UNFPA Sudan

Humanitarian Response Evaluation

2023-2024

Evaluation Management

UNFPA Independent Evaluation Office

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Foreword

The large-scale armed conflict in Sudan, which began in April 2023, has rapidly spiralled into one of the world's worst humanitarian crises. With over 30 million people requiring assistance and 11.5 million people displaced as of April 2025, Sudan has the highest number of internally displaced persons globally. The near-total collapse of essential services – particularly health and protection – has left women and girls vulnerable to gender-based violence and sexual and reproductive health issues.

In response, UNFPA Sudan demonstrated immediate operational agility, leveraging pre-positioned supplies and national staff to rapidly provide life-saving sexual and reproductive health services and establish women and girls safe spaces. UNFPA scaled up its gender-based violence Area of Responsibility leadership, supported subnational sexual and reproductive health coordination, and promoted localization and innovation with cash and voucher assistance.

This independent evaluation assesses UNFPA's performance in this complex and rapidly evolving humanitarian emergency. Its purpose is to reinforce accountability to affected populations and donors and provide the evidence base needed to inform the ongoing response, the next UNFPA programme cycle and regional or cross-border humanitarian strategies.

The evaluation finds that the UNFPA's humanitarian response was timely and addressed acute needs at the early onset of the crisis. However, it also identifies several areas for improvement. The UNFPA's response lost critical momentum, constrained by insufficient resourcing, development-oriented systems and a limited risk appetite. Systemic bottlenecks in human resource mobilization and supply chain management severely restricted the required speed and scale of the response, while lack of systematic and disaggregated data limited the targeting of the most vulnerable people.

I trust that the UNFPA Sudan country office, the Arab States regional office, and headquarters divisions will use this evaluation decisively. Implementing these recommendations will enhance future programming, strengthen operational efficiency and accelerate the UNFPA's contribution to results. This is essential to ensure more coherent, timely and effective delivery of life-saving services to the women and girls of Sudan and to strengthen UNFPA's global humanitarian action.

Marco Segone
Director, UNFPA Independent Evaluation Office

Acknowledgements

This independent evaluation assesses the UNFPA's critical humanitarian response in Sudan and covers the period of Inter-Agency Standing Committee's (IASC) system-wide scale-up.

This work would not have been possible without the dedication of the independent evaluation team. I sincerely thank Veronique de Clerk for her leadership and Lubaba Elhassan, Safia El Siddig, and Eylaph Muhammed for their thoughtful contributions and flexibility while working under highly constrained conditions.

On behalf of the evaluation team, I extend our deep appreciation to the UNFPA Sudan country office, especially Argentina Piccin, Gulnara Kadyrkulova, Bruno Husquinet and all their colleagues. Their practical support and contextual knowledge were critical in enabling this evaluation during an exceptionally difficult period for Sudan, the United Nations system and affected populations. Above all, we are grateful for their unwavering commitment to delivering life-saving aid under severely constrained conditions to women and girls most in need.

Lastly, we express our deepest respect and gratitude to the people of Sudan. Despite the immense hardships they continue to face, they graciously shared their experiences with us. Their voices are the foundation of this evaluation.

Camilla Buch von Schroeder
Evaluation Manager, UNFPA Independent Evaluation Office

Contents

Tables and figures

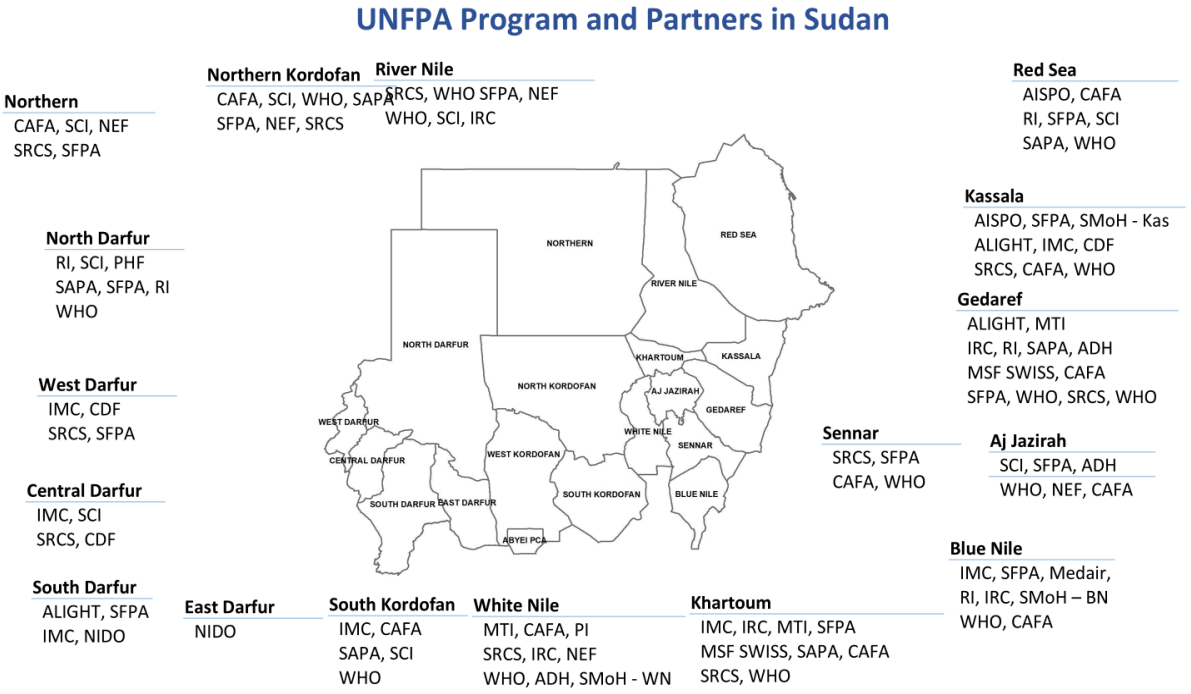
Volume II (Annexes)

Acronyms and abbreviations

AAP	Accountability to affected populations
AoR	Area of Responsibility
BeMONC	Basic emergency obstetric and newborn care
CDF	Community Development Fund
CeMONC	Comprehensive emergency obstetric and newborn care
CERF	Central Emergency Response Fund
CMR	Clinical management of rape
CPD	Country programme document
CRT	Crisis response team
CRSV	Conflict-related sexual violence
DHIS	District health information system
DHR	Division of Human Resources
DTM	Displacement tracking matrix
EPP	Emergency procurement procedure
ERM	Enterprise risk management
FGD	Focus group discussion
FGM	Female genital mutilation
FTP	Fast track procedures
GBV	Gender-based violence
GBViE	Gender-based violence in emergencies
GERT	Global emergency response team
HAC	Humanitarian Aid Commission
HCT	Humanitarian country team
HNO	Humanitarian needs overview
HNRP	Humanitarian needs and response plan
HQ	Headquarters
HRD	Humanitarian Response Division
HST	Humanitarian support team
IARH	Inter-Agency Reproductive Health (kits)
IASC	Inter-Agency Standing Committee
ICCG	Inter-Cluster Coordination Group
IDP	Internally displaced person
IEC	Information, education and communication
INGO	International non-governmental organization
IOM	International Organization for Migration
KII	Key informant interview
LNOB	Leaving no one behind
M&E	Monitoring and evaluation
MDSR	Maternal death surveillance and response
MHPSS	Mental health and psychosocial support
MISP	Minimum initial service package
NGO	Non-governmental organization
OCHA	Office for the Coordination of Humanitarian Affairs
OECD DAC	Organization for Economic Co-operation and Development – Development Assistance Committee
PSEA	Protection from sexual exploitation and abuse

RSF	Rapid Support Forces
SAF	Sudanese Armed Forces
SCMU	Supply Chain Management Unit
SOP	Standard operating procedures
SRH	Sexual and reproductive health
SRHiE	Sexual and reproductive health in emergencies
STI	Sexually transmitted infection
TPM	Third-party monitoring
UN	United Nations
UNCT	United Nations country team
UNDAF	United Nations Development Assistance Framework
UNDSS	United Nations Department of Safety and Security
UNFPA	United Nations Population Fund
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
UNMISS	United Nations Mission in South Sudan
UNSDCF	United Nations Sustainable Development Cooperation Framework
USAID	United States Agency for International Development
WGSS	Women and girls safe spaces
WHO	World Health Organization
WLO	Women-led organization
WRA	Women of reproductive age

Country map indicating areas of UNFPA programme implementation



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.

Key facts table

Table 1: Sudan key facts table, 2024

Land	
Geographical location	North-East Africa
Land area	1.86 million square kilometres[1]
Demographics	
Total population size	47.5 million[2]

[1] https://data.worldbank.org/indicator/AG.LND.TOTL.K2?locations=SD
[2] https://www.unfpa.org/data/world-population/SD

Population size by sex composition	49% F/51% M[3]
Population growth rate	2.5[4]
Life expectancy at birth (disaggregated by sex)	68[5]
Under-five mortality rate	60 (per 1000)[6]
Human Development Index	0.516, ranking 170th[7]
Gender Inequality Index	0.54, ranking 128th[8]
Young people	
Proportion of population aged 10-19	22[9]
School attendance rate (disaggregated by sex; level of education e.g. primary, secondary)	47 (2022 United Nations Statistics)
School completion rate (disaggregated by sex; level of education e.g. primary, secondary)	37 (2022 United Nations Statistics)
Teenage pregnancy rate (proportion of women aged 15-19 years who have begun childbearing)	30%[10]
Health and fertility	
Total fertility rate	4.3[11]
Adolescent birth rate	87[12]
Contraceptive prevalence rate (modern methods)	12[13]
Unmet need for family planning	26.8[14]
Proportion of births attended by skilled health personnel	77.7[15]
Institutional deliveries	27.7[16]
Maternal mortality ratio (deaths per 100,000 live births)[17]	270
HIV prevalence rate, 15-49 (total)	0.1[18]

[3] https://data.humdata.org/dataset/cod-ps-sdn
[4] Common Operational Datasets, Common Baseline Datasets, 2024.
[5] https://data.who.int/countries/729
[6] https://data.who.int/countries/729
[7] https://data.humdata.org/dataset/hdro-data-for-sudan?utm_source=chatgpt.com
[8] https://hdr.undp.org/data-center/thematic-composite-indices/gender-inequality-index#/indicies/GII
[9] https://data.humdata.org/dataset/cod-ps-sdn
[10] Sudan Investment Report, 2022. Available at https://nbs.gov.ss/wp-content/uploads/2022/08/south_sudan_investment_report-1.pdf
[11] https://data.humdata.org/dataset/cod-ps-sdn
[12] Sudan Multiple Indicator Cluster Survey, Central Bureau of Statistics, 2014.
[13] Sudan Multiple Indicator Cluster Survey, Central Bureau of Statistics, 2014.
[14] Sudan Multiple Indicator Cluster Survey, Central Bureau of Statistics, 2014.
[15] Sudan Multiple Indicator Cluster Survey, Central Bureau of Statistics, 2014.
[16] Sudan Multiple Indicator Cluster Survey, Central Bureau of Statistics, 2014.
[17] Sudan Multiple Indicator Cluster Survey, Central Bureau of Statistics, 2014.
[18] https://data.worldbank.org/indicator/SH.DYN.AIDS.ZS?locations=SD.

HIV prevalence rate, 15-24 (female)	0.1[19]
Economic	
Gross net national income (US$)	28,7[20]
Gross domestic product per capita (US$)	2183[21]
GDP growth rate (annual %)	-20,1%[22]
Adult unemployment (% of total labour force)	9.9%[23] (2001)
Inflation rate	130% (2022) [24]
Gini index	34.2 [25]
Major economic activity	Agriculture
Gender equality	
Proportion of women aged 20-24 years who were married or in a union before age 15 and before age 18 (child marriage)	35% before age of 18[26]
Proportion of ever-partnered women and girls aged 15 years and older subjected to physical, sexual or psychological violence by a current or former intimate partner in the previous 12 months	N/A
Political	
Type of government	Republic
Key political events (during period being evaluated)	Unstable political system – country in conflict since April 2023

Source: UNFPA

[19] https://data.worldbank.org/indicator/SH.HIV.1524.FE.ZS?locations=SD.
[20] https://data.worldbank.org/indicator/NY.ADJ.NNTY.CD?locations=SD.
[21] https://data.worldbank.org/indicator/NY.GDP.PCAP.CD?locations=SD.
[22] https://data.worldbank.org/indicator/NY.GDP.MKTP.KD.ZG?locations=SD.
[23] https://humancapital.worldbank.org/en/economy/SDN.
[24] https://data.worldbank.org/indicator/FP.CPI.TOTL.ZG?locations=SD.
[25] https://data.worldbank.org/indicator/SI.POV.GINI?locations=SD.
[26] Sudan Multiple Indicator Cluster Survey, Central Bureau of Statistics, 2014.

Executive summary

This independent evaluation presents the findings and conclusions of the evaluation of the humanitarian response by UNFPA in Sudan during the 2023–2024 crisis, following the activation of the Inter-Agency Standing Committee (IASC) Level 3 system-wide scale-up on 29 August 2023. It provides an independent and objective assessment of how UNFPA performed in one of the most complex and rapidly evolving humanitarian emergencies globally, offering evidence-based analysis, conclusions and recommendations.

The purpose of the evaluation is to reinforce accountability to donors and affected populations, while simultaneously broadening the evidence base to inform the ongoing response, the next UNFPA programme cycle and regional or cross-border humanitarian strategies.

- To provide an independent assessment of the relevance, coherence, coordination, effectiveness, coverage, efficiency and connectedness of UNFPA humanitarian assistance.
- To assess capacity within UNFPA to connect immediate, life-saving humanitarian support with long-term development goals.
- To examine the role played by the UNFPA Sudan country office within the coordination structures of the United Nations country team (UNCT) and the humanitarian country team (HCT), with the aim of enhancing the collective United Nations contribution to the humanitarian response and supporting sustainable recovery.
- To assess the extent and effectiveness of UNFPA Sudan's engagement in regional humanitarian responses and cross-border collaboration with Chad and South Sudan.
- To provide actionable, forward-looking recommendations for the ongoing response and the next programme cycle.

The evaluation scope covered UNFPA humanitarian interventions from April 2023 to March 2025, in eight crisis-affected states and relevant cross-border operations. Thematic coverage included life-saving sexual and reproductive health and gender-based violence (GBV) services, and inter-agency leadership roles. Cross-cutting issues such as accountability to affected populations (AAP), protection from sexual exploitation and abuse (PSEA), gender equality, humanitarian principles, human rights and leaving no one behind (LNOB) were integrated into the analysis.

Primary users are (1) the UNFPA Sudan country office, Arab States regional office and headquarters divisions; (2) the humanitarian country team and leads of the humanitarian clusters; (3) the Government of Sudan; (4) implementing partners (IPs) of the UNFPA Sudan country office; (5) rights holders involved in UNFPA interventions and the organizations that represent them (in particular women, adolescents and youth); (6) the UNCT/HCT; and (7) donors.

The evaluation adopted a mixed-methods design and a realist and theory-based approach. A reconstructed theory of change served as the central analytical framework, guiding the evaluation's design, data collection, and analysis. An evaluation matrix mapped evaluation criteria, questions, assumptions, indicators, and data sources. The methodology integrated multiple data collection methods to ensure triangulation, rigour and adaptability to Sudan's fluid and highly complex context. The evaluation was participatory in nature and adopted a contribution analysis in assessing effectiveness.

Main findings

Relevance

The response by UNFPA addressed urgent sexual and reproductive health (SRH) and GBV needs in a context of severe service collapse, including in conflict-affected states where health facility functionality was critically low. Needs assessments informed programming and the response was adapted to reach underserved populations despite movement restrictions and access challenges. However, data limitations – particularly the lack of disaggregated information by gender, age, disability and location – hampered targeted service delivery and limited the organization's ability to prioritize the most vulnerable. Integration of AAP and PSEA mechanisms was uneven, and feedback systems from affected populations were not consistently operational or utilized to inform programme adjustments.

Effectiveness

UNFPA's initiatives in supporting sexual and reproductive health and rights (SRHR) and GBV responses in crisis-affected areas have yielded significant positive outcomes, alongside notable challenges. The organization has successfully ensured the availability of lifesaving SRH services through mobile clinics, health facility rehabilitation and training of health personnel, particularly addressing obstetric emergencies in both stable and hard-to-reach areas. Similarly, UNFPA has made strides in GBV prevention and response by prioritizing clinical management of rape (CMR) and establishing women and girls safe spaces (WGSS), which have offered trusted entry points for vital mental health support and skills building despite the pervasive stigma surrounding GBV. UNFPA was also commended for improving GBV visibility and awareness, particularly in a highly GBV sensitive context. The incorporation of cash and voucher assistance (CVA) further enhanced access to these services by removing financial barriers for displaced and vulnerable women and girls. However, persistent barriers hinder the overall effectiveness of these efforts, including weak referral systems, limited community awareness, supply chain disruptions and service quality issues in the SRH domain, as well as insecurity, legal and policy constraints, and fragmented coverage in GBV services. The absence of integrative, survivor-centred approaches also undermines confidentiality and accessibility for those affected.

Coordination

UNFPA has demonstrated effective coordination and leadership in both SRHR and GBV response initiatives; however, several gaps still hinder optimal responsiveness. In the realm of SRH, UNFPA provided strong advocacy and technical leadership while supporting the coordination of the sexual and reproductive health in emergencies (SRHiE) working group, especially at the subnational level. Their efforts to promote the minimum initial service package (MISP) have been notable. Nevertheless, challenges persist, including delays in activation, the absence of a national coordinator, a lack of early partner mapping and limited joint planning, which have constrained an effective response to SRH needs. Regarding GBV, UNFPA has successfully scaled up its leadership of the GBV Area of Responsibility (AoR) by expanding subnational coordination structures, developing essential technical guidance, and promoting localization through national co-leadership. This progress is particularly commendable given the complex and politically sensitive context surrounding GBV. However, issues such as cautious advocacy on GBV and conflict-related sexual violence (CRSV), limited data sharing and overlapping mandates with UNHCR and UNICEF in the broader protection sector have led to a less coordinated GBV response and a lack of clarity surrounding referral pathways.

Coverage

UNFPA set ambitious coverage targets for its humanitarian response in 2024, particularly emphasizing GBV interventions and expanding its operational reach through mobile services, optimized partnerships and the establishment of new subnational offices. However, overall coverage has remained limited in relation to the scale of need, with supply distribution disproportionately focused on more accessible areas due to security and access constraints, raising concerns about the equity of

the response. Furthermore, while UNFPA has made targeted efforts to reach vulnerable groups – including adolescents, persons with disabilities and marginalized host communities – these efforts largely relied on partner-led selection processes and mobile service delivery. The organization's ability to identify and reach the most vulnerable populations, as well as adhere to the LNOB principle, has been significantly constrained by limited access in conflict-affected states and a lack of systematic, disaggregated data. Additionally, UNFPA's application of humanitarian principles has been inconsistent and largely implicit, with limited staff knowledge and reliance on the HCT for access, occurring within a severely shrinking and politicized humanitarian space. The challenging environment marked by significant access constraints and the presence of UNFPA only in areas held by the Sudanese Armed Forces (SAF), along with concerns regarding last-mile supply assurance, further challenges the organization's ability to uphold its principled humanitarian posture.

Efficiency

In efficiency terms, UNFPA demonstrated both strengths and critical areas for improvement. In timeliness, while UNFPA met the minimum preparedness actions and addressed acute needs prior to the IASC system-wide scale-up, the rapid escalation of the crisis throughout 2024 quickly outpaced the agency's capacity to mobilize resources effectively. Structural constraints, including development-oriented systems and slow internal processes, hindered the agility of UNFPA, particularly after a momentum loss from September 2023. However, the arrival of new leadership by mid-2024 introduced a renewed focus on flexibility and responsiveness.

Regarding human resources, UNFPA made timely mobilization efforts early in the response, including the deployment of a humanitarian coordinator and key national staff, which were crucial for initial effectiveness. Nonetheless, overall resource scaling did not meet expectations due to recruitment delays and a lack of experienced humanitarian staff.

Supply chain challenges emerged as critical bottlenecks, with internal inefficiencies such as delayed decision-making and inadequate planning, alongside external constraints such as the collapse of the national supply system and access restrictions, which severely impacted supply delivery. While UNFPA managed some successes, such as reaching 15 states with life-saving supplies, overall supply chain performance remained inadequate for a system-wide scale-up.

On the funding front, UNFPA successfully doubled external contributions compared to 2022, reflecting effective donor engagement and trust-building, particularly concerning GBV mandates. However, despite increased fundraising efforts, the organization remained underfunded, experiencing a widening gap in 2024 and 2025 and a failure to substantially increase the allocation of core resources to operational capabilities in Sudan.

UNFPA's engaged with national partners to strengthen its response and localization efforts, although challenges related to partner capacity and diversity persisted. Furthermore, monitoring of humanitarian efforts was often compromised by access and security issues, leading to reliance on third-party monitoring and insufficient real-time data for decision-making.

Finally, a risk-averse culture, weakened alignment with 'no regrets' principles and centralized decision-making processes at the country office hindered operational efficiency. Although improvements in leadership and coordination occurred by mid-2024, these changes came late, with early inefficiencies exacerbated by ambiguous lines of authority and siloed decision-making at the regional and headquarters levels. Collectively, these factors critically hindered the capacity of UNFPA to act with the required speed, scale, and risk tolerance expected in a humanitarian emergency.

Coherence

UNFPA demonstrated strong technical alignment with inter-agency standards in SRHiE and gender-based violence in emergencies (GBViE). The organization has established itself as a

collaborative and capable partner, contributing meaningfully to coordination platforms, assessments, and advocacy efforts for core priorities such as MISP and PSEA. Internally, UNFPA has promoted integrated service delivery at the field level, successfully implementing joint interventions that address both SRH and GBV through clinics, women and girls safe spaces (WGSS and community networks. However, strategic integration has faced limitations due to the existence of siloed systems, separate work plans and priorities driven by donor requirements. These challenges have hindered the full realization of a cohesive approach to service delivery.

Connectedness

UNFPA made strides in fostering connectedness between humanitarian and development efforts, although challenges remain in ensuring sustainability and resilience in volatile contexts. In the area of transition planning, UNFPA demonstrated proactive measures, developing a new country programme document (CPD) despite facing operational disruptions and shifting humanitarian priorities in a highly volatile context. This approach reflects UNFPA's commitment to align with national development frameworks and a forward-thinking strategy in connection with broader national goals. While UNFPA contributed to resilience-building efforts for national and subnational governments through targeted interventions and collaborations, these initiatives have been modest in scale. Technical assistance provided to government entities has likely enhanced health system resilience; however, the overall impact remains limited. Initial efforts to secure development funding aimed at strengthening systems, building resilience and supporting recovery have begun, but they are currently insufficient to fully fund the new country programme across the humanitarian-development-peace (HDP) continuum.

In terms of local capacity, UNFPA has achieved short-term gains that show strong potential for sustainability, pushing localization efforts forward. However, these gains are at risk of being lost without multi-year funding and sustained mentorship.

Evaluation conclusions

Conclusion 1: UNFPA's humanitarian response was timely and addressed acute needs at an early stage in the crisis.

UNFPA responded in a timely manner and demonstrated operational agility immediately following the April 2023 conflict, preceding the inter-agency scale-up. The agency rapidly reactivated SRH and GBV services in the post-Khartoum context, focusing on the acute needs of women and girls, including adolescents, in areas with large-scale displacement, collapsed health infrastructure, and heightened GBV risks. UNFPA played a life-saving role by establishing access to services like CMR, emergency obstetric and neonatal care (EmONC) and WGSS, despite insecurity and system collapse. Key enablers of this agility included the rapid deployment of a humanitarian coordinator, a draft response plan, experienced national staff, pre-positioned supplies and longstanding partnerships. Early rapid needs assessments, though limited, were adequate for initial life-saving interventions. This experience highlights UNFPA's enjoys a comparative advantage in timely, agile and flexible delivery under extreme conditions.

Conclusion 2: While UNFPA adapted its operational presence and programming to the evolving humanitarian crisis, its response lost critical momentum over time due to insufficient humanitarian resourcing, weak data systems, development-oriented systems and process bottlenecks, ultimately limiting its reach and relevance in the face of escalating needs.

As the crisis evolved (from September 2023), UNFPA made relevant programmatic adaptations, including extending its operational presence, opening sub-offices, diversifying service delivery (static/mobile) and introducing CVA to mitigate financial barriers. Cross-border operations from Chad were initiated, enabling service continuation in hard-to-reach areas. However, the response gradually lost momentum, and its overall relevance declined through mid-2024. The capacity of UNFPA to

sustain a humanitarian posture and mobilize resources fell short of both its ambitions and the scale of needs, as it increasingly operated under capacity constraints.

The response plan lacked tailored strategies for Sudan's varied contexts, and there was no systematic mechanism to prioritize the most vulnerable. Vulnerability-based needs assessments were largely absent; prioritization relied on insufficient data (the humanitarian needs and response plan [HNRP]), displacement data and outdated pre-crisis information). The absence of disaggregated data and systematic community feedback undermined strategic targeting. The core role that UNFPA plays in population data generation was not fully leveraged. Operational constraints, including a delayed national staff redeployment and unclear supply decision-making, compounded challenges. In 2024, UNFPA reached only 18 per cent of its total target population, insufficient given the crisis scale.

Conclusion 3: UNFPA made targeted efforts to reach vulnerable groups and strengthen accountability, but these initiatives were not scaled or systematized.

UNFPA made targeted efforts to reach vulnerable groups (adolescents, persons with disabilities and marginalized communities) through partner-led and mobile modalities, but these efforts were not implemented at sufficient scale. Community feedback mechanisms were underutilized by most partners, leading to an incomplete feedback loop. While UNFPA visibly advanced AAP at the inter-agency level, its subnational approach focused primarily on data collection, not on fostering inclusive participation or enhancing responsiveness. Affected women reported confusion about services, low awareness of feedback mechanisms, and persistent safety concerns (GBV risks). Progress on PSEA capacity strengthening was noted, but field-level implementation remained inconsistent; reports indicated limited awareness of complaints mechanisms and low trust, contributing to significant underreporting.

Conclusion 4: UNFPA provided strong technical leadership and coordination in SRH and GBV, but its strategic influence and inter-agency advocacy were partially under-leveraged, although incremental improvements were observed from 2024 onwards.

UNFPA's response aligned with the collective humanitarian effort, providing strong technical leadership and coordination in its roles as GBV AoR lead and SRHiE working group co-lead. The agency helped sustain essential services, set standards, promoted localization and supported key protocols (MISP, CMR). It was recognized for sustained subnational coordination. However, inconsistent data sharing in the GBV AoR due to confidentiality concerns was a hindrance. The delayed national activation of the SRHiE working group constrained partner mapping and information exchange, reducing the influence of UNFPA on prioritization. The agency's advocacy on GBV, particularly CRSV, was perceived as overly cautious, limiting joint United Nations messaging. Systemic coordination challenges and the comparatively smaller operational footprint of UNFPA reduced its visibility and leverage in key inter-agency processes (e.g. famine planning, access negotiations, 2025 HNRP).

Conclusion 5: Human resource mobilization by UNFPA during the crisis was insufficiently agile, limiting its ability to deploy sufficient and skilled personnel at the scale and speed required for the response.

Despite early deployment of a humanitarian coordinator and the timely reaction of the global emergency response team (GERT) personnel, the overall human resources surge by UNFPA fell short of emergency standards. Mobilization was marked by unclear, centralized decision-making, prolonged delays and a limited pool of experienced staff. While GERT deployments were timely, enduring structural inefficiencies at the corporate level impeded effectiveness. The humanitarian support team (HST) was not fully activated, delaying key personnel. Surge personnel faced onboarding challenges due to limited institutional knowledge. A significant proportion of national staff operated remotely until

August 2024, and the absence of a senior international operations manager further constrained scale-up. HR mobilization often used inappropriate service contracts. Internal HR bottlenecks, compounded by external factors (visa restrictions, access), critically undermined the timely deployment of qualified personnel at scale.

Conclusion 6: UNFPA's supply chain response, despite some innovative workarounds, ultimately fell short of the scale and speed of the response.

Despite efforts to find alternative supply corridors and mitigate constraints from mid-2024, UNFPA's response faced systemic supply chain inefficiencies. UNFPA delivered supplies to key states (Darfur, Kordofan, Khartoum) through non-traditional partners but failed to materialize planned cross-border deliveries via South Sudan. Procurement delays, customs bottlenecks and unclear delineation of roles (country office, regional office, HQ) caused distribution delays of up to nine months. Significant demurrage charges were incurred, reflecting both the crisis constraints and persistent structural inefficiencies. Key constraints included a shortage of experienced logistics staff, limited warehousing, poor pipeline visibility and weak end-to-end tracking. This led to periodic stockouts and inconsistent supply coverage. External factors (collapsed national logistics, high costs, access restrictions) further compounded the inability to scale. Ultimately, the supply scale-up delivered by UNFPA did not meet IASC benchmarks, limiting overall response effectiveness.

Conclusion 7: Despite the introduction of third-party monitoring in hard-to-reach areas, UNFPA's overall monitoring and evaluation systems fell short of humanitarian standards.

While third-party monitoring (TPM) was proactively engaged to address access limits, the overall monitoring systems used by UNFPA did not meet humanitarian standards or ensure a data-driven, accountable response. The agency lacked an overarching humanitarian monitoring framework for a prioritized, needs-based response. Available data was limited, focusing mainly on institutional inputs (e.g. training) rather than community outputs or outcomes. TPM data was not consistently integrated, analysed, or systematically used. There was no evidence of a functional monitoring and evaluation (M&E) framework or real-time performance monitoring. Internal reporting was process-oriented, and a lack of M&E capacity further constrained evidence generation for adaptive management.

Conclusion 8: UNFPA's corporate leadership and decision-making processes were not sufficiently adapted to the demands of a large-scale humanitarian crisis, with centralized, compliance-driven operations and a limited risk appetite, despite improvements under new country leadership from mid-2024.

Though new country leadership from mid-2024 improved responsiveness, UNFPA's corporate processes remained misaligned with the demands of the conflict-driven crisis. The response was largely centralized, compliance-driven and anchored in development-oriented systems. Decision-making was concentrated nationally, with ongoing ambiguity across HQ, regional office, and country office roles (HR, supply), causing delays in staff redeployment and remote management continuation. The crisis response team (CRT) was perceived as insufficiently assertive. UNFPA showed a limited risk appetite and inconsistent use of the IASC 'no regrets' principle. Bureaucratic processes and development contracting procedures constrained timely approvals and fund disbursement. Risk tolerance was not operationalized (April 2023–June 2024); country leadership prioritized risk aversion (fiduciary/compliance) over the consequences of inaction (disrupted services). This disconnect undermined expected agility and responsiveness.

Conclusion 9: UNFPA's response was effectively delivered through strong national partnerships, commitment to localization and early transition planning, but its partnership model remained largely operational and fragile, with insufficient investment in long-term capacity strengthening and resilience building.

UNFPA's response relied heavily on strong, long-standing national partnerships, including women led organizations (WLO), which proved essential for sustaining life-saving SRH/GBV services in high-risk, inaccessible areas. UNFPA sustained localization efforts, adopted a consortium model for subgrants, and used TPM to strengthen monitoring and oversight. A shift toward diversified, strategic partnerships (including international non-governmental organizations) from 2025 enhanced coverage and risk diversification. Localization initiatives yielded meaningful short-term capacity gains for partners and service providers. UNFPA also initiated early transition planning by aligning the new CPD with national frameworks, intending to bridge humanitarian and development work coherently. However, the partnership model remained primarily operational (funds management, capacity-building) with less focus on strategic oversight or mutual learning. Capacity gains are fragile due to the lack of predictable, multi-year financing and sustained investment. Local partners faced critical challenges, including limited capacity, high staff turnover, funding disbursement delays and inadequate long-term resource mobilization skills. Short-term funding cycles further constrained durable capacity strengthening.

Key evaluation recommendations

Recommendation 1: Use of the risk management system

The Sudan country office should adapt its risk posture and decision-making processes to operate effectively in volatile humanitarian contexts, applying the no-regrets principle and balancing risk with operational necessity, based on UNFPA's enterprise risk management (ERM) policy, risk appetite statement, and emergency policies and procedures (EPPs). This will require the support of regional offices and, particularly, HQ.

Recommendation 2: Human resources capacity

The Sudan country office should advocate with the Division of Human Resources (DHR) and the Humanitarian Response Division (HRD) for timely and efficient recruitment of staff, surge and GERT during scale-ups and to update the Delegation of Authority (DOA) to reflect lessons learned from Sudan, to align to the EPP, and seek to incorporate the key lessons learned in future emergency HR realignments. This will ensure that, during emergencies, the country office can rapidly deploy qualified staff with delegated authority, sustain critical functions in sub-offices and retain experienced personnel despite challenging conditions, contingent upon staff safety and the security environment. This will require the support and timely response and approval by the regional office and particularly HRD and DHR.

Recommendation 3: Supply chain management

The Sudan country office should strengthen its end-to-end supply chain management systems and processes to meet humanitarian emergency timelines, including a comprehensive supplies plan, timely customs clearance processes, pre-positioning commodities in strategic locations, and transparent last-mile delivery and tracking in coordination with partners and the logistics cluster. This will require the support and timely action of the regional office and particularly HQ, the Supply Chain Management Unit, HRD and GERT.

Recommendation 4: Adaptation to evolving needs

UNFPA should strengthen its adaptive capacity by implementing differentiated programming strategies for acute and protracted needs in diverse local contexts including humanitarian access realities, underpinned by real-time data, flexible programming modalities and proactive operational planning that responds to Sudan's shifting conflict dynamics and socio-cultural diversity.

Recommendation 5: Monitoring and data

The country office should strengthen its existing M&E systems based on the HRD's newly released Humanitarian Data Framework - a Guide for UNFPA Field Operations to facilitate real-time collection and use of humanitarian data for decision-making and response. The updated country office M&E systems should be designed to facilitate timely needs analysis (including population dynamics and vulnerability assessments), real-time performance monitoring, TPM integration, outcome tracking and meaningful use of community feedback.

