To: Darfur Emergency Unit
UNFPA Country Office/SUDAN

ECHO Funded: Darfur Emergency
Reproductive Health Project

Final Evaluation Report
(Phase II Continued Response)
October 2006 – June 2007
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<tr>
<td>ANC</td>
<td>Ante-natal care</td>
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<td>PNC</td>
<td>Post Natal care</td>
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<td>ARI</td>
<td>Acute Respiratory Infection</td>
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<td>RH</td>
<td>Reproductive Health</td>
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<td>CO</td>
<td>Country office</td>
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<td>FP</td>
<td>Family Planning</td>
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<tr>
<td>GOS</td>
<td>Government of Sudan</td>
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<tr>
<td>CBO</td>
<td>Community Based Organization</td>
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<tr>
<td>IEC</td>
<td>Information Education &amp; Communication</td>
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<tr>
<td>HIV/AIDS</td>
<td>Immunodeficiency Virus/ Acquired Immune Deficiency Syndrome</td>
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<tr>
<td>HV</td>
<td>Health Visitor</td>
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<tr>
<td>MA</td>
<td>Medical assistant</td>
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<tr>
<td>PHC</td>
<td>Primary Health Care/ Centre</td>
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<tr>
<td>SDP</td>
<td>Services delivery point</td>
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<tr>
<td>SP</td>
<td>Service provider (MD. MA. Nurse MW)</td>
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<tr>
<td>MW</td>
<td>Midwife</td>
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<tr>
<td>TIBA</td>
<td>Trained Traditional Birth Attendant</td>
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<tr>
<td>SMOH</td>
<td>State Ministry of Health</td>
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<tr>
<td>STI</td>
<td>Sexually Transmitted Infections</td>
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<td>Sexually Gender base Violence</td>
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<td>VCT</td>
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<td>TTBA</td>
<td>Trained Traditional Birth Attendant</td>
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<td>RH</td>
<td>Reproductive Health</td>
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<td>EMOC</td>
<td>Emergency Management of Obstetric Care</td>
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<td>BCC</td>
<td>Behaviour Change Communication</td>
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<td>DHP</td>
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TOR for Evaluation mission of UNFPA Darfur Reproductive Health Project funded by ECHO in 2007

Background:

UNFPA has maintained a presence in the three Darfur states since April 2003 and has consistently supported reproductive health services through provision of supplies and training for better quality of care. Secondary health care facilities (SHC) and primary health care (PHC) centres have also been reviewed in 2006 to determine the level of emergency obstetric care (EmOC) services available at basic EmOC and comprehensive EmOC facilities. In 2007, the UNFPA programme of support to health facilities and support for training was extended thru May 2008. The main objective of the intervention is that IDP women and men of reproductive age, including adolescents, have increased access to comprehensive emergency reproductive health services in greater Darfur region by the end of the project period.

In 2007, the majority of the funding for RH programming has been provided by ECHO and the Common Humanitarian Fund. ECHO grant agreement was extended through July 2007, beyond the terms of the original TOR for the project evaluation.

An evaluator will complete the final evaluation of the following UNFPA activities based on the ECHO grant agreement which was extended through June 2007. He will prepare an evaluation report assessing the achievements and constraints in light of operational and policy environment in Darfur in terms of **Results-based Management** and **UNFPA’s coordination role** and **collaboration/synergy between UNFPA and MoH**, and other relevant government institutions:

**Result 1:** Primary and secondary health care facilities have timely and continuous RH supplies and improved ability to utilize essential RH supplies, equipment and logistical support.

**Indicators:**
- At least one health facility supported in target IDP camps and visited for monitoring, assistance with referral mechanism and technical support on a monthly basis.
- Increase in number of deliveries conducted by skilled birth attendant among target population.
One new comprehensive EmOC facility per state supported with supplies and equipment and established comprehensive EmOC continue to be supported per state level distribution plan. Basic EmOC facilities supported by NGOs and SMoH supported with supplies and medicine per state level distribution plans

(4.8.2.) **Result 2:** Well-trained, competent reproductive health staff serving IDPs at both PHC and SHC facilities in greater Darfur region.

