The Sudanese Red Crescent Society (SRCS)

National Community Health Volunteer Program(NCHVP)

Mid-term Review Report

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ECONOMICS • FINANCE • SOCIOLOGY • RESOURCE • MANAGEMENT

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Table of contents

Acknowledgement 5

Acronyms 6

1 Executive Summary 7

1.1 Brief background 7

1.2 Key findings 7

1.3 Recommendations 10

2 Background 12

2.1 Overview of report 12

2.2 Purpose and scope of review 12

2.3 Methodology 13

2.4 Methodological limitations 14

3 Context 15

3.1 Political – socio-economic context 15

3.2 The Sudanese Red Crescent 16

3.3 Overview of program 17

4 Overall assessment 19

4.1 Relevance 19

4.2 Effectiveness 23

4.3 Efficiency 27

4.4 Outcome 34

4.5 Sustainability 36

4.6 Special issues pertaining to the NCHVP in South Sudan 39

5 Summing up 40

Bibliography 41

Annexes 43

Annex 1: Terms of Reference 43

Annex 2: Evaluation Criteria 48

Annex 3: Evaluation matrix 49

Annex 4: Program in Sudan 53

Annex 5: List of people and institutions consulted 54

Annex 6: Map of Sudan 56

Annex 7: Overview of SRCS branches involved in the NCHVP 57

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Trude Bang (Team Leader)

Acronyms

Aids	Acquired Immune Deficiency Syndrome
CBFA	Community Based First Aid
CBHFA	Community Based Health First Aid
EPI	Expanded Program for Immunization
FA	First Aid
FHO	Field Health Officers
HAC	Humanitarian Aid Commission
HQ	Headquarters
ICRC	International Committee of the Red Cross
IEC	Information, Education & Communication
IFRC	International Federation of the Red Cross and Red Crescent societies
MNCH	Mother, Newborn and Child Health
MDG	UN Millennium Development Goals
MFA	Norwegian Ministry of Foreign Affairs
MoH	Ministry of Health
MoU	Memorandum of Understanding
MTR	Mid Term Review
NCHVP	National Community Health Volunteer Program
NGO	Non Governmental Organization
Norad	Norwegian Agency for Development Cooperation
Norcross	The Norwegian Red Cross
NS	National Society
OD	Organizational Development
PLWHA	People Living with HIV/Aids
PMER	Planning, Monitoring, Evaluation and Reporting
SIDA	Swedish International Development Cooperation Agency
SRCS	Sudanese Red Crescent Society
TOT	Trainer of Trainers
UN	United Nations
UNICEF	United Nations Children's Fund
Watsan	Water and sanitation
WHO	World Health Organization

1 Executive Summary

1.1 Brief background

More than two decades of civil war between South and North Sudan ended in 2005 with the signing of the Comprehensive Peace Agreement (CPA). Following a referendum held in January 2011, the country is due to split 9. July 2011.

Poverty, sever food insecurity, poor health services, limited access to education, clean water and adequate sanitary conditions are common challenges in Sudan. The country is also extremely vulnerable to natural hazards, such as drought and floods, affecting hundreds of thousands of people every year.

In order to respond to some of the above mentioned challenges, and at the same time to increase its capacities, the Sudanese Red Crescent Society (SRCS) started implementing the Community Health Volunteer Program (NCHVP) in seven pilot branches in 2007. The program was later expanded to a total of nine branches.

The NCHVP attempts to build local capacities in order to deal with the most common health risks in targeted communities in Sudan. It seeks to empower people to take care of their own health and the management of SRCS volunteers plays a key role within the program. The program is currently funded by the Norwegian Red Cross, the Swedish Red Cross, the Finnish Red Cross and the Canadian Red Cross. Some of the main back donors are the Norwegian Agency for Development Cooperation (Norad), the Norwegian Ministry of Foreign Affairs (MFA) and the Swedish International Development Cooperation Agency (SIDA).

The main purpose of this Mid Term Review (MTR) is to assess the National Community Health Volunteer Programme (NCHVP) according to the OECD/DAC evaluation criteria[1] of relevance, effectiveness, efficiency, impact (outcome) and sustainability.