Recommendation 6: Accountability and participation of women and girls

UNFPA should institutionalize inclusive and accountable humanitarian programming by systematically strengthening participation and feedback mechanisms for women, girls and other vulnerable populations through accountability for affected populations mechanisms.

Recommendation 7: Partnerships and localization

UNFPA Sudan should further strengthen its localization efforts by developing and implementing a conflict-sensitive and context-specific localization strategy and operational plan based on the principles of the Grand Bargain and the UNFPA's Guidance note to operationalize UNFPA's humanitarian localization commitments. This should aim to enhance shared ownership, local response capacity, risk sharing and sustainable funding modalities, and build long-term resilience in both acute and protracted crises. This will require the guidance and support of regional offices and HQ

1. Introduction

1.1 Purpose and objectives of the evaluation

The evaluation is intended to fulfil both learning and accountability functions. By providing an independent and objective assessment, it will explicitly document the trajectory of United Nations Population Fund's (UNFPA) humanitarian interventions in Sudan, offering an evidence-based analysis of progress. In doing so, it aims to reinforce accountability to donors and affected populations, while simultaneously broadening the evidence base to inform the ongoing response, the next UNFPA programme cycle and regional or cross-border humanitarian strategies.

The objectives of the evaluation are:

- To provide an independent assessment of the relevance, coherence, coordination, effectiveness, coverage, efficiency and connectedness of UNFPA humanitarian assistance;
- To assess the capacity of UNFPA to connect immediate, life-saving humanitarian support with long-term development goals;
- To examine the role played by the UNFPA Sudan country office within the coordination structures of the United Nations country team (UNCT) and the humanitarian country team (HCT), with the aim of enhancing the collective United Nations contribution to the humanitarian response and supporting sustainable recovery;
- To assess the extent and effectiveness of UNFPA Sudan's engagement in regional humanitarian responses and cross-border collaboration with Chad and South Sudan;
- To draw key conclusions regarding the current contribution by UNFPA to the humanitarian response and to develop a set of actionable, forward-looking recommendations to inform the ongoing response and the design of the forthcoming programme cycle.

The intended users of the evaluation are: (1) the UNFPA Sudan country office, Arab States regional office and headquarters divisions; (2) the HCT and leads of the humanitarian clusters or working and coordination groups, (protection, health, logistics and access, protection from sexual exploitation and abuse (PSEA), mental health and psychosocial support (MHPSS); (3) the Government of Sudan; (4) implementing partners of the UNFPA Sudan country office; (5) rights holders involved in UNFPA interventions and the organizations that represent them (in particular women, adolescents and youth); (6) the UNCT and HCT; and (7) donors.

1.2 Scope of the evaluation

As outlined in the terms of reference (Annex 4), this evaluation focuses on UNFPA's humanitarian interventions in Sudan during the period 2023–2024.

The temporal scope extends from the onset of the Sudan crisis on 15 April 2023 through to the end of March 2025. Given that the humanitarian system-wide scale-up under IASC was activated on 29 August 2023, the evaluation also considers UNFPA's actions prior to this activation.

The geographic scope includes all UNFPA-supported states affected by the crisis, namely: Red Sea, Kassala, Gedarif, White Nile, North Darfur, South Darfur, River Nile and Northern State. It also accounts for cross-border operations that contributed to the Sudan response, such as deployments from the Global Emergency Response Team (GERT) in Chad.

The thematic scope includes all UNFPA humanitarian interventions:

- Provision of and access to life-saving sexual and reproductive health (SRH) services;
- Provision of and access to life-saving gender-based violence (GBV) services;
- UNFPA's inter-agency mandated leadership and coordination roles in the GBV Area of Responsibility (AoR) and the SRHiE working group.

The evaluation integrated cross-cutting issues in line with UNFPA's global commitments and core principles as laid out in its evaluation policy (2024).[27] It includes issues, such as accountability to affected populations (AAP),[28] PSEA,[29] gender equality, humanitarian principles, human rights, and leaving no one behind (LNOB) (including disability inclusion) across its design, methodology, analysis and recommendations. In practice, greater emphasis was placed on humanitarian principles (e.g. neutrality, impartiality and access) than on human rights, reflecting operational priorities. LNOB was understood primarily in terms of reaching hard-to-access or underserved areas and ensuring services for the most vulnerable, including persons with disabilities, based on the reconstructed theory of change. These issues were assessed under the coverage criterion. While UNFPA's guidance on humanitarian evaluations[30] does not explicitly mention AAP or PSEA, both were essential to ensuring that the response was ethical, inclusive, and accountable.

Design and methodology incorporated dedicated questions on cross-cutting themes under relevance, effectiveness, coverage and coherence. Data collection tools were adapted to include voices of diverse rights holders, including youth, persons with disabilities, internally displaced persons (IDPs), and women-led organizations. Quantitative (key informant interviews [KIIs], survey) and qualitative data like focus group discussions (FGDs) were disaggregated by age, sex, disability and displacement status, to the extent possible, enabling analysis of differential access and outcomes. An intersectional lens was applied in identifying how compounding vulnerabilities (e.g. disability, youth and displacement) influenced service access. This enhanced the depth of the findings and conclusions. Findings highlighted adherence to humanitarian principles, but inconsistent implementation of gender equality, and disability inclusion, AAP and PSEA. Gaps also included limited feedback mechanisms and limited aggregated data. The evaluation recommendations call for stronger integration of inclusive monitoring and aggregated data, including for disability- and gender, and enhancing AAP systems, including for intersectional targeting of vulnerabilities.

The evaluation excluded the following:

- UNFPA humanitarian interventions under the seventh country programme prior to the 2023 crisis, as these were covered by the Impact Assessment of the UNFPA Multi-Country Response to Humanitarian Crises[31];
- Regional responses or responses in neighbouring countries affected by the Sudan crisis;
- Country programme document (CPD) interventions not specific to crisis-affected areas;
- Refugee responses involving non-Sudanese populations inside Sudan or Sudanese refugees hosted in other countries;
- An assessment of the UNFPA's contribution to the 2023 and 2024 humanitarian needs and response plans (HNRPs) under the collective HCT framework.

[27] UNFPA Evaluation Policy, 2024. Available at https://www.unfpa.org/sites/default/files/admin-resource/UNFPA_Evaluation_Policy_2024.pdf
[28] https://www.unfpa.org/press/statement-principals-inter-agency-standing-committee-unfpa-executive-director-reaffirms
[29] https://www.unfpa.org/press/statement-inter-agency-standing-committee-protection-sexual-exploitation-and-abuse-and-sexual
[30] UNFPA, Guidance on humanitarian evaluations, 2024.
[31] UNFPA, Impact Assessment Report Of The UNFPA Multi-Country Response To Humanitarian Crises: Sudan, 2022.

The evaluation addressed eight evaluation questions (EQs), aligned with six evaluation criteria of the Organization for Economic Co-operation and Development Assistance Committee (OECD/DAC)[32] and Active Learning Network for Accountability and Performance in Humanitarian Action (ALNAP).[33] relevance, effectiveness, coverage, efficiency, coherence, and connectedness. Each evaluation question tested assumptions underpinning these pathways of change in the theory of change. The EQs are presented in the table below.

Table 2: UNFPA overarching evaluation questions, 2025

Overarching question	To what extent and how did UNFPA humanitarian responses contribute to meeting humanitarian needs in Sudan during 2023-2024?
Evaluation question 1 Relevance	To what extent and how did the UNFPA humanitarian response address and adapt to the needs of the affected populations, including the most vulnerable and marginalised groups?
Evaluation question 2 Effectiveness	To what extent and how was the UNFPA humanitarian response effective in ensuring continued access and utilization of quality SRH services for affected populations?
Evaluation question 3 Effectiveness	To what extent and how did UNFPA humanitarian response prevent, mitigate and respond to GBV and harmful practices for affected populations, including the most vulnerable and marginalized groups?
Evaluation question 4 Effectiveness Coordination	To what extent has UNFPA's leadership and coordination of the SRHiE TWG and the GBV AoRs contributed to continued access to SRH and GBV services for those in need?
Evaluation question 5 Coverage	To what extent and how has UNFPA's humanitarian response reached the affected populations, including the most vulnerable and marginalized?
Evaluation question 6 Efficiency	To what extent has UNFPA made good use of its human, financial and administrative procedures and resources, to respond timely to the humanitarian needs of the affected populations?
Evaluation question 7 Coherence	To what extent and how were UNFPA's interventions internally and externally coherent and coordinated with the Inter-Agency humanitarian response?
Evaluation question 8 Connectedness	To what extent did the UNFPA humanitarian programming take longer- term development goals into consideration, including strengthening the resilience of national and local actors to prepare for, respond to and recover from humanitarian crises?

The evaluation assessed 37 underlying assumptions, each systematically tested to respond to the evaluation questions. These assumptions did not serve as fixed benchmarks, but rather as adaptable analytical variables. This approach allowed for a context-sensitive evaluation of UNFPA's humanitarian response.

The assumptions were derived from the pathways of change outlined in the theory of change (see Fig 6). Their formulation was guided by UNFPA's fast track procedures (FTPs), standard operating procedures (SOPs) in humanitarian settings, and global best practices in humanitarian evaluation. Developed jointly with the IEO, the assumptions were further shaped during the document review, scoping interviews, and reconstruction of the theory of change. Each assumption was intentionally phrased to elicit both evaluative judgment (e.g. "to what extent") and analytical insight (e.g. "how"), encouraging reflection on both outcome-level effects and the processes that led to them. The evaluation used specific indicators to assess each assumption. These indicators were designed to

[32] https://www.oecd.org/en/topics/sub-issues/development-co-operation-evaluation-and-effectiveness/evaluation-criteria.html#:~:text=The%20OECD%20has%20defined%20six,two%20principles%20for%20their%20use.

[33] https://alnap.org/help-library/resources/evaluation-of-humanitarian-action-eha-guide/

produce indicative evidence and enable a structured, rigorous evaluation. Based on analysis and triangulation of the collected evidence, the evaluation applied transparent, objective and evidence-based judgments.

1.3 Evaluation approach

The evaluation adopted a sequenced, phase-based approach, underpinned by a mixed-methods design and a theory-based approach. The methodology integrated multiple data collection methods to ensure triangulation, rigor, and adaptability to Sudan's fluid and highly complex context.

The evaluation was conducted in alignment with the UNEG Norms and Standards for Evaluation,[34] the UNEG Ethical Guidelines,[35] the UNEG Code of Conduct for Evaluation in the United Nations System,[36] the UNFPA Guidance on Humanitarian Evaluations,[37] and the UNFPA Evaluation Handbook.[38] These frameworks informed the evaluation's commitment to independence, impartiality, credibility, accountability and the management of potential conflicts of interest. Ethical principles were contextualized to Sudan, with heightened attention to vulnerable groups such as women, adolescent girls, GBV survivors, and persons with disabilities. The team ensured informed, voluntary consent, and adapted procedures to local cultural and security conditions. Participation was confidential and risk-sensitive, applying do-no-harm principles and World Health Organization (WHO) guidance for any GBV-related inquiry.[39] Data collection emphasized dignity, fair representation across gender and vulnerability, and cultural respect, ensuring inclusion. Identifying information was never shared, and privacy was strictly protected. All documents were stored on a secure UNFPA server.

1.3.1 Theory of change and contribution analysis

The evaluation was guided by a theory-based approach, structured around a reconstructed theory of change that articulated how UNFPA's humanitarian interventions across 2023 and 2024 were expected to generate outputs, contribute to outcomes, and achieve the overarching goal of saving the lives of women and girls during the crisis. This theory of change served as a central analytical framework and informed the evaluation's design, data collection and analysis. To operationalize this framework, the evaluation team developed an evaluation matrix that mapped evaluation criteria, EQs, assumptions for verification, indicators and data sources to the reconstructed theory of change describing UNFPA's humanitarian response in Sudan.

A realist evaluation approach[40] was also applied, focusing on understanding what worked, for whom, and under what conditions. This allowed for a nuanced analysis of effectiveness, especially in a fluid and highly complex humanitarian setting where binary measures of success or failure would be insufficient.

The evaluation was participatory in nature, promoting inclusivity and transparency. It engaged stakeholders at both national and subnational levels, including government institutions, civil society organizations, United Nations agencies, donors, and rights holders such as women, girls and youth. Particular attention was given to amplifying the voices of marginalized groups, including persons with disabilities, hard to reach communities and female-headed households.

A mixed-methods approach was employed, combining qualitative and quantitative tools. These included document review, mini surveys and stakeholder consultations. Data collection was sequenced

[34] UNEG, Norms and Standards for Evaluation (2016). Available at https://www.unevaluation.org/document/detail/1914
[35] UNEG, Ethical Guidelines for Evaluation (2008). Available at https://www.unevaluation.org/uneg_publications/uneg-ethical-guidelines-evaluation
[36] UNEG Code of Conduct for Evaluation in the UN System (2008). Available at https://procurement-notices.undp.org/view_file.cfm?doc_id=245190
[37] UNFPA, Guidance on Humanitarian evaluations (2024).
[38] UNFPA, Evaluation Handbook (2024).
[39] https://www.who.int/publications/i/item/9789241595681
[40] https://www.betterevaluation.org/methods-approaches/approaches/realist-evaluation

so that insights from the design phase informed field-level interviews and contextual analysis. This iterative approach enhanced the credibility and depth of findings.

Contribution analysis was central to assessing effectiveness. It examined the extent to which UNFPA's outputs contributed to intended outcomes, acknowledging the presence of multiple influencing factors. While the evaluation did not attempt to establish direct attribution, contribution analysis[41] enabled the team to build a credible narrative based on triangulated evidence. Where data gaps existed, these were clearly acknowledged as limitations.

1.3.2 Data collection methods

The evaluation followed a sequenced data collection process, structured in line with the terms of reference and the UNFPA Evaluation Handbook. It unfolded in three phases: (1) design, (2) fieldwork, and (3) synthesis and reporting. Each phase informed the next, allowing for iterative adjustments based on emerging insights. Across these phases, eight data collection methods were applied:

Method 1: Document review - design phase

The evaluation began with a detailed qualitative review of 80 documents, sourced from UNFPA internal reports, external evaluations and relevant contextual and programmatic materials. This review supported analysis of both strategic and operational dimensions of the UNFPA response. All documents were systematically reviewed, and relevant data were extracted and categorized into an evidence matrix to enable triangulation during subsequent analysis.

Method 2: Stakeholder consultations - design phase

Eight structured scoping interviews were conducted with UNFPA staff and partners at the global, regional, and country levels, including technical sector experts. These consultations provided early insights into how UNFPA's humanitarian response operated in practice and helped refine the evaluation scope and priorities. Interviews followed a semi-structured guide, and the resulting transcripts or notes were entered into the evidence matrix.

Methods 3: Stakeholder consultations – field phase

During the field phase, the evaluation team held semi-structured interviews with 110 stakeholders, including UNFPA field staff, implementing partners, and other key actors. These consultations enabled deeper analysis of operational experiences. Data were captured through detailed notes or transcripts, which were categorized in the evidence matrix and analysed against the assumptions for verification.

Method 4: Mini survey – field phase

A paper-based mini survey was distributed to consultation participants to capture quantitative perspectives on the response from UNFPA. Due to logistical constraints and remote interviews, only 30 surveys were completed. The survey, consisting of closed-ended questions, was designed to complement qualitative insights and identify measurable patterns. Responses were entered into the evidence matrix and analysed in relation to the evaluation's assumptions for verification.

Method 5: Document review – field phase

Additional documents were collected during the field phase to address data gaps, particularly to trace links from outputs to outcomes and test theory of change assumptions. These included service delivery data, meeting notes and relevant correspondence. Extracted data were incorporated into the evidence matrix and used to validate or challenge emerging findings.

[41] See UNFPA Evaluation Handbook (2024) for a detailed explanation of the use of contribution analysis in UNFPA evaluations.

Method 6: Focus group discussions – field phase

The evaluation team conducted 15 FGDs with affected populations, service providers and government officials, reaching around 123 female and 19 male participants. An open-ended discussion guide was used to explore perceptions of service quality, UNFPA engagement and support, access and relevance. Notes were transcribed or summarized and fed into the evidence matrix to support thematic analysis and triangulation.

Method 7: Site visits – field phase

The evaluation team conducted site visits to observe UNFPA-supported GBV and SRH service delivery in health facilities (including mobile clinics), women and girls' safe spaces (WGSS), and camps and gathering sites hosting displaced populations. These visits enabled validation of reported practices and provided direct insights into service conditions, attendance, facility infrastructure, supplies and staffing. Unstructured observations notes were included in the evidence matrix for triangulated analysis.

Method 8: Debriefs and validation sessions

Following data collection, the evaluation team conducted an internal field visit debrief and an external validation session with the evaluation reference group. These sessions aimed to validate preliminary findings, gather additional insights on emerging findings, and verify the consistency of evidence across data sources. These consultations strengthened the credibility of the analysis, helped refine evaluative judgments, and ensured that conclusions reflected both operational realities. Notes from these sessions were incorporated into the evidence matrix and used to validate or adjust preliminary findings based on additional information obtained.

1.3.3 Stakeholder analysis, sampling and sites visited

A comprehensive stakeholder map was developed during the inception phase to identify key actors involved in or affected by UNFPA's humanitarian response in Sudan. This mapping exercise included rights holders (e.g. women, adolescent girls, persons with disabilities and IDPs), duty bearers (e.g. government entities, local authorities), implementing partners (national and international NGOs), and development and humanitarian partners (e.g. United Nations agencies, donors, cluster and sub-cluster leads). The map also outlined functional relationships between actors, including coordination roles, funding flows and service delivery responsibilities.

The evaluation sample was drawn directly from this stakeholder map, using a purposive sampling strategy to ensure balanced representation across stakeholder categories and geographic areas, while considering the scale and diversity of UNFPA's humanitarian response. A full analysis of all interventions implemented during the 2023–2024 period was not feasible due to the wide geographic spread, the fluid and highly complex context, data scarcity and access limitations. Instead, a targeted selection of interventions, stakeholders, and sites was sampled using transparent criteria aimed at maximizing analytical depth rather than statistical representativeness, acknowledging that findings may not be generalizable to all operations.

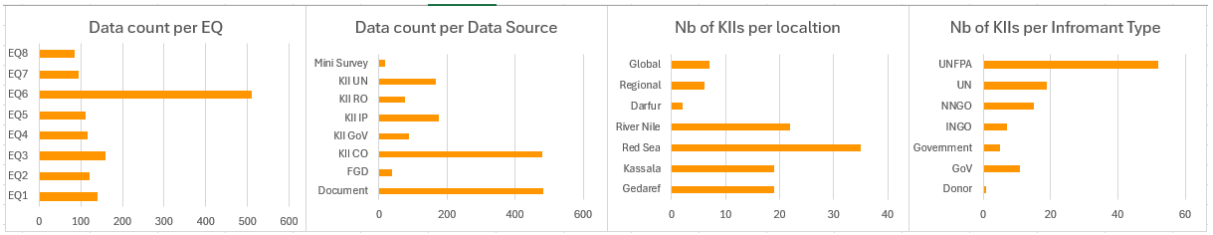
Selection criteria for sampling included geographic variation (displacement patterns and settlements, different states, and operating contexts); programmatic diversity (SRH, GBV, coordination mandates, LNOB, AAP and PSEA); partner type (including implementing partners, United Nations, civil society organizations and government actors); and accessibility and security constraints.

1.3.4 Analysis methods

An evidence matrix was developed in the inception phase. All collected data were coded in this matrix which functioned as a structured coding framework. This framework included the 37 assumptions for verification, as well as additional thematic codes such as lessons learned, recommendations and illustrative quotations. Distinct data points were entered into the matrix. The evidence matrix was systematically reviewed and cleaned to ensure consistency, remove duplicates or irrelevant entries and address any coding errors. A summary of the sampling strategy and data sources is presented in the table below.

The evaluation concluded that data availability was sufficient to enable robust triangulation across sources, geographic regions, and both primary and secondary evidence sources. A total of 1,530 distinct data points were systematically coded across the eight evaluation questions, with a relatively even distribution observed, apart from the evaluation question on efficiency, which collected substantially more. The evidence base comprised 80 documents sourced from both internal and external stakeholders (see Annex 1), alongside extensive primary data collection, which included 110 KIIs, 15 FGDs, and 30 mini surveys. Field visits were conducted in four locations aligned with UNFPA subnational hubs: Red Sea, Kassala, Gedarif and River Nile states. In addition, data was collected from Darfur and Kordofan through document review and some remote KIIs. The distribution of KIIs by source type and geographic coverage is presented in Figure 1 below.

Figure 1: Distribution of KIIs per type and geographic coverage, 2025



Source: UNFPA Sudan country office

1.3.5 Limitations and mitigation

Despite the complex humanitarian context, the evaluation encountered relatively few limitations. Where constraints did arise, the evaluation team, in collaboration with the UNFPA evaluation manager, adopted adaptive approaches to mitigate limitations. These included streamlining specific stages of the evaluation (inception and data collection), conducting remote interviews where necessary (including with previous staff no longer in Sudan), overlapping phases where feasible, and integrating certain activities into the field phase to maintain methodological rigour while ensuring operational feasibility.

Table 3: Limitations, implications, and measure during the evaluation

Limitation	Implications and measures
Constrained access for field visit	• Darfur, Kordofan and Khartoum were excluded from the field visits due to security and access constraints. • To mitigate this, the evaluation team conducted remote KIIs with UNFPA staff based in these locations. In addition, relevant results data, including third-party monitoring (TPM) reports, were obtained to ensure that outcomes and perceptions from these areas were at least partially reflected in the analysis.

Data gaps	• Scarcity of data was a critical limitation throughout. Reliable baseline and results data limited assessing relevance, effectiveness and coordination. Broader humanitarian data sources, such as dashboards and needs assessments, also showed notable gaps, and inconsistencies in available data hindered the ability to monitor trends over time. In particular, the limited availability of reliable results data for 2023 significantly constrained the analysis of effectiveness during that year, and the evaluation could only report on 2024. Data on implementing partners and supply chains were occasionally contradictory, making it difficult to draw definitive conclusions. Within the GBV AoR and SRHiE working group, data dashboards were not yet in place, and service and partner mapping was still under development. Population data remained outdated, requiring at times reliance on pre-conflict sources. Displacement data were often inconsistent across sources such as the displacement tracking matrix (DTM), Office for the Coordination of Humanitarian Affairs (OCHA), UNFPA and non-governmental organization (NGO) assessments. Data were not sufficiently disaggregated by priority or vulnerability needs and, more critically, lacked geographic granularity. As such, there is substantial doubt as to whether the reported results are representative of both conflict-affected and non-conflict-affected states, particularly given the greater scale and severity of needs in conflict-affected areas. • In response, for the purpose of drawing findings related to 'effectiveness' and 'coverage', the evaluation relied on 2023 and 2024 data. However, there were significant quality issues, especially with the 2023 annual result data. The evaluation team placed greater emphasis on KIIs to generate qualitative insights. Where possible, anecdotal evidence from situation reports and inter-agency data were used to provide indicative information on UNFPA's contributions and contextual dynamics.
High staff turnover	• High staff turnover within the Sudan response posed a challenge to institutional memory and continuity. • To address this, the evaluation team identified and interviewed staff who had previously held relevant roles, ensuring that their insights were captured even if they were no longer in post.
Access to populations	• Engaging directly with affected populations, particularly on sensitive topics, such as GBV, conflict or displacement, involved ethical and operational risks. • To mitigate these, the evaluation team adhered to 'do no harm' principles, ensured confidentiality, and applied robust data protection protocols. All participants were informed of their rights, including the right to withdraw, and gave oral consent before participating. In regions where access was not possible due to security concerns, primary data gaps were partially addressed through remote consultations and review of secondary sources.

2. Country context

This section describes the Sudan context, UNFPA's humanitarian response, and the inter-agency humanitarian response.

2.1 Development challenges, national strategies and the humanitarian context

Geopolitical, social and economic context
Sudan is classified as a low-income country, with an estimated population of 45.3 million in 2023 and projections indicating an increase to 85 million by 2050.[42] This demographic growth is largely driven by a persistently high fertility rate of 4.3 births per woman (2024).[43] Life expectancy remains relatively low at 64 years for males and 69 for females. [44]

Sudan's national development agenda has been shaped by political transitions, economic fragility and recurring humanitarian crises. The Sudan United Nations Development Assistance Framework (UNDAF) 2018–2021 served as an integrated planning framework aligning United Nations development programming with national priorities.[45] This framework emphasized national ownership, partnership, and the humanitarian-development nexus, addressing the root causes of vulnerability and displacement while promoting durable solutions. Recognizing the country's vulnerability to natural disasters, the Sudanese government has taken steps to integrate disaster risk management into its national development planning.[46]

Sudan's health system strengthening has been driven by the National Health Sector Strategic Plan II (2012–2016)[47] and the Reproductive Health Strategy and Maternal Mortality Reduction Roadmap,[48] which – alongside the Reproductive Health Policy, Child Health Policy and HIV/AIDS Policy – lays the foundation for integrating sexual and reproductive health into primary health care and guiding workforce capacity, governance and equity efforts.

The country faces ongoing development challenges, ranking 170 out of 193 on the Human Development Index (2022) [49] and 159 out of 166 on the Sustainable Development Goals Index.[50] Sudan's GDP per capita declined from $1,982 in 2011 to $751 in 2021, reflecting a decade-long economic contraction.[6] The proportion of the population living in extreme poverty (under $2.15 per day) nearly doubled from 30 per cent in 2022 to 57 per cent in 2024.[51] These indicators reflect a deepening socio-economic crisis, macroeconomic instability and the collapse of basic services. Rising

[42] https://data.who.int/countries/729
[43] https://www.unfpa.org/data/world-population/SD
[44] https://data.who.int/countries/729
[45] Sudan United Nations Development Assistance Framework (UNDAF), 2018-2021.
[46] Sudan Emergency Preparedness and Response Report, 2021. Available at https://www.gfdrr.org/en/publication/sudan-emergency-preparedness-and-response-report-2021?utm_source=chatgpt.com
[47] The Republic of Sudan National Health Sector Strategic Plan II (2012-16). Available at https://extranet.who.int/countryplanningcycles/sites/default/files/planning_cycle_repository/sudan/sudan_national_health_sector_strategic_plan_nhssp_2012-2016.pdf?utm_source=chatgpt.com
[48] UNFPA CPD.
[49] https://hdr.undp.org/data-center/human-development-index#/indicies/HDI
[50] https://dashboards.sdgindex.org/profiles/sudan
[51] https://thedocs.worldbank.org/en/doc/bae48ff2fefc5a869546775b3f010735-0500062021/related/mpo-sdn.pdf

inflation, displacement, and deteriorating health and education systems[52] have significantly affected access to essential services.

Sudan's political trajectory has been shaped by decades of civil conflict, regional violence and political instability. The 2005 Comprehensive Peace Agreement led to the secession of South Sudan in 2011, resulting in the loss of over 50 per cent of government revenue and 95 per cent of oil export earnings, precipitating a major economic crisis and widespread protests by late 2013.[53]

Mass demonstrations in December 2018 against economic hardship and autocratic rule led to the ousting of President Omar al-Bashir in April 2019. A transitional government was formed in September 2019 and began implementing reforms, including the Juba Peace Agreement (October 2020). However, a military coup in October 2021 dissolved the transitional government, halting democratic progress. The Political Framework Agreement (December 2022) failed to restore civilian rule, and tensions escalated into a power struggle between the Sudanese Armed Forces (SAF) and the Rapid Support Forces (RSF).[54]

On 15 April 2023, large-scale armed conflict broke out between SAF and RSF in Khartoum and other regions, plunging Sudan into one of the most severe humanitarian crises in its history.[55]

Humanitarian context

The conflict that erupted in April 2023 has triggered what has been described by the United Nations as "the most devastating humanitarian, displacement, and protection crisis".[56] Over the past 24 months, all key humanitarian indicators have deteriorated significantly, reflecting the rapid escalation of needs.[57]

- For the first time in modern humanitarian response, a single country, Sudan, registered over 30 million people in need of assistance.
- Sudan also became the country with the highest number of IDPs globally, with 11.5 million displaced as of April 2025, including 8.5 million since April 2023.
- Food insecurity reached unprecedented levels: more than 600,000 people are estimated to be in famine conditions, with an additional 8 million facing emergency or near-famine hunger levels.[58]

By October 2024, internal displacement had tripled to 8.8 million people, rising to 11.5 million by April 2025.[59] Displacement was driven by continued violence, particularly in Al Fasher (North Darfur) and Al Gitaina (White Nile), leading to further population movement into Al Jazirah and other states.[60] Khartoum remained the primary point of origin, accounting for 31 per cent of all IDPs, who have now spread across all 18 states.[61]

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[52] World Bank Sudan, outlook, April 10, 2025. Available at https://thedocs.worldbank.org/en/doc/bae48ff2fefc5a869546775b3f010735-0500062021/related/mpo-sdn.pdf?utm_source=chatgpt.com

[53] https://www.worldbank.org/en/country/sudan/overview

[54] https://www.worldbank.org/en/country/sudan/overview

[55] https://news.un.org/en/story/2025/02/1160161

[56] https://news.un.org/en/story/2025/02/1160161

[57] Sudan Crises, two years on, NRC, April 2025. Available at https://www.nrc.no/globalassets/pdf/sudan-crisis-two-years-on-report/sudan-crisis-two-years-on_report.pdf

[58] Sudan Crises, two years on, NRC, April 2025. Available at https://www.nrc.no/globalassets/pdf/sudan-crisis-two-years-on-report/sudan-crisis-two-years-on_report.pdf

[59] https://news.un.org/en/story/2024/12/1158396

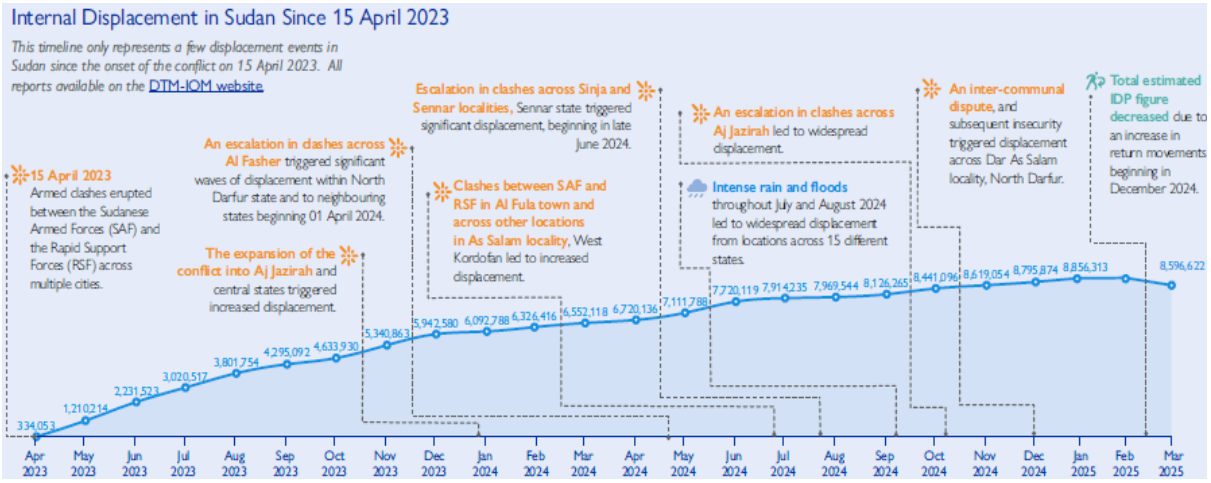
[60] https://dtm.iom.int/reports/two-years-conflict-sudan-visualizing-worlds-largest-displacement-crisis?close=true

[61] https://dtm.iom.int/reports/dtm-sudan-mobility-update-16?close=true

By April 2024, Greater Darfur hosted over 5 million IDPs, with South Darfur alone hosting approximately 1.84 million.[4] The Kordofan region accounted for 920,000 IDPs, while eastern states experienced major influxes: Gedarif (539,000), Kassala (210,000), Red Sea (261,000), Sennar (579,000), White Nile (577,000) and River Nile (726,000). Children under 18 comprised 53 per cent of the displaced population.[62]

Approximately 47 per cent of IDP households were hosted by families or communities. Others resided in camps (18 per cent), informal settlements or open areas (17 per cent), schools or public buildings (9 per cent), rented housing (6 per cent), or makeshift shelters (3 per cent).[63] Return movements led to the first recorded decrease in IDP numbers in March 2025. [64]

Figure 2: Internal displacement in Sudan since 15 April 2023, 2025



Source: DTM[65]

An estimated 3 million people have fled Sudan to neighbouring countries – including Egypt, Chad, the Central African Republic, South Sudan and Ethiopia – since April 2023.[66]

Sudan's food security situation deteriorated sharply in 2023. On 1 August, the Global Famine Review Committee confirmed IPC Phase 5 (famine) conditions in Zamzam IDP camp near Al Fasher, with plausible famine also reported in Al Salam and Abu Shouk camps.[67] By June 2024, over 26 million people were facing acute hunger, including 9.3 million at risk of catastrophic conditions (IPC Phase 4+).[68] The IPC identified women, children and the elderly as the most affected. Without urgent humanitarian assistance, famine was projected to spread to five additional areas by mid-2025, including Um Kadadah and El Fasher with 17 other localities at high risk.[69] In response, OCHA and

[62] DISPLACEMENT TRACKING MATRIX | DTM SUDAN DTM SUDAN - MOBILITY UPDATE 016 Publication Date: 23 March 2025
[63] https://dtm.iom.int/reports/dtm-sudan-mobility-update-16?close=true
[64] https://dtm.iom.int/reports/dtm-sudan-mobility-update-16?close=true
[65] https://dtm.iom.int/reports/dtm-sudan-mobility-update-16?close=true
[66] UNFPA Sudan New CPD (2026 – 2028), February 2025, White Paper
[67] IPC, Famine Review Committee: Combined Review Of: (i) The Famine Early Warning System Network (Fews Net) IPC Compatible Analysis For IDP Camps In El Fasher, North Darfur; and (ii)The IPC Sudan Technical Working Group Analysis Of Zamzam Camp (North Darfur), July 2024. Available at Sudan https://reliefweb.int/report/sudan/famine-sudan-ipc-famine-review-committee-confirms-famine-conditions-parts-north-darfur
[68] https://www.unocha.org/news/global-community-urge-action-escalating-sudan-crisis-un-general-assembly#:~:text=Sudan%20is%20now%20also%20the,many%20other%20areas%20at%20risk.
[69] https://news.un.org/en/story/2025/01/1158756

partners, including UNFPA, launched a famine prevention plan in April 2024 targeting 7.6 million people in priority locations. [70]

Sudan remains highly vulnerable to climate-related shocks. In 2023, severe flooding affected 89,000 people, including in UNFPA implementation areas,[71] destroying 8,000 homes and large areas of farmland. Water shortages, erratic rainfall, and extreme temperatures continue to undermine food security, malnutrition rates and access to essential services, disproportionately impacting women and children. These conditions disproportionately affect women and children, heightening risks of disease, violence and economic instability.