(4.8.3) **Result 3:** Increased demand for reproductive health services and greater awareness of positive reproductive health measures.

Indicators:
IEC material developed and disseminated on safe motherhood, HIV/AIDS and maternal nutrition.
Community outreach supported through three BCC campaigns in each state to encourage health seeking behaviours related to safe motherhood, family planning and prevention of HIV/AIDS among the target population in each state.
**Evaluation Methods:**

Due to the nature of the sources of verification of progress to achieve the results-based management objectives & the stated indicators of progress (See evaluation terms of Reference in Annex I) the major evaluation method used has been documents review & analysis. More than 78 documents – ranging from a 1 to 2 page reports to more than 30 pages – were consulted, practically covering all the sources of information specified in the terms of reference of evaluation. Meetings & interviews were held with the FSUs team leaders & the technical staff (mainly the RH officers). Also senior (DGs) & RH, HIV/AIDS officers & others were met at the state Ministries of Health. (See list of persons met in annex 2). Meetings were also held with the RH & programme coordinators of implementing partners. Visits to a limited number of IOP clinics & to the three Teaching/ CEmoc providing hospitals at the state capitals, were made. At least 3 days were spent in each state.
Findings

Results 1: as stated in TOR
"Primary and secondary health facilities have timely & continuous RH supplies and improved ability to utilize essential RH → supplies & equipment & logistics”.

Indicators:
1) The supply of the now famous RH kits to the greater Darfur region is a major pillar of its strategy to provide accessible RH services at all levels of the health care system to the needy people of the region. UNFPA image which is popular & appreciated by both RH providers & recipients – is largely identified with the supply of RH kits.

During the last quarter of 2006 all three Darfur states received a handsome supply of RH kits to be distributed to RH services providers.

South Darfur:
During 2006 the SFU in Nyala received 1082 RH kits of these 176 kits (kit 1 to 12) were distributed to Nyala Teaching Hospital & ten rural hospitals & to 15 NGO partners operating more than 80 PH centres providing basic RH services. These services are estimated to be accessible to 69% of the total population in the state (1146910) persons. However RH services are accessible to all the IDP population in the state (993438) according to data in Darfur Humanitarian profile No 28 at July 2007.

During the first two quarters of 2007 there was considerable shortage of RH kits that are imported from abroad. As might be expected the shortage affected all three Darfur states. The issue was raised in the RH coordination meetings, communicated to the CO; but there was no feed back to the states as to why there is shortage or when it was expected to be relieved. Feed back on these issues is important to the implementing partners who might seek alternative sources of supplies for a defined period of time. For further information on this recurring problem of RH kits shortage; the reader may refer to the project evaluation report of March – October 2005.

It is perhaps relevant to state that while & was in Nyala (20 sept.2007) a large consignment of RH kits was delivered to the FSU. Since a
distribution plan (by type of kit & quantity/partner) has already been prepared by the three FSU – distribution commenced immediately. It is also worthy to state that during the period of shortage the FSUs managed to locally prepare clean delivery kits & to distribute from their stocks a limited number of kits 3, 5, 8 & keep cool items to the hospitals to the implementing partners.

In the previous evaluation reports the need for the improvement of the management of RH suppliers & their logistics has been stressed. While some improvement has occurred (e.g. the tracking system which has get to operate in all health facilities & the rational estimates of supply requirements which also needs to be fine tuned through micro-planning that is based on target population for RH services & not on the total population as in west Darfur) much needs to be done. The RH supplies situation described above for south Darfur is very much true for the other two states as noted during discussions with the concerned field staff. However quantitative data was not readily available.

2) “Supportive Supervisory Visits to IDP camps clinics”.

Regular visits on a monthly basis are difficult to implement due to the following reasons:
Visits are frequently put on hold for security reasons. During the field visit for this evaluation only camps with in the town could be visited; e.g. Abozar in Genena & Sakali in Nyala.
Making time for visit could be difficult for the busy technical staff.
Shortage of fuel & lack of funds. X Lack of elements of support e.g. RH kits & funds for training. X-Road travel restrictions due to insecurity. In spite of this limitation monitoring/ supportive visits were undertaken in all three Darfur states during the first two quarters of 2007. However, due to the limiting factors above, these activities were more in the nature of “Management by exception” than a routine planned regular & repetitive nature. Given the emergency /conflict situation in Darfur management by exception i.e. visiting for specific reason.