1.2 Key findings

Based on the key findings summarized below, an overall recommendation of the MTR team is that with some adjustments, following the recommendations in this report, program implementation should continue in the current program branches and extension to other SRCS branches should be considered.

Relevance

The NCHVP is seen as highly relevant as it addresses major health challenges in the targeted communities mainly through health- and hygiene promotion, HIV/Aids prevention, First Aid (FA) and Water and sanitation (Watsan) activities. The activities of the program are consistent with the overall

[1] For further explanation of the evaluation criteria see Annex 2

program goal and they are still seen as valid. The program is also in coherence with national-, international- and Red Cross/Red Crescent policies and strategies. The program's inclusiveness' of different stakeholders in the planning and implementation process further emphasizes the relevance of the program, which again is reinforced by its ability to adapt to emerging needs. However, an increased focus on issues such as Mother, Newborn and Child Health (MNCH) and Watsan would further increase the relevance of the program.

Effectiveness

The objectives of the NCHVP have to a certain extent been achieved. Available data indicate progress in program implementation, exemplified by the fact that 44.512 community volunteers were trained in the program during the period 2007-2009 and 50.176 household visits were carried out in the same period. A key factor for success has been the SRCS's ability to recruit and retain volunteers, as well as its unique access to the communities through its volunteers. Challenges hampering the effectiveness of the program are related to transport, the lack of First Aid (FA) kits and the fact that latrines are scarce in the targeted communities. It has, however, been a challenge to measure the effectiveness of the program as specific indicators were not set prior to implementation of the NCHVP.

Efficiency

It is the impression of the MTR team that the overall financial input in the program is reasonable compared to the actual output. The NCHVP is thus considered to be cost efficient.

A main challenge in the program has been the delay in transfers of funds from partners. The reasons for the delays are multifaceted. E.g., in 2010 financial irregularities were detected in one of the program branches. Although irregularities were not detected in relation to NCHVP funds, donors were reluctant to transfer funds until this issue had been fully resolved. Funds were thus not transferred until August 2010. The unpredictability of transfers has to some extent affected the implementation of activities.

The program has a rather well functioning monitoring and reporting structure. A database of volunteers was established within the program in 2009 and it was later decided that the database would include volunteers from all SRCS branches. But, the data from all branches has not yet been entered in the database. Capacity building efforts have been effective and training is a major pull factor in the recruitment of volunteers, as it is an important incentive in a context where access to education is limited. The NCHVP activities are being coordinated with relevant local, national and international partners. However, the gender balance is still a challenge and the content and the quality of the reporting need to be strengthened.

Outcomes

The NCHVP has reportedly contributed to several positive changes in the targeted communities. It is likely that the First Aid skills provided to volunteers and community members have contributed to reduce vulnerability in the targeted communities. According to volunteers and community members spoken to in Northern Sudan, people are now much more aware of the importance of having their children vaccinated which again reportedly has increased the vaccination frequency of children. Several representatives of the communities also mentioned that the program activities have

contributed to improvements in hygiene behavior which, among other things, has contributed to cleaner communities and a decrease of diseases such as malaria and diarrhea. Although adequate statistic material was not available in order to confirm these reported changes.

The implementation of a comprehensive volunteer management system has made it possible to mobilize volunteers quickly in the program branches and the reporting structure introduced by the NCHVP has enabled the SRCS staff members to better structure their work. Additionally, the visibility of the NCHVP volunteers in the communities has clearly strengthened the image of the SRCS in most of the program areas and provides a sound platform for further program development.

Sustainability

The NCHVP has to a great extent managed to include relevant stakeholders in the planning and implementation of the program which has ensured ownership towards the program at different levels of the organization. However, representatives of the SRCS Secretariat in the South mention that they have not been adequately involved in the planning- and implementation process, but they also state that they have been increasingly involved in the program since October 2010.

The NCHVP is currently not receiving financial support from the Sudanese authorities at any level. However, in some of the program branches the local authorities provide the SRCS with office space and technical support during trainings. The potential for receiving additional support from the local authorities should be further explored as a continued close cooperation with the authorities might be an important factor for future sustainability of the activities.

