHTF directly funds some kinds of inputs and establishes the partnership for country offices to draw upon. For example, the MHTF has established partnerships with technical bodies that are critical to specific areas of support. The ICM for midwifery and the University of Geneva for the GIS used in the EmONC network development work are two examples. These partnerships benefit Sudan but are funded and managed directly by the MHTF. However, Sudan can use its resources to draw on ICM expertise to support the midwifery development process in the context of that institutional partnership.

In terms of delivery, for the most part, UNFPA allocates resources to the FMoH, which then contracts skilled workers directly to deliver specific roles (not as FMoH staff but as contracted employees). For example, the teams to monitor the EmONC networks at national and state levels are all contracted and managed by the FMoH using funds granted by UNFPA. While there are some significant advantages to this approach (the main one being FMoH leadership in identifying and meeting its own delivery needs), the lack of public resources for key roles weakens sustainability.

In most cases identified, where UNFPA provides a grant to the FMoH for programme delivery, there is a joint technical committee established that supervises progress (for example, the national technical committee with oversight of the MPDSR). The committee can take collective decisions about the overall use of resources, assess progress and make recommendations to the FMoH about the way forward. But it is for the FMoH to take the action and ultimately make operational decisions.

**UNFPA flexibility valued by implementors and across UNFPA**

The FMoH and other partners value UNFPA flexibility and adaptability. Many implementing partners said that UNFPA is more flexible and responsive than other United Nations partners. UNFPA is also seen by them as 'respectful' and 'deeply committed' to the mission they are delivering.

Over the period covered by the evaluation, UNFPA has used all available resources: technical, financial, human and infrastructure. The MHTF funds contribute to all of the three UNFPA goals on GBV, maternal health, and family planning. One key informant identified that the MHTF could be a pathfinder for resource mobilisation linked to the three UNFPA transformative results (leading on maternal health).

**The role of headquarters and the MHTF in relation to country office delivery**

Sudan-based stakeholders referenced technical expertise from the MHTF team as making valuable contributions in the technical focus areas. Technical guidance, an implementation structure and a clear model to follow, and technical expertise to support the UNFPA country office appear to be the main elements offered by the MHTF headquarters to the Sudan country office. The MHTF technical support is valued and considered essential to the success especially of the EmONC network development model (since it is based on a specific process), but also to other core areas of MHTF including midwifery and fistula.

On the other hand, headquarters delayed signing off workplans at the start of a new programme cycle such that funds often did not flow until the second or third month of the year (in most years reportedly but certainly in 2020). These delays hamper the delivery of planned programmes significantly. Resource shortfalls (about two-thirds of the approved budget was transferred to Sudan in 2020) affected delivery and implementation, which, in 2020, were exacerbated further by COVID-19 delays and interruptions.

**The role of the MHTF in UNFPA**

While MHTF technical support and resources are valued by the FMoH, the country office and others, there is a clear sense that more resources are needed. This is particularly the case in relation to the application of specific processes, like the application of the EmONC network model and associated GIS software. This is also true for the gap analysis tool introduced and led by the ICM which, with UNFPA country office support, enabled the FMoH and a wide range of stakeholders, to make significant policy decisions about the professionalisation of the health service (primarily midwives but with knock-on effects for other cadres as well, not least, doctors).

Several informants questioned whether UNFPA capitalises sufficiently on the successes engendered and nurtured through the MHTF. At various points, key informants suggested that at the broader level, UNFPA does not make enough of the MHTF model and its genuine successes. There have been really significant policy, technical, systems and capacity building gains made by UNFPA using – among other resources – the technical and financial support of the MHTF. Some express concern that the MHTF was not linked clearly enough to other major programmes in UNFPA (such as the family planning commodities programme).

That being said, there is a consistent sense from those interviewed that the MHTF might be trying to do too much in too many countries. Maternal mortality is a huge area and reflects many failures in a health system. Shifting maternal death rates requires investments against which the MHTF "is a drop in the ocean". With the funds available, it should (i) target fewer countries (ii) focus on fewer technical priorities, (iii) allow funds to be used more flexibly at the country office level (for example, to hire technical staff in country) and, one key informant also added, (iv) place more effort on integration of SRH and MNH into PHC as a platform and the core or heart of UHC.

Lastly, key informants pointed out that while the technical and systems support are crucial for credibility, leadership, coordination, and advocacy are equally important to maximise their impact and ensure that systemic change can be institutionalised and sustained.

Resource mobilisation is what headquarters can do and some suggested they are not doing this adequately in that they fail to make the most out of the MHTF, to market it as an innovative programme and to capture its contribution to the three transformative results. UNFPA, they suggested, could do more advocacy with all its partners to make sure they are fully on board with needs.

## 3.9 COVID-19

The COVID-19 pandemic severely disrupted MHTF-supported activities and processes and a large proportion of actions were curtailed, delayed or cancelled altogether. As part of the UNFPA response to COVID-19, the MHTF resources contributed to a UNFPA response that aimed to help countries maintain access to basic reproductive, maternal and newborn services. Technical guidelines supported health personnel to work safely and maintain maternity services; resources were targeted IPC training for midwives and nurses along with the distribution of personal protective equipment (PPE) and reproductive health kits to supplement supplies. Although COVID-19 has delayed the implementation of all MHTF-supported activities, it is one of several complex challenges unfolding in Sudan simultaneously.

For details of the evidence supporting findings in Section 3.9, see Annex 1: Assumptions 9.1 and 9.2

**The context of COVID-19 in Sudan**

The COVID-19 pandemic affected Sudan concurrently with other major challenges including the aftermath of its 2019 revolution during which the dictatorship of decades long ended, and a new civilian order was established. Multiple concurrent crises have unfolded over the last two years alongside these two complex and still ongoing situations. These include significant social upheaval, inflation and financial hardship and a sustained economic crisis, multiple humanitarian and natural disasters (flooding, locusts) in 2020. Sudan has also seen a rise in other epidemics (malaria, viral fevers) and the ongoing effects of neighbouring wars, which have created waves of refugees (for example, most recently in 2020 and 2021 from Ethiopia). Over the last three years, coinciding with the review period, this upheaval has brought with it a number of challenges and constraints but also opportunities and the prospect of fundamental political and social change, which could ultimately have more impact on health outcomes than any external programmatic support.

COVID-19 has thus been deeply disruptive for more than the usual reasons and has created a diversion of leadership and resources at a difficult time. The first case was identified in March 2020. There have been two long periods of lockdown in 2020 (until August 2020) and in early 2021 lasting more than three months each and/or states of health emergency declared during which movement of people has been severely limited and many activities suspended. A quick scan of UNFPA activity reporting demonstrates the widespread impact of lockdown on planned MHTF related activities and outputs with many delayed, only partially achieved or cancelled altogether.

**UNFPA focused on SRH-MNH even in the COVID-19 context**

By all accounts, UNFPA was quick off the mark in terms of its COVID-19 response. While it did provide resources for PPE and additional infection prevention control (see below), UNFPA was demonstrably focused on supporting countries to protect the health of women and girls, maintain access to essential SRH and MNH services and support health workers to stay safe while still working. Reference to the lessons learned through the West Africa Ebola epidemic were made by several key informants. UNFPA channelled its investments towards protecting access to SRH and MNH services and its main focus was on maintaining service delivery as evidenced by the following examples:

- With other United Nations health agencies and under the leadership of the FMoH, UNFPA supported the rapid development of technical guidance for the provision of basic maternal and child health (MCH) services during COVID-19 (case management, isolation, IPC) in order to ensure that services continued and were not suspended.

- Guidance and practical support to establish a triage system outside main hospitals to identify and re-route COVID-19 positive patients – including women in labour – to an isolation unit to be seen and to deliver safely. Caesarean sections were slow due to limited theatre space and the need to disinfect the whole unit between surgeries.
- UNFPA coordinated the SGBV sector response on behalf of the United Nations agencies including the provision of a hotline and associated policies, referral arrangements and guidance all of which stepped up during COVID-19.

**Delays in MHTF-supported programmes occurred as a result of COVID-19**

As the COVID-19 pandemic expanded, the MHTF-supported activities were more often than not suspended. The EmONC network development process should have been advanced faster including to the state level to initiate facility monitoring. Specifically, coordination meetings at the national level could not be held and in person meetings with officials were suspended at national and state levels. Training of trainers for state monitoring teams was suspended and resources diverted to other priorities. Progress on integrating active fistula case finding into community-based SRH interventions was limited and remains to be picked up again at some point in the future. However, some activities have continued albeit at a slower pace. For example, 392 maternal death reviews were undertaken in 2020 MPDSR and 114 girls and women living with fistula were given surgical repair.

**Opportunities**

Out of the pandemic, some opportunities have arisen. For example, 60,736 girls and young women have been reached through the integration of COVID-19 education into an ongoing MHTF-supported programme aimed at SRH communication to young people. Targeting resources to facilities (for example for IPC, triage and PPE) creates another opportunity to target capacity development and support. This is particularly the case for EmONC facilities in the network, with a view to reinforcing their role as referral services and to supporting community networking and engagement. Finally, the increased focus on digitalization of care approach reinforces coordination through regular mapping of services and supplies stock analysis.

**Redirection of funds to respond to COVID-19**

UNFPA redirected available resources – including MHTF resources – to respond to COVID-19 in flexible, rapid and efficient ways. Some examples include:

- Procurement of IPC items for state level hospitals.
- Distribution of midwifery delivery kits, including caesarean section kits and gynaecological theatre kits.
- Direct support was targeted in early 2020 to 11 EmONC facilities to ensure functionality of critical EmONC functions and IPC supplies availability.
- Training midwives in IPC in Blue Nile, White Nile, Khartoum and elsewhere. Temporary deployment of 20 additional skilled midwives in Nyala (South Darfur) to serve in five localities for three months to support essential obstetric care. 280 midwives trained on aspects of meeting humanitarian needs.
- Engagement of non-government partners to deliver training, fund mobile clinics, distribute PPE and avail other kinds of support. Training of trainers in IPC and trainings constructed in 18 states including obstetrics, paediatricians, 452 PHC providers and 1055 midwives.
- Support to the operational costs of ambulances to transport women in need of maternity services to hospital.
- In addition, Sudan was one of nine countries that benefitted from a UNFPA global programme focusing on protecting MNH in the poorest and hardest hit environments. The investment aimed to support services and help systems recover. Sudan was expected to have 82,625 deliveries

across 26 EmONC facilities supported by the programme. Of these, approximately ten per cent were expected to have complications requiring EmONC services.

# 4 CONCLUSIONS

Sudan is a large, complex country undergoing some large, complex changes. In this context, UNFPA is a highly valued but relatively small partner and the MHTF, funding less than USD 1 million over three years, is even smaller. The factors that underpin high rates of maternal and newborn death will take significant investments on multiple fronts to address. It is in that context that the evaluation of the MHTF and its influence and role in UNFPA-Sudan is situated. This section presents the conclusions of the field-based country case study of Sudan. The conclusions presented here are based on the findings provided in Section 3. They are drawn from the answers to the nine evaluation questions and address all areas of investigation of the evaluation.

## 4.1 The MHTF has delivered visible results

**The MHTF support has delivered definable results in four technical areas linked to MNH in Sudan.**

With its small resource envelope and established programmes of technical support, the MHTF has delivered visible and material results in Sudan. The MHTF worked with and through the country office to provide a range of resources as needed including direct technical and policy support, access to credible global partners, financial support and other relevant investments. In Sudan, the MHTF was seen as a valuable addition to UNFPA and was perceived by health authorities, the country office, and partners to add value.

## 4.2 The MHTF has enhanced credible UNFPA country office partnership

**Overall, the MHTF enhances the UNFPA office in Sudan and increases its credibility as a technical partner to the FMoH.**

The UNFPA country office drew effectively on the MHTF technical and financial resources to support the delivery of complex, multi-stage policy and systems reforms aimed at strengthening maternal and newborn service delivery capacity in Sudan. These included inputs from reputable global partners, links to global standards and best practice measures, and the use of innovative tools and digital systems. UNFPA brought all its skills and resources to bear to deliver several complex processes in part because the MHTF made available the right kind of technical expertise at the right time.

## 4.3 Long-term commitment is needed for sustainable results

**The MHTF has supported long-term investments and reinforced partnerships reflecting how vital sustained commitment is to achieving enduring and meaningful outcomes in country health systems.**

The resources of the MHTF and its areas of technical focus create entry points in Sudan yet are not the end of the story even where visible results are achieved. There is more that can be done and should be done, which requires advocacy, partnership, convening and broader leadership over the longer-term.

UNFPA (with MHTF inputs and supported activities) works through all five modes of engagement in Sudan, but it can only deliver results to the extent that its partners – principally the GoS and national and state health authorities – are engaged, committed and lead key strategy development and implementation. Over the medium-term, the MHTF has demonstrated that effective systems strengthening also requires sustained commitment and leadership among partners at all levels including national, state and local. Progress has been limited in Sudan by systems weaknesses such as those caused by high turnover of staff, a lack of priority given to addressing women's rights and

health outcomes, and exogenous challenges (including humanitarian disasters, a protracted economic crisis, and COVID-19). The country is currently re-negotiating its political compact and defining a new political settlement following the end of a long dictatorship in 2019. This opens a large scope for rapid change and for UNFPA to remain engaged in its support and nudging as opportunities arise.

## 4.4 The MHTF technical focus has advantages and limitations in the Sudan context

**The MHTF support is both enhanced and constrained by its focus on four technical areas. While it allows UNFPA to provide considerable and valuable expertise, the four technical areas do not easily allow for a country-tailored response.**

While the MHTF offers skills, knowledge and resources to the UNFPA country office in Sudan primarily around four technical areas, these are largely shaped around a predefined range of policies and processes. The need is significant as inequality in access and coverage is high and underpinned by both supply failures and weak demand. UNFPA support (funded partly by the MHTF) targets the means to strengthen maternal health systems – EmONC and midwifery services for example – and to deliver specific health outcomes for the most vulnerable women and girls (fistula repair). However, while the four technical areas are needed in Sudan, there is a question as to whether they are the most urgent or highest priorities. For example, the "Ten in Five Strategy" identifies ten primary health priorities to be addressed over five years (2016-2020) and midwifery training and standards of care was one of these. However, other issues of major concern in raising demand for maternal health services including transport, financing, and others, are not covered. There are also significant gaps in the HMIS, around case registration, disease tracking, and monitoring processes, that are flagged and need to be addressed and yet remain underdeveloped, including in the areas MHTF works. The MHTF covers four areas, very well and with skill, tools and partnership, which, given its budget, constitutes a valid choice. Collectively, the MHTF investments carry the potential to have some impact on maternal health outcomes in the Sudan context, but not on their own neither in isolation from broader systems investments that are also much needed.

## 4.5 Being catalytic only propels the MHTF and UNFPA so far

**MHTF demonstrates catalytic impact in Sudan in many ways. These are notable but limited in some important ways. As shown by the midwifery investments, the role of the MHTF as a catalytic instrument is significantly reduced if it is unable to connect its inputs to a comprehensive follow-on systems reform process.**

So far, midwifery reform has been visible, high quality, impressive and potentially high impact on many levels. UNFPA has taken a logical approach to midwifery development, drawing on established tools, methods, and partnerships to support a multi-stage process that: delivered a situation and gap analysis, developed a professionalisation strategy, developed the curriculum and assessment standards for a new midwifery diploma, and, laid out a pathway to reform professional care and quality standards through better performance management. This constitutes an impressive set of results that have been critical to making progress, but does it amount to a catalytic push?

In fact, it appears that the MHTF has just about run out of road in relation to its midwifery leverage. The ambivalent policy environment, larger national developments currently preoccupying the Sudan government, together with exogenous threats to systems reform, have led to paralysis for almost three years. This paralysis, given the abandonment of the previous approach to community midwifery training, now creates a dilemma because the gap between the old and new approach could result in as much as six years without midwifery training (provided that the diploma launches in the next few months). As of 2020, there appears to be a possible decision taken to resume the community midwifery pre-service training programme as a stop-gap measure. The potentially

catalytic and genuinely high-quality investment led by UNFPA with the MHTF support now starts to become a threat to women's health in that there is still insufficient midwifery training happening. Through natural attrition alone – let alone COVID-19, natural disaster, economic hardship and other causes – community midwives are leaving the service and increasing numbers of women have no birth attendants. This is a genuine dilemma since the argument that community midwives were not able to ensure a sufficient standard of care for women in delivery, is valid. For UNFPA, however, there is need of a strategy to address this impasse. Waiting for government action is not working.

## 4.6 Maximising the role of UNFPA as a convenor across the health sector

**An active partner to the Sudan government, UNFPA used its position in the country, its strategic global partnerships and its limited resources very effectively to influence the context, policy, and health systems environment. There was limited evidence, however, of UNFPA building on this to strengthen its convening role to link MHTF investments to larger national health systems reforms.**

UNFPA is focused on its role as a partner to the Sudan government and is a respected and valued partner. However, there is a need for broader convening activity in the health sector in Sudan. Convening, in this context, is around: agenda setting, alignment, coordination, shaping processes, managing change and understanding and accounting for the political economy environment. Individually, UNFPA staff are clearly highly competent in these areas. As an organization, UNFPA seems to adopt a lower than necessary profile given the quality of its inputs, the urgency of the agenda and the opportunities opening up in the current environment, complexities notwithstanding.

There was almost no evidence, for example, of an attempt to link MHTF inputs and processes to the larger systems reform around UHC, although the EmONC network development could be a major contribution to better service delivery (in terms of quality and coverage) for UHC. UNFPA funding – for EmONC for example – is consistent with UHC goals but is not overtly or clearly joined up with other funding sources to focus on strengthening infrastructure, equipment and service provision across the network. The new (draft) national health strategy (2021-2024) – called a recovery strategy – makes no mention of practical plans and processes to invest in the EmONC network, despite referring to the 2017 analysis. The efficient and, so far, highly effective strategy pursued by UNFPA to invest additional resources into EmONC infrastructure has not become a national strategy (yet).

It is important to note that in relation to this point, the absence of evidence does not equal evidence that UNFPA is not doing enough to work with other partners on UHC; just that the positive evidence was not found while assessing the MHTF. UNFPA has supported the identification of the EmONC network and has invested in strengthening some facilities with refurbishments and equipment. It is potentially hugely catalytic. However, as with midwifery developments, the catalytic gains of this effort largely remain to be achieved and will take place (or not) well beyond the usual locus of UNFPA.

# OTHER MATERIALS FROM THE EVALUATION

Available on the UNFPA Evaluation Office website

- Evaluation report
- Evaluation one-page brief (En, Fr)
- Executive summary (En, Fr)
- Evaluation presentation
- Annexes (Volume II)
- Country case studies (Benin, Sudan, Uganda, Zambia)
- Management response
- Evaluation Quality Assessment

# ANNEX 1: EVALUATION MATRIX

<table>
<tr><td colspan="2"><u>Area of</u> Investigation 1: Midwifery</td></tr>
<tr><td colspan="2">Evaluation Question 1: To what extent has the MHTF contributed to ensuring the education, training, and deployment of an adequately skilled/competent, motivated and sustainable midwifery workforce?</td></tr>
<tr><td colspan="2">Sub-questions:<br>a) How has the MHTF contributed to strengthening the enabling policy and regulatory environment for midwives, including reinforced regulation of midwives (Output 2) and increased use of gender-sensitive policies, strategies and plans to recruit, deploy and retain midwives (Output 4), and policies to regulate the work environment for midwives, including supportive supervision, mentorship professional development, and assurance of a conducive and safe work environment (Outcome 5)<br>b) To what extent has the MHTF contributed to the capacities of a skilled and competent midwifery workforce, educated according to global standards and that meet national needs (Output 1)<br>c) To what extent has MHTF contributed to strengthening the capacities of midwifery associations to help raise the profile of midwifery, represent the professional needs of midwives, and provide professional support and continuing education? (Output 3).</td></tr>
<tr><td>Evaluation Criteria</td><td>Relevance, effectiveness, efficiency, sustainability</td></tr>
<tr><td>Rationale</td><td>Midwives play a central role as caregivers for women and their newborns throughout the continuum of care from pre-pregnancy to the post-partum period; and are positioned to provide comprehensive SRH information and services, including family planning, antenatal care, safe normal deliveries, basic EmONC, essential newborn care, prevention of STIs and transmission of HIV from mother to child, prevention of fistula and other morbidities, and prevention of female genital mutilation/cutting. To fulfil these roles, there is a need to strengthen midwifery education and training, enable and support midwife autonomy including ensuring midwives can work across their scope of practice, strengthen workforce policies and create a work environment that empowers midwives. These aims are central to achieving other outcomes of the MHTF, i.e., through expanded linkages with fistula prevention and elimination of female genital mutilation/cutting, in collecting, analysing and using data as part of MPDSR; and the deployment of midwives in EmONC facilities.</td></tr>
<tr><td colspan="2">Assumption 1.1: MHTF inputs regarding norms, standards, policies, and guidelines relating to midwifery address key gaps in existing policy and regulatory framework and environment for midwives at global, regional and national level, including in MHTF partner countries.</td></tr>
<tr><td colspan="2">Indicators:<br>● National policies, strategies and plans to govern midwifery practice and workforce capacity development, including supporting midwife autonomy, gender-sensitive policies, strategies and plans to recruit, deploy and retain midwives, midwifery included in Human Resource policies<br>● Strengthened regulatory bodies that govern midwifery practice, certification, accreditation, monitoring and accountability and that regulate quality of care, client safety and satisfaction<br>● Strengthened policies, guidelines and standards related to supportive supervision, mentorship, professional development, and a safe and conducive work environment</td></tr>
</table>

| **Assumption 1.1: MHTF inputs regarding norms, standards, policies, and guidelines relating to midwifery address key gaps in existing policy and regulatory framework and environment for midwives at global, regional and national level, including in MHTF partner countries.** | |
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| ● Views and experiences of partners and health authorities at global and national level **regarding effectiveness** of UNFPA leadership to advocate for evidence-based policies, strategies, plans and regulations<br>● Alignment of UNFPA policy inputs with MHTF core principles (equity, quality of care, accountability plus human rights and gender equality). | |
| **Observations** | **Sources of Evidence** |
| **Skills shortage a risk to MNH health outcomes**<br>● *Another challenge faced while making EmONC networks functional is the **limited competencies among obstetric service health providers, including midwives**. This jeopardizes MNH health outcomes, a situation documented in Benin, Madagascar and Sudan. Skills are lacking due to poor curricula and teaching programmes. Given the needs in EmONC facilities, midwives should be able to manage all deliveries, and also have decision-making power to decide where and to whom to refer. Unfortunately, these decision-making powers are missing. EmONC facilities remain weak, with important competency gaps and shortfalls in quality of care. These persistent concerns need to be globally discussed and tackled to reach the SDGs*. | UNFPA, Maternal and Newborn Thematic Fund 2019 Annual Report, Sudan. Khartoum, 2020. p.46 |
| **SRH workforce challenges**<br>● "*In general, these countries have a **physician-dominated health care system**. Midwives constitute a large proportion of the SRH workforce only in Sudan and to a lesser extent in Morocco. Community health workers are present in … Sudan*." | Kabakian-Khasholian T, and Ali A, UNFPA Assessment of Sexual and Reproductive Health, Cairo, 2017, p.31 |
| **Process to develop midwifery norms and standards**<br>● **Workshop participants** included policy makers, representatives of the FMoH officers from different departments, UN Agencies, International NGOs (JICA and Carter Centre), representatives of civil society and the midwifery association. The workshop was highly participatory, with a series of discussions, group work and presentations, which presented platforms for **discussing sensitive issues and addressing tensions** between professional groups, individuals and different departments and institutions.<br>● The main activities included the official opening by the Undersecretary for Health, Dr Ismeldin Mohamed A. Abdalla and welcome by the UNFPA Country Representative, Dr Lina Moussa.<br>● On day one, the concept of **gap analysis**, an overview of ICM, a **definition of a midwife and roles and responsibilities** of a midwife in Sudan generated very useful discussions. This illustrated that although there is an urgent need for the development of professional midwives, the government and all its partners are eager to develop and strengthen midwifery competency and midwifery services.<br>● The gap analysis identified critical structural drivers of health that harm women and girls (for example, female genital cutting) anticipating the role of **gender-sensitive policies and strategies** needed across all elements of midwifery education and professionalisation.<br>● Days 2 to 4 were dedicated to sharing the **ICM Global Standards, competencies, gap analysis tools and the results.** All participants contributed to the development of each pillar of Education, Regulation and Association development. | UNFPA, International Confederation of Midwives (ICM), MoH, Sudan<br>Midwifery Gap Analysis, 2018, UNFPA, Khartoum, Sudan |

| **Assumption 1.1: MHTF inputs regarding norms, standards, policies, and guidelines relating to midwifery address key gaps in existing policy and regulatory framework and environment for midwives at global, regional and national level, including in MHTF partner countries.** | |
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| **UNFPA support to midwifery reforms**<br>● UNFPA supported the **midwifery reform starting from 2016** through direct coordination with the MCH directorate rather than with the Academy of Health Sciences directly. That support still continues. Although they make a limited direct contribution, UNFPA supports the Academy of Health Sciences to conduct monitoring and evaluation field missions and channels other support via the FMoH (MCH directorate).<br>● Celebrating 100 years for midwifery programme, UNFPA is now **supporting the FMoH to develop an advocacy plan to increase community awareness on the role of midwives**. The plan includes dissemination of messages through media, successful stories and other communications. | Interview, National Policy and Teaching Partner, Khartoum, 3 June 2021 |
| **Support in Sudan is part of MHTF global approach**<br>● In addition to skills-building initiatives for health workers, 16 MHTF-supported countries have recently completed **regulatory frameworks for midwives,** covering the scope of practice, a code of conduct and accreditation (Bangladesh, Burkina Faso, Côte d'Ivoire, Kenya, Liberia, Madagascar, Malawi, Nepal, Nigeria, the Republic of the Congo, Rwanda, Sierra Leone, Somalia, Sudan, Uganda and Zambia). | UNFPA, MHTF Annual Report 2019, 2020, UNFPA, New York, p.31 |
| **Communications and awareness raising**<br>● Celebrations held with UNFPA support to **commemorate the International Day of the Midwife**, which was important to do in order to raise awareness about the midwife, the role of the midwife and the new process underway to strengthen midwifery training and guidelines. | Review of programme activities, UNFPA CO, Sudan, 22 June 2021 |
| **Midwifery: a UNFPA priority**<br>● UNFPA identifies midwifery as one of its major areas of focus and says it is very engaged, "…*Taking the lead jointly with the government to support the midwifery programme*". UNFPA is **contributing to midwifery on several levels** including policy, guidelines, regulatory processes, awareness and communications, and training. The need is very high, and even together UNFPA and the FMoH cannot cover all the needs. | Interview, Research/ practitioner, Khartoum, Sudan, 15 June 2021 |
| ● UNFPA is considered **the main partner supporting the national midwifery programme**. UNFPA supports the midwifery reform, which aims to undertake a situation analysis and gap analysis and based on that, to develop a strategic framework to improve midwifery performance.<br>● The national midwifery programme is identified as a strategic opportunity **to accelerate the abandonment of harmful practices and increase gender equity for women and girls**. Midwives will need high quality training and ongoing supervision and management to strengthen progress. | Interview with National Health Sector Manager, FMoH, Khartoum, 1 June 2021 |
| **Variety of investments into midwifery**<br>● Gap analysis on midwifery education, regulation and association in Sudan and dissemination of the results; support to the retention of eight midwifery tutors and one consultant obstetrician in midwifery schools; development of midwifery educational materials; support to national midwifery associations establishment; assessment of midwifery schools; support National Technical Committee meetings. | Summary of programme activities, UNFPA CO, Sudan, 22 June 2021 |

| **Assumption 1.1: MHTF inputs regarding norms, standards, policies, and guidelines relating to midwifery address key gaps in existing policy and regulatory framework and environment for midwives at global, regional and national level, including in MHTF partner countries.** | |
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| **Progress on midwifery norms, standards and guidelines**<br>● Sudan Midwifery **Gap Analysis is completed**, and it will be followed by the development of **a midwifery strategy**, a process that is taking place in August 2018.<br>● Early in 2018, UNFPA supported MoH to conduct a second **study tour to Morocco** to comprehensively study the midwifery education programme implementation through field visits to midwifery schools/colleges. The visit also aimed at exploring opportunities for collaboration between Morocco and Sudan ministries of health.<br>● The CO completed the Sudan Midwifery Gap Analysis, and a **dissemination of the findings was done in a national workshop** that was facilitated by consultants from the ICM in August 2018. The workshop was attended by all relevant stakeholders including Federal and states MoH, academic institutions, the midwifery association, the national medical specialization board, nursing association, obstetrics and gynaecology association among other partners.<br>● A **four-year midwifery work-force improvement strategic plan was drafted** in the same workshop. Later, in November 2018, dissemination and endorsement of the strategic plans was done. | UNFPA, MHTF 2018 Midyear Progress Report - Sudan, 2018, UNFPA, Khartoum, Sudan, p.3 |
| ● The **results of the workshop** were handed over to the FMoH in a meeting attended by representatives of key stakeholders. ICM committed to supporting the finalisation of the strategic plan and next steps for another eight days.<br>● **Key next steps included** the finalisation and costing of the strategic plan, the endorsement of the technical working groups (TWGs) and the National Coordinating Committee members by the Undersecretary and then the implementation of the work by the TWGs. | UNFPA, ICM, MoH, Sudan Midwifery Gap Analysis, 2018, UNFPA, Khartoum, Sudan |
| ● In addition to **skills-building initiatives for health workers**, 16 MHTF-supported countries have recently completed **regulatory frameworks for midwives**, covering the scope of practice, a code of conduct and accreditation (Bangladesh, Burkina Faso, Côte d'Ivoire, Kenya, Liberia, Madagascar, Malawi, Nepal, Nigeria, the Republic of the Congo, Rwanda, Sierra Leone, Somalia, Sudan, Uganda and Zambia). | UNFPA, Maternal and Newborn Thematic Fund 2019 Annual Report, Sudan. Khartoum, 2020 |
| **Midwifery reform steps**<br>● The reform **aims at addressing the gaps** observed in regulation, education, and service provision. The reform will address the gaps and the needs of midwives at each level, finalizing job descriptions, minimum requirements, training packages, and improving the regulation system.<br>● **Three sub-committees** were established, and the relevant documents prepared.<br>● **A reform meeting** will be organized during 20-21 December 2020 and attended by key stakeholders and decision makers from line ministries, professional councils, and professional associations. | UNFPA and GoS, 2020 Annual Progress Report - 7th Country Programme Cycle 2018-2021, 2020, UNFPA, Khartoum, Sudan |
| **UNFPA works with major partners to advance midwifery**<br>● Strengthening the midwifery workforce is **a key strategic action for reducing maternal and newborn mortality** according to Sudan's Ten in Five Strategy for SRMNAH. The International Confederation of Midwives (ICM) was therefore invited to facilitate a gap analysis process between October 2017 and August 2018.<br>● Through **a systematic gap analysis** process to evaluate the current midwifery education, regulation, and association development in Sudan, ICM was able to establish what the gap is between the current status of midwifery and what is required to scale up a skilled, professional midwifery workforce in Sudan. | UNFPA, ICM, MoH, Sudan Midwifery Gap Analysis, 2018, UNFPA, Khartoum, Sudan. p.2 |

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| **Assumption 1.1: MHTF inputs regarding norms, standards, policies, and guidelines relating to midwifery address key gaps in existing policy and regulatory framework and environment for midwives at global, regional and national level, including in MHTF partner countries.** | |
| ● The gap analysis approach **creates an evidence-based platform for policy decision making** and provides focus on areas for investment as countries develop strategies for strengthening midwifery. A workshop to disseminate the results was conducted from 5 – 9 August 2018 in the Rotana Al Salam Hotel in Khartoum.<br>● The **objectives of the workshop** were to present the results of the gap analysis assessment; to facilitate the isolation and prioritization of the gaps in midwifery education, regulation and association development; to facilitate the development of a national strategic plan to address the gaps in midwifery education, regulation and association; to provide support for the creation of technical working groups and a national coordinating committee to oversee the work; and to agree on a way forward.<br>● The **expected outcomes were a clear list of gaps** in midwifery education, regulation and association development; a comprehensive strategic plan for each pillar to address the gaps; suggested terms of reference for the TWGs and a clear outline of the next steps. | |
| **National midwifery policies, strategies and regulation**<br>● UNFPA supported the midwifery reform which started in 2016. UNFPA supported the situation analysis, gap identification and development of a framework strategy to improve the midwifery programme interventions over several years.<br>● Although no direct support for recruiting or retaining midwives is provided, **UNFPA provide them midwifery-kits** from a different funding source (other than MHTF) to support safe deliveries.<br>● In addition, **UNFPA supports the national monitoring and evaluation programme to monitor midwifery performance**. | Interview, RH Team, FMoH, Khartoum, Sudan, 1 June 2021 |
| **Assumption 1.2: MHTF support to strengthening midwifery education programmes are technically sound and appropriate, responding to national needs, and aligned to national and global standards for midwifery education.** | |
| **Indicators:**<br>● Number of midwifery schools (public and private) supported by the MHTF that are **accredited by the government based on global standards** set by WHO and ICM<br>● MHTF support for midwifery education programmes aligns with national needs<br>● Examples of MHTF support to **strengthen capacity**[32] **of midwifery schools** to provide quality pre-service training, including necessary teaching materials, commodities and equipment and incentives to motivate teachers and students<br>● Examples of MHTF support for **standardized, competency-based education programmes** that bridge competency development trainings (i.e., in-service training, continuing education) for midwives and tutors<br>● National midwife education programmes are **aligned with global standards** for competency-based training and accreditation<br>● Views and experiences of partners, health authorities, and midwifery educators regarding the **relevance, technical quality, and effectiveness** of UNFPA support for midwifery education programmes<br>● National programme **plans include efforts to institutionalize**[33] **(sustain)** standardized, competency-based education of midwives<br>● Alignment of UNFPA policy inputs **with MHTF core principles** (equity, quality of care, accountability plus human rights and gender equality) | |

[32] The COM-B model of behaviour change (Mayne 2016) will be used to assess provider capacity based on three necessary conditions: 1) capability (necessary knowledge, skills, and attitudes to deliver quality care), 2) opportunity (having the necessary infrastructure, equipment, supplies and tools to deliver quality care), and 3) motivation (internal cognitive and emotional processes related to willingness and perceived personal benefit of providing good quality of services).