III. Mostly to solve a problem- would seem to be the appropriate approach.

**West Darfur:**
The RH /GBV officer & the GBV assistant visited Garsilla on 16-17/1/2007. A training activity was implemented & the requirements to up-grade Garsilla hospital to a CEmOC facility were assessed. Monitoring trip to Ardamata camp was undertaken by the RH officer & the GBV assistant. A second monitoring trip to Zalling & Garsilla was done during the period 6 -14/3/2007.
Further RH coordinator group has decided to execute a rapid assessment of RH services in the IDP camps. They have developed a smart assessment tool for the exercise in the form of a check-list. The data will provide valuable information about primary care RH services – which is very much lacking at present. A team made up of SMOH staff member, UNFPA/RH officer & an INGO partner carries out the assessment. The assessment tool is so good that there is reason to circulate it to the FSUs to use for data collection at the PHC level. No visits were undertaken during quarter 2 which was devoted to implement the Zallingi Fistula campaign.

Field monitoring visit reports are prepared in the standard CO forms.

South Darfur:
During the first quarter of 2007 the senior RH/GBV officer visited the IDP camps of Kalma, Otash, Seriaf, Sakali & Deraig. The visits main purpose was to assess the RH services in the partner clinics & to identify required actions to improve them. Since in several camps there is more than one clinic repeat visits. Were undertaken to a total of 10 visits. All camps are located in Nyala locality. A planned visit to Kass was not undertaken, because of insecurity. Nyala teaching hospital is often visited during the 2\textsuperscript{nd} quarter. ELSalam & Mosay camps were visited, both are in Nyala locality. Monitoring visits to three other localities; i.e. Kubum, Rehaid ELBirdi & Eelfirsan. The objective of the visit was to assess the capabilities of these rural hospitals to manage Emoc cases & the provision of RH services. The visit also aimed at involving the local communities in facilitating the referral of complicated obstetric emergency cases. Three PH centres were visited. Monitoring visit reports are compiled on the standard CO forms.

North Darfur:
Not much monitoring visits were undertaken in N. Darfur. The main reason being the worsening security situation in the state as indicated by car-jacking – which took place in ELFashir town it self, because of the worsening security for staff; three INGOs (IRC/GOAL Ireland & MSF.B.)were forced to close their clinics in 12 locations. However a joint RH/GBV assessment mission was conducted on 2/ Feb/2007 to kutum & ALwahda localities (no trip report available). Also Relief International had to leave Tawilla hospital, because of insecurity. Sister Hassanat ALnoor the SMOH/RH coordinator stated that staff can not even travel by air to AL-Leait , Tinna, Towaysha & Umkadada locality , because of insecurity. Lack of funds during the
first & 2nd quarters of 2007 must have limited the ability of the FSU to operate as planned.

3) “increase number of deliveries attended by trained health workers”:

The current status of the RH information system does not facilitate an objective evidence-based measurement of an increase in the number of deliveries attended by trained HWs. To be in a position to judge the increase data is needed:

On a serial manner, on regular basis (weekly or monthly on a determined time frame).

A determination of the expected normal/ abnormal deliveries in a specific population size.

The capacity & ability of the specific population (and their desire) to use health facility resources & capacity of the facility to offer the service. While the available data on safe deliveries does not provide these needs; it can generally be stated that judging by process inputs/indicators that safe home delivery numbers & institution based normal deliveries are increasing on time. It is the “impression” of many health workers that there is a considerable increase in the number of safe deliveries as judged by the project inputs. These include support to health facilities – technical, material & provision of RH kits. Increasing the number of institutional facilities (MWs, beds, delivery rooms,…etc) & informing the communities about them. The use of the data / information available in the series of the DHP will when used for micro-planning on the basis of the standard “assumptions” for calculating the size of RH kits & other supplies for RH services – over a period of specified time – allow an objective statement on this valuable objective. (Trend analysis).