Constraints on humanitarian access and operations

Humanitarian delivery in Sudan has been severely constrained by insecurity, bureaucratic and administrative impediments, and fragmentation of governance.[72] As of 2024, more than 70 per cent of international non-governmental organizations (INGOs) reported access challenges, including movement restrictions and delays in obtaining travel permits. In SAF-controlled areas, only 40 per cent of visa applications by INGOs were approved between September 2024 and March 2025.[73] Cross-border assistance has also been limited; although the Adré border crossing from Chad into Darfur reopened, bureaucratic bottlenecks and poor infrastructure keep delaying aid delivery.[74] Between August 2024 and February 2025, only 1,300 trucks reached Darfur, half the monthly requirement to prevent famine, as estimated by Médecins Sans Frontières (MSF).[75]

The operational presence of the United Nations remains importantly uneven across the country mainly due to access barriers. The SAF has restricted permanent United Nations deployment outside areas under its control, allowing only temporary mission-specific movements. In RSF-controlled zones, the absence of a central coordination mechanism has led to further fragmentation of the response, with only international and national NGOs currently being permanently on ground.[76]

The conflict is marked by severe violations of internal law, and significant targeting of aid infrastructure and its workers. Fragmented negotiations, the lack of international pressure and the continued support of external actors for warring parties have all impeded humanitarian access. The situation has been marked by systematic violations of international humanitarian law, human rights violations and abuses, and the deliberate targeting of civilians and aid workers.[77] [78] [79] From 2022 until today, 130 humanitarian workers have been killed and 152 health facilities destroyed, making these the

[70] OCHA, Sudan Famine Prevention Snapshot, April-June 2024.
[71] UNFPA Sudan Emergency Situation Report #15 - 11 August 2024. Available at https://www.unfpa.org/resources/unfpa-sudan-emergency-situation-report-15-11-august-2024
[72] https://www.unocha.org/publications/report/sudan/marking-two-years-sudan-war-call-peace-protection-and-humanity-statement-united-nations-resident-and-humanitarian-coordinator-sudan-clementine-nkweta-salami-enar
[73] The Cost of Neglect: Two years of war in Sudan, April 2025. Available at https://www.rescue.org/sites/default/files/2025-04/Sudan%20-%20The%20Cost%20of%20Neglect%20-%20FINAL%20DRAFT.pdf
[74] https://sudan.unfpa.org/en/news/sudan-citys-last-remaining-hospital-shelled-%E2%80%9Cwe-need-support-now%E2%80%9D
[75] https://www.msf.org/sudan-pregnant-women-and-children-dying-shocking-numbers-south-darfur
[76] https://www.emro.who.int/media/news/in-sudan-there-have-been-more-than-100-attacks-on-health-care-since-the-armed-conflict-began.html
[77] https://www.ohchr.org/en/press-releases/2025/02/sudan-entrenched-impunity-fuelling-gross-human-rights-violations-and-abuses
[78] https://www.msf.org/two-years-war-sudan-leave-millions-more-need-ever
[79] https://www.ohchr.org/en/press-releases/2024/09/sudan-un-fact-finding-mission-outlines-extensive-human-rights-violations

deadliest years on record for aid personnel in Sudan.[80] The conflict now threatens regional stability, particularly in neighbouring South Sudan and Chad, which are at risk of spillover effects.[81]

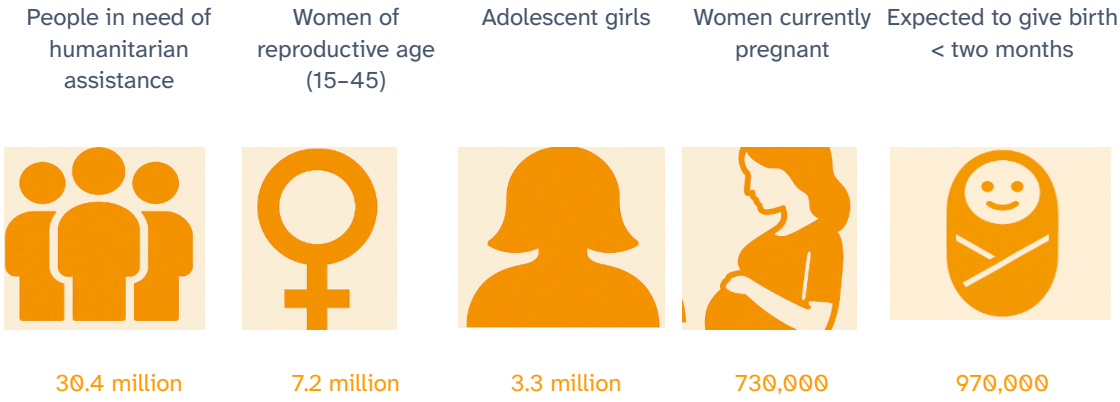
The suspension of funding from the United States Agency for International Development (USAID) and the U.S. State Department by the incoming U.S. administration in 2025 has already impacted Sudan and UNFPA. U.S. funding represented nearly half of all humanitarian assistance in Sudan.[82] The funding cuts have forced UNFPA to withdraw support from more than half of the 93 health facilities it was funding, and close 11 out of 61 safe spaces,[83] severely constraining its ability to provide life-saving maternal health care, GBV prevention services, and other critical support to women and girls in crisis-affected areas.[84]

The conflict in Sudan is at a crossroads. Although the SAF has recently gained momentum in Khartoum, Sennar and al-Jazirah states, prospects for peace are slim and peace initiatives[85] have thus far achieved no meaningful outcome. The SAF is expected to continue its offensive in Khartoum, Sennar and al-Jazirah. In the west of the country, the RSF will reportedly push on El Fasher to seize control of Darfur. With the conflict dragging on indefinitely, the risk of an increasingly fragmented conflict environment in 2025 increases.

Impact on women, girls and vulnerable populations

The conflict and displacement had catastrophic consequences for women, girls and other vulnerable populations, worsening challenges related to food insecurity, health system collapse and GBV. [86] Among the 30.4 million people in need of humanitarian assistance, 7.2 million are women of reproductive age (WRA) and 3.3 million are adolescent girls (aged 10–19).[87] Nearly 730,000 women are currently pregnant, and an estimated 970,000 are expected to give birth within the next two months.[88]

Figure 3: UNFPA people in need, women of reproductive age and target populations, 2025



Source: UNFPA[89]

[80] https://mapaction-maps.herokuapp.com/health
[81] https://acleddata.com/conflict-watchlist-2025/sudan/
[82] The Cost of Neglect: Two years of war in Sudan, April 2025. Available at https://www.rescue.org/eu/press-release/two-years-conflict-sudan-irc-recommends-action-catastrophic-humanitarian-and
[83] https://www.unfpa.org/press/sudan-rape-survivors-and-pregnant-women-cut-life-saving-services-funding-collapses
[84] https://www.unfpa.org/press/statement-unfpa-executive-director-united-states-government-funding-cuts
[85] Undertaken by the United States, Saudi Arabia, and the African Union.
[86] MSF Report, "A War on People: The Human Cost of Conflict and Violence in Sudan", July 2024.
[87] UNFPA HAO 2025.
[88] MISP calculator.
[89] UNFPA HAO 2025.

Crisis-level food insecurity has disproportionately affected women and girls. Approximately 1 million pregnant and breastfeeding women are acutely malnourished, a figure expected to increase in 2025.[90] Escalating food prices further constrained household purchasing power, limiting access to adequate nutrition and essential goods. These conditions have contributed to worsening maternal mortality, increased obstetric complications and adverse birth outcomes.[91] Basic service availability has severely deteriorated with 28 million people lacking access to basic sanitation and 5.6 million without safe drinking water.

Sudan's healthcare system has experienced near-total collapse.[92] The World Health Organization (WHO) estimates that 70 to 80 per cent of health facilities in conflict-affected areas, such as Al Jazirah, Kordofan, Darfur and Khartoum, and 46 per cent of those in other regions are either non-functional or closed.[93] [94] Supply chain disruptions have destroyed medical stockpiles, creating acute shortages of medicines and maternal health supplies.

The breakdown of maternal and reproductive health services has left thousands of pregnant women without access to basic obstetric care.[95] Pregnant and lactating women face elevated risks due to the near-total absence of referral systems and emergency obstetric services. Large parts of the country, particularly in Khartoum, Darfur and Kordofan, have health facilities that are non-functional or inaccessible, reflecting both infrastructure damage and severe shortages of health workers and supplies. Sexual and reproductive health service delivery is critically limited, with only 10 per cent of services fully available nationwide. Availability ranges from 100 per cent in Gedarif and Red Sea, to 92 per cent in Kassala, and just 10 per cent in Khartoum. No data was available for conflict-affected states. Currently, only 59 per cent of emergency and elective surgeries meet minimum standards, and just 35 per cent of ambulance requests are fulfilled. Basic emergency obstetric and newborn care (BEmONC) is up to standard in only 29 per cent of health service delivery facilities. Comprehensive emergency obstetric and newborn care (CEmONC) is not up to standard in 45 per cent, and comprehensive abortion care in 30 per cent of the health facilities (see table below). Although maternal mortality is widely believed to have increased, the disruption of the MPDSR (maternal and perinatal death surveillance and response) system prevents accurate measurement.[96]

Adolescent maternal care remains severely limited. Only 77 per cent of adolescent births are attended by skilled personnel. The HIV and sexually transmitted infection (STI) responses have similarly collapsed, with HIV testing, antiretroviral therapy (ART) coverage, and peer-driven outreach interventions declining by 60 to 72 per cent in 2023.[97]

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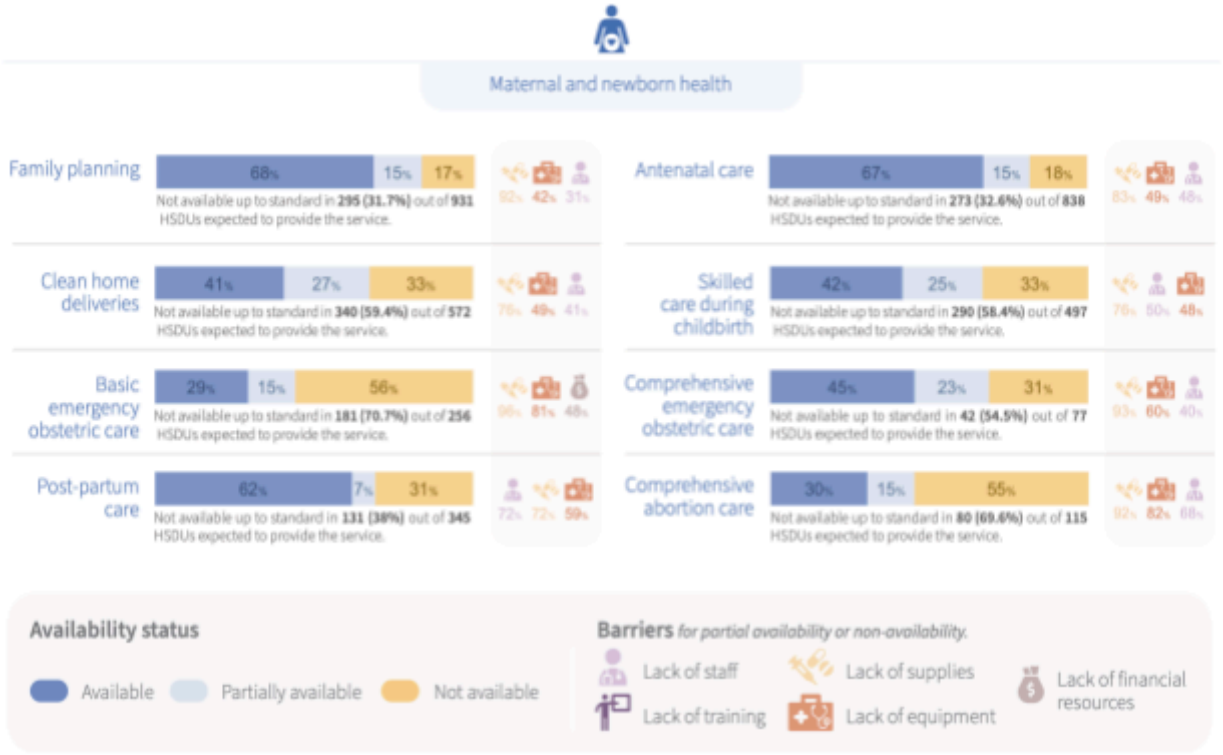
[90] https://arabstates.unfpa.org/sites/default/files/pub-pdf/2025-02/UNFPA%20Sudan%20Annual%20Report%202024.pdf
[91] https://arabstates.unfpa.org/sites/default/files/pub-pdf/2025-02/UNFPA%20Sudan%20Annual%20Report%202024.pdf
[92] https://www.gavi.org/vaccineswork/sudan-conflict-leaves-health-system-total-collapse
[93] https://www.afdb.org/en/countries/east-africa/sudan/sudan-economic-outlook
[94] https://www.emro.who.int/media/news/in-sudan-there-have-been-more-than-100-attacks-on-health-care-since-the-armed-conflict-began.html#:~:text=WHO%20estimates%20that,in%20recent%20memory .
[95] Bonavina,Giulia et al., Women's health amidst Sudan's civil war, The Lancet, Volume 403, Issue 10439, 1849 – 1850, 2024.
[96] HeRAMS Sudan Infographics, December 2024. Available at https://cdn.who.int/media/docs/default-source/documents/emergencies/herams/herams_sudan_infographics_2024-12.pdf?sfvrsn=e2406e90_3&download=true
[97] UNFPA White UNFPA Sudan New CPD (2026 – 2028), 2025.

Figure 4: Availability of sexual and reproductive health services in health facilities



GBV is widespread, with an estimated 12 million individuals at risk[98] and access to protection services severely restricted.[99] [100] [101] Incidents of conflict-related sexual violence and intimate partner violence have risen sharply.[102] Between December 2023 and December 2024, reported cases of GBV increased by 288 per cent.[103] Rape has been used systematically as a weapon of war, while intimate partner violence has intensified amid prolonged displacement, economic hardship and social stressors. Survivors face enormous barriers to care, including attacks on health facilities, restricted movement, telecommunications disruptions and widespread stigma – particularly in cases of pregnancy resulting from sexual violence.

Harmful practices, including child marriage and female genital mutilation, remain widespread. Prior to the conflict, child marriage affected 34 per cent of girls by age 18 (2023), while the prevalence of FGM was 87 per cent among women and girls aged 15–49, and 32 per cent among girls under 14.[104] These rates are among the highest in Africa.[105] The conflict has altered these dynamics: in some areas, displacement has disrupted harmful practices, but in insecure regions lacking law enforcement, rates

[98] https://www.unwomen.org/en/digital-library/publications/2024/12/gender-alert-no-excuse-calling-for-an-end-to-gender-based-violence-in-sudan#:~:text=More%20than%2011%20million%20people,Gender%20Alert%20by%20UN%20Women.

[99] https://www.unfpa.org/news/after-two-years-war-has-sudan-failed-its-female-revolutionaries

[100] Findings of the monitoring mission by OHCHR Sudan to the Chadian border with Sudan from 18 February - 3 March 2024, in the context of the hostilities between the Sudanese Armed Forces (SAF) and the Rapid Support Forces (RSF) in West Darfur. Available at https://www.ohchr.org/sites/default/files/documents/countries/sudan/ohchr-sudan-report-monitoring-mission-chad-february-2024.pdf

[101] UNFPA Humanitarian Action Overview, 2024.

[102] https://www.unwomen.org/en/digital-library/publications/2024/12/gender-alert-no-excuse-calling-for-an-end-to-gender-based-violence-in-sudan

[103] https://www.unwomen.org/en/digital-library/publications/2024/12/gender-alert-no-excuse-calling-for-an-end-to-gender-based-violence-in-sudan

[104] https://www.unfpa.org/sites/default/files/resource-pdf/Sudan2021FGM_AR.pdf

[105] https://www.unicef.org/sudan/media/9386/

are persisting or even rising. Despite international recognition of FGM as a grave human rights violation, its persistence highlights entrenched social norms and limited enforcement of protective legal frameworks.

The conflict has exacerbated long-standing gender inequalities rooted in social, political, economic, legal, cultural and religious structures.[106] Gender disparities have always persisted and are recently reported to have regressed,[107] with issues such as child marriage, limited access to education for girls and high rates of GBV being widespread. As of 2018, 53.7 per cent of girls completed lower secondary education,[108], surpassing both the Sub-Saharan African average and the average for low-income countries.[109] However, female adult literacy remains low at 56.1 per cent, compared to 65.4 per cent for males, trailing regional benchmarks. Labour market participation remains starkly gendered, with only 27.9 per cent of women engaged in the workforce, compared to 67.8 per cent of men (2023). Despite incremental progress in female labour force participation since 1990, the gender gap remains significantly wider than in other low-income economies.[110]

Sudan faces profound challenges in advancing human rights and LNOB including for people with disability. Human rights violations remain a critical concern. The United Nations Human Rights Council has documented serious abuses, including attacks on civilians and restrictions on freedoms of expression and assembly. These violations disproportionately affect marginalized groups, including women, children and ethnic minorities.[111] Persons with disabilities encounter significant barriers to inclusion and access to services. The United Nations Disability and Development Report 2024 emphasizes that individuals with disabilities are often left behind in humanitarian responses, lacking adequate support and representation.[112]

2.2 United Nations inter-agency response

The 2025 HNRP estimates that 30.4 million people in Sudan will require humanitarian assistance, with 20.9 million originally targeted for support and a total funding requirement of $4.16 billion. This represents a significant increase in both humanitarian needs and financial demands compared to the 2023 and 2024 HNRPs. However, driven by financial constraints, a reprioritization exercise was undertaken in 2025, adjusting the target population downwards from 20.9 million to 18 million, and allocating a reprioritized budget of $3 billion.

In 2023, only 44.6 per cent of the targeted population received assistance, with the HNRP funded at just 51.2 per cent of its total requirement. The 2024 HNRP aimed to reach 14.7 million people and achieved 95.5 per cent coverage, despite funding levels reaching only 65.3 per cent of the required budget (see Table 4).[113]

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[106] https://www.gicj.org/topics/countries/208-sudan/3132-sudan%E2%80%99s-systematic-cycles-of-violence-against-women
[107] https://press.un.org/en/2024/sgsm22152.doc.htm?utm_source=chatgpt.com
[108] https://data.worldbank.org/country/sudan
[109] https://data.worldbank.org/country/sudan
[110] https://data.worldbank.org/country/sudan
[111] Sudan UN Fact-Finding Mission outlines extensive human rights violations, international crimes, urges protection of civilians, 6 September 2024. Available at https://www.ohchr.org/en/press-releases/2024/09/sudan-un-fact-finding-mission-outlines-extensive-human-rights-violations
[112] United Nations Department of Economic and Social Affairs, Disability and Development Report 2024 Accelerating the realization of the Sustainable Development Goals by, for and with persons with disabilities, 2024. Available at https://indico.un.org/event/1010238/attachments/20948/59724/DDR%202024%20Full%20report%20-%20Unedited.pdf?utm_source=chatgpt.com
[113] https://humanitarianaction.info/plan/1188?bs=eyJibG9jay1iOGIxODYzMC01YjVmLTRjN2MtYWE4ZC0zNzAzNDk2ZTY0NDIiOnsidGFyZ2V0IjoxfX0%3D

Table 4: Humanitarian response plan overview 2023-2024

HNRP Indicators	2023	2024	2025	2025 re-prioritized
People in need	24.7 million (↑57% from 2022)	24.8 million	30.4 million	30.4 million
Targeted	18.1 million	14.7 million	20.9 million	18.0 million
Reached	8.1 million (44.6%)	14 million (95.5%)	-	-
Budget	$2.57 billion	$2.70 billion	$4.16 billion	$3.01 billion
Budget funded	51.2%	65.3%	-	

Source: UN OCHA[114]

In 2023, UNFPA allocated $65.8 million to the health cluster and $28.9 million to the protection cluster, making it the second-largest contributor to the Health Cluster (after UNICEF) and the third-largest contributor to the protection cluster (after UNHCR and UNICEF).[115] In 2024, the UNFPA's contribution to the health cluster declined by 71 per cent from 2023, while its funding to the protection cluster increased by 32 per cent. This shift reflects a reorientation towards GBV programming over sexual and reproductive health. As a result, UNFPA ranked fifth in health and maintained its third position in protection funding (see Table 5).

Table 5: UNFPA health and protection contributions 2023-2024

Cluster	2023	2024
Health cluster budget	$125.1 million (70% funded)	$167.4 million (93.7% funded)
UNFPA contribution	$65.8 million	$18.7 million (↓71%)
Protection cluster budget (GBV)	$83.6 million (35.6% funded)	$111.8 million (50.1% funded)
UNFPA contribution	$28.9 million	$38.4 million (↑32%)

Source: OCHA[116]

UNFPA's total contribution to the inter-agency humanitarian response amounted to $121.86 million in 2023, with 53 per cent allocated to SRH, 23 per cent to GBV, and 22 per cent to refugee response. In 2024, total contributions decreased by 34 per cent to $80.47 million. Funding for SRH declined by 72 per cent, while GBV funding increased by 32 per cent, and allocations to refugee response fell by 14 per cent (see Table 6).[117,118]

[114]https://humanitarianaction.info/plan/1188?bs=eyJibG9jay1iOGIxODYzMC01YjVmLTRjN2MtYWE4ZC0zNzAzNDk2ZTY0NDIiOnsidGFyZ2V0IjoxfX0%3D;
https://www.unocha.org/publications/report/south-sudan/south-sudan-re-prioritized-hnrp-addendum-glance-march-2025
[115]https://humanitarianaction.info/plan/1188/ge/7447?bs=eyJibG9jay0yMTc1YTBlOS0xZDgwLTQ2NzEtOWVkOC05MjE2OTY1ZGM4MDciOnsic29mdF9saW1pdCI6ImV4cGFuZGVkIn0sImJsb2NrLThhNzg0MzY4LWFlYzMtNDU3Mi1iZDZhLWYwYjkzNjBiMDliNSI6eyJ0YXJnZXQiOjF9fQ%3D%3D#page-title
[116]https://humanitarianaction.info/plan/1188/ge/7447?bs=eyJibG9jay0yMTc1YTBlOS0xZDgwLTQ2NzEtOWVkOC05MjE2OTY1ZGM4MDciOnsic29mdF9saW1pdCI6ImV4cGFuZGVkIn0sImJsb2NrLThhNzg0MzY4LWFlYzMtNDU3Mi1iZDZhLWYwYjkzNjBiMDliNSI6eyJ0YXJnZXQiOjF9fQ%3D%3D#page-title
[117]https://humanitarianaction.info/plan/1188/presence?bs=eyJibG9jay01NDQzNGY5Ni05NzdiLTQxYmItOWVhNS1kMGVmMWNlNDkyZDgiOnsic29mdF9saW1pdCI6ImV4cGFuZGVkIn19#page-title
[118]https://humanitarianaction.info/plan/1188/presence?bs=eyJibG9jay01NDQzNGY5Ni05NzdiLTQxYmItOWVhNS1kMGVmMWNlNDkyZDgiOnsic29mdF9saW1pdCI6ImV4cGFuZGVkIn19#page-title

Table 6: UNFPA contributions to the inter-agency response 2023-2024

Category	2023	2024
Total contribution	$121.86 million	$80.47 million (↓34%)
Health (SRH)	$65.6 million	$18.7 million (↓72%)
GBV	$28.9 million	$38.3 million (↑32%)
Refugee response	$27.1 million	$23.4 million (↓14%)

Source: UNFPA[119]

2.3 The role of external assistance

Between 2022 and 2024, external assistance played a crucial role in addressing Sudan's humanitarian crisis. In 2022, international donors contributed approximately $1.8 billion through the Sudan Humanitarian Response Plan, providing essential aid to at least 15.6 million people.[120] In 2023, the humanitarian situation deteriorated further. Major donors during this period included the United States (47.2 per cent), the European Commission (9.5 per cent), Germany (9.1 per cent) and Saudi Arabia (3 per cent). The Central Emergency Response Fund (CERF) also provided significant support, channelling $59.6 million from multiple donors (4.5 per cent).[121] In 2024, the United Nations launched an appeal for $2.7 billion to assist 14.7 million people in Sudan. However, funding challenges persisted, with only 65 per cent of the required amount received by the end of the year from roughly the same donors as in 2023.

As of May 2025, the United Nations and humanitarian partners have launched a $4.2 billion appeal to reach 20.9 million of the most vulnerable individuals. By the end of April 2025, only 6.3 per cent of the required amount had been received, leaving a significant gap in resources needed for life-saving interventions. Conversely, the United States implemented a 90-day pause on foreign aid in January 2025, leading to the suspension of numerous humanitarian programmes and exacerbating the crisis.[122] Following these abrupt funding cuts, major donors have increased their contributions. Both the European Union and the United Kingdom pledged over $750 million in aid during a London conference in April 2025.[123]

[119] https://humanitarianaction.info/plan/1188/presence?bs=eyJibG9jay01NDQzNGY5Ni05NzdiLTQxYmItOWVhNS1kMGVmMWNlNDkyZDgiOnsic29mdF9saW1pdCI6ImV4cGFuZGVkIn19#page-title

[120] Urgent appeal as major donors reduce life-saving funding amid Sudan crisis, 10 March 2025. Available at https://www.unocha.org/publications/report/sudan/urgent-appeal-major-donors-reduce-life-saving-funding-amid-sudan-crisis-statement-united-nations-resident-and-humanitarian-coordinator-sudan-clementine-nkweta-salami

[121] https://fts.unocha.org/plans/1123/summary

[122] https://news.un.org/en/story/2025/05/1163106

[123] https://www.reuters.com/world/britain-boosts-aid-victims-sudan-conflict-conference-2025-04-14/

3. The UNFPA Humanitarian Response

3.1 The UNFPA humanitarian response

This chapter outlines the evolution, structure and scope of UNFPA's humanitarian response in Sudan, providing context on its country programme, emergency scale-up following the 2023 crisis and financial contributions to the inter-agency response. It includes a summary of the response's theory of change.

3.1.1. Brief description of UNFPA in Sudan

UNFPA has maintained a presence in Sudan since 1973, delivering both humanitarian and development programmes. The CPD for 2018–2021, the seventh by UNFPA in Sudan, followed the 2016–2020 CPD and was extended in 2022, 2023, and 2024 to align with evolving United Nations and government priorities.[124] By the end of 2021, UNFPA had invested nearly $51 million (actual expenditure). During 2018-2020, the country programme was able to reach a total number of 3,207,336 direct beneficiaries. [125]

The 2018–2021 CPD and the national context were largely development-focused across much of the country, with some humanitarian programming in specific crisis-affected areas like Greater Darfur and Kordofan. The CPD aimed to reduce maternal mortality and morbidity through integrated approaches to SRH, family planning, and GBV. Implementation of the UNFPA humanitarian response was carried out by 39 partners (25 government, 14 NGOs) across 10 UNFPA focus states.[126] The programme focused on four outcome areas: SRH; family planning; gender equality and women's empowerment; and population dynamics and data for development. Although youth empowerment was not a standalone outcome, it was addressed through the SRH and family planning components, with a focus on increasing access to youth-friendly information and services.[127]

The CPD aimed to bridge the humanitarian–development nexus. Development interventions were aligned with national priorities, while humanitarian interventions targeted the needs of IDPs, particularly in Greater Darfur, South Kordofan and Blue Nile. UNFPA partnered with federal and state ministries of health and civil society to strengthen the maternal death surveillance and response (MDSR) system, upgrade midwifery education, enhance the quality of SRH services, and build provider capacity. The CPD also supported demand generation and the roll-out of the minimum initial service package (MISP) in humanitarian settings. [128]

On gender equality and GBV, UNFPA worked with government institutions and civil society actors to prevent and respond to GBV, with a specific focus on women and girls in humanitarian settings. Key activities included strengthening community-based protection and coordination mechanisms, supporting youth-serving organizations, piloting the gender-based violence information management system in selected states and conducting research on female genital mutilation and child marriage.

[124] DP/FPA/2024/4 Extensions of country programmes, 2024.
[125] UNFPA Sudan Country Office, 7th Country Programme Cycle 2018-2021, Executive Review Report, 30 July 2021.
[126] UNFPA focus / priority states, namely Kassala, Gedarif, White Nile, Blue Nile, North Kordofan, and the 5 Darfur States (North, South, West, East and Central).
[127] UNFPA, Country Programme Document for Sudan 2018-2021 (2017).
[128] UNFPA Impact Assessment of Humanitarian Interventions, Country report Sudan, 2022.

3.1.2 The current UNFPA humanitarian response and an analysis of its theory of change

Following the outbreak of conflict in April 2023 and the declaration of a system-wide emergency scale-up by the IASC on 29 August 2023,[129] UNFPA launched an appeal for $62.4 million, developed a humanitarian response strategy, activated its FTPs, [130] and reoriented and expanded its operational presence. The IASC scale-up has been extended through June 2025 in light of the ongoing crisis.

UNFPA humanitarian framework

At the global level, UNFPA's humanitarian commitments are articulated in its Strategic Plan 2022–2025, which emphasizes building response capacity, mainstreaming prevention and preparedness, and promoting humanitarian–development–peace coherence.[131]

Within the IASC structure, UNFPA leads the GBV AoR under the protection cluster and the SRHiE task team within the health cluster. UNFPA also contributes to strategic guidance for the HCT, advocates for MISP implementation, prioritizes GBV response and promotes system-wide accountability for GBV risk mitigation. UNFPA is a founding steering committee member of the inter-agency working group on reproductive health in crises, aligned with the International Conference on Population and Development (ICPD) Programme of Action, which places human rights and gender equality at the centre of both humanitarian and development efforts.

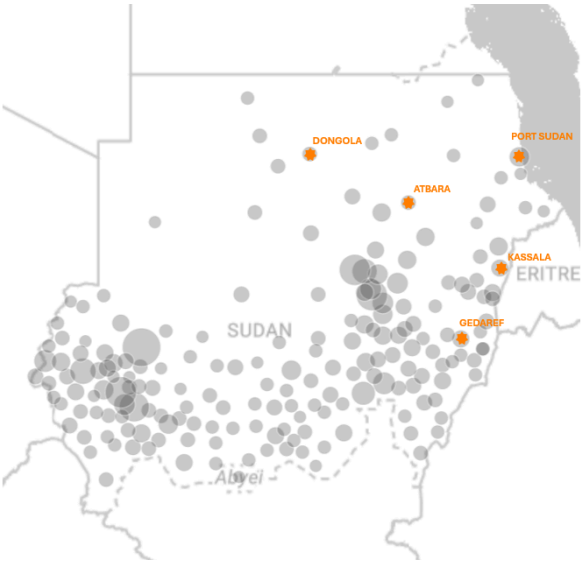
At country level, UNFPA's response was supported by its FTPs and guided by SOPs in humanitarian settings,[132]aligned with inter-agency response standards. The evaluation notes that the FTPs were more recently replaced by UNFPA EPPs.[133]. The SRH interventions are implemented in accordance with the MISP,[134] while GBV activities follow the minimum standards for gender-based violence in emergencies (GBViE). [135] UNFPA is also responsible for managing Inter-Agency Reproductive Health (IARH) kits and supporting PSEA leadership through the HCT. Lastly, UNFPA is responsible for the common operational dataset on population statistics and should provide associated updates of population data projections for humanitarian response.

UNFPA humanitarian response

UNFPA Sudan's response prioritized life-saving SRH and GBV services, including the deployment of mobile and temporary clinics, establishment of referral systems, stockpiling of medical supplies, deployment of community midwives and creation of WGSS. UNFPA delivered essential services, including basic and comprehensive emergency obstetric and neonatal care (BEmONC and CEmONC), clinical management of rape (CMR), and psychological first aid for GBV survivors (see theory of change Figure 6).

[129] https://interagencystandingcommittee.org/iasc-humanitarian-system-wide-scale-activations-and-deactivations
[130] UNFPA, Fast Track Policy and Procedures (FTPs), 2022.
[131] UNFPA Guidance Note, Humanitarian Programming in CPD.
[132] UNFPA, Fast Track Policy and Procedures (FTPs), 2022.
[133] UNFPA Policy and Procedures for Emergency Response, 1 March 2025.
[134] https://www.unfpa.org/resources/minimum-initial-service-package-misp-srh-crisis-situations
[135] https://www.unfpa.org/minimum-standards

Figure 5: UNFPA national and subnational hubs in Sudan, 2025



Source: UNFPA

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.

The reconstructed theory of change

The theory of change underpinning UNFPA's response was developed as part of this theory-driven evaluation. It was based on document review, stakeholder consultations and iterative refinement during analysis. The theory of change seeks to clarify how UNFPA's interventions were expected to contribute to life-saving outcomes during the Sudan humanitarian crisis and align with both UNFPA's institutional mandates and the priorities outlined in the 2023 and 2024 HNRPs.