The fact that the volunteers are recruited from within the program communities, points in the direction that capacity built will remain in the communities also after funding has been phased out. The delays in transfers of funds during the program period, confirms that activities, even though at a reduced level, have been ongoing independent of external funding. This is largely due to the strong commitment of the volunteers.

In order to keep the activities running in the future, a certain level of funding will be needed at all levels of the organization. The importance of establishing Income Generating Activities (IGAs) at branch level should not be underestimated in order to ensure sustainability of the NCHVP activities and to secure a safe exit for the partners.

The SRCS, both at national and state branch level, should look further into the possibility of attracting funding from relevant national actors, such as the MoH and private companies, as well as new international partners. This will require a focused marketing effort, which again is depending on the NCHVP's ability to document its results.

1.3 Recommendations

Based on the findings presented in this report the evaluation team would like to make the following recommendations:

Relevance

1. The SRCS should approach local authorities and/or relevant humanitarian actors in country, as e.g. UNICEF, Oxfam or the Carter center, in order to advocate towards the construction of latrines and ensure access to clean water in communities were the NCHVP is implemented, and where such interventions are not covered by the SRCS. Synergies with SRCS Watsan program should also be sought by linking capacity building efforts of volunteers and staff in the two program areas. In line with this, it is recommended that a workshop is arranged with the aim to train Field Health Officers (FHOs) in how to construct simple latrines and how to harvest rainwater. According to discussions held with the Norcross Watsan delegate, who is based in Rumbek up till the end of 2011, he will be able to conduct such training.

2. The SRCS should consider a more strategic approach to malaria prevention based on the IFRC standards for malaria prevention and control. This includes ensuring high mosquito net coverage and proper usage of the nets in target areas. The possibility of receiving mosquito nets through the IFRC or from external organizations, which are distributing mosquito nets in Sudan, should be explored. If none of these requests are met, it should be considered including funds for mosquito nets in the NCHVP budget.

3. A more strategic approach to Mother, Newborn and Child Health (MNCH) could be considered in the program. This could be done by further emphasizing issues pertaining to MNCH during trainings, as well as by providing pregnant women with "safe home delivery kits".

Effectiveness

1. The focus on the HIV/Aids component should be strengthened with regards to stigma and discrimination during trainings of volunteers and community members.

2. Expenses for maintenance of bikes and motorbikes should be included in the program budget. In order to enable monitoring visits to the most remote areas, expenses for renting cars should be considered included in the budgets in those branches where access to cars is a challenge.

3. A system for replenishment of First Aid (FA) kits should be implemented. The FHO in each branch should be responsible for the stock and all volunteers should be informed about who to address when refill is needed. In order to ensure that FA items are purchased and in stock, expenses for replenishment of FA kits should be included in budgets at branch level.

Efficiency

4. Transfer mechanisms and communication regarding funding should be strengthened. In order to improve transfer mechanisms the SRCS should as soon as possible call for a meeting with all funding partners with the aim to make the partners agree on some common principles for transfers, this in order to ensure predictability in program implementation. The NCHVP branches should as far as possible receive funds at the same time as it will facilitate coordination and it will make it possible for the SRCS HQ to provide timely reports to its partners.

5. It is recommended that the content and quality of the reporting is strengthened. A few key core indicators should be selected for reporting in the NCHVP and reported on from all program areas independent of funding partners. The IFRC CBHFA Indicator guide, which is following the global standards of community health programming in the Red Cross Movement, could be used as support when selecting indicators.

6. A baseline for the nine program branches should be finalized as soon as possible.

7. It should be considered to increase the incentives for the volunteers. It is recommended that T-shirts and caps are provided for all NCHVP volunteers. As a minimum, ID cards for all volunteers should be included in the program budget.

8. In order to keep staff and volunteers updated and motivated, as well as to ensure a high level of quality of the activities, regular refresher trainings should be conducted for staff and volunteers involved in the program.

Sustainability

9. The SRCS should, together with its partners, start discussing exit strategies. It is recommended that the program branches develop realistic plans for viable Income Generating Activities (IGAs) and that funds are included in the NCHVP budgets for IGAs.

10. The SRCS should develop a more strategic approach towards national partners, such as the MoH and private companies, as well as new international partners, with the aim to attract funding for the NCHVP activities. A Marketing plan could be developed with the technical support of RC partners, for instance from the Norwegian Red Cross Marketing department.