4) “One new comprehensive Emoc facility by state:

One new comprehensive Emoc facility per state supported with supplier & equipment”.

In South Darfur, Rehaid ELBirdi hospital is now providing CEmoc & is the referral centre for Kubum & Edelfersan hospitals which provide BEmOC. It has been supported by supplies & equipment (one delivery table, one infant cot, 10 Kit 2 A & 1 Kit 11A) in the first quarter of 2007 within the constraints of shortage of supplies mentioned above. In June 2007 it received its share of Kit 11 B, Kit 11 A & Kit 12. Once the locally made furniture is ready the CEmoc hospital will be
provided with one each of a delivery bed, infant bed, a trolley & a climb stair. The locality is in the process of rehabilitating the hospital theatre & lab our room.

Established CEmoc hospitals continue to be supported by the FSU to provide RH services in all three states). The SMOH/RH coordinator stated that it has been decided to upgrade Sheairya hospital to provide comprehensive EmOC & Labado hospital (which is under SLA control) to provide BEmoc.

In west Darfur in collaboration with SC-US, Morni hospital has been upgraded to provide Emoc to a total catchment population of 212000. UNFPA –FSU continues to support all facilities providing comprehensive & basic Emoc services in the state. Further an assessment to upgrade Garsilla hospital to provide CEmoc has been undertaken.

North Darfur state has yet to rehabilitate a health facility to provide CEmoc. The SMOH has in June selected Kutum rural hospital for upgrading & is processing the costs of the rehabilitation. The FSU should follow-up on the issue with the SMOH. In a meeting with the SMOH/RH coordinator (Sister Hassanat ALNoor) she stated that the security situation is very tense & that travel- even by air to AL-leeait, Tinna & Towasha is out of question. Thus many planned activities could not be implemented, because of poor or non-existent communication & transport. Further she said that Kabkabia & Kutum hospitals are not providing services. That might explain the delay in upgrading Kutum hospital to provide CEmoc.

Results 2:

"Well trained, competent reproductive health staff serving IDP at both PHC & SHC facilities in greater Darfur". The implementation of the very well formulated annual work plan 2007 for the RH Emergency in greater Darfur was impeded by a severe lack of funds that almost lasted during the first quarters of the year. The FSU received a modest amount (US $9000) in April. Most of it was spent on honoring previous commitments (e.g. North Darfur FSU contract with Malteser). The remaining amounts were spent to keep operations operating rather than on implementing project activities.

It is worthy of note that the planners mentioned in the proposal to fund the plan; that lack of fund is a major risk factor against its implementation. Unfortunately that happened. Obviously the flow of funds on timely & adequate manner lies squarely on the hands of the CO. there is no doubt that measures to avoid this situation in the future are already in motion. It is important to keep in mind that the Darfur emergency situation is a serious & appalling one. It is perhaps relevant
to mention here that the published results of the Sudan Household Health Survey (SHHS, 2006) estimated the maternal mortality ratio at 1107/100,000 live birth annually. Almost double the ratio of maternal death that was the yardstick, before this survey. Even, before this tragic finding – Darfur states were the worst off in terms of MMR among the Northern States of Sudan. The strategies, objectives & activities of the work plan for UNFPA in Darfur are relevant, practical & very much needed. All partners involved in its implementation should work hard on ensuring an uninterrupted, timely & secure flow of funds for its implementation.

In spite of this crumbling funding gap the UNFPA staff in Darfur did all they could to keep & uphold the agency cherished image as a leader of RH/GBV activities. The evaluator’s judgment is that they have done a good job. North Darfur FSU improvised in that they used unutilized funds remaining from 2006 to implement project activities in 2007. Though this took a long time to get an approval from the CO, & beyond, it was done. In March 2007 they implemented training activities planned for August 2006. Why this was not done at the right time is not clear, but it is important to note that it was done. With respect to the training of competent health workers to deliver quality RH services to IDPs & host communities in G. Darfur during this evaluation period; the following has been achieved.

**In North Darfur:**

More than 113 health workers have been trained on RH competencies (Post abortion care/ clinical management of rape, peer education of youth on prevention of HIV/AIDS, maternal nutrition survey methods & VCT workers in ELFashir.

