Provision of primary health care services in Kulbus Locality in West Darfur

Final evaluation report

Conducted in August 2014

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Acronyms

AFP	Acute Flaccid Paralysis
ARI	Acute Respiratory Infection Emergency
AWD	Obstetric and Acute Watery Diarrhoea
CHW	Community Health Worker
COSV	Coordinamento delle Organizzazioni di Servizio Volontario
CRS	Catholic Relief Services
EmONC	Emergency Obstetric-Neonatal Care
EWARS	Early Warning Assessment and Reporting System
FGD	Focus Group Discussion Project
GAVI	Global Alliance for Vaccine Initiative
GBV	Gender Based Violence
GFATM	Global Fund to combat AIDS, TB and Malaria
KAP	Knowledge Attitudes Practices
MO	Medical Officer
MA	Medical Assistant
MW	Midwife
MoH	Ministry of Health
NHSSP	National Health Sector Strategic Plan
OCHA	Office for the Coordination of Humanitarian Affairs
PE	Peer Educator
PCA	Procurement Coordination Agreement
RTI	Reproductive Tract Infection
SCM	Standard Case Management
PHC	Primary Health Care
PHCC	Primary Health Care Centre
PHCU	Primary Health Care Unit
SMoH	State Ministry of Health
UNICEF	United Nations Children Education Fund
UNAMID	United Nations Mission In Darfur
UNDP	United Nations Development Program
UNFPA	United Nations Fund for Population Assistance
WASH	Water, Sanitation and Hygiene

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1. Executive summary

The 14 months project *Provision of primary health care services in Kulbus Locality in West Darfur* was funded by the CHF and implemented by the NGO COSV in Kulbus Locality from 1st July 2013 until 31st August 2014, in active collaboration with SMoH, UNFPA, and UNICEF. The project aimed at reducing morbidity and mortality among highly vulnerable population with the improvement of the quality of integrated primary health care services provision in 12 PHCUs and 1 PHCC in Kulbus Locality. The project was implemented in fruitful collaboration with the SMoH, UNICEF, UNFPA, Nahda, and all concerned stakeholders.

This was pursued with an integrated approach that combined the provision of integrated PHC services with the support to the referral system and stakeholders' coordination, capacity building, drugs and equipment provision, structural rehabilitations and constructions' upgrades, community mobilisation and participation. The combination of these components was successful, promoting mutual reinforcement and positive synergies among achieved results. Integrated PHC services approach was also combined with WASH approach.

The conception of the intervention is relevant to Country, State and Locality priorities, to organisational strategies and action plans, and it responds to beneficiaries' urgent and priority needs. Its design is straightforward and pertinent. However, a few design adjustments could have limited the overlapping of a few targets and enhanced project's monitoring and effectiveness. Beneficiaries and stakeholders are aware and satisfied of the intervention and achieved results.

Mobilisation strategy was fairly effective in promoting beneficiaries' and stakeholders' active participation. In particular, the active involvement of Community Leaders organised in VHCs and of PEs in awareness and health education activities was fairly successful. However, community sense of ownership and participation to PHCUs activities are still quite inhomogeneous and create doubts in terms of sustainability.

Evaluation approach and methodology adapted to stakeholders' availability and interviews' settings. All relevant documents and data were available and fairly complete because of staff turnover of key project's human resources. Beneficiaries and stakeholders interviews were carried out directly on field, adapting them to the settings' characteristics and to time requirements. The adoption of translation for the majority of field interviews might have resulted in the possibility of distortion of the information.

The project accomplished all activities despite the observed delays, mainly caused by the exacerbation of conflicts all over Darfur, by the enhanced insecurity and by the irregularities of the flights to Kulbus Locality. In addition, intervention has a larger number of trainings and health awareness sessions as well as rehabilitations and upgrades than the ones initially planned, as the rehabilitation of the Units of Hajer Assal and of Dohoush.

Observed improvements in the quantity and quality of PHC services, including EPI coverage and RH package, fairly reached the set targets, although some heterogeneity among units' services emerged in terms of quality. Attendance rates, set target on attended deliveries and pharmacy stock out were negatively affected by the insufficient provision of RH kits since February 2014 and partly by security/mobility challenges. Achieved results are remarkable considering the severity of these external challenges. Communities' health and hygiene awareness has improved. Appropriate strategies were implemented to tackle cultural and social resistances to pursued attitudes and behavioural changes.

All trainings were implemented with success, resulting in the pursued improvements in health staff's and PEs' competences. The preparedness and control mechanisms for emergencies and diseases outbreak was reportedly improved. The coordination with SMoH and other stakeholders

is remarkable and fruitful. The involvement of local leaders to projects' activities with their organisation in VHC was fairly successful and should be further widened and strengthen to positively contribute to the impact and sustainability of achieved results. Referral system was improved and is still in need of further reinforcements to become fully operational and sustainable.

The intervention created aimed improvements in PHC care services including RH package, EPI coverage, capacity building of health personnel, communities' health awareness, and preparedness and control mechanisms for emergencies and diseases outbreak, and ultimately resulted in improved health of Kulbus population.

Project strengthened relevant positive change processes at community levels, in terms of health awareness and improved access to integrated PHC services. However, impact and sustainability of results and benefices might encounter a number of challenges, namely: the SMoH's lack of adequate resources, the archaic and patriarchal gender roles and rules, the traditional beliefs and taboos hampering the effectiveness and impact of aimed behavioural changes at community level, the "dependency" that communities have developed on external help which hampers their active participation and ownership in activities and results. The poor access to water sources, poor education opportunities, the volatile security and general underdevelopment of the area, besides its proximity to Chad, the steady decrease in international funds' availability, all these might also affect the potential impact and sustainability of project's achievements.

THINK2 and newly funded CHF projects are taking over project's beneficiaries and results, and will continue reinforcing weaker or challenging components. Attempted recommendations search to resume components or results that the abovementioned actions might enhance and reinforce. Recommendations also attempt the identification of possible suggestions for future interventions, in order to capitalise project's strengths and reduce potential weaknesses and challenges. Main recommendations are listed as follows. Collaboration and support to SMoH in the provision of PHC services in Kulbus locality, including EPI, laboratory, and capacity building, should be continued and widened, in both quantitative and qualitative terms; clarity in project design might be improved, especially in terms of targets and outcomes identification. Drugs and kits chain provision could be further improved, with the anticipation of seasonality challenges. Human resources' system and capacities should be further reinforced; in particular, monitoring and reporting competences of COSV's and Nahda's field staff should be further improved. VHCs should be further strengthened and communities' awareness, participation and ownership continuously strengthened, particularly focusing on gender roles and gender division of labour. Geographical and gender distribution of PEs should be improved. Advocacy efforts to encourage additional resources allocation for PHC and for structural needs of the area (e.g. roads) and to strengthen the HR policies and professional role at Kulbus Locality of MWs and PEs should be put in place to improve potential impact and sustainability of achieved results and benefices. The funding of WASH micro-project should be prioritised in the framework of future actions besides the development and implementation of adult literacy interventions: all these could strongly contribute to improve the potential durability and effectiveness of the achievements in the medium and long term.

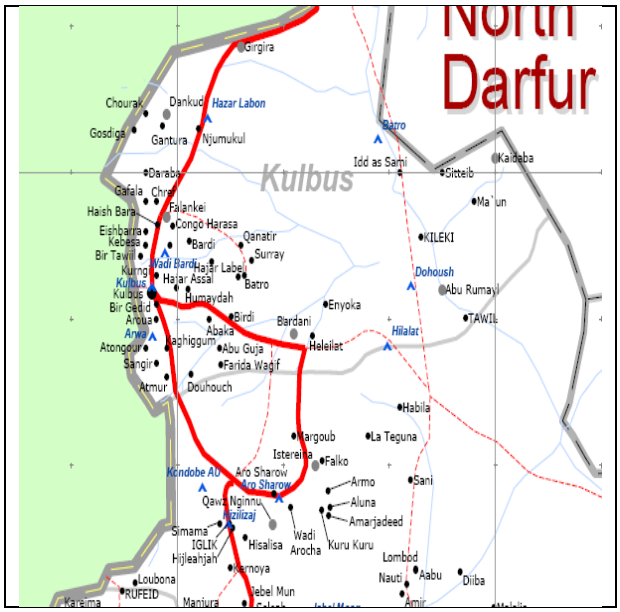
2. Introduction

2.1. Background and status of project

The project *Provision of primary health care services in Kulbus Locality in West Darfur,* funded by the Common Humanitarian Fund, has been implemented by COSV in collaboration with SMoH, UNICEF, UNFPA and the local organisation Nahda in 1 PHCC and 12 PHCUs in Kulbus Locality, situated in West Darfur at the border with Chad.

Darfur has been witnessing rebel and ethnic confrontations resulting in violence, death, and displacement since 2003. All these are rooted in a complex history of deeply entrenched social inequalities, environmental crisis and competition over natural resources, conflicting identities, militarisation of rural societies, together with the country-wide poor infrastructure, high unemployment rate, weak property rights, corruption and chronic political instability.

Agriculture, casual labour, trade and cattle herding are the main economic activities in Kulbus Locality[1]. Cultivation heavily depends on rainfall and land fertility. Population is therefore highly vulnerable to climatic changes and natural disasters. Conflict between pastoralists and sedentary farmers has been an important cause of the Darfur crisis besides a long history of ethnic marginalisation by Sudan's ruling elites. Darfur has also suffered from the instability of its neighbours, particularly Chad and Libya.



"The Darfur crisis, which has flared up in 2003, is still a challenge to the government and its partners. The signing of the Darfur Peace Agreement in Abuja 2006 has brought hopes of resolution to the conflict and initiated a recovery process. However, the situation is still fragile"[2].

West Darfur has witnessed high rates of injuries, resulting from Ethnic conflicts among the populations and sporadic rebel attacks that still occur in Kulbus locality. Relative calm characterised the year 2011 following cessation of military conflicts. However, security situation in West Darfur has been worsening since then, especially in Jebel Moon, Kerenik, Sirba, and Mornei. Situation in Kulbus Locality has been relatively calm, with some sporadic incidents except for Dar Moktar, Hililat and Adawie areas, where security has been challenging.

Recurrent disease outbreaks, and in particular Polio, Meningitis, Measles, Whooping cough and Cholera, and in recent years also Yellow Fever, have been affecting the area. Moreover, access to primary health care services of populations from remote areas, provision of maternal care, Accelerated survival Initiatives, including IMCI, EPI, all have been poor and not fully responding to the actual needs of the population. Children and women are the most vulnerable components of the population, and therefore the ones mainly affected by the negative effects of the crisis, in general, and by the poor PHC services, in particular. In fact, it has been claimed that Kulbus has the second highest maternal mortality rate in the Country[3].

[1] COSV, KAP Survey - Kulbus Locality - West Darfur - Sudan *KAP survey on PHC's main components and Outbreak preparedness in Kulbus – the clients' perspective,* December 2013.
[2] Human Resources for Health (HRH) – Strategic Work Plan for Sudan (2008 – 2012) – A Report for the World Health Organisation (WHO) and the Federal Ministry of Health (FMOH)/Sudan, December 2007.
[3] According to UNFPA Team Leader – Genina in the framework of an interview carried out in July 2013.

The already limited and overburdened health services in Kulbus have witnessed increasing pressure because of population movements resulting from returnees, IDPs movements, and also Chadian crossing the border, both in past and in recent times. The inadequate financial and human resources at Kulbus Hospital, run by SmoH, could not respond to the primary health care needs of Kulbus Locality's population. Moreover, SmoH does not have sufficient resources to support PHC services in remote areas and still faces difficulties in providing adequate secondary care, in terms of human resources, services, and drugs' and equipment's availability. It is important to highlight that SMoH has the technical competences and determination to improve and widen the health services. This will and effort find in the inadequacy of funding, infrastructures, and insufficient quantity of trained human resources their main challenges.

COSV collaborates with SmoH and other institutional partners in responding to Kulbus Locality's PHC needs since it arrived in that area in 2004. Since then, COSV has steadily upgraded existing units, and built new ones, progressively extending and strengthening PHC coverage to larger catchment areas. COSV's action has continuously supported PHC services in Kulbus with personnel and capacity building, facilitating access to essential drugs and equipment, supporting EPI routine and accelerating campaigns, raising awareness and behavioural change in health with IEC activities.

Kulbus locality has also benefited from the action of CONCERN and CRS, respectively in WASH, nutrition, agriculture and livelihood, and in education, WASH in schools, and blanket food distribution. However, the actions of these international partners have known a consistent reduction in their scope during recent times.

This project *Provision of primary health care services in Kulbus Locality in West Darfur* constitutes a sound continuation and reinforcement of COSV's action in Kulbus Locality. It aimed at contributing *to reduce mortality and morbidity among a highly vulnerable population in Kulbus Locality in West Darfur* through *the improvement of the quality of integrated primary health care services provision in 12 PHCUs and 1 PHCC in Kulbus Locality*. The approach to these medium and short-term objectives has been promoted throughout the pursued expected results listed as follows:

R1 Increasing quality of the service in one PHCC and 12 PHCUs in Kulbus Locality providing health services for men and women;

R2 Strengthening preparedness and control mechanisms for emergencies and disease in coordination with SMoH Hospital, local community committees and local authorities through also a gender focus training and activities;

R3 Increasing capacity of the health staff of the PHCC and PHCUs (Medical Assistant, EPI team, VCT, midwives, community health workers, nurses, health promoter);

The project supported the provision of basic package of PHC integrated services in one PHCC at Kulbus town and 12 PHCUs namely: Hajar Assal, Rahat Rahma, Dohoush, Arwa, Batro, Wadi Bardi Village, Wadi Bardi IDPs, Mastora, Andussa, Hajar Leban, Adawi and Helilat. This has been carried out with the followings:

- provision of essential drugs, equipment and furniture;
- provision of basic RH service package at the centre and at the units, comprising ANC, assisted delivery, PNC, FP, increasing awareness on GBV, STIs, HIV/AIDS, and emergency interventions;
- support to the MoH in the implementation of national and routine vaccination campaigns and activities;
- promotion of communities' health awareness and positive behavioural changes through the implementation of health awareness sessions, home visits, health events;
- continuous training and retraining of health staff, MWs and PEs, implemented throughout a gender sound approach and with gender-related specific workshops;
- support in strengthening preparedness and control mechanisms for diseases outbreak with all

key local, national and federal stakeholders;
- support to the awareness creation, participation and capacity building of communities' leaders in PHC and preparedness and control system;
- improving the quality of the health services with the rehabilitation of the delivery room at the PHCC and Batro unit;
- strengthening the referral system through the establishment of a Community based Referral mechanism for Emergency Obstetrics;
- strengthening of local partners' competences with Capacity Building in program management.

Overall project funding is USD 200.000,00, financed at 100% by the Common Humanitarian Fund Sudan.

The intervention was conceived to follow up, widen and strengthen the achievements of the project *Provision of primary health care services in 12 PHCUs and one PHCC in Kulbus Locality, West Darfur*[4]. The action aimed at targeting with comprehensive PHC services the entire population of the catchment area, that was initially estimated at 24721 individuals (10520 women), corresponding to the average half of the entire Kulbus Locality population[5]. Also, the project aimed at targeting:
- 4733 children U5 (F: 2840, M: 1893) with PENTA3 vaccinations;
- 61 human resources (35 Health staff + 12 PEs+14 hospital health workers) with capacity building activities;
- 40 local stakeholders (35 VHCs + 5 Local Authority - 12 of them women) with capacity building activities.

The action started on 1st July 2013[6] and initial end was set at 31st December 2013. CHF then granted a blanket no-cost extension of 3 additional months, extending it until 31st March 2014. Project management asked an additional no-cost extension of 5 (five) months together with a no-cost budget revision on 13th March 2014. The overall length of this intervention has therefore become *14 months*. The no-cost extension has been necessary in order to address some basic delays in the implementation of the activities as well as reallocate non-spent budget that had resulted from the followings:

- Difficult accessibility to Kulbus Locality throughout the period starting from September 2013 until the beginning of February 2014, resulting in hampered mobility of local staff and difficult implementation of adequate monitoring from local and international staff,
- insecurity hampering the access to some of the targeted communities, especially during February and March 2013[7],
- key health staff turnover,
- lack of prompt availability of professional health personnel from Kulbus area and West Darfur to replace resigning key staff;
- slow recruitment process to fulfil GoS Labour Law and procedures,
- dramatic depreciation of the Sudanese Pound during 2013, resulting in favourable exchange rate and augmented financial resources with respect to the initially planned and budgeted ones;
- efficient use of financial resources in the framework of co-funding.

Main amendments resulted in the followings:

[4] Project funded by the CHF 2012, which started 1st March 2012 and ended 31st July 2013.
[5] This beneficiaries' number estimates was grounded on the initial length of the project at 6 (six) months.
[6] Actual signature of the contract occurred on 4th April 2013 from UNDP's side and on 28th April from COSV's side. The actual initiation of the project waited the conclusion of the ongoing CHF-funded project which occurred in July 2013.
[7] The areas of Helilat and Adawie seem to constantly face these insecurity challenges. Moreover, Wadi Bardi area witnessed a rebels' attack to the joint Chadian-Sudanese forces on 4th March 2014, on the one hand, and the entire West Darfur a dramatic violence escalation during the same period. Although Kulbus Locality remained relatively calm, international staff's mobility was heavily limited during those weeks.

- the budget for rehabilitation works initially aimed at improving Batro Unit and PHCC's delivery room has been shifted to the improvement of Kulbus hospital's delivery room/theatre. In fact, the delivery room of Batro had already been rehabilitated in the framework of COSV's project funded by CHF 2012[8]. In addition, the rehabilitation of the PHCC's delivery room for emergency cases was deemed unnecessary, considering its proximity to Kulbus Hospital. Moreover, this budget line was also partly devoted to improve the Units of Dohoush and Hajer Assal, which were also in need of rehabilitation work;
- additional capacity-building of health staff and awareness activities;
- removal of the budget line to fund the training for three new village MWs, as this activity was already funded in the framework of the previous CHF-funded project;
- decrease of the budget lines covering the resigned staff;
- decrease of the budget lines covering the satellite mobile phones, as the number of Thurayas had been diminished from three to two, following the common mobile line coverage from Sudani provider throughout 2013, and the newly introduced Zein provider coverage since the beginning of 2014;
- increase of the budget lines covering partner's salaries, following the increased number of worked months.

Finally, Project Management asked for a last Allocation Revision on 18th August 2014 in order to promptly adjust financial costs' budget line in response to the enhanced financial costs that COSV has faced since April 2014. In fact, "all major European banks stopped all financial operations inward and onward the Republic of Sudan (since that date), resulting in a veritable financial embargo". Since then, COSV has managed to receive money through private money transfers services from COSV's Nairobi Office with considerable difficulties even in doing so, and incurring in enhanced financial fees that were not initially forecasted in the original Financial Allocation. Named Allocation Revision asked to decrease the Generator Budget line of -799,51 USD and reallocate that amount to the Financial costs' Budget Line of +799,51 USD, enhancing the total amount of that Budget line to USD 1.900,76. The Budget revision promptly received formal approval on 25th August 2014.