2 Background

2.1 Overview of report

The report has five chapters, starting with an Executive summary including a presentation of all the recommendations provided in the report. Chapter two presents the purpose of the Mid Term Review (MTR), as well as the methodological approach used during the review process. In chapter three a presentation of the Sudanese context and the Sudanese Red Crescent Society (SRCS) is provided, followed by an overview of the National Community Health Volunteer Program (NCHVP). Chapter four assesses the program's relevance, effectiveness, efficiency, outcome and sustainability. It also includes a special section on issues pertaining to the program in South Sudan. Recommendations are found at the end of each of these sections. Conclusions and the way forward are summed up in chapter five.

There are seven annexes attached to the report; Terms of Reference, Evaluation Criteria, Evaluation Matrix, Program in Sudan, List of people and institutions consulted, Map of Sudan and Overview of the SRCS branches involved in the NCHVP.

2.2 Purpose and scope of review

The main purpose of this Mid Term Review (MTR) is to assess the Sudanese Red Crescent Society's National Community Health Volunteer Program (NCHVP) according to the OECD/DAC evaluation criteria[2] of relevance, effectiveness, efficiency, impact (outcome) and sustainability. The NCHVP programme consists of the following main components:

- Community Based Health and First Aid (CBHFA)[3]
- Communicable diseases prevention
- Health in emergencies
- HIV/Aids prevention
- Water and sanitation
- Capacity building

The period under evaluation is from the beginning of 2009 up to March 2011. The programme did start in most of the program areas in 2007, thus the period prior to 2009 is to some extent taken into account in the below analysis.

According to the ToR the MTR will be used as bases when considering further support to the program in the Northern part of Sudan. It will also serve as background for a possible continuation of a revised

[2] For further explanation of the evaluation criteria see Annex 2

[3] Community-Based Health and First Aid (CBHFA) is a comprehensive approach to injury- and disease-prevention and health promotion through training and mobilization of volunteers to carry out activities in their communities (http://www.ifrc.org/en/what-we-do/health/community-based-health/)

NCHVP in South Sudan, perhaps in cooperation with the International Committee of the Red Cross (ICRC).

Due to the limited time frame for conducting the Mid Term Review the main focus has been on program implementation, while cooperation with the supporting Red Cross Movement partners has, in agreement with the Norwegian Red Cross (Norcross), not been subject to thorough examination.

2.3 Methodology

The MTR was commissioned by the Norwegian Red Cross and it was conducted by an external consultant from Nordic Consulting Group (NCG), being the Team Leader, the newly employed Program Coordinator for the International Federation of the Red Cross and Red Crescent Societies (IFRC) in Sudan and the Senior Health Advisor from Norcross. The latter took part in the fieldwork in South Sudan, while the IFRC Program Coordinator participated in the mission in North Sudan. During the visit to North Sudan the SRCS Food Security Coordinator assisted with translation. None of the team members had been involved in the program prior to the review. However, as two of the team members were representatives of SRCS' cooperation partners the review must be considered as semi-external.

The review was planned and carried out within a time frame of 26 working days, including 13 days of field work in North and South Sudan. The following methodology was used:

Desk study: Relevant documents[4] such as strategies, policies, manuals, annual plans, applications and reports were reviewed. Prior to the field work two meetings were held in Oslo with the Norcross Programme Coordinator for Sudan in order to further clarify the ToR of the evaluation and also for an interview. Additionally, the evaluation methodology was developed and an evaluation matrix[5], including interview guides for the different stakeholder groups, was prepared.

Field work: The field work was carried out between 30. April and 13. May 2011[6]. The team started by interviewing key representatives at the Sudanese Red Crescent Society's (SRCS) Headquarters (HQ) in Khartoum, followed by field trips to El Gadaref state and El Gazera state in the Northern part of Sudan. Before moving on to South Sudan the team returned to Khartoum where a debrief and discussions about the initial findings were held with the SRCS Secretary General, the SRCS NCHVP team and the Norcross Country Representative in Sudan. The Team Leader then proceeded to the Southern part of the country where she teamed up with the Norcross Senior Health Advisor. The team visited Lakes state (Rumbek) and Juba where the SRCS Secretariat for Southern Sudan is based. Before leaving South Sudan, a debrief- and discussion session was held with the Deputy Director General for the SRCS Secretariat in South Sudan and the SRCS NCHVP Coordinator for South Sudan.