Problem statement:

The conflict that erupted in April 2023 significantly disrupted access to life-saving SRH and GBV services. Women and girls, particularly those most vulnerable, including in conflict-affected and hard-to-reach areas, faced compounded risks due to displacement, collapse of health systems, increased GBV risks, and weakened referral pathways. There was a critical need for coordinated, inclusive and scalable humanitarian action to preserve life, restore dignity and mitigate further harm.

Goal:

> To save lives, reduce suffering and restore dignity of women and girls, particularly in conflict-affected areas, and contribute to the 2023 and 2024 HNRPs.

Outcomes:

1. Utilization of SRH services by those in need is continued by IDPs and host communities.
2. Utilization of GBV services is scaled up and GBV risks are reduced among IDPs and host communities.

Outputs:

1. Output 1: Humanitarian coordination ensured at national and subnational level.
2. Output 2: Lifesaving quality SRH services (EMonC, family planning, HIV/STI) are available and accessible.
3. Output 3: Communities are informed and aware of SRH services and referral mechanisms.
4. Output 4: Lifesaving quality GBV services are available and accessible, and prevention and mitigation ensured.
5. Output 5: Communities are informed and aware of GBV risks, services and referral mechanisms.

Pathways of change

The theory of change assumes that ensuring availability and facilitating accessibility in combination with quality services, community awareness and effective coordination, reinforced by operational enablers (e.g. FTPs, SOPs, localization), will result in greater utilization of SRH and GBV services and improved GBV protection outcomes. It also assumes that increasing service coverage in both IDP and host communities, coupled with inclusive community mobilization (e.g. deploying community midwives, awareness and community protection networks), will reduce social and structural barriers to access.

Cross-cutting commitments

The theory of change integrates UNFPA's commitments to PSEA, AAP, LNOB and core humanitarian principles. These are embedded across all levels of the theory of change and are viewed as both enabling conditions and outcomes in themselves, particularly in relation to quality and equity of SRH and GBV service delivery.

UNFPA's fast track procedures (FTP) and accompanying SOPs are key institutional and enabling policies that provide greater delegation of authority to the country office and the subnational levels and operational flexibility during emergency response for a defined, time-bound period. These processes are distinct from UNFPA's standard development programming modalities. When applied comprehensively, FTPs are expected to enhance the efficiency and flexibility of UNFPA's emergency response, particularly in mobilizing human resources, expediting procurement of supplies and by introducing increased thresholds for financial transactions.

Underlying assumptions for verification

As described above, the evaluation team identified key cause-and-effect assumptions, which underpin the pathways of change embedded in the reconstructed theory of change. These assumptions for verification "encapsulate how [the UNFPA humanitarian response] (specific interventions or components) were expected to influence or contribute to the intended results".[136]

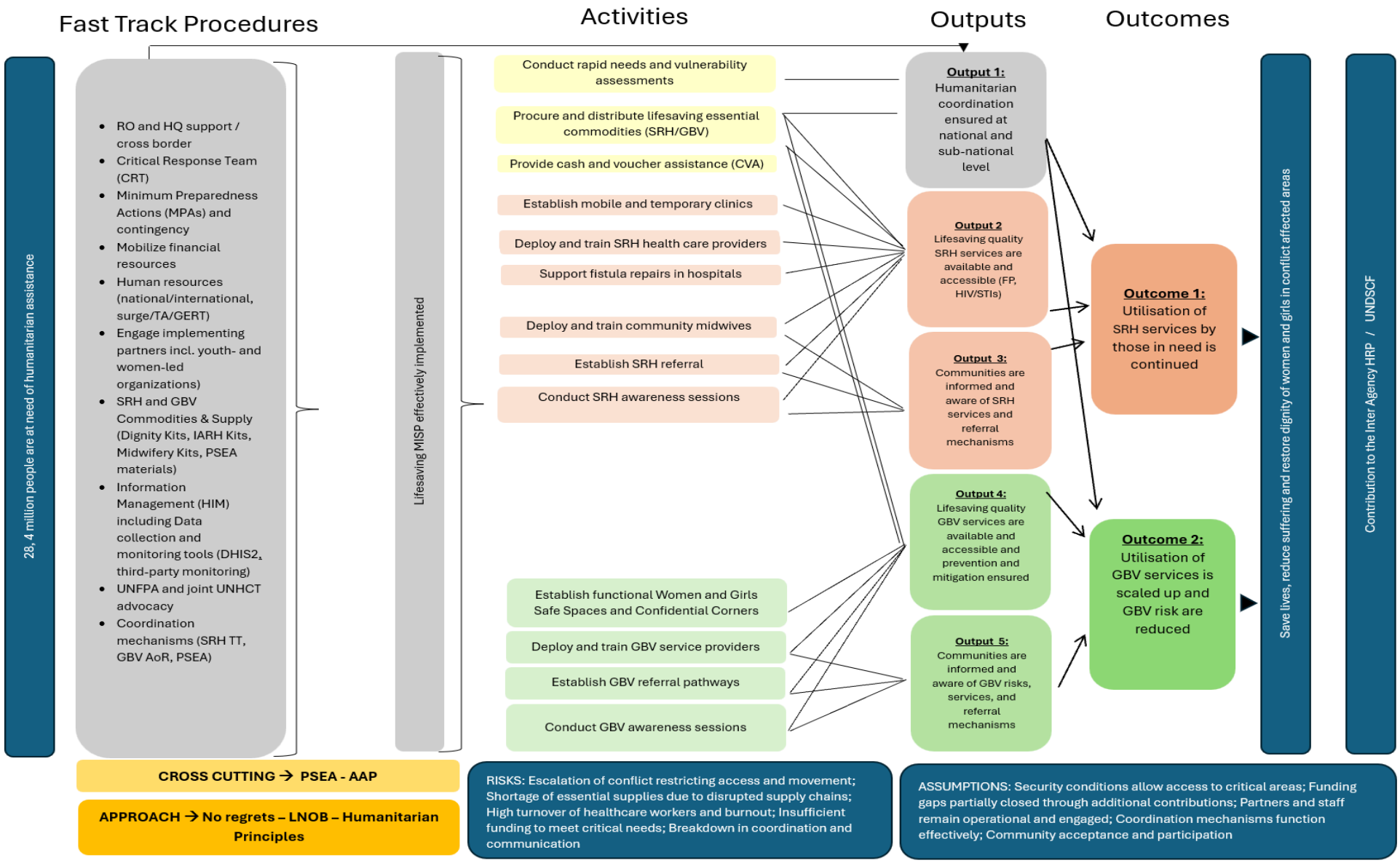
Key assumptions underpinning this theory of change include, first, the expectation that security conditions will allow safe and sustained access to conflict-affected and hard-to-reach areas, permitting UNFPA and its partners to deliver SRH and GBV services, particularly where they are most needed. It also assumes that funding gaps will be at least partially closed through additional donor contributions, ensuring the continuity and coverage of interventions. The model relies on the continued operational presence and engagement of both UNFPA staff and implementing partners, as well as their capacity to respond and scale up services in a volatile context. Another key assumption is that FTPs will function

[136] UNFPA Evaluation Handbook (2024), p. 26

as intended, facilitating timely procurement, the deployment of human resources and adjusting thresholds for financial transactions. Additionally, coordination mechanisms such as the SRHiE working group and GBV AoR are expected to function effectively to ensure alignment, reduce duplication and enable coordination, information sharing, and integrated planning and response within the broader inter-agency framework. Lastly, the theory of change depends on community acceptance and participation, and on maintaining trust in UNFPA and its partners through a principled humanitarian response and inclusive engagement (e.g. AAP).

These assumptions for verification, which constituted hypotheses that were tested during the data collection and analysis, are further specified in the evaluation matrix.

Figure 6: Theory of change UNFPA's humanitarian response in Sudan, 2023-2024



3.1.3 The financial structure of the UNFPA humanitarian response 2023-2024

In 2023, UNFPA appealed for a total of $89 million to support its humanitarian operations in Sudan, followed by $82,9 million in 2024 and $88 million projected for 2025. Of the amount requested in 2023, approximately $43 million was mobilized, representing only 48 per cent of the total amount required. In 2024, the total resources mobilised amounted to $30 million, indicating a widening funding gap in 2024 as compared to 2023.[137] [138]

Funding was secured through a combination of core resources (18 per cent) and external contributions (82 per cent), including allocations from the CERF, the Humanitarian Thematic Fund, the Sudan Humanitarian Fund and bilateral donor support. The table below illustrates expenditures in 2023 and 2024 across institutional budget, core resources, non-core resources (external contributions), and main budget lines.[139]

Table 7: Sudan country office expenditures/implementation 2023-2024

2023 implementation				
Category	Core	Institutional budget	Non-core	Grand total
HR	2,255,913.82	1,301,067.78	4,222,093.43	7,779,075.03
Operations	417,734.49	617,333.71	1,265,080.20	2,300,148.40
Programme-NEX	838,966.62		8,146,263.86	8,985,230.48
Programme -DEX	253,035.53		4,063,609.48	4,316,645.01
Grand total	3,765,650.46	1,918,401.49	17,697,046.97	23,381,098.92

2024 implementation				
Category	Core	Institutional budget	Non-core	Grand total
HR	1,450,403.70	1,312,165.08	5,577,871.65	8,340,440.43
Operations	803,282.68	303,876.82	2,164,427.63	3,271,587.13
Programme-NEX	590,623.40		12,773,955.82	13,364,579.22
Programme -DEX	268,518.25		9,265,834.73	9,534,352.98
Grand total	3,112,828.03	1,616,041.90	29,782,089.83	34,510,959.76

Source: UNFPA Sudan country office.

[137] https://www.unfpa.org/publications/humanitarian-action-overview-report-2024
[138] file:///C:/Users/Camilla/Downloads/UNFPA%20HAO%20Report%202025%20F1%20(Dec%204%202024)%20(2).pdf
[139] DEX refers to UNFPA direct execution which mainly covers procurement of supplies, training and monitoring missions, while NEX represents the funds implemented by partners.

The most generous donors over the two-year period included the United States, Sweden, CERF, Norway, Canada and OCHA,[140] whose contributions were critical in sustaining life-saving SRH and GBV interventions. Funding streams included both earmarked, softly earmarked and flexible funding, with a notable share dedicated to emergency service delivery, supply chain support and coordination activities.

[140] In 2023, the top donors were: (1) United States, (2) Sweden, (3) CERF, (4) Norway, and (5) Canada. In 2024, it was (1) CERF, (2) Canada, (3) Sweden, (4) ECHO, (5) United States. Source: UNFPA Sudan country office.

4. Findings

4.1 Relevance

Evaluation question 1: To what extent and how did the UNFPA humanitarian response address and adapt to the needs of the affected populations, including the most vulnerable and marginalized groups?

Strategy and needs-based response

Finding 1.1. The UNFPA's humanitarian response plan articulated key priorities relevant to the SRH and GBV needs of women, girls and other vulnerable groups, such as people with disabilities and youth. While ad hoc rapid needs assessments were critical to identify and respond to acute needs, the response strategy was not sufficiently tailored to the diverse local contexts across states, with continued lack of comprehensive needs and vulnerability analyses, and strategic prioritization and targeting. As displacement escalated in 2024, UNFPA and its implementing partners undertook localized rapid assessments. However, UNFPA lacked the operational capacity on the ground to establish more comprehensive data collection systems for SRH and GBV. Consequently, UNFPA relied primarily on data from the HNRP, the OCHA DTM, and pre-conflict health facility data to inform the evolving response. These sources were insufficient to support a robust, data-driven approach aligned to UNFPA's specific mandate areas.

The UNFPA humanitarian response was guided by a response plan developed shortly after the outbreak of conflict, with updated versions issued in July 2023,[141] in July 2024[142.] and in December 2024.[143] The latest revision provided a more comprehensive plan with results indicators and a costed workplan. The initial July 2023 plan articulated key pillars, including integrated SRH and GBV programming, cash and voucher assistance (CVA), cross-border operations, localization, implementing partner capacity-building, monitoring and evaluation (M&E) adapted to humanitarian contexts, and coordination of GBV and SRH service delivery. These priorities were well-aligned with the known needs at the time.

UNFPA response plans appropriately prioritized the needs of women and girls and prioritising vulnerable groups in IDP camps, gathering sites, and host communities, with additional attention to adolescents, youth, and persons with disabilities. The response was well aligned with the humanitarian needs overview (HNO) and HNRP, targeting 7.6 million people for health and 1.3 million for GBV services. Notably, the plans demonstrated a strong commitment to equitable access to life-saving SRH and GBV services, explicitly identifying vulnerable groups such as survivors of violence, individuals at risk of sexual exploitation and abuse, and women and girls with disabilities (including those with fistula) as priority groups. The inclusion of community-based, rights-based, and 'do no harm' approaches, alongside efforts to uphold the LNOB principle and strengthen PSEA and AAP mechanisms, reflects a rights-conscious, inclusivity and accountability planning approach. The overall design of the response represented a considered effort to address vulnerabilities, particularly in areas affected by both conflict and new displacements.

UNFPA conducted some rapid needs assessments at the subnational levels which informed acute and localized responses. UNFPA conducted ad hoc rapid needs assessments in various locations as the situation evolved and caused new displacements, which appropriately informed localized responses.

[141] UNFPA Humanitarian Response Plan Sudan June-December 2023 (Update September 2023).
[142] UNFPA Humanitarian Response Plan Sudan July-December 2024.
[143] UNFPA Humanitarian Response Plan Dec 2024.

These assessments, which were often led by implementing partners already present in the field, played an important role during acute displacement influxes by providing immediate data and information to address acute needs. For example, UNFPA's August 2023 assessment in Al Jazirah, which targeted 200,000 IDPs, helped inform the GBV and IDP response.[144] Additional GBV assessments were conducted in August 2023 across conflict-affected states like Darfur, Khartoum and Kordofan.[145] These assessments contributed to programming by identifying GBV risk factors and improving understanding of the needs of affected populations.[146] The evaluation survey results rated the performance of UNFPA on needs-based response at 78 per cent overall, with UNFPA staff achieving a higher rating (85 per cent) compared to implementing partners (75 per cent). [147]

While the response plans prioritized vulnerable groups, there was no systematic approach to assessing and prioritizing specific needs and vulnerabilities of IDPs and host communities. The response plans did not explicitly state how UNFPA planned to identify target priority needs or particularly vulnerable groups, indicating that the targeting was assumption-based. For instance, IDPs in formal gathering sites were assumed to be most vulnerable, an approach agreed with government and United Nations actors, but there was limited data to support this compared to IDPs in host communities or camps, or other underserved host groups.

Comprehensive and vulnerability-focused needs assessments remained largely absent from the onset of the conflict until today. Despite recognition that the needs had surpassed the response capacity since the acute onset of the crisis in 2023, the updated 2024 response plan was not accompanied by a detailed situational or needs analysis, scenario planning to address unexpected developments, or geographic prioritization informed by fluid conflict dynamics, displacement patterns and evolving needs. The response plan mainly relied on HNRP data, International Organization for Migration (IOM) DTM data, and MISP calculations rather than a tailored, data-driven approach, with limited disaggregated or sector-specific analysis, particularly regarding gender, intersecting vulnerabilities and the most at-risk populations. By 2025, UNFPA defined needs as being mostly the same as the year prior.[148] For example, the functionality and quality of CEmONC and BEmONC services remained unclear even in stable areas, despite a BEmONC assessment being included in the December 2024 response plan. Across multiple operational sites, both UNFPA and IP staff reported the persistent absence of standardized humanitarian assessment tools, clear guidance, and sufficient staff and M&E capacity to collect and analyse needs data. The limited capacity of UNFPA to address these data gaps was further hindered by factors largely outside the control of the country office, including ongoing access and security constraints, particularly in conflict-affected states, as well as internal staffing shortages and limited partner capacity.

While UNFPA's interventions were relevant to respond to the critical SRH and GBV needs of affected populations, they were not sufficiently tailored to the diverse local contexts, with limited involvement of implementing partners and voices of local actors in the design. While displacement numbers had nearly doubled by December 2024,[149] the updated response plan retained largely the same strategic pillars without any contextual or data-driven differentiation. Several IP informants reported that UNFPA's response strategies were perceived as generic and largely top-down, with limited incorporation of local voices and contextual insights from implementing partners or adaptation to the

[144] UNFPA Sudan Emergency Situation Report No 5, 11 August 2023.
[145] UNFPA Sudan Emergency Situation Report No 5, 11 August 2023.
[146] UNFPA COAR 2023.
[147] based on Likert-scale scoring.
[148] IPD and host community women and girls in need of sexual and reproductive health and gender-based violence services, and those at risk of gender-based violence.
[149] From 5,9 IDPs in December 2023 to 8,7 IDPs in December 2024.

unique context of each state. For example, GBV programming faced heightened sensitivity and significant government-related blockages in Atbara and Gedarif compared to Red Sea and Kassala, which needed very different approaches to implementing GBV. UNFPA was also new to working with the Atbara government and had not established the same degree of trust that it had in other states.

UNFPA participated in selected inter-agency assessments, including, for example, in the multi-sector needs assessment in Al Jazirah and Gedarif in 2024. However, it did not appear to lead or leverage inter-agency data collection related to its core mandates of SRH and GBV. While UNFPA contributed to the United Nations joint needs assessment for IDPs and refugees in Port Sudan[150] (alongside UNHCR, IOM, UNDP, UN Women, WFP, WHO, and UNICEF), there was no evidence of it using these platforms to strengthen data generation on population dynamics or to service gaps in its areas of focus.

Adaptation to evolving needs

Finding 1.2. UNFPA responded promptly and with agility to the acute needs of women and girls within 72 hours at subnational level while ensuring business continuity at the national level despite systemic collapse. It adapted effectively to the evolving crisis and needs by leveraging existing partnerships, progressively expanding its presence to new acute displacement-affected areas through expanding logistics and supply across the Chad border, and introducing CVA modalities for the first time to meet the evolving needs of women and girls. Specific to cross-border relief, UNFPA efforts demonstrated relevant intent and adaptive leadership but this activity also remained constrained in consistency due to persistent political resistance, logistical complexity, and a cautious and incremental approach. While UNFPA responded effectively to acute natural disasters and health emergencies, it adapted insufficiently to Sudan's famine infliction pivot.

At the subnational level, at early onset, UNFPA responded promptly to the acute needs of women and girls. Within 72 hours of the fall of Khartoum, UNFPA staff mobilized supplies, engaged IPs and civil society, and linked women to sexual and reproductive health and GBV services through digital platforms such as WhatsApp and Facebook. Despite significant security and logistical constraints, a core team remained operational, agile and delivered services, prioritizing acute life-saving interventions. This remote response was led by staff with prior humanitarian experience in Darfur and Kordofan, who were familiar with the principles of humanitarian action. This case serves as an important lesson learned for UNFPA and illustrates that UNFPA can be timely, agile and flexible under extreme conditions, including insecurity, communication blackouts and concurrent staff evacuations. UNFPA's ability to continue operating was enabled by the presence of staff with humanitarian response experience, decentralized decision-making, life-saving focus over processes and existing field-level relationships.

> *"We responded within 72 hours. The emergency rooms (civil society) were already connected to us, so we moved fast. I appointed 13 focal points across Khartoum, mostly medical doctors, and we set up WhatsApp groups to stay in touch. We asked for help with CMR. Even with all the background noise and instability, we made an effort to build capacity quickly. In fact, we started responding within just 24 hours. We also saw Facebook groups offering first aid and MHPSS, so we reached out and linked them with a functioning service delivery. CAFA had a trained CMR team ready, and we divided Khartoum into zones so each partner could cover specific areas. We set up a coordinated call line to connect GBV survivors with emergency rooms remotely. The emergency rooms themselves began sourcing emergency contraception and post-exposure prophylaxis (PEP) from nearby pharmacies. In parallel, we integrated*

[150] Sudan Emergency Situation Report No.2 (Revised), 22 May 2023.

psychosocial through personal networks. At one point, there were around 150 case workers delivering counselling. This really made a difference"

-KII UNFPA

At the national level, UNFPA focused on business continuity, staff safety and evacuation. The collapse of Khartoum was an immediate threat to business continuity and delayed UNFPA's humanitarian programming. The ability of UNFPA to maintain business continuity in a context of systemic collapse (loss of country office, mass staff evacuation from Khartoum to Port Sudan and other safe states in the country or outside of Sudan, electricity and communication black outs, banking collapse) demonstrated resilience. Though adaptation was initially constrained by logistical challenges, and UNFPA had only five international staff in Port Sudan at onset, UNFPA re-established its new operational base in Port Sudan, alongside other United Nations agencies, where it faced significant barriers related to securing office space, accommodation, internet connectivity and ensuring staff safety and welfare.

UNFPA relied on and effectively leveraged its pre-existing network of IPs to respond to acute needs. With conflict restricting access, the number of operational states fell from 11 to six in 2023[151], and the organization relied on self-relocated staff and IPs to implement services. UNFPA realigned its partnerships including in non-UNFPA states such as Northern and River Nile. By early 2025, it had established nine IPs in its new operational hubs of Dongola and four in Atbara.[152] TPM mechanisms were introduced in Greater Darfur to compensate for the limited on-ground presence and to maintain some oversight. With time, and by 2025, UNFPA managed to increase its IPs in greater Darfur from two in 2023[153] to five in early 2025.[154]

UNFPA appropriately extended its operational presence to areas experiencing new IDP influxes. Following the collapse of Khartoum and staff evacuations, UNFPA established a presence in Port Sudan to coordinate the response at the national level. Moreover, it expanded its operations to other states following new population influxes across Medani/Gezira state in December 2023, Sinja and Sennar/Sennar State in June 2024, and the Aj Jazirah/Gezira State in December 2024. With new IDP influxes in River Nile State, UNFPA opened a new operational hub in Atbara (in August 2024). In order to maintain oversight on the Darfur operations a new office was opened in Dongola (in August 2024). Existing sub-offices in Kassala and Gedarif were reinforced with staff to respond to the new influxes in Sennar and Gezira state by mid-2024.

UNFPA demonstrated responsiveness to natural disasters and health emergencies, building on its previous experience in responding to floods and disease outbreaks. Some UNFPA sub-offices had previous experience responding to floods, enabling them to adapt and respond to acute crises. For example, UNFPA participated in the multisectoral needs assessment in Al Jazirah following floods in November 2024 and adapted its programming during the September 2023 cholera outbreak by revising midwifery training and circulating SRHiE guidelines.[155] While the UNFPA field teams with prior experience in these localized responses reported having flexible contingency funding in their workplans, this was inconsistent across all sub-offices and IP work plans, inhibiting rapid adaptations and responses.

[151] UNFPA Annual Report, 2023.
[152] UNFPA Implementing Partner Mapping Proposal 241203.
[153] PHF, SFPA.
[154] GAH, NIDO, CDF, PHF, SFPA.
[155] UNFPA Sudan Emergency Situation Report No 9, 27 Dec 2023.

UNFPA's adaptation to the famine declaration in Darfur was limited, with missed opportunities for adapting and integrating its SRH and GBV programming with other United Nations agencies' programming for a more effective multisectoral response. Evidence did not present an important strategic repositioning despite the famine prevention plan[156] being a major inflection point in the crises. UNFPA's response remained largely unchanged, apart from establishing a GBV risk mitigation mechanism, together with the food security, livelihood and nutrition sectors.[157] Most UNFPA informants reported that programming remained largely within existing SRH and GBV frameworks, missing an opportunity to adopt a more multisectoral approach by linking its mandate to famine-related needs.

UNFPA's cross-border strategy demonstrated relevant intent and adaptability in response to severe access constraints into Darfur. At the onset of the conflict, while several agencies leveraged Chad as an operational base, UNFPA opted for a more cautious engagement, aiming to avoid over-investing in a model that was (and still is) contested by the authorities in Port Sudan. The cross-border approach was designed to facilitate the delivery of essential supplies and maintain programmatic and coordination presence in areas otherwise inaccessible due to frontline dynamics and governmental restrictions. While the initial presence was deliberately limited to avoid over-investment in a model contested by authorities in Port Sudan, UNFPA eventually expanded its footprint. This included the deployment of staff to Farchana for GBV coordination and programming, followed by surge and GERT personnel to Abeche (Chad) to establish warehousing in September 2024, logistics SOPs and finally a logistics coordinator embedded in the country office of Chad in January 2025. Lastly, UNFPA deployed a GERT access specialist in Farchana (the Chad–Sudan border) who facilitated and participated in four cross border missions in 2023 and 2024. These efforts reflected an incremental and adaptive approach that strongly aligned with the targeting priority needs for populations in Darfur.

Despite these efforts, the operationalization of the cross-border strategy was heavily constrained by both political and logistical barriers. Internally, several capacity-related limitations further constrained the effectiveness of cross-border operations. UNFPA's presence in Chad remained limited and inconsistent, with heavy reliance on short-term deployments and dependency on the country office in Chad for customs clearance, warehousing and administrative tasks. Here, the absence of a clearly defined modus operandi and robust SOPs spanning multiple transit points – including Cameroon, Chad and Sudan – caused delays. Further, the Sudanese government's resistance to visible United Nations support in Darfur further hindered progress, delaying permits and approvals. Additionally, intentions to deliver supplies through South Sudan were unsuccessful due to conflict dynamics and shifting territorial control, cancelling out the feasibility of this route. Still, the organization drew valuable lessons from this experience. Key insights included: the importance of hybrid coordination models combining remote and physical presence; strategic and cross border investment in surge and GERT personnel to strengthen operational capacity; the value of maintaining flexibility within inter-agency mechanisms to enable independent decision-making; and the importance of establishing strong relationships with local authorities, notably the Humanitarian Aid Commission (HAC), through trusted Arabic-speaking interlocutors.

Finding 1.3. While UNFPA contributed to strengthening accountability to AAP at the national level through the CERF AAP grant, and at subnational levels through its implementing partners, AAP systems remained insufficiently institutionalized within UNFPA. Beneficiary engagement remained

[156] OCHA Famine Prevention Plan 2024, Through Accelerated Mitigative Actions to Halt Deterioration of Food Insecurity, Livelihood Impoverishment and Malnutrition.
[157] UNFPA Sudan Emergency Situation Report No 14 - 2 July 2024.

limited, with few opportunities for meaningful participation in informing the response. Moreover, feedback loops were not consistently closed, partly due to limited implementation capacity of UNFPA's implementing partners. Important results were achieved for PSEA, including guidance and enhancing IP capacity, despite field level implementation remaining inconsistent.

UNFPA contributed to strengthening AAP, both at the national and subnational levels, primarily through its implementing partners and in the framework of the AAP CERF grant. This included joint efforts with UNICEF and UNHCR to expand the UNICEF-run AAP feedback mechanism. UNFPA provided targeted technical support, including AAP training that enabled implementing partners to adopt feedback and complaint mechanisms such as suggestion boxes, hotlines and community consultations, in line with good humanitarian practice.[158] As part of the CERF initiative, UNFPA supported the training of 40 implementing partner managers and 2,229 service providers, community leaders, youth and staff on AAP principles and tools,[159] [160] contributing to expansion of the UNICEF-run feedback mechanism.[161]

However, consultations with women and girls were frequently described as "light", with limited evidence of feedback informing UNFPA programme design or adjustment. FGDs highlighted concerns such as the lack of responsiveness to feedback and follow-up. For example, supplies were not distributed following life-skills training, which hindered women from starting income generation activities.[162] Some women also reported not knowing how to file complaints. While the response plan referenced AAP, UNFPA did not have a clear process for aggregating community feedback or integrating it into programme planning. The UNFPA Crisis Response Team (CRT) called for improved AAP systems in 2024,[163] but interviews confirmed that feedback pathways between communities, implementing partners, and decision-makers were underdeveloped. AAP was new to many implementing partners, who were already overstretched.

UNFPA made visible progress on PSEA systems. All IPs were assessed for PSEA capacity, and training was provided to 110 personnel in 2023 (in addition to 414 in 2022). Over 10,000 information, education and communication (IEC) materials were distributed, and 26,000 individuals were reached with awareness-raising efforts.[164] UNFPA launched a PSEA helpline administered by an IP, embedded messaging in GBV activities (e.g. during dignity kit distribution and in WGSS),[165] [166] and collaborated with partners to produce Sudan-specific awareness tools and facilitator guides.

Some PSEA successes were highlighted including:

- UNFPA mobilized dedicated positions on PSEA.
- Collaborated with Child Development Foundation (CDF) to develop facilitator guidelines for community-level PSEA awareness, including distinctions between GBV and PSEA.
- Conducted IP capacity mapping and assessments prior to the conflict. All implementing partners have maintained full capacity since then.

[158] UNFPA Accountability to Affected Populations Operational Guideline, 2021.
[159] UNFPA COAR 2024.
[160] UNFPA, Basic Information, Response Plan Sudan June-December 2023 (Update September 2023).
[161] https://www.unicef.org/sudan/stories/phone-call-away-solutions-and-support
[162] Red Sea, Atbara, Gedarif.
[163] UNICEF, Meeting Minutes Programme Cairo Feb 18, 2024.
[164] UNFPA, Basic Information, Response Plan Sudan June-December 2023 (Update September 2023).
[165] UNFPA Sudan Emergency Situation Report No 1, 9 May 2023.
[166] FGD WGSS women Port Sudan.

- Expanded capacity building to include not only staff but also SRH and GBV service providers at the service delivery level.

Nonetheless, implementation of PSEA at the field level was inconsistent, depending on implementing partner capacity, location and access constraints. Many IPs lacked the capacity to manage CFM and PSEA, particularly in hard-to-reach areas such as Darfur and Kordofan, where UNFPA operated through CDF. Operational challenges included staff turnover and limited institutional understanding of the distinction between GBV and PSEA. Reports indicated minimal community trust, poor confidentiality and underreporting (only seven cases in 2024), suggesting that PSEA mechanisms were not perceived as safe or accessible. UNFPA also reportedly lost strategic leadership within the inter-agency PSEA working group due to staff shortages, with UNICEF more quickly assuming the role.

> *"Confidentiality is practically non-existent in Sudan"*
>
> *-KII, Gedarif*

Alignment with HNRPs and the UNFPA mandate areas

Finding 1.4. UNFPA's response plan was strongly aligned with its SRH and GBV mandates, including leadership roles in the GBV AoR and SRHiE working group, and the application of SRHiE and GBViE standards. Cross-cutting priorities such as AAP and PSEA were well integrated. UNFPA's response was broadly aligned with HNO and HNRP frameworks and target populations. However, alignment with emerging priorities, such GBV mainstreaming across sectors, was less visible.

UNFPA's response plan was strongly aligned with its core mandates, particularly with the UNFPA strategic plan 2022-2025, but also through its leadership of the GBV AoR, the SRHiE working group and its integration of cross-cutting commitments such as AAP and PSEA. The response plan and activities largely conformed to what is expected under SRHiE[167] and GBViE[168] standards. However, it was also clear that UNFPA's commitments would be hard to achieve given the security and access issues - similar to most United Nations agencies - particularly in conflict-affected states.

UNFPA's humanitarian response in Sudan was broadly aligned with the HNRPs and HNOs between 2023 and 2025. The agency actively contributed to inter-agency planning processes and used these frameworks to guide its prioritization of SRH and GBV services, including through the application of the MISP calculator to estimate reproductive health needs. UNFPA targeted 40 per cent of all WRA under health cluster people in need and 5 per cent of males under health cluster people in need. It also reached 64 per cent of the GBV target under the protection cluster.[169] UNFPA's interventions clearly reflected the strategic priorities, population priorities (IDPs, host communities, women, girls)[170] and thematic focus (GBViE, SRHiE). Its programming targeted key population groups identified in the HNRP and HNO, such as women, girls, adolescents and IDPs, and integrated cross-cutting concerns such as disability inclusion, PSEA and AAP.

However, continued alignment with other evolving priorities appeared limited. GBV mainstreaming was largely absent, with efforts concentrated primarily on response rather than on prevention, mitigation or integration across sectors.

[167] UNFFPA Minimum Initial Service Package for Sexual and Reproductive Health.
[168] UNFPA Minimum Standards for Prevention and Response to Gender-Based Violence in Emergencies.
[169] UNFPA HAO, 2025.
[170] UNFPA HAO 2024.

4.2 Effectiveness

Evaluation question 2: To what extent and how was the UNFPA humanitarian response effective in ensuring continued access and utilization of life-saving quality SRH services for affected populations, including the most vulnerable and marginalised groups?

SRH effectiveness

Finding 2.1. UNFPA contributed to the continued availability of life-saving SRH services in crisis-affected areas by operationalizing mobile clinics, supporting health facility rehabilitation, training health personnel and cross-border delivery of supplies. These efforts enabled the provision of critical SRH care, particularly for obstetric emergencies, and helped maintain access in both stable and hard-to-reach areas. However, persistent barriers, including weak referral systems, limited community awareness, supply chain disruption and service quality issues, constrained consistent access and utilization, particularly in remote and conflict-affected states.

UNFPA's performance data across 2023 and 2024 reveal mixed results that are difficult to interpret conclusively due to several data constraints, as noted in the methodological limitations section. Many of the targets, particularly for 2023, were set at or near baseline values, limiting their utility in measuring progress. Additionally, missing data for several indicators in 2024, as well as inconsistencies in indicator formats (e.g. percentages versus. absolute numbers), further constrained meaningful comparisons. Finally, there are inconsistencies in data between UNFPA annual reporting and UNFPA's HAO reporting.

Across 2023 and 2024, the UNFPA SRH response had reached approximately 340,000 women with SRH services, including 8,754 adolescents and youth (aged 10–24) in 2024 alone[171]. Of this, a total of 47,002 women delivered in UNFPA-supported health facilities in 2024. Additionally, 260,000 women received family planning methods across 51 UNFPA supported health facilities, including 32 mobile clinics.

Across the two years, 6 out of 10 measurable indicators were reported as achieved in the first year, and 7 out of 10 in the second year. However, performance in some areas remained static or showed only marginal improvement.

For example, while the targets for hospitals providing CEmONC services were reached in both years, the overall percentage dropped in 2024 from 2023. In contrast, fistula repairs exceeded or nearly met high targets, reflecting continued support for this life-saving intervention.