The action was conceived and implemented complementarily with the project *THINK – Total Health Integrated Network in Kulbus*, funded by the EU and implemented by COSV from 1st January 2012 until 30th August 2014, with the other CHF-funded nutrition project *Establishment of basic nutrition programme in Mastora, Rahat Rahma, Hajar Assal PHCUs and Kulbus PHCC, at Kulbus Locality, West Darfur,* implemented by COSV from 1st March 2012 until 31st March 2014, and with the project *Supporting and Enhancing Reproductive Health Referral System in West Darfur*, funded by UNFPA and implemented from February to January 2014[9]. The three interventions were developed and implemented in order to mutually reinforce and strengthen each other, creating synergies that have jointly supported the effectiveness, impact and sustainability of achieved results and benefices. The evaluated action is presently ended, and its results and benefices are being taken over and will possibly be further widened and strengthened by the project *Promotion of maternal and child health in Kulbus Locality, West Darfur*, financed by the EU[10] and the action *Support to primary health care services for vulnerable people (women, children, IDPs, and returnees) in the Kulbus and Jebel Moon localities, West Darfur*, funded by CHF 2014[11].

[8] This activity was introduced with NCE towards the end of that intervention, and present project had already been approved.
[9] Official implementing dates were from 26th February to 26th June 2013, as indicated in the MoU between COSV and UNFPA. However, COSV received authorisation, by e-mail and orally, to proceed with the implementation of activities "as long as they were within the framework of the approved activities".
[10] This EU-funded project, also known as *THINK2*, was at the final stage of the approval process while this Final Evaluation was ongoing. That action is supposed to start in September 2014 and last for 24 months.
[11] This CHF-funded project has an initial duration of 6 months.

2.2. Methodology of the evaluation

The evaluation was aimed at assessing intervention's outcomes and achieved results, in quantitative and qualitative terms, according to relevance, efficiency, effectiveness, sustainability, and impact criteria. Particular attention was paid in assessing the strengths and weaknesses, in the identification of successes and shortcomings, with a special focus on impact and sustainability issues, in order to attempt possible recommendations for the immediate future and for forthcoming interventions. Moreover, the evaluation aimed at appreciating the methodologies and approaches adopted throughout the project, in order to identify best practices and eventually shortcomings.

The evaluation was carried out in August 2014 by a single consultant. Evaluation Methodology has adopted a variety of techniques, combining **documents and data review and analysis, open and semi-structured interviews, field visits,** and **direct observation**. Interviews were carried out individually or in-group, adapting the technique to the time available and to the settings.

Initial review and analysis of project's main documents was carried during the evaluation initial phase in Italy and in Sudan at COSV Khartoum Office, in order to efficiently utilise the time necessary for HAC to grant the consultant's travel permit to the West Darfur State. Additional relevant project documents were collected once arrived in Geneina and then in Kulbus, in West Darfur. Reviewed data and documents permitted to enhance and update information of the main Federal, State and Locality's development policies and strategies, as well as of the implementing organisations, of the intervention, of its achievements, of its main challenges and successes.

The majority of interviews with key actors, stakeholders and beneficiaries[12] were mainly conducted in Kulbus and Genina, individually and in-group. **Interviews** were paramount in order to: 1) gather first-hand insight on project's perceived benefices; 2) assess the extent of achieved results' effectiveness and sustainability; 3) identify possible gaps or major weaknesses of the project and/or of its components; 4) appreciate its successes and best practices; 5) identify main recommendations, in order to strengthen and widen achieved benefices, as well as to improve/tackle assessed weaknesses in the framework of future homologue interventions; 6) appreciate the impact of achieved benefices wherever possible; 7) identify gaps or strengths for results' and benefices' sustainability in the medium term.

A number of **field visits** was carried out[13], in order to directly appreciate the achieved results and benefices throughout the improved staff's knowledge and competences, the improvements of health units and health awareness, and ultimately the improved health service provision. Field visits were also conducted to meet key stakeholders and beneficiaries directly in their living and working environment.

Debriefing to COSV Country Representative has been carried out on a daily basis. Final evaluation findings were then fully discussed in this report.

2.3. Limitations and challenges of the evaluation

The final evaluation encountered a number of challenges. Main ones are listed as follows.

Language and translation
The majority of field interviews was carried out with the support of a translator. This has often led to **lack of complete control on the interviewing process** and dynamics when translation was

12 See Attachment N. 3 - List of consulted persons.
13 The consultant visited the PHCC in Kulbus town and the PHCUs in Wadi Bardi IDP, Wadi Bardi Village, Hajar Assal, Rahat Rahma, and Arwa.

necessary. Some information provided during the interview might have been lost along the translation process or distorted.

Cultural and positions-related obstacles
Questions were initially developed in a non-directive manner, in order to avoid suggestions to the interviewees. Questions had therefore a quite abstract character. The evaluator had to adjust questions during the interviews with the interlocutors in Kulbus, as **abstract and generic questions were not often understood**. The evaluator believes that these adjustments were appropriately carried out, carefully avoiding the suggestion of the answers to the interlocutors. However, some distortion or suggestion in the interviewing process might have occurred. The results of interviews were generally satisfying at the end of that process in terms of quantity and quality of information provided.

Staff characteristics and turn over
- UNICEF's new Health Focal Point in Genina just arrived to cover that position while the final evaluation was ongoing. The Consultant deemed unnecessary to proceed with the interview to that stakeholder.
- Similarly, UNFPA new Focal Point in Genina just arrived to cover that position. The Consultant deemed unnecessary to proceed with the interview to that stakeholder.
- **COSV field staff underwent major turn over** during the project life. Therefore, key staff that served during the first part of the intervention[14] was not available for interview. On the other hand, all necessary data and statistics were available, as present key staff, and especially the Health Coordinator and Medical Officer, had implemented a systematic data and statistic monitoring and revision effort. Also, they were interviewed and were able to account for the second half of project life.

Security and seasonality challenges
New security procedures, enforced in all Darfur since April 2014, require the police escort to any expatriate visiting Darfur Localities. A police escort was therefore promptly organised by Project Management. Police's presence has slightly slowed down the step of the field visits, but the attained achievements in quantitative and qualitative terms are deemed adequate.

On the other hand, the final evaluation was carried out during the rainy season, when heavy rainfalls can result in *wadi* suddenly flooded in few hours and consequently in accessibility challenges to some of the Units. This occurrence happened during the field mission, and the unit of Dohoush could not be reached because of mentioned accessibility obstacles. However, the Unit of Arwa was visited in place of the one of Dohoush.

The evaluator was able to interview only part of the project field staff because of the large number of personnel involved in the action, on the one hand, and because of security and seasonality factors limiting the accessibility of some units, on the other. Also, the Consultant could interview only one village MW because of the following reasons:
- All MWs were engaged in a two-day training while the field part of the final evaluation was ongoing, and their interviews could not be carried out during those days.
- Arwa's MW was on leave and could not be interviewed when the Consultant was assessing that Unit.
However, the majority of relevant health and field staff was available and collection of relevant data and information was sufficient to accomplish this evaluation.

Main evaluation challenges were promptly overcome because of the tireless collaboration of COSV staff and stakeholders.

[14] We are here referring to the previous Field Coordinator and previous Medical Officer, who left respectively in December 2013 and March 2014.

3. Findings and evaluation outcomes
3.1 Project design

Project **design's choice of results** to be pursued throughout the implementation of identified activities has proved to be **pertinent**. It responds to an appropriate correspondence between identified needs/problems and objectives.
Project design is straightforward and is grounded on the implementation of appropriate activities responding to urgent needs, namely: 1) insufficient health care services and care practices in the target area; 2) still weak health staff capacities, in quantitative and qualitative terms; 3) still weak preparedness and control mechanisms for emergencies and disease control. However, **some inconsistencies and lack of clarity have emerged in the Log-Frame,** namely in overlapping between some OVI (Objectively Verifiable Indicator),as follows:
- Overlapping between OVI (Objectively Verifiable Indicator) of activity 1.2, of activity 1.5 and OVI2 of R2 has emerged. More tailored OVIs could be developed to account for these activities- Overlapping between OVI of SO (Specific Objective), OVI1 of R2, and OVI of activity 2.1 has emerged. More tailored and diversified OVIs could be developed to account for these

3.2 Project relevance

Sudan's health system is organised in three layers following on the decentralisation reform occurred in the 1990s: Federal, State and Locality. The Federal Ministry of Health (FMoH) is responsible for the development of national health policies, the overall health planning, human resources' development and international relations. The FMOH also supervises lower levels and is directly consulted in case of emergencies and health disasters. The state ministries of health (SMOHs) are entrusted with the planning, management and delivery of health services, and with the development and management of activities at state level. The Locality Health Department is responsible for the management and delivery of PHC services, inclusive of environmental health activities (e.g. vector control activities). PHC services are supposed to be delivered through health units, health centres and rural hospitals besides ambulatory services for immunisation programs.

The National Health Sector Strategic Plan (NHSSP 2012-16) is presently the main strategic document guiding and regulating public health in Sudan. It was developed in the framework of the Government's National Development Plan, and it derives its overall orientation from the 2005 Constitution, the previous NHSSP (2007-2011), the 25 Year National Strategic Plan for Health (2003-27), the National Health Policy (2007), and the Public Health Act. The NHSSP identifies three strategic objectives, built on the health related MDGs, the overarching national development policies and the I-PRSP: "1) Strengthen Primary Health Care (PHC) to improve equity in access and expand coverage of health services, especially in the rural areas; 2) Strengthen the referral care by improving the quality and efficiency of hospital services; 3) Ensure social protection, by increasing health insurance coverage, reducing reliance on Out Of Pocket payments and thus providing Universal Health Coverage". However, it has been claimed that the strategy through which the NHSSP proposes to deliver its minimum package of health interventions across the different levels is in need of clarification to be appropriately actualised and effective.

The Human Resources for Health (HRH) Strategic Work Plan for Sudan (2008 – 2012) is another key document, which affirms the Federal and State MoH's strategic HR priorities as follows: to "ensure adequate finance and funding for health work force" and to "achieve the balance towards production of the right number and skill mix of the health workforce". It also confirms the actual trend of a "geographical distribution" biased "towards urban setting" and "especially Khartoum State where 65% of specialist doctors and 58% of technicians are found"[15]. Finally, the National

[15] Joint Assessment of Sudan's National Health Sector Strategic Plan (NHSSP, 2012 – 2016), International Health Partnership, January 2013.

Human Resources for Health, Strategic Plan for Sudan 2012-2016, directly derived from the abovementioned, reaffirms the identified priority and strategies of intervention as follows: support health service needs through adequate HRH planning; develop policies/systems to ensure more equitable distribution of health workers - especially doctors and nurses; improve individual performance management systems; improve production and orientation of education and training towards health service needs; strengthen HRH functions at the decentralised levels.

The project is relevant to national, regional and local priorities, and the **pursued objectives respond to Federal/State/Locality priorities**, as expressed in Official Documents and Strategy Paper[16] resumed above, and confirmed by consulted all stakeholders. Intervention's priorities and strategies also adhere to State and Locality ones, and major Institutional stakeholders' ones. Head of Departments of West Darfur State Ministry of Health and main international partners confirmed the relevance of COSV's intervention in Kulbus locality, and the adherence of its priorities to the acknowledged needs in the catchment area. In addition, territorial choice is pertinent, as project has been located in one of the most remote and undeserved areas of the State, as briefly described in chapter 2.1. **Pursued objectives respond to urgent and priority needs of beneficiaries and all implemented actions have been judged as equally important by all stakeholders**.

Project's **integrated strategy has been successful**. It has promoted the **development of synergies** among the various **activities** and therefore **mutual reinforcement** among intervention's **results**. The combination of PHC service's improvement, personnel and health staff capacity building, with the provision of essential drugs and equipment has been successful. The **support to the referral system and to preparedness and response capacity to disease outbreaks including EWARS, MoH's EPI** activities, **combined with the promotion of community's ownership, attitudes and behavioural changes through awareness activities and active involvement of community and religious leaders** has also been **successful**. The **integration** of **PHC approach** with a **WASH approach,** that has implied attention to sanitation and environmental components, has also been appropriate, although daily access to water remains an ongoing challenge that potentially hampers or diminishes achieved results, especially in terms of promoted hygiene practices.

The intervention has pursued aimed results throughout **community and community leaders' mobilisation** and promotion of their active participation to decision-making processes and activities' implementation by supporting their involvement in Village Health Committees. Mobilisation strategy actively involving Imams, Sheiks, Omdas, Community Leaders and Ackama[17] to mobilise and reach the entire community **has contributed to fairly develop communities'** sense of **ownership** of achieved results and benefices.

Moreover, the project put in place an **IEC strategy** that has combined continuous health awareness activities at the units with home visits and health sessions at village level, besides some celebration and large campaigns day to deliver health messages on a larger scale. **Mobilisation and IEC strategies** have certainly contributed to the **achievement**, or **approach**, of **pursued results and benefices**. PEs suggested that the number and variety of IEC materials could be improved, in order to provide a wider support to their IEC activities.

Gender equity has been transversally promoted with the followings:
- Through capacity building of female human resources (nurses, MWs and PEs);
- With home visits directly targeting female beneficiaries in their households;

[16] Please, see attachment N. 9 for the complete list of consulted documents.
[17] Ackama are women traditional leaders or women representative, Omdas are male traditional leaders, Sheiks are tribe leaders, and Imams are religious leaders.

- Actively sensitising men on crucial aspects like female circumcision, safe delivery and family planning.
However, **Kulbus society is still quite archaic and rigid** in terms of **family and gender roles** intertwined with a number of cultural and traditional believes and practices: all these tended to hamper the full achievement of result R1, especially in terms of RH.
Gender equity has also been directly promoted with capacity building activities 3.3 and 3.4.

All actions were developed and implemented in close collaboration with all key stakeholders, and in particular the MoH, Kulbus Commissioner, HAC, UNICEF, and UNFPA. **All have expressed great appreciation of COSV's action, of all activities, strategies and approaches, and of achieved results**.
Beneficiaries' awareness on and satisfaction for the project and its results and benefices are high. In fact, all stakeholders and beneficiaries deemed COSV's action essential because of the followings:
- it provides support to SMoH PHC service in Kulbus;
- it complements Kulbus Hospital service, while also reducing the pressure on it;
- it strengthens the referral system in Kulbus Locality;
- it sustains capacity building of local human resources;
- it sustains human resources reallocation with financial incentives;
- it has provided PHC in remote and often inaccessible areas;
- it has strongly enhanced rural population's access to PHC in Kulbus and remote areas improving the availability of the services, in quantitative terms, and also facilitating their accessibility with the provision of free services and essential drugs.

All partners, stakeholders and beneficiaries are asking COSV to further strengthen and extend in scope its actions, in order to widen and reinforce results and cover a larger catchment area touching villages and communities that have not been reached yet.

3.3. Project implementation and performance
3.3.1. Efficiency and effectiveness

Intervention created desired benefices in terms of:
- provision of an integrated primary health care service and strengthening of emergency preparedness and outbreak response, through
- increased quality of health services in one PHCC and 11 PHCUs in Kulbus area,
- increased health staff capacity of the PHCC and PHCUs (reinforcing previous and following achievements),
- strengthened preparedness and control mechanisms for emergencies and disease outbreak in coordination with SMoH Hospital, local health community committees, and local health staff and partners.

The total number of targeted beneficiaries and outcomes is wider than the planned one for activities N. 1.1, 1.4, 1.6, 2.2, and 2.3. Activities N. 2.1, 2.4, 2.5, 3.1, 3.2, and 3.3 achieved pursued targets. Activities N. 1.2, 1.3, 1.5, and 3.4 partly achieved set targets and outcomes[18].

Financial efficiency was guaranteed by COSV's compliance to donor's financial, administrative and procurement procedures.

[18] The dynamics and factors that have contributed to all these are fully discussed in the following paragraphs and in the *Detailed presentation of efficiency and effectiveness for each project component according to LF's OVIs.*

All allocated financial resources were appropriately spent. **All planned activities were carried out**. **Additional activities were added** because of budget reallocation: this permitted to widen the scope of rehabilitation and capacity building activities and therefore widen these results.

Units' upgrades were carried out with this intervention. In particular, the opening of the Adawie and Hililat units was carried out, together with the upgrades of Dohoush and Hajer Assal Units. It is important to highlight that the newly constructed Unit of Adareeb, which was not originally mentioned in this project, also benefited from this intervention. In fact, that Unit was built in the framework of the NCE of the previous project *Provision of primary health care services in 12 PHCUs and one PHCC in Kulbus Locality, West Darfur* and was officially opened in October 2013. Adareeb was not indicated in the project proposal as the procedure of approval of this intervention ended various months before its actual initiation. Moreover, Adawi's Unit, which was supposed to be open in December 2013 after the completion of the selection process of the CHW and MW, actually recently opened in June 2014 because of the insecurity that has characterised that area. Also, an EPI solar fridge was in the process of being installed at Adawie Unit. This would then become the EPI storage Unit for mobile activities, and allow serving the underserved Dar Mokhtar area with EPI mobile activities.

The **procedures of recruitment** privileged human resources from Kulbus locality, in compliance with MoH's policy. Part of the health staff is seconded from the SMoH, and part is directly hired by COSV. COSV aims at obtaining direct recruitment of all health staff by the MoH (health staff) and Kulbus Locality (MWs, trained TBAs and PEs) in order to guarantee the positive impact and sustainability of achieved results. All these **contributed to the effectiveness** of the action.

Generally speaking, interviewed human resources have shown **fair technical competence**, communication skills, and fair motivation. Acquired competences are fairly applied. **Heterogeneity** has emerged **in the degree of acquired and applied competences among the consulted CHWs**. In fact, it has clearly emerged during field visits that CHWs have different degrees of capacities.

The **PEs' recruitment and organisation strategy was only partly successful**. PEs' coverage of units is not fully adequate, as some unit does not have any a PE at all (Adawie, Hililat, Wadi Bardi IDP, Adareeb, Andussa, Dohoush), and other units do not have adequate PE gender distribution: Kulbus town has 8 female PEs and no male PE, Mastura has 2 male PEs and no female one, Arwa, Wadi Bardi Village, Hajer Assal and Hajer Leban have respectively one male PE and no female ones, Rahat Rahma has 2 female PEs and no male one. It seems that PEs' activities were run very smoothly, as the communities themselves participated in their selection, therefore accepting their awareness and education activities, regardless their gender. PEs were trained in the appropriate procedures and approaches to tackle sensitive issues. It was claimed by some PEs that shyness might occur, and that certainly some gender sensitive aspects might be tackled more effectively accordingly.

Reorganisation of awareness and education activities' modalities was ongoing, planning wider proportions of mobile activities in order to respond to the ongoing inadequate coverage of awareness activities and improve awareness and education achievements in remote and insufficiently covered areas. Moreover, 13 PE were in the process of accomplishing the official SMoH vaccinators training, and would soon start serving as mobile EPI vaccinators, in order to boost EPI coverage of underserved and remote areas.

Punctuality of planned activities has encountered a variety of **challenges**, listed as follows.
- Genina – Kulbus flights' suspensions and/or irregularities between September 2013 and April 2014 hampered the timing implementation of some of the activities and the adequate monitoring of all activities.