However in North Darfur only 22% of planned activities have been implemented up to the end of the second quarter of 2007 due to lack of funds.

As indicated in N.D work plan monitoring tool on the RH component at the end of quarter 2 of 2007 – only 7 of the 32 planned activities have been implemented. Six activities were particularly started (e.g. informing the SMOH about the activity which partially means that it was not implemented). The remaining 19 activities were not implemented. The rate of none implementation (not completed + partially completed) is a high 78% in North Darfur.
South Darfur:

Training during quarter 4/2006 was held for (30) participants on FP, on Emoc for (23) participants & (30) awareness sessions on HIV/AIDS/STI were held in collaboration with UNMIS. These were attended by (865) men & women – including youth from at risk groups. Also (50) MWs were trained on methods of prevention of mother- to- child –transmission of HIV (total of (70) HWs.

During quarter 1/2007 a total of (85) health workers were trained on FP (32). TOT on Emoc (24), clinical management of rape (14) & on maternal nutrition survey (15) only two training activities took place in quarter 2/2007. TOT on maternal nutrition was held for 19 participants & a group of (21) media personnel from Nyala TV and radio station were trained on relevant RH issues to air to the public. That is a total of (40) during the quarter & a total of (195) for the three quarters. In comparison (348) health workers were trained during 2006 in south Darfur. This difference is most likely due to the funding gap which is still persisting while the field work for this mission is being carried out. The fact that 77% of planned activities were partially completed (i.e. not done) confirms the lack of funding. Many activities have been rescheduled for later months of the year in the hope that funds will be available.
Annex I:
A. Results-based Management:

As noted in the first ECHO evaluation, the evaluator will examine the extent to which planned activities were carried out and the extent to which they achieved the intended results as noted in the below indicators. He will also assess coverage of services, consulting the Darfur Humanitarian profile for information.

<table>
<thead>
<tr>
<th>Indicators</th>
<th>Source of Verification</th>
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<tbody>
<tr>
<td>1) At least one health facility supported in target IDP camps and visited for monitoring and technical support on a monthly basis.</td>
<td>➢ Monthly health management information system data</td>
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<tr>
<td>2) Increase in number of deliveries conducted by skilled birth attendants among target population.</td>
<td>➢ Hospital and clinic registers, MoH and Partners reports.</td>
</tr>
<tr>
<td>3) One new comprehensive EmOC facility established and supported.</td>
<td>➢ Hospital reports</td>
</tr>
<tr>
<td>4) One new basic EmOC facility in place and accessible to the target population in each state.</td>
<td>➢ Training plan and results of follow up visits with trainees.</td>
</tr>
<tr>
<td>5) At least 300 health providers trained on Standards of Care, STI-HIV/AIDS, management of EmOC and standard management of Obstetric case.</td>
<td>➢ Project periodic reports and evaluation report</td>
</tr>
<tr>
<td>6) At least 100 RH health managers trained on RH data collection and analysis.</td>
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<tr>
<td>6) Community outreach supported through three BCC campaigns in each state to encourage health seeking behaviours related to safe motherhood, family planning and prevention of HIV/AIDS.</td>
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B) The evaluator will examine:

1. Progress against and achievement of indicators above.
2. Mechanisms for collecting data and analysing the outcome that UNFPA programme outputs and inputs are having in Darfur, comparing them to outcomes noted in the programme agreement.
3. Extent to which mid-term recommendations have been taken into account in second half of the grant.
C) The evaluator will assess the completion of activities as outlined in the proposal:

1. Procure and transfer supplies and equipment to rural hospitals and clinics in Darfur with focus on UNFPA-assessed/ supported BEmOC & CEmOC facilities (see annex)
2. Support to supervision and quarterly reporting of EmOC facilities (conducted by MOH&UNFPA staff)
3. Support at least one facility in each state to strengthen referral system for emergency obstetric care as a pilot, including by advocating with SMoH and documenting pilot.
4. Provide support for basic repairs and supplies for maternity units and laboratory areas of referral hospitals (comprehensive EmOC facilities)
5. Support to RH data collection and preparation of reports on medical supplies and equipment utilization
6. Conduct assessment of quality of training conducted during March 2006 up to June 2007
7. Organize training courses on EmOC for doctors & senior nurses who run the health facilities of implementing NGOs & SMOH (90)
8. Organize training courses on family planning, infection prevention & universal precaution for health providers (60 doctors, health visitors & nurses)
9. Organize training courses on clinical management of rape for health providers in health facilities authorized to have form 8 (45 medical doctors and medical assistants)
10. Organize training courses on STI/HIV for health providers & community promoters
11. Provide training material & supplies needed for training (modules, IEC, etc.)
12. Training on post abortion care targeting 60 staff (medical doctors and nurses)
13. Training of Field officers (staff with management responsibilities) of UNFPA & Partner agencies in management of Project cycle (20 participants)
14. Organize training workshops on provision of adolescent/ youth reproductive health information and services for service providers
15. Organize training sessions for community promoters on danger signs in EmOC (90 per state)
16. Conduct follow up to training through monitoring trips to identify gaps and provide in service technical support
17. Organize community based seminars on role of youth, religious leaders and decision makers on combating HIV/AIDS.
18. Carry out family planning awareness raising at the community level.
19. Review, revise available material and develop IEC materials in Arabic/English on reproductive health topics for use during awareness raising activities.
20. Carry out a programme monitoring of the interventions on a regular basis as well as at the end of the implementation period.
21. Provide training for medical staff.
22. Build and strengthen professional capacity of UNFPA staff.
23. Conduct awareness raising on HIV/AIDS.

B. Perceptions of UNFPA role as the coordinator for RH/GBV according to the following specified task delineated in the project:

1. Leading monthly RH/GBV coordination meetings focused on operational concerns and actions.
2. Documenting RH/GBV coordination meeting and ensuring follow-up on action points.
3. Coordinating GBV as a key protection issue linked to other forums for a multi-sectoral approach.

C. Collaboration/synergy between UNFPA and MoH, and other relevant government institutions.
West Darfur:
During quarter 1/2007 the FSU, in collaboration with the SMOH & War Child /NGO held five training activities in which 203 participants took part. Topics covered included data collection for the RHIS, maternal nutrition survey methods, infection prevention (in response to infection spread in a ward of Gineana hospital which was successfully controlled) & two workshop instructors from War Child shared in training the (15) participants.
Of the (13) planned activities for quarter 2/2007 (6) concern training of RH personnel. Only one has was completed as two doctors were sent to Dr. Abbo Fistula centre in Khartoum to be trained on fistula repair. On the whole more than half the planned activities (56%) were not completed. The comparatively high rate of completion is due to the fact that the quarter was almost completely devoted to the Fistula campaign in Zalingi Hospital. The campaign was very successful, witnessed exemplary intersectoral cooperation (UN agencies & NGOs) & was very well coordinated by the FSU – (51) cases were successfully repaired.

West Darfur:
1) Total deliveries at BEmoc + CEmOC facilities
2) C/S
   1/1/2007 → 16/9/2007 = 434
3) Crude Birth Rate = 2.6
4) Expected deliveries
   1/1/2007 → 16/9/2007 = 33150
% of deliveries at BEmOC + CEmOC out of total deliveries = \( \frac{3751}{33150} \)
= 11.3% including NVD.
% of C/S = \( \frac{434}{33150} \) = 1.3%

Note:
total population of west Darfur estimated at 1.700.000.

Source:
An example of how the data of the DHP can improve the quality of available information.
**Results 3:**

“Increased demand for reproductive health services & greater awareness of positive reproductive health measures”. The suggested indicators (in TOR) for the increased demand are:

- IEC material developed & disseminated on safe motherhood, HIV & maternal nutrition.
- Community outreach supported through three BCC campaign in each state to encourage (positive) behaviours related to safe motherhood, FP, & prevention of HIV/AIDS among the target population in each state.

Both indicators measure process. At this stage of the development of the RH information system they are relevant indicators. However, demand needs to be measured -at least- by output numbers.