Some indicators, such as the number of females reached with CVA and health care providers trained on GBV and psychological first aid (PFA) show notable improvements in 2024, surpassing targets by a large margin.

However, there was underperformance in other areas, such as contraceptive stockouts, which did not meet the targets. While community-based obstetric referral mechanisms did not meet targets in 2023, targets were exceeded in 2024, indicating that performance improved over time.

The HIV prevention programme reached a plateau, with identical figures for both years despite increasing targets. System-level indicators like the e-logistics management system remained only partially functional, and training on emergency health packages was marginally below target in 2023, with no data for 2024.

[171] HAO UNFPA SRH achieved results 2024.

Table 8: UNFPA achieved results, SRH 2023-2024

Indicators	Baseline 2022	Targets 2023	Achieved 2023	Baseline 2023	Targets 2024	Achieved 2024
Percentage of hospitals providing CEmONC services	43%	43%	43%	34%	34%	34%
Number of fistula cases repaired with the support of UNFPA	1,773	1,793	1,822	1,822	1,882	1,842
Number of functional community-based obstetric referral mechanisms	147	159	103	103	123	141
Number of key population and vulnerable groups received HIV prevention services	982,515	989,515	991,946	989,515	1,003,196	989,515
Number of health facilities providing CMR and psycho-social support services	76	62	62	n/a	n/a	n/a
Number of health[172] service providers trained on the MISP with support from UNFPA	314	352	349	n/a	n/a	n/a
Percentage of hospitals providing comprehensive EmONC services in the UNFPA priority states	n/a	n/a	n/a	43%	43%	43%
Number of females reached with CVA to enable access to SRH services[173]	-	-	-	0	40	1,066
Number of health care providers trained on CMR, GBV and PFA	n/a	n/a	n/a	0	25	233
Number of beneficiaries reached with SRHiE services	n/a	n/a	n/a	182,000	289,000	342,608
Functional e-logistics management information system for forecasting and monitoring reproductive health commodities in place[174]	Yes, partially	Yes, partially	Yes, partially	-	-	-
Number of health facilities providing at least 3 modern contraceptive methods including long-acting method in the priority states	17%	30%	17%	82	120	120
Percentage of facilities that experienced no stockout of contraceptives in UNFPA priority states	42%	60%	42%	n/a	n/a	n/a
Number of current users of modern family planning methods in UNFPA-supported states (non-cumulative)	232,000	140,000	147,252	0	140,000	120,000

Source: UNFPA

[172] With some due to new units of measurement.
[173] CVA was first introduced in 2024, hence no data reported in 2023.
[174] This indicator was in 2024 because the National Medical Supplies Fund moved out of Khartoum and the investment was not feasible in the conflict environment.

Output: SRH services available and accessible

SRH activities under this output contributed meaningfully to Outcome 1, which aimed to ensure utilization of quality SRH services. Mobile and temporary clinics filled some gaps in hard-to-reach areas, IDP camps and gathering sites as noted during the field visit observation. Solar energy installations and facility rehabilitations ensured continuity of EmONC services, which several informants highlighted as essential: "Just with one click of a button (solar energy), you can continue surgery when the power goes off. That clearly saves lives." Training of community-based midwives and task-shifting strategies, such as family planning training for nurses, helped strengthen frontline service capacity. CVA was used to facilitate referrals for obstetric complications, covering transport or medication costs. Free service provision, while not always attributable directly to UNFPA, was however consistently cited in FGDs with hospital staff as a key enabler for IDPs to access care.

Output: SRH community awareness and referral

Conversely, the contribution of UNFPA to SRH awareness and referral activities to increased utilization of SRH services (Outcome 1) was limited, although it slightly improved over time. Awareness of available services and referral pathways remained limited, especially in 2023. Several EmONC hospitals reported being overwhelmed at onset, facing stockouts and treating women with severe complications due to late presentation. FGDs revealed that many women and men were unaware of available services at the onset of the crisis. By 2024, awareness had improved, particularly for IDPs in host communities, although this was attributed more to time, familiarity and word of mouth than to structured awareness-raising by UNFPA. In some areas, women stated that health services had ceased entirely by 2025 (e.g. Atbara Village 6), and confusion around the presence of multiple health providers (e.g. UNFPA static clinics, MSF, Save the Children) created uncertainty about service roles and referral systems. Transport and ambulance availability were frequently reported by FGDs and service delivery staff as lacking, especially in remote areas or IDP camps, despite UNFPA having purchased ambulances.

Barriers to SRH availability, access and utilization

Health facility observations, FGDs with women and key informant interviews identified several factors internal to the UNFPA's response that hindered UNFPA's full contribution to improved access and utilization of SRH services:

- **Quality and availability of care:** Equipment and drug shortages were common in both fixed and mobile facilities, including in non-conflict states. EmONC centres lacked essential and life-saving medicines, forcing women to purchase them privately. Hygiene conditions were significantly substandard as observed by the evaluation team and reliable access to supplies, blood and oxygen was repeatedly reported as significant gap, despite anaemia being highly prevalent. Previous Sudan evaluations cited similar barriers, indicating that such gaps seem systemic to the Sudan context and less attributable to the recent conflict.[175]
- **Logistical and financial barriers:** Access was impeded by a lack of transport and ambulances, delayed referrals and late or no delivery of IARH kits. Although SRH services were intended to be free, many IDP women reported being required to pay out of pocket, often incurring debt. The expiration of the national free care policy in 2025 was cited by EmONC staff as a critical barrier. FGDs confirmed that financial constraints discouraged attendance for preventive services such as antenatal and postnatal care. UNFPA contributed to addressing this barrier through the introduction of CVA.
- **Uneven service coverage:** SRH service availability varied significantly across geographic areas. In many remote communities and IDP locations, supply chain breakdowns and staffing shortages left facilities unable to meet basic needs. Several UNFPA-supported mobile clinics were observed operating without essential SRH commodities. Though responsibility for these gaps was sometimes attributed to WHO or the inefficient national supply system, the net result was reduced access to quality health care. In such cases, women were issued prescriptions but had to travel

[175] Impact Assessment of Humanitarian Interventions - UNFPA Sudan Report 2022.

long distances (e.g. 45 km) to purchase medicine from private pharmacies. FGDs repeatedly stated that “primary clinics are not activated and there are no drugs, even before the conflict.” (see finding 6.3 below for more details on supplies).

Feedback from partners and UNFPA staff suggested that UNFPA’s contribution to improving access to SRH services was generally adequate. Survey data reflected this, with UNFPA’s contribution to ensuring SRH access rated at 79 per cent overall, 85 per cent among UNFPA staff and 76 per cent among partners. Contributions to improving community awareness and referral knowledge were rated somewhat lower, at 72 per cent overall (74 per cent by staff and 70 per cent by partners). However, these generally positive perceptions were hindered by several internal challenges noted by respondents, including delays in staff deployment, limited subnational decision-making authority and inefficiencies in supply chain management, which were seen as key constraints to a more effective response.

The findings above primarily reflect UNFPA’s work in non-conflict, IDP-hosting states. Due to the military government’s heavy restrictions on the physical presence of the United Nations in the opposition controlled areas, namely the five states of Darfur and three states of Kordofan, UNFPA provided its assistance through implementing partners and relied on TPM reports for information; therefore, the evaluation could not systematically assess contributions to outcomes in conflict-affected areas, despite these being among the most severely impacted (for more details, see the limitations section above).

Evaluation Question 3: To what extent and how did the UNFPA humanitarian response prevent, mitigate and respond to GBV and harmful practices for affected populations?

Gender-based violence effectiveness

Finding 3.1. UNFPA reached women, girls and men and contributed meaningfully to the prevention of, and response to, GBV through the delivery of essential GBV services. This included prioritization of CMR as a live-saving intervention and support to WGSS, which served as trusted entry points for MHPSS, referrals and skills-building, which were particularly valuable in a context marked by heavy stigma around, and denial of, GBV. UNFPA was also commended for improving GBV visibility and awareness, particularly in a highly GBV sensitive context. However, there was limited evidence of improved community knowledge or strengthening of formal referral pathways. Overall GBV service quality and access were significantly constrained by insecurity, legal and policy barriers, persistent stigma and fragmented coverage. The absence of integrative, survivor-centred approaches further undermined confidentiality and accessibility for affected populations.

The 2023–2024 data on the UNFPA GBV response shows a mix of significant progress and data-related constraints that limit the ability to draw reliable findings. Several GBV indicators demonstrate strong results, particularly in 2024, but interpretation is hindered by inconsistencies in indicator definitions, gaps in baseline and achievement data, and instances where targets appear significantly misaligned with actual performance.

Across 2023 and 2024, the UNFPA GBV response had reached approximately 266,000 individuals with dignity kits and sanitary pads. This included 6,886 men.[176] An additional 227,000 people were reached with in-person awareness-raising and life-saving information on GBV. UNFPA also provided CVA to 7,369 individuals (including 722 men in 2024), trained 6,843 humanitarian and frontline workers, and supported 70 WGSS offering MHPSS, set up confidentiality corners, referrals to SRH care, and skill-based training.[177]

Out of the 14 indicators for which achievement data was available, 10 were met or exceeded, indicating targeted programmatic gains, especially in service delivery expansion and awareness raising. Notably, communities supported in preparation for FGM abandonment consistently met or surpassed targets in both years (reaching 256 in 2024 against a target of 250). Awareness and capacity building targets were achieved. The number of community members reached with key GBV messages rose sharply in 2024 to over 227,000, more than doubling the 2024 target. Similarly, support to marginalized girls through life skills programmes exceeded targets for 2023, while there was no data for 2024. Encouragingly, 2024 saw a dramatic scale-up in GBV-related training, with over 6,800 service providers trained versus a modest target of 35. Likewise, the roll-out of CVA expanded significantly, reaching 7,369 beneficiaries against a 2024 target of only 100.

However, other indicators signal key limitations in the GBV response. For instance, the number of functional community-based GBV referral pathways dropped steeply from the 2023 target of 145 to only 41 achieved. And the number of women and girls benefiting from dignity kits did not achieve its target. Only one GBV helpline was reported to be in operation in 2023 compared to a target of 13. These figures suggest challenges in scaling GBV protection, although a lack of corresponding 2024 data makes it unclear whether corrective action was taken. Some indicators, such as those related to GBV service delivery points, show declines between 2023 and 2024 despite raised targets, and the functionality of GBV referral systems remain a concern.

[176] HAO UNFPA GBV achieved results, 2024.

[177] Psychological First Aid, gender-based violence pocket guideline, and gender-based violence referrals, survivor-centred approach.

Table 9: UNFPA achieved results, gender-based violence 2023-2024

Indicators	Baseline 2022	Targets 2023	Achieved 2023	Baseline 2023	Targets 2024	Achieved 2024
Number of functional community-based gender-based violence referral pathways	135	145	41	n/a	n/a	121
Number of communities reached and supported in preparation for declaration of abandonment of FGM	213	223	223	223	250	256
Number of marginalized girls that are reached by life skills programmes that build their health, social and economic assets	2,462	2,942	3,167	n/a	n/a	n/a
Number of girls and women who receive, with support from UNFPA, prevention and/or protection services and care related to FGM	51,106	63,106	64,233	n/a	n/a	n/a
Number of GBV helplines supported and functional	12	13	1	n/a	n/a	n/a
UNFPA is prepared to coordinate a functioning inter-agency GBV coordination body with required number of functionality areas (5 or more out of 7) in place,	Yes	Yes	Yes	Yes	Yes	Yes
Number of marginalized girls, including girls with disabilities and girls affected by UNFPA other core furthest behind factors, reached by girl-centred programmes that build their life skills, health, social and economic assets	n/a	500	705	n/a	n/a	n/a
Number of operational and specialized GBV service delivery options supported	n/a	n/a	n/a	106	126	70
Number of operational community-based and specialized GBV protection and service delivery points supported.	n/a	n/a	n/a	147	167	118
Number of service providers (health care providers, social workers, volunteers, community leaders and legal aid providers) trained on GBV related topics	n/a	n/a	n/a	0	35	6,843
GBV risks assessed, identified and mitigation measures taken	n/a	n/a	n/a	No	Yes	Yes
Number of females reached with CVA within clinical management and hygiene services	n/a	n/a	n/a	0	100	7,369
Number of women and girls who benefited from distribution of dignity kits and sanitary pads	n/a	n/a	n/a	200,000	386,131	266,384

Number of community members (women, girls, men and boys) reached with key GBV messages during information dissemination sessions and mass awareness raising campaigns	n/a	n/a	n/a	0	112,000	227,329

Source: UNFPA

GBV prevention and response available and accessible

GBV activities under Output 3 contributed meaningfully to Outcome 2, which aimed to ensure utilization of quality GBV services. This was particularly the case in accessible areas. The scale-up of 74 functional WGSS and confidentiality corners provided access points for women and girls to receive MHPSS, skills training, peer support and case management. In Sudan's highly restrictive and stigmatizing context, where GBV is underreported, politically sensitive and often denied, these achievements were notable. Women described WGSS as "safe spaces" and "peer-to-peer support" that reduced their isolation and trauma but also cited that they needed money to move forward in their lives. CBPNs also played a role, with some uncertainty as to how critical this role was, in identifying and referring survivors for CMR and WGSS. Dignity kits were cited as an effective entry point for identifying women at risk or survivors of GBV, but also as the only GBV tangible item which could easily be deployed and measured for UNFPA programming. Survivors' interviews in WGSS widely acknowledged WGSS services citing it as "a place where they feel safe" and where they "learn skills", though several women pointed out that the skills training was the primary benefit to "changing their life".

Community awareness of GBV services, risks, and referral

GBV activities under Output 4 also contributed partially to Outcome 2 by strengthening community knowledge of GBV risks and available services. While there is not strong evidence that engagements through awareness campaigns facilitated referral, CBPNs and, particularly, frontline worker training informed women of available support. Training in CMR for EmONC health staff was particularly well received, as many participants had not previously received any training or practical experience in providing care to GBV survivors. Referrals were made mostly to psychosocial, and SRH (CMR) services, including safe abortion or adoption support. Although FGM was not explicitly included in the response plan, some implementing partners maintained FGM prevention through ongoing awareness activities. Notably, providers in Kassala reported that 3 of 10 communities had reportedly abandoned FGM practices following CBPN-led engagement which could not be triangulated with other data and appeared somewhat overly positive.

> *"There are some women who just close themselves inside their houses, they have serious GBV issues at home, but with the home visits (CBPN), they started coming to the WGSS and received services. A lot of cases are being identified, and they are referred to services. We are the only provider in some of the areas"*
>
> *-Staff of an implementing partner, Gedarif*

UNFPA was commended for improving GBV visibility and awareness, particularly in a highly GBV sensitive context. Informants pointed towards the high value of WGSS, mobile clinics, "coffee meetings", door-to-door outreach and CBPN initiatives. These helped increase survivor reporting. However, respondents frequently noted that the scale of services remained limited, underreported and inconsistent, particularly in conflict-affected states like Darfur and Kordofan. Quality was limited by short-term funding, poor coordination, high staff turnover, lack of legal referrals and restrictions from the government. Stigma, distrust of providers and logistical barriers further constrained service use.

FGDs with women and girls in camps, gathering sites and in WGSS revealed high awareness of GBV risks, but reported on continued exposure to unsafe environments, including the inability to move away from those that violate them. Key protection concerns included the lack of fencing, lighting and

security in IDP camps, harassment by unidentified men (including military actors and host community members) in camp, but also mistrust of humanitarian actors like local NGOs and government services. Such threats reduced trust in public spaces and reportedly discouraged women from seeking assistance.

> *"There are unknown men offering "charity" at night."*
>
> *– FGD, women and girls, Gedarif IPD camp*

> *"I work in a café and men from the community know I am an IDP and ask for favours like sex, so I can't continue this job."*
>
> *– Gedarif, IDP camp*

Barriers to GBV availability, access and utilization

Despite progress, important internal and external structural and operational issues impeded a full contribution by UNFPA to Outcome 2:

- First, in terms of service quality and systemic weaknesses, high staff turnover, limited supervision for trained personnel, the absence of legal services and the absence of a gender-based violence information management system, weakened the consistency and quality of care.
- Second, in terms of access, insecurity, lack of transport, movement restrictions (particularly in Darfur, Kordofan, and Khartoum) and political sensitivity surrounding GBV constrained both the availability but also use of services. Survivors reported heavy stigma and fear of retaliation, while some WGSS were forced to relocate due to government or community resistance. In several areas, survivors avoided services linked to government actors or certain IPs perceived to be aligned with authorities.
- Third, in terms of legal and confidentiality challenges, legal services and access to safe abortion care were extremely limited, and women were required to obtain approval from the Ministry of Health with bureaucratic and ethical constraints, a process that further deterred access. In many cases, women were required to seek Ministry of Health approval for abortion services. Several reports described survivors who chose not to seek care, remained in hiding, or, in some cases, committed suicide due to unwanted pregnancies.

> *"We have one girl who has left her family because she was raped and is now pregnant and does not want her family to know. She's just hiding till she can deliver the baby and give it to adoption."*
> *-KII, WGSS Atbara*

- Lastly, in terms of utilization, although UNFPA expanded coverage, GBV services remained concentrated in areas with direct partner presence. Missed opportunities to integrate GBV into SRH services further limited access and utilization and disfavoured confidentiality. Some CBPNs ceased functioning in 2025 due to funding gaps. Legal service referrals were nearly absent, with only one partner reportedly providing such services. Service integration between WGSS, SRH, and CMR providers was inconsistent. Several WGSS lacked direct links to health or CMR services, and vice versa. Mapping of GBV services came late in the response and raised concerns over data confidentiality. Delays in CVA and the widespread inability to meet the 72-hour window for CMR were also reported (especially CRSV cases). EmONC staff noted increased cases of unwanted pregnancies and growing demand for safe abortion or adoption.

"We have one girl who has left her family because she was raped and is now pregnant and does not want her family to know. She's just hiding till she can deliver the baby and give it to adoption"

-KII WGSS Atbara

Perceptions of UNFPA's contribution to GBV access were generally rated as adequate, though some differences emerged between internal and external informants. Survey findings rated the UNFPA contribution to gender-based violence service access at 79 per cent overall (95 per cent by UNFPA staff; 72 per cent by partners). The contribution to community awareness of gender-based violence and referral pathways was rated at 69 per cent overall (73 per cent by staff; 67 per cent by partners).

CVA effectiveness

Finding 3.2. CVA played an important role in facilitating referrals and access to sexual and reproductive health and gender-based violence services, by removing financial barriers, particularly among displaced and vulnerable women and girls.

In 2024, the introduction by UNFPA of CVA, despite being a first-time initiative and rolled out under crisis conditions, demonstrated promising effectiveness in addressing both sexual and reproductive health and gender-based violence needs. Through partnerships with three national organizations, the programme reached 1,066 women across Kassala, Gedarif, West Darfur and North Darfur with targeted cash support for safe childbirth and pregnancy-related complications, caesarean sections and obstetric emergencies. An additional 7,369 individuals across eight states received CVA for gender-based violence-related needs.

The use of a mixed-modality approach, informed by local service mapping, risk assessments[178] and post-distribution monitoring,[179] [180] enabled UNFPA to determine transfer values to context-specific needs. Where healthcare services were free, cash was redirected to other critical expenses such as transport, food, hygiene items and delivery supplies demonstrating flexibility to local context. Although the evaluation did not directly interview CVA recipients, FGDs confirmed that women regarded cash assistance as essential, especially to meet basic needs for their children.

Overall, the initiative strengthened access to life-saving sexual and reproductive health and gender-based violence services, by helping to reduce financial barriers among vulnerable women through CVA. While the scale remained limited and systems were built from scratch in a compressed timeframe, the allocation by UNFPA of $1.7 million to CVA, including in conflict-affected states via e-vouchers, highlights a relevant shift toward more adaptive, people-centred humanitarian assistance. The experience offers a case for further learning and scaling of CVA within the UNFPA response strategy.

[178] UNFPA, risk and mitigation measures for cash assistance under gender-based violence and sexual and reproductive health, Sudan.
[179] UNFPA Sudan post distribution monitoring, December 2024.
[180] UNFPA Sudan guidance paper for cash and voucher assistance (CVA).

Evaluation Question 4: To what extent has UNFPA leadership and coordination of the SRHiE working group and the gender-based violence AoRs contributed to continued access to sexual and reproductive health and gender-based violence services for those in need?

Leadership and coordination of the SRHiE working group

Finding 4.1. UNFPA effectively advocated for sexual and reproductive health, provided strong technical sexual and reproductive health leadership, and supported coordination of the SRHiE working group, primarily at the subnational level, including effective promotion of the MISP. However, the coordination of the sexual and reproductive health working group also faced gaps, including delayed activation, lack of a national coordinator, absence of early partner mapping, and limited joint planning, which constrained an effective response to sexual and reproductive health needs.

UNFPA was widely recognised for its strong technical leadership in sexual and reproductive health, consistent subnational coordination support, and promotion of the MISP. Within the health cluster, collaboration between sexual and reproductive health and MHPSS was described as particularly effective, with UNFPA leading sexual and reproductive health service delivery and WHO managing the supply chain. Survey findings confirmed broadly positive perceptions of coordination: UNFPA leadership of the SRHiE working group under the health cluster was rated 71 per cent effective at the national level and 68 per cent at the subnational level. Among UNFPA staff, ratings were higher at 75 per cent for national and 83 per cent for subnational levels. In the early stages of the response, available IPs and UNFPA field staff helped sustain subnational coordination in the absence of a national focal point, ensuring continuity and representation. Notably, the SRHiE working group also successfully advocated for the inclusion of MISP priorities in the 2025 HNRP reprioritization exercise.

However, the establishment of the national-level SRHiE working group was significantly delayed, only becoming operational in December 2024, 21 months after the onset of the conflict. This delay critically constrained early coordination efforts, limiting partner and service mapping, weakening evidence-based planning and reducing the effectiveness of strategic advocacy. Inconsistent partner reporting – 14 partners failed to submit updates by the end of 2024 – further limited data availability and coordination of the sexual and reproductive health response.

The limited visibility of UNFPA at the Inter-Agency Cluster Coordination Group (ICCG) compounded these challenges. As the SRHiE working group does not have a seat at the ICCG[181] because (as opposed to GBV AoR), under the IASC Cluster system, the SRHiE working group is not a sub-cluster, but rather a technical working group under the health cluster, it must rely on the health cluster to represent sexual and reproductive health interests. This external constraint reduced UNFPA influence in key inter-agency decision-making forums and limited its ability to consistently advocate for example on the "non-negotiable" inclusion of MISP in the Essential Humanitarian Package.[182] As one key informant noted, "We don't have a seat at the table to advocate for ourselves, and we still need to justify that MISP is non-negotiable." Although technical advocacy remained aligned with global standards, MISP was initially excluded from the Essential Humanitarian Package, only EmONC was retained, and its eventual inclusion required direct intervention by senior UNFPA leadership.[183]

The SRHIE Working Group faced several important challenges related to its visibility and influence. In a context of declining humanitarian funding, the disconnect between technical sexual and reproductive health coordination and inter-agency representation contributed to the marginalization of

[181] Under the IASC cluster system, SRHiE is not a sub-cluster (as opposed to the gender-based violence AoR), but rather a technical working group under the health cluster and therefore does not have a seat at the ICCG.
[182] Sudan Humanitarian Country Team Essential Humanitarian Package, Draft 28 April 2025.
[183] Implementing the MISP is not optional or negotiable; it is an international standard of care that should be implemented at the onset of every emergency. It is one of the Sphere standards, and it is aligned with the life-saving criteria of the United Nations CERF. Available at https://www.unfpa.org/resources/minimum-initial-service-package-misp-srh-crisis-situations?utm_source=chatgpt.com

sexual and reproductive health. Compared to other sub-sectors, the SRHiE Working Group was described as “the poor cousin”, with limited influence relative to sectors led by larger agencies such as UNICEF. HNRP allocations were widely perceived to prioritize child health and nutrition over women’s health and sexual and reproductive health. Although UNFPA had estimated a balanced split between gender-based violence and sexual and reproductive health in its 2024 response budget, actual funding received was skewed in favour of gender-based violence, reflecting a broader donor preference for protection-focused programming.

Leadership and coordinating of the gender-based violence AoR

Finding 4.2. UNFPA effectively scaled up its leadership of the gender-based violence AoR, expanding subnational coordination structures, developing key technical guidance and promoting localization through national co-leadership, an achievement that was particularly commendable given the complex and politically sensitive gender-based violence environment. However, cautious advocacy on gender-based violence and CRSV, limited data sharing, and overlapping mandates with UNHCR and UNICEF within the broader protection sector contributed to a lesser coordinated gender-based violence response and a lack of clarity around referral pathways.

UNFPA consistently scaled up its leadership and coordination role in the gender-based violence AoR. Coordination capacity was scaled up at both national and subnational levels, with the gender-based violence AoR extended to 16 subnational locations.[184] Despite some gaps in coordination deployments, UNFPA sustained its commitment to deploying capable national coordinators, seen as essential to sustaining gender-based violence AoR meetings, increasing partner engagement (including national NGOs and community-based actors), setting standards and guidance and tools. For example, in Gedarif, the gender-based violence AoR was described as “functional and inclusive”, with membership growing from 15 to over 30 organizations. Key technical documents developed under the gender-based violence AoR included SOPs for case management, remote psychosocial support, and CMR protocols in 2023,[185] followed by the gender-based violence pocket guidelines in Arabic and English in 2024[186]and likely contributed to improved service delivery.

Informant perceptions of the gender-based violence AoR were generally very positive. Survey findings suggest that UNFPA effectively led and coordinated the gender-based violence AoR, which received a 74 per cent effectiveness rating overall at both national and subnational levels. UNFPA staff rated their own coordination performance more highly, at 95 per cent at the subnational level and 88 per cent nationally. In contrast, external stakeholders rated this more modestly at 69 per cent and 65 per cent, respectively. Overall, the gender-based violence AoR was described as inclusive and staffed by technically competent personnel. It was credited with driving the expansion of gender-based violence services and was often perceived as one of the few actors addressing gender-based violence at scale in Sudan’s complex environment.

The gender-based violence AoR advanced key localization efforts in a meaningful and contextually relevant manner. Notably, it completed a national mapping of women-led organizations (WLOs), a critical step toward improving the visibility and inclusion of local actors in coordination mechanisms. The appointment of the national NGO Nada Azhar as co-chair of the gender-based violence AoR, the only nationally-led co-chair arrangement in Sudan, demonstrates shared leadership and local ownership within the gender-based violence coordination. High-profile advocacy initiatives, such as the 16 Days of Activism Against Gender-Based Violence campaign, supported by the United Nations emergency relief coordinator, further emphasize a call for local leadership and long-term shifts in

[184] Namely in South, North, West, Central, Darfur, Blue Nile, South Kordofan and White Nile, Kassala, Gezira, Khartoum, Red Sea, Sennar, Northern State and Gedarif.
[185] Guidance notes on gender-based violence awareness sessions, remote psychological first aid remote case management, key considerations for gender-based violence prevention and response and conflict-related sexual violence messages, were developed in 2023. UNFPA Annual Report, 2023.
[186] UNFPA Annual Report, 2024.

social norms around gender-based violence.[187] While largely symbolic, such platforms provided national actors with visibility in a space usually dominated by international agencies.

UNFPA effectively kept fulfilling its gender-based violence AoR mandate despite facing critical external challenges. In some areas, gender-based violence-related activities faced political backlash, and national staff were targeted, raising significant concerns for both survivor and staff and IP safety. As a result, UNFPA adopted a cautious and "careful and discreet" coordination approach to their AoR mandate.[188] This included delaying the release of referral pathways and limiting early data sharing to protect partners and survivors. This non-sharing policy was also scrutinized by United Nations agencies and NGOs. However, while protective in intent, the lack of shared referral pathways contributed to duplication, gaps and fragmentation in gender-based violence service delivery. Parallel referral systems emerged across child protection, sexual and reproductive health and gender-based violence, often without clarity or integration. Informants also raised concerns about breaches of confidentiality and data protection. Gender-based violence coordination was described by some as siloed, overly complex and affected by overlapping mandates between the gender-based violence AoR, the protection cluster, the child protection sub-cluster, and UN Women-led groups. However, improvements in coordination and coherence were also noted in late 2024 and into 2025, and overall, UNFPA kept fulfilling its gender-based violence AoR mandate despite these challenges.

While UNFPA was commended for its advocacy efforts through the gender-based violence AoR, stakeholders also raised concerns about the limitations of the UNFPA approach and the lack of a joint United Nations advocacy strategy. Although UNFPA visibility and influence improved in late 2024 and was recognised by the HCT, several informants, including United Nations staff and partners, wished that UNFPA had taken a stronger public or behind-the-scenes stance on gender-based violence issues, especially following the publication of the OHCHR report on conflict-related sexual violence.[189] Concerns were also raised about the lack of unified advocacy strategies between UNFPA,[190] UN Women,[191] and UNICEF.[192] The absence of common messaging and coordinated positioning across the protection architecture contributed to perceived mandate creep, competition and fragmentation. Some stakeholders viewed this as a "United Nations turf war", which undermined the potential for a collective, survivor-centred gender-based violence response that could have benefited all agencies, and more importantly, the people in need of gender-based violence services.

[187] https://x.com/_UnfpaSudan/status/1861038072487367052
[188] Under the AoR system, the focus is on prevention, mitigation and response to gender-based violence, especially in humanitarian settings, with an emphasis on survivor-centred services (case management, referrals, psychosocial support, etc.).
[189] https://www.ohchr.org/sites/default/files/documents/hrbodies/hrcouncil/sessions-regular/session57/A-HRC-57-CRP-6-en.pdf
[190] https://www.unfpa.org/news/sexual-violence-and-conflict-sudan-war-bodies-women-and-girls
[191] https://www.unwomen.org/sites/default/files/2024-12/sudan-gender-alert-no_excuse_en_2024.pdf
[192] UNICEF developed documents for private advocacy purposes.

4.3 Coverage

Evaluation Question 5: To what extent and how has the UNFPA humanitarian response reached the affected populations, including the most vulnerable and marginalized?

Reach across geography and needs

Finding 5.1. UNFPA set ambitious coverage targets for its humanitarian response in 2024, prioritising gender-based violence interventions and expanding its operational footprint to improve reach, particularly through mobile services, optimization of partnerships, and establishment of new subnational offices. However, overall coverage remained limited relative to the scale of need, and supply distribution was disproportionately concentrated in more accessible areas, mainly due to security and access constraints, raising concerns about the equity of the response.

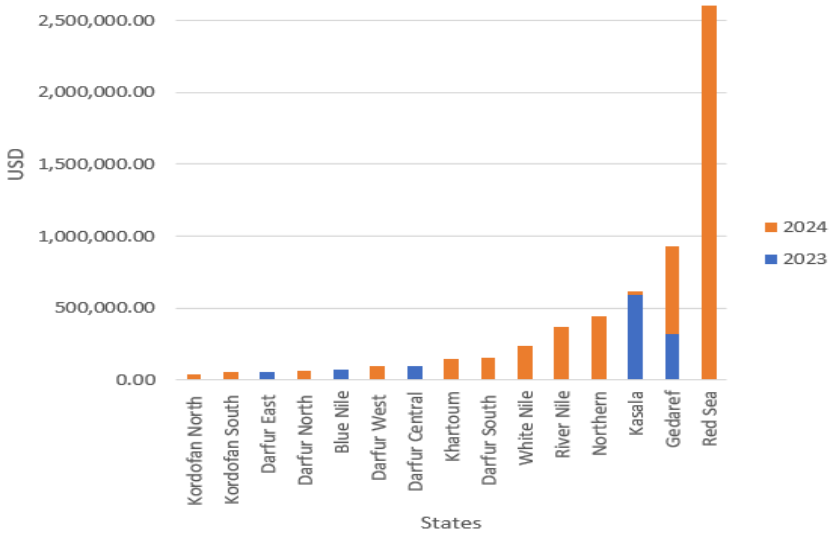
In 2024, UNFPA set ambitious targets for its humanitarian response, with a strong emphasis on gender-based violence interventions. Based on MISP calculations, The UNFPA Humanitarian Action Overview 2024 estimated that 5,760,000 WRA (aged 15–49) were in need of assistance. UNFPA defined its target population as 2,068,095 individuals, including 753,770 males and 719,851 WRA. To address these needs, UNFPA funding allocated 78 per cent to gender-based violence compared to 22 per cent to sexual and reproductive health interventions.[193] In 2024, NFPA reached 365,928 individuals, equivalent to 18 per cent of its total target and 51 per cent of its WRA target.[194] This data was not available for 2023.