- **Security** has been **challenging**, especially since the beginning of 2014, which witnessed major exacerbation of conflicts throughout all Darfur. Kulbus Locality has known only sporadic incidents, but was affected by population movements and potential insecurity, as insecurity has been worsening all over West Darfur.
- UNICEF did not provide all kits, both in quantity and variety terms, the provision of which was agreed in the PCA covering the period February 2013 – February 2014. This often resulted in shortages of essential drugs. Moreover, **delays in renewing the 2014 PCA with UNICEF**[19] contributed to increase the extent of mentioned challenges. COSV promptly bought them on the market and asked for support to the SMoH, which in its turn also provided some spear kit to COSV. However, on the one hand, some IMCI drugs shortage has occurred in spite of the implemented efforts; on the other hand, **important quantities of drugs** provided by the MoH resulted being **expired or approaching expiration**. Similarly, **shortages of delivery kits**[20] both at UNFPA and at MoH during the last months of the action have hampered the adequate provision of RH services at Kulbus health services' premises. All these together with **insecurity** affected project performance and contributed to limit the adequate implementation of activities 1.1, 1.2, and 1.3.
- A**greement with UNFPA aimed at supporting and improving the referral system** in Kulbus Locality and in the axis Kulbus-Genina expired on February 2014, and was not yet renewed because of UNFPA focal point's turn over. This might have limited the scale of **potential effectiveness** of achieved results, and especially of those under Activities 1.5 and 2.1.
- Staff's **turnover,** and especially the one related to the MO and Health Coordinator, also affected the punctuality of activities, from the inward organisational point of view.
- SMoH's trainers' availability has sometimes been challenging.
- Logistic has often been challenging, especially because of the remoteness of the area of intervention, and because of the abovementioned flights' irregularities and security, ultimately resulting in delays in project implementation.

A number of **challenges** emerged at **human resources**' level.
- Staff **quantity** is still insufficient to ensure service continuity in case of leave or sickness of the present staff and to guarantee awareness and education services in areas that are not fully covered.
- **6 CHWs resulted not having the required CHW official certificate**[21]**,** which is provided by MoH upon completion of the formal course. Project Management was in the process of promptly negotiating an agreed and viable solution[22] to this issue with the concerned Department of the SMoH.
- **Project's human resources' turnover negatively affected project's efficiency and effectiveness. MO's and Health Coordinator's turnover** resulted in a weakening in PHC services and in some i**nconsistency in data organisation and monitoring.** Field stuff's turnover seems to be mainly motivated by the above-mentioned remoteness and perceived insecurity of the area. This also **led to delays** in field activities and **overload** of remaining staff. Negative outcomes related to field staff's turnover was worsened by **slow recruitment procedures** due to the difficulties in selecting trained and competent staff willing to be deployed in Kulbus locality as well as by the Labour Office procedures.
- Project's HR system relies on the presence of all human resources to be fully functioning and results in shortcomings when one of them is lacking.
- SMoH is directly responsible to select local HR (CHWs and MWs) and send them to its

[19] New PCA was not signed yet as the final evaluation was ongoing.
[20] Delivery kits are provided by UNFPA and UNICEF. MoH can occasionally provide them, if spear delivery kits, also coming from UNFPA and UNICEF, are available. Last delivery kits provision occurred in February 2014. First units which run out of delivery kits were Mastura and Kulbus town. Last unit to run out of delivery kit was Andussa one in June 2014.
[21] This aspect was claimed to be known and agreed at the initial phases of COSV's presence and action in Kulbus Locality. However, no written documents were found to attest agreements among COSV and SMoH.
[22] COSV Management was agreeing with SMoH's PHC Dept the following way forward: SMoH will provide substitute CHWs in the needy units while COSV would fund a one year intensive training at Genina SMoH training premises for those CHWs without official certificate. Formal and written agreement was not accomplished yet while the final evaluation was ongoing.

professional training centres: SMoH cannot cover all needs in all remote areas, and availability of HR at local level directly depends on this, hampering the implementation of an adequate HR system;
- SMoH strongly relies on international donors' and partners' support to carry out the above-mentioned key function, and its performance is therefore directly dependent on external resources.

In particular, the above-mentioned turnover of the MO and Health Coordinator resulted in the following negative outcomes:
- delays in the implementation of trainings;
- some delays in the delivery of monitoring reports, especially while the turnover was ongoing;
- difficulties in efficiently implementing monitoring and supervision of the essential drugs'/equipment's availability and consumption, and therefore in fully avoiding the occasional occurrence of essential drugs' stock out.

Some data and report is missing or incomplete, mainly because of staff turnover at COSV and at SMoH. Information gaps were present among the reports of activities carried out by SMoH's trainers, by RedR, and by external consultants. Also, some of these training reports were compiled by the local NGO Nahda, which organised a number of training for COSV in Kulbus. Reporting capacities of Nahda are still showing some weakness in terms of quantity and quality of information provided. Finally, some training was still ongoing during the final evaluation period and the details of these training were not available yet. Details and beneficiaries' characteristics of trainings could not be fully assessed because of all these.

Visibility has shown some weaknesses (e.g. boards not displaying all years of funding or IEC materials still in the process of being distributed to the units) and is in the process of been further improved.

An important **external positive change** occurred during the lifetime of this intervention: **Zain** had joined **Sudani** with the implementation of its **mobile network** in part of the locality, therefore resulting in improved communications capacities both at project and at MoH levels. This is an important improvement for Kulbus locality in general, and for PHC in particular. In fact, mobile network permitted a more efficient and effective capacity to promptly communicate key health information and monitor key health data. Radio, Turayas and satellite connections were the only ways to communicate before Zain and Sudani mobile networks arrived. In general, the implementation of Zain mobile network, which comes now to couple with Sudani network, resulted in improved capacities to communicate in the Locality and with the outside, therefore improving the general living and working conditions in the locality, and certainly the capacity and possibility to better monitor the trends in population's health and diseases outbreak, and to promptly respond to emergency situations.

External factors that contributed to limit project's achievements are listed as follows:
- Increased insecurity all over Darfur.
- Irregular provision of humanitarian flights to and from Kulbus, also hampered by the irregular provision of police coverage of the landing area.
- HAC's recurrent delays in the signature of the technical agreement, which tends to result in a constant degree of uncertainty and in delays in the development of activities.
- HAC's procedures of recruitment imposed to humanitarian organisations for the recruitment of their staff, besides its mandate of supervision of all aspects of NGOs' work, here including the approval of questionnaires in case of surveys' implementation and the approval of travel permits, certainly contributes to strengthen the full adequacy of humanitarian actors to Sudanese procedures and technical requirements, and the full participation of key Sudanese humanitarian actors to the NGOs decision-making process. On the other hand, all these sometimes tend to contribute to delay activities, negatively affecting project's efficiency and effectiveness.

- **Cultural and social resistances** towards promoted health/RH practices. The extent of aimed behavioural changes is still limited by environmental and cultural factors: for instance, PLWs hardly care about their appropriate nutrition, as they are overloaded by their countless duties and do not have time, or sufficient attention, to care for their nutrition and the one of their young children as well.
- Remoteness of the area and **very limited local** logistics.
- General underdevelopment of the area, especially in the fields of education, agriculture, and infrastructure.
- **Input** availability, as already discussed in the previous paragraph when addressing factors that have negatively affected activities' punctuality.
- High drugs and kits consumption in units that borders Chad.
- The capacity of Kulbus Hospital is not at its best yet, and has been facing recurrent lack of drugs, of adequate HRs, insufficient laboratory services[23], and insufficient emergency equipment.
The project has been relaying on Kulbus Hospital's laboratory because only some rapid tests[24] are available at the PHCC and/or PHCUs. The efficiency and effectiveness of the intervention might have encountered some delay and limitation because of this and because of the just mentioned Hospital's limited capacity. In fact, COSV is evaluating the possibility to develop a lab at the centre in Kulbus in order to enhance the quality of its action, on the one hand, while reducing the pressure on Kulbus hospital capacity, on the other.

Kulbus Hospital's s **EPI fridge, and solar system** to run it, is in need of major maintenance because it is quite old[25]. This might have contributed to hamper the achievement of pursued results and benefices in terms of vaccination coverage, although achieved results are very positive.

Referral system is also strongly challenged by external factors:
- poor, or lack of, roads,
- very poor, or lack of, public transportation hampering the mobility of patients,
- MoH's poor logistic means and resources,
- insecurity of roads[26],
- the above-mentioned weak capacity of Kulbus Hospital.
COSV has been responding to these challenges actively supporting the MoH[27]. However, the referral system is still far from being fully operative, as it directly depends on COSV's support, which in its turn depends on UNFPA's funds.

Limited access to education opportunities, both in quantity and quality terms, in Kulbus locality certainly contributed to hamper adequate availability of fully literate local human resources: certainly, this might have hampered the accuracy of record keeping and the monitoring of essential data (e.g. accuracy of data keeping, accountability of drugs consumption, full reliability of the statistics).

Doctors' availability is challenging in West Darfur, and this has affected the quantity and quality of health care in the area. For instance, Kulbus hospital has only one doctor also serving as Hospital Manager. This often resulted in inadequate human resources to respond to emergencies and in additional burden to COSV's MO[28]. This is related to the remoteness and potential insecurity of the area: the majority of medical doctors prefer to spend short amount of

[23] Head of PHC Dept of SMoH suggested that COSV could upgrade its PHCC with lab basic service provision.
[24] Mainly rapid Malaria, urine, and pregnancy tests.
[25] It was donated and installed by UNICEF in 2004.
[26] Ambulance referring cases from Kulbus to Geneina has always to be escorted by armed officials in order to possibly avoid armed attacks. Also, international staff is not allowed to travel by road.
[27] One ambulance has been repaired and is now functioning at Kulbus; other 2 ambulances were repaired with UNFPA funds; COSV has also provided some financial resources to the hospital to cover the expenses of referrals to Genina in the period September 2013 – February 2014
[28] COSV's MO has been promptly available to support Kulbus Hospital in case of emergencies or critical cases, when a doctor was not present at the Hospital, or when the hospital doctor was not sufficient to respond alone to the occurring emergencies.

times in West Darfur and be then relocated to Khartoum as soon as they find an opportunity there. Also, MoH's salaries are not as attractive as NGOs or International Organisations' ones. On the other hand, MoH provides other kind of incentives to its staff, as the possibility to work in private clinics, the provision of scholarships, and it seems that the working experience with the MoH is deemed more valuable than the working experience with NGOs at CV level. However, some of these incentives, and especially the possibility of having private clinics while also serving in the public health service, seem to contribute in hampering the adequate provision of health services instead of boosting it.

S**hortage of or delays in funds/donation provision of main donors/international partners**, and especially UNICEF and UNFPA, during 2014 has led to essential drugs' and equipment's shortages and therefore in recurrent stock out of essential inputs, on the one hand. On the other, the referral system supported by COSV with UNFPA funds was halted since March 2014 as UNFPA has signed a new agreement yet.

Despite the encountered challenges, WHO monitoring visits[29] assessed COSV's PHC services in Kulbus locality in very positive terms.

[29] Named monitoring visit was carried out in the framework of CHF13-funded project's monitoring on 13th March 2014.

Detailed presentation of efficiency and effectiveness for each project component according to Log-Frame OVIs[30] (Objectively Verifiable Indicators) is presented as follows.

Result 1: Increased quality of health services in one PHCC and 12 PHCUs

All activities were carried out, all targets are fully achieved except for OVIs of activities 1.2, 1.3 and 1.5.

PROJECT DESCRIPTION	INDICATORS	OVIs TARGET	OVIs at WHO monitoring mission	OVIs at Final Evaluation	OBSERVATIONS
R1. Increased quality of the service in one PHCC and 12 PCHUs in Kulbus Locality to provide primary health services for men and women.	15780 outpatient consultations per all health facility (direct beneficiaries receiving the service) during the 6 months of project implementation One delivery room at the PHCC has been rehabilitated and equipped during the 6 months of project implementation.		Delivery room was already rehabilitated for Kulbus hospital including the theatre[31].	51,544 cases were assessed and treated in Kulbus Locality Health facilities supported by COSV during the reporting period, 20,610 of which were U5 patients cases. Rehabilitation at Dohoush and Hajer Leban Units completed	Target largely achieved. Target largely achieved.
1.1 Provision primary health care services through 12 PHCUs and one PHCC in Kulbus locality, including the ANC and PNC services for Women.	1.2 utilization rate per beneficiaries per 6 months.	24721 people (10519 women)	From 1st July 2013 until January 2014: 41,455 adults (19,617 men and 21,838 women) and 26,637 U5 (12,487 boys and 14,150 girls) (target exceeded). Increased trend of consultation due to new displacements and patients from Chad	51,544 cases were assessed and treated in Kulbus Locality Health facilities supported by COSV during the reporting period, 20,610 of which were U5 patients cases.	Target achieved in terms of number of consultations. Utilisation rate could be roughly estimated through WMMB and RH forms, as re-utilisation is not indicated.

[30] Data from: Individual and group interviews; field visits; Project Proposal; Project Budget and Project Budget reallocation; Project no-cost extension; Narrative Progress Report (Interim Report) – 29th April 2014; Report of KAP Survey on PHC's main components and Outbreak preparedness in Kulbus Locality – the clients' perspective / KAP Survey - Kulbus Locality - West Darfur – Sudan; December 2013; Project Partnership Agreement for Common/Pooled Humanitarian Funds (Contract) between the United Nations Development Funds and COSV; Sudan CHF Project Monitoring Visit Form (Visit of 13th March 2014); RH Monthly reports (July 2013 – July 2014); WMM reports Week 28/2013 – Week 32/2014; HeRAMS – Health Resources Availability Mapping System.

[31] Project proposals have to undergo a long revision and approval process before being approved. This is the why this activity, which was initially previewed in this action at its conception phase, resulted then being already accomplished in the framework of the previous CHF12 funded project. In fact, this last was also extended in length and scope of its activities following the depreciation of the Sudanese pound which allowed for additional rehabilitation expenses.

PROJECT DESCRIPTION	INDICATORS	OVIs TARGET	OVIs at WHO monitoring mission	OVIs at Final Evaluation	OBSERVATIONS
1.2 To provide basic RH services packages	65% of births assisted by skilled birth attendant	10520 women from the 12 villages and Kulbus town, including 1052 PLW	60.4% up to Feb 2014 exceeded the target. Possible reasons: quality of HR services provided; trained Midwives. Community asking for MWs to work next to the TBAs. Positive progress towards behavioural change.	58% of births assisted by skilled birth attendant in the reporting period	Target not achieved 1.067 deliveries registered in total during the reporting period, 450 of wich attended by TBAs (42%). 6.761 women received ANC visits during the reporting period.
1.3 Purchase and provision of essential medicines. Provision of UNICEF PHC kits and reproductive health supplies from UNFPA at 13 health facilities (12 PHCUs and 1 PHCC)	Stock out of essential & emergency drugs <7 days at PHCC	24721 people (10519 women)	The stock out was less than 3 days (in 2 PHCUs) according to the records and physical statistics during the monitoring visits for main store pharmacy and the PHCU. Reasons: access problem due to insecurity in remote PHCUs. UNFPA did their part and some drugs were received from UNICEF (enough received in January). Drugs used to be purchased by COSV to fill the gap. Overall COSV have a pharmacy and an effective drugs distribution system. COSV have signed agreements with UNICEF and UNFPA for kit reception		Target not achieved in the last months of the project, as reported stock out at remote units ranged from 2 days to 2 weeks.

PROJECT DESCRIPTION	INDICATORS	OVIs TARGET	OVIs at WHO monitoring mission	OVIs at Final Evaluation	OBSERVATIONS
1.4 Support the SMoH in the implementation of the National and routine vaccination campaigns	60% of coverage of PENTA3 Vaccine in below one year/catchment area	4733 children U5 F: 2840, M: 1893	66% coverage of PENTA3 was achieved in all Kulbus locality with support of COSV until Dec 2013	72% coverage achieved in 2013: 1,142 children U1 vaccinated with PENTA3 40% coverage achieved at 31st July 2014[32]: 705 children U1 vaccinated with PENTA3	Target largely achieved.
1.5 To establish Community based Referral mechanism for Emergency Obstetrics.	65% of births assisted by skilled birth attendant	10520 women from the 12 villages and kulbus town, including 1051.5 PLW.	COSV has supported referral system in agreement with UNFPA up to January 2014. MoU with UNFPA in collaboration with Kulbus and Geneina hospitals. Repairing 3 Ambulances	Same as in Activity 1.2	Same observations as in Activity 1.2
1.6 Rehabilitation of the delivery room at the PHCC and Batro unit	Two delivery room rehabilitated and equipped at the PHCC centre and Batro PHCUs.	2630 women in reproductive age	Same as per OVI1 of R1	Same as per OVI2 of R1	Target achieved. Same observation as per OVI2 of R1

Utilisation rate in the 12 months going from January to December 2013 were estimated in the framework of a KAP survey implemented by the implementing organisation in December 2013[33] in the framework of the THINK project, which is the other main PHC action implemented by COSV in Kulbus Locality. Named estimates are very positive, indicating an estimated achieved utilisation rate of 2.4.

Present WMMB and RH report forms do not allow the discernment between attendances/consultations and prescriptions/services provided. This gap in the forms leads to the raising of doubts on the possibility of over prescriptions' occurrence. Assessment of this issue and exchanges among COSV Health Coordinator and key SmoH cadres are ongoing in order to positively respond to this concern and improve the monitoring system and the data quality besides the health service provided and the drugs supply chain.

Last PCA with UNICEF started on 20th February 2013 and ended 19th February 2014. Kits provided have not covered the entire agreed amount, both in quantity and in variety terms, and since February UNICEF's kits provision has halted. COSV promptly responded to drugs shortages, purchasing essential drugs directly in the market. In particular, COSV purchased IMCI drugs, and

[32] National EPI statistics and targets refer to periods starting the 1st January and enduing 31st December.
[33] This estimate therefore refers to a period that overlaps but does not coincide with the reporting period. However, estimates in object could be considered indicative of the trends.

especially suspension drugs, to integrate UNICEF's supply and respond to the actual demand in Kulbus health centre and units. MoH has also been very supportive in providing some drugs which it had available in its stocks. Also, MoH provided IMCI kits upon demand of COSV. Some of the items contained in these kits resulted being expired or with imminent expiration dates. All these could not fully compensate for the lack of drugs encountered, even if the measures put in place were appropriate and timely. In fact, all these have partly affected IMCI drugs provision, resulting in occasional stock out of those drugs in some of the units. Also, insecurity and seasonality challenges contributed to the occurrence of these occasional stocks out. COSV new Health Coordinator and Medical Officer were in the process of reorganising the drugs and delivery supply chain and monitoring system, also improving the supervision of drugs consumption at units' level, in order to further improve its performance and better anticipate future challenges. Also, named improvements to the drugs consumption and supply monitoring system are also aimed at verifying the eventual occurrence of over prescriptions, which could partly explain the occurrence of occasional stock out of some drugs, and especially suspension ones. This would also respond to the concerns already mentioned in the previous paragraph with regard to number of units' attendances versus number of prescriptions. Finally, careful assessments on population movements could also help in verifying eventual major changes in population's pressure to the different units, also following the recent exacerbation of conflicts and consequently of population movements since the beginning of 2014.