[33] Institutionalization means that the Ministry of Education and/or Health has adopted UNFPA-supported curriculum changes as their own standard for midwifery education.

| **Assumption 1.2: MHTF support to strengthening midwifery education programmes are technically sound and appropriate, responding to national needs, and aligned to national and global standards for midwifery education.** | |
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| ● Number of innovations developed to enhance midwifery education and continuous training. | |
| **Observations** | **Sources of Evidence** |
| **Need for better midwifery training**<br>● Sudan is **far from reaching 70 deaths per 100,000 live births**; data are not clear and many data missing. But "***80 per cent of births still take place at home*.**" Notifications are poor. Maternal health services are not optimal.<br>● **Community based midwives are no longer trained** or supported. Their training was about 15 months long, which was not sufficient. Availability of basic health services in Sudan is not to a sufficient standard.<br>● There is a serious problem with **brain drain** in Sudan; people are trained, and they leave to the private sector or out of the country. Retention mechanisms are needed. | Interview, UNFPA CO Leadership, Khartoum, 9 June 2021 |
| **The role of midwives in the Sudan health system**<br>● **High school degrees** were reported as the **minimum requirement** to be trained as a midwife, auxiliary midwife, and nurse-midwife in all countries offering academic training in these professions, which require three to four years to complete. A prior university degree or a high school degree is required to enter medical schools in these countries, depending on the local educational system.<br>● As followed in all educational models, the training of physicians takes around six to seven years, and specializations in obstetrics and gynaecology require an additional four to five years. An obvious **lack of complementarity arises in the division of tasks between general physicians, obstetrician/gynaecologists (OB/GYNs), and the midwifery cadre**.<br>● Physicians and specialists bear the majority of responsibilities, with **minimal exclusive roles given to midwifery** personnel.<br>● An exception to this is Sudan, where midwives are given more roles than in other countries in this assessment. In general, the **emphasis is more on clinical tasks than on other aspects of care**, such as cross-cultural communication and promotion of shared responsibility with women, families, and the community in all these countries. Tasks relating to labour and birth care are shared between general physicians, OB/GYNs, and midwives. | Kabakian-Khasholian T, and Ali A, UNFPA Assessment of Sexual and Reproductive Health Integration in Selected Arab States, The Middle East and North Africa Health Policy Forum (MENA HPF) and UNFPA ASRO, Cairo, December 2017. p.32 |
| **Perspective of midwives**<br>● **Capacity building programmes support in-service training**. For example, one midwife explained she became a nurse-midwife in 2016 and since then she has received many additional training sessions. There are different training sessions including infection control training, patient safety, quality control, and others.<br>● Another midwife had fewer trainings in the same time frame. She was **uncertain how participants were selected for training** and also noted the number of trainings that some staff had compared to others.<br>● UNFPA supported and sponsored training but so did CAFA, WHO and UNICEF. There was **less coordination among these agencies** than there could have been in terms of rationalizing content, distribution across geographies or health setting, targeted health workers. | Interview with midwives, Omdurman Maternity Hospital, Khartoum, 2 June 2021 |

| **Assumption 1.2: MHTF support to strengthening midwifery education programmes are technically sound and appropriate, responding to national needs, and aligned to national and global standards for midwifery education.** | |
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| ● **Training is delivered under the auspices of SMoH or FMoH,** so the midwives do not know who is funding it. African Development Bank or UNFPA or another intervention. | |
| **UNFPA provides a limited contribution to the Academy of Health Science**<br>● UNFPA supported the Academy to develop an **academic diploma for midwives. Curriculum is now ready** and approval by the Ministry of Higher Education is underway.<br>● Also, UNFPA contributed to **the retention of staff** at the Midwifery School in Omdurman Maternity Hospital (Aldayat hospital) before it closed, funding the salaries of one lecturer (PhD level) and seven assistants (all midwives) and they received USD 70 and USD 55 respectively (per month). By 2020, this had eroded to a negligible value and was not enough to retain staff. | Interview, National Policy and Teaching Partner, Khartoum, 3 June 2021 |
| **Pre-service training capacity**<br>● Although the Academy has an essential role in delivering midwifery and nursing programmes, not just in Sudan but in Africa including Somalia and some other countries, there is serious **shortage of resources** to support activities and staff salaries/retention which causes a serious delay to interventions. | Interview, National Policy and Teaching Partner, Khartoum, 3 June 2021 |
| **The transition to the midwifery diploma at State level**<br>● **UNFPA is our main partner in support of the midwifery schools** and for a long time supported the midwifery schools. UNFPA covered the cost of transportation and the subsistence of the student midwives. They also contributed to staff retention costs. In addition, separately from midwifery training, UNFPA provides midwifery kits, supplies and commodities.<br>● Unfortunately, the school is closed (since 2018) and **at national level basic training is no longer supported.**<br>● There are concerns that the plans for a midwifery diploma will not work well here in this state and the diploma **will not really produce enough midwives to fill the gap** as there is a huge training need in this area.<br>● Usually, **women in this state do not receive even basic education** and the diploma needs at least secondary school certificates. | Interview, SMoH, Ad Damazin, Blue Nile, Sudan, 7 June 2021 |
| **UNFPA supports national policy and no longer trains community midwives**<br>● Usually, UNFPA supports a wide range of RH programmes<br>● SMoH conducts activities, which are agreed upon after a needs assessments and discussion between the two parties on ways to address identified problems and challenges. Then an MoU is signed.<br>● However, sometimes urgent needs outside of the MoU appear and to which UNFPA usually responds if they are able. Unfortunately, this year there were a number of **serious needs for basic midwifery training in 42 areas where deliveries are done by non-trained community midwives and UNFPA refused to support** because the policy has changed in that basic training is no longer offered to community midwives due to the imminent launch of the new diploma. | Interview, SMoH, Ad Damazin, Blue Nile, Sudan, 7 June 2021 |
| ● **UNFPA is the main partner** that support the midwifery needs<br>● **UNICEF** used to support some midwifery in-service training and the newborn intensive care unit<br>● We are in real need for further community midwives to be trained and recruited as we are only two nurse-midwives, and the load is steadily increasing<br>● "We **really miss the midwifery school, which is unfortunately closed** three years ago" | Interview, Nurse-Midwife, Ad Damazin, Blue Nile State 7 June 2021 |

| **Assumption 1.2: MHTF support to strengthening midwifery education programmes are technically sound and appropriate, responding to national needs, and aligned to national and global standards for midwifery education.** | |
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| **Progress on midwifery diploma**<br>● The **framework and educational curriculum of the new midwifery diploma** was finalized with its annexes (teacher's guide and student's book). The curriculum was developed locally by national experts and CO plans on reviewing and finalizing the curriculum by international experts by February 2019.<br>● **Midwifery gap analysis was completed** through support from ICM and was followed by the development of a national midwifery strategic plan 2019 – 2022. The plan was endorsed by the government and partners.<br>● In addition, Sudan Medical Specialization Board has engaged in the midwifery education and established a **new programme for the postgraduate education in Midwifery**. This is a key step that will ensure the availability of teaching staff for the planned midwives diploma in the future. | UNFPA, MHTF Annual Report: Sudan, 2018, UNFPA, Khartoum, Sudan. p.2 |
| **UNFPA engagement in midwifery training**<br>● The **diploma was arranged with a direct push from UNFPA** as quality of pre-service training was poor. There was agreement to shift to a **full three-year training programme**.<br>● **ICM had undertaken an assessment in 2017 of training and skills of community midwives**. One of the conclusions was a recognition that the training community midwives received was not enough. They needed more and better training delivered through in-service programmes.<br>● A discussion was held about **interim or bridge phase for building the capacity of existing midwives**. Those in service were all reached with an updated service training package. Enrolment may have been less well managed which accounts for the variability [in access] however, there are others providing similar or adjacent training including CAFA, UNICEF, WHO etc.<br>● In addition, SMoH and FMoH each have their training programmes and budgets and activities. There was an intention to admit midwives to in-service training based on clear criteria. Although there may have been some coordination, there is **a possibility that duplication occurred**.<br>● **The training** included infection prevention control and **generally aimed to support the FMoH direction** of travel on upgrading midwifery capacity. | Interview, RH Team, UNFPA CO Khartoum, 17 June 2021 |
| **Midwifery diploma**<br>● **UNFPA fully supported** the development of the diploma including the curriculum and design.<br>● In the context of the PHC expansion programme, **MoH undertook an assessment of skills and delivery of PHC**. In 2019 100% coverage of community midwives had been achieved (40,000 midwives in Sudan) according to the FMoH.<br>● The government believed that from a programme perspective, the **community midwives were not delivering the standards needed** in terms of the package of services they could offer, the duration and depth of their training, and the selection criteria around their admission to the programme.<br>● There was an **ICM recommendation to upgrade the training of community midwives**. The majority were not delivering with quality it seemed (through no fault of their own). The **government suspended the community midwifery schools**, developed the **new diploma curriculum in 2018** and passed it to the FMoH, which approved it and passed it to the Ministry of Higher Education.<br>● The **revolution then delayed things in 2019** and not too much moved forward. | Interview, RH Team, UNFPA CO Khartoum, 17 June 2021 |

| **Assumption 1.2: MHTF support to strengthening midwifery education programmes are technically sound and appropriate, responding to national needs, and aligned to national and global standards for midwifery education.** | |
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| ● Then **COVID-19 delayed things further** in 2020.<br>● Now, in 2021, there is every hope that the **Ministry of Higher Education** will approve it.<br>● The **Academy of Health Science**, which helped develop the curriculum will host the course and award the diploma. | |
| **Diploma midwives will fill a critical skill gap**<br>● The dilemma is that **there is nothing between the community trained midwife/Dayat and the specialist gynaecologist**. Thus, the idea of the midwifery diploma was born.<br>● The diploma programme is fully designed and currently with the Ministry of Higher Education. However even once approved and launched, **there will be a three-year delay before the first midwives are joining the health workforce**. | Interview, UNFPA Country Team, CO, Khartoum, 9 June 2021 |
| **Diploma curriculum aims and objectives**<br>● To prepare **a competent midwife** who will provide safe, compassionate, professional and comprehensive care and services to mothers, new-borns, families and communities to contribute to the reduction of maternal and new-born morbidity and mortality.<br>● To provide **a career development structure** in midwifery as practitioners, educationists, researchers and public health specialist at all levels of service delivery. | Academy of Health Science, Education and Curricula Development Centre, Whole Life Midwifery: Technical Diploma of Midwifery Teacher's Guide, 2017, Khartoum, 2017. P.4 |
| **Challenges in the transition**<br>● Delivery in Blue Nile is currently much more often **by untrained birth attendants working in the community**. The State RH Coordinator approached UNFPA State Office for support to train untrained/unskilled community midwives.<br>● Rainy season: accessibility is a huge challenge in Blue Nile because of the rain and poor road network so there is a **high reliance on community midwives and home births.**<br>● UNFPA concentrated its effort and support on the diploma for midwifery but **there are challenges**:<br>  ○ **Admission requires a secondary school certificate**, but many girls do attend secondary school.<br>  ○ **Language skills** may also be a challenge<br>● MoH aims to do the diploma for those coming out of secondary school and then also step-up skill reinforcement to trained midwives.<br>● **Additional planned course**: Baccalaureate in nursing and then an additional 18 months for midwifery for nurse-midwifery. | Interview, Research/ practitioner, Khartoum, Sudan, 15 June 2021 |
| **UNFPA support to midwifery skill building**<br>● **UNFPA has supported most of the midwifery capacity building** programmes including basic and in-service training with provision of commodities and skill lab preparation.<br>● Although there is **no direct financial support** to the midwives, **UNFPA provides safe delivery kits** to them in coordination with FMoH.<br>● UNFPA **through the Academy of Health Science,** supported the midwifery schools on capacity building programmes providing skill labs for training, and support to both basic and in-service training. | Interview, RH Team, FMoH, Khartoum, Sudan, 1 June 2021 |

| **Assumption 1.2: MHTF support to strengthening midwifery education programmes are technically sound and appropriate, responding to national needs, and aligned to national and global standards for midwifery education.** | |
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| ● A decision was taken to up the skills and capacity of midwives therefore through the development of a **diploma programme and a three-year training course**. UNFPA supported the Academy of Health Sciences to develop an academic diploma for midwives. The curriculum is now ready and approval by the ministry of high education is under process.<br>● The **ICM assessment, conducted in 2017** with support from UNFPA, identified the shortcomings in community midwife training. | |
| **UNFPA activities in support of midwifery**<br>● Pre-service training including midwifery diploma:<br>● UNFPA supported finalization of the **midwifery diploma curriculum** which is pending the validation of the Ministry of Higher Education<br>● Procurement of **skill lab equipment** for four states<br>● Supported the **bachelor (of nursing) programme** through deployment of eight midwifery tutors and clinical instructors, and one obstetrician<br>● **196 students enrolled and 32 were graduated in 2020** | UNFPA and GoS, 2020 Annual Progress Report – 7th Country Program Cycle 2018-2021, 2020, UNFPA, Khartoum, Sudan |
| **Development of curriculum**<br>● The **curriculum was developed locally** by national experts and the CO plans on having the curriculum reviewed by international experts.<br>● **Teaching staff** in the ICM-like midwifery school was retained by provision of monthly salaries for eight midwifery tutors and one consultant obstetrician.<br>● All are providing teaching services to the BSc midwifery programme and contributed to developing the midwifery diploma curriculum. | UNFPA, MHTF 2018 Midyear Progress Report - Sudan, 2018, UNFPA, Khartoum, Sudan |
| **Coordination with partners**<br>● **UNFPA and WHO** are both part of the technical committee for the midwifery reform lead by the FMoH, and both supported many of midwifery in-services trainings.<br>● **WHO** supported policies, strategies, training manuals and guidelines while UNFPA supports the direct service provision and capacity building programmes although they also contribute to policies development, “and this is the complementarities that I was talking about”. | Interview, UN Partner, Khartoum, 3 June 2021 |
| **Identification of inter-related midwifery investments for maternal health**<br>● Over the last five years, findings from MDSR have generated actions by the National Maternal Death Review Committee (NMDRC) for both health system and community level, which contributed to **progress in many forms of responses**, which are centred mainly on improving health at facility, **without considering interventions regarding first and second delays**.<br>● These interventions have led to **improved quality of care through mobilization of additional resources**, including training of midwives, availing of clean delivery kids, availing of delivery and operating tables, equipped ambulances and essential drugs for emergency obstetrics care.<br>● Among these actions are **improvement in midwifery services and management of emergency obstetric problems**. | UNFPA, Maternal Death Surveillance and Response Annual Report, Sudan, UNFPA Khartoum, 2019 |

| **Assumption 1.2: MHTF support to strengthening midwifery education programmes are technically sound and appropriate, responding to national needs, and aligned to national and global standards for midwifery education.** | |
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| ● There was **increased coverage in midwifery services** during the last five years, whereby the end of the year 2018 villages covered by midwives reached 96 per cent, the rest were not able to select their clients to join midwifery schools due to socio-cultural barriers.<br>● **Only 48.7 per cent of community midwives were fully recruited into the health system** while 43.5 per cent were receiving regular incentives from FMoH in collaboration with the Ministry of Social Affairs. | |
| ● Midwifery interventions included **in-service training coordinated** with SMoH in Khartoum, White Nile state, Blue Nile state. | Interview, National NGO, Khartoum, 3 June 2021 |
| **Midwifery programme support during COVID-19**<br>● **Infection prevention and control** (IPC) training package updated and adapted to the needs of the midwives, with additional modules on COVID-19 orientation<br>● Established national core team of midwives (15) on Infection prevention and control IPC and **COVID-19 orientation**<br>● 1,370 midwives working in seven localities in Khartoum state received IPC training and PPEs<br>● Deployment of 20 midwives in six localities of South Darfur state<br>● 280 midwives trained on different RH issues including in **humanitarian setting.** | UNFPA and GoS, 2020 Annual Progress Report - 7th Country Programme Cycle 2018-2021, 2020, UNFPA, Khartoum, Sudan |
| ● Currently interventions are limited, however during COVID-19. CAFA supported midwifery training on the national **module to perform safe delivery in COVID-19 patients** funded by UNFPA.<br>● In addition, some in-service midwifery training was supported on White Nile state, and two trainings in coordination with the Khartoum SMoH. | Interview, national NGO, Khartoum, 3 June 2021 |

| **Assumption 1.3**: **Efforts to strengthen the capacity of midwifery organizations result in enhanced professionalization of midwives and increased opportunities for continuous professional education and career progression and support** | |
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| **Indicators:**<br>● Examples of UNFPA-supported costed strategic action plans for midwifery associations<br>● Examples of UNFPA-supported communication, advocacy and resource mobilization activities geared to strengthen capacity of midwifery associations<br>● Examples of capacity building actions by midwifery associations to provide **continuous professional education,** to build capacity of young midwifery leaders and to provide improved access to quality SRHR information by adolescents through social and traditional media<br>● Views and experiences of global and national leaders and members of midwifery associations regarding relevance, effectiveness and efficiency of UNFPA efforts<br>● Plans to sustain capacity building efforts within midwifery associations are in place and being implemented | |
| **Observations** | **Sources of Evidence** |
| **The Sudan Midwifery Association (SuMA)**<br>● SuMA was founded under close supervision of the **Academy of Health Sciences** and is now hosted and technically supported by it.<br>● **Still working on ICM registration,** which is yet to completed<br>● UNFPA contributed on the foundation of SuMA although **more technical and financial support are required**. | Interview, National Policy and Teaching Partner, Khartoum, 3 June 2021 |
| **ICM support to Sudan**<br>● Reforming and supporting midwifery in Sudan. | Interview, UNFPA Khartoum, 9 June 2021 |

| **Assumption 1.3**: **Efforts to strengthen the capacity of midwifery organizations result in enhanced professionalization of midwives and increased opportunities for continuous professional education and career progression and support** | |
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| ● Working on **regularisation and professionalisation** of midwifery through SuMA as well as through the **diploma curriculum and training standards.**<br>● ICM engaged to celebrate International Day of Midwifery and **raising the profile of midwifery** in Sudan. | |
| **SuMA**<br>● Midwives happy about the establishment of the association. Waiting for registration from the ICM.<br>● No individual midwifery contributions made yet (or registration)<br>● SuMA is hosted by the Academy of Health Sciences which provides space for meetings, offices and so on. | Interview, Research/ practitioner, Khartoum, Sudan, 15 June 2021 |
| **Midwifery Association**<br>● One national Midwives Association established which includes both sister midwives and health visitors.<br>● A **constitution – based on national standards – is being developed** by a national consultant.<br>● The necessary **documents for the registration** are cleared by the Humanitarian Aid Commission. The association General Assembly meeting is planned during the last week of December. | UNFPA and GoS, 2020 Annual Progress Report - 7th Country Programme Cycle 2018-2021, 2020, UNFPA, Khartoum, Sudan |
| **Associations at the state level**<br>● **UNFPA support includes technical and financial assistance** to the midwifery associations at State level to conduct their regular meetings and build their capacities and organizational arrangements. | Review of programme activities, UNFPA CO, Sudan, 22 June 2021 |
| ● UNFPA assistance for the implementation of costed plans of the national and state midwifery associations "*to support the development of the EmONC network. Due to the COVID-19 context, and the competing priorities of the country to respond to the pandemic, the activity is planned to be implemented as part of third tranche. As well it is attributed to the finalization of the prioritization report".* | UNFPA, MHTF Mid-Year report for 2020, 2020, UNFPA, Khartoum, Sudan. p.4 |
| **UNFPA support to SuMA**<br>● UNFPA supported the foundation of the SuMA. During this process UNFPA provided both **technical and financial support**.<br>● They are still waiting for the **ICM registration** of the association and recognition of its sufficient professional standard to join.<br>● SuMA has the proposed role to support **increased professionalisation of midwives** across the system and to start improving quality of care everywhere but especially in rural and underserved areas | Interview, RH Team, FMoH, Khartoum, Sudan, 1 June 2021 |
| **Building midwifery as a career**<br>● Engaging **young midwives** is instrumental for improving the midwifery profession and leadership. UNFPA will continue to support the young midwives and promote their role in SRHR through the new midwifery reform process. | UNFPA and GoS, 2020 Annual Progress Report - 7th Country Programme Cycle 2018-2021, 2020, UNFPA, Khartoum, Sudan |
| **UNFPA is the main counterpart to FMoH addressing MNH and SRH issues.**<br>● UNFPA support to midwifery programmes includes supporting policy development, capacity building programme, midwifery diploma, **foundation of the SuMA**, provision of midwifery KITs, and supports supervision visits. | UNFPA Country Team initial evaluation group discussion, 5 June 2021, Khartoum |

| Area of Investigation 2: Emergency obstetric and newborn care | |
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| **Evaluation Question 2**: ***To what extent has the MHTF supported ministries of health to design, strengthen and scale-up a national network of basic level and referral maternity facilities staffed with skilled health personnel and capable of providing quality SRH services as well as maternal and newborn care, including EmONC?*** | |
| **Sub-Questions**:<br>a) How and to what extent does the MHTF contribute to the **development of nationally aligned strategies and policies to define and monitor the national network of EmONC** facilities and strengthen referral linkages?<br>b) To what extent has the MHTF contributed to the **strengthened functioning of the national network of EmONC facilities** to provide **equitable, accountable, and quality SRHR services** including through QI and monitoring processes?<br>c) To what extent does the MHTF contribute to **strengthened capacities of skilled health personnel in EmONC facilities** to provide equitable, accountable, and quality SRHR services? | |
| **Evaluation Criteria** | *Relevance, effectiveness, efficiency, sustainability* |
| **Rationale** | Women and newborns are at high risk of death and morbidity during labour, childbirth and the first week after birth. UNFPA activities to promote evidence-based policies and plans in support of increased access to equitable, accountable, and quality EmONC services aim to reduce maternal and newborn mortality and morbidity. UNFPA is building on lessons from previous MHTF phases to support planning and monitoring of the national network of EmONC facilities, strengthened quality improvement (QI) processes, scale-up in additional countries, and to strengthen integration via further support to post-partum and post-abortion family planning and cervical cancer prevention. |

| **Assumption 2.1: MHTF efforts at global, regional and national level in evidence-based advocacy, policy dialogue, coordination, and knowledge management lead to national plans for a well-functioning national network of EmONC facilities with the capacity to provide quality SRHR services and maternal and newborn care, including EmONC** | |
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| **Indicators:**<br>● Alignment between global and regional **evidence-based guidance** and national strategies for defining, monitoring and scaling- up of strengthened EmONC and SRHR services<br>● Examples of **MHTF advocacy and policy dialogue and partner coordination** in support of national plans designed to strengthen and scale-up quality SRHR and MNH, including EmONC services within a well-defined network of facilities<br>● Trends over time in proportion of population covered by a functioning EmONC network of facilities (within two hours travel time)<br>● MHTF workplans include application of lessons learned **(knowledge management)** from prior phases to improve quality and support scale-up of services within countries and to new countries<br>● Views and experience of health authorities and partner institutions at global, national, and sub-national level regarding **relevance, effectiveness and synergy** between other UNFPA interventions and MHTF efforts to address EmONC and support integrated SRHR and MNH services<br>● Views and experience of health authorities and partner institutions regarding UNFPA **leadership on core principles** of equity in access, quality of care, accountability, and on principles related to human rights and gender equality. | |
| **Observations** | **Sources of Evidence** |

| **Assumption 2.1: MHTF efforts at global, regional and national level in evidence-based advocacy, policy dialogue, coordination, and knowledge management lead to national plans for a well-functioning national network of EmONC facilities with the capacity to provide quality SRHR services and maternal and newborn care, including EmONC** | |
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| **EmONC need and utilization identified (evidence base established)**<br>● There is a **68 per cent gap in EmONC availability** in Sudan. Only 127 out of 396 recommended facilities provide basic and comprehensive EmONC.<br>● The biggest gap is in basic EmONC **(BEmONC) availability (95 per cent).** Only 15 facilities are classified as BEmONC out of the 317 recommended. However, one-third (204) of the facilities included in the assessment were, **"*Almost there*" partially functioning EmONC sites** (only missing one or two signal functions). Rural facilities accounted for the majority of "*Almost there*" facilities (66 per cent).<br>● The gap in EmONC availability was **severely inequitable across states**, ranging from 9 per cent of the recommended number of EmONC facilities in East Darfur to 98 percent of the recommended number in River Nile.<br>● The **proportion of expected births that took place in health facilities** was only 23 percent. When looking at EmONC facilities only, this proportion drops down to 13 percent of expected deliveries.<br>● **Met need for obstetric complications was very low** (3 per cent in EmONC facilities), while caesarean delivery rate as a proportion of expected births was within the UN recommended range (8 per cent in all facilities and 5 per cent in EmONC facilities).<br>● Nationally, 545 maternal deaths were recorded in the facilities assessed (this did not include maternal deaths at lower facilities or those that happened in the community).<br>● The **most common direct causes of maternal death** were consistent with other country reports: PPH/retained placenta (35 per cent of maternal deaths from a direct cause), severe pre-eclampsia and eclampsia (21 per cent), and postpartum sepsis (18 per cent). If antepartum haemorrhage is included, haemorrhage accounted for 43 per cent of maternal deaths due to a direct cause. | MoH, Mapping and Assessment of Maternal, Neonatal and Child Health Emergencies and Rehabilitation Services 2017, MoH, Khartoum, Sudan, 2018 |
| ● **Institutional deliveries are estimated at 25 per cent** (EmONC needs assessment) and contraceptive prevalence rate is 13.5 per cent (MICS 2014). In 2018, the State has notified 46 maternal deaths (MDSR 2018). | UNFPA, EmONC Prioritization - Technical Report: State Level Analysis, Khartoum, Sudan 2017-2018 |
| **Cause of maternal deaths**<br>● Home delivery, late presentation, unavailability of blood and poor referral system, poor implementation of management protocols, unavailability of functioning ICU or high dependency unit (HDU) are the main factors behind maternal death.<br>● *Sepsis/pneumonia (28 per cent), birth asphyxia (28 per cent); and complications of preterm birth (35 per cent) are the factors driving newborn deaths.* ***Many of these conditions are preventable and closely linked to the absence of skilled birth attendance at delivery***.<br>● *Originally, a* total of 631 health facilities (17 Referral/specialized hospitals, 58 state/general hospitals, 365 locality/rural hospitals, 53 private or NGO maternity/general clinics and 138 public or NGO/private health centres) that had provided childbirth services at the time of the assessment were included. | MoH, Sudan Standards and Norms for Emergency Obstetric and Newborn Care, 2020, MoH, Khartoum, Sudan. p.12 |

| **Assumption 2.1: MHTF efforts at global, regional and national level in evidence-based advocacy, policy dialogue, coordination, and knowledge management lead to national plans for a well-functioning national network of EmONC facilities with the capacity to provide quality SRHR services and maternal and newborn care, including EmONC** | |
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| ● The **UN guideline** recommends a minimum of five EmONC facilities for every 500,000 population. Accordingly, 396 EmONC facilities were recommended to be functioning and only 127 were fully functioning as EmONC (32 per cent), leaving **a gap of 275 EmONC facilities**. | |
| **FMoH engagement and commitment**<br>● **In 2017, the FMoH conducted EmONC assessment** with almost total coverage to all health facilities in Sudan identifying the gaps to make strategic work plan network formation. It was "*a very huge work*".<br>● Currently most of the cost is covered by the government with some contribution from UNFPA. However, **UNFPA supported the task group to meet for the prioritization of health facilities and network formation** (a major job that continued throughout 2017 and 2018) and supported the dissemination of the plans in 2018.<br>● Due to the country context and political instability at that time, the **work stopped in 2019 during the revolution** and was then re-endorsed in July 2020 by signing an agreement with UNFPA. Validation of the network is now being supported technically by an international consultant. | Interview, RH Team, Federal MoH, Khartoum, Sudan, 1 June 2021 |
| ● **Each BEmONC needs to link to a CEmONC within two hours travel: that is part of making a *network*.** In Sudan, there are 89 links between CEmONC and BEmONC of which 54 per cent were green (active).<br>● **From 2019, the FMoH prioritised the EmONC network**. This decision came about because of low availability of functioning EmONC facilities discovered in the 2018 survey. | Webinar presentation, FMoH, Khartoum, 17 June 2021 |
| **UNFPA investment in EmONC globally**<br>Health ministries in Benin, Côte d'Ivoire, Chad and **Sudan requested for MHTF technical expertise and financial support** to develop their national networks of EmONC health facilities. With the support of UNFPA COs, various health ministry stakeholders, and with the GIS expertise of Geneva University, experts from each region of each country designed networks of designated EmONC health facilities. | UNFPA, MHTF Annual Report 2019, 2020, UNFPA, New York, USA |
| **Specific Objectives of FMoH EmONC investments**<br>Through the financial and technical support from partners (UNFPA, UNICEF, and others), the **2017 Sudan EmONC assessment** was a national cross-sectional facility-based census of both public and private hospitals and all mid-level facilities (health centres and private clinics) that provided maternity services at the time of the assessment...the first in its kind for the country<br><br>FMoH outlined their **objectives** to provide:<br>● Clear definition of **national standards and norms** that govern the EmONC services delivery<br>● **Guidance to programme managers and policy makers** to plan for EmONC services<br>● A field friendly, step by step **guide to implement**, improve and upgrade EmONC services in Sudan. | MoH, Sudan Standards and Norms for Emergency Obstetric and Newborn Care, 2020, MoH, Khartoum, Sudan |