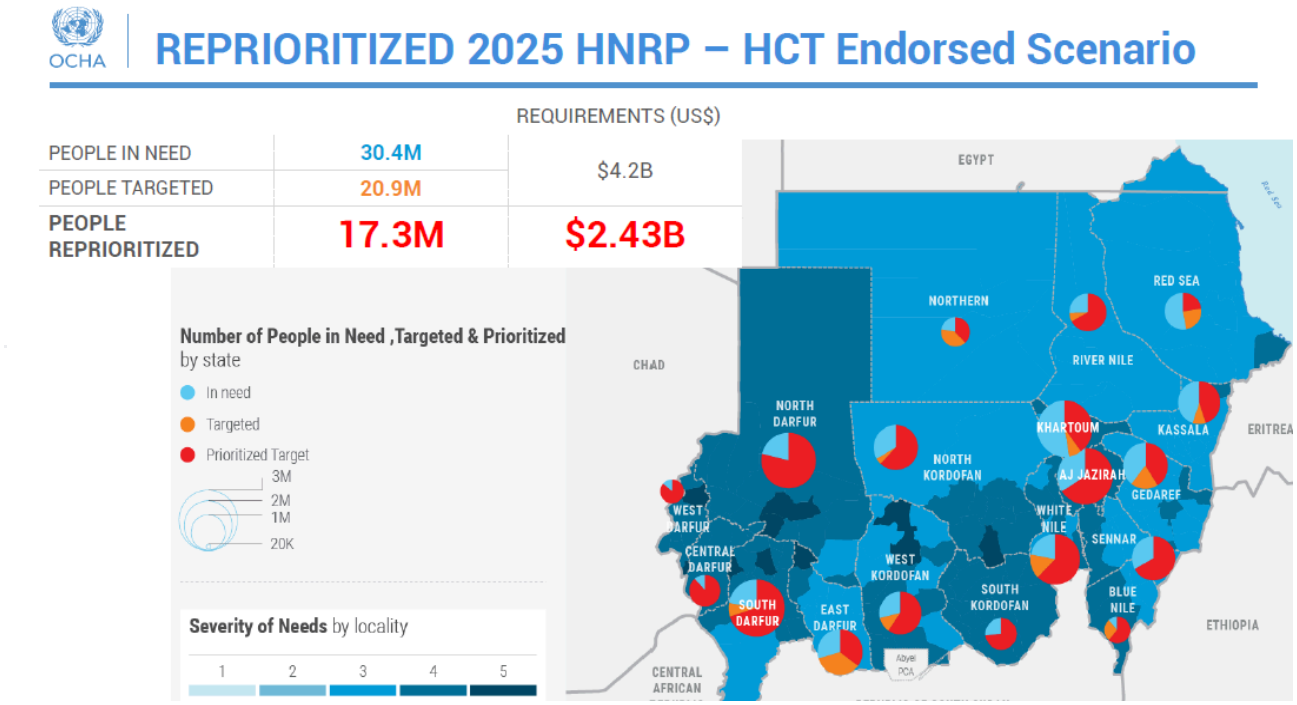
UNFPA progressively expanded its geographic reach as the conflict and internal displacements evolved. UNFPA expanded services particularly following large IDP influxes into Kassala, Gedarif and Red Sea. Key enablers included the presence of IPs, deployment of mobile service delivery strategies to reach populations outside formal health catchment areas and the expansion of the UNFPA operational footprint. In addition to maintaining sub-offices in Kassala and Gedarif, UNFPA established a new country office base in Red Sea in 2023 and opened sub-offices in Atbara and Dongola in 2024. With the number of IPs having declined from 37 in 2023 to 32 in 2024 and further to 22 in 2025,[195] UNFPA cited this rationalization as having improved operational efficiency and expansion including in conflict-affected states.

While UNFPA delivered life-saving supplies to 15 states, including some hard-to-reach areas through cross-border delivery, supply coverage appeared overall disproportionate to the scale and severity of needs across states. UNFPA delivered supplies to 15 states, including hard-to-reach locations such as Darfur, Kordofan and Khartoum, with supply budget allocations appearing skewed toward accessible eastern states. Red Sea, while receiving the largest supply budget, represents donations to the Ministry of Health that were afterwards redistributed to all states. This was a UNFPA strategic choice due to the FMOH available warehousing capacity and internal national transportation mechanisms. Gedarif and Kassala, while relatively low on scale and severity of needs, received the largest proportion of the supply budget, compared to conflict-affected states such as Darfur, Al Jazeera, White Nile and Kordofan. Nonetheless, UNFPA was able to deliver cross-border supplies to high-need areas, with a total of $720,000 allocated to Darfur, Kordofan and Khartoum – representing 12 per cent of the total supply budget across 2023 and 2024. Lastly, the supply chain, including last-mile delivery, faced significant external barriers that are further discussed in section 4.6.

[193] UNFPA Humanitarian Annual Overview, 2024.
[194] 365,928 people reached, including 226,374 for sexual and reproductive health and 139,554 for gender-based violence.
[195] While 27 IPs were selected in 2025, only 22 have active funded workplans.

Figure 7: Sudan severity of needs across states





Source: OCHA, 2025.

Reach across vulnerability

Finding 5.2. UNFPA made targeted efforts to reach vulnerable groups, including adolescents, persons with disabilities and marginalized host communities, primarily through partner-led selection processes and mobile service delivery. However, due to limited access in conflict-affected states and the absence of systematic, disaggregated data, UNFPA capacity to identify and reach the most vulnerable populations and uphold the LNOB principle remained significantly constrained.

The UNFPA humanitarian response in 2024 reached some vulnerable individuals. While vulnerability disaggregated data was lacking, there was anecdotal emphasis on youth, as well as some marginalized

populations in host communities, camps and gathering sites. For example, 8,754 adolescents and youth (ages 10–24) were reached, and 4,378 vulnerable women, as well as 16 per cent of vulnerable men, received CVA.[196] Some initiatives also targeted persons with disabilities. For example, in Kassala, 225 women and girls with disabilities were trained on FGM, child marriage and other gender-based violence-related issues.[197] UNFPA further supported disability-focused NGOs through small grants and participation in advocacy events. Survey results reflected this overall effort, with the capacity of UNFPA to target vulnerable groups rated at 79 per cent. UNFPA staff were more positive (90 per cent) than IPs (75 per cent) which potentially reflects an organizational bias in the absence of comprehensive data.

However, the exact reach of the most vulnerable cannot be quantified due to a lack of systematic and disaggregated vulnerability data (see limitation section).

At the service delivery level, some IPs applied targeting criteria based on vulnerability. These included community committees or selection processes prioritizing female-headed households, widows, women at risk of violence or exploitation, and women and girls with disabilities. Sexual and reproductive health services were generally inclusive and extended beyond IDPs to the broader population. In some areas, such as WGSS facilities, more host community women than IDPs were served, suggesting broad-based access. UNFPA also reached hard-to-reach and marginalized host communities, including, for example, people with disabilities through mobile clinics in Gedarif.

> *"We established a committee to identify the women that were vulnerable and prioritized their needs"*
>
> *–KII*

Importantly, the capacity of UNFPA to reach the most vulnerable populations in conflict-affected states appeared to be very limited, with access constraints limiting UNFPA capacity to fully adhere to the LNOB principle.

Humanitarian principles

Finding 5.3. While UNFPA application of humanitarian principles was inconsistent and largely implicit, with limited staff knowledge, guiding frameworks and a reliance on the HCT for access, it is crucial to recognize that this occurred within a severely shrinking and politicized humanitarian space. The challenging environment, marked by significant access constraints, impacted all actors. Still, having a presence only in SAF-held areas, along with concerns over last-mile supply assurance, are factors that challenge UNFPA on its principled humanitarian posture.

Views on the principled approach taken by UNFPA varied considerably among stakeholders. Interview findings revealed differing levels of awareness and operational application of humanitarian principles among UNFPA staff and partners. Staff with prior humanitarian experience demonstrated a strong understanding of the principles and their implications. In contrast, others, particularly those with development-focused backgrounds, were less familiar with how these principles apply in crisis contexts, particularly in relation to maintaining neutrality and independence while engaging with state actors. As one informant reflected, "We don't do this in UNFPA", referring to negotiating access with both parties to the conflict.

Humanitarian principles did not explicitly guide UNFPA operational decision-making. The response plan did not reference humanitarian principles or 'no regrets' approaches, and there was no indication of a formal risk appetite framework. UNFPA staff familiar with the principles perceived the organization as highly risk-averse, which reportedly constrained its ability to act decisively in accordance with core humanitarian values. UNFPA does not engage directly with conflict parties to negotiate access as it relies primarily on the UNSMS system and the United Nations Delegated Official (DO) and HCT to coordinate humanitarian access. As a result, its operational footprint remained

[196] UNFPA HAO, 2024.
[197] UNFPA Annual Report, 2023.

concentrated in areas controlled by the SAF, with no UNFPA staff presence in RSF-controlled conflict-affected states.

In addition, last-mile delivery of supplies was inconsistent and a reputational risk, with data indicating that the areas of greatest need received the lowest supplies budgets, but also that there are uncertainties on last mile delivery in the non-conflict states. Strong operational ties to state institutions, while beneficial in development settings, were perceived by many INGOs as limiting the ability of UNFPA to demonstrate independence and impartiality within Sudan's politicized conflict environment. Several health facilities visited by the evaluation team had no sexual and reproductive health supplies in stock at the time of visit. There were several uncertainties among staff, government staff and hospital staff as to who was accountable for this and how last mile delivery was assured. Some UNFPA staff highlighted the risk of potential 'aid diversion' in this context while others stated that the whole supply chain is inefficient.

The shrinking humanitarian space challenged all humanitarian actors, not just UNFPA. Despite sustained negotiation efforts, access constraints continued to intensify. According to one OCHA informant, negotiations with military actors absorbed as much as "30 per cent of a coordinator's time." Checkpoint fees, transport restrictions and bureaucratic hurdles significantly increased the cost and complexity of operations. Access in relatively non-conflict-affected states was still highly dependent on relationships with state authorities and the HAC. Multiple informants reported interference from HAC, including in recruitment processes, beneficiary list approvals, obstruction of assessments and restriction of movement.

There was a shared view among NGO informants that the United Nations system, including UNFPA, had not engaged sufficiently in defending humanitarian principles when faced with such government overreach. While several UNFPA informants supported this, they also noted that UNFPA largely depends on the resident coordinator or humanitarian coordinator and United Nations Department of Safety and Security (UNDSS) to obtain security clearances and negotiate access in hard-to-reach areas. Further, UNFPA local IPs often lacked the leverage to resist interference and expressed a desire for stronger advocacy and protection from international actors, including UNFPA.

4.4 Efficiency

Evaluation Question 6: To what extent and how has UNFPA made good use of its human, financial and administrative procedures and resources, to respond timely to the humanitarian needs of the affected populations?

Timeliness

Finding 6.1. While UNFPA met the minimum preparedness actions and responded to acute needs prior to the IASC system-wide scale-up, the capacity of UNFPA to mobilize the necessary resources on time was quickly outpaced by the escalating crisis throughout 2024. The agency lost critical momentum from September 2023, and the delayed and partial use of FTPs hindered its ability to maintain the necessary agility and timeliness. Structural constraints, including the persistence of development-oriented systems, limited humanitarian staffing and slow internal processes, collectively reduced the ability of UNFPA to deliver a sustained, credible humanitarian response. The arrival of new leadership by mid-2024 brought increased focus on flexibility and responsiveness, supported by stronger humanitarian experience and capacity.

UNFPA had addressed all 13 minimum preparedness actions by 2023,[198] indicating that the country office had established the necessary structures, plans and capacity to respond to humanitarian crises. The office had prior experience responding to emergencies in Darfur, Southern Kordofan and Blue Nile. States like Kassala were reportedly better prepared, given their ongoing cycles of emergency response and the presence of existing infrastructure and partners.

Despite these efforts, UNFPA, alongside the broader humanitarian community, was not sufficiently prepared for the unprecedented scale and severity of the 2023 crisis. Many informants acknowledged the unique nature of the emergency, which exceeded planning assumptions. While some preparedness measures were initiated during the response, including the development of state-level contingency plans, service delivery mapping and stock availability tracking, these actions were limited in scope and came late. [199]

UNFPA began responding in April 2023, prior to the activation of the IASC system-wide scale-up which was viewed positively by many stakeholders.

> *"A response within 24 hours has never happened in my 11 years of experience. A 72-hour response might be feasible"*
>
> *–KII UNFPA*

The response slowed down over time and this was critical. The application of FTPs was neither comprehensive nor fully adapted to humanitarian operational needs and therefore did not result in a significantly accelerated response. On the contrary, from September 2023 onward, the speed and agility of UNFPA operations declined markedly. The organization faced challenges transitioning from development-oriented processes to those required for humanitarian action despite previous experience responding to humanitarian crises in Sudan. It lacked critical human resources with humanitarian experience on the ground due to staff evacuation and self-relocation outside and within Sudan, as well as the supply systems and operational flexibility needed to respond rapidly to evolving needs. Many UNFPA staff expressed dissatisfaction with the agility and flexibility of the response. While several bottlenecks were attributed to country-level operational constraints and an insufficient number of humanitarian personnel on the ground, staff also noted that many delays stemmed from internal UNFPA systems. These were widely recognised as systemic limitations that continue to hinder the organization's ability to function as a responsive and credible humanitarian actor.

The arrival of new leadership by mid-2024 brought increased focus on flexibility and responsiveness, supported by stronger humanitarian experience and capacity. From this point onward, discussions

[198] UNFPA Annual Report, 2023.
[199] Kassala contingency plan, June 2024.

during the CRT workshops in Cairo began to address the agency's lack of agility, contributing to a partial recovery of UNFPA operational posture. Efforts were initiated to improve internal processes, reallocate teams at the subnational levels, tackle supply challenges, ensure consistent HCT engagement and begin instituting a more humanitarian-oriented mindset. These developments marked notable progress, and the performance of UNFPA progressively improved as the response advanced toward 2025.

Human resources

Finding 6.2. UNFPA took several positive steps early in the response, including the timely mobilization of a humanitarian coordinator and key national staff that stayed and delivered – which was critical to the early onset response. The deployment of GERT personnel was viewed as effective, as it brought in rapid and capable technical capacity with direct access to UNFPA systems, in contrast to the surge deployments. However, UNFPA scale-up of human resources was overall not in line with what is typically expected under an IASC scale-up, due to significant recruitment delays and insufficiently humanitarian experienced staff, which significantly hampered the ability of UNFPA to effectively scale up its response. Mobilization of humanitarian human resources were overall delayed and fell short of FTP standards. Surge deployments were delayed due to a mix of internal and external factors, and many key staff remained outside Sudan, working remotely long after other United Nations agencies had returned. Staffing realignment and contracting remained slow, risk-averse, with limited decentralized authority, and overly reliant on short-term contract arrangements.

A humanitarian coordinator was deployed early on, though the humanitarian support team (HST) was not deployed in accordance with the SOPs.[200] UNFPA SOPs call for the immediate deployment of a HST, comprising senior staff with extensive humanitarian experience, capable of making rapid decisions and coordinating with other United Nations agencies. The intended composition includes a humanitarian coordinator, as well as specialists in logistics, finance, reproductive health, human resources, and communications and media. While a humanitarian coordinator and a logistics specialist were deployed promptly in May 2023, none of the other required HST specialists with humanitarian expertise were ever deployed, limiting the implementation of the HST model. Given the persistent challenges observed in supply chain management, human resource mobilization, and external communication throughout the response, the full activation of the HST would have been essential to UNFPA operational performance.

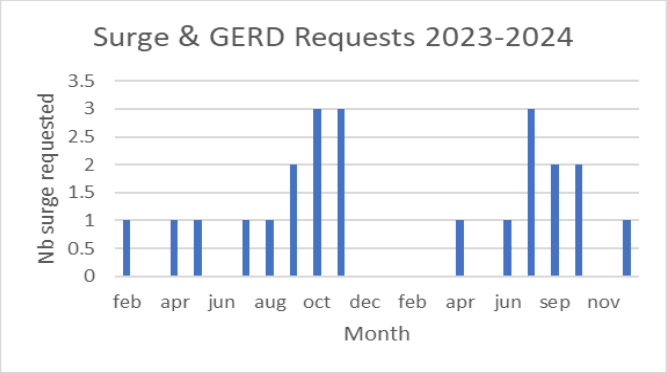
While surge deployments were requested before the system-wide scale-up, there were significant deployment delays caused by a mix of internal and external factors. In 2023, limited staff presence was initially constrained by the unpredictable environment. At the request of UNDSS, United Nations agencies were instructed to reduce essential staff to ensure manageable evacuation capacity from Port Sudan and other states. Delays in surge deployments were also driven by external factors such as prolonged visa processing times and restrictions imposed by the Government of Sudan, which exacerbated the timely arrival of international staff. Of the 24 surge deployments requested across 2023 and 2024, all but one were eventually completed; however, they were delayed by an average of 46 days in 2023 and 33 days in 2024, far exceeding what was expected on ground.

Notably, no new surge requests were submitted between December 2023 and April 2024, despite ongoing clashes and significant new internal displacement,[201] which limited UNFPA response capacity during this critical period.

[200] UNFPA. The UNFPA Standard Operating Procedures for Humanitarian Settings, 2011, page 21.

[201] Wave of clashes in Medanine in Dec 2023, Wad Medani December 2023, Omdurman February 2024, Sinja June 2024.

Figure 8: UNFPA surge and GERT deployments to Sudan, 2023-2024



Source: UNFPA.

The GERT deployments were perceived as highly efficient and of strong technical capacity. In July 2024, UNFPA deployed GERT personnel to support activities in CMR, sexual and reproductive health, access and supply from Chad. On average, GERT deployments took only 18 days, significantly faster than surge deployments. GERT staff were also reported to possess stronger humanitarian expertise and demonstrated greater familiarity with, and direct access to, UNFPA systems, a key limitation frequently noted in relation to surge personnel.

UNFPA had limited temporary appointments (TAs) and fixed-term appointments (FTAs) on the ground and kept relying mostly on service contracts and surge. Although UNFPA FTPs allow for fast-tracking recruitment of TAs or FTAs, many staff were kept on service contracts and surge, reportedly due to internal risk aversion and a reluctance to make long-term commitments. Staff under surge, ideally three months per the FTPs, did not have access to internal UNFPA systems, hampering their own functionality. While this may not have directly disrupted operations, it contributed to low morale and limited retention. Moreover, several informants highlighted that the UNFPA human resource base lacked the specialized humanitarian international and national expertise necessary for an emergency of this scale, an issue described as a recurring institutional challenge in the past.[202]

National staff played a critical role in the response, under very difficult conditions. Following the collapse of Khartoum, the United Nations focused on evacuating international staff only,[203] and UNFPA national staff were left with no option but to flee the capital on their own. Many of the national staff fled to safe states like Gedarif and Kassala and commendably responded to evolving displacements to the extent possible. Many staff were displaced themselves, lost family members and faced important financial and asset losses. In the initial phase, they were provided with limited security guidance and received no compensation to support their relocation or immediate needs. UNFPA, in the absence of clear global guidance on compensation packages for displaced staff, eventually negotiated a support package but this process took several months to materialize. Subnational staff in particular reported excessive workloads and frequent double- or triple-hatting, often carrying responsibilities for both coordination and programme implementation. They consistently cited that decision-making authority was centralized at the national level and they needed approval for everything, with delays in reply or failure to respond incurring further delays. This was particularly evident around requests for supply and finance, which were further constrained by the delays in surge, GERT and operational staff.

[202] Evaluation of the UNFPA capacity in humanitarian action, 2012-2019.
[203] https://www.aljazeera.com/news/2023/4/23/foreign-citizens-evacuated-as-factions-battle-in-khartoum

The return of national staff stationed outside Sudan was significantly delayed which impacted the ability of UNFPA to scale up. Most national staff continued working remotely from outside Sudan. According to multiple informants, the return of national staff to Sudan in August 2024 required a decisive push from the Humanitarian Response Division (HRD) and was delayed compared to returns by other United Nations agencies, which started bringing staff back towards the end of 2023. The delay had an important impact on the ability of UNFPA to scale up. For example, in June 2024, 14 months after the onset of the crisis, only 29 out of 89 staff[204] were present in-country, with very limited field presence (three in Kassala, four in Gedarif, two in Kosti and one in Wadi-Halfa),[205] a number viewed as insufficient for a system-wide scale-up. UNFPA staff noted that the agency prioritised "duty of care" and "being nice to national staff", waiting too long to call them back to Sudan.

The absence of senior international operations staff in the country for over a year significantly affected the efficiency of operations. Senior operations staff, who are critical to ensuring effective humanitarian operations on the ground, were also evacuated and remained more than one year outside the country. For example, the international operations manager, who oversees procurement, human resources, finance, administration, ICT, facilities, fleet and logistics, was first working remotely, and then on extended leave, without any internal international staff replacement brought into the country in the interim. The absence of senior international operations staff in Port Sudan significantly affected the ability of the country office to scale up operations, including ensuring adequate and timely human resources and supplies. Moreover, while several key informants saw the arrival of an interim senior country representative with substantive humanitarian experience as a positive "key turning point" in mid-2024, they also deplored the significant delays in appointing a new country representative in 2025. In addition, the deputy representative was evacuated in April 2024 and never returned to the country.

Several procedural challenges and delays were noted in human resource decision-making. The country office, with strong support from the regional office, initiated an emergency staffing reconfiguration process to facilitate the return of staff to Sudan. However, despite discussions beginning in September 2023, formal approval took several months. Delays were attributed to slow decision-making at the Division of Human Resources (DHR) and executive management levels, compounded by a cumbersome internal process.[206] Prolonged negotiations around the relocation package further hindered progress, largely due to the absence of an institutional policy for staff relocation in such contexts.

The June 2024 staffing reconfiguration primarily involved relocating existing posts to new duty stations but failed to create additional humanitarian positions needed to strengthen the CO's response capacity. The initial staffing reconfiguration was approved in June 2024, with staff returning to Sudan and being relocated to different duty stations by the end of August. However, the new country office leadership, arriving mid-2024, recognized the limitations of this structure and initiated a more comprehensive human resources realignment to support a large-scale humanitarian response and the anticipated transition and recovery phase. This process, involving the DHR at both regional and headquarters (HQ) levels, extended over several months and remained pending approval as of April 2025. Key internal stakeholders questioned why the country office continued to rely on short-term surge, instead of applying the FTPs to fast-track the recruitment of qualified humanitarian staff on other contract modalities, such as TAs, who would have had full access to UNFPA systems and could

[204] Some of the 89 positions were vacant, and 3 staff decided not to return to Port Sudan in August 2024, and therefore resigned. Source: UNFPACO.
[205] Email: June24_Scale up benchmark and Staff update_June24
[206] Email exchange, Mar 5, 2024

have obtained a United Nations-Laissez-Passer (UNLP) facilitating visa applications, while waiting for the formal HR realignment to be approved at the HQ level. Stakeholders also highlighted the need for a unified vision for human resources in humanitarian contexts, across both acute and protracted crises, supported by stronger internal coordination among the DHR, HRD surge and GERT secretariats.

Supply

Finding 6.3. Despite some positive efforts to adapt to contextual access constraints, supply was one of the most critical bottlenecks of the response and remained largely inefficient throughout 2023 and 2024. Internal challenges, including delayed decision-making, inadequate planning, limited warehousing capacity and weak end-to-end oversight, negatively impacted service delivery and contributed to stockouts and financial losses. These inefficiencies had been previously identified in Sudan and are recognized as recurring global challenges within UNFPA, pointing to persistent, systemic weaknesses. External constraints that further exacerbated supply chain bottlenecks included the collapse of the national supply system on which UNFPA relied, high in-country transport and logistics costs, insecurity and access restrictions. Nonetheless, UNFPA distributed life-saving supplies to 15 states and commendably ensured that $720,000 worth of life-saving materials reached Darfur and Kordofan where needs were most critical. By mid-2024, the agency had taken tangible steps to address supply issues, including deploying a joint Supply Chain Management Unit (SCMU) and HRD mission, and onboarding GERT staff. However, these measures were reactive rather than anticipatory, and overall supply chain performance remained below the level required for a system-wide scale-up.

UNFPA allocated a substantial portion of its budget to sexual and reproductive health and gender-based violence supplies. Between 2023 and 2024, approximately $10 million was spent on medical supplies, nearly half of which (46 per cent) was allocated to dignity kits and sanitary pads. The family planning budget decreased significantly from 22 per cent to 2 per cent between 2023 and 2024 despite family planning commodities being reported as one of the most common stockouts. Stakeholders raised concerns regarding prioritization in a funding restricted environment, as well as the potential for more cost-effective local procurement of non-medical items like dignity kits and sanitary pads. Moreover, the composition of supply spending remained heavily weighted toward dignity kits, partly due to donor preferences, raising concerns about whether supply strategies were sufficiently needs-based.

Table 10: UNFPA supply budget distribution across commodity type, 2023-2024

Item Category	2023	2024	Total	%
Dignity kits	$ 2,427,734.52	$ 1,703,663.04	$ 4,131,397.56	41%
IARH kits	$ 774,234.77	$ 921,140.56	$1,695,375.33	17%
Family planning methods	$ 1,209,293.36	$ 103,501.00	$ 1,312,794.36	13%
Maternal health medicines	$ 943,825.99	$ 800.00	$ 944,625.99	9%
Medical consumables		$ 9,805.76	$ 9,805.76	0%
Medical kits			$ -	0%
Miscellaneous	$ 1,600.00	$ 155,043.66	$ 156,643.66	2%
Sanitary pads		$ 495,025.00	$ 495,025.00	5%
Tents		$ 103,825.00	$ 103,825.00	1%
Medical equipment	$ 149,838.60	$1,096,789.28	$ 1,246,627.88	12%
Total	$ 5,506,527.24	$ 4,589,593.30	$ 10,096,120.54	

Source: UNFPA.[207]

The UNFPA supply budget decreased from 2023 to 2024, and the distribution did not always seem proportionate to needs. Despite a growing humanitarian caseload, the overall supply budget decreased from $5.5 million in 2023 to $4.5 million in 2024. Across states, supply allocations did not consistently align with the severity of needs. Table 11 presents UNFPA supply budget distribution by state. The Red Sea State received the largest share of the supply budget – 43 per cent – despite hosting only 3 per cent of the country's IDP population (282,421 individuals). However, as supplies were distributed to the Ministry of Health in Red Sea, the evaluation was unable to verify onward distribution to other states. In comparison, Gedarif, which hosted an estimated 1.1 million IDPs, received 18 per cent of the supply budget, while Kassala, hosting around 350,000 IDPs, received 10 per cent. River Nile, with a reported 1,017,942 IDPs, received just 6 per cent.

These discrepancies raised concerns about the alignment of resource allocation with actual needs on the ground.

Commendably, UNFPA demonstrated its ability to deliver supplies through third-party mechanisms in access-constrained states such as Darfur, Kordofan, and Khartoum. These included the distribution of 379 IARH kits, valued at approximately $720,000, via NGO partners, highlighting its capacity to navigate operational barriers in hard-to-reach areas.

Table 11: UNFPA supply budget distribution across states in Sudan, 2023-2024

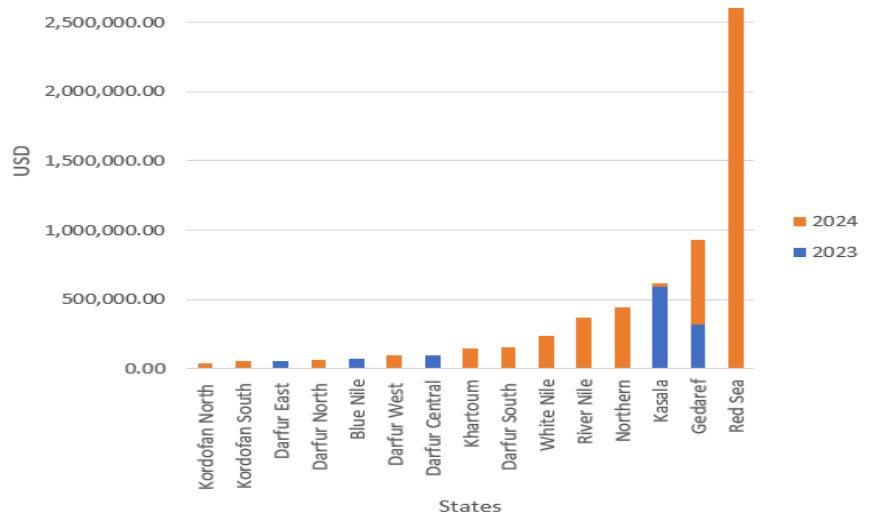
States	2023 ($)	2024 ($)	Grand total ($)	IDPs
Kordofan North	6,935	31,084	38,019	202,960
Kordofan South		60,029	60,029	449,458
Darfur East	8,083	52,671	60,754	784,618
Darfur North	903	63,685	64,588	1,614,715
Blue Nile	5,364	65,714	71,078	470,910
Darfur West	6,870	90,482	97,351	312,247
Darfur Central	3,729	95,043	98,772	312,247
Khartoum	15,861	130,820	146,681	98,331
Darfur South	1,545	152,078	153,623	1,832,270
White Nile	4,112	238,011	242,123	656,463
River Nile	5,464	365,595	371,059	1,017,942

[207] UNFPA Data Supply total expenditures on supply 2022–2024.

Northern	2,206	439,504	441,710	553,708
Kasala	2,942	617,645	620,587	354,527
Gedaref	11,668	921,683	933,351	1,100,840
Red Sea	7,263	2,592,580	2,599,844	282,421
Grand total	$82,945.49	$5,916,623.13	$5,999,568.62	10,043,657

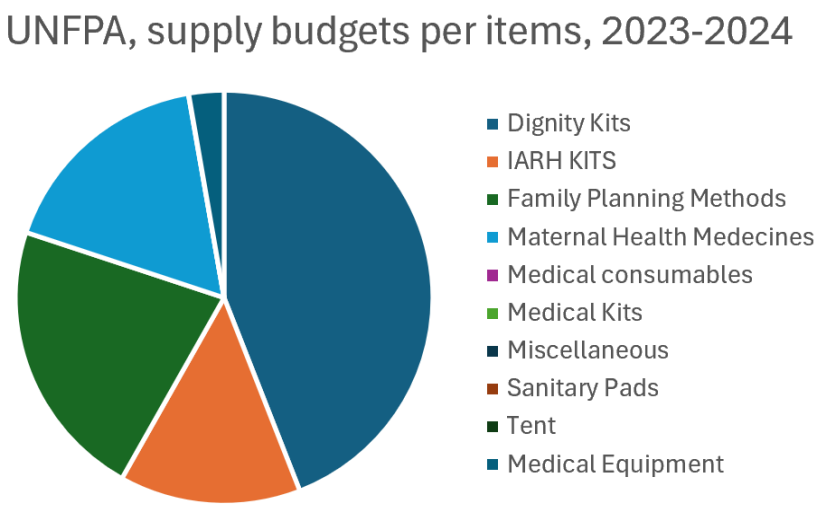
Source: UNFPA[208]

Figure 9: UNFPA supply budget distribution across states in Sudan



Source: UNFPA.

Figure 10: UNFPA supply budget distribution across commodity types in Sudan, 2023-2024



Source: UNFPA.

[208] UNFPA Data Supply Budget versus States 2023-2024.

Procurement and delivery, and the supply chain remained delayed and critically inefficient, disrupting programme implementation. Although the conflict escalated in April 2023, the first distribution of IARH kits did not occur until October 2023, and most of the 839 kits ordered were only delivered by late 2024. Procurement and customs clearance processes reportedly took up to nine months. Stockouts were observed at mobile clinics and CEmONC facilities during the evaluation field visit, with UNFPA staff expressing frustration at supply bottlenecks. As one implementing partner noted, "We have no supplies in our mobile clinics, apart from ibuprofen and multivitamins." Another reported that they were "still waiting since November 2024" for IEC materials due to stalled procurement linked to shifting fund codes.

UNFPA incurred significant losses due to supply chain inefficiencies and high logistics costs, including $570,356 in demurrage fees across 2022 to 2024. While some informants attributed the 2023–2024 demurrage fees to conflict-related disruptions and remote working modalities of national staff, it is notable that demurrage costs were already high in 2022, prior to the escalation of the conflict. This suggests that structural and performance-related issues,[209] including weaknesses in day-to-day supply chain management, may have contributed to persistent inefficiencies. In 2024 only, this meant that demurrage was 8 per cent of the supply budget, raising questions about how UNFPA ensures accountable and timely supply processes. The demurrage fees not only represented a direct financial loss but also led to further waste, as delayed clearance contributed to the expiry of time-sensitive supplies. Beyond UNFPA control, it further lost $2.1 million in medical supplies due to looting, which compromised prepositioned stock. UNFPA staff also noted that high logistics costs were largely due to the context and thus outside the control of UNFPA.

Table 12: UNFPA costs related to logistics and supply

Cost type	2022	2023	2024	Total
Customs clearance	$ 498,274.68	$ 109,870.07	$ 70,958.87	$ 679,103.62
Demurrage	$ 199,563.59	-	$ 370,793.17	$ 570,356.76
Distribution	$ 160,812.02	$ 75,936.59	$ 161,844.76	$ 398,593.37
Shipping cost	$ 452,016.97	$ 229,168.62	$ 534,297.59	$ 1,215,483.18
Total	$ 1,310,667.26	$ 414,975.28	$ 1,137,894.39	$ 2,863,536.93

Source: UNFPA logistics database

Internal factors hindering efficiency included inadequate planning and delayed decision-making between country office and HQ on supply orders, inadequate UNFPA warehousing capacity and limited oversight on pipelines, customs and storage. Across all operational levels, UNFPA staff suggested that the organization's global supply system lacked the agility required for humanitarian contexts, prompting calls for UNFPA-wide structural reform. At the country level, the response lacked an early supply and procurement plan (it was however developed in 2025). As such, UNFPA supply needs became reactive subject to fund codes.

Supply inefficiencies within UNFPA remain systemic and impact service delivery. A prior assessment of UNFPA Sudan had already identified nearly identical issues to those experienced during the current response, including lack of access to essential medicines at health facilities, procurement delays, recurrent stockouts of family planning and life-saving drugs, shortages of reproductive health kits and weak logistics systems that prevented the transfer of federal supplies to state-level facilities.[210] Persistent challenges such as high demurrage costs and last-mile delivery failures further undermine UNFPA supply chain performance, raising concerns about the organization's ability to address long-standing inefficiencies.[211]

[209] It should be noted that UNFPA country office did have a supply chain unit until the end 2022 led by an international staff.
[210] Impact Assessment of Humanitarian Interventions - UNFPA Sudan Report 2022.
[211] UNFPA Impact assessment of the UNFPA multi-country response to humanitarian crises: Sudan, 2022.

At the global level, the 2019 evaluation of UNFPA humanitarian capacity highlighted several systemic supply chain issues. While some progress has been made since mid-2024, key weaknesses remain. The 2023 audit of the FTPs rated the performance of UNFPA as "partially satisfactory with major improvement needed", indicating that while governance, risk management and controls were in place, they were insufficient to ensure effective implementation.[212] Although this evaluation does not assess UNFPA global supply systems, these institutional challenges likely affected UNFPA Sudan's ability to procure and deliver humanitarian commodities in a timely and efficient manner.