COSV supports EPI Department of SMoH in the implementation of EPI campaigns, both accelerated and routine, with the provision, among others, of a vehicle, budget for transport and incentives to the VCT. EPI activities encountered a steady improvement in their organisation and implementation since the new EPI focal person arrived in October 2012, resulting in a steady improvement in EPI coverage. LF OVI for activity 1.4 uniquely accounts for PENTA3 vaccinations. Other vaccinations' coverage achieved in the framework of this action is as follows:
- 610 children in total received BCG vaccinations between January and July 2014, 35% of coverage: achievements deemed *on track* for the ongoing year[34].
- 1,479 pregnant women received TT vaccination between January and July 2014, 37% of coverage: achievements deemed *on track* for the ongoing year.
- 9,661children (1419 children U1 and 8242 children 1-U5) in total received Polio drops during the Third Polio campaign round for 2013 from 5-7 November 2013, reaching 126% coverage in Kulbus Locality, of which 187 received first dose.
- 10,073 (1501 children U1 and 8572 children 1-U5) in total received Polio drops during the Fourth Polio campaign round for 2013 from 5-7 November 2013, reaching 126% coverage in Kulbus Locality, of which 146 received the first dose
- 10,827 children in total received Polio drops at First Polio round of 2014 on 12th May 2014 reaching 125% coverage in Kulbus Locality.
EPI focal point in Kulbus declared that vaccinations coverage target set by MoH in 2013 was largely reached: in fact set target was 60%, and achieved target was 72%. Ongoing achievements were judged very positively, leading to the expectation to reach 80% coverage by the end of 2014.

Moreover, Dar Mokhtar area will start benefiting from the presence of an EPI stock point at the newly opened Adawie Unit. In fact, the challenging situation of Dar Mokhtar area has been recurrently claimed in the last years, as its coverage, both in terms of EPI and PHC services, has been very challenging for insecurity and seasonality reasons[35]. EPI coverage statistics from EPI Dept of SMoH also reflect that[36], as Kulbus Locality's statistics are negatively affected by the low

[34] SMoH's EPI Dept sets and assesses targets based on fiscal year, starting 1st January and ending 31st December of the same year.
[35] Dar Mokthar area is difficult to be reached during rainy season. Moreover, the road to reach that area is quite insecure.
[36] This was claimed by the Head of EPI Dept of SMoH during the interview carried out at his offices on 26th August 2014. SMoH EPI statistics were provided to the Consultant, explaining that data are not disaggregated by unit, and therefore that achieved coverage were negatively affected by the low coverage of Dar Mokhtar area, while in all other areas of Kulbus Locality the achievements were judged as very satisfactory. These EPI statistics are not displayed in this report as they are not broken down by unit and area of intervention.

coverage in that area. The opening of the new unit in Adawie and the set up of the EPI fridge in that unit has therefore been warmly welcomed by all concerned stakeholders.

COSV signed an Agreement with UNFPA, that guaranteed the support to the SmoH's referral system in Kulbus and Genina. Three ambulances were rehabilitated (1 for Kulbus Locality, 1 for Kerenik, 1 for Mornei) and referral costs supported for six months, until February 2014[37]. 16 pregnant women were referred from Kulbus to Genina for delivery OBS and gain. 6 women from other localities of West Darfur were referred for delivery OBS and gain.

COSV was in the process of trying to renew a new MoU with UNFPA since the old one expired. However, some delay in finalising that agreement was probably due to the recent vacant Focal Point position at UNFPA in Genina. Also, delivery kits' availability has been challenging in the last months of the action, as UNFPA itself had no delivery kit[38] since February 2014. SmoH then supported COSV with the provision of some delivery kit. However, SmoH also run out of delivery kits. These delivery kits' stock out faced at Kulbus health centre and units during the last months of the action might have contributed to the mild deflation that assisted deliveries have encountered since the monitoring visit that was carried out at the beginning of March 2014, when assisted deliveries from trained personnel were at 60,4%[39]. Positive trends were also confirmed by results of a KAP survey[40] carried out in December 2013 in the framework of the complementary action THINK. In fact, 60,3% of respondents declared that they recurred to assisted deliveries in recent pregnancies/deliveries[41], and 78% declared they would recur to assisted deliveries for their forthcoming ones.

The **results of RH activities**, here including awareness sessions[42] directly carried out by the MWs, are therefore **remarkable**. However, MWs and consulted stakeholders claimed that mothers still have resistances in carrying out the necessary ANC and PNC visits and to be assisted by MWs instead of TBAs at delivery, as already explained and presented in the previous paragraph.

Details of RH awareness sessions directly carried out by the MWs are presented as follows.
970 BNF were reached by awareness sessions on FP[43], 886 BNF were reached by awareness sessions on safe motherhood, 753 on STIs/HIV, and 399 on GBV, for a total of 3.008 BNF reached in total. It must be stressed that RH awareness sessions encountered remarkable results until the beginning of 2014, when the number of BNF started to decline. This could be mainly due to the mentioned shortage of delivery kits that affected Kulbus units, which might have affected attendances related to RH. It is important to stress at this stage that RH monthly forms are a bit confusing with regard to the information required at the awareness sessions part. In fact, it is unclear whether MWs should put the number of beneficiaries or the number of sessions. It seems that MWs indicated the number of BNF, and data were organised and read under this light. This issue was promptly raised by COSV Health Coordinator and was in the process of being discussed and solved in coordination with the SMoH's Head of PHC Dept: a new RH monthly form was in the process of being finalised by the MoH.

[37] Referral system was supported until February 2014, although actual MoU expired in January 2014, after formal agreement among the two agencies.
[38] Delivery kits are provided by UNFPA and by UNICEF. If one of them has no delivery kits' availability normally also the other agency is facing the same challenges.
[39] That percentage of assisted deliveries was presumably calculated on the period starting 1st July 2013 and ending end on February 2014.
[40] Please, refer to Attachment N. 9 displaying consulted documents.
[41] These answers refer to deliveries occurred in the two years before the interviews, which were carried out in December 2013.
[42] Statistics on awareness sessions carried out by the MWs during consultations and at the units are presented in this section, conceiving them as essential component of the basic RH service package provided according to Activity n. 1.2. Statistics on awareness sessions presented in the next section of R2 refer to activities carried out by PEs, as planned in the action LF.
[43] Please refer to Attachment N. 5 displaying the statistics as reported in the monthly RH reports.

The **quality of PHC** service provided at the units is **quite heterogeneous**. Units differ among them also in terms of available equipment, efficiency and effectiveness in the organisation of spaces, and of cleanliness of the place. In general, units are fairly cleaned. Hired cleaners have recently been halted due to budget's limitations: this was claimed as a challenge by all consulted CHWs, besides the difficult accessibility of water. In fact, water sources are sometimes very far from the units: the necessary quantity of water for the routine functioning of the units has mainly been on the shoulders of the CHW, limiting the effectiveness of their action. Some particularly active VHC is supporting the CHW in accessing the water for the units; however, water constant availability still remains challenging at many units, mainly due to the distances to the water point and/or to the poor support of the VHC. Finally, it was claimed that units' lack of adequate fences[44] is often resulting in the presence of animal waste around the units and therefore in inadequate hygienic conditions. Again, some VHC is particularly active in supporting CHWs also with the provision and maintenance of fences at the unit, while others are not supportive at all. Some of the consulted VHCs asked for COSV's support to build fences in lasting materials: they proposed that the VHC could provide labour force and local materials, while COSV could help with the provision of cement and iron posts.

Witnesses from the field – Observed behavioural changes

A MW declared that she noticed positive improvements in the population's acceptance of her presence during deliveries. Presently she is accepted at a delivery even when the TBA is not there, while this was not accepted in the past, when the presence of TBA was compulsory to accept the MW's one.

The same MW also stated that pregnant women are presently attending the centre to undergo several ANC visits, while they previously tended to recur to the health centre only at the end of pregnancy to receive the safe delivery kit.

Also, an increasing number of pregnant women are accepting to be vaccinated for Tetanus, and mother are more and more accepting to vaccinate their children. These behaviours were not as recurrent in previous times.

Since the units are now functional at the various locations, the trends of recurring to health services have massively changed. In the past, population of remote areas were forced to recur to Chadian health facilities or to travel until Kulbus town to access any kind of health services. Kulbus population is presently recurring to Kulbus Hospital and health facilities in Kulbus town only in case of serious diseases or complications, preferring to normally recur to village units, which are closer and more accessible.

[44] Units are presently fenced with some trees' harms, or not fenced at all. Present fences have to be maintained quarterly because of the fast materials' erosion mainly due to the termites.

Result 2: Health Staff capacity

All activities were carried out, all targets are fully achieved and additional sessions were been carried out. Only OVI2 of R2 is not fully reached. Main explanations are provided in the previous section discussing achievements of R1, as this OVI is also adopted to account for Activities 1.2 and 1.5.

PROJECT DESCRIPTION	INDICATORS	OVIs TARGET	OVIs at WHO monitoring mission	OVIs at Final Evaluation	OBSERVATIONS
R2. Strengthened 20 midwives (including the hospital MWs) 26 TBAs (two from each village where COSV has a PHCUs preparedness and control mechanism for emergencies and diseases in coordination with SMoH, the local community committees, local authorities and local partner. Through also a gender focus training and activities.	100% of communicable disease outbreak alerts detected and response initiated within 72 hours. 70% of births assisted by skilled birth attendant	20 midwives (including the hospital MWs) 26 TBAs (two from each village where COSV has a PHCUs)		58% of births assisted by skilled birth attendant in the reporting period	Target achieved for OVI1 of R2. Target not achieved for OVI2 of R2. Please, refer to observations presented at activities 1.2 and 1.5.
2.1 Strengthen the coordination system with WHO and SMoH in order to assure the basic qualitative standards for the implementation of an efficient outbreak and emergency preparedness and response system.	100% of outbreaks and health emergency are promptly detected and responded during the project implementation.	24721 people(10520 women)	100% of WMMD, Midwifery and RH reports submitted timely up to date March 2014. Mild delays while the monitoring visit was occurring because of ongoing MO's and Health Coordinator's turn over.		Target achieved. All WMMB and RH reports submitted in time. Mild delays registered during MO's and Health Coordinator's turn over.
2.2 To conduct awareness sessions on FP, ANC, PNC, HIV /AIDS and danger signs of pregnancy for women in RH and mothers	26 health sessions is conducted during 6 months of project implementation.	24721 people (10520 women)	1 awareness session on FP, ANC, PNC HIV/AIDS, and danger signs of pregnancy for women in RH and mothers implemented in August 2013 and one in March 2014.	86 health sessions conducted between March and June 2014, reaching 2,942 BNF in total (447 M and 2,495 F)	Target largely achieved.
2.3 Home visits, VCT session and	1440 home visits are done during 6	24721 people (10520 women)	1,440 home visits have been conducted	2,890 HH visited in the	Target largely achieved for PEs'

PROJECT DESCRIPTION	INDICATORS	OVIs TARGET	OVIs at WHO monitoring mission	OVIs at Final Evaluation	OBSERVATIONS
distribution of IEC materials through the primary health care units, centre and health promoters.	months of project implementation.		during the first 3 months of project implementation. However, Total home visits up to 31 December 2013 were 1760. 3 VCT sessions were conducted in August 2013, September 2013, and February 2014	reporting period[45], targeting a total amount of 13,150 BNF (6,562 males and 5,588 females):	home visits[46]. Target not set for VCT; positive achievements. Achieved target for posters distributions unclear.
2.4 Training to VHCs and local authorities on topics including Supervision & monitoring, facility management, referral pathways and community mobilization.	Six trainings to local authorities and VHC is achieved in 6 months.	40 = 35 VHCs + 5 Local Authority (12 women)	2 trainings out of planned 6 were conducted (22/12/2013 Community Base Surveillance, 28/01/2014 maternal death). The missing 4 trainings have been planned for next months. Reason of delay was due to suspension of flights to Kulbus as a result of insecurity	6 trainings accomplished between March and August 2014.	Target achieved. Some of the trainings were ongoing during the FE, and the number of BNFs was still not accounted for. Available details are displayed in the discussion part following this table.
2.5 Capacity building of local partner staff in program cycle management.	Number of people trained during 6 months.	10	Activity fully implemented. RedR training conducted in Genina targeted 18 participants from (SMoH and NAHDA NNGO) on 15-19/09/2013.	Same as per OVI at WHO monitoring mission.	Target achieved.

Overlapping and inconsistencies among OVI of activity 1.2 and 1.5 and OVI2 of R2 was already appointed in Section 3.1.

Peer educators' activities are appropriately organised and strongly contributed to the improvement of pursued results (e.g. improvement of BNFs' acceptance of modern medicine, reduction of EPI defaulters through group and individual outreach, improvement of beneficiaries' awareness, the increase of VCT sessions' participants, general improvement of population's health) continuously promoting behavioural change in basic health and hygiene, and RH attitudes and behaviours. The **PE's strategy of assessing first the household/village conditions**, in order **to choose the most urgent aspects to be covered** with their sessions, seems appropriate. **Messages are also chosen according to the incidence of diseases at the units, and to seasonality and to the recurrent challenges** directly related to it: for instance, Malaria control is more likely covered during rainy reason, while flu and ARI are more likely covered during winter. The PEs' strategy of addressing and convincing first the elderly, in order to then have their support in the IEC activities to the rest of the community, seems appropriate. Finally, PEs strongly

[45] Reporting period for these data is 1st July 2013 – 31st July 2014. Data of ongoing visits carried out during August 2014 are not reported in this report as they werecarried out while the final evaluation was ongoing.
[46] Target for the initial duration of 6 months was set at 1,440 visits in total. Target achieved for the actual 14 months duration of this action is therefore proportionally adequate, also under the light that last month of visits is not accounted for in this report (see also previous foot note n. 48).

contribute to support the referral system in their areas, as they recommend and address BNFs to the Unit or to the health centre when they observe resistances or cases that would need the provision of adequate health service.

Details of health sessions conducted in the framework of this action are as follows:
- 26 Sessions conducted in immunisation, breastfeeding, personal and family hygiene between March and June 2014[47]: reached 934 BNFs (99 males, 835 females).
- 12 Sessions conducted in Personal and food hygiene between 14th and 28th May 2014: reached 374 BNFs (94 males, 280 females)
- 24 Sessions conducted in Personal and food hygiene between 12th and 27th June 2014: reached 825 BNFs (133 males, 692 females).
- 24 Sessions conducted in Personal and food hygiene between 8th and 19th June 2014: reached 809 BNFs (121 males, 688 females).
- 1 large awareness campaign was conducted in Rahat Rahma on 12th June 2014, reaching around 120 BNFs mainly mothers and PLW.
- 1 large awareness campaign was conducted in Kulbus town on 14th August 2014. Number of BNFs was still not accounted for.

Details of Home Visits and VCT sessions are as follows:
- 1,100 HH visited in the period 1st July – 31st December 2013, targeting a total amount of 4,781 BNF (2,362 males and 2,419 females);
- 1,790 HH visited in the period 1st January – 31st July 2014, targeting a total amount of 8,369 BNF (4,200 males and 4,169 females);
- 1 VCT Session carried out on 25th August 2013 in Hajer Assal reached 230 BNF (5 M and 225 F);
- 1 Health Session on HIV carried out on 29th September 2013 in Army Camp reached 170 BNF, all male BNFs;
- 5 VCT sessions carried out between March and July 2014 reached 222 BNF in total, targeting 29 BNF (8 M and 21 F) in Jirgira (Mastura), 16 BNF (16 F) in Kulbus VCT centre, 14 BNF (5 M and 9 F) in Arwa, 84 BNF (35 M and 49 F) in Turra (Rahat Rahma), and 79 BNF (6 M and 73 F) in Goz Diga (Mastura).

The lack of sufficient availability of IEC support materials was lamented by PEs and CHWs, and directly observed by the Consultant during the field visits. Some posters from MoH were in the process of being distributed while the final evaluation was ongoing. The production of IEC support materials was not planned in the framework of this action, and no budget line was allocated to this purpose. However, wider availability of IEC materials could be appropriate to improve the extent of awareness' activities results.

The **unbalanced geographical and gender distribution of PEs** was claimed as hampering the full achievement of all results, as some unit does not have a PE at all, and the majority of female PE are concentrated in Kulbus town. Also, PEs claimed they have difficulties in reaching far villages, as the areas they cover are characterised by scattered and far villages. Resistances of old women and men respectively with regard to exclusive breastfeeding[48] and condom adoption have also been reported.

Lack **of mobility means** seems to limit the extent of achieved results, especially in terms of awareness creation and behavioural change promotion. Project Management was in the process of addressing mentioned gaps planning targeted health sessions to compensate for the lack of PEs or of female PEs in some of the units. PEs also claimed they do not have a dedicated room at the units and PHCC to put in place sessions addressing particularly sensitive subjects.

[47] Please, see Attachment N. 7 displaying details of conducted health sessions.
[48] Old women believe that newborns should drink water as soon as they are born in order to ward off the occurrence of deafness.

This action has not previewed the implementation of Health Education Session in the schools, as this target was not eligible in the past. This set of activities has been included in forthcoming actions that the implementing organisation will start from September/October 2014 as this was allowed by present funding. This will allow targeting school students in their learning environment, and it will possibly increase the basic health and hygiene competences of Kulbus young population, while enhancing the potential acceptance of health messages, and therefore boost aimed behavioural change.

Details of VHCs and LAs trainings are as follows:
- Training carried out 15-16/05/2014, reached 33 VHC members from: Adareeb [2], Hajer Assal [2], Kulbus [8], Andussa [3], Batro [2], Rahat Rahma [1], Arwa [3], Hililat [1], WB V [2], WB IDP [2], Hajer Leban [2], Mastura [2], Dohoush [2], WB not specified [1];
- Training carried out 15/06/2014, reached 20 VHC members +LA from Mastura;
- Training carried out 11/07/2014, reached 19 VHC members + LA (villages not indicated);
- Training carried out 20/07/2014 in community participation /partnership /ownership, reached 20 VHC members;
- Training carried out 10/08/2014 in Advocacy on community participation /partnership /ownership, targeting VHC members. Number of participants was not accounted yet;
- Training carried out 12/08/2014, targeting VHC members. Number of participants not accounted yet.

Case study

A PE recalled the example of a case she faced in the past. One of her female beneficiaries was not accepting any of the messages the PE was trying to promote. The woman was not attending ANC visits, she was refusing to attend the health unit and was not accepting modern medicine nor prescribed treatments, which she deemed as items that were provided “against her”. One day the woman got tetanus. The PE realised the gravity of the illness and convinced the woman to be accompanied to the health centre, where she received the correct treatment. The woman positively recovered from tetanus and is now in good health. Since then, she has overcome her resistances: she attended ANC visits when she got pregnant, and then she was assisted by the MW at the delivery: the woman greats and warmly thanks the PE all the times she cross her.

Result 3: Preparedness and control mechanisms for emergencies and disease control

All targets and outcomes have been successfully achieved except targets set with activity N. 3.4, which have been partly achieved because some categories of health staff was not targeted as planned.