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| **EmONC Network development**<br>● Support of the CO to FMoH for the **assessment of health facilities across the country** to determine/identify a network of suitable facilities for the EmONC network.<br>● Should have **30 deliveries per month** to be sufficiently active.<br>● **Each State prioritised facilities** to target for inclusion in the network. The process used the **GIS approach.**<br>● There was then a process of undertaking the **needs assessment of these facilities** in each state network across the country. | Interview, RH Team, UNFPA CO Khartoum, 17 June 2021 |
| **Low access in Blue Nile State**<br>● Overall geographic accessibility to EmONC health facilities in Sudan is good with **most of the population able to access the closest facility within two hours**. This is mostly due to very low population concentration in the red zone, which is mainly desert.<br>● An **exception is the State of Blue Nile**, where only 48 per cent of the population has access within two hours due to poor road networks and insecurity. Most functioning EmONC health facilities face major shortfalls in quality of care, however.<br>● **Closer monitoring** will help the State Ministry of Health to address these issues, including unnecessary surgical interventions such as caesarean sections. Through UNFPA support, the ministry will also strengthen its midwifery workforce and **ensure more basic EmONC health facilities function and offer quality of care**. | UNFPA, MHTF Annual Report 2019, 2020, UNFPA, New York, USA |
| **Evolution of the EmONC Network**<br>● **Updated EmONC network** based on recommendations by the senior technical team (FMoH, UNFPA HQ, and the university of Geneva)<br>● The **GIS mapping finalized** by the FMoH in 2019<br>● **Khartoum state network validated** in 2019; an additional five states (Sinnar, White Nile, North Kordofan, Gedaref and River Nile States) are expected to finalize the prioritization before the end of 2020<br>● EmONC **standards and norms and service quality improvement package** were developed in 2019<br>● Established the **National EmONC support team** to provide technical assistance including to the states. | UNFPA and GoS, 2020 Annual Progress Report - 7th Country Programme Cycle 2018-2021, 2020, UNFPA, Khartoum, Sudan |
| **EmONC Network policy and evidence**<br>● A plan was made by UNFPA and the FMoH to do an **assessment of the network.**<br>● The results were good, and **more partners have been increasingly engaged** in this programme including the African Development Bank.<br>● Despite challenges like the **revolution, COVID-19 and the floods**, the EmONC network continues to exist, "*We are still working on the network.*"<br>● **Under process**: technical issues and reassessing needs of selected health facilities. "We are reassessing health centres for the network and to assess the gaps that need to be addressed most urgently." | Interview, (RH coordinator/ MCH director/UNFPA) Research/practitioner, Khartoum, Sudan, 15 June 2021 |
| **Partnerships for EmONC Network development** | University of Geneva, Workplan 2021: Concept Note, Geneva, 2020 |

| **Assumption 2.1: MHTF efforts at global, regional and national level in evidence-based advocacy, policy dialogue, coordination, and knowledge management lead to national plans for a well-functioning national network of EmONC facilities with the capacity to provide quality SRHR services and maternal and newborn care, including EmONC** | |
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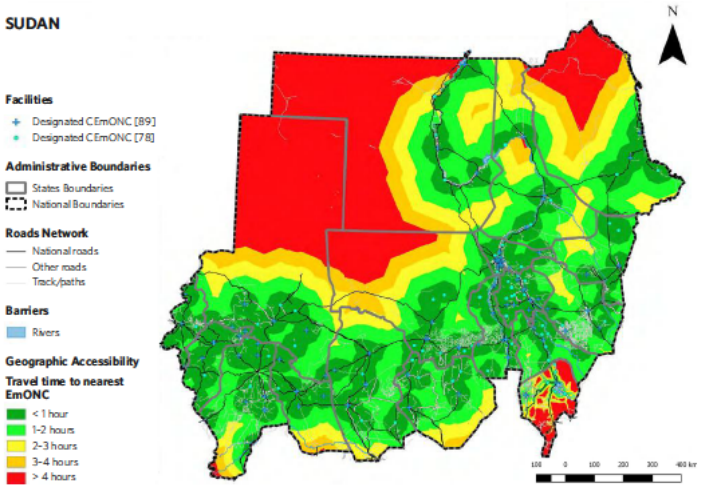
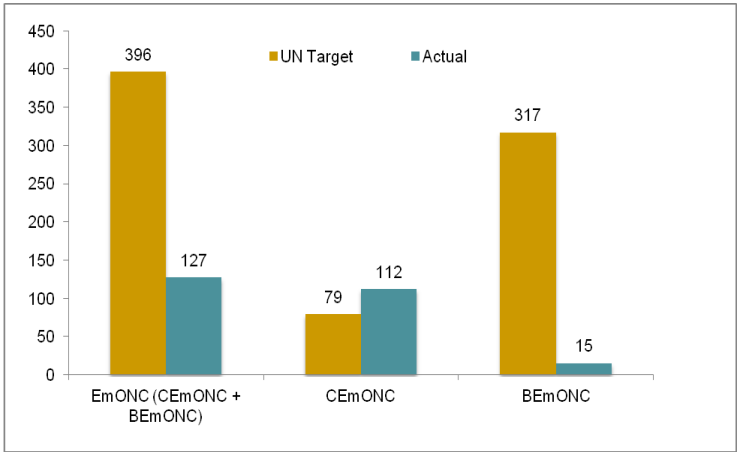
| • UNFPA, notably through its **MHTF**, has helped several countries to develop their EmONC networks. **An innovative methodology has been put in place** in the last five years and used in ten countries (Benin, Chad, Cote d'Ivoire, Guinea-Conakry, Burundi, Senegal, Togo, **Sudan**, Madagascar, Rep. of Congo).<br>• This methodology has been recently published in a new **UNFPA guidance document** "Implementation manual for developing a national network of maternity units - Improving Emergency Obstetric and Newborn Care (EmONC)", published in September 2020, with University of Geneva (UNIGE) contributing to it.<br>• In Sudan, UNIGE has also promoted ***GIS/AccessMod*** to UNFPA technical staff and has participated in the development of a UNFPA internal brief on "*Designing an Integrated, Global Population Data Platform for UNFPA*" targeting the UNFPA Population and Development branch, as well as a key multimedia product shown as a movie during the Nairobi Summit on ICPD 25 last year. | |
| **The EmONC Network mapping for Sudan**<br>  | UNFPA, MHTF Annual Report 2019, 2020, UNFPA, New York, USA, p.16 |
| **Continuing EmONC support**<br>• The **EmONC networks development** and health facilities prioritization and dissemination<br>• **Development of core EmONC documents** (Standards& Norms and Quality improvement packages and the maps for EmONC facilities)<br>• **Training of GIS** local (government) experts on Access mode by Geneva University to facilitate the EmONC network development workshops<br>• **Establishment of EmONC support team** and conducting of first round monitoring | Review of programme activities, UNFPA CO, Sudan, 22 June 2021 |

**Assumption 2.1: MHTF efforts at global, regional and national level in evidence-based advocacy, policy dialogue, coordination, and knowledge management lead to national plans for a well-functioning national network of EmONC facilities with the capacity to provide quality SRHR services and maternal and newborn care, including EmONC**

**The EmONC Network: Distribution of health facilities across Sudan**




MoH, Sudan Standards and Norms for Emergency Obstetric and Newborn Care, 2020, MoH, Khartoum, Sudan. p.11

**Assumption 2.2: MHTF inputs at national and sub-national level regarding the use of QI processes, tools and data collection are consistent with improved monitoring and quality of SRHR services and maternal and newborn care, including EmONC**

**Indicators:**

- Examples of MHTF efforts to **strengthen QI processes, tools and data collection** at national and sub-national level
- Views of health officers at national and sub-national level in geographies supported by UNFPA, which confirm implementation of **QI monitoring** on a regular basis and the **utilisation of findings to support improvements** in services
- Examples of how **QI efforts incorporate MHTF core principles**, human rights and gender equality within supervision and mentorship
- Views of health officials, including facility managers, providers, and community members regarding how **SRHR and MNH services, including EmONC services, are monitored to ensure quality**

Availability of plans to **sustain (institutionalize) UNFPA-supported QI processes** within national performance and supervision systems.

| **Observations** | **Sources of Evidence** |
|---|---|
| **Continued urgent need for improved care**<br>● Sudan, with a maternal mortality ratio **(MMR) of 311** (95 per cent CI: 214- 433) deaths per 100,000 live births and a 1 in 72 lifetime risk of dying due to pregnancy or childbirth, stands **one of the highest in Africa** and highest in Northern region of the continent.<br>● **Institutional delivery rate in the health facilities is very low** (27.7 per cent). The neonatal mortality rate was 38 per 1,000 live births in 1999 and 33 per 1,000 live births in 2014 accounting for 44 per cent of total U5MR (68/1000 LB). Up to 50 per cent of neonatal | FMoH, Sudan Standards and Norms for Emergency Obstetric and Newborn Care, 2020, MoH, Khartoum, Sudan |

| Assumption 2.2: MHTF inputs at national and sub-national level regarding the use of QI processes, tools and data collection are consistent with improved monitoring and quality of SRHR services and maternal and newborn care, including EmONC | |
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| deaths occur in the first 24 hours of life, with over 75 per cent of them arising in the first week of life. **Newborn mortality is a sensitive indicator of the quality of care** provided during the antenatal period, delivery and immediate postnatal period. | |
| **Technical interventions to boost quality services**<br>● **Six comprehensive EmONC facilities in Sudan were fully equipped** with high-quality family planning clinics in 2019, and health providers were trained to provide post-partum and post-abortion family planning services. **Additionally, 50 health centres instituted cervical cancer screenings** using visual inspection of the cervix with acetic acid (VIA) method, and five hospitals were prepared to provide cryotherapy treatment. | UNFPA, Maternal and Newborn Thematic Fund 2019 Annual Report, Sudan. Khartoum, 2020 |
| **Police engaged to support health**<br>● Some interesting experiences included: Sudan's **partnership with the police to address delays in timely transport** to facilities. | UNFPA, Maternal and Newborn Thematic Fund 2019 Annual Report, Sudan. Khartoum, 2020 |
| **UNFPA material and other investments to improving care**<br>● UNFPA has made some **contributions in kind (essential equipment, delivery room furniture, and supplies)** to support EmONC services in several health facilities including hospitals and PHC centres. | Interview, RH Team, FMoH, Khartoum, Sudan, 1 June 2021 |
| ● UNFPA **supports the EmONC assessment**, selection of health facilities, improved EmONC services through supporting capacity building programmes, rehabilitation, provision of commodities and supplies and training of EmONC support team and also UNFPA supports the referral system. | UNFPA Country Team Group Meeting, 5 June 2021, Khartoum |
| ● UNFPA **supported training programmes**, the provision of **commodities and supplies**, **building and rehabilitation** of emergency room and operating theatre, support to **referral of patients and staff retention** through rehabilitation of the doctor rest area for doctors (to include furniture, wi-fi, facilities for refreshments). | Interview, SMoH, Ad Damazin, Blue Nile, Sudan, 7 June 2021 |
| ● UNFPA supported the **renovation of the emergency building**, the theatre, the family planning centre, the fistula centre and the gender-based violence (GBV) centre with provision for all necessary equipment. | Interview, Referral Hospital Medical Director, Ad Damazin, Blue Nile, 7 June 2021 |
| **Limited service availability**<br>● All countries provide **neonatal and childcare** in their public health care facilities whether they are specialized centres, hospitals, or different types of PHC centres.<br>● **Prevention of unsafe abortion and post-abortion care** are provided only in Morocco and Sudan. Abortion services are restricted by law in all of these countries.<br>● In contrast to **antenatal and postnatal care and family planning services**, other RH conditions such as **cervical and breast cancer screening and prevention** and management of **gender-based violence and sexual health conditions** are not universally available at PHC facilities.<br>● **BEmONC** is provided mainly in hospitals. The provision of **CEmONC** through PHC centres is virtually non-existent. In all countries, CEmONC is provided in hospitals and similar facilities in the six countries, with the exception of the PHC centres in … Sudan | Kabakian-Khasholian T, and Ali A, UNFPA Assessment of Sexual and Reproductive Health Integration in Selected Arab States, The Middle East and North Africa Health Policy Forum (MENA HPF) and UNFPA Arab States Regional |

| **Assumption 2.2: MHTF inputs at national and sub-national level regarding the use of QI processes, tools and data collection are consistent with improved monitoring and quality of SRHR services and maternal and newborn care, including EmONC** | |
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| | Office, Cairo, December 2017. p.22 |
| **UNFPA convenes partners for EmONC development**<br>● CO in collaboration with FMoH and through MHTF support organized the **dissemination of the results of the EmONC Needs Assessment** in the presence of His Excellency the Minister of Health and more than 80 participants from national and subnational levels and technical and financial partners.<br>● Representatives from UNFPA HQ, UNFPA ASRO, AMDD/Columbia University, and ICDDR, Bangladesh participated in this dissemination and facilitated **a three-day national advocacy workshop** in August 2018 on EmONC development, involving senior officials of the FMoH (national and State levels) as well as professional associations and civil society organisations.<br>● This was followed by **state-level 'advocacy workshops' in four states** (as a start) conducted by a national team of experts who worked on the EmONC assessment. | UNFPA, MHTF Annual Report: Sudan, 2018, UNFPA, Khartoum, Sudan. p.2 |
| **UNFPA advocacy and coordination support to EmONC delayed due to COVID-19**<br>● Due to the COVID-19 context, and the competing priorities of the country to respond to the pandemic, some **activities were delayed from 2020**:<br>○ **Coordination meetings** for the EmONC stakeholders at national levels, including report development and sharing<br>○ **Advocacy interventions** targeting senior government officials, stakeholders, partners and donors to deploy graduated midwives to the selected EmONC facilities | UNFPA, MHTF Mid-Year report for 2020, 2020, UNFPA, Khartoum, Sudan |
| **UNFPA supports quality monitoring and evaluation**<br>● UNFPA supported development of quality package to monitoring and evaluation, which aims to **build the capacity of the support team responsible for monitoring and evaluation** activities at both federal and states level.<br>● Eighteen states were targeted. | Interview, RH Team, FMoH, Khartoum, Sudan, 1 June 2021 |
| **Recommendations from the EmONC Facility Network Mapping and Assessment Process**<br>● **Strengthen the 204 "*almost there*" health facilities** (191 hospitals and 13 health centres) to meet the minimum recommended number of EmONC facilities.<br>● Decisions for which facilities to upgrade first should be based on **suitable criteria** such as staffing, case load, equipment requirement, proximity to referral facilities, availability of ambulance, etc.<br>● All **nurses, midwives, and clinicians should be equipped, mentored, and supported** to perform all EmONC signal functions for a BEmONC facility.<br>● Emphasize the **use of best practice guidelines** including the use of oxytocin and magnesium sulphate.<br>● Given the importance of the use and completeness of register books, and the lack of data on deliveries, newborn outcomes, complications, maternal and newborn deaths, and associated services, the MoH and its partners should **mobilize resources to improve data through strengthening the HMIS system** and capacity building of health providers in all facilities. | MoH, Mapping and Assessment of Maternal, Neonatal and Child Health Emergencies and Rehabilitation Services 2017, 2018, MoH, Khartoum, Sudan |

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| ● UNFPA contributed to the government-led process to **conduct initial assessment and gap analysis** all over the country in 2017 and supported the dissemination in 2018 and the training on monitoring came after that.<br>● Having some concerns about the modality, **UNFPA initially supported only one state out of 18 on the capacity building programme of the supporting team** who is responsible for implementation of plans in addition to monitoring and evaluation of the intervention.<br>● **UNFPA was concerned about the approach and the quality of the training as they considered it insufficiently detailed and careful**.<br>● However, after several discussions, **the training programme resumed with a new approach that was more detailed and specific about measuring capacity, the condition of equipment and identifying/grading standards of care**. | Interview, RH Team, Federal MoH, Khartoum, Sudan, 1 June 2021 |
| **Gaps in reporting**<br>● There are chronic problems with **lack of data and lack of availability of a systematized register book** for deliveries, newborn outcomes, direct and indirect obstetric complications, and maternal deaths. | FMoH, Mapping and Assessment of Maternal, Neonatal and Child Health Emergencies and Rehabilitation Services 2017, FMoH, Sudan, 2018 |
| **State level identification of EmONC facilities**<br>● **Four designated EmONC health facilities are supported by UNFPA**, WHO, and UNICEF (Aggdi Centre, Damazin Hospital, Bidoos Hospital, Boutt Hospital, Abdulkhalag Hospital). | FMoH and UNFPA, EmONC Prioritization Technical report: State Level Analysis, 2017-18, Khartoum, Sudan |
| **Improving monitoring**<br>● EmONC network development helped identify the **prioritized health facilities for BEmONC & CEmONC**<br>● It was also a chance for **capacity building for senior health staff**<br>● **Next steps include** validation and endorsement at state level (few states already did this) and then a national EmONC upgrade plan followed by effective resource mobilization strategy. | Comments, UNFPA CO staff, Khartoum, Sudan, 23 June 2021 |
| **Needs are complex**<br>● EmONC health facilities proposed by the working group (**number of EmONC facilities**, referral links, staff, strengths, and weaknesses).<br>● The working group of Blue Nile State has selected seven health facilities to be part of the EmONC network, including two CEmONC and five BEmONC. This number is below the international recommendation but above the expected number set by the FMoH of five designated EmONC health facilities.<br>● The **referral linkages between the selected BEmONC and CEmONC health facilities are difficult** due to financial barriers, poor road network especially during the heavy rainy season, and insecurity.<br>● Major gaps include the a**bsence of ICU and HDU, shortage in surgical equipment, Oxygen supply, equipment for assisted vaginal delivery.** The lack of latrines and electricity have also been highlighted in most health facilities. | FMoH and UNFPA, EmONC Prioritization Technical report: State Level Analysis, 2017-18, Khartoum, Sudan |

| **Assumption 2.2: MHTF inputs at national and sub-national level regarding the use of QI processes, tools and data collection are consistent with improved monitoring and quality of SRHR services and maternal and newborn care, including EmONC** | |
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| ● In terms of management and monitoring of the designated EmONC health facilities, the working group highlighted the **absence of supportive supervision, health facility registers, and monitoring dashboard**. However, coordination staff meetings are held in all designated facilities, led by the medical doctor(s). | |
| **Workshops for the development of the national EmONC network**<br>● **National workshop for the presentation of the EmONC development approach and monitoring** (14-16 August 2018)<br>○ Following the EmONC dissemination workshop, the Maternal and Child Health Directorate of the FMoH and UNFPA co-chaired a workshop on EmONC development with about 60 participants, including representatives from the FMoH and from the 18 States (RH coordinators, Child Health coordinators), representatives of professional associations, and technical and financing partners (UNFPA, UNICEF, Italy, Sudanese American Medical Association).<br>○ The **objectives of the workshop were**: (1) To define the approach for the development of the national network of EmONC facilities in Sudan, (2) To analyse the results of the EmONC NA and make preliminary recommendations to address gaps in human resources, availability of essential medicines, infrastructure, and referrals.<br>● **National technical workshop on the development and monitoring of the national network of EmONC facilities** (06-08 November 2018)<br>○ This **workshop aimed to** … get a common understanding of the health management information system in Sudan (HMIS/DHIS2) and the monitoring processes of health facilities already in place… and define the approach for monitoring the national network of EmONC facilities (from data collection to analysis and response) and the key MNH/RH indicators to be monitored in EMONC facilities (national 'monitoring sheet').<br>○ This workshop was **co-led by the FMoH and UNFPA** and was attended by MNH technical staff from the FMoH (including from HMIS); two participants from each State, including the Directors of RH; UNFPA, WHO, UNICEF, NGOs; private sectors focal persons. | FMoH and UNFPA, EmONC Prioritization Technical report: State Level Analysis, 2017-18, Khartoum, Sudan |
| **Rehabilitation of health facilities creates opportunities for integration**<br>● Health facilities in targeted areas to provide **cervical cancer screening services** and also health facilities which will provide confirmation tests for suspected cases and management services for **precancerous lesions** have been identified.<br>● The **screening will be integrated into other SRH services**, like family planning, ANC, post-natal care and EmONC.<br>● Also, **referral pathways for management of cervical cancer cases** that need advanced interventions were identified.<br>● Essential cervical cancer prevention and pre-cancerous management *equipment and supplies were procured* and will be deployed after the health facilities assessment. Procurement of some consumables was initiated in 2019. | UNFPA, Prevention of Uterine Cervical Cancer in East Sudan, 2019, UNFPA, Khartoum, Sudan |
| **Referral networks are multi-directional**<br>● **55 facilities covered 74 per cent of the population within 2-hour travel time**. The national network was finalised in 2019. Phase III of the development process is to move forward and connect these EmONC centres to PHC centres and to start monitoring and upgrading the quality of care offered in EmONC facilities.<br>● **EmONC facilities also need onward referral links to be more clearly established**. For some of these links, other ministries are needed to be involved including Ministry of Infrastructure, Social Protection, and they have been included in the process. | Webinar presentation, FMoH, Khartoum, 17 June 2021 |

| Assumption 2.2: MHTF inputs at national and sub-national level regarding the use of QI processes, tools and data collection are consistent with improved monitoring and quality of SRHR services and maternal and newborn care, including EmONC | |
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| **Blue Nile State: referral hospital investments**<br>● **Aldmazeen hospital:** no intensive care unit (ICU) beds in the obstetrics-gynaecology ward. HDU is for less serious cases than ICU.<br>● There are **incubators for newborns** but "not functioning well". The baby warmer is not working. HDU beds used for eclampsia patients. Sometimes use the anaesthesiology machine from the theatre for monitoring patients. | Interview, Research-practitioner, Khartoum, Sudan, 15 June 2021 |
| **Khartoum State referral hospital: infrastructure affects quality**<br>● **Limited number of health staff** especially in the last two years mainly due to recurrent strikes<br>● **Limited resources** including beds and consumables caused by shortage of supplies and increasing patient demand<br>● Limited beds in the nursery for a long time as the main nursery is under rehabilitation<br>● **Unsustainable ICU services** due to turn over of staff and no support to retain them<br>● Hot and cold **gynaecological operations** including abortion services have been suspended for due to COVID-19 and health staff strikes have happened in the last year<br>● In addition, the **building is under rehabilitation**. | Interview, Referral Hospital Medical Director, Sudan, 5 June 2021 |

| Assumption 2.3: UNFPA inputs at national and sub-national level to address gaps in capacity of skilled birth attendants in EmONC facilities results in improved quality of integrated SRHR services and maternal and newborn care, including EmONC | |
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| **Indicators:**<br>● Demonstrable improvements in health care provider capacity (as defined by the COM-B[34] model of behaviour change) in the MHTF-supported facilities to deliver quality integrated SRHR services and MNH care in accordance with service standards and guidelines<br>● **Trends in the proportion of functioning BEmONC and EmONC facilities within the national network**<br>● Views of implementing partners (national health officials, NGOs, CSOs, community leaders and individuals) regarding effectiveness of capacity development efforts by UNFPA and how it has improved the performance of skilled birth attendants<br>● Alignment of UNFPA **capacity development inputs with MHTF core principles** (Equity in access, quality of care and accountability; plus, principles of human rights and gender equality. | |
| **Observations** | **Sources of Evidence** |
| ● Quality improvement is needed. "*The concept of respectful maternity care is completely absent*". | Webinar presentation, FMoH, Khartoum, 17 June 2021 |
| **A critical gap**<br>● Staff shortages and personnel availability and capacity are the most important areas of shortfall.<br>● Main resources are in Khartoum but even there, MNH services are limited because of insufficient health staff.<br>● Need retention mechanisms as the salaries are too low. | Interview, Research/ practitioner, Khartoum, Sudan, 15 June 2021 |

[34] The COM-B model of behaviour change (Mayne 2016) will be used to assess provider capacity based on three necessary conditions: 1) capability (necessary knowledge, skills, and attitudes to deliver quality care), 2) opportunity (having the necessary infrastructure, equipment, supplies and tools to deliver quality care), and 3) motivation (internal cognitive and emotional processes related to willingness and perceived personal benefit of providing good quality of services).

| **Assumption 2.3: UNFPA inputs at national and sub-national level to address gaps in capacity of skilled birth attendants in EmONC facilities results in improved quality of integrated SRHR services and maternal and newborn care, including EmONC** | |
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| ● A while ago, low salaries were still acceptable. For example, UNFPA retention for a midwifery tutor was only USD 55 per month. Now though, with inflation and everything that has happened, this is insufficient to attract/retain skills.<br>● Health workers now look for best offers in private sector, and there is more migration especially to the Middle East. | |
| ● Most functioning EmONC health facilities face major shortfalls in quality of care, however. Closer monitoring will help the Ministry of Health to address these issues, including unnecessary surgical interventions such as caesarean sections. | UNFPA, Maternal and Newborn Thematic Fund 2019 Annual Report, Sudan. Khartoum, 2020 |
| **Main challenges facing MNH service provision in Blue Nile State**<br>● Neonatal care capacity building for health providers including doctors and nurses<br>● Rehabilitation of the health facilities especially the building whose condition worsens during rainy season<br>● Need more training, recruitment and retention of the midwives due to high rate of turnover.<br>● Referral of cases. The hospital has no functioning ambulance. | Interview, SMoH, Ad Damazin, Blue Nile, Sudan, 7 June 2021 |
| **UNFPA support to strengthen midwifery skills across EmONC**<br>● The EmONC network has become an important resource and means to target additional training capacity.<br>● For example, using the national protocol, UNFPA supported an **advocacy programme (communications) to help midwives perform safe deliveries for COVID-19** affected patients focusing in EmONC facilities. | Interview, RH Team, FMoH, Khartoum, Sudan, 1 June 2021 |
| **FMoH capacity building**<br>● **In-service training and pre-service training for midwives** has been largely stopped as of 2021 and indeed pre-service training of community midwives was stopped in 2018. The midwifery focal point identified that the FMoH is now working on the technical and teaching manuals and is yet to start with training. | Interview, RH Team, FMoH, Khartoum, Sudan, 1 June 2021 |
| ● **At health facility level**: 66,845 deliveries were performed in health facilities supported by UNFPA; 59 BEmONC and 49 CEmONC facilities received medical equipment and supplies; 8900 pregnant women benefitted from lifesaving medical supplies; 65 EmONC facilities received PPEs; supported the referral services through maintenance of 18 ambulances; deployment of temporary ambulances in Khartoum state during COVID-19 lockdown; establishment of 23 community based referral groups; reimbursement of transportation cost in three states. | UNFPA and GoS, 2020 Annual Progress Report - 7th Country Programme Cycle 2018-2021, 2020, UNFPA, Khartoum, Sudan |
| **Assessment of needs at EmONC sites**<br>● **EMONC training refers to the training of the teams that will conduct the first-round monitoring**.<br>● FMoH teams trained to assess needs at the EmONC facilities including among staff (capacity, skills)<br>● The content of the training is **quality improvement and control for the EmONC selected sites/facilities, and EMONC standards and norms**.<br>● The first main training was during 2020 and due **to COVID-19** "*we were not able to proceed to the state level monitoring, prioritisation, and finalisation of the response plans*".<br>● It is a prerequisite for the monitoring mission to strengthen the monitoring teams' capacity on the monitoring tools. | Interview, UNFPA CO, Khartoum, Sudan 23 June 2021 |

| **Assumption 2.3: UNFPA inputs at national and sub-national level to address gaps in capacity of skilled birth attendants in EmONC facilities results in improved quality of integrated SRHR services and maternal and newborn care, including EmONC** | |
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| ● **Two BEmONC health facilities are expected to refer to a CEmONC health facility in another State** (to be completed) In terms of human resources, there are only graduate nurse midwife and nurse midwives in the Damazin Maternity Hospital.<br>● **Most designated health facilities have a doctor**, with Damazin having 12 doctors and 3 OBGYNs. Elmidin 10 is the only health facility without any doctor. **There is an important gap of 14 midwives** to be filled-in in the short/medium term in order to ensure the provision of services 24/7.<br>● Other major gaps identified by the working group are the **absence of anaesthetists and neonatologists** in the major hospital (Damazin) and the **absence of anaesthetists and OBGYN** in the Boutt Hospital. In terms of infrastructure and equipment, the Damazin hospital has a **functioning laboratory** for advanced tests and three other hospitals have a functioning laboratory for basic tests (Aggdi Centre, Bidoos Hospital, Boutt Hospital). | FMoH and UNFPA, EmONC Prioritization Technical report: State Level Analysis, 2017-18, Khartoum, Sudan |
| **UNFPA supports FMoH identified priority activities**<br>● Contribute to the **implementation of the costed EmONC work plan** to cover the gaps of the prioritized health facilities. This includes procurement of equipment and capacity building of EmONC staff.<br>● **Capacity building for 11 EmONC facilities staff on IPC** in two states was conducted, the rest of the budget will be utilized in semester two to cover the identified gaps in EmONC facilities after finalizing the EmONC network.<br>● Support the Ministry of Health at national and states levels to **monitor the network of EmONC facilities** (including monitoring of the deployment of skilled staff, MNH data using the agreed upon indicators and referral links).<br>● The HQ and FMoH are working on finalizing the **prioritization report**. The monitoring visits were planned to be implemented in late 2020 using the third tranche of MHTF funds. However, COVID-19 affected progress. | UNFPA, MHTF Mid-Year report for 2020, 2020, UNFPA, Khartoum, Sudan |
| ● Activity: Support implementation of **community-based referral mechanisms to improve referral to EmONC facilities** and address financial barriers to access EmONC services The preparatory exercise is done, targeting 28 EmONC facilities in seven states. | UNFPA, MHTF Mid-Year report for 2020, 2020, UNFPA, Khartoum, Sudan |
| ● Problem in Sudan relates to a **preference for home births that persists**. The quality of care and a functional EmONC network can help shift attitudes over time, but this is a bigger problem. The EmONC network investment programme is about improving health outcomes and results for women already in the care of the health facility. Most deaths happen because of a failure to provide care at primary level and a failure to refer. Another line of investment is around strengthening family planning to incentivising women, educating women and empowering them. | Webinar presentation, FMoH, Khartoum, 17 June 2021 |
| ● A lot of money has been invested in capacity building programmes: **most health providers are well trained**. And there is a high demand for services from well-trained health providers. But there is **not enough investment in infrastructure** (leaking roof) **and consumables** (medicines) and equipment repair (baby warmer not working). | Interview, Research/ practitioner, Khartoum, Sudan, 15 June 2021 |