External bottlenecks further aggravated UNFPA supply efficiency. The collapse of the national supply system, which UNFPA partially relied on, further compounded these difficulties, contributing to persistent stockouts and delays in distribution. High in-country logistics costs and excessive transport costs, worsened by insecurity and limited carrier availability, created critical bottlenecks for all United Nations agencies. United Nations-wide inefficiencies, including United Nations siloed transport arrangements and the absence of a coordinated, collective logistics strategy, further decreased affordability of in-country supply delivery. However, not all national supply deficiencies could be attributed to the recent conflict with many stemming from longstanding weaknesses in Sudan's chronically underperforming supply infrastructure.[213]

Despite persistent challenges, UNFPA took tangible steps to address supply constraints from mid-2024 onwards. This included deploying an expert assessment mission with SCMU, HRD, and the regional office; fielding GERT and surge staff; and onboarding supply and logistics personnel by 2025 to strengthen logistics and supply capacity. UNFPA cross-border strategy via the Chad (Adré border) also resulted in supplies reaching RSF-controlled areas in Darfur.

Funding

Finding 6.4. UNFPA successfully scaled up its resource mobilization efforts in 2023, resulting in a doubling of external contributions compared to 2022. Effective engagement with donors helped build trust in UNFPA and fostered strong partnerships with key donors, including Sweden, Norway, OCHA, CERF and the United States government, which demonstrated strong commitment to UNFPA mandate areas, especially on gender-based violence. However, while UNFPA successfully raised additional funds to scale up its response, it remained significantly underfunded, with a widening funding gap in 2024 and 2025. Moreover, internal resource mobilization targets were significantly surpassed, which could indicate an unrealistically low target setting and opportunities for more ambitious resource mobilization. Despite a significant increase in external contributions (see table 14 above) to support the UNFPA humanitarian response, UNFPA did not significantly increase the allocation of core resources to the Sudan CO, which would have been necessary to scale up the country office's operational capacity to respond to the crisis.

UNFPA surpassed its internal annual resource mobilization targets in 2023 and 2024 by over 100 per cent. During this period, UNFPA submitted 33 proposals to donors, of which 27 were funded, representing a resource mobilization success rate of 82 per cent. According to UNFPA stakeholders, key donors were highly supportive of the UNFPA mandate, particularly GBViE, and additional funds to scale up the humanitarian response were relatively easily accessed through close communication and collaboration with the donors. Reportedly, some bilateral donors approached UNFPA offering a top-up to existing funds, based on needs, UNFPA past performance and its ability to implement and absorb funds.

[212] UNFPA Office of Audit and Investigation Service (2023). Audit of the UNFPA fast track policy and procedures for the procurement of humanitarian supplies. final report no AI/2023-04 24 May 2023, p. 2.
[213] Impact Assessment of Humanitarian Interventions - UNFPA Sudan Report 2022.

Table 13: UNFPA internal resource mobilization targets and received, 2022-2025

Year	Resource mobilization (other resources)	
	Target	Received[214]
2022[215]	$8,000,000	$14,600,000
2023	$15,000,000	$31,900,000
2024	$18,000,000	$24,300,000
2025	$18,000,000	$13,100,000

Source: UNFPA.

However, the internal annual resource mobilization targets[216] were far below UNFPA humanitarian funding appeals, which raises questions about UNFPA ambitions and realistic target setting. Moreover, while UNFPA significantly scaled up its resource mobilization efforts in 2023, its humanitarian response remained significantly underfunded, with a 52 per cent funding gap in 2023, and 64 per cent in 2024 (see table 16 below), based on the official funding requirement communicated in the annual UNFPA Humanitarian Action Overviews. This indicates a widening funding gap over time.

Table 14: UNFPA humanitarian appeals and funds received, 2023-2025

Year	Humanitarian appeal / funding requirement	Funds received (other resources, OR)	% funding gap
2023	$89,000,000	$43,000,000	52%
2024	$82,900,000	$30,000,000	64%
2025	$88,000,000	n/a	n/a

Source: UNFPA.

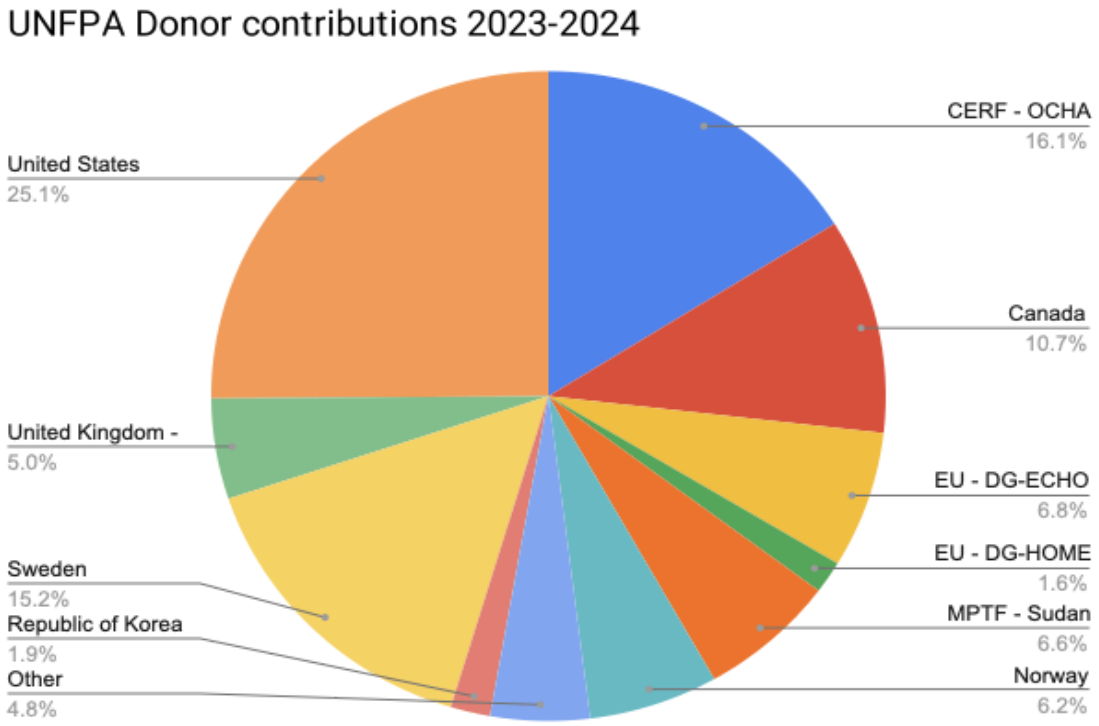
The top five donors providing external resources (non-core) to UNFPA to scale up the humanitarian response in 2023 and 2024 were USAID, CERF-OCHA, Sweden, Canada and ECHO, which together provided 74 per cent of the total contributions over the two years, closely followed by the MPTF-SFP, Norway and FCDO. In total, UNFPA signed new agreements or cost-extensions with 18 different donors at a total value of approximately $73.3 million (see table 17 below). The country office proactively engages with donors to advocate for UNFPA mandate areas and reportedly receives significant donor support, especially for GBViE.

[214] Funds received is defined as the total value of new contribution agreements signed each year.

[215] 2022 has been included to illustrate the difference between the pre-conflict situation in a largely development context in 2023, and the scale-up of resource mobilization efforts and performance in 2023, the year of the IASC system-wide activation.

[216] UNFPA sets internal annual targets for its resource mobilization. These were far below the targets officially reflected in the UNFPA Annual Humanitarian Action Overview (HAO) which indicates the actual funding requirement to respond to the sexual and reproductive health and gender-based violence needs of affected women and girls. It is not clear as to why the internal RM targets were set lower than the targets in the HAO.

Figure 11: UNFPA donor contributions 2023-2024



Source: UNFPA.

While there are some positive examples of joint programmes and pooled funds with other United Nations agencies, including CERF, some stakeholders noted that UNFPA could be more pro-active in advocating and securing funds for longer-term joint development programmes, especially with the larger sister agencies. For example, WHO, UNICEF and FAO, reportedly secured substantial multi-year development financing from the World Bank and African Development Bank, which UNFPA is not part of. Reportedly, UNFPA participated in the World Bank–United Nations agencies consultations in 2023 shortly after the conflict outbreak. However, the World Bank ultimately chose to award the grant to a limited number of larger United Nations agencies to limit administrative work related to multiple grants.

UNFPA increased its implementation and fund absorption capacity from 2023 to 2024. While the utilization of core resources remained relatively steady across 2022 and 2023, and slightly decreased in 2024, the non-core expenditures first dropped between 2022 and 2023, and then significantly increased again in 2024. Overall, this accelerated implementation could be explained by the change of country office leadership in 2024, the efforts to progressively strengthen operational capacity, bringing back national staff into the country and reassigning them to UNFPA sub-offices around mid-2024. Moreover, the table below illustrates that human resources and operations costs constituted 31 per cent of the total expenditures in 2022, drastically increased to 43 per cent in 2023, and then dropped again to 34 percent in 2024. The high costs in 2023 could be explained by the high administrative costs related to staff displacement, which dropped again when staff returned to (new) duty stations within Sudan by mid-2024.

Table 15: UNFPA institutional budgets 2022-2024

2022 implementation					
Category	Core (FPA90)	Institutional budget	Non-core	Grand total	%
Human resources	1,446,389.15	1,191,303.55	3,236,339.09	5,874,031.79	23.74%
IP	969,074.18		10,662,633.78	11,631,707.96	47.01%
Operations	802,968.30	99,024.64	791,101.21	1,693,094.15	6.84%
Programme	810,625.56		4,730,988.58	5,541,614.14	22.40%
Grand total	4,029,057.19	1,290,328.19	19,421,062.66	24,740,448.04	100.00%

2023 implementation					
Category	Core (FPA90)	Institutional budget	Non-core	Grand total	%
Human resources	2,255,913.82	1,301,067.78	4,222,093.43	7,779,075.03	33.27%
IP	838,966.62		8,146,263.86	8,985,230.48	38.43%
Operations	417,734.49	617,333.71	1,265,080.20	2,300,148.40	9.84%
Programme	253,035.53		4,063,609.48	4,316,645.01	18.46%
Grand total	3,765,650.46	1,918,401.49	17,697,046.97	23,381,098.92	100.00%

2024 implementation					
Category	Core (FPA90)	Institutional budget	Non-core	Grand total	%
Human resources	1,450,403.70	1,312,165.08	5,577,871.65	8,340,440.43	24.17%
IP	590,623.40		12,773,955.82	13,364,579.22	38.73%
Operations	803,282.68	303,876.82	2,164,427.63	3,271,587.13	9.48%
Programme	268,518.25		9,265,834.73	9,534,352.98	27.63%
Grand total	3,112,828.03	1,616,041.90	29,782,089.83	34,510,959.76	100.00%

Source: UNFPA.

Moreover, despite a significant increase in external contributions to support the UNFPA humanitarian response, UNFPA HQ did not significantly increase the allocation of regular resources, which would have been necessary to scale-up the country office's operational capacity. This indicates that the core resource allocations were not commensurate with the increase in external resources.

The core resources allocated to the country office by HQ decreased successively from 2022 to 2024, dropping from $4,041,224 in 2022 to $3,791,501 in 2023 and $3,153,208 in 2024. The initial annual core allocation in 2024 was reduced by $288,600, as these funds were reallocated to the HRD to cover the salaries of GERT staff deployed to support the Sudan response. The table below illustrates the core funds (regular resources) allocated to the country office versus actual expenditures.

Table 16: The core resources allocated to the country office by HQ 2022 to 2024

Year	Initial allocation	Adjustment (+ / -)	Core ceiling budget	Total consumption	Funds available amount	Unspent balance in %
2022	3,341,224	699,999.99	4,041,224	4,029,057	12,167	0.3%
2023	3,441,501	350,000.00	3,791,501	3,765,650	25,851	0.6%
2024	3,441,808	-288,600.00	3,153,208	3,112,828	40,380	1.3%

Operational versus programmatic costs: The table below illustrates the expenditures in 2023 and 2024 across institutional budget, core resources, non-core resources (external contributions) and main budget lines.

Table 17: Sudan country office expenditures/implementation 2023-2024

2023 implementation				
Category	Core	Institutional budget	Non-core	Grand total
Human resources	2,255,913.82	1,301,067.78	4,222,093.43	7,779,075.03
Operations	417,734.49	617,333.71	1,265,080.20	2,300,148.40
Programme-NEX	838,966.62		8,146,263.86	8,985,230.48
Programme-DEX	253,035.53		4,063,609.48	4,316,645.01
Grand total	3,765,650.46	1,918,401.49	17,697,046.97	23,381,098.92

2024 implementation				
Category	Core	Institutional Budget	Non-Core	Grand Total
Human resources	1,450,403.70	1,312,165.08	5,577,871.65	8,340,440.43
Operations	803,282.68	303,876.82	2,164,427.63	3,271,587.13
Programme-NEX	590,623.40		12,773,955.82	13,364,579.22
Programme -DEX	268,518.25		9,265,834.73	9,534,352.98
Grand total	3,112,828.03	1,616,041.90	29,782,089.83	34,510,959.76

Source: UNFPA Sudan.

Impact and uncertainty of USAID. The recent reduction in United States government funding to UNFPA has negatively affected UNFPA Sudan's ability to ensure continuous access to sexual and reproductive health and gender-based violence services for affected populations in 2025. Since the conflict, UNFPA has received $18.4 million from the US government, representing approximately 26 per cent of the UNFPA 2023 and 2024 humanitarian response budget. With United States support (Bureau for Humanitarian Assistance and Bureau of Population, Refugees and Migration [BPRM]), UNFPA has reached over 120,000 women and young people with integrated sexual and reproductive health and gender-based violence services. UNFPA also had a $16 million top-up in the pipeline from the Bureau for Humanitarian Assistance, which was unfortunately not obligated in time before the United States government stop-working-orders came into effect.[217]

[217] UNFPA. Sudan Donor Overview, January 2025, unpublished internal RM document.

Partnerships

Finding 6.5. The UNFPA's response was strongly anchored in national partnerships and a commitment to localization, including support for WLOs, capacity-building and the elevation of local leadership. National partners played a critical role in sustaining service delivery and accessing hard-to-reach and high-risk areas. While some challenges emerged, such as capacity gaps, risk exposure and limited partner diversity, the 2025 shift by UNFPA to a more diversified partnership showed a strategic improvement.

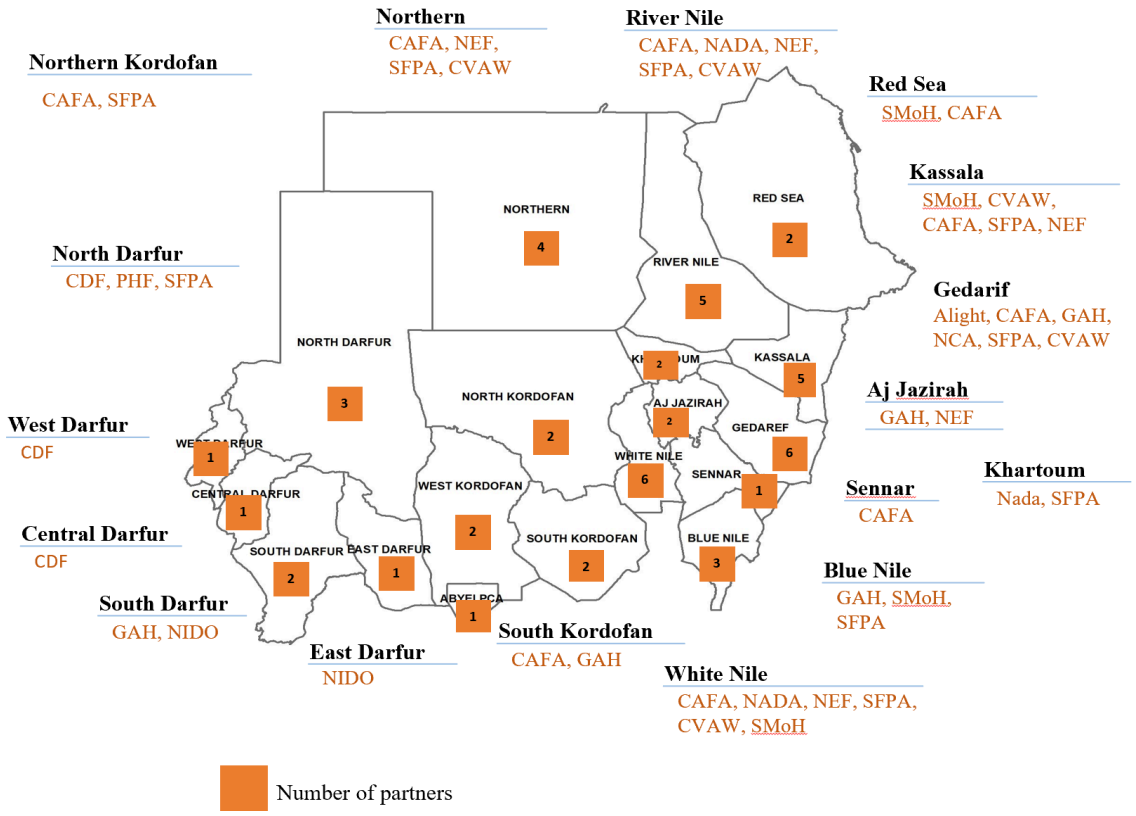
Local IPs were instrumental to the UNFPA response, which relied heavily on pre-existing partnership agreements, established trust and administrative systems. UNFPA leveraged long-standing relationships with national NGOs and demonstrated a strong commitment to localization, supporting access, readiness, third-party monitoring and WLOs. Local IPs such as CDF, CAFA, PHF and SFPA played a critical frontline role in maintaining and expanding service delivery, often stepping in where international actors or ministries had withdrawn (e.g. Khartoum) or were unable to gain access (e.g. Darfur and Kordofan). While many partners withdrew from RSF-controlled areas, some remained and ensured continued access to populations in high-risk zones. UNFPA also expanded engagement with WLOs through a consortium model and subgrants, launched capacity-building efforts under the gender-based violence AoR, and elevated local leadership, including establishing a national gender-based violence AoR co-chair position for Nada.

UNFPA made commendable efforts to advance localization, although IP feedback on UNFPA was mixed: some commended UNFPA for its responsiveness, flexibility and technical support, while others raised concerns about persisting limitations. Several IPs reported positively on UNFPA as being a flexible donor, responding in a timely manner to requests for reprogramming and providing relevant technical support. However, national NGOs (NNGOs) also faced significant risks operating in RSF-controlled areas. Informants expressed concern that risk was sometimes transferred to partners without adequate mitigation, raising questions about the agency's risk management strategy. While UNFPA remained committed to localization, many local partners lacked the institutional capacity to absorb large grants, scale operations or adapt to humanitarian delivery standards. IPs frequently reported challenges such as high staff turnover, internal displacement, weak reporting systems and limited ability to scale up geographically. Oversight mechanisms were described as largely procedural and at times donor-driven, with inconsistent field monitoring or direct technical support. Feedback from IPs was mixed: some reported that UNFPA responded promptly to their requests, while others felt excluded from strategic decision-making, citing a top-down approach and bureaucratic delays.

Several informants also raised concerns about the political affiliations of some IPs, which reportedly discouraged gender-based violence survivors from accessing services. Informants highlighted a lack of partner diversity, with the same traditional IPs receiving multiple grants from different United Nations agencies. In the absence of comprehensive partner mapping, this raised concerns around duplication, coordination and accountability.

In 2025, UNFPA revised its partnership strategy to improve operational efficiency, diversify implementation modalities and strengthen humanitarian outcomes. The number of IPs with active work plans decreased from 37 in 2023 to 32 in 2024 and to 22 in 2025, by applying a 'less is more' strategy. The revision and reduction in 2024 primarily reflected the inability of government and NNGOs to operate in RSF-controlled areas such as Khartoum and Darfur. During that year, UNFPA had only two partners active in Darfur, none in Kordofan and one in Khartoum. Towards 2025, UNFPA took steps to rebalance and diversify its partnership base, increasing engagement with INGOs to expand coverage and gain access in Darfur and Kordofan. By March 2025, UNFPA had engaged, or was in the process of engaging, a broader mix of partners, including a third of which were INGOs. This shift aimed to enhance reach, reduce risk concentration and support a more robust and inclusive humanitarian response. Finally, UNFPA established a consortium model in which an IP can engage sub-implementing partners, typically local NGOs, in line with its localization agenda.

Figure 12: UNFPA local IPs per state, March 2025



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.

Monitoring humanitarian response

Finding 6.6. Due to access and security constraints, UNFPA proactively engaged a third-party monitoring (TPM) company and relied on IPs to monitor its response in inaccessible conflict areas. While this offered some oversight, UNFPA overall response lacked a strong evidence base, with no systematic humanitarian monitoring framework in place and limited collection, aggregation, analysis and use of real-time data for decision-making.

UNFPA proactively engaged TPM providers to maintain oversight in inaccessible conflict-affected states, a decision broadly seen as necessary given access constraints. TPM was recognized as a pragmatic solution under the circumstances, providing at least a minimum layer of verification in the absence of direct monitoring. However, it was also widely viewed as costly (reportedly $40,000 per month), insufficiently contextualized and often limited to a “tick-box” approach, particularly lacking depth in sexual and reproductive health and gender-based violence-sensitive issues.

Oversight from UNFPA was inconsistent, and TPM efforts were not well integrated into a broader monitoring framework. Community-based monitors, especially in areas such as Darfur, provided some value, yet they often operated without structured guidance or linkages to formal reporting systems. In parallel, UNFPA leveraged its IPs for data collection, but many IPs struggled to report consistently due to limited digital capacity and the absence of M&E budget lines in their workplans. While upward reporting occurred, systems for aggregating, analysing and using this data for strategic decisions remained underdeveloped, reflecting a mismatch between UNFPA standard M&E processes and the fluid demands of a complex context.

The response was largely not evidence-based. While some reporting mechanisms were in place – such as situational updates, COARs and an amended CPD results framework – these were widely perceived as overly optimistic and disconnected from realities on the ground. The amended CPD framework, although updated, was not seen as a practical tool for real-time, evidence-based response planning. There was also no evidence of a systematized or aggregated humanitarian-specific reporting framework or dashboard to guide response efforts.

UNFPA may have missed an opportunity to fulfil its core mandate on population data. Although there were anecdotal achievements, such as technical and financial support to the Central Bureau of Statistics and initial efforts to revive the collapsed MDRS, these efforts did not adequately address the population data opportunities that came with the demographic shifts triggered by the crisis. Several informants questioned whether UNFPA fully recognized or prioritized this responsibility in humanitarian contexts. IPs also indicated that their workplans do not have M&E budget lines, all affecting the minimum of systematic oversight of the response.

These challenges, including fragmented data systems, lack of data collection and analyses tools, and lack of sufficient investment, were also highlighted in UNFPA global evaluability assessment as organization-wide gaps, which therefore may also have affected UNFPA Sudan's ability to effectively implement an evidence-driven response. [218]

Processes, risk and accountability

Finding 6.7. The UNFPA response was hindered by a risk-averse culture, limited application of FTPs and weak alignment with 'no regrets' principles, directly affecting timeliness and operational efficiency. Despite the early response being characterized by agility and flexibility, the organization shifted back to its development-centric processes towards the end of 2023, prioritized compliance over responsiveness and did not fully leverage FTP flexibilities. Decision-making remained centralized at the country office in Port Sudan, and delays in supply, staffing and finance reflected persistent bottlenecks. These constraints critically undermined the ability of UNFPA to act with the speed, scale and risk tolerance expected in a system-wide humanitarian emergency.

The UNFPA response lacked the urgency, agility and scale typically expected under IASC system-wide scale-up. The whole country crisis reduced the feasibility of UNFPA pursuing CPD related programming. Although humanitarian action is formally embedded within the CPD as one of the six interconnected outputs,[219] the 2023–2024 context demanded a near full pivot to positioning humanitarian response as the primary modality. While UNFPA was very reactive and agile immediately after the conflict started, the organization did not maintain this pace from the end of 2023 through to August 2024. Scaling up became very challenging as a result of UNFPA capacity constraints, but also as a consequence of what some people called "UNFPA culture". Internal survey data reflected these concerns. Ratings for efficiency stood at 67 per cent for timeliness, 65 per cent for finance, 64 per cent for human resources and 70 per cent for supplies. These figures were particularly low among external informants (average rating of 64 per cent), with some UNFPA staff rating efficiency as low as 40 per cent.

Even after business continuity was established and needs were intensified (by December 2024), UNFPA leadership and support structures failed to uphold the agility, and this translated into persistent delays in implementation (see section on human resources and supply).

FTPs were known, underused and not comprehensively institutionalised. Despite the inclusion of the FTPs in the UNFPA response plan, their application was inconsistent. FTPs, "facilitating greater delegation of authority and flexibility",[220] were known broadly to most UNFPA staff. However, the

[218] Baseline and evaluability assessment on generation, provision and utilization of data in humanitarian assistance, UNFPA IEO, 2021.
[219] UNFPA Strategic Plan 2022-2025.
[220] UNFPA Fast Track Policy and Procedures, 2022.

evaluation questions to what extent UNFPA staff were aware of the FTP and humanitarian SOPs.[221] FTPs were applied for functions such as activating the CRT, surge, fuel purchases and cash requests, but not sufficiently for FTAs and TAs. There was a sense that the FTPs, while at times providing process flexibility, did not always result in 'fast' processes. The persistent delays on supplies and human resources were also cited by many informants because of delayed decision-making at HQ level. with "many back and forth" and "delayed decision making". As one UNFPA staff member put it, "FTPs were not used to the extent they were intended".

The organizational development-oriented culture limited an efficient pivot to humanitarian action. While humanitarian ambition was clearly articulated in its response plan, UNFPA continued operating with its development-oriented norms, limiting a pivot to emergency response despite a system-wide scale-up. At the onset of the crisis the organization had only few national staff with prior humanitarian experience on the ground, while most of the personnel were predominantly development-trained, both national and international, many of whom lacked familiarity with humanitarian systems and fast-paced, high-risk operations. The introduction of Quantum further exacerbated delays and inefficiency. Many UNFPA informants at country, regional and global level described the development mindset as a key inhibitor, with several labelling the organization's culture as fundamentally "non-humanitarian". The organizational culture was also highlighted in the UNFPA global humanitarian evaluation as a key factor influencing UNFPA humanitarian capacity.[222]

Many informants attributed these inefficiencies to UNFPA being overly risk-averse and to limited alignment with a 'no regrets' approach. Although the FTPs do not explicitly reference 'risk appetite' or 'no regrets', these principles are globally recognized as fundamental to humanitarian response. UNFPA did not consistently apply them to decentralize decision-making or accelerate action. Decision-making remained centralised at the national level, which frequently constrained timely field-level response. Respondents across the country office, regional office and HQ described an organizational culture that prioritized the risks of action, such as audit findings or fiduciary exposure, over the risks of inaction, such as delayed services or unmet needs. UNFPA maintained a strongly compliance-driven approach, characterized by complex workplans, standard contracting procedures and a preference for service contracts over humanitarian-appropriate temporary appointment or fixed-term appointment modalities. This mindset prevented resources from reaching the right place at the right time.

As mentioned in previous sections, the change in leadership to one with extensive humanitarian experience, in mid-2024, led to more responsive and flexible programming and decision-making, and to a more comprehensive, costed response plan.

Country office-regional office-HQ coordination, support mechanisms and leadership

Finding 6.8. While leadership and coordination improved significantly by mid-2024, following key senior appointments, the CRT Cairo consultations and clearer delegation of authority, these changes came late in the response. Prolonged ambiguity in leadership and decision-making at the country office level contributed to critical delays and inefficiencies well into 2024. During that time, the CRT lacked assertiveness to resolve inefficiencies early on, and internal coordination was hindered by unclear lines of authority. At the regional office and HQ levels, similarly siloed decision-making and delayed strategic direction further compounded operational challenges for the country office.

Until mid-2024, the UNFPA response was marked by ambiguity over lines of authority and decision-making between the country office, regional office and HQ (both HRD and DHR). While the delegation of authority is clearly defined as "the country office maintains overall management and accountability of the response"[223], multiple informants noted confusion over who was leading the response, across the three levels, particularly when operational challenges emerged. There were

[221] The UNFPA Standard Operating Procedures for Humanitarian Settings, 2011.
[222] Evaluation of the UNFPA capacity in humanitarian action, 2012-2019.
[223] UNFPA Standard Operating Procedures for Humanitarian Settings, 2011.

reports of much going back and forth, and important decision-making delays. While internal leadership at the country office level improved over time, it was reportedly well-versed in development programming but less on humanitarian response to acute crises, an issue that was reportedly common in UNFPA.[224] Several UNFPA informants said that a UNFPA CR holds too much power, at times sidelining humanitarian capacity, and that development and humanitarian programmes remain managed in siloes.

The CRT appeared insufficiently assertive to ensure timely and critical decision-making. The CRT is expected to "facilitate coordination and decision-making within headquarter divisions and from headquarters to regional and country office"[225] but this mechanism did not always assertively intervene to course-correct, even as delays mounted. While the CRT met on several occasions, several key UNFPA staff pointed towards the CRT not being an efficient platform for operational decision-making. This decision-making ambiguity was particularly evident in the prolonged remote working arrangements of national staff, with many remaining off-site until August 2024, well after other United Nations agencies (see section on human resources).

UNFPA took important steps to improve leadership and coordination by mid-2024. The appointment of a new interim representative, delegation of decision-making to sub-offices (supply, administrative) and additional staff with stronger humanitarian experience contributed to a shift in responsiveness. The CRT Cairo consultations[226] provided room for strategic dialogue between HQ, regional office and country office levels, and clarified expectations, and decision-making. Field visits from HRD and regional office leadership elevated critical issues (return of national staff, staffing restructuring) and provided direct support and recommendations to country-level teams. Although these adjustments came relatively late in the crisis, they were seen as important steps toward improving leadership, coordination and accountability across UNFPA.

4.5 Coherence

Evaluation Question 7: To what extent and how was UNFPA programming internally and externally coherent and coordinated with the inter-agency humanitarian response?

External coherence

Finding 7.1. UNFPA demonstrated strong technical alignment with inter-agency standards in SRHiE and GBViE and was recognized as a collaborative and capable partner at both national and field levels. It contributed meaningfully to coordination platforms, assessments and advocacy for core priorities like MISP and PSEA.

UNFPA contributed actively to overall inter-agency coordination, aligning its humanitarian response with established IASC standards, particularly in the areas of SRHiE and GBViE. It ensured that core priorities such as the PSEA, MISP, CMR, WGSS, CVA and localization were consistently reflected in its own programming, and inter-agency strategies and coordination platforms. UNFPA played a key role in maintaining gender-based violence and sexual and reproductive health as standing agenda items at senior humanitarian coordination forums. Several external informants acknowledged that UNFPA had a strong presence in strategic-level coordination and increasing visibility, although this became more evident only later in the response. Notably, UNFPA leadership played a role in successfully influencing the re-prioritization of the HNRP, helping to ensure that the MISP, while considered non-negotiable, remained a core component.

[224] Evaluation of the UNFPA capacity in humanitarian action, 2012-2019.
[225] UNFPA Standard Operating Procedures for Humanitarian Settings, 2011.
[226] UNFPA organised meetings with the country office, RO and HQ members in Cairo to reflect on its programming in Cairo.

Across the United Nations system, UNFPA was consistently viewed as a collaborative, technically strong and influential partner, with informants highlighting the added value of its Access Focal Point in Chad, seconded to OCHA. At the field level, UNFPA was seen as a reliable collaborator with robust technical leadership in sexual and reproductive health and gender-based violence, recognized for its expertise and strong commitment to community-level engagement and localization.

However, broader coordination challenges across the humanitarian architecture in Sudan weakened overall response coherence. Many informants described the system as fragmented, with United Nations agencies operating in siloes and lacking a collective strategy and strong humanitarian leadership. Despite strong commitment and efforts from UNFPA, this context limited its visibility and influence in inter-agency platforms, partly due to its smaller operational scale and limited capacity to compete with larger actors such as WFP, UNICEF and UNHCR. As a result, UNFPA was reportedly sidelined in key decision-making spaces, including those related to famine response, joint logistics, access coordination and the 2025 HNRP reprioritization process.

Internal coherence

Finding 7.2. UNFPA promoted integrated service delivery at field level, notably through joint sexual and reproductive health, and gender-based violence interventions in clinics, WGSS and community networks. However, strategic integration remained limited, hindered by siloed systems, separate workplans, and donor-driven priorities.

UNFPA made visible efforts to promote integrated service delivery at the field level. Some integration of sexual and reproductive health and gender-based violence services was achieved through WGSS, mobile clinics, and established referral linkages. Mobile sexual and reproductive health clinics staffed by midwives often included gender-based violence social workers, allowing for both health and protection services to be delivered at the point of care. In some WGSS, midwifery staff were embedded, while community-based protection networks were leveraged to screen for both sexual and reproductive health and gender-based violence needs. Additionally, CMR-trained personnel were placed in EmONC facilities to support clinical response. These efforts supported more survivor-centred service models, enabling individuals to access multiple services in a single location.

Strategic integration was inconsistent, particularly in high-need or gender-based violence sensitive areas. Despite achievements, several informants reported that strategic integration lagged, especially in areas with referral. Barriers included siloed operations between the sexual and reproductive health and gender-based violence team, as a result of separate systems, and donor preferences. Separate systems and workplans limited opportunities for joint planning. While gender-based violence programming received relatively more targeted funding and donor attention, sexual and reproductive health was underrepresented in coordination spaces and continued to face important underfunding.

4.6 Connectedness

Evaluation Question 8: To what extent and how did the UNFPA humanitarian programming take longer-term development goals into consideration, including strengthening the resilience of national and local actors to prepare for, respond to and recover from humanitarian crises?

Transition, the UNSDCF and CPD

Finding 8.1. UNFPA demonstrated early transition planning in a highly volatile context through its development of a new CPD. Despite operational disruptions and evolving humanitarian priorities, the country office continued aligning with national development frameworks and pursued an approach to bridge humanitarian and development programming.

The UNFPA CPD for Sudan, covering 2018–2021, was extended through 2022, 2023 and 2024 to align with evolving United Nations and government priorities. Despite the humanitarian crisis, which

disrupted CPD implementation, the CO continued to pursue CPD priorities and align its planning with national progress toward the new United Nations Sustainable Development Cooperation Framework (UNSDCF).