PROJECT DESCRIPTION	INDICATORS	OVIs TARGET	OVIs at WHO monitoring mission	OVIs at Final Evaluation	OBSERVATIONS
R3. Increased capacity of the health staff of the PHCC and PHCUs (Medical Assistant, EPI team, VCT, midwives, community health workers, nurses, health promoters…).	34 female and 22 male of the health staff trained and retrained in 6 months project implementation.			All planned trainings accomplished; all personnel targeted.	Target achieved. The details of trained staff could not be fully assessed because of information gaps in training reports, and because reports of ongoing trainings were not available yet.
3.1 Trainings for the health staff (CHW, Nurses, etc.) in topic such as ARI, Measles, Diarrhea, Malaria, Eyes Infections and Meningitis, EWARS.	60 health staff trained and retrained in 6 months.	**35** person(13 CHWs 15 MWs 1 MA 2 Nurses 3 EPI team, 1 VCT counselor) + 14 health workers from Kulbus hospital	2 AWD trainings conducted: 20-21/07/ 2013 AWD training for PEs and health staff (# of participants: 25); 31/08-02/09/2013 AWD training for the hospital health staff (# of participants: 19). 1 workshop for CHWs done in March 2014 (# of participants: 13). The 3 missing trainings planned for the next months. The delay in implementation was due to suspension of flights to Kulbus as a result of insecurity	5 trainings accomplished: 84 BNFs reached. 2 trainings were in the process of being carried out while the FE was ongoing.	Target achieved. Same observations as above.
3.2 Trainings for the midwives and TBAs on topic such as anti post-natal care, save delivery, family planning and RH complication	20 midwifes and 26 tbas trained during the 6 month of project duration.		N/A	2 trainings accomplished: 28 BNFs reached. 2 trainings were in the process of being carried out while the FE was ongoing.	Target achieved. Same observation as above.
3.3 Training for Peer educators on Mother and child care, Dangerous signs during pregnancy, HIV, GBV…etc	12 peer educators trained	12 peer educator (7 women and 5 men)	The only no-cost activity training for KAP survey in Dec 2013. Some PE has already received training in nutrition and health integrated program in the framework of CHF-nutrition funded action	3 trainings accomplished: 56 BNFs reached.	Target achieved.
3.4 Gender focuses session for the health staff.	34 health staff assisted at the gender sessions.	**35** health workers: (13 CHWs 15 MWs	Gender with health staff and VHC conducted in September 2013 (# of participants: 27).	2 workshops accomplished: 47 BNFs reached.	Target partly achieved. Targeted BNFs are PEs and members of VHCs:

PROJECT DESCRIPTION	INDICATORS	OVIs TARGET	OVIs at WHO monitoring mission	OVIs at Final Evaluation	OBSERVATIONS
		1 MA 2 Nurses 3 EPI team 1 VCT counsellor 17 women and 18 men) + 14 health workers from Kulbus hospital	One was already done and others sessions are planned with the NCE period.		some of the previewed health staff was not targeted with this activity.

Details of training carried out under Activity 3.1 are as follows:
- 03/09/2013: training in AWD targeted 19 health staff BNFs;
- 22/06/2014: training in Rational use of drugs targeted 15 BNFs (14 CHWs and 1 store keeper);
- 04/07/2014: training in Fill out format and strengthen reporting system targeted 13 CHW BNFs;
- 16/07/2014: training in Infection and Prevention and Control targeted 17 BNFs (8 CHWs and 9MWs - villages not indicated);
- 18/07/2014: training in Tuberculosis and Typhoid fever targeted 20 health staff BNFs;
- On going training in ARI, Measles, Diarrhea and EWARS during August targeting CHWs.
- On going training in Skin diseases, STI and HIV targeting CHWs/MWs[49];

Details of training carried out under Activity 3.2 are as follows:
- 16/06/2014: training in Basic EmoC targeted 18 MWs (village not specified);
- 05/07/2014: training in Post Natal Care, safe delivery, RH and FP targeted 10 MWs (villages not indicated);
- On going training in Post Natal Care, safe delivery, RH and FP targeting MWs;
- On going training in Post Natal Care, safe delivery, RH and FP targeting TBAs.

Details of training carried out under Activity 3.3 are as follows:
- 21/07/2013: training in AWD targeted 25 BNFs (1 MA, 1 lab tec, 12 CHWs, 3 nurses, 2 EPI/PEs, 6 MWs);
- 30/01/2014: training in EWARS targeted 19 PEs;
- 15/07/2014: training in EPI and vaccination targeted 12 PEs.

Details of training carried out under Activity 3.4 are as follows:
- 09/09/2013: GBV workshop targeted 27 VHCs from: Arwa [3], Hospital (?) [2], Kulbus [6], Batro [2], Hajer Leban [2], Adareeb [1], WB IDP [1], Mastura [1], Hililat [1], WB V [2], Hajer Assal [4], Danks [1], Dohoush [1];
- 09/07/2014: GBV workshop targeted 20 PEs.

Details of training beneficiaries (roles, units, gender) could not be fully assessed because of information gaps in training reports.

Mobilisation and education strategy targeting community leaders has proved successful, as community leaders showed high appreciation and fair implication in project's activities, showing a mild proactive attitude. **VHCs are key actors in the promotion of community ownership** of the units and in fostering PHC's sustainability in remote areas. They certainly need to be further strengthened in order to enhance the impact and durability of achieved results and benefices. Also, evident **heterogeneity** among different VHCs emerged, in terms of recent histories and achieved capacity and commitment outcomes. Capacity and commitment of VHCs seem directly related to

[49] The details of the activity were not available as it was just accomplished when the final evaluation was ongoing.

CHW's capacities and leadership, and to local characteristics as well. The MO has put in place no guidance to those VHC, as the turn over that that role has known could not permit to fully know the details of each VHC and build their capacities. Al Nahda organisation has taken the lead of the capacity building activities addressed to the VHCs.

Prompt availability of MoH's trainers has sometimes been challenging, often resulting in delays in the implementation of mentioned activities. Those trainers have often missed the submission of training reports.

3.3.2. Project suitability and impact

Project performance was substantial, despite encountered delays and challenges. In general terms, **project has widened and strengthened PHC services in Kulbus locality**, widening and reinforcing benefices achieved in homologue previous interventions, throughout a continuity and learning approach, ultimately **resulting in improved health of the targeted population**.

Project potential positive impact and sustainability have been continuously promoted with the followings:
- The **active involvement of SMoH** as institutional and technical partner has been paramount in order to create adequate synergies to develop and improve provision and access to PHC in Kulbus Locality.
- The close collaboration with SMoH and international agencies and partners has certainly contributed to the coherence, acceptability and impact of the action.
- The involvement, capacity building and support of local NGO Nahda.
- **COSV's recruitment and continuous capacity building strategies**.
- The **creation of synergies with the UE funded project** and with the **CHF-funded nutrition action**, which resulted in the availability of considerable resources and the achievement of pursued results on a larger scale.
- The development and proposal of *Promotion of maternal and child health in Kulbus Locality, West Darfur*, which will be hopefully financed by the EU and the action *Support to primary health care services for vulnerable people (women, children, IDPs, and returnees) in the Kulbus and Jebel Moon localities, West Darfur*, which will be funded by CHF 2014. **The new CHF and EU funded intervention will continue strengthening and widening results and benefices, attempting to improve weaknesses and to fill the gaps**.

Sustainability

COSV's strategy of creating and supporting village health committees is an important mean of contributing to the sustainability of achieved results.

COSV's strategy of **adding health infrastructures** at each intervention has also contributed to the sustainability of achievements. This is certainly a positive strategy, as it foresees the possibility for the organisation to leave the area in the future, being certain that these infrastructures will stay to the benefit of the communities.

However, a number of factors could undermine the potential positive impact and sustainability of the project. Main **internal critical factors** are listed as follows.

The **gratuity** of **PHCUs' and PHCC's services** and drugs, which was indicated by all respondents as strength of the intervention, could reversely be judged as a potential weakness in the long term. In fact, on the one hand that gratuity has facilitated the access of vulnerable and underserved population to PHC services, certainly resulting in their improved health conditions. On the other hand, the gratuity of services could become a great challenge in the medium term, if the MoH will not be able to support the services when, at a certain moment, inevitably it will have to take over

the PHCC and PHCUs presently run by COSV. COSV aims at continuing providing its support in the Locality while also possibly expanding it to uncovered areas and populations, and the SMoH expressed its clear will and need for this fruitful collaboration to continue and expand PHC coverage in the locality. However, this sustainability challenge should not be underestimated as the donors' funds availability has progressively reduced.

Lack of CHW certificate for 6 COSV's CHW could potentially challenge the adequate provision of PHC in the concerned villages if prompt correction measures will not be quickly implemented. COSV was in the process of negotiating a viable solution to named issue while the final evaluation was ongoing.

VHCs resulted quite different among them. Some VHC **seemed still very weak**, while someone else was quite **active and engaged**, like the Arwa's VHC. Additional effort is required to enhance community participation and ownership, and improve VHC's understanding and capacities to homologue standards, as the VHCs' inadequate capacities could potentially undermine the impact and sustainability of achieved result.

External factors that could undermine or limit sustainability, and therefore also the impact, of achieved results are listed as follows.

Taboos, traditional beliefs and practices, especially concerning RH, could still undermine attained and pursued behavioural changes.

International humanitarian organisations have known a reduction in the scope of their actions, mainly because of the relative calm that characterised the area until the end of 2013, and because of the decline in funds' availability. However, security situation has dramatically worsened since the beginning of 2014, while available funds have not mirrored the actual funding needs to respond to the changing situation. In addition, Sudanese stakeholders do not have sufficient means to take over and sustain humanitarian actions' results, and this could negatively undermine the impact and sustainability of achieved results and benefices.

Situation in all Darfur remains highly volatile and conflicts have worsened in this 2014 all over West Darfur. New IDPs or returnees movements might continue to occur, therefore leading to potential uncertainty and to possible increase in population pressure to PHC services[50]. This and the declining available funds to international agencies might ultimately challenge the PHC service's quality and sustainability.

Impact

Achieved results and benefices are certainly promising in terms of lasting impact.

Communities are slowly changing their health attitudes and behaviours in response to awareness activities. Occurring changes are progressively supporting the achievement of pursued objectives. In fact, it emerged that COSV's efforts throughout the years is resulting in positive achievements: CHWs claimed that the incidence of diarrhoea and malaria is progressively reducing in the years. Positive improvements in Malaria control was also confirmed by the SMoH's Head of Malaria Department. Also, positive improvements in EPI coverage resulted from the widened EPI activities and also from the enhanced awareness at household and community levels. It was reported that community members contribute to convince the mothers on the need to vaccinate their newborn, contributing to widen the EPI vaccination coverage, therefore dramatically limiting the incidence of

[50] New returnees and IDPs are moving toward Kulbus locality, following the conflicts' exacerbation of last months. HAC together with OCHA and UNHCR are now studying the changing situation.

EPI diseases and ultimately improving the children's and wider population's health. Also, PEs indicated other main observed positive changes in the growing number of mother recurring to modern health services, including assisted deliveries, and in the improved hygiene and care of children.

Some **critical factors** that could undermine the potential positive impact of the intervention were already listed in the previous parts of this section 3.3.2[51]. Additional ones are listed as follows:

Present geographic and gender distribution of PEs is not adequately covering all targeted villages, resulting in inhomogeneous results and therefore in jeopardised potential impact.

Reported resistances of old women and men respectively with regard to exclusive breastfeeding and condom adoption could undermine the durability of achieved results. Also, men have reportedly shown resistances and wider misconceptions in accepting, and therefore also putting into practice, promoted FP behaviours. Old women of the household are often responsible of hampering assisted deliveries of the younger ones, imposing traditionally assisted deliveries.

Gender organisation of labour and duties at family and community levels still represent a high obstacle in the lasting achievement of some of the promoted changes. In fact, women still marry at a very young age and are overwhelmed by incredible amount of duties. Family roles are still rooted in patriarchal and conservative dynamics, anchored to ancestral beliefs and rules.

Uncertainty with regard to Kulbus Locality's capacity to adequately take over project human resources could dramatically affect the positive impact of achieved results in the RH's field directly related to MWs' and PEs' activities. In fact, these human resources cannot be hired from the MoH but from the Locality itself. COSV was undergoing negotiations with Kulbus Commissioner with regard to this central issue while the final evaluation was ongoing.

The massive humanitarian action that has benefited West Darfur since the beginning of its crisis presently knows a reduction. **Continuous humanitarian action has created some degree of dependency syndrome in local communities**. In fact, it was repeatedly claimed that communities tend to strongly rely on external help. This attitude could undermine the potential impact of achieved results.

Proximity to the Chadian border results in unpredictable risks of communicable diseases outbreak, as Chadian living in those bordering areas cannot access routine immunisation activities. It was claimed that Chadian are also exerting pressure on Kulbus Hospital and Kulbus Units services and drugs' availability. Also, migratory movements from/to West Africa were creating high concern while this final evaluation was carried out. In fact, the ongoing Ebola virus outbreak in West African Countries was reason of concern for Darfurian stakeholders and population. Darfur area is normally touched by the passage of numerous Nigerian who have families in Darfur, and of Pilgrims coming from West Africa on their way to Port Sudan (to then reach the Mecca). However, hopefully these concerns will not become actual challenges, wishing that the ongoing Ebola outbreak will be soon halted and circumscribed, on the one hand, and that the ongoing preparation of Health stakeholders for the eventual arrival of Ebola in Sudan would uniquely remain a capacity-building exercise.

The actual situation in Kulbus area is quite stable. However, **security** of the area is still a challenging factor, and unpredictable and fast deteriorations of the security situation can occur at any time. Also, health staff coming from Genina and/or other Sudanese localities still perceive

[51] A factor that is affecting project sustainability normally also affects its potential positive impact.

Kulbus locality as insecure and remote, therefore creating resistances to be relocated and difficulties in avoiding staff turnover, both for COSV and for the SMoH.

Interlocutors indicated in the **absence or difficult access to water** a crucial factor potentially hampering the positive impact of achieved results and benefices. In fact, limited access to water could also become an obstacle to the general improvement of community health as it might partly hamper the impact of awareness related results, especially concerning positive behavioural changes improving hygiene and health in the household and in the community. However, it must be highlighted that COSV has planned to support small-scale community-led micro-project in the framework of the forthcoming new UE-funded project. The aim is to promote viable actions that could positively respond to this challenging factor, on the one hand, while also promoting community ownership, on the other.

3.4 Project successes and best practices

Integrated approach that combined project's components has been successful, resulting in the mutual reinforcement of achieved results. The **integration of PHC with WASH approach** and actions was also appropriate and contributed to strengthen achieved results and benefices.

Mobilisation strategy levering on the active involvement of **communities' and religious leaders** with the support to VHCs was fairly successful in promoting PHC services' ownership and active participation to project's activities. However, community mobilisation is still in need of further reinforcement. Also PEs' strategy that addresses the communities' members, boosting their support in the IEC activities to the rest of the community seems successful to boost the acceptance and promotion of behavioural change in such archaic and rural communities.

The adoption of **community PEs** and their daily effort in community mobilisation and awareness activities is proving successful, although their geographical and gender distribution is not adequate to cover all villages and beneficiaries.

The **identification of IE messages based on seasonality and on the actual needs assessment** carried out on spot by the PEs both at household and at village levels is also very appropriate and should be replicated and widened.

COSV's human resources' policies and procedures privileging personnel from Kulbus locality and from the SMoH whenever possible, promoting active community participation in the selection process, sustaining continuous training and capacity-building certainly contributed to the quality and appreciation of the implemented services and activities. All these are certainly still hampered by the limited availability of local competent human resources and by the limited resources at the SMoH.

COSV's long-term strategy of progressively **adding new constructions, continuously building the capacity of human resources** and **widening the PHC services** in the locality was judged highly appropriate to the needs of Kulbus' remote and underserved population.

4. Main conclusions and recommendations

The performance of the project *Provision of primary health care services in Kulbus Locality in West Darfur* was substantially successful in all its components, despite challenges and delays encountered in the implementation of activities. **The project resulted in remarkable achievements, both in quantitative and qualitative terms**. Improvements in PHC care services including RH package, EPI coverage, capacity building of health personnel, communities' health awareness, and preparedness and control mechanisms for emergencies and diseases outbreak ultimately resulted in improved health of Kulbus population.

The **conception of the intervention is relevant** to country, state and locality policies, to implementing organisation's strategies and action plans, and it responds to beneficiaries' and stakeholders' urgent and priority needs. Its **design is fairly straightforward and pertinent**. A few design adjustments, in terms of development of indicators and targets, could have further enhanced project's clarity and projects' monitoring capacity.

Mobilisation was fairly effective in promoting beneficiaries' and stakeholders' active participation and ownership. The organisation of community leaders in VHCs and the active involvement of PEs in health education and awareness activities were particularly effective. However, c**ommunity participation** is still inhomogeneous and quite weak in some of the targeted areas, despite the constant efforts to boost it. In general terms, the patriarchal and traditional character of Kulbus population contributes to the persisting resistances and obstacles to the promoted behavioural changes. In particular, traditional gender roles and gender division of duties within and outside the family were indicated as persisting obstacles to lasting behavioural changes, despite the massive gender equity transversally promoted throughout the action.

The **need to further expand the scope of the action** was acknowledged, in order to cover larger catchment areas benefiting additional rural communities that have no access to PHC services. Also, **achieved results need to be strengthened to guarantee their positive lasting impact and sustainability**.

A number of additional **critical factors** have also repeatedly emerged and are indicated as follows.

It is not clear whether faced drugs' shortages could be related to the occurrence of over prescription in some of the units. Certainly seasonality and/or security factors contributed to hamper the regular provision of drugs and equipment. Also, recent exacerbation of conflicts throughout all Darfur and around Kulbus Locality might have contributed to enhance population movements, and consequently also population pressure on the health facilities, therefore contributing to the mentioned occasional stock out of drugs. The extent of this latter factor is presently not known or quantified. Also, observed challenging availability of delivery kits was due to shortages of Delivery and IMCI Kits at UNFPA and UNICEF level.

Present geographical and gender distribution of PE is not adequate to cover all target areas and beneficiaries' categories**.**

Secondary level of health service in Kulbus locality is weak and referral system still needs further improvements to become fully efficient and effective, especially in sustainability terms. This is certainly negatively contributing to the achievement of pursued general objectives.

Sustainability and impact of intervention's achievements are promising, as attained results may be ultimately judged as quantitatively and qualitatively satisfactory. However, **the durability and repeatability of results and benefices could encounter negative obstacles** especially in the followings: **inadequate resources of the MoH** to take over PHCC and PHCUs services,

communities' ownership levels which are still quite low, general **underdevelopment of the area**, and the **security** situation remaining volatile.

A number of recommendations are attempted as follows. They were conceived in order to enhance results' effectiveness, and to promote their potential impact and sustainability, especially considering that they are in the process of being taken over by the EU funded project THINK2 and by the new health intervention funded by CHF 2014. Recommendations also attempt suggestions to improve forthcoming and future homologue interventions.

More clarity in the development of future actions' LogFrames might contribute to further improve data collection and organisation, and to strengthen the monitoring and evaluation system of future interventions.

COSV should continue supporting the SMoH, strengthening and widening PHC services[52], **referral system and capacity,** and disease outbreak preparedness in Kulbus Locality. The strengthening of secondary health service in Kulbus through incentives to medical doctors and specialists to be relocated in Kulbus hospital could also be pursued. However, the risk of further enhancing the SMoH's dependency on external support and general distortions resulting from incentives provision should not be underestimated.

EPI coverage in remote areas might be further strengthened through the implementation of additional fix EPI service at strategic units, indicated by the EPI focal person in Mastura and Dohoush or Rahat Rahma. However, this possible activity should be carefully assessed in terms of its technical feasibility while also verifying whether it would be cost-effective or if the strengthening of present EPI activities would be sufficient. The assessment of the forthcoming utilisation of the newly installed EPI fridge in Adawie Unit might serve as reference to develop mentioned possible future EPI fix centres.

The possibility to develop a laboratory at the centre in Kulbus could be assessed, besides its feasibility, in order to enhance the quality and efficiency of implemented activities, on the one hand, while reducing the pressure on Kulbus hospital's capacity, on the other. Sustainability issues should also be carefully assessed.

Drugs and kits provision could be further improved, trying to anticipate seasonality factors that normally hamper the adequate supply chain. Also, priority could be given to the assessment and eventual reorganisation of the supply chain serving the units bordering Chad, where the pressure on the PHC units and on the degrees of drugs and kits consumption was reportedly being particularly challenging. Finally, careful assessments on population movements could be carried out to verify eventual major changes in population's pressure to the different units.