| Area of Investigation 3: Maternal and perinatal death surveillance and response | |
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| **Evaluation Question 3: To what extent has the MHTF contributed to firmly establish the main components of the MPDSR programme (guidelines and tools, mandatory notification, costed national plan); to support its implementation at national scale; and to increase the notifications of maternal deaths and strengthen the quality of maternal death reviews and implementation of the "response" component?** | |
| **Sub-questions:**<br>a) How, where and to what extent has the MHTF contributed to the **establishment and scale-up of MPDSR**?<br>b) To what extent has MHTF support contributed to **sustained or increased quality and credibility of MPDSR** as evidenced by increased notification of maternal deaths among other features?<br>c) Where and how has MHTF contributed to **service and systems improvements as a result of MPDSR findings**? | |
| **Evaluation Criteria** | *Relevance, effectiveness, sustainability* |
| **Rationale** | MPDSR efforts intensified globally following the publication of technical guidance by WHO in 2013. By 2015, over 76 countries adopted policies for the systematic review of maternal deaths, and 41 and 56 countries have adopted policies for review of stillbirths and neonatal deaths, respectively. Since then, WHO and UNFPA have monitored progress in MPDSR implementation. They noted substantial gaps between adopting national MPDSR policies, setting up national and subnational review committees and monitoring other aspects of implementation. Quality of reviews varies within and between countries. MPDSR methodology requires comprehensive investigation of causes, circumstances, and preventability of each maternal death identified and a no-blame atmosphere is essential to pinpoint and make policy and operational changes that would improve quality of care. UNFPA supports countries to develop MPDSR with tracking indicators that are clear and measurable, and methods for analyses that best assess quality of death reviews and can track the impact of death reviews on health service quality. Strengthening MPDSRs is supported by the MHTF as a vital mechanism to build sustainable systems strengthening for better MNH and is linked to the EmONC response. |
| **Assumption 3.1: MHTF technical support to the establishment and national scale-up of MPDSR in its partner countries is evidence based and comprehensive** | |
| **Indicators:**<br>● Alignment between global and regional **evidence-based guidance** and national strategies for establishing and operating a MPDSR process<br>● Examples of **UNFPA advocacy and policy dialogue** in support of national plans designed to strengthen and scale up MPDSR<br>● Strengthened **coordination and capacity** including increasing number of timely, complete death audits<br>● MHTF workplans include application of lessons learned **(knowledge management)** to improve quality and support scale-up of MPDSR within countries and to new countries<br>● Number of **MPDSR components that are implemented** (out of four)<br>● Examples of investment by health authorities and partner institutions at global, national and sub-national level with a focus on the **relevance, effectiveness, and sustainability** of MPDSR process and relevant follow up<br>● Health authorities and partner institutions regard MHTF **leadership on core principles** of equity in access, quality of care, accountability, and on principles related to human rights and gender equality as a critical underpinning of the MPDSR approach. | |
| **Observations** | **Sources of Evidence** |
| **Assumption 3.1: MHTF technical support to the establishment and national scale-up of MPDSR in its partner countries is evidence based and comprehensive** | |

| Assumption 3.1: MHTF technical support to the establishment and national scale-up of MPDSR in its partner countries is evidence based and comprehensive | |
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| **Implementation of MDSR in Sudan**<br>● In **Sudan, MDR started since 2009,** where clinical causes of MD were identified: haemorrhage, hypertensive disorders or its complications and sepsis. Areas of delays were determined after regular reporting of maternal death through focal person networks and discussion of MD at states maternal death review committees (SMDRCs) and NMDRC. **In 2014, MDSR was introduced** in Sudan using WHO guidance, hoping that with regular review of MD and analysis of causes of death; Recommendations could be made and implemented to reduce maternal mortality at states and country level through access to quality maternity care. | UNFPA, Maternal Death Surveillance and Response Annual Report, Sudan, 2018 |
| **Progress in 2018**<br>● Knowing the number of maternal deaths alone is not enough to reach the SDGs, but it is important to identify causes and implement intervention to prevent further maternal death<br>● In Sudan; maternal death review **(MDR) has been the standard method** for determining maternal mortality, establishing the clinical causes of maternal death, and identifying areas of delay since 2009.<br>● Although this **maternal mortality ratio (114** maternal deaths per 100,000 live births) is still high, with discrepancies between states, **it is the least to be reported over the last nine years since establishing of MDR** [maternal death review] system. | UNFPA, Maternal Death Surveillance and Response Annual Report, Sudan, 2018 |
| **Where and how to strengthen MPDSR**<br>● About **two-thirds of the deaths (66.4 per cent) occur within the first 24 hours of their arrival at the hospital**.<br>● Some stakeholders interviewed advocate for the monitoring system to integrate the socio-economic determinants of maternal mortality, to involve private sector data and the study of near miss maternal morbidity. It is clear that in most cases, despite political declarations and integration into action plans, the **MDSR is still considered a pilot project and suffers from its institutionalization** in maternal health programmes and in information and epidemiological surveillance. There is now a need to institutionalize this intervention at central and regional level by integrating the different partners and adapting a new legislative framework. | Université Mohammed VI des Sciences de la Santé and UNFPA Arab States Regional Office, Regional MDSR Workshop, Casablanca, 22-23 July 2019. p.69 |
| **Mixed quality and variable results**<br>● Each year there was a **national MDSR report containing evidence-based recommendations**, addressing policy makers, managers, care providers involved in women health at hospitals and community.<br>● However, the reports and evaluation during the last five years showed that **MDSR is still suboptimal in many states**, despite the investments and efforts of federal ministry of health and the supporting partners; particularly UNFPA, UNICEF, WHO and national agencies.<br>● The reports also showed that there is relatively **low information obtained about community related factors** affecting maternal mortality, under reporting of early pregnancy related maternal death, and health determinants affecting maternal health. | UNFPA, Maternal Death Surveillance and Response Annual Report, Sudan, 2018, UNFPA Khartoum |
| **Supportive supervision for MDSR** is important particularly in the initiation stage.<br>● In Sudan at national level, it is almost regular, covering all states, at least once a year for each state.<br>● However, **at states level, it is infrequent**, largely dependent on donor funding, reflecting the weak health system at states, which is consistent with that found in many African countries.<br>● During these supervision tours, **many gaps between national recommendations of the NMDRC and implementation at state levels** were reported in most of the states. During the last five years, management protocols for emergency obstetric problems | UNFPA, Maternal Death Surveillance and Response Annual Report, Sudan, 2018, UNFPA Khartoum |

| Assumption 3.1: MHTF technical support to the establishment and national scale-up of MPDSR in its partner countries is evidence based and comprehensive | |
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| (haemorrhage, hypertensive disorders and its complications and sepsis), have been designed and endorsed, however implementation and adherence to is so deficient in almost all health facilities.<br>● **Poor live birth registration in health facilities and home deliveries** have been reported, most of the statistical records are incomplete or not available.<br>● The **SMDRCs do not regularly meet** to discuss their maternal deaths to timely generate recommendations and implement interventions for reducing maternal deaths. | |
| **Integration of perinatal deaths**<br>● "*Looking at UHC as a proxy for universal SRH coverage, UNFPA's Arab States Regional Office in partnership with University of Mohamed VI for Health Sciences launched an in-depth **multi-country MDSR assessment in 2017** that covered ... Sudan…UNFPA supported a regional experts' group meeting to discuss the findings of the assessment that came up with **a way forward that included provision of support to add perinatal deaths surveillance to MDSR**, considering the **integration of "near-miss" cases** and the **specificities of humanitarian settings**.*" | Université Mohammed VI des Sciences de la Santé and UNFPA Arab States Regional Office, Saving Mothers' Lives Casablanca, 22-23 July 2019, p.2 |
| **Achievements**:<br>● **MDSR is accepted and ongoing** at national and states level, with regular notification, review, and regular national report with many interventions being recommended and implemented.<br>● Good investment, particularly from relevant donors on **midwifery training** and FMoH and SMoH in **recruiting midwives** in the health system to improve women's health. However **in-service training is poor**. Management **protocols for emergency obstetrics have been implemented but are poorly adhered to**. | UNFPA, Maternal Death Surveillance and Response Report, Sudan, 2019 |
| **Conditions for success: Leadership**<br>● **Functioning MDSR requires teamwork and commitment from all partners**. Frequent turnover of team dependent persons (RH focal persons and registrars at states level) can negatively affect the process.<br>● Maternal death review meetings should not depend solely on focal persons and should continue even in their absence. Providing incentives such as sponsoring the meetings may motivate participants. Usually review teams need technical and moral support as well as **building their technical analytical skill**.<br>● They need to be guided by a senior particularly expert doctor or a consultant obstetrician. It needs **guidance, coordination, and support** from FMoH and SMoH by allocation of resources in each annual health budget.<br>● FMoH is taking a leadership role in supervision, training and availing of requirements, however other partners (**UNFPA**, UNICEF and WHO) **play a vital role** in sponsoring national and states meeting and the supportive supervision tours. More intensive **advocacy is needed to institutionalize MDSR** at HMIS. | UNFPA, Maternal Death Surveillance and Response Annual Report, Sudan, 2018 |
| **MPDSR reforms to strengthen systems**<br>● Survey data were vertical but a review "*is underway now to identify options and opportunities for **integration of MPDSR** into the national health information system*".<br>● Technical Working Group members and the group itself draws on **support from MHTF for meetings**. Currently, WHO and UNFICEF participate on a technical level only. The FMoH funds about 20 per cent of needs and MHTF funds the other 80 per cent. | Interview, RH Team, UNFPA CO Khartoum, 17 June 2021 |

| Assumption 3.1: MHTF technical support to the establishment and national scale-up of MPDSR in its partner countries is evidence based and comprehensive | |
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| ● However, in addition, the FMoH aims to integrate the MPDSR into the national and state health system such that it will become part of the routine health services management approach. Previously it had been set up as a parallel and external system affiliated to the Sudan Medical Board.<br>● The current reform process underway is aimed at **trying to integrate the system into the national health system** more operationally so linking it to the levels of care (primary, secondary, and tertiary etc.) and to the DHIS. **This is a slow process**, and the working group will review progress later in 2021 to decide whether and how to make adjustments. | |
| **UNFPA Support**<br>● **UNFPA works on MPDSR in an active and highly engaged way**. There have been challenges documenting the programme, however.<br>● UNFPA supports the MPDSR through **supporting the development of policy and support the regular meetings** at federal and states levels and capacity building programmes.<br>● In 2020, the FMoH started a process of **updating the MPDSR system and planning a new approach**. | Interview, RH Team, UNFPA CO Khartoum, 17 June 2021 |
| **Reporting activities 2020**<br>● **This activity includes** notification, investigation, committee's meetings, supervision, production of MDSR annual report and Operational support to MDSR national registry office. | Review of programme activities, UNFPA CO, Sudan, 22 June 2021 |
| **Partnerships**<br>● **WHO and UNICEF have become more engaged** and have supported the integration of the perinatal/newborn death audit processes with the maternal death audits that had been underway for some years. | Interview, RH Team, UNFPA CO Khartoum, 17 June 2021 |
| **Assumption 3.2: MHTF support has addressed the need for sustained or increased quality or credibility of maternal and perinatal death audit as evidenced by increased notification of maternal, perinatal and neonatal deaths in national and sub-national systems and increased implementation of responses** | |
| **Indicators:**<br>● Quantifiable **increase in the notification of deaths** to health facilities, districts and other authorities<br>● In target areas, increasing or continuing number and frequency of MPDSR **events and hearings with multi-stakeholder participation**<br>● Examples of **policies and processes to support improved quality** and comprehensiveness of death audits at national and at sub-national levels<br>● Examples of UNFPA efforts to **strengthen QI processes, tools and data collection** at national and sub-national level linked to MPDSR<br>● National and sub-national health and district supervisory officers in areas supported by UNFPA implement **MPDSR monitoring** on a regular basis and **utilize findings to support improvements** in services<br>● Views of health officials, including facility managers, providers and community members regarding **credibility of MPDSR processes.** | |
| **Observations** | **Sources of Evidence** |
| **Achievements**<br>● **MDSR is now introduced [at national and state level] and focal persons network is fully established**. MDSR is accepted and ongoing at national and states level, with regular notification, review, and regular national report with many interventions have been recommended and implemented.<br>● **Good investment**, particularly from relevant donors on **midwifery training** and FMoH and SMoH in **recruiting midwives** in health system to improve women health, however **in-service training is poor**.<br>● Management **protocols** for emergency obstetrics have been implemented but **are poorly adhere to.** | UNFPA, Maternal Death Surveillance and Response Annual Report, Sudan, 2018, UNFPA Khartoum. |

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| **MDSR activity**<br>● UP to the end of Q3 of 2020 UNFPA supported the notification and investigation of 703 maternal deaths.<br>● The national and state level MDSR committee meetings continued to function in 2020 but the regularity was **affected by COVID-19 pandemic.**<br>● Two **zonal technical committees' meetings** were conducted in Darfur zone (Alfashir) and Kordufan zone (Elfula); the third meeting is planned for the Eastern zone (Kassala).<br>● The **2019 MDSR report** was finalized and disseminated in early 2020 to the key stakeholders. | UNFPA and GoS, 2020 Annual Progress Report - 7th Country Programme Cycle 2018-2021, 2020, UNFPA, Khartoum, Sudan |
| **Influx of vulnerable people affects coverage**<br>● Sudan has international borders with the nascent state of South Sudan. Reporting maternal deaths was a huge problem due to **a lack of a properly functioning information system**. Although the work of MDR in White Nile State started in 2009, it was not possible for it to cover all of White Nile State due to **lack of resources**. | UNFPA, Summary report on the use of mobile phones, 2017, UNFPA, Khartoum, Sudan |
| **UNFPA support to MPDSR**<br>● **UNFPA supported the MPDSR process** with support to: Regular **meetings** of the technical committee.<br>o All meetings of technical committees are supported by UNFPA in addition to **notification and investigation** of cases at both community and health facility level. These are **quarterly and annual.**<br>o Notification and investigation activities although **financial support to investigations at community level is limited.**<br>o **Technical support** to the programme through expert consultant is "well-appreciated" by FMoH.<br>o UNFPA also supports **capacity building programmes at both federal and state levels** to help identify the MPDSR model and approach and to improve reporting, the review process and monitoring. However, capacity building in the FMoH team is yet to be completed. | Interview, RH Team, FMoH, Khartoum, Sudan, 1 June 2021 |
| **MPDSR reporting in Blue Nile State**<br>● **Regular weekly meetings are conducted** to review the performance and outcomes of the week including discussing maternal deaths and ruling out whether and how these were avoidable. "*Then we raise regular reports to SM*oH". | Interview, Referral Hospital Medical Director, Ad Damazin, Blue Nile, 7 June 2021 |
| **At the maternity referral hospital**<br>● The hospital has a **maternal death committee that meets regularly** and is responsible for investigation of any maternal death.<br>● This supports the hospital to **understand the main causes** of maternal death and then to **take action**, develop plans and procedures to avoid similar deaths in the future.<br>● **Large staff turnover so same points come up repeatedly.** | Interview, Referral Hospital Medical Director, Sudan, 5 June 2021 |
| **Leveraging more partners to become engaged in MPDSR**<br>● It was firstly called MDR and was fully supported only by UNFPA. As the programme showed good impact and more potential for expansion appeared, other organisations were involved including **WHO and UNICEF**, which have a technical role now in the technical committees. | Interview, UN Partner, 9 June 2021, Khartoum |

| **Assumption 3.2: MHTF support has addressed the need for sustained or increased quality or credibility of maternal and perinatal death audit as evidenced by increased notification of maternal, perinatal and neonatal deaths in national and sub-national systems and increased implementation of responses** | |
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| **MPDSR: Role of UNFPA**<br>● UNFPA supports the **quarterly and annual meetings of the technical committees.**<br>● Also, UNFPA supports **investigation of cases at both community and health facility level**.<br><br>**Main issues facing the programme**<br>● **Payment of community-based investigation is limited** although supported by UNFPA.<br>● **Consistent reporting** at the State level/district level.<br><br>**Partners**<br>● It is mainly by government and UNFPA funded with **limited contribution of UNICEF.**<br>● **UNICEF and WHO** offer technical support and guidance. | Interview, SMoH, Ad Damazin, Blue Nile, Sudan, 7 June 2021 |
| **Impact of MPDSR**<br>● Involved in driving implementation of MDSR in Sudan including the FMoH, SMoH, and supporting partners particularly UNICEF, WHO, Sudan Society of Obstetricians and Gynaecologists, doctors, midwives and national NGOs/CSOs. All played **important roles in technical support, data collection, SMDRC meetings** without personal remuneration for their participation.<br>● Many states demonstrated **good reduction in MMR** compared to previous reports, which might be due to managerial commitment and personal interest in reducing MMR [by individuals].<br>● These interventions have led to **improved quality of care** through mobilization of additional resources, including training of midwives, availing of clean delivery kids, theatre equipment, equipped and functioning ambulances and essential drugs for emergency obstetrics problems. | UNFPA, Sudan Maternal Death Surveillance and Response Annual Report, UNFPA Khartoum, 2018. p.7 |
| **Challenges**<br>● **MDSR is not institutionalized** in the health system, with weak response in implementing actions to recommendation. High turnover of MDSR trained staff members, poor record keeping at all levels of care and poor supportive supervision at the states.<br>● There is **lack of legal framework** for regulation of MDSR and fear of blame with absence of financial support, capacity development, and adequate community engagement, many competing priorities in health system, inadequate leadership, and follow up of recommendations.<br>**Recommendations**<br>1. **Scaling up of notification and identification of maternal death** by focal persons at institutes and home, midwives are to be strengthened for reporting of maternal and neonatal deaths at both hospitals and home.<br>2. **A one-day short reminder workshop** for each state, including all stakeholders and participants on how to notify and record. Strengthening state supervision for midwives and focal persons.<br>3. **Improving interpretation of analysed maternal death** by strong commitment of SMDRC for regular meeting and response to every maternal death.<br>4. **Strengthen referral system by midwives and medical officers** with strict criteria for hospital delivery and refer for hospital delivery in ample time, using tel. communication before referral. | UNFPA, Sudan, Maternal Death Surveillance and Response Annual Report, UNFPA Khartoum, 2019. p.9 |

| **Assumption 3.2: MHTF support has addressed the need for sustained or increased quality or credibility of maternal and perinatal death audit as evidenced by increased notification of maternal, perinatal and neonatal deaths in national and sub-national systems and increased implementation of responses** | |
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| 5. **Strengthen utilization and adherence to management protocols** at all levels with strict criteria for monitoring adoption of protocols and availing of requirements for implementation through adequate political commitment and support, adequate human and financial resources and proper stakeholder's participation.<br>6. **Improve implementation and monitoring of recommended interventions**.<br>7. **Design and endorse legal framework for MDSR,** for mandatory maternal death notification and review, and information gained are not for litigation. | |
| ● UNFPA funded a technical position to **support the coordination** of MPDSR. A **technical working group** meets regularly, and all interested/engaged partners are there. The quality of the identified technical staff is not always what they should be to ensure maximum effectiveness and impact of the programme. In this case, the Technical Working Group, **chaired by FMoH**, will decide to terminate a contract and seek other candidates. This has happened once. "*That person and the system under them were not running in an efficient way*". A new consultant was brought on board agreed by the whole Technical Working Group. Although their performance is better the RH team is still working on adjusting the direction of development. The **Working Group will soon make a recommendation about, but it is for FMoH to decide whether they want to proceed**. | Interview, RH Team, UNFPA CO Khartoum, 17 June 2021 |

| **Assumption 3.3:** MHTF has fostered strengthened reporting and operational research in ways that support quality and service delivery improvements resulting from the implementation of MPDSR notification, review and response | |
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| **Indicators:**<br>● Annual MPDSR report is completed and published<br>● Examples of impact where possible and range of **consequences emanating** from MPDSR death audits in target areas including **on procedures, review and audit practices, approaches to addressing maternal death in health facilities and in communities**.<br>● Records of MPDSRs that show evidence of conforming to national standards, are comprehensive and use national tools<br>● Number of peer reviewed MPDSR publications<br>● Availability and credibility of plans to **sustain (institutionalize) UNFPA-supported MPDSR** within community and health systems<br>● **Establishment of training, mentoring or QI programmes that support implementation of recommendations resulting** from MPDSR assessments<br>● Results of death audits that are **meaningful, actionable, and verifiable** in terms of QI, systems or policy strengthening, or process changes<br>● Examples of **community engagement or participation** in MPDSR as critical stakeholders linked to the first two "delays" (delayed decision to seek care, delay reaching care)<br>● Examples – if any – of negative consequences from death audits and whether and how UNFPA supported the response and recovery from these. | |
| **Observations** | **Sources of Evidence** |
| **Maternal death reporting a long-standing effort**<br>● **Reporting mother deaths was a huge problem** due to lack of a properly functioning information system. Although the work of the MDR committee in White Nile State started in 2009, it was not possible for it to cover all of WNS [White Nile State] due to lack of resources.<br>● With support from UNFPA and **since 2010, registration of maternal mortality was "*in full swing*"** and continued for years<br>● **Mobile phones** were distributed and worked well to increase reporting of maternal deaths | UNFPA, Summary report on the use of mobile phones, Khartoum, 2017 |

| **Assumption 3.3:** MHTF has fostered strengthened reporting and operational research in ways that support quality and service delivery improvements resulting from the implementation of MPDSR notification, review and response | |
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| ● Problems included **lack of electricity to charge batteries**, use of phones for other purposes, loss, breakage<br>● **Technology a helpful but not sufficient** element of the solution to improved maternal death reporting | |
| **Reporting summary identifies majority of reported deaths happened in hospital**<br>● Maternal deaths from **obstetric haemorrhage** were 471 (37.2 per cent); mainly PPH 330 (70.4 per cent) due to uterine atonia 40.1 per cent, retained placenta or retained products 10.8 per cent and ruptured uterus 18.3 per cent.<br>● Only 167 (34.5%) presented with bleeding, the rest developed bleeding inside hospitals.<br>● One third (34.0%) **died at home**, 124 (26.3%) were seen by senior consultants, 164 (34.8%) received blood.<br>● **Failure of transfusion** was due to unavailability of blood 260 (55.2%), and no ICU in 246 (52.2%). | UNFPA, Sudan Maternal Death Surveillance and Response Annual Report, UNFPA Khartoum, 2018. p.3 |
| **UNFPA assistance supports regularity of meetings and reporting**<br>● **Support to the implementation of MPDSR at national and states level** through support for notification, review, responses and MPDSR committee meetings. This activity is continuous throughout the year and is progressing as planned. **Support for the development of the MPDSR annual report**. | UNFPA, MHTF Mid-Year report for 2020, UNFPA, Khartoum, Sudan, 2020 |
| **FMoH confirms UNFPA support to reporting**<br>● The **technical committee meets** regularly (several external partners are present including WHO and UNICEF) but FMoH does not yet have sufficient capacity to deliver the MPDSR without **technical assistance from UNFPA**.<br>● All meetings of technical committees are **supported by UNFPA** in addition to **notification and investigation of cases** at both community and health facility level. These are quarterly and annual.<br>● UNFPA also supports **capacity building programmes at both federal and state levels** to help identify the MPDSR model and approach and to improve reporting, the review process and monitoring. | Interview, RH Team, FMoH, Khartoum, Sudan, 1 June 2021 |
| **Institutionalization of MDR in Blue Nile State**<br>● Regular **weekly meetings** are conducted to review the performance and outcomes of the week including discussing maternal deaths and ruling out whether and how these were avoidable. Then we raise regular reports to SMoH. | Interview, Referral Hospital Medical Director, Ad Damazin, Blue Nile, 7 June 2021 |
| **MPDSR process: hospital level**<br>● The hospital is responsible for **investigation** of any maternal death<br>● There is a **maternal death committee** that meets regularly or when there has been a death<br>● A **focal point** is nominated for the investigation and to report the death<br>● This enables the hospital to **understand the main causes** of maternal death and to **take action** by developing plans and procedures to avoid similar deaths in the future. | Interview, Referral Hospital Medical Director, Sudan, 5 June 2021 |
| **UNFPA provides practical support and training**<br>● **Workshop** held to enable teams from across Arab States Region to learn, share experience and build skills.<br>● **Strategy** includes to strengthen national plan for the improvement of the civil registration and vital statistics system.<br>● Seven strategic areas to support quality improvement included: | Université Mohammed VI des Sciences de la Santé and UNFPA Arab States Regional Office, Saving Mothers' Lives through advancing Maternal |

| **Assumption 3.3:** MHTF has fostered strengthened reporting and operational research in ways that support quality and service delivery improvements resulting from the implementation of MPDSR notification, review and response | |
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| ○ **Integration of MDSR into the routine** epidemiological surveillance system to make maternal deaths a reportable event just like epidemic diseases<br>○ **Master the major inequities between regions** through coaching, training, support, monitoring and evaluation, motivation<br>○ Invest more in the **advocacy and empowerment** of decision-makers<br>○ Integrate maternal death review into the sectoral strategy as a lever for the quality of care, and human rights<br>○ The **human factor is the key** to success: The stability of health providers depends on the continuity of the staff motivation to embark in MDSR process and on the quality of data collected (speed and completeness)<br>○ Strengthen the **leadership** of the central unit and the focal point of the region<br>○ Ensure **coordination** between all actors outside the health department and between levels of care<br>○ **Monitor recommendations** so that the MDSR is action-oriented and improves the quality of care locally<br>● There is a need to "lighten" the collection and monitoring tools (make them easier, more user-friendly) in order to enable health professionals to contribute more systematically to the success of this approach and ensure that recommended actions and interventions have been implemented. | Death Surveillance and Response, Arab States regional MDSR Workshop, Casablanca, 22-23 July 2019. p.69 |
| **MPDSR reporting culture still lacking**<br>● **Focus is needed on the "*proper identification and reporting pathway*** *(no shame no blame), efficient quality improvement process, stakeholders' participation at national and states levels and legal framework addressing mandatory notification and information should not be for litigation*."<br>● Improvements to **reporting and notification** suggested including:<br>○ Short reminder **workshop** of two days for each state on how to notify and record<br>○ Strengthen **referral system by midwives** with strict criteria for hospital delivery and refer for hospital delivery in ample time, using tel. communication before referral<br>○ Strengthen **state supervision for midwives** and commitment of SMDR for regular meeting and response to every maternal death<br>○ Strengthen **utilization and adherence to management protocols** at all levels to hospitals with strict criteria for monitoring adoption of protocols<br>○ Design and endorse **legal framework for MDSR**, to abolish fear of litigation. | UNFPA, Sudan Maternal Death Surveillance and Response Annual Report, UNFPA Khartoum, 2018. p.18 |
| **Role of UNFPA**<br>Newborn and Maternal Death Review Committee publicly acknowledged the efforts of **UNFPA** Sudan "*for their **appreciated efforts** in MDSR, particularly, supporting of supervision visits and their inputs in their target states*" and to UNICEF Sudan office for "*their support **in conducting supportive supervision visits & NMDRC meetings** and WHO for their technical support*". | UNFPA, Sudan Maternal Death Surveillance and Response Annual Report, UNFPA Khartoum, 2018. P.8 |

| Area of Investigation 4: Obstetric fistula and other obstetric morbidities | |
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| **Evaluation Question 4: To what extent has the MHTF contributed to the capacity of governments to develop, implement and monitor costed and time-bound national strategies for ending fistula cases that are founded on: prevention; access to quality treatment of fistula cases and other obstetric morbidities; and social reintegration of obstetric fistula survivors?** | |
| **Sub-questions:**<br>a) To what extent has MHTF/UNFPA contributed to the **government capacity to develop, implement and monitor costed and time-bound national strategies for ending fistula**?<br>b) To what extend has MHTF/UNFPA contributed to building **government capacity at national and sub-national levels equally across prevention, access to quality treatment and social reintegration of survivors**?<br>c) To what extent has MHTF been an effective platform for the **global Campaign to End Fistula**? | |
| **Evaluation Criteria** | *Relevance, effectiveness, efficiency* |
| **Rationale** | Obstetric fistula is caused by prolonged obstructed labour and is an extreme consequence of poor access to basic emergency maternal health care. Once fistula occurs, surgical repair is the only option. Surgical skills needed draw across disciplines (gynaecology, urology, general and plastic surgery, in some cases also gynaecology). Recovery time is protracted and not certain. Post recovery, women and girls may not be able to return home and, in most cases, may need a range of social protection support. Obstetric fistula is thus a complex development problem that has multiple dimensions. MHTF aims to support countries to take steps to prevent and respond to fistula and similar conditions to reduce maternal emergencies, save the lives of newborns, and improve quality and availability of care. Fistula incidence reflects proximity and use of emergency obstetric care (EmONC) and referral capacity making prevention part of a comprehensive maternal health strategy. Post fistula repair depends, to some extent, on identifying sufferers and connecting them with services. Post fistula recovery depends on a multi-sectoral approach to well-being, employment and skills, social reintegration and other factors. As fistula is still poorly understood and sufferers are hidden, data needs to be treated carefully as increasing numbers could be a sign of improved service response rather than increasing incidence. Although it has its own fistula aims, the MHTF also hosts the global Campaign to End Fistula which works with a mandate from the UN Secretary General & UN member states to end fistula in 55 countries. The Campaign is largely merged with the MHTF goals on fistula but reaches beyond the scope of the MHTF and brings its own funds to bear. |
| **Assumption 4.1: MHTF and UNFPA, including through leadership of the Campaign to End Fistula, support is consistent with strengthened government leadership and capacity at national and sub-national levels to develop, implement and monitor costed and time-bound national strategies for preventing and treating fistula** | |
| **Indicators:**<br>● Development of **costed time-bound national and sub-national strategies** that set out meaningful **prevention, treatment and recovery objectives and strategies**.<br>● Examples **of implementation of plans and progress rolling out plans** to sub-national and community levels<br>● Fistula indicators incorporated into the HMIS at national and sub-national levels<br>● **Monitoring arrangements** in place for fistula strategies across the three dimensions (prevention, treatment, recovery)<br>● Examples of **policy dialogue and development** between national and sub-national health authorities especially around linking to EmONC networks<br>● Examples of **engagement with communities** around fistula prevention and management, for example, maternal emergency transportation plans<br>● Trends in **the identification fistula cases**<br>● **Examples of investments in preventing, treating and supporting** recovery from fistula | |

| **Assumption 4.1: MHTF and UNFPA, including through leadership of the Campaign to End Fistula, support is consistent with strengthened government leadership and capacity at national and sub-national levels to develop, implement and monitor costed and time-bound national strategies for preventing and treating fistula** | |
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| ● Establishment and operation of programmes for **staff training** to implement strategies (surgery and nursing and community health workers).<br>● Number of fistula repairs undertaken<br>● National and local systems incorporate **multisectoral engagement** to address fistula, for example with nutrition, social protection, employment and training sectors. | |
| **Observations** | **Sources of Evidence** |
| **Interest in and commitment to developing a fistula Strategy**<br>"…***More focus and strategic interventions*** *to speed the ending fistula campaign in the country that started years ago*…"<br>● The weak health system in general and the presence of other competitive priorities challenged the health sector and UNFPA to mobilize adequate resources to ensure the **sustainability of the programme and services**.<br>● According to the 2018 national EmONC assessment, **15 per cent of health facilities in Sudan are able to provide surgical repair** to Obstetric Fistula survivors, but **the indicators to measure the quality of the services are still a missed point**. | UNFPA, Overview Obstetric Fistula in Sudan, 2018, UNFPA, Khartoum, Sudan. p.3 |
| **Sudan Fistula Strategy 2019**<br>By the end of 2019, 69 per cent of MHTF-supported countries had developed national strategies to end fistula. Four more countries, Liberia, Malawi, Rwanda and **Sudan, began developing national fistula strategies**. | UNFPA, Maternal and Newborn Thematic Fund 2019 Annual Report, Sudan. Khartoum, 2020 |
| **Fistula Strategy**<br>● UNFPA also supported the **technical review of the National Fistula strategy** once it was completed.<br>● The core document and the operational plan were finalized; **the costing exercise is ongoing.**<br>● The Strategy was intended to be endorsed by the FMoH before the end of December 2020 according to this report.<br>● The Strategy has still not been endorsed as of July 2021. | UNFPA and GoS, 2020 Annual Progress Report - 7th Country Programme Cycle 2018-2021, 2020, UNFPA, Khartoum, Sudan |
| Fistula is "*moving in the right direction*". As of 2021, **UNFPA is working with FMoH on a fistula plan and costing** to guide the country on ending fistula in Sudan. The strategic plan is currently under review and UNFPA is awaiting endorsement of the new plan, which is ready, but the FMoH needs to approve it. | Interview, RH Team, UNFPA CO Khartoum, 17 June 2021 |
| **Expanding the fistula response beyond repair**<br>Through MHTF support, Sudan developed an **evidence-based social reintegration programme** that informed its national fistula strategy. | UNFPA, Maternal and Newborn Thematic Fund 2019 Annual Report, Sudan. Khartoum, 2020 |
| **Ongoing strategy and policy process**<br>This activity includes the development of **fistula strategy, National Fistula Task Force, identification of fistula treatment sites (central and state levels) and investments needed** in fistula treatment sites in six states (Kassala, Blue Nile, North Darfur, South Darfur, West Darfur and Central Darfur). The strategy draft is now being reviewed in the FMoH and CO staff are "nudging" but at the same time are aware that the FMoH is diverted by other challenges. | Review of programme activities, UNFPA CO, Sudan, 22 June 2021 |
| ● **UNFPA** support to Fistula programme included **support to national strategy development**, in addition to most of the **task force meetings** and **capacity building** programmes. | FMoH, Interview with National Fistula |