UNFPA began its transition planning early in a highly fluid environment. The UNFPA transition approach has emerged primarily through the development of the next CPD. Several visits by HRD have generated strategic recommendations, and UNFPA has initiated a transition process with an emphasis on recovery, infrastructure rehabilitation and sustained engagement with local actors, particularly youth- and women-led organizations. In parallel, there is evidence of subnational contingency planning underway, including emergency response planning and stock mapping, which enhances its preparedness efforts.[227]

UNFPA presented its strategic positioning to the UNCT, but progress has stalled. While the development of a new CPD and its alignment with the UNSDCF diminished in relevance during the 2023 conflict, UNFPA nonetheless positioned itself to integrate concrete contributions into the 2026–2028 UNSDCF. However, the visibility of UNFPA within the UNSDCF is currently limited to a single output (development), despite its dual mandate and humanitarian leadership. Key informants noted that the humanitarian-development continuum remains ambiguous within the UNSDCF, with the government prioritising development through the Ministry of Foreign Affairs. This has led to uncertainty, in addition to donor hesitancy and the 2025 funding constraints. While UNFPA has actively engaged several development donors at the country level, the absence of a clear and endorsed CF, which is required for CPD finalization, likely limits the possibility that the CPD is fully aligned with UNSDCF priorities though this lies beyond UNFPA control.

Resilience to national and subnational government and systems

Finding 8.2. UNFPA contributed to some resilience-building efforts for the government and its system. A few targeted interventions likely contributed to health system resilience through technical assistance and government collaboration, albeit on a modest scale. There are some initial efforts to secure development funding and financing to support system strengthening, resilience building and recovery, although these are insufficient to fully fund the new country programme across the HDP continuum.

The shift to recovery and resilience was not strategic but the response included some resilience interventions. As yet, there is no clear strategy to transition responsibilities to government systems in an environment where the government is highly dependent on UNFPA for sexual and reproductive health service continuity due to its limited national absorption capacity, underfunding, brain drain and destroyed infrastructure. While some training and coordination support was provided, actual resilience of systems has so far not materialized.

Some targeted interventions – such as support for CMR services – likely contributed to health system resilience through technical assistance and government collaboration, albeit on a modest scale. UNFPA supported the National Population Council on demographic data and policy planning. It supported the Ministry of Health to relaunch the district health information system/MDSR in November 2024, but there are varying reports on its functionality and there is still a lack of MDSR data, especially in the conflict-affected states. There is no evidence that these efforts have contributed to results yet. Several training programmes targeted state health staff including on CMR, LMIS and sexual and reproductive health data systems. UNFPA contributions to resilience were probably most appreciated through its CMR training provision and policy, with several informants noting that it had not been known or practised before.

While UNFPA resource mobilization efforts have led mainly to additional short-term funding for the ongoing humanitarian response, there are also some initial efforts to secure development funding to support longer-term system strengthening, resilience building and recovery, including from Canada, UNDP-MPTF and Sweden, which provides unearmarked funding for UNFPA Sudan's country programme. However, these efforts are still limited and largely insufficient to fully fund the new

[227] UNFPA Contingency Plan Sudan, Kassala, June 2024.

country programme and consistently support resilience building across the HDP continuum. UNFPA has not yet consistently engaged with international financing institutions like the World Bank to obtain development financing.

Resilience of local capacity

Finding 8.3. UNFPA efforts led to short-term local capacity gains with strong potential for sustainability and have pushed localization components forward. Those important gains risk being lost in the absence of multi-year funding and sustained mentorship.

There have been solid short-term capacity gains that have sustainability potential. UNFPA has achieved short-term capacity gains among local organizations. Youth groups in Kassala were trained on gender-based violence, FGM, and child marriage; community midwives received training on referral pathways inclusive of CVA support; and girls' clubs and community-based referral systems were established to strengthen local advocacy and service access. UNFPA support for women's committees in selecting case managers reinforced community ownership. The gender-based violence AoR's inclusion of women-led groups in SOP development, CVA programming, safety audits and M&E reporting was positive, and the national co-chairing of the gender-based violence AoR by the NGO NADA stands as an important achievement in localization.

However, these gains remain fragile in the absence of predictable, multi-year financing and strategic mentorship. Local IPs, while appreciative of UNFPA flexibility and technical guidance, face persistent constraints stemming from short-term work plans, delayed disbursements, brain drain and high staff turnover, and insufficient capacity in resource mobilization. IPs reported that disruptions in gender-based violence referral pathways limited their capacity to scale up. Further, the absence of comprehensive IP mapping across inter-agency coordination, and anecdotal informant reports indicating that most funding continues to benefit the five large national NGOs, presents a risk of duplication and uneven funding distribution. Although UNFPA has made strides in sexual and reproductive health and gender-based violence capacity strengthening, local actors report the need for more sustained mentorship, including in independent fundraising, financial management and accountability mechanisms. Without this, efforts to build a robust and locally-driven humanitarian response risk stalling.

5. Conclusions

Conclusion 1: The UNFPA humanitarian response was timely and addressed acute needs at the early onset of the crisis.

Links to evaluation finding 1.1, 1.2, 2.1, 3.1

UNFPA responded in a timely manner and demonstrated operational agility in the immediate aftermath of the April 2023 conflict outbreak, preceding the inter-agency system-wide scale-up. The agency rapidly reactivated sexual and reproductive health and gender-based violence services in the post-Khartoum context, addressing critical gaps in areas with large-scale population displacement, collapsed health infrastructure, and heightened gender-based violence risks. This early response was essential and clearly focused on the acute gender-based violence and sexual and reproductive health needs of women and girls, including adolescents, during the initial phases of displacement. In this context, UNFPA played a distinct and life-saving role within the collective humanitarian response by establishing access to services, including CMR, EmONC and WGSS, to the extent possible, despite insecurity, staff evacuations and the collapse of operational systems.

While the country office necessarily re-established business continuity at the national level under highly challenging conditions, the rapid deployment of a humanitarian coordinator, the availability of a draft response plan, and the presence of national staff with prior humanitarian experience were key enablers of UNFPA operational agility and flexibility at the subnational level. In addition, the agency leveraged its pre-positioned supplies and long-standing partnerships to meet acute needs under severely constrained circumstances. Early rapid needs assessments conducted by UNFPA and its IPs at subnational level, while limited in coverage, were adequate to inform life-saving interventions during the initial crisis phase.

This experience highlights comparative advantage that UNFPA has in delivering time-sensitive interventions during the onset of acute emergencies and demonstrates the agency's ability to operate with timeliness, agility and flexibility under extreme conditions, including insecurity, financial system collapse, communication blackouts and staff evacuations.

Conclusion 2: While UNFPA adapted its operational presence and programming to the evolving humanitarian crisis, its response lost critical momentum over time due to insufficient humanitarian resourcing, weak data systems, development-oriented systems and process bottlenecks, ultimately limiting its reach and relevance in the face of escalating needs.

Links to evaluation finding 1.1, 1.2, 2.1, 3.1, 3.2, 5.1, 5.2, 5.5

As the crisis evolved and displacement patterns shifted, from September 2023 onwards, UNFPA undertook several relevant programmatic adaptations. These included extending its operational presence to areas experiencing new internal displacement, opening sub-offices, reallocating staff geographically and adapting to emerging displacement dynamics. The agency diversified its service delivery through static and mobile modalities and introduced CVA, which contributed to improving access to sexual and reproductive health and gender-based violence services by mitigating financial barriers, particularly for those most in need in conflict-affected states. UNFPA also explored alternative delivery mechanisms in Darfur, engaged non-traditional partners to support last-mile supply delivery, activated TPM to ensure a minimum level of oversight, and deployed several GERT personnel for supply, logistics and access negotiation. Cross-border relief operations from Chad were

initiated as a promising modality, although similar efforts via South Sudan did not materialize. These adaptations, while introduced incrementally and some at modest scale, enabled the continuation of services in hard-to-reach areas where the United Nations had no presence.

However, the response gradually lost momentum, and its overall relevance declined, particularly between September 2023 and mid-2024. UNFPA's capacity to sustain a humanitarian posture and mobilize the required resources in a timely and geographically appropriate manner fell short of both the agency's own ambitions and the scale of humanitarian needs. UNFPA increasingly operated under capacity constraints.

IPs also faced limitations in meeting the growing demand and complexity of needs. The UNFPA response plan remained largely uniform and did not incorporate tailored strategies responsive to Sudan's varied socio-cultural and geographic contexts. Despite the heterogeneous nature of needs across states, there was no systematic mechanism in place to identify and prioritize the most vulnerable populations or to address differentiated risks and vulnerabilities.

Comprehensive, vulnerability-based needs assessments were largely absent from the onset of the crisis through 2025. Instead, UNFPA prioritization relied heavily on HNRP guidance, displacement tracking data and outdated pre-crisis health facility information, data sources which proved insufficient to support a robust, evidence-based response aligned with the agency's sexual and reproductive health and gender-based violence mandate. The absence of disaggregated data, structured needs assessments and systematic community feedback mechanisms undermined strategic targeting. The comparative role of UNFPA in population data generation, core to its humanitarian mandate, was not fully leveraged to inform either its own or the inter-agency response.

Operational constraints further compounded these challenges. The HST was not fully activated, and national staff who had relocated were redeployed too late. Decision-making around supply remained delayed and unclear. These factors directly impacted the UNFPA field presence and its ability to scale up and maintain essential service delivery. In 2024, UNFPA reached approximately 18 per cent of its total target population and 51 per cent of its target for women of reproductive age, figures that, while notable, remain insufficient given the scale and severity of humanitarian needs in Sudan.

Conclusion 3: UNFPA made targeted efforts to reach vulnerable groups and strengthen accountability, but these initiatives were not scaled or systematized.

Links to evaluation finding 1.1, 1.3, 1.4

UNFPA undertook targeted efforts to reach vulnerable population groups, including adolescents, persons with disabilities, and marginalised host communities, primarily through partner-led modalities and mobile service delivery. While these efforts reflected a degree of alignment with the LNOB principle, they were not implemented at sufficient scale. Mechanisms for collecting community feedback, an essential component of inclusive and accountable humanitarian programming, were operationalized by only a limited number of IPs and remained largely underutilized. The feedback loop was incomplete, limiting the extent to which community perspectives informed programmatic adaptation and prioritization.

At the inter-agency level, UNFPA played a visible role in advancing AAP. However, at the subnational level, the agency's approach to AAP was primarily focused on data collection rather than on fostering inclusive participation or enhancing accountability and responsiveness in service delivery. Reports from affected women highlighted confusion about available services, low awareness of complaint and feedback mechanisms, and persistent safety concerns, particularly in relation to gender-based violence risks in displacement settings.

While progress was noted in capacity strengthening related to the PSEA, – including training, awareness-raising and support to partners – field-level implementation remained inconsistent and fragmented. Reports from affected communities indicated limited awareness of complaints mechanisms, ongoing concerns regarding safety and confidentiality, and low levels of trust. These issues contributed to significant underreporting, suggesting that PSEA systems were not consistently perceived as safe, accessible or reliable by the population.

Conclusion 4: UNFPA provided strong technical leadership and coordination in sexual and reproductive health and gender-based violence, but its strategic influence and inter-agency advocacy were partially under-leveraged, although incremental improvements were observed from 2024 onwards.

Links to evaluation finding 1.4, 7.1

The agency's response was broadly aligned with the collective humanitarian effort and contributed actively to inter-agency coordination mechanisms. UNFPA leadership and coordination mandates played a stabilising role in the sexual and reproductive health and gender-based violence sectors during a period of acute disruption, helping to sustain the delivery of essential services.

UNFPA provided strong technical leadership in humanitarian coordination, particularly in its role as lead of the gender-based violence AoR, and to a lesser extent, as co-lead of the SRHiE Working Group. The agency contributed to standard-setting, promoted localization, and supported the implementation of key humanitarian protocols, including the MISP and CMR. UNFPA was recognized for its sustained subnational coordination and technical assistance. It remained aligned with key inter-agency frameworks, including those related to the PSEA, and engaged in joint assessments and humanitarian planning under the HNRP. However, within the gender-based violence AoR, data sharing practices were inconsistent and hindered by breaches of confidentiality.

At the same time, the delayed national activation of the SRHiE Working Group constrained timely mapping of partners and services, impeded information exchange and reduced the ability of UNFPA to influence inter-agency prioritization processes. The agency's advocacy and communications on gender-based violence, particularly regarding CRSV, were perceived as overly cautious, limiting its contribution to joint United Nations messaging.

More broadly, systemic coordination challenges within the humanitarian architecture, including siloed approaches among larger United Nations entities, affected overall coherence and reduced the visibility and strategic positioning of SRHR and gender-based violence as life-saving in high-level inter-agency platforms. This was especially apparent in key processes such as the famine response planning, access negotiations, joint logistics coordination and the 2025 HNRP reprioritization exercise, where the comparatively smaller operational footprint of UNFPA limited its leverage.

Conclusion 5: UNFPA human resource mobilization during the crisis was insufficiently agile, limiting its ability to deploy sufficient and skilled personnel at the scale and speed required for the response.

Links to evaluation finding 6.1, 6.2, 6.7, 6.8, 2.1, 3.1

Despite the early deployment of a humanitarian coordinator, timely mobilization of GERT personnel and the initiation of a staffing reconfiguration process, the overall humanitarian human resource surge by UNFPA fell short of established emergency standards. The mobilization of humanitarian human resources was marked by unclear and centralized decision-making, prolonged delays and a limited pool of staff with the required humanitarian experience.

The deployment of the surge humanitarian coordinator in May 2023, ahead of the IASC system-wide scale-up, facilitated initial humanitarian planning and coordination. GERT deployments were timely and fit-for-purpose, with deployed personnel demonstrating relevant emergency expertise and familiarity with UNFPA systems, thereby supporting operational continuity.

However, enduring structural inefficiencies at the corporate level significantly impeded the overall effectiveness of the response. The agency did not fully activate its HST in line with internal protocols, resulting in delayed deployments of key personnel in human resources, finance and communications. Despite early surge requests by the country office, deployments exceeded emergency benchmarks. Unlike GERT staff, surge personnel faced onboarding and integration challenges stemming from limited institutional knowledge of UNFPA systems and procedures.

Additionally, a significant proportion of national staff operated remotely until August 2024, long after other United Nations entities had resumed physical presence. The absence of a senior international operations manager in-country for over a year further constrained the country office's ability to scale operations. Human resources mobilization was frequently channelled through service contracts, rather than more appropriate contractual modalities such as TAs or FTAs. Delays in finalizing the internal staffing reconfiguration, attributable to protracted discussions and decision-making across the country office, regional office and HQ, remained unresolved as of April 2025.

While access constraints, the bureaucratic and administrative impediments, security considerations and Government of Sudan visa restrictions further complicated operational conditions, it was the cumulative effect of internal human resources bottlenecks that critically undermined the ability of UNFPA to deploy qualified personnel, at scale, in a timely and context-appropriate manner.

Conclusion 6: The UNFPA supply chain response, despite some innovative workarounds, ultimately fell short of the scale and speed of the response.

Links to evaluation finding 6.1, 6.3, 6.7, 6.8, 2.1, 3.1

Despite efforts to identify alternative supply corridors to Darfur, where humanitarian needs were most acute, and concrete steps taken from mid-2024 to mitigate supply constraints, the UNFPA response continued to face systemic supply chain inefficiencies.

UNFPA succeeded in delivering critical supplies to Darfur, Kordofan and Khartoum through non-traditional partners, navigating complex political and logistical challenges. However, planned cross-border deliveries via South Sudan did not materialize due to the continued escalation of conflict.

Procurement delays, customs clearance bottlenecks, and unclear delineation of roles and responsibilities between the country office, regional office and HQ resulted in supply distribution delays of up to nine months. Between 2022 and 2024, the agency incurred significant demurrage charges, reflecting both the extraordinary operational constraints of the crisis and persistent structural inefficiencies previously noted in internal and external reviews.

Key supply-side constraints included a shortage of experienced logistics and supply personnel capable of responding to the scale of demand, limited warehousing infrastructure, poor pipeline visibility, inadequate storage and distribution planning, and weak end-to-end tracking systems. These factors contributed to periodic stockouts and interruptions to service delivery. Supply coverage remained inconsistent and, in several instances, fell short of operational requirements. Frontline service providers, including mobile health teams in hard-to-reach areas, reported ongoing shortages of essential commodities. Many of these supply chain constraints were long-standing challenges specific to Sudan and systemic within the broader UNFPA operational model.

Operational complexity was further compounded by the collapse of national logistics systems, high in-country transport costs, restricted humanitarian access and administrative barriers imposed by the Government of Sudan. These external factors further impeded the capacity of UNFPA to expand supply operations at the required scale.

Ultimately, the scale-up of supply operations achieved by UNFPA did not meet the operational benchmarks expected under an IASC system-wide scale-up, limiting the effectiveness of the agency's humanitarian response.

Conclusion 7: Despite the introduction of TPM in hard-to-reach areas, UNFPA overall monitoring and evaluation systems fell short of humanitarian standards.

Links to evaluation finding 1.1, 6.6

While the proactive engagement of TPM by UNFPA helped address access limitations in conflict-affected and inaccessible areas, its overall monitoring systems did not meet established humanitarian standards and were not sufficient to ensure a data-driven or accountable response. The agency lacked an overarching monitoring framework capable of guiding a prioritized, needs-based response. Available results and disaggregated data were limited and primarily focused on institutional inputs, such as training sessions and awareness activities, rather than community-level outputs or outcomes.
Although TPM contributed to filling access gaps where feasible, it was not consistently integrated into broader monitoring structures and lacked systematic aggregation, analysis and use. There was no evidence of a functional M&E framework or a real-time performance monitoring system across UNFPA-supported sites. Internal reporting remained largely process-oriented and was not well adapted to the operational demands of a humanitarian emergency.

Basic tools, digital systems and internal platforms required to support data collection, analysis and adaptive management were either unavailable or underdeveloped. The lack of sufficient M&E capacity further constrained the ability to generate and use evidence for decision-making and course correction across UNFPA humanitarian operations.

Conclusion 8: UNFPA corporate leadership and decision-making processes were not sufficiently adapted to the demands of a large-scale humanitarian crisis, with centralized, compliance-driven operations and a limited risk appetite, despite improvements under new country leadership from mid-2024.

Links to evaluation finding 6.1, 6.2, 6.3, 6.8, 7.2

While new country leadership in mid-2024 contributed to improved responsiveness and accountability, UNFPA corporate leadership and decision-making processes remained misaligned with the operational demands of a fast-evolving, conflict-driven humanitarian crisis. Despite early ambitions, the agency's response remained largely centralized, compliance-driven, and anchored in development-oriented systems and modalities.

Decision-making was concentrated at the national level, with ongoing ambiguity across HQ, regional office and country office roles and responsibilities, particularly in relation to human resources and supply functions. This contributed to delays in staff redeployments, the continuation of remote management practices well after other United Nations entities had re-established a physical presence, and inefficiencies in supply chain delivery. Coordination structures such as the CRT were perceived as

insufficiently assertive in navigating early operational bottlenecks or in enforcing timely corporate-level decisions.

The UNFPA response reflected a limited risk appetite and an inconsistent application of the IASC-endorsed 'no regrets' principle. Bureaucratic workplan processes and standard development contracting procedures constrained the timely approval of workplans and disbursement of funds to IPs. Although FTPs were embedded within UNFPA policy, their operationalization was partial, with decision-making often subject to iterative approval cycles at the HQ level.

Risk tolerance was not operationalized, particularly from April 2023 to June 2024, and there was no clear internal framework to support the balancing of fiduciary risk against humanitarian imperatives. As a result, the country leadership tended to prioritize risk aversion related to action, such as audit exposure or compliance breaches, over the potential consequences of inaction, including disruption of life-saving services and failure to meet critical needs. The disconnect between risk appetite and the 'no regrets' approach undermined the agility and responsiveness expected of agencies operating under an IASC system-wide scale-up.

Conclusion 9: The UNFPA response was effectively delivered through strong national partnerships, commitment to localization and early transition planning, but its partnership model remained largely operational and fragile, with insufficient investment in long-term capacity strengthening and resilience building.

Links to evaluation finding 1.1, 1.2, 6.5, 8.1, 8.2, 8.3

The UNFPA response was effectively implemented through its long-standing national partnerships, including with WLOs, which constituted the backbone of its operations. In the face of access constraints, the agency adapted by leveraging its pre-existing partnership network, which proved essential for sustaining the delivery of life-saving sexual and reproductive health and gender-based violence services. These partnerships enabled UNFPA to reach high-risk and hard-to-access areas where United Nations agencies or government ministries could no longer operate.

UNFPA sustained its localization efforts and adopted a consortium model to channel subgrants to WLOs. It also introduced TPM to compensate for limited in-person oversight in conflict-affected states. In 2025, the agency transitioned toward a more diversified and strategic partnership approach, increasing collaboration with INGOs in Darfur and Kordofan. This shift enhanced service coverage and contributed to risk diversification. UNFPA localization initiatives delivered meaningful short-term capacity gains among national partners, ministries and frontline service providers, thereby strengthening components of Sudan's public health and protection systems.

Under fluid and uncertain conditions, UNFPA also initiated early transition planning by aligning the development of its new CPD with national frameworks and the strategic directions of the United Nations Country Team. These efforts remain ongoing and reflect the agency's intent to bridge its humanitarian action and development programming in a coherent and forward-looking manner.

However, the partnership model remained largely operational in nature, with an emphasis on funds management and capacity-building, and less focus on strategic oversight, accountability or mutual learning platforms. Capacity strengthening gains also remain fragile in the absence of predictable, multi-year financing and sustained investment. Many local partners continued to experience critical operational challenges, including limited response capacity, high staff turnover, delays in funding disbursement, restricted access to mentorship opportunities and inadequate capacities for long-term resource mobilization. The short-term nature of most funding cycles also shaped humanitarian donors, further constraining durable capacity strengthening.

6. Recommendations

As UNFPA Sudan is developing a new country programme for 2026-2028, the evaluation findings, conclusions and recommendations can help further refine its strategic direction and priorities. Where applicable, it can also help align the country office's humanitarian programming with the ongoing Humanitarian Reset's direction to ensure that UNFPA not only meets internal benchmarks but also contributes visibly to system-wide transformation in Sudan and joint inter-agency efforts to meet the humanitarian needs of Sudanese women and girls.

The evaluation of the UNFPA humanitarian response in Sudan from 2023 to 2025 has yielded important insights and highlighted lessons that are of relevance to UNFPA beyond the Sudan CO. Notably, the evaluation findings and conclusions have pointed to key systemic issues pertaining to humanitarian human resource managements, supply chain management, data, and accountability frameworks during humanitarian scale-ups at the corporate level. While some of these issues are being addressed through the effective application of the UNFPA emergency policies and procedures (March 2025) and regular revision of other relevant policies, there is a need for further action by the HRD, DHR and SCMU to ensure that UNFPA has the necessary systems, policies and procedure, and the operational capacity to respond effectively and timely to major acute humanitarian crises similar to the one in Sudan, including adequate support and delegation of decision-making authority to UNFPA COs.

While the recommendations of this evaluation report are mainly addressed to the UNFPA CO, the conclusions and lessons stemming from this evaluation have been used to inform the recommendations of the centralized Evaluation of UNFPA Capacity in Humanitarian Action (2019-2025). More specifically, this report has been used as a secondary data source, analysed and triangulated with multiple other data sources from a large sample of UNFPA countries, and used to inform the recommendations contained in the report of the centralized evaluation. Therefore, this evaluation report, covering the UNFPA humanitarian response in Sudan, does not contain any recommendations pertaining to the regional and HQ levels.

Recommendation 1: Use of the risk management system

The Sudan country office should adapt its risk posture and decision-making processes to operate effectively in volatile humanitarian contexts, applying the 'no-regrets' principle and balancing risk with operational necessity, based on the UNFPA enterprise risk management (ERM) policy and operational plan, risk appetite statement and emergency procurement procedures (EPPs).

1) Priority: High
2) Timeline: Short
3) Based on conclusions: 8
4) Directed to: UNFPA Sudan country office with support from ASRO and HRD

Actions:

- Ensure effective implementation of the country office's ERM system by updating risk factors to reflect the Sudan current context and closely monitoring the implementation of the risk response plan. This should include an assessment of the risks associated with the TPM in North Darfur and other inaccessible areas.
- Revise and streamline country office's internal workplan management and disbursement approval processes compliant to corporate policies and ensure that country office staff are fully aware of, and correctly apply, the flexibilities provided within the existing policy

framework (including the EPPs), to reduce bureaucratic delays and ensure timely service delivery during humanitarian crises.
- Continue training the country office's senior managers and sub-office heads on the 2025 EPPs, humanitarian leadership, adaptive management, and context-sensitive risk navigation based on the country office's ERM and risk response plan.
- Establish and implement clear country office-specific accountability mechanisms for the application of the EPPs during activation of a UNFPA scale-up and ensure all country office staff are informed thereof, including performance oversight linked to the compliance with emergency timelines and procedures.

Recommendation 2: Human resources capacity

The Sudan country office should advocate with DHR and HRD for timely and efficient recruitment of staff, surge and GERT during scale-ups and to update the Delegation of Authority (DOA) to reflect lessons learned from Sudan, to align to the EPP, and seek to incorporate the key lessons learned in future emergency HR realignments. This will ensure that, during emergencies, the country office can rapidly deploy qualified staff with delegated authority, sustain critical functions in sub-offices and retain experienced personnel despite challenging conditions, contingent upon staff safety and the security environment. This will require the support of, and timely response and approval by the regional office and, particularly, HRD and DHR.

1) Priority: High
2) Timeline: Medium
3) Based on conclusions: 2, 5, 8
4) Directed to: UNFPA Sudan country office with the support of ASRO, HRD and DHR

Actions:

- At the country office level, establish a Sudan-specific surge roster of national candidates (including gender-based violence, sexual and reproductive health, logistics, and administration and finance roles) who are pre-vetted, security-cleared and available for deployment within 72 hours to maintain continuity during surge gaps (e.g. external constraints hindering rapid deployment of GERT and surge).
- Decentralize country office decision-making authority and empower staff for adaptive humanitarian programming, and workplan and resource management (e.g. budget manager, REQ and PO creators and approvals) to the subnational levels during a humanitarian scale-up.
- Ensure timely deployment of the GERT and surge at the onset of a humanitarian crisis following IASC and UNFPA internal emergency activations and ensure that deployed staff can immediately access UNFPA operational systems and enable swift operational decisions during the acute phase.
- Ensure that the EPPs, when activated, are timely and correctly applied for accelerated creation and recruitments of temporary appointment and fixed-term appointment positions following the initial GERT and surge deployments, thus ensuring that GERT and surge remain temporary and short-term response mechanisms only.
- Advocate with DHR to delegate decision-making and significantly reduce the time for developing and approving HR realignment exercises in COs operating in humanitarian contexts. This includes requesting DHR update the DOA to reflect lessons learned from SDN and align to the EPP.

Recommendation 3: Supply chain management

The Sudan country office should strengthen its end-to-end supply chain management systems and processes to meet humanitarian emergency timelines, including a comprehensive supplies plan, timely customs clearance processes, pre-positioning commodities in strategic locations, and transparent last-mile delivery and tracking in coordination with partners and the logistics cluster. This will require the support and timely action of the regional office and particularly HQ, SCMU, HRD and GERU.

1) Priority: High
2) Timeline: Medium
3) Based on conclusions: 2, 6, 8
4) Directed to: UNFPA country office with the support of HQ divisions, and ASRO

Actions:

- Implement the recommendations from the 2025 regional office, HRD and SCMU mission to Sudan, to strengthen the country office end-to-end supply chain management, ensuring that procurement, customs clearance, warehousing and in-country last-mile distribution match humanitarian emergency timelines and field constraints.
- Strengthen local-level supply accountability by clarifying country office staff and partner roles, conducting regular stock audits and enabling country office-led tracking of commodity movement, ensuring last-mile delivery of humanitarian commodities in accessible areas. This entails ensuring that country office staff correctly and timely apply the EPPs during scale-ups and existing Last Mile Assurance (LMA) processes and tools.
- Contribute effectively to the inter-agency logistics cluster's efforts to expand pre-identified and new delivery routes, including cross-border modalities for access constraints states.
- Under the HCT, strengthen advocacy and negotiation for improved United Nations collective warehousing, transport and supply systems and addressing of external barriers. This will also require significant support from the regional office, HRD and SCMU.

Recommendation 4: Adaptation to evolving needs

UNFPA should strengthen its adaptive capacity by implementing differentiated programming strategies for acute and protracted needs in diverse local contexts including humanitarian access realities, underpinned by real-time data, flexible programming modalities and proactive operational planning that responds to Sudan's shifting conflict dynamics and socio-cultural diversity.

1) Priority: High
2) Timeline: Short
3) Based on conclusions: 1, 2
4) Directed to: UNFPA country office in collaboration with the regional office and HQ

Actions:

- Based on the UNFPA Priority Emergency Response Interventions Guidance (2025), adapt different operational programming models (e.g. CVA, mobile teams, life-saving prioritization, static clinics, cross-sectoral linkages, intersectional vulnerabilities, resilience building and integration of services) according to humanitarian needs and operational context.
- Update the country office response strategy and operational plan to include differentiated programming and intervention packages that meet the differentiated and intersecting vulnerability needs and that are adapted to diverse subnational socio-cultural and operational contexts.
- Scale up CVA, particularly in hard-to-reach and conflict-affected areas, to reach those most in need, prioritize vulnerable populations and support IDP returnees (contingent upon funding).

- Align UNFPA Sudan's delivery capacity with its humanitarian ambition while also considering prioritization frameworks.

Recommendation 5: Strengthen monitoring and accountability

The country office should strengthen its existing M&E systems based on the HRD's newly released Humanitarian Data Framework - a Guide for UNFPA Field Operations to facilitate real-time collection and use of humanitarian data for decision-making and response. The updated country office M&E systems should be designed to facilitate timely needs analysis (including population dynamics and vulnerability assessments), real-time performance monitoring, TPM integration, outcome tracking and meaningful use of community feedback.

1) Priority: Medium
2) Timeline: Short
3) Based on conclusions: 2, 3, 7
4) Directed to: UNFPA country office with support from ASRO and HRD

Actions:

- Ensure that all M&E and programme staff are familiar with the content of the new HRD Humanitarian Data Framework and know that it is being actively used for revising and updating country office M&E systems to strengthen country office adaptation of M&E in humanitarian context.
- Adapt RRF indicators and milestones tailored to the Sudan crisis contexts, including population movement, service coverage and vulnerability dimensions. This should include establishing higher-level indicators to go beyond activity tracking and assess whether needs are being met effectively and UNFPA Sudan contributes to the 3TRs.
- Integrate real-time performance monitoring tools (e.g. mobile data collection, dashboards, updating and strengthening the existing DHIS2 monitoring system, TPM) that provide disaggregated vulnerability data (by sex, age, disability, displacement status and other relevant factors, ensuring findings feed directly into programme adaptation).
- Digitizing (remote and/or physical) field monitoring (real-time) to adaptive planning based on updated data and periodic reprioritization with the support of Information Technology Solutions Office.

Recommendation 6: Accountability and participation of women and girls

UNFPA should institutionalize inclusive and accountable humanitarian programming by systematically strengthening participation and feedback mechanisms for women, girls and other vulnerable populations through accountability for affected populations mechanisms. This will require structured engagement with local partners, improved community engagement structures, and integration of LNOB and AAP into planning, delivery and monitoring.

1) Priority: Medium
2) Timeline: Short
3) Based on conclusions: 2, 3, 7
4) Directed to: UNFPA country office and IPs, M&E and programme staff

Actions:

- Institutionalize inclusive targeting strategies by co-developing inclusion criteria with affected communities and IPs through participatory approaches, such as community consultations, FGDs and ensuring feedback loops.

- Integrate principled access and LNOB frameworks in operational planning, ensuring that access negotiations and site selection explicitly consider the needs of underserved and hard-to-reach groups.
- Strengthen existing AAP mechanisms (e.g. hotlines, complaint desks, community committees) to collect, analyse and inform programme adaptations, including embedding actionable feedback loops with pro-active programme revisions.
- Embed participation indicators into M&E systems to monitor the extent and quality of engagement of women, girls and vulnerable groups.

Recommendation 7: Partnerships and localization

UNFPA Sudan should further strengthen its localization efforts by developing and implementing a conflict-sensitive and context-specific localization strategy and operational plan based on the principles of the Grand Bargain and the UNFPA guidance note to operationalize UNFPA humanitarian localization commitments. This should aim to enhance shared ownership, local response capacity, risk sharing, sustainable funding modalities and build long-term resilience in both acute and protracted crises. This will require the guidance and support of the regional office and HQ.

1) Priority: High
2) Timeline: Medium
3) Based on conclusions: 9
4) Directed to: UNFPA country office and IPs, HCT

Actions:

- Develop a country office localization strategy based on the UNFPA guidance note to operationalize UNFPA humanitarian localization commitments and through a consultative process with key stakeholders, including IPs and local organizations. Such a localization strategy should be aligned to and operationalized through the new CPD and UNFPA humanitarian response plans.
- Ensure co-ownership in programme and workplan design, implementation, review and adaptations, ensuring that local partners, including WLOs, youth groups and civil society organizations, participate in all stages of the humanitarian response and integration of humanitarian, development and peace programming under the new country programme.
- Facilitate structured learning and peer exchange opportunities among local and international partners to strengthen programming, managerial and implementation capacities.
- Incorporate flexible contingency budgets within annual workplans to enable rapid scale-up in acute localized emergencies and during activation of UNFPA EPPs and/or IASC scale-ups.
- Implement shared risk management approaches, including shared risk assessments, scenario planning and risk mitigation plans based on UNFPA policies and procedures.
- Based on a comprehensive conflict-sensitive analysis, continue building consortium partnership models that pool capacities and resources, particularly with WLOs, to broaden reach and improve sustainability.

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