SMoH could possibly provide more attention in **timely providing qualified trainers** to COSV when requested. **Some improvements in the reporting capacities** of these trainers might be desirable to improve the monitoring system of implemented activities and of the quality of achieved results.

COSV should possibly continue advocating at Kulbus Locality for the permanent recruitment of all staff, and in particular MWs and PEs, that cannot be recruited by the MoH in order to guarantee the positive impact and sustainability of achieved results.

[52] HAC Commissioner in Kulbus indicated the area of Jamjam as particularly in need of PHC coverage, because of the enslavement it normally faces during rainy season.

The **human resources system needs improvements** in order to avoid shortcomings deriving from temporary gaps in positions in case of sicknesses, leave and/or turnover. Also, adequate handing over mechanisms should be identified in order to avoid gaps in data collection and supervision in case of staff turnover on the on hand, and to guarantee constant and timely reporting of all relevant data and statistics, on the other.

Geographical and gender distribution of PEs should be urgently addressed, in order to fill present gaps and to even the provision of adequate health awareness and education, ultimately resulting in more homogeneous achievements. Priority should be given to the recently opened units, which are facing an evident lack of IEC activities, and to those units that have more suffered from the absence of a PE, as Wadi Bardi IDP one.

COSV might start considering the implementation of actions aimed at **improving PE's mobility with some logistic support**, in order to allow them to better cover remote areas. The feasibility and sustainability of mentioned support actions should be carefully assessed. The feasibility and opportunity of availing a room dedicated to PEs' activities could be assessed.

Health staff's competences should be further strengthened with retraining, and with training in new topics, in order to improve the impact and quality of their work. **Staff's competences in data collection, monitoring and reporting need to be further reinforced** to improve minor weaknesses and gaps that emerged from this evaluation. Also, continuous retraining could be appropriate, especially in the early diagnosis of diseases such as ARI, Bilharzias, in the treatment of WD and in sterilisation, as indicated by consulted CHWs. PEs particularly mentioned they would appreciate additional training in children growth monitoring, in EPI/vaccinations, nutrition, HIV/AIDS, ANC, Malaria control, ARI, Measles, STIs and Ebola[53].

CHWs' competences in drugs' prescription and drugs' consumption monitoring should be further improved. Besides, a strict pharmacy management's supervision should also be implemented, in order to ensure that errors or malfunctions are limited to the minimum, therefore enhancing the efficiency and effectiveness of drugs' management, which would ultimately result in improved access to essential drugs' and equipment's availability.

Health staff should be retrained and continuously supervised in hygiene and cleaning as well as in PHC service standards to be guaranteed in the units. Some visits to the units that are better organised, also in terms of hygiene, could be organised for on-the-job learning, if this will not be deemed potentially creating conflicts and envies among the CHWs.

Nahda's capacity building should be further supported. In particular, reporting capacities of Nahda should be further improved, in order to enhance the clarity of its reports, and the quality of data and information accounted for.

VHC mobilisation strategy should be replicated and widened in future actions. Additional training and awareness sessions addressed to local authorities at village level should be possibly put in place, in order to further strengthen their knowledge and improve their competences in promoting communities' participation and ownership, positive health behaviours and lasting attitudes' changes in their villages. In fact, these are key change actors at community level whose capacity and active contribution is crucial to the sustainability and lasting impact of achieved results and benefices, both in terms of preventive and curative terms. Efforts should be put in place **to minimise observed heterogeneity** among them, maybe also valorising the capacities and choices of the most active VHCs.

[53] Normally Ebola is not a priority in terms of capacity-building and control mechanisms in West Darfur and Kulbus Locality. However, concerns on the Ebola virus were rising among MoH , COSV's staff, and Kulbus population while the final evaluation was carried out, as an ongoing Ebola outbreak was occurring and spreading in Western African Countries.

Health education at community level needs to be further strengthened on all key messages, in order to further improve and strengthen communities' awareness and knowledge on health, hygiene and RH, and to progressively overcome their resistances in changing harmful behaviours (e.g. female circumcision) adopting healthy and preventive ones. It is advisable to follow the indications of the KAP survey carried out in December 2013, which appoint the areas where gaps are more evident and the subjects to be urgently addressed. Also, PEs confirmed that the degree of awareness and knowledge varies dramatically among Villages. Finally, they particularly mentioned FP, female circumcision, exclusive breastfeeding, Malaria control, Hygiene, nutrition in pregnancy, IYFP, STIs as messages to be principally boosted in the communities**. Old women and men should be addressed with targeted awareness activities**, in order to overcome their resistances to accept some of the delivered messages, while also involving them as key actors in the positive promotion of aimed behavioural change. Men should be further targeted with awareness activities on FP, as they have been reportedly resistant in accepting delivered messages.

Future intervention should possibly **continue in supporting the provision of RH comprehensive activities, especially awareness creation and continuous sensitisation**, in order to further improve mothers' and communities' awareness and understanding of the importance of recurring to trained health staff for their deliveries and to appropriate RH services. This should be carried out continuously **as traditional beliefs and taboos still hamper the effectiveness of these activities** and potentially undermine the impact and sustainability of achieved results. Awareness activities on FP and HIV prevention should be continuously carried out in order to improve communities' health awareness and further promote positive attitudes, disconfirm distorted or harmful believes, and ultimately result in positive lasting behavioural changes.

IEC activities aimed at improving **gender equity** could be put in place, in order to progressively improve gender balance, and decrease the weight that traditional gender roles and socio-cultural patriarchal rules still strongly play on the division of labour within and outside the family, as well as on the accepted behaviours and changes. For instance, the promotion of the decrease in women's duties during pregnancy and lactation could directly result in improved nutrition of the mother and the child, and ultimately in improved well-being of both.

Implementation of health awareness activities in schools, which is previewed in the forthcoming UE-funded action, is also highly appropriate to enhance health awareness of new generations and also to contribute to limit the still persisting resistances. **The development of an education strategy aimed at targeting teachers together with pupils could be developed, with the aim of accompanying the development of health education curricula to be possibly included in the official curricula**.

Particular attention could be given in guaranteeing that IEC support materials are always available and sufficient to the implemented awareness and education activities. The adoption of practical demonstrations could also be encouraged when possible, in order to further promote positive changes through a practical and probably more effective approach for rural communities.

It could be appropriate to provide some incentive to sustain community mobilisation, while also limiting the possible dependency that incentives could result in. Adequate incentives' strategies should therefore be developed possibly privileging in-kind benefices directly related to the implemented activity (e.g. soap, buckets).

COSV could privilege and prioritise the **funding of community-based WASH micro-interventions** in the framework of the forthcoming UE-funded action, which has planned such

activities, in order to sustain the achieved results and strengthen the durability of the achieved benefices.

PEs' competences should possibly be strengthened to further improve the positive results of their work, in terms of community mobilisation, identification of EPI defaulters, and also to constantly promote behavioural changes related to cultural and traditional practices that intrinsically need constant awareness efforts and time to take place. Also, **additional PEs should be possibly recruited** and trained in order to have pairs of PEs (one male and one female) in every community and improve the effectiveness in the delivery of gender-sensitive messages.

Units' fences could be improved in order to avoid animals' invasions. Although a direct funding by COSV would certainly provide a response to the problem, the consultant would suggest to rather involve communities in this task, in order to improve their ownership towards the units, to limit the "dependency" of communities on external support, and therefore to contribute in improving results' sustainability. Certainly, the active involvement of the communities in that activity will require more time and efforts to be successful than a direct intervention with external funds.

Future interventions might **start conceiving additional lobbying activities at State and Federal levels to the Government and relevant Ministries**, in order to **advocate for the improvement of resources allocation, both in human and financial terms**, as well as for a progressive shift towards more sustainable strategies of action. All this would be aimed at encouraging SMoH to progressively improve its capacity to run the PHC services sustained and supported by COSV in the last years.

Advocacy actions could be put in place in order to raise awareness at State and Federal level on the structural needs of the areas (e.g. roads) addressing them to the appropriate governmental and international interlocutors.

COSV could develop and implement adult literacy interventions, in order to strengthen staff's and communities' competences, and therefore reinforce the attained results and strengthen the durability of achieved benefices. This would be particularly important to improve health staff's understanding and competences in monitoring and accounting for the PHC service provided, for the implemented activities and achieved results. This would also result in improved health staff's training effectiveness. Enhanced adult literacy at village level would imply an improved and quicker comprehension of the health messages and of the advantages of putting into practice the promoted changes in crucial attitudes and behaviours (hygiene, delivery, breastfeeding, family planning, wash) besides obvious benefices and advantages related to the capacity of basic reading, writing and counting, especially for female beneficiaries. This would certainly strengthen achieved results and benefices, indirectly promote gender equity and improve their sustainability and impact. Again, these pursued efforts of COSV should possibly encounter the availability of adequate funds.

International donors should possibly continue supporting COSV and actively collaborating to the smooth achievement of pursued results and aimed benefices, as they have been doing until now.

Attachment N. 1 – Final Evaluation ToRs

TERMS OF REFERENCE EXTERNAL FINAL EVALUATION OF THE PROJECT: "Provision of primary health care services in Kulbus Locality in West Darfur." COSV (Coordinamento delle Organizzazioni per il Servizio Volontario)

1. Background Project description: COSV supports primary health care service delivery in Kulbus locality of West Darfur state in Sudan since 2004. Overall, the project aims at reducing the mortality and morbidity among highly vulnerable population through provision of integrated Primary Health Care services and strengthening emergency preparedness and disease outbreak response and control mechanisms in Kulbus locality. The health facilities supported include one Primary Health Care Center at Kulbus township and 12 Primary Health Care Units namely: Hajar Assal, Rahat Rahma, Dohosh, Arwa, Batro, Wadi Barda Village, Wadi Barda IDPs, Mastora, Andussa, Hajar Liban, Adareeb and Helilat. The total number of beneficiaries in the catchment area of these facilities is up to 49,360 out of which 15,718 are local men residents, 19,742 are local women residents and 10,610 are children. In addition, 3,290 other beneficiaries are mainly composed of returnees, Sudanese people who returned from Chad following stability in the area. A further number of indirect beneficiaries include Nomadic groups and Refugees who live in Chad along the border with Sudan. Women and Children remain a highly vulnerable group forming a majority (61%) of the total population and feeling the effects of conflicts. The project therefore targeted them to ensure quality Maternal health through post-ante natal care, RH services, routine and national vaccination campaign (in collaboration with the State Ministry of Health) together with Accelerated Child Survival Initiatives. The health staff (medical assistant, Nurses, Midwives, Community health worker, Expanded Program on Immunization team, Health promoters, etc.) is at the center of the intervention, periodically trained on the main health and emergency response topic.
The awareness activities are a key component in COSV health intervention, planned to increase capacity building of the beneficiary population in Kulbus Locality. Organized by health promoters in the villages around Kulbus, they include the distribution of educational material and the relation and training of the Village Health Committees on topics such as the unit management system.

Overall Objective: To contribute to reduce mortality and morbidity among a highly vulnerable population in Kulbus Locality in West Darfur. Specific Objective: To improve the quality of integrated primary health care services provision in 12 phcus and 1 phcc in Kulbus Locality. Results: 1. Increased quality of the service in one PHCC and 12 PCHUs in Kulbus Locality to provide primary health services for men and women. 2. Strengthened preparedness and control mechanism for emergencies and diseases in coordination with SMoH, the local community committees, local authorities and local partner. Through also a gender focus training and activities. 3. Increased capacity of the health staff of the PHCC and PHCUs (Medical Assistant, EPI team, VCT, midwives, community health workers, nurses, health promoters…). ***2. Evaluation purpose*** To assess the degree to which the objectives pursued have been achieved, in terms of qualitative and quantitative results; To investigate to what extent the project's outcomes (physical and immaterial services delivered to the beneficiaries) will be sustainable in the long term. ***3. Evaluation Results:*** • Relevance and programme design. • Efficient use of resources, human and financial. • Effectiveness of the project to meet population health needs. • Impact and visibility. • Potential sustainability.
 Conclusions and recommendations at both the strategic and operational level.

 The consultant will submit a written report within two weeks of the visit.

4. Evaluation criteria and analysis levels
Relevance: The evaluation team should analyze if the intervention is pertinent and relevant to its objectives and the needs identified in the field. Efficiency and effectiveness The team should

analyze the management of the human, technical, financial resource. Impact: The evaluation study should include an analysis of project impact to the beneficiaries population. ***5. Evaluation Unit and Consultant's role*** The evaluation unit will be composed by a team at least of two independent consultants, either part of an organization or acting as independent consultant. One of them will assume the team coordination. The consultants should have the following required skill:

 University degree in public health, international development or related social science.

 Experience in the formulation, monitoring and evaluation of projects in Maternal, Child and Public Health.

 Similar work in the last 3 years.

 Solid experience in fields of work relevant to the evaluation is required.

 A demonstrated high level of professionalism and an ability to work independently and in high-pressure situations under tight deadlines.

 High proficiency in written and spoken English.

 Excellent reporting and communication skills.

6. Work plan The overall duration of the consultancy should not be more than 30 days. The work shall realize in the following three phases: *Phase I: Desk studies*
Briefing information about the project and staff at the Country Office level in Khartoum, during which all the documents available for the mission and necessary clarification will be provided to the evaluation team. This should take up 7 days. During this period mission planning and field work should be organized. *Phase II: Field work* After the first phase the consultant shall undertake a field visit to West Darfur, Geneina and Kulbus. The consultant will be in contact with COSV office in Geneina and Kulbus, where the project activities run. (Maximum 20 days including travel). *Phase III: Drafting* The first draft report shall be submitted by electronic transmission within 15 calendar days after the consultant's return from the field. Cosv will have 5 working days to make its comments. *IV. Submission* of the final evaluation report should be submitted to COSV within 10 calendar days after the comments from the partner being evaluated. ***7. Methodology and activities***

 Evaluators will review all activities with on-site observations and considering the quality of the work accomplished. A combination of observation and discussion will allow identification of the changes in community patterns.

 This can be considered on both a community and household level. A participatory approach will be used to evaluate the community activities. Follow-up interviews with beneficiaries will be an appropriate tool.

 Interviews with communities including community councils will provide an insight into the impact of the community-based approach.

 Interviews with all actors: local authorities, other NGOs and key sources of information in the area.

Activities:

 Study of documents related to the project

 Interview/working groups with NGO staff

 Field visits

 Focus groups and interviews with local stakeholders

 Further evaluation activities (the need for which will be identified by the evaluator during preparation of the final ToR and the field work)

 Report writing.

8. Report The evaluation will result in the drawing up of 1 report written in English, including the Executive Summary which should appear at the beginning of the report.

 Table of contents: Introduction; Approach used; Operational context; Project relevance; Project efficiency and effectiveness; Methodology; Survey conclusion

 Executive Summary It should be short, and should focus on the key purpose or issues of the evaluation, outline the main points of the analysis, and clearly indicate the main conclusions, lessons learned and specific recommendations.

 Main body of the report It will include references to the methodology used for the evaluation and the context of the action. In particular, for each key aspect (Relevance, efficiency, effectiveness, impact and sustainability). Recommendations should be as realistic, operationally sound and pragmatic as possible; that is, they should take careful account of the circumstances currently prevailing in the context of the action, and of the resources available to implement it locally.

9. Sources and documentation The following documentation will be available from the NGO:

 Project proposal

 Budget

 Contract

 Interim report(s)

 Any other available technical documentation

10. How to Apply

The proposal and CV of evaluator have to be sent by email to: cosv.countryrepsudan@gmail.com
Deadline: 30th of June 2014

5.2 Attachment N. 2 - Itinerary and field visits

Date	Activity	Place	Interlocutors
11/08/14	Departure from Bologna – Italy		
12/08/14	Arrival in Khartoum – Sudan / Initiation of travel permit procedures / Collection of project documents / Revision of project LF and indicators	Khartoum COSV Office	COSV Country Rep / COSV HR Admin Assistant / COSV Logistic Officer
13/08/14	Desk Review / development and adjustment of indicative interviews / development of tentative field agenda	Khartoum COSV Office	COSV Country Rep
14/08/14	Desk Review / adjustment of indicative interviews / adjustment of tentative field agenda	Khartoum COSV Office	COSV Country Rep
15/08/14	Desk Review / adjustment of indicative interviews / adjustment of tentative field agenda	Khartoum COSV Office	COSV Country Rep
16/08/14	Desk Review / adjustment of indicative interviews / adjustment of tentative field agenda	Khartoum COSV Office	COSV Country Rep
17/08/14	Desk Review / development and adjustment of indicative interviews / adjustment of tentative field agenda / Initiation of draft FE Report	Khartoum COSV Office	COSV Country Rep / COSV HR Admin Assistant
18/08/14	Finalisation of support documents for final evaluation / finalisation of indicative interviews / adjustment of tentative field agenda	Khartoum COSV Office	COSV Country Rep / COSV HR Admin Assistant
19/08/14	Travel Khartoum – Genina / Registration to HAC office and validation of travel permit / Interview to Head of Malaria Dept SMoH / Collection of key project documents, data and statistics / adjustment of field agenda / initiation interview to COSV Health Coordination	HAC Office / Genina COSV Office /SMoH offices	COSV Country Rep / COSV HR Admin Assistant / COSV logistic and security responsible / Director of SMoH Malaria Dept. / COSV Health Coordinator
20/08/14	Travel Genina – Kulbus / Registration at National Security / Finalisation of field visits and meetings agenda and check of logistics / Organisation of escort for field visits with Police / Individual Interviews / Meeting with HAC Commissioner in Kulbus	National Security office / HAC Commissioner for Kulbus base / COSV Kulbus office / COSV PHCC	COSV Country Rep / COSV logistic and security responsible / EPI and VCT Focal Point, COSV PEs Supervisor, VCT / COSV Nutrition Supervisor and Base Manager / COSV Medical Officer / Kulbus Police Deputy Commander / COSV pharmacist and stock keeper / HAC Commissioner in Kulbus
21/08/14	Meeting with Kulbus Commissioner and HAC Commissioner / Individual interviews / Units visits / Assessment of Hajer Assal's rehabilitation works	Kulbus Commissioner Office / Wadi Bardi IDP Unit / Wadi Bardi Village Unit / Hajer Assal Unit / COSV Kulbus Office	COSV Country Rep / COSV logistic and security responsible Kulbus Commissioner / HAC Commissioner in Kulbus / COSV PHCC pharmacist / COSV PHCC pharmacy stock keeper / Wadi Bardi IDP CHW / Wadi Bardi IDP OMDA and VHC member / Wadi