The MTR Team visited four communities related to the program. Interviews and focus group discussions were held with the total number of 146 informants. The informants included Norcross-,

[4] For further details see Bibliography

[5] Annex 3

[6] See Program in Sudan – Annex 4

SRCS-, Netherlands Red Cross-, IFRC- and ICRC staff, as well as representatives of the authorities at different levels, beneficiaries and SRCS volunteers. Some of the interviews were conducted in English and some were conducted in Arab and Dinka with the support of a translator. A full list of people and institutions consulted is provided in Annex 5.

A combination of open questions and semi structured interviews outlined in the evaluation matrix were used in the data collection process. Triangulation of findings was done in order to validate information obtained. Additionally, observations were made in program communities, in beneficiaries' homes, in one IDP[7] camp in Lakes state, one guest house/training hall under construction in El Gadaref and of several garbage areas. The team also participated in two graduation ceremonies of SRCS volunteers in El Gazera and El Gadaref respectively. A draft report was shared with SRCS, Norcross and the IFRC and comments received before the final report was published.

2.4 Methodological limitations

The Team leader was the only team member visiting all the program areas. Time would have been saved if all team members had participated both in the North and the South, also this would have provided the team members from IFRC and Norcross with a more holistic view of the program.

It has been challenging to respond fully to the TOR as data for 2010 was not available during the review process, a baseline was not prepared prior to implementation of the program and limited use of indicators has been applied in the program. Additionally, reliable and comparable data on the current state of socio-economic development that are disaggregated by states is hard to obtain in Sudan.

The team was originally planned to visit Upper Nile state for three days, but the visit was cancelled in the last minute because of security issues. Due to logistical challenges this trip was substituted with only one full working day in Lakes state. Limited time was thus available for interviews and observations in Lakes state. The security situation in the South further prevented the team from visiting program communities and to meet with beneficiaries and observe volunteers in action. As a consequence, the MTR team was only able to meet with beneficiaries in one IDP camp in the South which was not directly linked to the program.

The team did not have the opportunity to meet with the MoH in Juba and interviews with relevant external actors, such as the World Health Organization (WHO), were, due to time constraints, not included in the program. This was unfortunate as it most likely would have provided the team with valuable contextual background information.

In total only three out of the nine program states were visited. However, while in El Gazera both the SRCS Field Health Officers (FHOs) from Northern Kordofan- and Sennar state met up with the team for interviews. Additionally, the FHOs from Upper Nile and Unity were interviewed in Juba. Representatives from seven out of nine program states were thus interviewed, reports from all states

[7] Internally Displaced People

have been assessed and the team believes that the data collected is fairly representative for the program as a whole.

3 Context

3.1 Political – socio-economic context

Sudan[8] has a complex religious, ethnic, cultural and linguistic diversity. It is also the largest and one of the most geographically diverse countries in Africa. More than two decades of civil war between South and North Sudan ended in 2005 with the signing of the Comprehensive Peace Agreement (CPA). In accordance with the CPA a referendum was conducted 9. January 2011. The citizens of the South voted for an independent South Sudan and the country is due to split 9. July 2011. North Sudan consists of 15 states, while the South is comprised by 10 states.

The North - South civil war cost the lives of 1.5 million people and a continuing conflict in the western region of Darfur has driven two million people from their homes and killed more than 200,*000*[9] people. Currently over 300.000 South Sudanese people, living in the north for many years, have returned to South Sudan[10].

Poverty, sever food insecurity, poor health services and limited access to education, clean water and adequate sanitary conditions are common challenges in Sudan. The country is also extremely vulnerable to natural hazards, such as drought and floods, affecting hundreds of thousands of people every year.

The governmental health system is mainly based on Primary Health Care centers and units. There are few peripheral clinics in villages and many of them are not functional or closed most of the time. Adding to this, there is a great lack of trained health personnel in Sudan, in particular in remote areas. Consultations are to a large extent managed by Community Health Workers with nine months of training[11].