| **Assumption 4.1: MHTF and UNFPA, including through leadership of the Campaign to End Fistula, support is consistent with strengthened government leadership and capacity at national and sub-national levels to develop, implement and monitor costed and time-bound national strategies for preventing and treating fistula** | |
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| ● There is **still a lot of work to do including dissemination of the strategy, strengthening of the reporting system**.<br>All proposed work is **well coordinated with UNFPA**. Practical **challenges include human resources capacity for prevention, diagnosis and repair** but now expanding to develop a comprehensive approach to reintegration. This element of fistula is multisectoral. | Coordinator, Khartoum, Sudan, 1 June 2021 |
| **Investments and practical focus at sub-national level**<br>● **UNFPA supports** the development of the **national strategy** and **capacity building** programmes, **notification and referral** of cases and also **surgeries**, **medical treatments** and **costs for patients** during hospital admission. | Interview, SMoH, Ad Damazin, Blue Nile, Sudan, 7 June 2021 |
| ● **Fistula services are expanded** with practical support, investment in prevention measures, diagnosis and notification, management of patients and support to patient referral. | UNFPA Group Meeting, 5 June 2021, Khartoum |

| **Assumption 4.2: MHTF and UNFPA, including through leadership of the Campaign to End Fistula, have engaged with national leadership, to enhance ownership and accountability in ways that build <u>health systems, and community capacity</u> at national and sub-national levels across prevention, access to quality rehabilitation and social reintegration of survivors** | |
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| **Indicators:**<br>● Increase in reported **progress in all stages of fistula prevention, diagnosis, repair and recovery**<br>● **Guidance available to health workers** including midwives (prevention, diagnosis), surgeons (repair) and community health workers (prevention and recovery)<br>● **Policies and programmes in place to support rehabilitation** of fistula survivors<br>● Trends in **number of fistula survivors who benefit** from rehabilitation and reintegration programme and support<br>● Examples and of **community engagement and advocacy** regarding the causes and consequences of fistula<br>● Examples of **changing community and health worker attitudes** towards fistula sufferers and survivors<br>● Documented multisectoral approaches which include life skills, nutrition, and social protection especially in the recovery phase<br>● Examples of concrete **integration of fistula** strategies into EmONC and maternal health plans and approaches. | |
| **Observations** | **Sources of Evidence** |
| **UNFPA practical support to fistula repair**<br>● 90 fistula **repair operations** were performed during 2020<br>● 220 fistula **hygiene kits** were procured and distributed to facilities providing fistula services. | UNFPA and GoS, 2020 Annual Progress Report - 7th Country Programme Cycle 2018-2021, 2020, UNFPA, Khartoum, Sudan |
| **UNFPA invests in fistula response capacity**<br>● Annual report identified "**Minor rehabilitation** to Alfashir fistula centre" which includes rehabilitation of the infrastructure, including the theatre, additional equipment and consumables. | UNFPA and GoS, 2020 Annual Progress Report - 7th Country Programme Cycle 2018-2021, 2020, UNFPA, Khartoum, Sudan |
| **Technical focus supported by UNFPA**<br>● Midwifery **Trainings**<br>● Provision of **consumables** including drugs, gloves, other supplies etc and commodities including midwifery kits | Interview, Referral Hospital Medical Director, Ad |

| **Assumption 4.2: MHTF and UNFPA, including through leadership of the Campaign to End Fistula, have engaged with national leadership, to enhance ownership and accountability in ways that build <u>health systems, and community capacity</u> at national and sub-national levels across prevention, access to quality rehabilitation and social reintegration of survivors** | |
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| ● Support **patient referral** through contribution to the cost of transportation which is directly provided to the patients when they arrive at the hospital following referral<br>● UNFPA supports the regular quarterly and annual **meetings of the MPDSR committee/group**<br>● UNFPA supports the **notification** of fistula patients at community based through a weekly clinic and involvement of community leaders. Furthermore, it supports the transportation of patients, and covers all the costs of the clinical tests, operations and post operation care including DSA costs.<br>● The **fistula operation** used to be regularly done when the surgeon was there. He was the leader of the fistula interventions in Blue Nile state. Unfortunately, due to personal issues he moved to Khartoum and then travelled abroad. Then the operations stopped for a long time to be restarted this year through a fistula campaign supported by UNFPA. The operations are done now by a consultant visitor from Nyala, South Darfur State. | Damazin, Blue Nile, 7 June 2021 |
| **Preventing fistula**<br>● Prevention measures include conducting **deliveries by trained midwives** who are capable of diagnosing and notifying obstructed labour.<br>● **Community leaders** had been involved in notification and referral of cases.<br>● Weekly **mobile fistula clinic** done at community level to diagnose cases. | Interview, Referral Hospital Medical Director, Ad Damazin, Blue Nile, 7 June 2021 |
| **A happy ending for one fistula sufferer**<br>● There was a fistula patient diagnosed and operated on by the resident fistula surgeon. The operation was successfully done supported all through by UNFPA although there is no ongoing support to community reintegration after surgery neither by the government nor by UNFPA. The surgeon followed the patient to her family and found that she is divorced. With some community leaders, the surgeon went to her husband to assure him how well his wife was, and that she had recovered from the fistula and could even get pregnant again. Her husband returned to her and within a short time, she got pregnant and was fully attended throughout her antenatal period by the surgeon. She and her husband have a baby boy who they named after the doctor. | Interview, Referral Hospital Medical Director, Ad Damazin, Blue Nile, 7 June 2021 |
| **Fistula activities national and state 2018**<br>● Focus on finalizing the **Sudan National Strategy** to end obstetric fistula in order to have base for resource mobilization.<br>● Establish proper **case identification and registration** so that the HMIS can accommodate obstetric fistula.<br>● **Capacity building** of medical doctors and obstetrics and gynaecology skills.<br>● **Assessment and analysis** of the obstetric fistula situation in the country (from a gender and health perspective).<br>● **Community education and awareness** creation on obstetric fistula nationwide including to rural regions. Rehabilitate and equip the fistula centres to scale up the number of obstetric fistula repairs. Operationalize of AlFashir Fistula Hospital in 2019.<br>● Support **restoration of psychosocial status** of those women who have been treated for obstetric fistula.<br>● Potential obstetric fistula surgeons identified and for participation in the International Federation of Obstetricians and Gynaecologists (**FIGO) fistula fellowship programme**. | UNFPA, Overview Obstetric Fistula in Sudan, 2018, UNFPA, Khartoum, Sudan |

| **Assumption 4.2: MHTF and UNFPA, including through leadership of the Campaign to End Fistula, have engaged with national leadership, to enhance ownership and accountability in ways that build <u>health systems, and community capacity</u> at national and sub-national levels across prevention, access to quality rehabilitation and social reintegration of survivors** | |
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| ● The MHTF continued to address the issue of **mental health support and social stigma** accompanying obstetric fistula. With its support and in partnership with government ministries and Campaign to End Fistula partners, 1,906 women and girls from nine countries (Bangladesh, Côte d'Ivoire, the Democratic Republic of the Congo, Mauritania, Niger, Nigeria, Sierra Leone, Togo and Uganda) benefitted from **various social reintegration programmes**. MHTF support facilitated assessments, evaluation and monitoring of existing social reintegration programmes in Benin, **Sudan** and Uganda, contributing to an evidence base to inform and improve programmes in line with the needs of fistula survivors. | UNFPA, Maternal and Newborn Thematic Fund 2019 Annual Report, Sudan. Khartoum, 2020 |
| **UNFPA fistula activities in 2020: COVID-19 impacts**<br>● Support to the implementation of community-based identification of obstetric fistula and referral for treatment services. This includes integration of case identification into existing community based SRH interventions. Due to COVID-19 epidemic and constraining context, **active case finding was not feasible due to mobility restriction.**<br>● Support the fistula repair centre in three states for routine repairs of fistula patients through the provision of surgical repair services and implement a follow up system to assess the 3- and 6-months success rates. The **repair operations are progressing as planned and the follow up will continue** in semester two. **80 per cent of the activity is achieved** and the remaining 20 per cent will be implemented as part of third tranche. The repaired cases were previously identified.<br>● Planned support implementation of evidence-based and **efficient social reintegration programme for fistula survivors** although this is in the early stages and has been affected by COVID-19 related delays.<br>● Conduct **training of care providers** on obstetric fistula treatment (Nurses, sociologist and operation support staff).<br>● Conduct **annual meetings of national Task Force** and the obstetric fistula surgeons, supporters and activists. | UNFPA, MHTF Sudan Mid-Year report for 2020, UNFPA, Khartoum, 2020 |
| **Fistula repair impeded by limited capacity**<br>● **Midwives** need to diagnose and refer<br>● Unfortunately, there is no other intervention in this area (fistula)<br>● Although there is a qualified surgeon to undertake fistula repair surgery, **there is no suitably equipped operating theatre in the hospital.** | Interview, Referral Hospital Medical Director, Sudan, 5 June 2021 |
| **UNFPA partnering with others on fistula**<br>● In 2017, an **international obstetrician attended two fistula repair training camps in Darfur and trained 11 consultants on fistula repair**. That in addition to the international procurement of fistula repair kits, rehabilitation/equipping of satellite centres, awareness activities and media programming, trainings for religious leaders. Fistula investments build on this in 2018.<br>● "***UNFPA is leading the obstetric fistula program in Sudan …*** *aiming to prevent and repair cases of obstetric fistula, and socially reintegrate survivors of this disability in their communities. The program has succeeded so far in treating cases across Sudan: including Darfur, Kordofan, East Sudan, Khartoum and Blue Nile and others. UNFPA, as the leader of the program, in partnership with the Ministry of Health, USAID and the Italian Agency for Development Cooperation, over the past 4 years supported the treatment of 1259 women and girls in Sudan*." | UNFPA, Overview Obstetric Fistula in Sudan, 2018, UNFPA, Khartoum, Sudan. p.1 |

| **Assumption 4.2: MHTF and UNFPA, including through leadership of the Campaign to End Fistula, have engaged with national leadership, to enhance ownership and accountability in ways that build <u>health systems, and community capacity</u> at national and sub-national levels across prevention, access to quality rehabilitation and social reintegration of survivors** | |
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| **Repairs and re-engagement**<br>● UNFPA supports prevention of fistula by contributing to **capacity-building programmes for health workers and at community level** through involvement of community leaders and a weekly mobile clinic. UNFPA covered all the costs of the operations, medical treatments, transport, and even the subsistence of patients through the duration of hospital treatment. They covered training costs as well. Regarding re-engagement of patients to community, actually, there is no intervention in this area even from the government. | Interview, SMoH, Ad Damazin, Blue Nile, Sudan, 7 June 2021 |
| **Increased and flexible mobile repair capacity**<br>● Previously, UNFPA mobilised an international team to train a team of surgeons to do fistula repair (2017/2018). They are based **in Al-Fasher**, at what is now a fistula repair centre in North Darfur State. **In 2020, this team did 115 fistula repairs of which 45 were funded by MHTF**. The team has the capacity to move around the country and is a 'roving team' by which is meant they are mobile and can travel to where they are needed. MHTF provides some support but also resources drawn from Core funds.<br>● Gradually the team should be able to address the backlog of fistula repairs. As prevention improves, fistula should hopefully decline as a risk but that is some time in the distance. | Interview, UNFPA RH Team, CO Khartoum, 17 June 2021 |
| ● *"**Survivors of obstetric fistula in Sudan** are overwhelmed with the social and economic instability of decades. Darfur traditionally had the largest numbers of fistula cases in Sudan followed by Blue Nile and Kordofan, due to the combination of lack of access to even basic delivery care as well as early marriage and childbearing this has been further exacerbated by lack of access to services due to insecurity during the height of the armed conflict. The current Obstetric Fistula Data that reported by Darfur SMOHs showed that near to 366 fistula survivors are waiting for surgical repair, we expected that more cases are not discovered yet."* | UNFPA, Overview Obstetric Fistula in Sudan, 2018, UNFPA, Khartoum, Sudan. p.1 |
| ● In Blue Nile State, the MoH face difficulties in implementing fistula treatment campaign due to the health condition of the trained surgeon. **UNFPA CO** in coordination with sub offices in Blue Nile and North Darfur states managed to coordinate with Al-Fasher fistula centre and make the necessary arrangement to **bring two fistula surgeons to conduct the campaign in Blue Nile state**. The outcome was that 23 fistula cases were operated. | UNFPA, 2020 template for MHTF reporting, 2020, UNFPA, Khartoum, Sudan |

| Area of Investigation 5: Integrated SRHR | |
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| **Evaluation Question 5: To what extent has the MHTF contributed to strengthened integration between maternal health and SRH (with a focus on family planning, post-partum family planning, post-abortion care and safe abortion care (where legal); cervical cancer prevention; PMTCT, and SGBV to achieve quality service delivery, to increase client satisfaction and to stimulate greater public demand for SRHR services?** | |
| a) How and to what extent has UNFPA **advocacy** for strengthened integration between maternal health and SRHR resulted in adoption within various strategies and initiatives at global, regional and national level?<br>b) To what extent have UNFPA-supported **models and approaches** for linking MNH and SRHR been implemented at national level within health service delivery settings (supply) and behaviour change and communication efforts (demand)?<br>c) To what extent has UNFPA supported **integrated programming and synergies within MHTF** (across the four core technical areas) and with **other UNFPA technical areas** (UNFPA Supplies, SRHR, Gender, Youth, etc.)? | |
| **Evaluation Criteria** | *Relevance, effectiveness, efficiency, coordination* |
| **Rationale** | In order to support women and adolescent girls across their lifespan, there needs to be in place a continuum care from SRH through to pregnancy and the postnatal period and wellness across all stages. Women and newborns are at the highest risk of death and morbidity during labour, childbirth and in the first week after birth. The MHTF aims to support countries to address the "three delays" in accessing quality maternity care and improving the post-partum or post-abortion period. The MHTF supports countries to strengthen access to and the quality of antenatal care, with special attention to adolescent girls and youths. The antenatal care package includes essential SRH information and services, such as for the prevention of unsafe abortion, access to safe abortion (where legal) and the prevention of mother-to-child transmission of HIV. |

| **Assumption 5.1: UNFPA is active in advocacy for the full integration of SRHR and MNH into health systems, national strategies including UHC and other platforms and for initiatives that strengthen linkages between MNH and SRHR within global, regional and national strategies and plans** | |
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| **Indicators:**<br>● MNH services **integrated into PHC and UHC protocols**, approaches, GFF investment cases and SDG3 GAP process, where applicable<br>● Examples of **MHTF leadership** for ensuring global and regional attention to MNH-SRHR integration within global initiatives, (such as the Global Strategy for Women's Children's and Adolescents' Health, the ICPD 25 Nairobi business, and the SDG3 GAP process)<br>● **GFF investment cases** (where applicable) include a full complement of SRHR and MNH services.<br>● Activities in countries **linked to the Global Action Plan initiative**<br>● **National health sector strategies and plans incorporate linkages and integration** of MNH and SRHR, including post-partum contraception, postabortion care, safe abortion care (where legal), cervical cancer prevention, PMTCT)<br>● Views of partners and stakeholders on the **role of UNFPA leadership on progress toward integration** with global, regional and national strategies and plans. | |
| **Observations** | **Sources of Evidence** |
| **Advocacy and strategies for integration**<br>● "***Integration is one solution to scarcity***". In response to the situation in which there is not enough of anything (staff, commodities, facilities etc), integration enables more to be done with less. Midwives, for example, do not just do maternal health. They also attend the needs of babies and children, for example, with vaccination. | Interview, RH Team, UNFPA CO, Khartoum, 17 June 2021 |

| **Assumption 5.1: UNFPA is active in advocacy for the full integration of SRHR and MNH into health systems, national strategies including UHC and other platforms and for initiatives that strengthen linkages between MNH and SRHR within global, regional and national strategies and plans** | |
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| ● Integration is **a core component of health systems strengthening** and the EmONC network reinforces this approach and enables support to be focused on other services as well. | |
| **Midwifery Diploma centred on an integrated curriculum**<br>● UNFPA will continue to support the **young midwives and promote their role in SRHR** through the new midwifery reform process.<br>● Diploma **curriculum includes integrated services across SRHR and MNH** including comprehensive care across the reproductive life course. | UNFPA and GoS, 2020 Annual Progress Report - 7th Country Programme Cycle 2018-2021, 2020, UNFPA, Khartoum, Sudan |
| **Integration has a range of determinants**<br>● **At the facility level**, UNFPA adopts a health/medical/service-oriented approach with people. But they adopt a socio-political approach **at the higher political level**. FGM abandonment, for example, is a strategy for maternal health as is the policy on raising the age of marriage. So, there are sensitivities about implementing/enforcing the law that has raised the age of consent/marriage to 18. The UN agencies in Sudan work together and discuss a lot with the government.<br>● **FGM abandonment** is there and growing but not so much is happening with abandoning **early marriage**. Slow progress. "*Not 100 per cent support though"*. | Interview, Partner to UNFPA Sudan, Khartoum |
| **Coordination and collaboration**<br>Direct one to one **coordination between the two UN organisations (WHO and UNFPA) is limited**. Usually, the work is coordinated and lead by the FMoH and roles are based upon the mandate of each organisation. However, "*we have some joint works on FGM and child marriage together with UNFPA. And we also worked on family planning and gender-based violence*". Still, we **need to improve the level of coordination** between them as sister UN agencies with respect to the mandate of each one. | Interview, UN Partner, Khartoum, 3 June 2021 |
| **Social policies and health equity**<br>"*The current public outcry for SRH is focused on blaming the health system and on requesting quality health care and sophisticated medical technologies.* ***The fair allocation of resources and social arrangements are not recognized as main determinants*** *of preventing ill SRH and promoting well-being. Clearly, public demands need to be built on information and knowledge*." | Rashad H, Khadr Z, Reproductive Health Equity in the Arab Region. Cairo, 2019. p.8 |
| **Assumption 5.2**: **Evidence-based models and approaches to support programming for integrated MNH and SRHR service delivery promoted by UNFPA are adopted and implemented by national authorities for both supply of and demand for services** | |
| **Indicators:**<br>● National health authorities confirm adoption/adaptation of **evidence-based models and approaches for integration** of MNH and SRHR, including but not limited to post-partum family planning (PPFP), post-abortion care (PAC), safe abortion services – (where legal), PMTCT<br>● Operational guidelines for health services staff include **protocols for integration** of MNH and SRHR information, services and referrals<br>● Reported results from UNFPA-supported **programmatic interventions** to pilot, adapt, or scale-up integration models and approaches (PPFP, PAC, PMTCT, etc.)<br>● Reported results from efforts to expand antenatal **care package for essential SRHR information** and services for adolescent girls and youth<br>● Reported **experiences and views** of selected national health authorities and implementing partners on progress and challenges related to integration of MNH and SRHR. | |
| **Observations** | **Sources of Evidence** |

| **Assumption 5.2**: **Evidence-based models and approaches to support programming for integrated MNH and SRHR service delivery promoted by UNFPA are adopted and implemented by national authorities for both supply of and demand for services** | |
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| **SRH-MNH integration in the Sudan health system**<br>● *"Every member of the **health care work force is engaged in the provision family planning**-related services in ... Sudan. Sudan is the only country [among the study countries] with a **large number of trained midwives** working in the public health care system. These midwives share all the responsibilities of **providing SRH services**, very few roles are exclusive to them. These include the vital roles of promotion of family planning, cross-cultural communication with beneficiaries, education of women and their families/supporter in self-care, and promotion of shared responsibility with women, their families, and communities, leaving most of the clinical or other psychosocial roles to be covered primarily by physicians and, to a lesser extent, the rest of the cadre. ...**work force-related challenges** encountered in the provision of SRH services, mainly related to **lack of capacity-building opportunities** and **shortage of staff time**, in addition to **maldistribution of qualified staff** between rural and urban regions **and brain drain**. Shortages...of midwives and nurses...**low wages** in the public sector."* | Kabakian-Khasholian T, and Ali A, UNFPA Assessment of Sexual and Reproductive Health Integration in Selected Arab States, The Middle East and North Africa Health Policy Forum (MENA HPF) and UNFPA ASRO, Cairo, December 2017. p.32 |
| **UNFPA Support to Integrated Services**<br>● UNFPA is supporting CAFA running many **Peer Driven Intervention** centres in Khartoum, Blue Nile, and White Nile states. These centres provide **HIV service** including counselling and testing in addition to **STI services.** | Interview, National NGO, Khartoum, 3 June 2021 |
| ● UNFPA "*has a good contribution to make*" on integration of services.<br>● UNFPA supported the development of the **integrated EmONC training manual**, which includes training for the delivery of both maternal and neonatal care services.<br>● UNFPA advocated for and supported the **development of comprehensive SRH services** including delivery services that are available at same place and concurrent with **MNH services include ANC, FP, vaccination, nutrition**, etc. | Interview, RH Team, FMoH, Khartoum, Sudan, 1 June 2021 |
| **Service integration in Blue Nile State**<br>● **MNH and SRH services are "*well integrated*".**<br>● All women after delivery are counselled for **family planning** which is provided at a specialized centre inside the hospital.<br>● In addition, they receive guidance and information about **lactation and breast feeding**, its importance, and the best ways to do it and solve breast-feeding problems.<br>● **Vaccination** for pregnant women and newborn services are "well supplied".<br>● **Post-abortion care** services are also provided. | Interview, Referral Hospital Medical Director, Ad Damazin, Blue Nile, 7 June 2021 |
| "*We received trainings to provide **health education to new mothers** including initiation of breast feeding after delivery, the importance of family planning, newborn care, vaccination, and nutrition advice*". | Interview, Nurse-Midwife, Ad Damazin Hospital, Blue Nile State, 7 June 2021 |
| **Demand**<br>"*I have not talked to anyone yet about **family planning, healthy birth spacing, timing of births** but I am not finished here yet.*" | Interview, Community Member, Blue Nile State, 8 June 2021 |
| **Capacity-building and the provision of family planning services**<br>● 75 community **pharmacists** received training on family planning counselling<br>● 200 **midwives** received on-the-job training and orientation on provision of quality family planning services | UNFPA and GoS, 2020 Annual Progress Report - 7th Country Programme |

| **Assumption 5.2**: **Evidence-based models and approaches to support programming for integrated MNH and SRHR service delivery promoted by UNFPA are adopted and implemented by national authorities for both supply of and demand for services** | |
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| ● 7,780 **women** received family planning methods via mobile clinics<br>● 123,270 **women at reproductive age** received contraceptives. | Cycle 2018-2021, 2020, UNFPA, Khartoum, Sudan |
| **Family Planning last mile commodity distribution**:<br>● **UNFPA supported State Medical Supplies Funds** in 18 states with a total of USD 129,000 for direct distribution of commodities and lifesaving drugs.<br>● The **Reproductive Health Commodity Supply** (RHCS) Health Facility based national survey was conducted.<br>● 24 health centres and 9 hospitals received **monitoring visits.**<br>● UNFPA supported the **procurement and distribution** of 10,336 long acting and permanent methods and 935,469 short-term methods.<br>● **Counselling for family planning** done by midwives during postnatal visits as well as at other times. | UNFPA and GoS, 2020 Annual Progress Report - 7th Country Programme Cycle 2018-2021, 2020, UNFPA, Khartoum, Sudan |
| **Adolescent services**<br>● **There are no adolescent-targeted RH services in Sudan** to speak of. Some may be just starting at the level of education, but services are oriented to married women/couples. | Interview, Research/ practitioner, Khartoum, Sudan, 15 June 2021 |
| **Perceived practical integration**<br>● Services "*well integrated*".<br>● "*Midwives especially **nurse-midwives** used to counsel the patient about self-hygiene, importance of family planning, the right way of breastfeeding, vaccination of the baby, how to follow the health of her baby including provision of good nutrition*."<br>● UNFPA supports "*family planning centres and the health education training programme for **midwives***". | Focus group discussion, Nurse-midwives, Omdurman, Khartoum, 5 June 2021 |
| **Integrated approach in practice**<br>During her last ANC visit they provided **counselling services for family planning** she said, and explained the importance of healthy spacing and timing of births, and contraception; and other concerns such as HIV/STI prevention | Interview, Community member, Blue Nile State, Sudan, 7 June 2021 |
| **Complementarity among UN partners**<br>● **UNFPA and UNICEF are part of all technical committees** at national levels where all work is well lead and coordinated by the government. However, the work is complementary as UNFPA supports ANC, UNICEF supports provision of folic acid, vaccination, and nutrition services.<br>● While UNFPA supports **delivery rooms**, UNICEF provides **neonatal care service commodities**.<br>● Both organisations support the **integrated in-service midwifery training** with both RH and newborn care components. | Interview, UN Partner, 9 June 2021, Khartoum |
| **Coordination among UN partners could improve**<br>● "***UNFPA is taking the lead of GBV** and playing good role doing this and coordinating activities although sometimes UNFPA does not involve WHO in many GBV related plans and actions. However, we are looking for better collaboration and complementarity in the future*." | Interview, UN Partner, Khartoum, 3 June 2021 |
| **UNFPA supported the integration of cervical cancer screening into the health system**<br>● "*The **screening by VIA services were available** in 50 health centres and treatment services were available in 5 hospitals; however, the **COVID-19 pandemic affected the continuity of the services** during the year*" | UNFPA and GoS, 2020 Annual Progress Report - 7th Country Programme Cycle |

| **Assumption 5.2**: **Evidence-based models and approaches to support programming for integrated MNH and SRHR service delivery promoted by UNFPA are adopted and implemented by national authorities for both supply of and demand for services** | |
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| ● 531 women were screened with VIA<br>● 20 **religious leaders were sensitized** on prevention of cervical cancer in Kassala state<br>● Six **media sessions** on cervical cancer prevention and screening were broadcasted in Kassala state<br>● Supported minor **rehabilitation for the colposcopy unit** in El Saudi maternity hospital in Kassala | 2018-2021, 2020, UNFPA, Khartoum, Sudan |
| ● The [**cervical cancer] screening will be integrated into other SRH services, like FP, ANC, PNC and also EmONC.** Also, referral pathways for management of cervical cancer cases that need advanced interventions were identified.<br>● Essential cervical cancer prevention and pre-cancerous management equipment and supplies were procured and will be deployed after the HFs assessment.<br>● Procurement of some **consumables** was initiated this year and still under process. | UNFPA, Prevention of Uterine Cervical Cancer in East Sudan, 2019, UNFPA, Khartoum, Sudan |
| **Assumption 5.3: The MHTF was an effective programme to shape the overall strategic direction of UNFPA in relation to the integration of SRHR and MNH and has acted as a catalyst within UNFPA to build commitment to SRHR – MNH integration as a vital strategy** | |
| **Indicators:**<br>● Evolution over time of coordination **mechanisms within MHTF for ensuring linkages** in programming and outcomes across the four technical areas, i.e., fistula, EmONC, midwifery and MPDSR<br>● Structure and operation of **coordination mechanisms at global, regional and country** level within UNFPA for ensuring linkages between MHTF and other areas of work, i.e., SRHR/the Supplies Partnership, SGBV/gender, adolescents and youth etc. | |
| **Observations** | **Sources of Evidence** |
| **Taking steps towards integration within UNFPA itself**<br>"*Within the UNFPA CO, a decision was taken in 2019 that all the sub-units related to SRH and MNH would be better linked up. Thus, all departments, including **MNH, emergencies, RH supplies, MHTF** and so on, are **all coordinated together in a single unit within the country office** and under clearer joint leadership. This was a physical as well as structural change. Three technical coordinators now work closely on a daily basis, and this helps manage gaps. For example, they use their access to RH Kits to ensure the gaps in Sudan are covered to some extent and this is facilitated by the new integrated structure in the country office.*" | Interview, RH Team, UNFPA CO Khartoum, 17 June 2021 |
| **EmONC Network as a driver of integration during COVID-19**<br>"*The EmONC Network has served as a **platform for a range of services including comprehensive RMNCAH**. Integration has been essential to maximising the benefit of the network*." | Webinar presentation, FMoH, Khartoum, 17 June 2021 |
| **Shift integration to focus on comprehensive PHC**<br>● **There should be a greater focus by partners on integrating all basic services into PHC**. RH is just one of multiple components and it is more productive to work towards a strong system that can delivery all seven basic types of services offered by the PHC Platform (vaccination, SRH, MNH, nutrition and child growth monitoring, etc.). Family health is part of PHC. UNFPA has adopted a focus on family health in a context of PHC where 85 per cent of services are delivered to women and children. Within this there are teams delivering RH. | Interview, Leadership, UNFPA CO, Khartoum, 9 June 2021 |

| Assumption 5.3: The MHTF was an effective programme to shape the overall strategic direction of UNFPA in relation to the integration of SRHR and MNH and has acted as a catalyst within UNFPA to build commitment to SRHR – MNH integration as a vital strategy | |
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| • **The PHC approach also allows for the adoption of a psycho-social health care approach**. A holistic approach enables UNFPA to take a wide-ranging perspective. Maternal and newborn health is affected/underpinned by a range of harmful practices including FGM and adolescent pregnancy, women's empowerment and so on.<br>• **UNFPA works across its programme to address FGM**, for example, taking a wide view of its integration. So, the question of integrating SRH and MNH at the policy, planning and delivery levels misses the larger, more important goal of supporting partner countries to deliver a comprehensive, strong, quality primary health service. | |

| Area of Investigation 6: Equitable and accountable access | |
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| **Evaluation Question 6: To what extent has the MHTF contributed to strengthening the availability and quality of health service delivery and health information system to meet the diverse and differentiated needs of the women, newborns, and adolescent girls including in the lowest wealth quintiles, living in hard-to-reach areas, facing discrimination (based on identity, ethnicity, and/or faith) and/or living with disabilities?** | |
| **Sub-questions:**<br>a) To what extent has UNFPA been effective in **promoting and supporting national strategies and programmes**, which consider the diverse and differentiated needs of women, newborns and adolescent girls, including the most vulnerable and disadvantaged?<br>b) To what extent have national governments responded positively to UNFPA advocacy and technical support by **allocating resources, altering policies, and implementing programmes that strengthen the supply and demand sides of care, ensure equitable and accountable access to quality MNH and SRHR services** and that meet the needs of and empower women and adolescent girls?<br>c) Have UNFPA-supported programmes been effective **in increasing the availability and utilization of MNH and SRHR services to women, adolescents and newborns,** including the most vulnerable and disadvantaged? | |
| **Evaluation Criteria** | *Relevance, effectiveness, sustainability* |
| **Rationale** | Globally, maternal mortality is the second largest cause of deaths among **adolescent girls** aged 15 to 19. Of all births globally each year, around 16 million (11 per cent) are among girls in this age range; about 2 million are among girls under the age of 15.[35] Stigma, discrimination, judgmental treatment, lack of confidentiality, and inability to physically access services are important barriers to care for adolescent girls. The MHTF supports countries to improve access among adolescent girls to broader SRH services. Further, **poor women in rural and urban areas** and **minority women** have less access to quality maternal health care than wealthier women in urban areas. The MHTF supports their equitable access to MNH care and broader SRHR. |
| **Assumption 6.1: UNFPA promotes and supports national strategies and programmes which consider the diverse and differentiated needs of women, newborns and adolescent girls, including the most vulnerable and disadvantaged** | |
| **Indicators:** | |