			Bardi Village CHW / Wadi Bardi Village PE / Wadi Bardi Village Sheik and VHC member / Hajer Assal CHW / Hajer Assal PE
22/08/14	Collection of key project documents, data and statistics; initial assessment of project data and statistics / Individual Interviews	COSV Kulbus Office	COSV Country Rep / COSV logistic and security responsible / EPI and VCT Focal Point
23/08/14	Individual Interviews	COSV Kulbus Office	COSV Country Rep / COSV logistic and security responsible / Kulbus town PEs
24/08/14	Individual interviews / Units visits / Collection of additional key project documents, data and statistics	Rahat Rahma Unit / Arwa Unit / COSV Kulbus Office	COSV Country Rep / COSV logistic and security responsible / Rahat Rahma CHW / Rahat Rahma MW / Rahat Rahma Sheik and VHC member / Arwa CHW / Arwa PE / Arwa Sheik and VHC members / COSV Medical Doctors
25/08/14	Collection of additional key project documents, data and statistics / Travel Kulbus – Genina / Individual interviews	COSV Kulbus Office / COSV Genina Office / SMoH Dept of PHC and RH	COSV Country Rep / COSV logistic and security responsible / SMoH Head of Dept of PHC and RH
26/08/14	Individual Interviews / Initial review and systematisation of statistics and data	COSV Genina Office / SMoH DG and EPI Dept Offices	COSV Country Rep / COSV logistic and security responsible / COSV Health Coordinator / SMoH DG / Head of Dept of PHC and RH / SMoH Head of EPI Dept
27/08/14	Travel Genina – Khartoum / Review and systematisation of statistics and data		COSV Country Rep
28/08/14	Review and systematisation of statistics and data	Khartoum COSV Office	COSV Country Rep
29/08/14	Review and systematisation of statistics and data	Khartoum COSV Office	COSV Country Rep
30/08/14	Departure from Sudan / Arrival in Bologna - Italy		

5.3 Attachment N. 3 - List of consulted persons (in chronological order)

Name	Position
Flavia Nigri	COSV Country Representative
Magdi Ibrahim Malik	COSV Logistic Officer
Faisal Zakaria Hussein	COSV HR Admin Assistant
Abdelrhman Mohammed Abdelwha	COSV Health Coordinator
Gamma Yahya Ali	COSV logistic and security responsible
Dr. Osman Ali	Director of SMoH Malaria Dept.
Maamia Khedir Adriss	EPI Focal Point, COSV's PEs Supervisor, VCT
Abulgasim Mohammed Ibrahim	COSV Nutrition Supervisor and Base Manager
Dr Mohammed Mahmoud	COSV Medical Officer
-	Kulbus Police Deputy Commander
Selma	COSV PHCC pharmacist
Salim	COSV PHCC pharmacy stock keeper
Haidar Adam Ali	HAC Commissioner in Kulbus
Mohammed Abdallah Adam	Kulbus Commissioner
Abdallah Hassan Idriss Ismail	CHW - Wadi Bardi IDP
Mohammad Isaac Yahya	OMDA and VHC member - Wadi Bardi IDP
Abdelaziz Suleiman Aaron	Community member - Wadi Bardi IDP
Eltyb Ahmad Abaker	CHW - Wadi Bardi Village
Ismail Dawood	Sheik and VHC member - Wadi Bardi Village
Mohammed Adam Mahmoud Fadul	PE - Wadi Bardi Village
Fadul Yahya Adam	CHW – Hajer Assal
Ishag Osman Musa	PE – Hajer Assal
AzzaHabeeb Abubakar	PE - Kulbus
Haja Adam Abdurahman	PE – Kulbus
Maria Ahmed Musa	PE – Kulbus
Yasmin Yousif Yahya	PE – Kulbus
Mahasin Abakar Hussein Adam	PE – Kulbus
Maria Abdalla Ishag Mursal	PE – Kulbus
Sheik Adam Mokhtar	President – Al Nahda NNGO
Abaker Addoum Hassan	CHW – Rahat Rahma
Fatme Suleiman Mohammed	MW – Rahat Rahma
Abdallah Mohammed Zein	Sheik / VHC member – Rahat Rahma
Amsa Isaac	Sheik / VHC member – Arwa
- (2 names not provided)	2 VHC members – Arwa
Mohammad Fadul Idriss	CHW – Arwa
Abakar idriss Ibrahim	PE – Arwa
Abdeldraman Mohammad Idriss	Sheik / VHC Head – Arwa
Abdallah Isah Adam Aldoum	VHC member – Arwa
- (6 names not provided)	6 VHC members – Arwa
Dr. Asma Amhaim	Director of SMoH PHC and RH Dept.s
Dr. Younis Harun Adam	DG SMoH
Dr. Moubarak	Director of SMoH EPI Dept.

Attachment N. 4 – WMMB Project Statistics (From Week 28/2013 until Week 32/2014[54])

Totals July - December 2013					Total January - August 2014			
>=5		0-4			>=5		0-4	
الوفيات Deaths	الحالات Cases	الوفيات Deaths	الحالات Cases	Health event الوضع الصحى	الوفيات Deaths	الحالات Cases	الوفيات Deaths	الحالات Cases
0	711	0	1422	Other Diarrhea	0	1144	0	1784
0	0	0	0	الاسهال المائى الحاد (Acute watery diarrhea)	0	0	0	0
0	0	0	0	الشلل الرخو الحاد (AFP)	0	0	0	0
0	903	0	1052	الالتهاب التنفسى الحاد (ARI)	0	1136	0	1290
0	752	0	376	الاسهال المصحوب بدم- دسنتاريا (Bloody diarrhea – Dysentery)	0	1021	0	546
0	873	0	419	الاصابات والجروح (Injuries, violent)	0	1513	0	647
0	551	0	242	الملاريا (Malaria)	0	302	0	144
0	0	0	0	الحصبة اشتباه (Suspected Measles)	0	0	0	0
0	0	0	0	تتانوس حديثى الولادة (Neonatal Tetanus)	0	0	0	0
0	2	0	180	سوء التغذية الحاد (Severe Malnutrition)	0	11	0	450
0	0	0	0	اشتباه التهاب السحايا (Suspected Meningitis)	0	0	0	0
0	938	0	666	حميات مجهولة (Unexplained Fever)	0	1251	0	984
0	0	0	0	حاد يرقان (Acute Jaundice syndrome)	0	0	0	0
0	10878	0	5246	اخرى (Others)	0	8948	0	5162
No Remarks								

[54] Week 27/2013 and 42/2013 could not be found, and are not included in presented totals.

>=5		<5		الوضع الصحى Health Events	>=5		<5	
الوفيات deaths	الحالات cases	الوفيات deaths	الحالات cases	Classifications of Others	الوفيات deaths	الحالات cases	الوفيات deaths	الحالات cases
0	864	0	591	الامراض الجلديه skin infections	0	1039	0	787
0	989	0	954	أمراض العيون Eye Infections	0	1132	0	1503
0	0	0	0	الديدان Worms	0	0	0	0
0	550	0	17	الامراض المنقوله جنسيا STI	0	641	0	129
0	0	0	0	مشاكل الاسنان Dental Problems	0	0	0	0

Attachment N. 5 – RH Statistics (RH Monthly Reports from July 2013 to July 2014)

	Totals 2013			Totals 2014		
	< 18 y اقل من 18 سنة	> 18 y اكبر من 18 سنة	Total المجموع	< 18 y اقل من 18 سنة	< 18 y اقل من 18 سنة	Total المجموع
No. women attended ANC – 1st visit عدد النساء اللائى حضرن لكشف زيارة واحدة -الحمل	406	547	**953**	424	764	**1188**
No. women attended ANC – 2nd visit عدد النساء اللائى حضرن لكشف زيارتين -الحمل	367	466	**833**	343	612	**955**
No. women attended ANC – 3rd visit عدد النساء اللائى حضرن لكشف زيارات 3-الحمل	287	416	**703**	288	493	**781**
No. women attended ANC – 4th + visit عدد النساء اللائى حضرن لكشف زيارات او اكث 4-الحمل	227	367	**594**	270	484	**754**
Number of ANC total مجموع النساءاللائى حضرن لكشف الحمل	1074	1580	**2654**	1325	2353	**3678**
No. of women with Diastolic BP > 90 عدد النساء ذوات ضغط انبساطى اكثرمن90	5	14	**19**	15	42	**57**
No. of anaemia cases clinically diagnosed عدد حالات الانيميا اكلينيكيا (في حالة عدم توفر فحص معملى	0	2	**2**	0	2	**2**
No. of women received iron/folic acid عدد النساء اللائى تلقين حبوب حديد/ فولك اسد	1082	1444	**2526**	1033	1479	**2512**
No. of women received TT1 عدد النساء اللائى تلقين تتانوس توكسويد (جرعة واحدة)	554	517	**1071**	541	554	**1095**
No. of women received TT2+ عدد النساء اللائى تلقين تتانوس توكسويد (جرعتين او اكثر)	466	635	**1101**	469	702	**1171**
Number of miscarriages / abortion عدد حالات الاجهاض	10	15	**25**	7	19	**26**
No. of home deliveries عدد الولادات بالمنزل	170	253	**423**	244	267	**511**
No. of Health facility deliveries عدد الولادات بالمؤسسة الصحية	48	45	**93**	16	24	**40**
No. of births attended by TBA عدد الولادات التى تمت تحت قابلة تقليدية اشراف	94	161	**255**	80	115	**195**

No. of women developed any complications عـدد النسـاء اللائـى حـدثت لهـن مضـاعفات	1	3	**4**	0	4	**4**
Reasons of referrals: اسـباب التحويـل	Abnormal presention / 3 weeks uterine contraction / 2IUFD / 14years old prime-gravida / premature labour / 14years PG /antipartum hemorrhage / CP / APH / 14 ys PG					
No. of maternal deaths عـدد وفايـات الامهـات	0	0	**0**	0	0	**0**
Causes of deaths: حـالات الوفايـات	None reported					
No. of neonates developed complications عـدد المواليـد الـذين حـدثت لهـم مضـاعفات	2	0	**2**	0	0	**0**
Number of stillbirths عـدد المواليـد الميتيـن	4	0	**4**	4	3	**7**
Number of neonatal deaths عـدد وفيـات حـديثى الـولادة	2	0	**2**	0	1	**1**
No. babies weighing less than 2500 gr من اقـل اوزانهم الـذين المواليـد عدد. كجم 2500	20	25	**45**	2	1	**3**
Number of post natal visits فـترة فـى المنزليـة الزيـارات عدد النفـاس	307	399	**706**	450	470	**920**
Number of women with post natal complications عـدد اللائـى حـدثت لهـن مضـاعفات بعـد الـولادة	7	6	**13**	2	3	**5**
No. of male condoms distributed عـدد العـوازل الذكريـة الموزعـة	103	394	**497**	109	82	**191**
Total No. of cases treated for STDs الجنسـية الامراض حـالات عدد مجموع العـلاج اتلقـو الـذين	20	19	**39**	40	64	**104**
No. of clients used combined pills حبوب هرمون -عـدد المسـتفيدات مزدوجة	44	75	**119**	59	65	**124**
No. of clients used mini pills هرمون حبـوب -المسـتفيدات عدد 1(مرضـعات)واحد	63	89	**152**	86	97	**183**
No. of clients used injectables حقـن -عـدد المسـتفيدات	10	10	**20**	20	19	**39**

Total No. of users of FP methods عدد المستفيدات مجموع	203	235	**438**	162	190	**352**
No. Clients using FP methods for first time عدد مرة المستفيدات لاول	78	99	**177**	51	56	**107**
No. awareness sessions on family planning عدد حلقات التثقيف الصحى تنظيم الاسرة بخصوص	267	416	**683**	126	161	**287**
No. awareness sessions on safe motherhood عدد الصحى التثقيف حلقات الامنة الامومة بخصوص	307	354	**661**	103	122	**225**
No. awareness sessions on STIs, HIV/AIDS عدد الصحى التثقيف حلقات والامراض الايدز بخصوص جنسيا المنقولة	317	262	**579**	81	93	**174**
No. awareness sessions on GBV التثقيف حلقات عدد المبنى العنف بخصوص الصحى النوع على	120	149	**269**	58	72	**130**

Attachment N. 6 – Home visits

MONTHS / YEARS	NUMBER OF VISITS	NUMBER OF PEOPLE REACHED		
	HOUSEHOLDS	MEN	WOMEN	TOTAL
1 July - 31 December 2013	**1100**	**2362**	**2419**	**4781**
January 2014	200	460	454	**914**
February 2014	280	612	617	**1229**
March 2014	270	614	614	**1228**
April	270	673	685	**1358**
May	270	689	677	**1366**
June	270	644	605	**1249**
July	230	508	517	**1025**
Total 2014	**1790**	**4200**	**4169**	**8369**
Total 1st July 2013 - 31st July 2014	**2890**	**6562**	**6588**	**13150**

Attachment N. 7 – Health Sessions

Date	Venue	Topic	Participants		
			Total	M	F
02/03/2014	gergera	immunization + breastfeeding	27	0	27
04/03/2014	krngla	immunization + breastfeeding /personal & f.h	47	10	37
mar-14	habela	immunization + breastfreeding	33	1	32
mar-14	remta	immunization + breastfeeding	43	2	41
mar-14	helilat	immunization + breastfeeding	38	2	36
mar-14	shgog + mrnog	immunization +breastfeeding	23	2	21
mar-14	sania + amsiala	immunization +breastfeeding	33	1	32
25/03/2014	sania + hela noreen	immunization + breastfeeding	35	3	32
01/04/2014	hemida	immunization + breastfreeding	40	1	39
06/04/2014	adarreb	immunization + breastfreeding	34	0	34
08/04/2014	sag alnaam	immunization + reproductive / personal & f.h	30	1	29
13/04/2014	hajer teoeer	immunization + breastfreeding / personal & f.h	49	16	33
15/04/2014	nama	immunization + breastfeeding	37	1	36
20/04/2014	mta bnoo	immunization + breastfeeding	38	7	31
22/04/2014	ostanie	immunization +personal & f.h	33	4	29
04/05/2014	hratha + dhol alkher	immunization + breasfreeding	33	27	6
06/05/2014	koorna +	immunization + breastfeeding / personal & f.h	38	0	38
11/05/2014	grdood	immunization + breastfeeding	41	4	37
13/05/2014	hbelaia + asspor	immunization + personal & f.h	36	3	33
18/05/2014	hila ageed	immunization + breastfeeding	36	3	33
20/05/2014	fiafe	immunization + breastfeeding / personal & f.h	31	0	31

Date	Venue	Topic	Participants		
03/06/2014	dohoosh	immunization + breastfeeding / personal & f.h	38	4	34
10/06/2014	taklng	immunization personal & f.h	35	1	34
17/06/2014	omgrgo + goz mkhet	immunization + breastfeeding / personal & f.h	31	3	28
24/06/2014	goshosh	immunization + breastfeeding	33	0	33
29/06/2014	arowa	immunization + breastfeeding	42	3	39
Totals			934	99	835

Dates	Venues	N. Sessions	Topics	Participants		
				Total	M	F
14-28/05/2014	Hajer Leban south	1	Personal and food hygiene Reproductive health Breastfeeding FP	36	11	25
	WBV east	1	same as above	32	8	24
	Entedaat A Kulbus Town	1	same as above	52	7	45
	Entedatt B Kulbus town	1	same as above	56	12	44
	Adareeb east	1	same as above	31	9	22
	Al Kefah Kulbus town	1	same as above	22		22
	Attadamon Kulbus town	1	same as above	28	8	20
	Salam B Kulbus town	1	same as above	20	4	16
	Adareeb west	1	same as above	21	5	16
	Assalam A Kulbus town	1	same as above	20	8	12
	WB IDP	1	same as above	23	8	15
	Hajer Leban north	1	same as above	33	14	19
	totals	12				

Dates	Venues	N. Sessions	Topics	Participants		
12-27/06/2014	Kulbus town (Nassour, Imtedat A, Assalam A, Assalam B, Attadamoun, Al Nahda, El Kefah, Azawie, Imtedat B areas), Denkis (Adareeb), Adareeb, Sad en Naam (Adareeb), Mastura, Rimta (Mastura), Immeda (Adareeb), Rahat Rahma, Mayelo (Hajjer Assal), Matabano (WB Village), Moahammad Morussal (Mastura), Habila (Mastura), Shid Fuok (Hajer Assal)	24	Personal and food hygiene Reproductive health Breastfeeding FP	825	133	692
08-19/06/2014	Kulbus town (Al Kifah, Al Nahda, Entedaat A, Entedaat B, Annosour A, Annosour B area), Hajer Assal, Hajer Leban west, RR, WB Village centre, Hajer Assal west, Arwa, Rahat Rahma, Adareeb north, Takaian (Hajer Assal), Mastura, Gos deiga (Mastura), Naga Village	24	Personal and food hygiene Reproductive health Breastfeeding FP	809	121	688

Attachment N. 8 – List of Trainings

LogFrame Activity Code	Dates	BNFs	Training Subject
3.3	21/07/2013	25 TOT: 1 MA + 1 lab tec + 12 CHW + 3 nurse + 2 EPI/PE + 6 MW	AWD
3.1	03/09/2013	19 (role not specified in list of participants)	AWD for health staff
3.4	09/09/2013	27 from: Arwa [3], Hospital (?) [2], Kulbus [6], Batro [2], Hajer Leban [2], Adareeb [1], WB IDP [1], Mastura [1], Hililat [1], WB V [2], Hajer Assal [4], Danks (?) [1], Dohoush [1]	GBV workshop for VHCs
2.5	15-19 /09/2013 tutto contabilizzato al 19	17(role not specified in list of participants)	PCM: Project writing, Report writing, M/E
2.4	22/12/2013	39 VHC members (villages not indicated)	CBS
3.3	30/01/2014	19 PE	EWARS
2.4	15-16/05/2014 contabilizzato al 16	33 VHC members from: Adareeb [2], Hajer Assal [2], Kulbus [8], Andussa [3], Batro [2], Rahat Rahma [1], Arwa [3], Hililat [1], WB V [2], WB IDP [2], Hajer Leban [2], Mastura [2], Dohoush [2], WB not specified [1]	
3.2	16/06/2014	18 (village not specified)	basic EMoC
3.1	22/06/2014	15: 14 CHWs + 1 store keeper	Rational use of drugs
2.4	15/06&2014	20 VHC members +LA from Mastura	not specified
2.2	41802	NOT accounted as no incentives, but checked with CR	
3.1	04/07/2014	13	Fill out format and strengthen reporting system
3.2	05/07/2014	10 MW (villages not indicated)	Post Natal Care, safe delivery, RH and FP
3.3	15/07/2014	12 PE	EPI and vaccination

LogFrame Activity Code	Dates	BNFs	Training Subject
3.1	16/07/2014	17: 8 CHWs + 9MWs (villages not indicated)	Infection and Prevention and Control
3.1	18/07/2014	20 health staff (roles and villages not indicated)	Tubercluosis and Typhoyid fever
2.4	11/07/2014	19 VHC members + LA (villages not indicated)	not specified
2.4	20/07/2014	20 (roles and villages not indicated)	community participation /partnership /ownership
3.4	09/078/2014	20 PE	GBV workshop
3.1/3.2	August	CHW/MW	1 training on Skin diseases, STI and HIV
3.1	August	CHWS	1 training session on ARI, Measles, Diarrhea and EWARS
3.2	August	MW	1 Training on Post Natal Care, safe delivery, RH and FP
3.2	August	MW	1 Training on Post Natal Care, safe delivery, RH and FP
2.4	08/10/2014	Community/local Aouthorty	1 training of Advocacy on community participation /partnership /ownership
2.2	14/8/2014	Community	1 Commemoration day / Large Awareness Campaign - in Kulbus
2.4	08/12/2014	VHCs	1 workshop with local authorities and VHCs

Attachment N. 9 – List of Consulted Documents

COSV, Report of KAP Survey on Primary Health Care Service in Kulbus Locality West Darfur State, February 2011

COSV, KAP survey on PHC's main components and Outbreak preparedness in Kulbus Locality – the clients' perspective / KAP Survey - Kulbus Locality - West Darfur – Sudan; December 2013

Government of Sudan - Federal Ministry of Health - Directorate General of Human Resources for Health Development - National Human Resources for Health, Strategic Plan for Sudan 2012-2016

Human Resources for Health (HRH) – Strategic Work Plan for Sudan (2008 – 2012) – A Report for the World Health Organization (WHO) and the Federal Ministry of Health (FMOH)/Sudan, December 2007

IASC – Inter-agency Standing Committee, Guidelines for Gender-based Violence Interventions in Humanitarian Settings – Focus on Prevention of and Response to Sexual Violence in Emergencies, 2005

Inter-Agency Reproductive Health Kits for Crisis Situations – Manual - 4th Edition January 2008, UNFPA

Joint Assessment of Sudan's National Health Sector Strategic Plan (NHSSP, 2012 – 2016), International Health Partnership, January 2013

National Human Resources for Health Strategic Plan for Sudan 2012 – 2016, Government of Sudan, Directorate General of Human Resources for Health Development.