In meetings with the limited numbers of reproductive providers (3 PHC/BEmOC, 3CEmOC teaching hospitals & the health coordinator of SC-US & the RH/Officers of SC-US-serving a population of 212000 out of 9 health facilities providing BEmOC) the impression is that yes there is increased demand for RH services. This impression has been confirmed by the SMOH staff in the three states of Darfur.

IEC materials display in the visited clinics is not an eye-catching thing – may be, because they are being produced – or held Up temporary because of the lack of funds.

CO staff has visited the three states where prototype posters were displayed to RH health workers, community members, partners and service users for comments. Some changes have been suggested and will be applied before the new generation of posters – for HWs and service users are produced. Mean while the existing IEC materials on FP, HIV/AIDS, use of ANC and assistance of delivery by a trained health worker will continue – in addition to holding awareness sessions to the target communities mentioned above.

**Darfur Humanitarian profile (DHP):**

This is an important document produced quarterly by OCHA. It contains valuable and rich data and information about the population characteristics and movements in the three Darfur states. Population size is given by village / town in each locality. Also changes in the size of the population between consecutive profiles are given. For example the population in south and north Darfur – between April and July / 2007 (DHP numbers 27 and 28) increased by 16016 and 16997 respectively. However, 68486 people left west Darfur state – a fact worthy of investigations as it is important for RH services. Another section of the profile – tilted “who is doing what?” describes the humanitarian services
provided to IDPs and resident communities. From which access to services per population can be calculated. In this sections there is very little – if anything at all – about what UNFPA is doing in Darfur. It is hoped that the CO will remedy this unfair situation as UNFPA is doing a lot that should be acknowledged.

**Service coverage:**
The distinction between access and coverage is important. Access refers to the existence of the service structure, the availability of the service, its adequacy and its acceptability by the target community who should be aware of the service and can afford it. Coverage refers to the utilization and use of the service and thus requires a specific size of the catchments population and a reliable up – to date information system. For example access to a children immunization service could be 100% in a community, while coverage is a measure of the rate of use of the service – may at 73% of the target population.
Coverage by RH services cannot at this point be measured as there is no knowledge about the catchments / target population size and the information system is in the process of being established in Darfur. The same argument is true for the measurement of results of RH interventions which require measurement of outputs and outcomes as a prerequisite for analyzing them to measure results. Through the use of the data in the DHP the FSUs can move a long way in the direction of operating a lively and reliable RHIS. Another important use of this data is in micro – planning of RH activities.

**Comments on the activities in the proposal:**

Most of the activities in the proposal have been analyzed and commented on the preceding sections of the report. However, some comments of an operational nature need to be made on some activities – numbered as they are in the TOR.
6. The best assessment of the quality of training in through the method cannot be done during an evaluation of this nature as it needs special tools relevant to the training content and special study. However, training methods e.g. role playing and practicals, recently introduced in training activities will definitely improve quality. This is reflected in the results of the pre and post tents.
13. Field staff are unclear about this activity as to who is the target group, who e=will implement the activity, ie. CO or FSU, and who are the trainers and what in the training content?
21/22. Also not clear to the field staff – who raised the same questions as in 13 above.
Perception of UNFPA Role:

All three FSUs are carrying out the specified coordinating tasks in an admirable manner. Minutes of coordination meetings. RH & GBV are well written, up-to-date & action points if identified & their tasks allocated to members. What is, perhaps missing here is a statement on the completion & results of the actions. The involvement of the SMOH has been intensified as now coordinators of HIV/AIDS, PHC, NUT are added members to the RH coordination group.

Implementation of the Mid-term Evaluation Recommendations:
The staffing of the FSUs has considerably increased, but there need to expedite the recruitment process. The internet facilities are in place & the problem has been solved. Training in management remains to be done. BEmOC facilities are slowly expanding.

UNFPA IMAGE:
Is still being held very high & its work highly appreciated & valued by SMOH, partners & UN agencies.

Conclusion:
Had it not been for the funding gap & the RH kits shortage during the first half of 2007. This project performance would have been judged excellent.

Recommendation:
In addition to those above & these mentioned in the text of the report. Hold are planning workshop for each state to reschedule the unimplemented activities. Use the DHP data for micro-planning. Appoint a logistician/ driver. Consider providing North Darfur with new computers.