[35] UNFPA (2017). Maternal and Newborn Health Thematic Fund – phase III Business Plan, p.18

| **Assumption 6.1: UNFPA promotes and supports national strategies and programmes which consider the diverse and differentiated needs of women, newborns and adolescent girls, including the most vulnerable and disadvantaged** | |
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| ● National strategies and plans support programmes and approaches that promote, assess, and address the differentiated needs of women, newborns and adolescent girls, including the most vulnerable and disadvantaged<br>● National **official statements regarding the protection of the rights** of women and girls and "leaving no one behind". | |
| **Observations** | **Sources of Evidence** |
| **An unequal burden**<br>*The findings demonstrate a very unequal burden of ill SRH across the three-selected social classifications. A summary measure of inequality in the burden of ill SRH exceeding 10% is not an exception in the Arab region across the three social classifications. For example, the inequality summary measures for the infant mortality by the geographic areas in Egypt, Morocco and Sudan reach as high as 11.4, 19.6, and 9.7 per cent, respectively.*<br><br>*…Moreover, the improvement in SRH indicators overtime did not guarantee improvement in the inequality distribution and was, in some cases accompanied by a worsening of such a distribution. This implies that **the improvement in SRH is not equally shared by all social groups**.* | Rashad H, Khadr Z, Reproductive Health Equity in the Arab Region. Cairo, 2019. p.2 |
| **Complexity of vulnerability and disadvantage**<br>● The problem in Sudan relates to the **preference for home births** that persists. The quality of care and a functional EmONC network can help shift attitudes over time, but this is a bigger problem.<br>● The **EmONC network investment** programme is about improving health outcomes and **results for women already in the care of the health facility**.<br>● Most deaths happen because of a **failure to provide care at primary level and a failure to refer**.<br>● Another line of investment is around strengthening **family planning** to incentivising women, educating women and empowering them. | Webinar presentation, Director of Primary Health Care, FMoH, Khartoum, 17 June 2021 |
| **Delivering services to marginalized groups**<br>● *I participated in a field visit to Kassala and sat in on very good discussions held with UNFPA and the health authorities at the state level. UNFPA clearly contributed and helped to build capacity and resources. But there is a **high turnover at the state ministry and in the hospitals** which is a big problem. They have to keep stopping and starting. I can say that when I am sitting with them in the field, they tried to integrate a full package of SRHR. They really do that but in Sudan, they do not have the full scope to do that because of legal and cultural issues*.<br>● **UNFPA "*has to be very sensitive all the time*".** There are rights that are not granted fully to women and girls. All the time one needs to think "*how far can I push in this environment, with these women, in this setting*". For example – UNFPA is the only organization to support prostitutes/sex workers with health care. Also, the way to discuss LGBT rights requires sensitivity and care. Women working on the streets with condoms and health care. UNFPA takes a medical view, a system's view and "*that sees them through*" in the sense that this approach enables UNFPA to raise difficult issues in a wide range of contexts. | Interview, Partner to UNFPA Sudan, Khartoum, 10 June 2021 |
| **UNFPA juggles a range of exogenous challenges and events** | UNFPA and GoS, 2020 Annual Progress Report - |

| **Assumption 6.1: UNFPA promotes and supports national strategies and programmes which consider the diverse and differentiated needs of women, newborns and adolescent girls, including the most vulnerable and disadvantaged** | |
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| ● **Accessibility** – **conflicts and civil unrest** in certain areas had its impact on programme implementation and achievement of expected results<br>● **Economic** – unstable exchange rate, increased market prices and shortage of fuel were major constraining factors for timely implementation. | 7th Country Programme Cycle 2018-2021, 2020, UNFPA, Khartoum, Sudan |
| **Early engagement delivers better results for the disadvantaged**<br>Early engagement in the response to different types of **emergencies including floods, haemorrhagic fever, local conflicts, and influx of Ethiopian refugees** helps in addressing the needs of women of reproductive age and facilitate their access to services. | UNFPA and GoS, 2020 Annual Progress Report - 7th Country Program Cycle 2018-2021, 2020, UNFPA, Khartoum, Sudan |
| **Assumption 6.2: UNFPA advocacy and technical support to national authorities focuses on the need to increase allocation of resources, adopt favourable policies, and strengthen accountability mechanisms to ensure equitable access to quality MNH and SRHR services that meet the needs of and empower women and adolescent girls, including the most vulnerable and disadvantaged** | |
| **Indicators:**<br>● Changes over time in national strategies and plans that **reflect increased attention to the differentiated needs** of women, newborns and adolescents, including in the four technical MHTF focal areas<br>● Shifts and increases in **financial allocations and expenditures** to address needs of women, newborns and adolescents, including the vulnerable and disadvantaged<br>● Use of disaggregated data by health information systems to track equity in access to MNH and SRHR services, in particular **EmONC and fistula care**<br>● Views of national, district and community stakeholders regarding **equitable access to MNH and SRHR services** for women, newborns and adolescent girls, including the most vulnerable and disadvantaged<br>● Examples and results from UNFPA-supported programmes to **strengthen supply and demand sides of MNH and SRHR care** and empower women and adolescent girls. | |
| **Observations** | **Sources of Evidence** |
| Quality improvement is needed to encourage women to attend public health services especially for deliveries. **"The concept of respectful maternity care is *"completely absent"*.** EmONC aimed at addressing trust and quality. | Webinar presentation, FMoH, Khartoum, 17 June 2021 |
| **Low demand; lack of trust**<br>● **Low demand for services:** Community itself has low level of demand. | Interview, Research/ practitioner, Khartoum, Sudan, 15 June 2021 |
| **Communication insufficient**<br>● What needs to be discussed in Sudan is **why do women give birth at home?**<br>● No behaviour change or campaigns to explain to women why to attend at a clinic. **People don't trust the health system.** But there do not seem to be campaigns to change this or a focus on the rights of patients to quality care or dignity.<br>● The situation in Sudan is difficult; **few referral services** and women give birth at home.<br>● UNFPA does relevant work. "*I believe they do try to focus on the most targeted and needed tasks including for **vulnerable women.***" | Interview, Partner to UNFPA Sudan, Khartoum, June 10 2021 |

| **Assumption 6.2: UNFPA advocacy and technical support to national authorities focuses on the need to increase allocation of resources, adopt favourable policies, and strengthen accountability mechanisms to ensure equitable access to quality MNH and SRHR services that meet the needs of and empower women and adolescent girls, including the most vulnerable and disadvantaged** | |
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| ● But **there are so few services**, the majority of women need access and equity and coverage. | |
| ● Given the **challenges related to quality of care** and efforts to create a "respect for the patient" culture in Sudan (FMoH quotation), what are the ways UNFPA can best support progress?<br>● "We are far behind this concept in Sudan. Considerable and sustained efforts are needed to work on this. This is a long-term investment. But we need to start now as this investment needs a long time." | Comments, RH team, UNFPA CO, Khartoum, Sudan, 23 June 2021 |
| **The non-state sectors**<br>*"The research and non-state sectors need to move from advocacy to recommendations of concrete actions. These sectors should move from just understanding what causes the inequalities in SRH to how to address them."* | Rashad H, Khadr Z, Reproductive Health Equity in the Arab Region. Cairo, 2019 |
| **Some services for vulnerable are progressing**<br>● **Youth engagement in SRH/COVID-19 awareness campaigns** ensured that SRH/COVID-19 response plans are sensitive and responsive to youth-specific needs and expectations. | UNFPA and GoS, 2020 Annual Progress Report - 7th Country Programme Cycle 2018-2021, UNFPA, Khartoum, Sudan, 2020 |
| ● **Monitoring through direct regular supervision** and regular meetings with heads of units. The hospital has also made a committee for regular assessment of the work and planning in order to address the needs and fill the gaps. There has been some improvement in services delivery with regards to sustainability, quality and outcomes. | Interview, Referral Hospital Medical Director, Sudan, 5 June 2021 |
| **Barriers to reaching the most vulnerable**<br>● **Shortage of health workers**, low level of **drug supply** and **family planning commodities**, especially those covered by national health insurance (free of charge).<br>● **No place for 24-hour admission** of patients or those who need special care for 24-hour care.<br>● **Clean Delivery Kits are not regularly available** although demand remains high. | Interview, PHC Service Provider, Blue Nile State, Sudan, 7 June 2021 |
| **Vulnerability of fistula survivors**<br>● **Survivors of obstetric fistula in Sudan are overwhelmed with the social and economic instability** for decades. Darfur traditionally had the largest numbers of fistula cases in Sudan followed by Blue Nile and Kordofan, due to the combination of lack of access to even basic delivery care as well as early marriage and childbearing this has been further exacerbated by lack of access to services due to insecurity during the height of the armed conflict.<br>● The current obstetric fistula data reported by all the Darfur State Ministries of Health showed that near to 366 **fistula survivors "*are waiting for surgical repair* *and we expect that more cases are not discovered yet.*"** | UNFPA, Overview Obstetric Fistula in Sudan, 2018, UNFPA, Khartoum, Sudan. p.1 |
| **Improving quality needs resources**<br>● To improve the service, we are in bad **need of neonatal care capacity building** for health providers including doctors and nurses<br>● **Rehabilitation of the health facilities** especially the building as the condition worsens every rainy season<br>● **Need more training, recruitment, and retention of the midwives** due to a high rate of turnover. | Interview, SMoH, Ad Damazin, Blue Nile, Sudan, 7 June 2021 |

| **Assumption 6.2: UNFPA advocacy and technical support to national authorities focuses on the need to increase allocation of resources, adopt favourable policies, and strengthen accountability mechanisms to ensure equitable access to quality MNH and SRHR services that meet the needs of and empower women and adolescent girls, including the most vulnerable and disadvantaged** | |
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| ● Referral of cases: the hospital has **no ambulance.** | |

| **Assumption 6.3**: **UNFPA MHTF inputs are directed toward increased availability and utilization of MNH and SRHR services to women, adolescents and newborns, including the most vulnerable and disadvantaged** | |
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| **Indicator:**<br>● Trends in data on MNH and SRHR service utilization, disaggregated by age, ethnicity, wealth, geography, and other available indicators[36] | |
| **Observations** | **Sources of Evidence** |
| **MHTF investments**<br>● Most **supplies are provided under other programmes** including commodities under the UNFPA Supplies Programme and RH kits and midwifery kits under different humanitarian funding streams such as the Central Emergency Response Fund.<br>● Sudan has a range of complex humanitarian settings such that it received **humanitarian support** in each of 2018, 2019, 2020 and 2021. | Interview, RH Team, UNFPA CO Khartoum, 17 June 2021 |
| **Politics and equality**<br>● "***Women's rights*** *are part of the political game and there is a need for keeping the political balance and that affects the government and its decisions*"<br>● UNFPA understands and is sensitive to the fact that there are political, policy, systems, socio-economic, cultural and other factors that affect how vulnerable and marginalised groups access basic services. **They can do some things but not all things.** | Interview, Partner to UNFPA Sudan, Khartoum. 7 June 2021 |
| **Governance impacts equity even with UNFPA support**<br>● UNFPA supported partners face **challenges delivering integrated RH services to rural or harder to access places** due to weak coordination between localities and state authorities, and between different directorates within the SMoH. | Interview, National NGO, Khartoum, 3 June 2021 |
| **UNFPA funds mobile services for outreach**<br>● We mobilize **mobile clinic** for outreach areas providing both antenatal and family planning and other services and have stepped up support to midwifery cadres to perform safe delivery to COVID-19 patients. | Interview, Director, National NGO, Khartoum, 3 June 2021 |
| ● UNFPA supports provision of **PHC services through mobile clinics** especially to humanitarian areas and refugee camps service **includes GBV services.** | UNFPA Group Meeting, 5 June 2021, Khartoum |
| **UNFPA supports HIV services for adolescents and vulnerable women**<br>● UNFPA mainly support CAFA to work in the area of HIV, including **community awareness, youth engagement, capacity building for health workers** especially on performing safe delivery for HIV positive women, awareness of vertical transmission of HIV and support to many Peer Driven Intervention Centres. Providing HIV and STI services. Centres are mainly located in Khartoum, Blue Nile and White Nile states. | Interview, Director, National NGO, Khartoum, 3 June 2021 |

[36] Given the COVID-19 pandemic, it is unlikely that data will be available for 2020; however, anecdotal information may be useful here to capture the implications of COVID-19 for maternal care.

| **Assumption 6.3**: **UNFPA MHTF inputs are directed toward increased availability and utilization of MNH and SRHR services to women, adolescents and newborns, including the most vulnerable and disadvantaged** | |
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| **Low demand for services a hindrance**<br>● **The community itself has a low level of demand**. Preference is for home delivery as "*they believe it is less expensive and there may be **issues of quality and trust***". Community health midwives deliver these babies and in Blue Nile they are much more often untrained birth attendants working in the community. For example, in 42 areas, services are provided by **untrained midwives (unskilled birth attendants)** who have not had even the basic training that was suspended some years ago. | Interview, Director of MNH Services, SMoH, Blue Nile, Sudan, 8 June 2021 |
| **UNFPA, including MHTF, supports complex setting in Sudan**<br>● **UNFPA is highly valued and much appreciated in Sudan** where needs are high, resources limited and as a result of the context, **much of the support is directed to refugees and humanitarian needs** rather than delivery of essential health services through normal channels. | Interview, RH Coordinator, FMoH, Khartoum, Sudan, 1 June 2021 |
| **Geography and roads affect access**<br>● It was not easy at all to get to the clinic considering the **lack of available transport and the high cost of transportation.** | Interview, Community member, Blue Nile State, 8 June 2021 |
| **Lessons learned to increase access and utilization in emergencies**<br>● Early engagement in the response to different types of **emergencies including floods, haemorrhagic fever, local conflicts and influx of Ethiopian refugees** helps in addressing the needs of women in reproductive age and facilitate their access to services. | UNFPA and GoS, 2020 Annual Progress Report - 7th Country Programme Cycle 2018-2021, 2020, UNFPA, Khartoum, Sudan |
| **The MPDSR-linked research identifies where equity falls short**<br>● Although **magnesium sulphate** is now available in most of the states, it is not well utilized for treatment and prevention of severe pre-eclampsia and eclampsia in most of the states, 70 per cent received magnesium sulphate in this report.<br>● Although **since 2015, midwives have been authorized to use magnesium sulphate and uterotonics under supervision** for reducing maternal mortality from obstetric haemorrhage and hypertensive disorders, implementation of this policy is **still limited to two pilot states** and the results have not yet been disseminated or implemented across other states.<br>● The evidence has shown that the **availability of trained midwives had the highest protective effect on maternal death** reducing case fatality by 80 per cent. | UNFPA, Maternal Death Surveillance and Response Report, 2018, UNFPA Khartoum, Sudan. p.8 |
| **UNFPA, including through MHTF, directs resources to reducing harmful practices:**<br>● Providing of **family planning, skilled birth, lifesaving services** at birth<br>● **Reducing the harmful traditional practices**, particularly FGM | Maternal Death Surveillance and Response Report, 2019, Khartoum, Sudan. p.7 |

| Area of Investigation 7: Catalytic role | |
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| **Evaluation Question 7: To what extent has the MHTF fulfilled its catalytic role enabling UNFPA to 'punch above its weight' in support of MNH outcomes and integration with SRHR?** | |
| **Sub-questions:**<br>a) To what extent has UNFPA used the MHTF as a vehicle to **play a broker role for the promotion of MNH** and wellbeing in high MMR countries, improving coordination and partnerships, leveraging more funding from both international and national sources, and providing effective strategic direction, technical assistance, and capacity building through country-driven interventions?<br>b) To what extent has the MHTF leverages a range of **discernible, tangible, and practical results**, including political commitments and policy support and financial commitments and investments?<br>c) To what extent has global and regional technical support from UNFPA supported country teams and national health authorities through strengthening reliable data and information collected through monitoring and review, stimulating knowledge sharing approaches, and **identifying, scaling-up or replicating innovation** and good practices within and between countries? | |
| **Evaluation Criteria** | *Relevance, efficiency, coordination* |
| **Rationale** | Catalytic is defined as an agent that provokes or speeds significant action. In this evaluation, catalytic actions are those that are assessed to provoke or accelerate relevant change or progress. A catalytic role is therefore one that identifies, promotes and advances those actions. There is an implied counterfactual which is that without the catalytic investment, significant change would not have occurred or would have occurred only very slowly. Given its wide scope, its relatively low resource envelope, its commitment to sustainability, equity, human rights and gender equality, the MHTF gains more traction and achieves better results if it concentrates its effort on catalytic investments and actions, playing a broker role within UNFPA and with external partners, and sparking political, programmatic and financing commitment beyond its own investments. Catalytic support includes using the UNFPA mandate to good effect, focusing on its role to strengthen partnerships, coordination, strategy and capacity building, and extending innovation through knowledge management strategies including the identification of best practices. |
| **Assumption 7.1: The MHTF is an effective vehicle to play a broker role both internally within UNFPA and externally with programme countries and other partners at global, regional, and national levels for the promotion of MNH in high MMR countries through its comparative advantage to coordinate, build partnerships, leverage funding** | |
| **Indicators:**<br>● MHTF engagement in or support to strategy, policy and planning development especially involving other partners and players to **forge partnerships and negotiate coordinated approaches** and strategies including the allocation of roles and responsibilities<br>● Examples of UNFPA convening partners to assist with the development of **costed maternal health approaches and strategies** including national plans<br>● Examples of UNFPA leadership or coordinated working with other country level partners to provide effective **strategic direction, technical assistance, and capacity building** through country-driven interventions<br>● Examples of MHTF support to UNFPA intervention to bring partners together around **plans, ideas, proposals, strategies** in ways they otherwise would not have and to allocate additional resources, focus, effort to these | |

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| ● Specific examples of how MHTF at global level or through support to UNFPA CO efforts at country level helped negotiate the **involvement of new partners, increased resources, better approaches**, or innovations to support/fund MNH at any level (global, regional or country)<br>● Clear definition of the **role and approach of UNFPA to working with SDG3 GAP agencies** at country level especially on MNR related activities and plans. | |
| **Observations** | **Sources of Evidence** |
| **Coordination among UN and other partners in emergencies**<br>● UNFPA was actively engaged in national and state level **emergency preparedness and response coordination** platform, including the health cluster.<br>● **SRHR is a standing agenda in the health cluster**, and it is chaired by UNFPA.<br>● The role enables UNFPA **to promote SRHR across emergency and humanitarian coordination** processes.<br>● Thus, **primary health care** departments and relevant counterparts are encouraged to reflect and promote the provision of essential SRHR services. | UNFPA, COVID-19 impact on SRH services and maternal health, 2020, UNFPA, Khartoum, Sudan |
| **Coordination with NGO partners**<br>● UNFPA is widely acknowledged as **the main partner of the FMoH** in RH.<br>● FMoH challenged to address the real needs given the scale but the **lack of coordination in all levels** compounds this.<br>● Sometimes **UNFPA works with NGOs "away" from the government**. The Ministry doesn't have visibility of where NGOs are working which impacts on efforts to do a real needs assessment.<br>● Better for UNFPA to be more open about their needs assessment and to involve FMoH more on understanding the **needs across the different partners**. | Interview, RH and MNH Teams, FMoH, Khartoum, Sudan, 1 June 2021 |
| **A step change in coordination since 2019**<br>● UNFPA is currently re-shaping the position it plays on coordination in Sudan. "*Cannot say there was no coordination under the previous government – level of acceptance of coordination was not much though under the old government. The **new government leadership is much more open to support from donors** and their engagement with coordination*." Four specific coordination processes currently underway:<br><br>**a. SRHR coordination forum**<br>UNFPA pushing the government to take the lead in re-establishing the Reproductive Health Forum. UNFPA motivated to re-launch an old SRHR coordination forum: UN Agencies, NGOs and others working on SRHR would all join. Early days but seems like it will be reactivated and start to work.<br><br>**b. RH Standing Agenda**<br>Under UNFPA leadership and takes place within the context of the overarching health cluster which is led by WHO. Active since last year. UNFPA 'moderates' the agenda but humanitarian cluster is under WHO. There are also humanitarian working groups in certain states, and UNFPA has been able to lead SRH sub-groups there as well (Darfur etc.). | Interview, UNFPA CO, Khartoum, Sudan, 23 June 2021 |

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| **c. MOU with H6 partners**<br>In discussion with WHO and already signed with UNICEF UNFPA is negotiating a MoU to strengthen coordination matters around SRH including child marriage, FGM, GBV etc. with key H6 partners. Might also then look for triple agency coordination (UNFPA, WHO, UNICEF). UNFPA actively promoting MoU negotiation.<br><br>**d. Tripartite MOU with UN Partners**<br>Launching an UN-wide process to integrate SRH into all elements of programming. Establishing a cross-UN coordination platform to address SRH in the widest sense. This would be done in the context of the full SRMNCH agenda not just SRH though.<br><br>**e. Global Ending Preventable Maternal Mortality Initiative** (EPMM Initiative) in Sudan<br>UNFPA requested recently to be the respondent on this global process for Sudan. The request is to develop and submit a report to the global initiative from the platform in Sudan. Not yet active but will require coordination and communication with other partners. | |
| **Coordination**<br>● Although there is an MOU between the two organisations, **most of the joint work is lead and coordinated by the government through technical committees** rather than direct coordination between the two organisations. However, **UNFPA has the "*catalytic role* *supporting the RH programme*"**. | Interview, UN Partner, Khartoum, 9 June 2021, |
| ● **UNFPA and WHO** together were part of the technical committee, jointly supported the FMoH developing policies, EmONC training manual, post abortion care guidelines and capacity building programmes.<br>● **UNFPA is taking the lead of GBV** sector and playing good role doing this and coordinating activities although need more coordination and involvement of WHO.<br>● However, we are looking for better collaboration and complementarity in the future. | Interview, UN Partner, Khartoum, 3 June 2021 |
| **Coordination across partnership for integration of a new area**<br>● A policy brief document on **cervical cancer** was developed and endorsed by FMoH. The document recommends adoption of screening and awareness raising as main interventions of cervical cancer prevention. It also supports the adoption of VIA for the cancer screening and to be implemented at PHC level by PHC care providers who will be trained on this procedure.<br>● Coordination between stakeholders. A **national technical committee for cervical cancer** programme was formulated by the General Directorate of PHC at FMoH to oversee the programme development and follow up.<br>● This committee was formulated from representatives of partners (UN agencies, academic institutions, Donors, Technical individuals and NGOs). The committee oversaw the development process of the policy brief, the situation analysis, the development of national protocols and the training manuals and guidelines. | UNFPA, Prevention of Uterine Cervical Cancer in East Sudan, 2019, UNFPA, Khartoum, Sudan |
| Table below<br>**Technical coordination groups attended/supported by UNFPA** | |

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| Name of the group | Group Chair | Members | Frequency of meetings |
|---|---|---|---|
| EmONC National Committee | PHC Director – FMoH | Representatives of stakeholders; Directors of relevant Departments at FMoH; UN agencies (UNFPA, UNICEF, WHO, …); Obstetrics and Gynaecology Society; Paediatricians Society | Every two weeks (for specific tasks until accomplishment) |
| Midwifery Committee | Co-chairs: SRH Director FMoH and Dean, Academy of Health Sciences | UNFPA, UNICEF, WHO, Departments of Training, Midwifery and Nursing Council, Midwifery Association representative. | Not regular. |
| Fistula National Task Force | Undersecretary of FMoH | UNFPA, UNICEF, WHO, SRH Department, Curative Medicine Department, Donors, Obstetrics and Gynaecology Society, | Biannual |
| National Technical Committee for Cervical Cancer | MCH Director | UNFPA, UNICEF, WHO, SRH Department, Curative Medicine Department, Donors, Obstetrics and Gynaecology Society, | Quarterly |
| MDSR National Committee | Undersecretary of FMoH | UNFPA, UNICEF, WHO, SRH Department, Curative Medicine Department, Obstetrics and Gynaecology Society, | Biannual |

UNFPA, List of Maternal Health Functioning Technical Working Groups in Sudan, Khartoum, 2020

**Advocacy, partnership and coordination**

- These three elements need to be included. Not just about how to use the resources at country level.
- **Question about whether the coordination at global and regional level is being done**. Given the limited funding, identification of strategic interventions and they approve it.
- However, MHTF as MHTF – are they doing the coordination and partnership and advocacy at higher level not just at country level?

Interview, UNFPA CO, Khartoum, Sudan, 23 June 2021

- A **change has occurred since the revolution in 2019** and there is more openness to changing laws, implementing laws designed to protect the reproductive rights of women and girls. **But progress is "*lumpy*".** Things move forward and then there is a backlash. Then they move forward again.

Interview, UNFPA Partner, Khartoum, 13 June 2021

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| **Assumption 7.1: The MHTF is an effective vehicle to play a broker role both internally within UNFPA and externally with programme countries and other partners at global, regional, and national levels for the promotion of MNH in high MMR countries through its comparative advantage to coordinate, build partnerships, leverage funding** | |
| ● Political negotiation between Islamic powers and the civilian government sometimes come into it: tradition vs. new powers. The government is "*not taking all steps – they take some steps but not all*". It is a new government still and facing many challenges. | |
| **Need to step up coordination**<br>● The EmONC Network mapping process was "*a huge exercise*" using a scientific approach with population and geography and roads all considered as well as other objective factors. It was an important step forward to building a systems strengthening process and very meaningful as a contribution to the delivery of services for maternal health.<br>● There are many dimensions to it, and they have found ways to enhance the **use of the EmONC network** even further. It does and will continue to help the country to strategize other investments.<br>● But now, in addition to EmONC, **UNFPA needs to strengthen more advocacy for multi-level coordination**. Others are sometimes the coordinators because UNFPA is not always there. Optimise maternal health interventions to maximise the value of Partnership. | Interview, UNFPA CO, Khartoum, Sudan, 23 June 2021 |
| **Sustained commitment leverages support from partners**<br>● UNFPA funded a technical position to support **the coordination of MPDSR**. A Technical Working Group meets regularly, and all interested/engaged partners are there. One role of the Technical Working Group is to discuss the use of resources to support the advancement of MPDSR (including consultants and their work).<br>● The **quality of the identified technical staff** are not always what they should be to ensure maximum effectiveness and impact of the programme. In this case, the Technical Working Group, chaired by FMoH, will decide to terminate a contract and seek other candidates.<br>● This has happened once, "t*hat person and the system under them were not running in an efficient way*". A new consultant was brought on board, agreed by the whole TWG. Their performance will be monitored by the Group and ultimately FMoH will decide what to do.<br>● In this example, UNFPA provides funding through the FMoH for inputs (consulting fees) that are then discussed and managed at the level of a wider group. | Interview, UNFPA CO<br>Team discussion, Khartoum, 17 June 2021 |
| **Assumption 7.2: The MHTF leverages a range of discernible, tangible, and practical results, including political commitments and policy support, and financial commitments and investments** | |
| **Indicators:**<br>● Documented and reported progress on policy processes and political commitment in partner countries<br>● Examples of increased financial commitment from other donor partners for SRHR-MNH efforts in partner countries linked to MHTF advocacy and investments<br>● Examples of trends in financial commitments in countries to MNH<br>● Examples of UNFPA technical or programmatic support to country teams and national and sub-national health authorities that were taken forward by other partners<br>● Assessed **technical quality** of UNFPA assistance as reported by health authorities and partners<br>● **Relevance of UNFPA technical assistance** as reported by health authorities, practitioners and implementing partners<br>● Examples of UNFPA engagement in **capacity building,** which is sustained, relevant and meaningful in monitoring, research, review and knowledge management | |

| **Assumption 7.2: The MHTF leverages a range of <u>discernible, tangible, and practical results</u>, including political commitments and policy support, and financial commitments and investments** | |
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| ● Examples of UNFPA at country level building momentum and supporting **tangible policy and programming changes.** | |
| **Observations** | **Sources of Evidence** |
| **Bringing other partners into successful programmes**<br>● **EmONC and MPDSR** are both programmes started firstly with full support from UNFPA only.<br>● With progress in those programmes and increased needs for the support, **other partners** including UNICEF, WHO and others contributed and **became increasingly involved** (although in many cases on a technical level not as funders). | Interview, Research/ practitioner, Khartoum, Sudan, 15 June 2021 |
| ● RH Director said this: MDSR programme – about 8 years ago, when the FMoH started the programme, it was MDR (just women), and only supported by UNFPA. As the programme showed results, it became **MPDSR it expanded to other donors UNICEF and WHO.** | RH Director, FMoH, Khartoum, Sudan, 1 June 2021 |
| ● **UNFPA funding is "*playing a catalytic role* *supporting CAFA to raise fund from other donors"***. CAFA uses funds from UNFPA to demonstrate their capabilities and raise additional funds to extend remit and geography. | Interview, National NGO, Khartoum, 3 June 2021 |
| **UNFPA support to the midwifery Gap Analysis kicks off a multi-faceted, multi-year process**<br>● **Strengthening the midwifery workforce** is a key strategic action for reducing maternal and newborn mortality, according to Sudan's Ten in Five Strategy for SRMNAH. The ICM was invited to facilitate a gap analysis process between October 2017 and August 2018.<br>● Through a **systematic gap analysis process** to evaluate the current midwifery education, regulation and association development in Sudan, ICM was able to establish what the gap is between the current status of midwifery and what is required to scale up a skilled, professional midwifery workforce in Sudan.<br>● The gap analysis approach creates an **evidence-based platform for policy decision-making** and provides focus on areas for investment as countries develop strategies for strengthening midwifery.<br>● A **workshop to disseminate the results** was conducted from 5 – 9 August 2018 in the Rotana Al Salam Hotel in Khartoum. | UNFPA, ICM, MoH, Sudan Midwifery Gap Analysis, 2018, UNFPA, Khartoum, Sudan. p.47 |
| **UNFPA support to the EmONC Network process has been an innovation**<br>● EmONC Network – plan made by UNFPA and FMoH to do an assessment of the network. Good results were achieved, and the **concept and practicality of the network attracted attention**. It was a scientific approach and considered important factors like roads, transport routes, geography and where people actually lived so this created a realistic and workable result in terms of identifying referral networks. The results were sound and there was a lot we could do with it.<br>● As the assessment progressed, need of more funds was clear and **funds were raised from other organisations** including WHO, UNICEF who started to contribute once they saw the progress made. More partners have become engaged in this programme, including the African Development Bank.<br>● The EmONC network continues to exist and is being strengthened currently. There is a process in place now to start the **quality improvement and monitoring**. The FMoH is still working on this, "*we are still working on the network…we are reassessing health centres for the network and to assess the gaps that need to be addressed*". | Interview, RH Team, Interview, RH Team, FMoH, Khartoum, Sudan, 1 June 2021 |