Project Proposal

Project Budget and Project Budget reallocation

Project no-cost extension and project Allocation revisions:
CHF 2013 Allocation Revision Request Form – Project SUD-CODE, presented 18/08/2014

Narrative Progress Report (Interim Report) – 29 April 2014

Project Partnership Agreement for Common/Pooled Humanitarian Funds (Contract)

RH Reports from July 2013 until July 2014

Republic of Sudan, Federal Ministry of health, The National Strategy for Reproductive Health 2006-2010

Sikainga, A. *'The World's Worst Humanitarian Crisis': Understanding the Darfur Conflict*, in "ORIGINS – Current Events in Historical Perspective", online newspaper, Vol. 2, Issue 5, February 2009

Sudan CHF Project Monitoring Visit Form (Visit of of 13th March 2014)

UNFPA, Clinical Management of Rape Survivors – Developing Protocols for use with refugees and internally displaced persons, 2011, Revised Edition.

"Yellow Fever Outbreak in Darfur, Sudan" - Situation Report No 15, 10 January 2013, Federal Ministry of Health / World Health Organization

WHO – Sudan, HeRAMS – Health Resources Availability Mapping System, 2013/2014

WHO/UNFPA/UNHCR, Reproductive Health in refugee situations – an Inter-agency Field Manual, 1999

WMMB reports from Week 28/2013 to Week 32/2014

Women's Commission for refugee women and children, Minimum Initial Service Package for Reproductive Health in crisis Situations: A Distance Learning Module, 2007

Attachment N. 10 – Beneficiaries and stakeholders interviews – Indicative key questions

Indicative Key questions to COSV Medical Officer
Main challenges encountered in general and in the daily work
Main strengths of the intervention
Main positive changes observes since toy are COSV MO
Main negative changes observes since toy are COSV MO
Stock out pharmacy: when, why, how solved
Stock out units: which ones, when, why, how solved

Indicative Key questions to MoH State level (locality Heads/responsible if applicable)
Is COSV's action in line with your Ministry's strategy at State and Locality level? Is it in line with Ministry's priorities (Health Sector Strategic Plan at Federal, State (and Locality levels)?
Where all activities/trainings (Batro unit and PHCC delivery room rehabilitation, units rehabilitations, trainings and PHCC and PHCUs activities) relevant?
Was there some action more relevant in terms of priority than others this last year? And why?
Was there some action or activities that could be done in a different way this last year? Which one/s, and why?
To which COSV's training has the MoH directly collaborated in this last year? What strengths and what weaknesses can you identify for the trainings?
How was the collaboration with COSV in order to carry out the vaccination campaigns? What strengths and what weaknesses can you identify?
How was collaboration? (seconded personnel to COSV) (referral and ambulances) (rehabilitation of delivery room)
What can be done to improve the collaboration?
What is the feedback from the field?
Do you think achieved results will last? Why?
Do you think something more should be done to reinforce achieved results? What? Why?
COSV's MWs and TBA recently got job number – discussion on the issue
CHWs with no certificate – discussion on the issue

Indicative Key questions to project staff (Health Coordinator, CHW coordinator, VCT)
How has interaction among components been during these last 14 months? Why?
How has internal coordination been during these last 14 months? Why?
How has interaction and coordination with local Ministries/counterparts stakeholders been during these last 14 months? Why?
How has interaction and coordination with beneficiaries been during these last 14 months? Why?
Which activities were more relevant/more needed and more urgent? Which less, if any? Why?
Which activities were more effective? Which ones were less effective?

Do you think there are needs and/or priorities that were not covered by COSV action that should be included in future programs? Which ones, and why?
What results have been achieved (in general, positive/more appreciable, less/less appreciable, unexpected positive/negative)? In general and these last 14 months
Do you think achieved results and benefices will last?
How could achieved results and benefices be strengthened and/or widened?
What has changed (less/more) because of the project, and why?
How have changes occurred? Why?
Who (which beneficiaries) has benefited more or less from the activities during these last 14 months? Why?
When have changes (benefices) occurred during these last 14 months? Why?
What could have been done differently? Why?
Which were major weaknesses during these last 14 months? Why?
Which were major strengths during these last 14 months?? Why?
What is the plan for the future?
If applicable: How were volunteers/PEs selected? Vaccinators?
How were PEs geographically distributed?
VCT sessions? HIV test promotion?

Indicative Key questions to MWs
Since when did you start participating in project's activities?
Describe your typical day.
What trainings have you received during these last 14 months?
Were they useful? Why?
Which one/s do you find more useful? Why?
Are you observing changes in your work because of what you learned in these trainings? Which ones?
Which one/s in particular (more or less changes)?
Are you observing negative changes because of what you learned in these trainings? Which ones?
Do you think there are more trainings (additional trainings on new topics) to be done? Which ones? Do you think there are trainings to be done more (retrain)? Why?
Do you think something was not necessary? Or even harmful? Why?
Were drugs and RH kits sufficient at PHCC/PHCU level to cover the patients' needs? Why?
What major challenges do you face/have you faced in your work these last 14 months?
Was there any moment of pause during these last 14 months? Of lack of intervention?
How many times per week do you register new births?
How do you know about deliveries assisted by TBAs? How do you verify them?
How do you carry out awareness sessions? What are the challenges and what are the strengths?

Indicative Key questions to PEs
Since when are you PE?
What does a PE do? Describe your typical day/week.
What training have you received during these last 14 months? Where they useful for your PE activities? Why? Was there some training more or less useful? Which one/s, and why? Would you need additional training, and why?
Which activities were more relevant/more needed and more urgent during these last 14 months? Which less, if any? Why?
How do select the BNFs?
How do you choose awareness and education messages?
EWhich messages were more effective? Which less?
Which activities were more effective during these last 14 months? Which ones were less effective?
Do you think achieved results and benefices will last?
How could achieved results and benefices be strengthened and/or widened?
Do you think there are need and/or priorities that were not covered by COSV action that should be included in future programs? Which ones, and why?
Which activities (e.g. home visits, health awareness sessions) result in more positive outcomes and why? What shortcomings, if any?
Have you faced challenges in your work during these last 14 months? Which one, and why? What have you done to overcome it?

Is there any part of the community that you cannot reach (that is more difficult to reach, e.g. women, men, elderly, other categories)? Why?
Was there any moment of pause during these last 14 months? Of lack of intervention?
What next? Will you continue to carry on? How? Why?

Indicative Key questions to CHWs
Since when are you CHW, and since when do you work with COSV?
What does a CHW do? Describe your typical day/week.
What training have you received during these last 14 months? Where they useful for your CHW activities? Why? Was there some training more or less useful? Which one/s, and why? Would you need additional training, and why?
How do you mobilise the community? How do you reach community's members?
Which activities result in more positive outcomes during these last 14 months and why? What shortcomings, if any?
Have you faced challenges in your work during these last 14 months? Which one, and why? What have you done to overcome it?
Was there any moment of pause during these last 14 months? Of lack of intervention?
What next? Will you continue to carry on? How? Why?

Indicative Key questions to VHC
Since when do you have a PHCU in your village?
Since when do you voluntary supervise the Unit's work?
Please, can you describe me what you do daily/weekly to monitor and supervise the unit?
Which COSV/MoH's activities were more relevant/more needed and more urgent in your community? Which less, if any? Why?
Which activities were more effective? Which ones were less effective?
Do you think achieved results and benefices will last?
How could achieved results and benefices be strengthened and/or widened?
Do you think there are need and/or priorities that were not covered by COSV action that should be included in future programs? Which ones, and why?
What COSV activities/training did you attend? Please describe.
Were they useful? Why?
Was there a training/workshop you deemed more/less useful than others? Which one/s and why?
Do you think you need more training? Why?
Do you and other village volunteers meet regularly (VHC)? How often?
Do you think there's need for more recurrent meetings? Why?
What challenges have you observed at the units? If applicable: have you got suggestions to overcome them?
What benefices have you observed (from Unit's service to the village/community, from mobile activities – EPI, Nutrition, VCT, others)? Please describe.
Do you think they will last? Why?
What next? Will you continue to carry on? How? Why?

Indicative Key questions to Nahda
Since when have you started collaborating with COSV? How?
Is COSV's action in line with your organisation's strategy and priorities? Why?
What activities have your organisation carried out with COSV?
What results have been achieved because of these activities?
What benefices have resulted from these activities?
Which activity was more useful? And which less? Why?
Do you think something more should be done to reinforce achieved results? What? Why?
Do you think achieved results and benefices will last? Why?
How was the collaboration with COSV?
What strengths and what weaknesses can you identify (in activities implementation, in the collaboration between COSV and the organisation?
What can be done to improve the collaboration?
What is your organisation's plan for the future?

Indicative Key questions to UNFPA
Is COSV's action in line UNFPA's strategy and priorities of action in the State/Locality?
How has the collaboration/interaction with COSV been?
What challenges have you encountered during last year?
How were challenges overcome?
Which actions were more relevant/more needed and more urgent? Which less, if any? Why?
Which actions were more effective? Which ones were less effective?
Do you think achieved results and benefices will last?
How could achieved results and benefices be strengthened and/or widened?
Do you think there need and/or priorities that were not covered by COSV action that should be included in future programs? Which ones, and why?

Indicative Key questions to State Commissioner
How do you know COSV and COSV actions?
Is COSV action in line with your Locality's health priorities and needs?
Which actions were more relevant/more needed and more urgent? Which less, if any? Why?
Which actions were more effective? Which ones were less effective?
Do you think achieved results and benefices will last?
How could achieved results and benefices be strengthened and/or widened?
Do you think there need and/or priorities that were not covered by COSV action that should be included in future programs? Which ones, and why

Attachment N. 11 – Project Log-Frame and Work plan

LOGFRAME

	PROJECT DESCRIPTION	INDICATORS	SOURCE OF VERIFICATION	ASSUMPTIONS
	Overall Objective (OO): *Describes the expected long-term change*			
	To contribute to reduce mortality and morbidity among a highly vulnerable population in Kulbus Locality in West Darfur.	Crude mortality rate in target populations maintained at below 1 death/10,000 people/day, under-5 mortality rate in the target population maintained at below 2/10,000/day	WMMB, Maternity department regisister, ANC and PNC reports.	Collaboration with SmoH and other partner. Smooth accessability to the Villages.
	Purpose/Specific Objective: *The immediate effect of the intervention measured at the end of the project*			
	To improve the quality of integrated primary health care services provision in 12 phcus and 1 phcc in Kulbus Locality.	100% of outbreaks and health emergency are promptly detected and responded. Number of consultations per all health facilieties.	WMMB, PCHUs and PHCC register, staff report, Weekly surveillance reports, pharmacy register.	Smooth cooperation between the local health actors continues. Availability of essential medicines and kits.
	Results/Outcomes: *specific and measurable achievements during the project period*			
1	1. Increased quality of the service in one PHCC and 12 PCHUs in Kulbus Locality to provide primary health services for men and women.	15780outpatient consultations per all health facility (direct beneficiaries receiving the service) during the 6 months of project implementation One delivery room at the PHCC has been rehabilitated and equipped during the 6 months of project implementation.	PHCUs and PHCC registers. ANC register, pharmacy register. Pictures and inernal reports.	Availability of essential medicines and kits. Good cooperation with UN agency for the provision of the Kits.
2	2. Strengthened preparedness and control mechanism for emergencies and diseases in coordination with SMoH, the local community committees, local authorities and local partner. Through also a gender focus training and activities.	100% of communicable disease outbreak alerts detected and response initiated within 72 hours. 70% of births assisted by skilled birth attendant	WMMB, epidemiological department of MOH (even Zero report). ANC register of the PHCUs and PHCC, RH reports.	Access to the field and good collaboration with SmoH and WHO to prevent cases of emergency.
3	3. Increased capacity of the health staff of the PHCC and PHCUs (Medical Assistant, EPI team, VCT, midwives, community health workers, nurses, health promoters…).	34 female and 22 male of the health staff trained and retrained in 6 months project implementation.	Attendance list of the training, reports and pictures.	Good collaboration with SmoH for the training. Positive participation of the health staff.

	PROJECT DESCRIPTION	INDICATORS	SOURCE OF VERIFICATION	ASSUMPTIONS
	Activities:			
1				
1.1	Provision primary health care services through 12 PHCUs and one PHCC in Kulbus locality, including the ANC and PNC services for Women.	1.5 utilization rate per beneficiaries per 6 months.	PHCUs and PHCC registers. WMMB.	Smooth cooperation with SmoH and access in the area.
1.2	To provide basic RH services packages	65% of births assisted by skilled birth attendant	RH report and maternity dep register	UNPFA agreement signed up.
1.3	Purchase and provision of essential medicines. Provision of Unicef phcc kits and reproductive health supplies from UNFPA at 13 health facilities (12 phcus and 1 phcc)	Stock out of essential & emergency drugs <7 days at PHCC	Pharmacy register	Availabilty of PHCC kits from Unicef and from SmoH.
1.4	Support the SMoH in the implementation of the National and routine vaccination campaigns	60% of coverage of PENTA3 Vaccine in below one year/catchment area	EPI reports.	Smooth cooperation between COSV and EPI SmoH department
1.5	To establish Community based Referral mechanism for Emergency Obstetrics.	65% of births assisted by skilled birth attendant	RH report and maternity dep register	Accessabilty and cooperation with SmoH hospital.
1.6	Rehabilitation of the delivery room at the PHCC and Batro unit	Two devlivery room rehabilitated and equipped at the PHCC centre and Batro PHCUs.	Pictures and registers	Accessability to the aerea.
2				
2.1	Strengthen the coordination system with WHO and SMoH in order to assure the basic qualitative standards for the implementation of an efficient outbreak and emergency preparedness and response system.	100% of outbreaks and health emergency are promptly detected and responded during the project implementation.	Epidemiological zero report to SMoH	Smooth cooperation with SMoH.
2.2	To conduct awareness sessions on FP, ANC, PNC, HIV /AIDS and danger signs of pregnancy for women in RH and mothers	26 health sessions is conducted during 6 months of project implementation.	Peer educator report and pictures.	Interesting and active participation of the community.
2.3	Home visits, VCT session and distribution of IEC materials through the primary health care units, centre and	1440 home visits are done during 6 months of project implementation.	Peer educator report.	Interesting and active participation of the community and accessibility to the villages.

	PROJECT DESCRIPTION	INDICATORS	SOURCE OF VERIFICATION	ASSUMPTIONS
	health promoters.			
2.4	Training to VHCs and local authorities on topics including Supervision & monitoring, facility management, referral pathways and community mobilization.	Six trainings to local authorities and VHC is achieved in 6 months.	Report and pictures.	Positive cooperation with local authorities,
2.5	Capacity building of local partner staff in programme cycle management.	Number of people trained during 6 months.	Report Nahda and pictures.	Smooth collaboration with the local partners.
3				
3.1	Trainings for the health staff (CHW, Nurses, etc.) in topic such as ARI, Measles, Diarrhea, Malaria, Eyes Infections and Meningitis, EWARS.	60 health staff trained and retrained in 6 months.	Training test and pictures,	Active participation of the staff during the training and accessability to the field for the facilitator.
3.2	Trainings for the midwives and TBAs on topic such as anti post-natal care, save delivery, family planning and RH complication	20 midwifes and 26 tbas trained during the 6 month of project duration.	Training test and pictures,	Active participation of the Midiwifes and TBAs during the training and accessability to the field for the facilitator.
3.3	Training for Peer educators on Mother and child care, Dangerous signs during pregnancy, HIV, GBV…etc	12 peer educators trained	Training test and pictures,	Active participation of the Peer educators during the training and accessability to the field for the facilitator
3.4	Gender focuses session for the health staff.	34 health staff assisted at the gender sessions.	Training test and pictures,	Accessability to the field.

PROJECT WORK PLAN

This section must include a workplan with clear indication of the specific timeline for each main activity and sub-activity (if applicable).
The workplan must be outlined with reference to the quarters of the calendar year.
If the project lasts for 12 months, then for planning purposes start the activities in January. If funding is delayed, the work-plan can be updated at the time of contracting in consultation with UNDP.

Activity	Q1 / 2013			Q2 / 2013			Q3 / 2013			Q4 / 2013		
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec
Result 1												
Activity (1.1) Provision primary health care services through 12 PHCUs and one PHCC in Kulbus locality, including the ANC and PNC services for Women.							X	X	X	X	X	X
Activity (1.2) To provide basic RH services packages							X	X	X	X	X	X
Activity (1.3) Purchase and provision of essential medicines. Provision of Unicef phcc kits and reproductive health supplies from UNFPA at 13 health facilities (12 phcus and 1 phcc)							X			X		
Activity (1.4) Support the SMoH in the implementation of the National and routine vaccination campaigns							X	X	X	X	X	X
Activity (1.5) To establish Community based Referral mechanism for Emergency Obstetrics.								X				
Activity (1.6) Rehabilitation of the delivery room at the PHCC and Batro Unit.									X			
Result 2												
Activity (2.1) Strengthen the coordination system with WHO and SMoH in order to assure the basic qualitative standards for the implementation of an efficient outbreak and emergency preparedness and response system.							X	X	X	X	X	X
Activity (2.2) To conduct awareness sessions on FP, ANC, PNC, HIV /AIDS and danger signs of pregnancy for women in RH and mothers							X	X	X	X	X	X
Activity (2.3) Home visits, VCT session and distribution of IEC materials through the primary health care units, centre and health promoters.							X	X	X	X	X	X
Activity (2.4) Training to VHCs and local authorities on topics including Supervision & monitoring, facility management, referral pathways and community mobilization.							X	X	X	X	X	X
Activity (2.5) Capacity building of local partner staff in programme cycle management.										X		
Result 3												
Activity (3.1) Trainings for the health staff (CHW, Nurses, etc.) in topic such as ARI, Measles, Diarrhea, Malaria, Eyes Infections and Meningitis, EWARS.							X	X	X	X	X	X
Activity (3.2) Trainings for the midwives and TBAs on topic such as anti post-natal care, save delivery, family planning and RH complication							X	X	X	X	X	X

PROJECT WORK PLAN

This section must include a workplan with clear indication of the specific timeline for each main activity and sub-activity (if applicable).
The workplan must be outlined with reference to the quarters of the calendar year.
If the project lasts for 12 months, then for planning purposes start the activities in January. If funding is delayed, the work-plan can be updated at the time of contracting in consultation with UNDP.

Activity	Q1 / 2013			Q2 / 2013			Q3 / 2013			Q4 / 2013		
Activity (3.3) Training for Peer educators on Mother and child care, Dangerous signs during pregnancy, HIV, GBV…etc								X		X	X	
Activity (3.4) Gender focuses session for the health staff.							X	X	X	X	X	X

*: TIMELINE FOR EA