| **Assumption 7.2: The MHTF leverages a range of <u>discernible, tangible, and practical results</u>, including political commitments and policy support, and financial commitments and investments** | |
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| ● In process, a number of technical issues and reassessing needs of selected health facilities and how to cover these needs. No detailed information about the health facilities they selected. "*According to what I heard*", there is no plan yet for intervention and assessing these needs. Still planning and re-planning. Already started EmONC support team. **Assessment and supervision of EmONC needs** – each state in Sudan should have a team. The manual for the training of this team is developed and UNFPA trained one team originally. The FMoH and UNFPA have since worked together to refine the training and teams for other states are scheduled to be trained. The teams will then assess all the facilities in the network in their states. A monitoring process will be put in place. | |
| ● "*It is **obviously catalytic**, for example, **the EmONC and MPDSR** are both programmes started firstly with full support from UNFPA only. With the huge progress in those programmes and increased needs for the support, other partners including UNICEF, WHO and others contributed and strongly involved."* | Interview, UN Partner, 9 June 2021, Khartoum |
| ● The links between the **Humanitarian – Development – Peace nexus offer opportunities to be catalytic**. For example, channelling resources for infrastructure renovation/revitalisation to those facilities prioritised in the EmONC network would be one example; Using RH kits to help close gaps in the availability of supplies is another. | Interview, Leadership, UNFPA CO, Khartoum, 17 June 2021 |
| **Operational innovation: flexible and mobile surgical capacity**<br>● In Blue Nile State, the ministry of health faces difficulties in implementing **fistula treatment campaign** due to the health condition of the trained surgeon. UNFPA CO in coordination with sub offices in Blue Nile and North Darfur states managed to coordinate with Alasher fistula centre [where the roaming surgical teams are based] and make the necessary arrangement to bring two fistula surgeons to conduct the campaign in Blue Nile state. The outcome of that is that 23 fistula cases were operated.<br>● Thus, the aim to build **flexible fistula surgical capacity** – a very specific skill set – was put into practice such that the surgical team could move around to do batches of fistula surgery without each district having to have its own (scarce) surgery team. | UNFPA, 2020 template for MHTF reporting, 2020, UNFPA, Khartoum, Sudan |
| **Digital technology only takes one so far though**<br>● The **use of mobile phones by community midwives** with the view of enhancing the Reproductive Health's Information System in White Nile State, Sudan.<br>● The idea of granting mobile phones to community midwives emerged at a joint meeting between UNFPA, Kosti and its government counterpart back in 2011. The intention was to resolve the communication problem between community midwives and their supervisors in different districts and hence augment reporting of maternal mortality in White Nile State. The conclusion reached at that meeting was to provide persons involved in the investigation of maternal deaths with **mobile phones to help them carry out their job** in an efficient manner.<br>● Community midwives issued with mobile phones **ran into a range of technological problems**: in remote villages they had to send their mobiles to the nearest village with electricity service to charge them which could take days. Credit ran out and was not replaced on time. Phones became a valuable resource for the whole village. Because of this, on numerous occasions supervisors could not reach their midwives. Many midwives also experienced problems related to poor network coverage. All in all, although useful, this is **an example of technology not solving the original problem** fully and actually creating many more. | UNFPA, Summary report on the use of mobile phones, UNFPA, Khartoum, 2017, Sudan |

| **Assumption 7.2: The MHTF leverages a range of discernible, tangible, and practical results, including political commitments and policy support, and financial commitments and investments** | |
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| **Innovations are not always successful**<br>● The use of mobile **ambulance vehicles (modelled on the tuk-tuk)** has been distributed in Sudan. One vehicle was handed to an NGO in Blue Nile State to aid with the transportation of women to hospital. The tuk-tuk ambulance will be managed by a committee of 11 (representing a number of women's groups) who are also responsible for the costs of running the ambulance.<br>● The tuk-tuk ambulance **has not yet been deployed** (although it was handed over in March 2021) as a result of some unspecified **legal and logistical challenges**.<br>● But **the terrain is not suited to motorcycles** and the weather in the rainy season will make roads impassable in anything less than a sturdy 4x4. Evidence is limited, but in this case a single tuk-tuk offered by UNFPA may not be the solution needed to transportation challenges (which clients and midwives both referenced as a challenge). | Interview, CSO Partner, Blue Nile State, Sudan 7 June 2021 |
| **Assumption 7.3: Global and regional technical support from UNFPA fostered, identified, and scaled-up innovation and good practices within and between countries** | |
| **Indicators:**<br>● Documented and reported progress by UNFPA in developing and implementing a **knowledge sharing strategy** and approach that was systematically disseminated at global and regional levels<br>● Examples of regional level knowledge sharing, **identification of innovations** and good practices<br>● Examples of UNFPA approaches to **gathering evidence about best practices and developing ideas and strategies** to take these to new countries or settings<br>● Examples of UNFPA support to better monitoring and review and to **more knowledge sharing** among country teams and national and sub-national health authorities<br>● Reported timeliness of UNFPA **technical assistance**<br>● Assessed **technical quality** of UNFPA assistance as reported by health authorities and partners<br>● **Relevance of UNFPA technical assistance** as reported by health authorities, practitioners and implementing partners<br>● Examples of UNFPA engagement in **capacity building,** which is sustained, relevant and meaningful in monitoring, research, review and knowledge management<br>● Examples of UNFPA at global and regional level building momentum and supporting **sustained roll out of innovation or best practices**<br>● Examples of knowledge development, management, and communication especially around **good practices in the MHTF programme.** | |
| **Observations** | **Sources of Evidence** |
| **Catalytic investments**<br>● Three **examples of genuinely catalytic investment** are offered.<br>● (i) Strategic guidance of the MHTF around **the EmONC assessment**. This was a good example of funds being used to provide evidence and strategic orientation for the future of the programme which lies at the heart of the mandate of UNFPA. MHTF investment enabled training and mobilization of capacity in the system and the country to generate evidence. The resulting evidence enabled the mobilization of partners including the country government to do more on MNH through EmONC because it identified a clear pathway for something specific to be done and then set out the steps to get there. The EmONC network, now reaching a point of operability, influences resource allocation decisions and helps improve value for money. | Interview, RH team, UNFPA CO, Khartoum, Sudan, 23 June 2021 |

| Assumption 7.3: Global and regional technical support from UNFPA fostered, identified, and scaled-up innovation and good practices within and between countries | |
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| ● (ii) More than this, however, the **identification of the EmONC network** – ostensibly to improve MNH outcomes – has already served additional needs. For example, following the floods of 2020, more than USD 4 million was made available to UNFPA Sudan to support the rehabilitation of health infrastructure in affected states. Because the EmONC Network development process had clearly identified agreed referral facilities at BEmONC and CEmONC level, rehabilitation was directed to these facilities first and the resources were used to acquire equipment and furniture and specialist facilities (theatre, sluice, etc) needed to raise the quality of services at these facilities.<br>● (iii) in a separate example, MHTF engagement in **advocating for and supporting the development of a fistula strategy** resulted in a widened scope of interventions beyond just repair to include prevention and recovery and reintegration. Other funding was mobilised to widen coverage – 30% of all repairs are financed now by MHTF but the rest are financed by others including FMoH itself and other resources made available from the UNFPA CO budget. | |
| **MDR became the MDSR and is now the MPDSR**<br>● The long history of **UNFPA support to maternal death notification and review** suggests that it has attracted other partners into the process over time.<br>● As the MPDSR has become more capable of identifying and recording maternal deaths, it **has attracted other partners** including UNICEF and WHO. | Interview and group discussion, FMoH, RH Team, Khartoum, Sudan, 1 June 2021 |

| Area of Investigation 8: MHTF governance and management | |
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| **Evaluation Question 8: To what extent have the MHTF management mechanisms and internal coordination processes contributed to the overall performance of the programme? Specifically, how have these facilitated: (i) resource mobilization for the MHTF; (ii) the breaking of silos among UNFPA programmes; (iii) the integration of MNH within country programmes; and (iv) effective oversight and guidance by the MHTF Advisory Committee?** | |
| **Sub-questions:**<br>a) To what extent has the **MHTF management mechanisms and internal coordination processes contributed to the overall performance** of the programme including through influencing the overall strategic directions and efforts of UNFPA in MNH and broader SRHR more broadly?<br>b) To what extent have MHTF management mechanisms and internal coordination processes benefitted from **effective oversight and guidance by the MHTF Advisory Committee and contributed to MHTF resource mobilization**?<br>c) To what extent have MHTF management mechanisms and internal coordination processes contributed **to breaking silos among UNFPA programmes at global and national levels including strengthening integration of MNH** within country programmes? | |
| **Evaluation Criteria** | *Effectiveness, efficiency, coordination* |
| **Rationale** | The MHTF is one of several thematic funds in UNFPA. Focused on maternal health, it is also one of the few global maternal health funds (others include the GFF) but is distinguished in part by its specific focus on four technical areas (midwifery, EmONC, MPDSR and fistula) in 32 countries. Resources are generally declining as global MNH is less prioritised in the SDGs. Coordination, management, leadership, and efficiency are critical in order to ensure the aims of the fund are met and maximum impact from available resources is realised. |

| **Assumption 8.1: MHTF management mechanisms and internal processes within the MHTF and with other UNFPA departments fostered effective and efficient coordination of programmes and prioritization of financial and human resources to deliver** | |
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| **Indicators:**<br>● MHTF programme guidance which incorporates **required adjustments/improvements in SRHR policies** and programmes communicated to other branches<br>● MHTF staff/secretariat participation in forums and meetings at global, regional and CO to develop broader SRHR policies and to integrate services<br>● MHTF results frameworks and **programme reports incorporate linkages** to SHRH policies and programmes<br>● UNFPA staff in other branches engaged in SRHR report MHTF input and **influence on policies** and programmes<br>● Minutes and report of intra-UNFPA coordinating bodies note **cross influence of MHTF and SRHR** on policies and programmes<br>● Examples of mechanisms to **support coordination, strategic direction, forward momentum, and overall performance** at global, regional and country levels<br>● **MHTF investments and activities contributed to strengthening coordination** with other UNFPA thematic programmes<br>● **COs approached thematic areas holistically, in line with countries' own systems** (integration at the country level)<br>● Examples of efforts to **integrate across the SRMNCAH agenda** at global, regional and country level<br>● MHTF support **enabled increasingly effective performance** of the programme, breaking down barriers to programmatic silos and supporting increased efficiency<br>● Examples of the MHTF role and activities in relation to **regional knowledge and management approaches.** | |
| **Observations** | **Sources of Evidence** |
| **COVID-19 led to reallocation of resources**<br>● COVID-19 had significant implications for **programme continuity**. Most of the planned activities were revised to accommodate the COVID-19 prevention. | UNFPA and GoS, 2020 Annual Progress Report - 7th Country Programme |

| **Assumption 8.1: MHTF management mechanisms and internal processes within the MHTF and with other UNFPA departments fostered effective and efficient coordination of programmes and prioritization of financial and human resources to deliver** | |
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| ● **Focus was still SRH-MNH services** despite COVID-19: increased awareness about how to deliver essential services despite the pandemic. | Cycle 2018-2021, 2020, UNFPA, Khartoum, Sudan |
| **UNFPA management valued by partners**<br>● **CAFA** had been working with UNFPA on SRHR service delivery since 2014.<br>● Working with UNFPA compared with other partners **is well coordinated with clear monitoring and evaluation plans**, they are very committed and respectful to partners.<br>● There is **some weakness in coordination** between localities and state level in addition to coordination between different directorates in the SMoH especially when conducting integrated services | Interview, National NGO, Khartoum, 3 June 2021 |
| **Flexible and responsive resources**<br>● UNFPA is different as RH is its main mandate and primary focus.<br>● **UNFPA is more flexible than many partners** and is usually able to provide technical support in a range of areas.<br>● UNFPA provides support by transferring resources to the FMoH and then we can hire our own contractors. We consult with UNFPA, but **the leadership remains with the FMoH**. | Interview, RH Team, FMoH, Khartoum, Sudan, 1 June 2021 |
| **Resources**<br>● Would like more money but **technical resources** are also resources and "*we need these as well*".<br>● Financial, human, infrastructure are the three main types of resources, but technical resources are also important and relevant. | Interview, Leadership, UNFPA CO, Khartoum, Sudan 23 June 2021 |
| **Reported facilitating factors included HQ support**<br>● **CO received strong technical guidance and facilitation** on several interventions from UNFPA HQs and from ASRO. This has been instrumental to achieving the expected outcome from the EmONC assessment and EmONC development processes.<br>● **Working closely and jointly with HQs and Regional SRH advisors** and experts enhances adoption of more strategic interventions and facilitates the adoption and implementation of results and decisions. | UNFPA, MHTF Annual Report Sudan 2018, 2019, UNFPA, Khartoum, Sudan. p.3. |
| **…but HQ also hindered progress**<br>● **Late signature of work plans** and the start of a new programme cycle delayed the start of implementation until the second quarter of the year. | UNFPA, MHTF Annual Report Sudan 2018, 2019, UNFPA, Khartoum, Sudan |
| **Country Programme outputs 2020 are articulated clearly**<br>● Output **1: Strengthened capacities of health ministries and civil society partners** at federal and priority states level to ensure access to high-quality SRH services, including in humanitarian settings<br>● Output **2: Enhanced capacities to develop and implement policies**, including financial protection mechanisms that prioritize access to information and services for SRH and reproductive rights for those furthest behind, including in humanitarian settings<br>● Output **3: Strengthened capacities to provide high-quality, integrated information and services** for family planning, comprehensive maternal health, STIs and HIV, as well as information and services that are responsive to emergencies and fragile contexts<br>● Output **4: Strengthened capacities of the health workforce**, especially those of midwives, in health management and clinical skills for high-quality and integrated SRH services, including in humanitarian settings | UNFPA, 2020 template for MHTF reporting, UNFPA, Khartoum, Sudan, 2020 |

| **Assumption 8.1: MHTF management mechanisms and internal processes within the MHTF and with other UNFPA departments fostered effective and efficient coordination of programmes and prioritization of financial and human resources to deliver** | |
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| ● Output 5: Improved domestic accountability mechanisms for SRH and reproductive rights through the involvement of communities and health-system stakeholders at all levels | |
| **Lessons learned**<br>● How processes, successes, including unexpected results and challenges inform future planning<br>● The frequent changes in MoH structure along with phasing out of the OB-GYN registrars had a significant impact on the **MDSR system** functionality<br>● Technical assistance to support MoH to restore the system must be maintained in 2021<br>● **Interventions involving field work** should start towards the beginning of the year as they require more preparations.<br>● The **delay in receiving the first tranche** late in Q1, had a significant impact on the implementation rate which was further impacted by the COVID-19 pandemic.<br>● Impact of lessons learned on the 2021 work plan<br>● Receiving the first tranche in January to enable early kick off for the activities to contribute positively to achieving the desired results. | UNFPA, 2020 template for MHTF reporting, UNFPA, Khartoum, Sudan, 2020 |
| **Resource flows interrupted**<br>● The CO ceiling was set to be USD 450,000. However, **the third disbursement was not fully received;** the CO was notified and adjusted the implementation accordingly. Loss of funds given the limited budget has impact on outcomes. | UNFPA, 2020 template for MHTF reporting, UNFPA, Khartoum, Sudan, 2020 |
| **UNFPA investment in core skills for surgeons (fistula)**<br>● Need for technical support in 2021 to improve the **capacity of midwifery associations** through experience sharing between associations at states particularly in resource mobilization and advocacy<br>● Improve the technical **capacity of staff at fistula centres** through external training and linking fistula centres with other training centres for more experience sharing<br>● **Enabled sufficient capacity to be built in Sudan**. Foreign surgeons not needed to run fistula camps as sufficient country-based teams.<br>● Needs to be continued and nurtured, however. | UNFPA, 2020 template for MHTF reporting, UNFPA, Khartoum, Sudan, 2020 |
| **Internal linkages between HQ and CO**<br>● Question from country team member: does the UNFPA CO sufficiently maximise opportunities created by the MHTF? "***MHTF is so helpful, and HQ is providing great technical support*** *through MHTF which should continue. It makes follow ups for the long term and this is what is needed for the targeted countries. It also pushes for strategic interventions. It provides opportunity for experience sharing.*"<br>● **MHTF needs more funds**, which HQ should lead on and at CO level, UNFPA needs to **capitalize on MHTF investments**. | Comments, UNFPA CO staff, Khartoum, Sudan, 23 June 2021 |
| **Challenges include:**<br>● **Weak health system**<br>● Limited **human resources** and rapid turnover, poor retention<br>● Need to strengthen the **supply chain** | Interview, RH Team, FMoH, Khartoum, Sudan, 1 June 2021 |

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| **Assumption 8.1: MHTF management mechanisms and internal processes within the MHTF and with other UNFPA departments fostered effective and efficient coordination of programmes and prioritization of financial and human resources to deliver** | |
| ● Build **community demand** for services<br>● Weak concept of **patient-centred culture.** | |
| **Some MHTF support channelled to a sub-set of states**<br>● UNFPA focused its **midwifery support on some of the States** (Kassala, North Kordofan, Gedarif, White Nile, Blue Nile, East Darfur, North Darfur, South Darfur, West Darfur, and Central Darfur). | Review of programme activities, UNFPA CO, Sudan, 22 June 2021 |
| **Other elements of MHTF support are national in scope**<br>● The **midwifery programme is mainly a national level intervention** in relation to standards, guidelines and preparation of the new curriculum. The development of the EmONC network is national in scope as well. | Review of programme activities, UNFPA CO, Sudan, 22 June 2021 |
| ● Within **UNFPA CO, in 2019, all the sub-units including MNH, Emergencies, RH Supplies, MHTF etc were all linked together into a single unit** within the CO. The three technical coordinators now work closely on a daily basis, and this helps manage gaps. For example, they use their access to RH Kits to ensure the gaps in Sudan are covered to some extent and this is facilitated by the new integrated structure in the CO. | Interview, Leadership, UNFPA CO, Khartoum, 17 June 2021 |
| **Assumption 8.2: The MHTF management mechanisms and internal coordination processes benefitted from effective oversight and guidance by the MHTF Advisory Committee and UNFPA leadership, and contributed to MHTF resource mobilization** | |
| **Indicators:**<br>● Advisory Committee role is clearly identified through **terms of reference and performance standard**<br>● Meetings and other engagement enabled the Advisory Committee to meet its terms of reference<br>● Materials distributed in the form of briefing and information sharing were sufficient to **ensure the Advisory Committee could provide strategic guidance and oversight**<br>● **Guidance of the Advisory Committee** was considered and incorporated into the MHTF approach and rollout efforts<br>● **Trends in resources mobilized** and constraints identified<br>● Advisory Committee contributed to **resource mobilisation strategy**<br>● Examples of resource mobilisation efforts and results<br>● Examples of inter-relatedness of **funding modalities** within MHTF and between MHTF and other funding streams in UNFPA including core funds. | |
| **Observations** | **Sources of Evidence** |
| **A flexible vehicle**<br>● Can see the value of the MHTF but there is a ceiling of **financial limits**<br>● **MHTF contributes to all the three major UNFPA goals**: GBV, maternal health and family planning<br>● The MHTF is flexible to respond to country needs but is linked to maternal and newborn health. A focused intervention therefore and could probably have a wider remit. "**Not clear the value of having a standalone MHTF** as it could be more effective to have the fund be able to channel funds attached to each of the three transformative goals of UNFPA"<br>● MHTF could be the pathfinder to support the way the UNFPA works on/channels funds towards the three 'endings'. Look at **UNFPA investment to be more into the three transformative results** | Interview, Leadership team, UNFPA CO, Khartoum, Sudan 23 June 2021 |

| **Assumption 8.2: The MHTF management mechanisms and internal coordination processes benefitted from effective oversight and guidance by the MHTF Advisory Committee and UNFPA leadership, and contributed to MHTF resource mobilization** | |
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| ● **MHTF would then be the pilot for the first of the three transformative results**. Capitalise on the MHTF and mobilise resources for the three results learning from where and when the MHTF works. | |
| **Functionality of MHTF in the Sudan Context**<br>● **Maternal mortality is exacerbated by the three delays**: decision to seek care, finding transportation to a health care facility, ensuring the availability of resources and knowledge to refer if needed? CPR is very low, and sixty percent of the Sudanese population is comprised of young people.<br>● **MHTF funding is a "drop in the ocean"** compared to what is needed; there are four ways to get more value from the MHTF:<br>1. **Fewer countries:** The MHTF should invest in fewer countries but channel more resources to each one. Currently resources are channelled too thinly across countries.<br>2. **Fewer priorities:** The MHTF should focus on fewer technical issues and challenges in each partner country to avoid spreading resources too thinly across too many priorities.<br>**3. More scope to use MHTF resources for human resources:** MHTF resources should be available to source high quality technical staff who would then lead/galvanise fund raising for major activities rather than the current situation where MHTF is for activities but not technical assistance.<br>● **Integration:** There should be a greater focus on integrating all basic services into PHC. RH is just one of multiple components and it is more productive to work towards a strong system that can delivery all seven basic types of services offered by the PHC Platform (vaccination, RH, MNH, nutrition and child growth monitoring etc). | Interview, UNFPA Leadership, UNFPA - Khartoum, Sudan, 9 June 2021 |
| **Technical and Systems Support also needs Coordination and Leadership**<br>● The **MHTF is a useful vehicle** and has made available crucial resources for maternal health<br>● The **EmONC Network** process and work is particularly valuable and high impact<br>● Jean-Pierre Monet, Dr Dalya Eltayeb, Dr Ahmed Sidahmed have really led the EEmONC process in Sudan and have made an enormous difference to impact, ***"a guiding experience"***<br>● It was a huge exercise using a scientific approach with population and geography and roads all considered as well as other objective factors. It was an important step forward to building a systems strengthening process and very meaningful as a contribution to the delivery of services for maternal health. There are many dimensions to it, and they have found **ways to enhance the use of the EmONC Network even further**. It does and will continue to help the country to strategize other investments.<br>● But now, in addition to EmONC, **UNFPA needs to do more to strengthen advocacy for multi-level coordination**, for strategic investment and for targeted support working with others and building coherence.<br>● Other partners are sometimes the coordinators because **UNFPA is not always there and not able to step up** when needed to coordinate and lead or support the FMoH to lead.<br>● Need to optimise maternal health interventions to **maximise the value of partnership**. | Interview, UNFPA CO leadership, Khartoum, Sudan 23 June 2021 |
| ● Particular support was received from Jean Pierre in MHTF HQ and also from Sarah in the midwifery programme of MHTF. | Interview, RH Coordinator, UNFPA CO, Khartoum, 17 June 2021 |

| **Assumption 8.2: The MHTF management mechanisms and internal coordination processes benefitted from effective oversight and guidance by the MHTF Advisory Committee and UNFPA leadership, and contributed to MHTF resource mobilization** | |
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| **UNFPA grip on the MNH mandate and issues**<br>● In Sudan, **UNFPA needs both technical and financial resources** to support the country effectively, to provide guidance and then also mobilize others to support activities. Issues also involve gender-based violence and a range of complexities. UNFPA needs to reposition its resources over the full mandate of the organization. Needs to **regain control on coordination on issues of maternal health**.<br>● UNFPA at different levels should re-gain coordination of the mandate. Lagging behind in that and more agencies are coming to fill perceived gaps. **UNFPA not mobilising resources effectively**. Major cuts from the UK on family planning for example – this will impact countries and ability of UNFPA to deliver its agenda.<br>● **UNFPA needs to take a leading role on advocacy** of this agenda. There are serious gaps in Sudan and it falls on UNFPA shoulders to mobilise to fill these and to support the government. Need to ensure WHO and other partners are very well oriented around the needs and can bring their resources to bear in a coordinated and constructive way to address agreed priorities. | Interview, Leadership, UNFPA CO, Khartoum, Sudan 23 June 2021 |
| **Coordination, Partnership and Advocacy**<br>● These three elements – **coordination, partnership and advocacy – need to be included** as the MHTF is not just about how to use the resources at country level but actually what entry points the MHTF creates at the country level.<br>● However, there is a **question about whether the coordination at global and regional level is also being done**. Given the limited funding, the identification of strategic interventions is essential to maximising impact.<br>● Question then is HQ (and regional offices) also doing the coordination and partnership and advocacy **at the higher level in ways that complement and support/reinforce the MHTF in countries**. | Interview, UNFPA CO, Khartoum, Sudan 23 June 2021 |
| **Broader context of sustainable change needed in Sudan**<br>Lessons from supporting fragile transitions point to **the importance of building an inclusive and resilient social contract between citizens and the state** and strengthening the legitimacy and capacity of core institutions. (Para 44).<br><br>The World Bank will capitalize on its comparative advantage of working through country systems to strengthen Government capacity and build trust in the institutions. **Partnership with UN agencies will be critical to successful Bank engagement** in early recovery activities especially in regions emerging from conflict building where UN has a strong comparative advantage (para 48). | World Bank Sudan Country Note, 2020, Khartoum<br>Sudan - Country Engagement Note for the Period FY21-FY22 (English). Washington, D.C.:<br>World Bank Group.<br>http://documents.worldbank.org/curated/en/879871602253859419/Sudan-Country-Engagement-Note-for-the-Period-FY21-FY22 |

| Area of Investigation 9: COVID-19 | |
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| **Evaluation Question 9: To what extent has the MHTF been able to respond to emerging and evolving needs of national health authorities and other stakeholders at national and sub-national level due to the COVID-19 pandemic?** | |
| **Sub-questions:**<br>a) To what extent have MHTF programmes pursued a **flexible and adaptive approach to generate evidence on the availability of SRH services** amidst the pandemic to ensure access to a continuum of comprehensive life-saving maternal and SRH services as part of the COVID-19 response and recovery efforts?<br>b) To what extent did the MHTF **reallocation of funds and reprogramming help maintain the continuity of SRMNH services**, in particular maternity services; ensure the protection of healthcare workers (in particular obstetricians, midwives and anaesthesiologists); and strengthen the SRMNH coordination mechanisms in response to COVID-19 at national and sub-national levels? | |
| **Evaluation Criteria** | *Relevance, efficiency, coordination, sustainability* |
| **Rationale** | In 2020, the COVID-19 pandemic spread to every country in the world leading to a range of complex and far-reaching health, socio-economic and other impacts. COVID-19 affected the health system and equitable access to MNH and SRHR services in detrimental ways. UNFPA, working alongside other partners, adopted a flexible approach to ensure continuation of access to RMNCAH services. The reprogramming and reallocation of funds, combined with mobilisation of additional resources for the emergency response, was aimed at mitigating the negative effects of COVID-19 on the ability of the health system to deliver quality MNH and SRHR services and to ensure continuous access to those services. MHTF partner countries pivoted their health system capacity to prevent, identify, treat and manage COVID-19 cases. UNFPA, including the MHTF, like other United Nations agencies and global partners, took steps to support countries to respond quickly and effectively to COVID-19 while ensuring the continuity in the provision of essential services. |
| **Assumption 9.1: MHTF programmes pursued a flexible and adaptive approach to generate evidence on the availability of SRHR services amidst the pandemic and to ensure continued access to a continuum of essential life-saving sexual, reproductive and maternal health services as part of the COVID-19 response and recovery efforts** | |
| **Indicators:**<br>● Number of MHTF funded assessments conducted on continuity of essential and lifesaving RMNCAH services amidst Covid-19 pandemic<br>● Documented and reported adjustments in MHTF programmes in terms of scope, timing, and targeted outcomes in light of the pandemic at global and country levels<br>● Examples of joint work by thematic teams within MHTF and across UNFPA to prioritise and address the COVID-19 related needs of partner countries<br>● Examples of how MHTF processes, activities and goals continued to be delivered even during the COVID-19 response where that was possible<br>● Examples of policies and programme adjustments related to practical changes and reorganization of processes or systems<br>● Participation by UNFPA and the MHTF in studies and reviews to assess the impact of COVID on women and adolescents and identify critical needs for support to them as the COVID-19 pandemic unfolded<br>● Incorporation of the response to COVID-19 impacts into annual MHTF plans and budgets. | |
| **Observations** | **Sources of Evidence** |

| **Assumption 9.1: MHTF programmes pursued a flexible and adaptive approach to generate evidence on the availability of SRHR services amidst the pandemic and to ensure continued access to a continuum of essential life-saving sexual, reproductive and maternal health services as part of the COVID-19 response and recovery efforts** | |
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| **Economic, government and legislative context in Sudan 2019-2020 alongside the pandemic**<br>● As the **transitional government of Sudan was established in September 2019**, there has been major changes across all layers of the government. All directors-general of the different departments of the federal and state ministries of health were frequently changed during 2020. Towards the second half 2020, the FMOH was managed by the undersecretary as acting minister due to directives from the office of Prime Minister.<br>● **The economic crises** affecting the country had a significant echo on the health system response in Sudan. The shortage in hard currency, as well as the very high inflation rate, in addition to the overall global implication of COVID-19 on supplies, resulted in significant shortage in lifesaving and essential medicine. Moreover, in certain areas of the country conflict and states of emergency were still observed.<br>● On other note, and with efforts of the ministry of justice and related line ministries, there has been **significant amendments to the policy and laws with positive impact on access to SRHR**, for example criminalization of FGM. | UNFPA, 2020 template for MHTF reporting, 2020, UNFPA, Khartoum, Sudan |
| **COVID-19 and health related changes in the Sudan Context**<br>● By March 2020, the first case of COVID-19 was reported in Sudan, followed by a declaration of the **state of health emergency**. This was in force until August 2020.<br>● The health system of Sudan is weak, and it was not ready to respond to the impact of COVID-19 with relatively high case fatality rate compared to the global data. The **capacity to respond** was affected by the limited financial and human resources as well as shortages in essential and lifesaving medical supplies.<br>● **Annual flooding** affects people; during 2020, heavy rains and flash floods affected 557,000 individuals in 17 out of 18 states. An assessment conducted by UNFPA indicated 57 health facilities were partially destroyed by floods and heavy rains.<br>● Around 1.3 million positive **malaria cases** were diagnosed during 2020 until September, pregnant women and U5 children are identified as at high at risk. Viral haemorrhagic fevers cases reached 2,863 affecting mainly northern and eastern states, as well as Darfur states. and recently the influx of the Ethiopian refugees from the Tigray region in the eastern zone of Sudan, have further exacerbating the humanitarian needs, including access and availability of health care services.<br>● While the plan for Sudan CO MHTF workplan in 2020 was endorsed early in the year, due to the COVID-19 pandemic there was a major need to revise the plan and consequently the amendment was done toward the end of semester one in 2020. The **majority of the activities of the original work plan were not feasible** due to the need of social distancing, as well as the movement restrictions due to the state of emergency.<br>● Both the CO and HQ agreed to **amend the work plan** to reflect and address the competing and emerging priorities, including supporting the functionality of the lifesaving and essential SRHR services during COVID-19. | UNFPA, 2020 template for MHTF reporting, 2020, UNFPA, Khartoum, Sudan |
| **UNFPA focus on maternal health during COVID-19**<br>● As part of the operationalization of its Global Response Appeal, and in addition to the support provided through the MHTF, **UNFPA proposes to ensure access to quality maternal and newborn healthcare during the COVID-19 pandemic in nine countries with a** | UNFPA, Review of COVID-19 Response in nine countries, Results |

| **Assumption 9.1: MHTF programmes pursued a flexible and adaptive approach to generate evidence on the availability of SRHR services amidst the pandemic and to ensure continued access to a continuum of essential life-saving sexual, reproductive and maternal health services as part of the COVID-19 response and recovery efforts** | |
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| **high burden of maternal mortality and morbidity** that are among the most affected by COVID-19 in Sub-Saharan Africa…including Sudan...<br>● This proposal will **complement UNFPA support** to countries and regions in these nine countries affected by humanitarian crisis and fragility. It has been developed by the UNFPA COs and regional offices in support of the ministries of health's responses to COVID-19 and in collaboration with UN partners and NGOs.<br>● The **proposed response duration is nine months (from May 2020 to January 2021) to ensure the continuity of maternal and newborn health services** during the COVID-19 pandemic and the recovery and strengthening of the health system after the crisis. | Indicators Framework, UNFPA, 30 April 2020 |
| **Justification for maternal health focus during COVID-19 on Sudan (and eight other countries)**<br>● These are countries with **fragile and poorly resourced health systems.**<br>● A **limited number of hospital beds** per population, poor infrastructure, skilled health care providers and medical supplies, rendering them unable to quickly scale up an epidemic response.<br>● A **large proportion of their populations live in crowded cities** with poor conditions and the need to earn money daily to survive.<br>● Despite having young populations…some countries in the region have a **high prevalence of disease** that require immunosuppression (such as HIV and AIDS); hypertension; and diabetes which may result in sharp increases in the number of deaths due to COVID-19.<br>● **These conditions are also risk factors for pregnant women**, implying increased maternal mortality due to underlying risk factors. | UNFPA, Review of COVID-19 Response in nine countries, Results Indicators Framework, UNFPA, 30 April 2020 |
| **Activities undertaken early in the COVID-19 response**<br>● Contribution to COVID-19 response for 11 prioritized EmONC health facilities. This includes ensuring **functionality of critical EmONC facilities and ensuring the availability IPC supplies**, and the "*procurement process is initiated; items are expected to be received by August 2020*". | UNFPA, MHTF Mid-Year report for 2020, 2020, UNFPA, Khartoum, Sudan |
| **Rapid provision of materiel**<br>● **UNFPA is very supportive of the hospital** both directly and through the FMoH.<br>● Provided **consumables** especially during COVID-19 when most of the health facilities were closed and the needs were beyond what the State hospital could meet.<br>● UNFPA provided **PPE, medications**, including magnesium sulphate and misoprostol covering all needs at the hospital.<br>● Furthermore, they provided some **midwifery delivery kits** including caesarean section kits and gynaecological theatre kits. | Interview, Referral Hospital Medical Director, Sudan, 5 June 2021 |
| **MHTF Annual Work Plan (AWP) affected by COVID-19**<br>Some **activities were fully cancelled**:<br>● Examples: Intention to conduct an assessment of Damazin and Al-Fashir midwifery schools to identify gaps (linked to the application to ICM for accreditation of midwifery curriculum) was cancelled for 2020.<br>● Review and finalization of the professional midwifery education programme, including the undergraduate and postgraduate midwifery curricula and education materials development and associated activities were all cancelled.<br>Other **activities were curtailed**: | UNFPA, 2020 template for MHTF reporting, UNFPA, Khartoum, Sudan, 2020 |

<table>
<tr><td colspan="2">Assumption 9.1: MHTF programmes pursued a flexible and adaptive approach to generate evidence on the availability of SRHR services amidst the pandemic and to ensure continued access to a continuum of essential life-saving sexual, reproductive and maternal health services as part of the COVID-19 response and recovery efforts</td></tr>
<tr><td>● Support to the MoH at national and states levels to monitor the network of EmONC facilities (including monitoring of the deployment of skilled staff, MNH data using the agreed upon indicators and referral links) which is the third phase of the EmONC process were not fully achieved due to movement limitations.</td><td></td></tr>
<tr><td>
<table>
<tr><th>Activity [1]</th><th>Expected results [2]</th><th>Status of expected result [3]</th><th>Comments on expected results achievement</th></tr>
<tr><td>Support the implementation of the costed plans of the national and states midwifery associations to support the development of the EmONC network</td><td>National and states midwifery associations support the EmONC network, particularly continuous in-service training through mentorship and advocacy for deployment of midwives in EmONC facilities</td><td>Partially Achieved</td><td>With the joint efforts of CO and FMOH, the two existing associations (sister midwives and heath visitors) are Merged in one body named Sudan Midwives Association. A national consultant was recruited to assist with the development of the constitution according to the national standards. The necessary documents for the registration are prepared and cleared by Humanitarian Aid Commission. The association general assembly meeting is planned to be in fourth week of December.</td></tr>
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</td><td>UNFPA, 2020 template for MHTF reporting, UNFPA, Khartoum, Sudan, 2020</td></tr>
<tr><td>Disruptions of COVID-19 on MHTF programmes<br>● Direct MHTF supported programmes were mainly re-programmed because of movement restriction and the fact that the majority of activities were centrally based.<br>● Many services were stopped as a result of the lack of PPE etc. so prioritising this was urgent and relevant. MDSR was affected and community verification was affected – could not effectively perform community-based verification while lockdown restrictions were in place. Neither could they do EmONC monitoring. Had to go for procurement of PPE to support delivery of basic services for PPE.<br>● MHTF funds were reprogrammed to ensure service continuity and for the procurement of PPE.<br>● FMoH people were not working 100% and the capacity to do the EmONC monitoring, and the associated prioritisation and response plan was affected and delayed.</td><td>Interview, UNFPA CO, Khartoum, Sudan 23 June 2021</td></tr>
<tr><td>Impact of COVID-19 on service utilization<br>● FMoH conducted an assessment of the impact of COVID-19 on the availability of services: ANC 12 per cent reduction; Access to EmONC and facility-based deliveries at EmONC-based deliveries reduced by 9 per cent; and access to skilled birth personnel was 18 per cent. Reduction in access to family planning as well.</td><td>FMoH report reviewed and summarised during Interview with the UNFPA CO, Khartoum, Sudan, 23 June 2021</td></tr>
<tr><td>COVID impacts on progress with the EmONC investments</td><td>UNFPA, MHTF Results Frameworks, Indicators, Baselines and Targets, Sudan, 2020. p.5</td></tr>
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**Assumption 9.1: MHTF programmes pursued a flexible and adaptive approach to generate evidence on the availability of SRHR services amidst the pandemic and to ensure continued access to a continuum of essential life-saving sexual, reproductive and maternal health services as part of the COVID-19 response and recovery efforts**

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| **Output 8 indicator: Direct obstetric case fatality Rate is reduced below 1%** | 2% (all facilities)<br>4% (EmONC facilities) | Mapping and Assessment of Maternal, Neonatal and Child Health Emergencies and Rehabilitation Services, 2017 | | |
| **8.1** Proportion of functioning B EmONC facility in the national network | No data for 2020 | | The National EmONC network is not validated yet and the monitoring visits were not conducted.<br>From 2017 Mapping and assessment Report; 15 BEmONC facilities were functioning | |
| **8.2** Proportion of EmONC facilities with no gaps in midwives according to the national standard | No data for 2020 | | The national EmONC network is not validated yet and the monitoring visits were not conducted | |
| **8.3** Proportion of EmONC facilities with Quality Improvement (QI) process in place | 0 | | The national EmONC network is not validated yet and the monitoring visits were not conducted | |

- But **some activities continued**. For example, 392 **maternal and perinatal deaths were reviewed**
- 114 girls and women living with **fistula** were given surgical repair.

**UNFPA Lessons Learned**

- The immediate response of UNFPA to COVID-19, "as illustrated by the contingency planning, facilitated the application of the required **modification to the programmes** supported by the agency".
- COVID-19 had **significant implications on the programme continuity**. Most of the planned activities were revised to accommodate the COVID-19 prevention.
- **Youth engagement in SRH/COVID-19 awareness campaigns** ensured that SRH/COVID-19 response plans were targeted to sensitive and responsive youth-specific needs and expectations.

UNFPA and GoS, 2020 Annual Progress Report - 7th Country Programme Cycle 2018-2021, 2020, UNFPA, Khartoum, Sudan

**Coordination with partners**

- **Pooled support** among UN agencies/the H6 partners in country
- During COVID-19, UNFPA led the **SGBV sector.**

Interview, UN Partner, 9 June 2021, Khartoum

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| **Assumption 9.1: MHTF programmes pursued a flexible and adaptive approach to generate evidence on the availability of SRHR services amidst the pandemic and to ensure continued access to a continuum of essential life-saving sexual, reproductive and maternal health services as part of the COVID-19 response and recovery efforts** | |
| Impact of COVID-19: **% of households unable to access main staple foods** in the Seven Days Prior to interview | World Bank, **The Impact of COVID-19 on Sudanese Households Reveals Growing Hardship, Social Despair**<br>May 2021<br><br>https://www.worldbank.org/en/news/feature/2021/05/12/the-impact-of-covid-19-on-sudanese-households-reveals-growing-hardship-social-despair |
| **Increased role for national NGOs/CSOs to support SRH**<br>● During COVID-19 CAFA supported midwifery training on the national module to perform safe delivery in COVID-19 patients funded by UNFPA.<br>● In addition, some in-service midwifery training was supported in White Nile state. And two trainings in coordination with Khartoum – SMoH.<br>● This was a new role for them. | Interview, National NGO, Khartoum, 3 June 2021 |
| **But international partners less engaged due travel restrictions**<br>● During 2020, and despite the COVID-19 crisis that prevented travel to countries, UNIGE continued to support countries remotely through:<br>(1) finalizing analyses and technical reports (for Benin, Cote d'Ivoire, Chad, Madagascar, Sudan), and<br>(2) remote consultations to enable analyses and data gathering (DRC, Timor Leste, Burkina Faso). | University of Geneva, Workplan 2021: Concept Note, Geneva, 2020 |
| **Assumption 9.2: MHTF reallocation of funds and reprogramming helped maintain the continuity of lifesaving SRMNH services, particularly maternity services/units** | |
| **Indicators:**<br>● National and subnational data DHIS2/HIMS indicate continuation of SRMNH services, in particular in maternity units<br>● Reported (quantitative and qualitative) effectiveness of UNFPA support to procurement, distribution and use of PPE by health care providers (in particular obstetricians, midwives and anaesthetists) to protect them against COVID-19 infections<br>● Examples of UNFPA support to SRMNH coordination mechanisms at national and sub-national level which has helped to prevent overlap/duplication and enhance complementarity and synergies with other SRMNAH programmes and actors. | |

| Assumption 9.2: MHTF reallocation of funds and reprogramming helped maintain the continuity of lifesaving SRMNH services, particularly maternity services/units | |
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| **Observations** | **Sources of Evidence** |
| **Concerns about maintaining progress on maternal and newborn health**<br>● The pandemic will most likely negatively impact the progress made in increased numbers of institutional deliveries in these countries, with **devastating consequences for timely access to quality delivery services including emergency care**. In addition, the nine proposed countries have a robust maternal health programme which enables a rapid response to COVID-19 at scale.<br>● They all have a **national network of maternity units**, aiming to be better staffed and equipped to provide obstetric care and manage obstetric and perinatal emergencies.<br>● With UNFPA support, these nine countries have **monitored obstetric data**, which facilitates the interventions management and reporting. They are not only able, but also need to be at the forefront of efforts in making childbirth safe for all women and newborns during the COVID-19 pandemic.<br>● These health facilities cover a majority of the population within one or two hours of travel time and their functioning is closely monitored, providing a **response at scale and reactive to the needs of women and newborns**. | UNFPA, Review of COVID-19 Response in nine countries, Results Indicators Framework, UNFPA, 30 April 2020 |
| **Measures to ensure service continuity**<br>● **Temporary deployment of 20 additional skilled midwives** in Nyala states to serve in five localities for period of three months to support the timely response to essential obstetric care<br>● **Contribution to COVID-19 response for 11 prioritized EmONC health facilities**. This includes ensuring functionality of critical EmONC facilities and ensuring IPC supplies availability. | UNFPA, MHTF Mid-Year report for 2020, 2020, UNFPA, Khartoum, Sudan |
| **Continuity of services**<br>● During COVID-19 with UNFPA support, **CAFA deployed several mobile clinics** providing ANC and family planning services as well as distributing PPE to health providers. | Interview, National NGO, Khartoum, 3 June 2021 |
| ● **Temporary deployment of 20 additional skilled midwives** in Nyala states to serve in five localities for a period of three months to support the timely response to essential obstetric care. The locality and health facilities at which the midwives will serve are identified and they will continue to provide their services throughout Q3. | UNFPA, Sudan MHTF Mid-Year report for 2020, UNFPA, Khartoum, 2020 |
| **Mid-year reporting shows the extent of disruption on MHTF activities.** | UNFPA, MHTF Mid-Year report for 2020, 2020, UNFPA, Khartoum, Sudan |

| Assumption 9.2: MHTF reallocation of funds and reprogramming helped maintain the continuity of lifesaving SRMNH services, particularly maternity services/units | | | | | | |
|---|---|---|---|---|---|---|
| 2 | Review and finalize the professional midwifery education programme, including the under and postgraduate midwifery curricula and education materials | 0 | 0 | Cancelled | 0 | |
| 3 | Support monitoring and evaluation of the implementation of ICM curricula and post-graduate curricula of midwifery. | 0 | 0 | Cancelled | 0 | |
| 4 | Support the implementation of the costed plans of the national and states midwifery associations to support the development of the EmONC network | 12,000 | 0 | Not achieved | 12,000 | |
| 5 | Support the Ministry of Health at national and states levels to monitor the network of EmONC facilities (including monitoring of the deployment of skilled staff, MNH data using the agreed upon indicators and referral links) | 34,414 | 0 | Not achieved | 34,414 | |
| 6 | Support implementation of community based referral mechanisms to improve referral to EmONC facilities and address financial barriers to access EmONC services | 70,000 | 0 | Partially achieved | 40,000 | |
| 7 | Conduct coordination meetings for the EmONC stakeholders at National levels, including reports sharing. | 6,000 | 0 | Not achieved | 6,000 | |
| 8 | Conduct advocacy interventions targeting Senior Government Officials, Stakeholders, Partners and Donors to deploy the graduated midwives in the selected EmONC facilities. | 2,000 | 0 | Not achieved | 2,000 | |
| 9 | Contribute to the implementation of the costed EmONC work plan to cover the gaps of the prioritized HFs. This includes procurement of equipment and capacity building of the EmONC staff. | 75,000 | 16150 | partially achieved | 58,850.00 | |
| 10 | Support the availability and utilization of family planning modern methods in maternity wards of the prioritized EmONC facilities by implementing postpartum and post-abortion FP. This includes renovation and equipping the HFs to provide the service; training of care providers and monitoring and evaluation. | 0 | 0 | Cancelled | 0 | |

| **Assumption 9.2: MHTF reallocation of funds and reprogramming helped <u>maintain the continuity of lifesaving SRMNH services</u>, particularly maternity services/units** | |
|---|---|
| **Impact of COVID-19 on SRH service continuity**:<br>● **Interruption of service provision at health facilities**: health care facilities including EmONC faced limited capacities in the first period of the pandemic, and limited number of facilities were operating.<br>● **Interruption of health care provided at community level**: services mainly delivered by community midwives were impacted due to limitation on movement as well as low access to PPE/infection prevention materials and knowledge.<br>● **Referral services were consumed by COVID-19 cases** creating significant gaps in ability to attend to non-COVID-19 cases. | UNFPA, COVID-19 Impact on SRH Services and Maternal Health, Sudan. UNFPA, Khartoum, 2020 |
| **UNFPA support to risk communication**<br>● Provision of technical assistance to FMoH and technical partners for the development of materials aimed at the general population as well as pregnant women, breastfeeding women, and health care providers linked to SRHR services<br>● Support to youth-peer network to lead a nationwide COVID-19 risk communication campaign. Reached app 60,736 women and girls. | UNFPA, COVID-19 Impact on SRH Services and Maternal Health, Sudan. UNFPA, Khartoum, 2020 |
| **UNFPA support to Case Management**:<br>The MCH Directorate at FMOH jointly with UNFPA, WHO, and UNICEF led the development of the *Technical Guidance for Provision of Maternal and Child Health Services during COVID-19 Outbreak within Health Facilities and Communities*, which included the essential package of services mandatory to continue, required triage, patient flow, and guidance for health care worker protection.<br>The guidance led to a number of specific adjustments supported by UNFPA to ensure continuity:<br>● A reassessment of the recommended number of health care workers at each facility depending on COVID-19 caseload<br>● Dissemination of case management protocols nationwide (printing and distribution)<br>● Mapping of isolation centres<br>● Identification of the SRHR gaps in each facility and improved provision of care to pregnant women and to women who have recently given birth, at risk of COVID-19 ensuring available lifesaving drugs and supplies, skilled health personnel and isolation room/location in EmONC facilities. | UNFPA, COVID-19 Impact on SRH Services and Maternal Health, Sudan. UNFPA, Khartoum, 2020 |
| **SRH Service delivery support by UNFPA during COVID-19**<br>● Referral of obstetric complications through supporting ambulances<br>● Distribution of IPC<br>● Distribution of inter-agency RH kits<br>● Continuity in the supply of medical commodities required for the clinical management of rape | UNFPA, COVID-19 Impact on SRH Services and Maternal Health, Sudan. UNFPA, Khartoum, 2020 |
| **Current and expected needs**<br>● Active referral services in areas with limited access or interrupted services<br>● Supporting community midwives with midwifery kits, clean delivery kits, linkages with referral services<br>● Deployment of midwives to health facilities with human resource gaps<br>● Supply with inter-agency RH kits as well as family planning commodities<br>● Regular mapping of CMR services, updating the situation with pre-positioning of CMR kits. | UNFPA, COVID-19 Impact on SRH Services and Maternal Health, Sudan. UNFPA, Khartoum, 2020 |
| **Infection Prevention & Control**:<br>● FMoH and UNFPA jointly worked on updating the training packages for infection prevention, which were specifically adapted to the RH context. | UNFPA, COVID-19 Impact on SRH Services and |

| **Assumption 9.2: MHTF reallocation of funds and reprogramming helped <u>maintain the continuity of lifesaving SRMNH services</u>, particularly maternity services/units** | |
|---|---|
| ● Core team of trainers were trained at federal level, who conducted trainings at the 18 states of Sudan mid-April 2020, series of trainings were conducted to each strata of care providers, obstetric specialist & paediatricians (254), PHC care providers (452) and community midwives (1055)<br>● Adaptation of the training package to context of COVID-19 by using e-learning methods (videos)<br>● Moreover, UNFPA provided the critical EmONC facilities with infection prevention materials, "*total of 12 facilities received supplies, and supplies covering ten facilities are in the pipeline*". | Maternal Health, Sudan. UNFPA, Khartoum, 2020 |
| **UNFPA identified opportunities within the COVID-19 response:**<br>● Investing more in improving capacity specifically of EmONC facilities, including targeting them for the rehabilitation of referral services, as well as supporting community networking and referral<br>● Digitalization of care approach: strengthening coordination through regular mapping of services and supplies stock analysis<br>● Sustaining the provision of essential and lifesaving services through strengthening the capacity of health care providers<br>● Strengthening referral services including through limiting periods of stockout of life-saving drugs and supplies. | UNFPA, COVID-19 Impact on SRH Services and Maternal Health, Sudan. UNFPA, Khartoum, 2020 |
| **In Blue Nile State**<br>● UNFPA supported training and guidance to midwives to perform safe deliveries for COVID-19 patients, providing PPE to health providers and facilitating access to health services – especially EmONC – by contributing to transportation costs. UNFPA supported COVID-19 isolation units with kits, commodities, and supplies. | Interview, State Ministry of Health, Ad Damazin, Blue Nile, Sudan, 7 June 2021 |
| ● Although the resources are limited, and there were needs for more consumables including masks and gloves, the patient load was lower than usual. | Interview, PHC Service Provider, Blue Nile, Sudan, 7 June 2021 |
| ● Through the SMoH, UNFPA organized advocacy training for midwives to conduct safe deliveries to COVID-19 patients. They provided some consumables as well. | Interview, Nurse-Midwife, Ad Damazin, Blue Nile State, 7 June 2021 |
| **UNFPA support to maternal health outcomes during COVID-19**<br>● The main challenge of maintaining service delivery was the limited number of health providers<br>● From the triage unit, suspected or confirmed patients were referred to the isolation section at the hospital where they received services by trained health providers<br>● Midwives were trained to provide safe delivery for COVID-19 patients<br>● PPE, consumables and commodities were supplied by UNFPA<br>● Triage, midwifery training, PPE and other commodities were supported by UNFPA. | Interview, Referral Hospital Medical Director, Ad Damazin, Blue Nile State, 7 June 2021 |
| **UNFPA support to triage and patient management**<br>● Health workers, including doctors, nurses and midwives, were trained to provide services for COVID-19 patients.<br>● A triage station was placed at the entrance of the Emergency Room and covered by a medical doctor and nurse to identify suspected COVID-19 patients, using simple measures like pulse oximeter, thermometer and taking some key information from patients.<br>● Suspected and confirmed COVID-19 patients were sent to an isolation centre where they received services from trained health workers (doctor and midwives). | Interview, Referral Hospital Medical Director, Omdurman, Sudan, 5 June 2021 |

| Assumption 9.2: MHTF reallocation of funds and reprogramming helped maintain the continuity of lifesaving SRMNH services, particularly maternity services/units | |
|---|---|
| ● The challenge was to provide emergency caesarean section to women where no specialized operation room or staff were available to do it. The hospital used special staff to attend theatre and then closed the theatre until it was re-sterilized.<br>● Despite precautions, at this one hospital, two consultants died from COVID-19 and two other doctors were infected while providing the service to COVID-19 patients. | |
| **UNFPA support according to the FMoH**<br>● UNFPA supported midwives to perform safe delivery for COVID-19 patients (training, guidance, manual of instructions for triage and protection)<br>● The advocacy of midwifery to perform safe delivery to COVID-19 patients<br>● Provision to midwives of PPE and safe delivery kits<br>● Support was also received for a few ambulances (covering operational costs) to ensure women could continue to access emergency assistance in pregnancy and childbirth. | FMoH, Khartoum, Sudan, 1 June 2021 |
| **Multiple emergencies; prioritised response**<br>● In the first wave, Sudan experienced wide-spread and very damaging flooding as well as COVID-19.<br>● Limited supplies were available, and these were pooled and directed towards the prioritised EmONC facilities in the network.<br>● Active coverage with PPE etc also focused on the EmONC network.<br>● Staff were redistributed to ensure the EmONC facilities were all functional. | Webinar presentation, FMoH, Khartoum, 17 June 2021 |
| ● During COVID-19, UNFPA was one of the main contributors and was a third-party in supporting monitoring the interventions and responding to the pandemic. | UNFPA Group Meeting, 5 June 2021, Khartoum |
| **Partnerships for COVID-19 response**<br>● The two organisations were part of the **national emergency committee,** hence the support was for pooling<br>● During COVID-19, "working closely with UNFPA who leading the GBV sector and promoting a hotline for GBV including associated policies and guidelines"<br>● Aware that UNFPA supported a number of ambulances for the emergency transfer of women in both Khartoum and Aljazeera state to improve access to services despite COVID-19<br>● Also, aware that UNFPA provided PPE for health workers at several health facilities. | Interview, UN Partner, Khartoum, 3 June 2021 |
| **UNFPA coordination during COVID-19 response**<br>● UNFPA was actively engaged in the national and state level emergency preparedness and response coordination platform, including the health cluster.<br>● SRHR was a standing agenda at the government platform.<br>● The different technical working groups (on IPC, case management etc) linked to COVID-19.<br>● COVID-19 policy and resources coordination forum with OCHA relevant pillars' lead and coordination forum.<br>● Primary health care departments and relevant counterparts to ensure reflecting the provision of essential SRHR services. | UNFPA, COVID-19 Impact on SRH Services and Maternal Health, Sudan. UNFPA, Khartoum, 2020 |
| ● In Sudan, an estimated 82,625 deliveries across 26 EmONC facilities would be supported over nine months of targeted COVID-19 support of which 10 per cent (estimated) will have complications requiring EmONC services. | UNFPA, Review of COVID-19 Response in nine countries, Results |

| Assumption 9.2: MHTF reallocation of funds and reprogramming helped maintain the continuity of lifesaving SRMNH services, particularly maternity services/units | |
|---|---|
| | Indicators Framework, UNFPA, 30 April 2020, p. 10 |
| **Results for COVID-19 investments in Sudan**<br>● Personal Protective Equipment (PPE) for healthcare workers,<br>● Cleaning materials and related infection prevention and controls trainings<br>● Support establishment of roster of midwives to support targeted health facilities for the provision of services 24/7<br>● Support 26 EmONC facilities through temporary expansions for triage capacity and provision of service to suspected cases in isolated areas. | UNFPA, Review of COVID-19 Response in nine countries, Results Indicators Framework, UNFPA, 30 April 2020 |

# ANNEX 2: PERSONS INTERVIEWED IN SUDAN

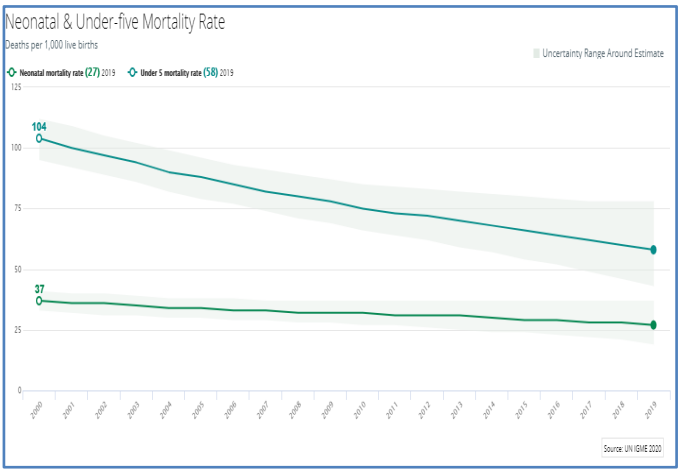
| Name of informants | Title/ Role | Key informant | Locality |
|---|---|---|---|
| **Esmehan Elkhair Babekir** | MCH director | Federal Ministry of Health | Khartoum City |
| **Iman Hajo Ibrahim** | RH director | Federal Ministry of Health | Khartoum City |
| **Amel Mohamed** | Midwifery focal point | Federal Ministry of Health | Khartoum City |
| **Huda Farah** | Fistula focal person | Federal Ministry of Health | Khartoum City |
| **Amani Mohamed Ahmed** | EmONC focal person | Federal Ministry of Health | Khartoum City |
| **Mawada Mohamed Ali** | NRHP Supplies | Federal Ministry of Health | Khartoum City |
| **Mawahib Alfadul** | NRHP / M&E officer | Federal Ministry of Health | Khartoum City |
| **Elaf Ali** | Family planning focal point | Federal Ministry of Health | Khartoum City |
| **Walaa Mahjoub** | RH cancer focal point | Federal Ministry of Health | Khartoum City |
| **Dr Dalya Eltayeb** | PHC Director | Federal Ministry of Health | Khartoum City |
| **Dr Mateen Shaheen** | Country Deputy Representative | UNFPA Country Office | Khartoum City |
| **Dr Majid Alameen Elnour** | RH Coordinator –FMoH focal point | UNFPA Country Office | Khartoum City |
| **Dr Sulafa Satti** | RH Analyst- MISP focal point | UNFPA Country Office | Khartoum City |
| **Dr Sarah Abas** | RH Advocate – Midwifery focal point | UNFPA Country Office | Khartoum City |
| **Dr Rania Hassan** | PHC Coordinator | UNFPA Country Office | Khartoum City |
| **Dr Mohammed Ahmed Sidahmed** | Assistant Representative | UNFPA Country Office | Khartoum City |
| **Dr Sawsan Eltahir** | MNH Coordinator | UNICEF Country Office | Khartoum City |
| **Dr Maison Elameen** | Women's SRHR and GBV focal point – MCH Directorate | World Health Organization | Khartoum City |
| **Dr Osama Alnour** | General Director | Academy of Health Sciences | Khartoum State |
| **Yassir Ibrahim Awad** | SRH/HIV Projects Manager | CAFA (Community Animator Friendly Association) | Khartoum City |
| **Dr Khalid Abdualla Tahir** | Recent General director | Omdurman Maternity Hospital | Khartoum State |
| **Dr Imad Abd Almonem Alkhair Altaib** | Previous General director | Omdurman Maternity Hospital | Khartoum State |
| **Amna Awad Edeid** | Health Provider-Nurse midwives | Omdurman Maternity Hospital | Khartoum State |
| **Unnamed** | Client/ Community member | Omdurman Maternity Hospital | Khartoum State |
| **Dr Nuha Sulaiman** | General Director and Health Provider | Hay Alzour Primary Health Care Centre | Khartoum State |
| **Dr Waleed Alnour Mohammed Daif** | General Medical Director | Aldamazin Hospital | Blue Nile State |
| **Kateera Ibrahim Ahmed** | Health provider- Nurse midwives | Aldamazin Hospital | Blue Nile State |
| **Unnamed** | Client/ Community member | Aldamazin Hospital | Blue Nile State |
| **Dr Sawsan Omer Fadul** | PHC Director | State Ministry of Health | Blue Nile State |

| | | | |
|---|---|---|---|
| **Hanan Khamees Akock** | RH Director | State Ministry of Health | Blue Nile State |
| **Intisar Altoum Dafa Allah** | Child Health Coordinator | State Ministry of Health | Blue Nile State |
| **Omar Alaees Mussa** | Director | CAFA (Community Animator Friendly Association) | Blue Nile State |

# ANNEX 3: SUDAN COUNTRY DATA PROFILE

| General and Health Financing Profile | | | | | |
|---|---|---|---|---|---|
| **Indicator** | **Value** | **Source** | **Indicator** | **Value** | **Source** |
| Total population: estimated size of population at mid-year, in millions, 2021 | 44.9 | (1) | Life expectancy at birth in years, 2021 (male/female) | 64/68 | (1) |
| GNI per capita, Atlas method (current USD) 2019 | 820 | (3) | Current health expenditure as per cent of GDP, 2018 | 5% | (2) |
| Primary Health Care expenditure as per cent of current health expenditure, 2018 | 6% | (2) | Domestic general government health expenditure (% of current health expenditure/% of general government expenditure) | 22.8 %/6.8 % | (3) |
| Out-of-pocket expenditure (% of current health expenditure**)** 2018 | 66.2 % | (3) | External health expenditure (% of current health expenditure) | 7.6% | (3) |

| Health and population profile | | |
|---|---|---|
| **Indicator and Definition:** | **Indicator value** | **Source** |
| Total fertility rate: Number of children born per woman in her lifetime. | 4.2 | (1) |
| Average annual rate of population change: Average exponential rate of growth over one year based on a medium variant projection | 2.4 | (1) |
| Maternal mortality ratio, 2017: Number of maternal deaths per 100,000 live births | 295 | (4) |
| Neonatal mortality rate (deaths in babies in the first month of life per 1000 live births) 2019 | 27.2 | (3) |
| Births attended by skilled health personnel, 2014: Percentage of births attended by skilled health personnel (doctor, nurse or midwife) | 77.7 | (5a) |
| Contraceptive prevalence rate, modern method (CPR): Percentage of (all) women aged 15-49 who are currently using any modern method of contraception | 10 | (1) |
| Unmet need for family planning: Percentage of (all) women aged 15-29 who want to stop or delay childbearing but are not using a method of contraception | 18 | (1) |
| Adolescent birth rate, 2020: Number of births per 1,000 adolescent girls aged 15-19 | 87 | (1) |
| Child marriage by age 18, 2014: Proportion of women aged 20-24 years who were married or in a union before age 18 | 34 | (5b) |


(1) United Nations Population Division https://www.unfpa.org/data/world-population-dashboard (2) World Health Organization Global Health Expenditure database https://apps.who.int/nha/database/ViewData/Indicators/en; (3) World Bank Data Bank: https://databank.worldbank.org/home accessed on 28 June 2021; (4) UN Interagency group for maternal mortality estimation https://www.who.int/data/gho/indicator-metadata-registry/imr-details/26 (5) UNICEF (a) https://data.unicef.org/topic/maternal-health/delivery-care/ (b) https://data.unicef.org/resources/dataset/child-marriage/ (6) Source of graphics: https://profiles.countdown2030.org/#/ds/UGA

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