In 2008, life expectancy at birth for both sexes in Sudan was 57 years compared to the global average which is 68. The under 5 mortality rate per 1000 live births were 109 compared to a global average of 65. The main cause of death among children under 5 is malaria (25% of the cases). The prevalence of HIV (per 1000 adults between 15-49 years) is 14. [12]

[8] Map of Sudan – Annex 6
[9] BBC News – Sudan Country profile: http://news.bbc.co.uk/2/hi/africa/country_profiles/820864.stm
[10] The Norwegian Red Cross in Sudan – memo, March 2011
[11] Program Document – National Community Health Volunteer Program, The Sudanese Red Crescent Society
[12] World Health Organization (WHO) – Sudan Health Profile (2008)

Malaria, being the leading cause of morbidity and mortality in Sudan, annually affects some 7.5 million people, of which 35,000 die. Preventable diseases (meningitis, acute watery diarrhea, yellow fever and rift valley fever) are rampant. Furthermore, there are considerable disparities in living conditions between the different states and between the North, West and the South, as well as between rural and urban areas. As an example, 26 % of the population is living below the poverty line in Khartoum, while the figure is 62, 7 % for Darfur[13] and 51% for South Sudan. In the South 55% of the population in rural areas is classified as poor, compared to 24% in the urban areas.[14] Other relevant indicators are displayed in the below table.

Table 1

Indicator	Unit of measure	North Sudan	South Sudan
Literacy rate of 15-24 year-olds	%	77 Male: 84 Female: 71	27 Male: 40 Female: 16
Proportion of population using an improved drinking water source	%	65	49,5
Proportion of population using an improved sanitation facility	%	42	23,9

Source: Sudan Central Bureau of Statistics: Sudan National Baseline Household Survey (NBHS) (2009) and Southern Sudan Centre for Census Statistics and Evaluation: Poverty in Southern Sudan: Estimates from NBHS (2010)

The Government of Sudan has launched a Five-Year Development Plan (2007-2011), within a 25 years strategy (2007-2031), where it states its intention to reduce poverty and achieve the Millennium Development Goals (MDGs).

According to the Sudan Millennium Development Goals Progress Report (2010) the country has made some tangible progress towards achieving many of the MDGs. The reduction in estimated malaria cases and deaths from 2001 to 2010 and the launch of Sudan's national policy on HIV/Aids in 2004 are some main achievements. However, the above data shows that the living conditions for most people in the Sudan are still harsh which can be further exemplified by the fact that a 15 year old girl living in South Sudan actually has a higher chance of dying in childbirth than finishing school.[15]

3.2 The Sudanese Red Crescent

The Sudanese Red Crescent (SRCS) was established in April 1956 and was at the same time recognized as auxiliary to the government in accordance with the Red Cross/Red Crescent Movement Fundamental Principles. The SRCS HQ is based in Khartoum and the NS is organized and present in 25 branches corresponding to the current 25 states in Sudan. The NS is further organized at locality- and unit level (community level). The SRCS is the only organization in Sudan with a countrywide network

[13] Sudan Central Bureau of Statistics: Sudan National Baseline Household Survey (NBHS) (2009)
[14] Southern Sudan Centre for Census Statistics and Evaluation: Poverty in Southern Sudan: Estimates from NBHS (2010)
[15] Aiding the Peace – A Multi-donor Evaluation of Support to Conflict Prevention and Peacebuilding Activities in Southern Sudan 200-2010. Final report (December 2010: page 21)

of community based volunteers. It is estimated that the National Society (NS) has 400,000 members/volunteers of whom 40,000 are active.

In 2006, following the end of hostilities in 2005, the SRCS was able to set up a secretariat in Juba, Southern Sudan. The NS has since, with support from its partners[16], slowly been able to build up a SRCS branch network in the South. At present there are 10 more or less functioning SRCS branches corresponding to the 10 states in South Sudan.

There are differences between the 25 SRCS state branches when it comes to capacities and infrastructure, some of the branches are well established as others are still in their infancy. For further information of the particular branches included in the NCHVP program see Annex 7.

In recent years, the SRCS, supported by the IFRC and partner National Societies, has embarked on an internal restructuring process, the ultimate goal of which is to provide those in need with better services. During the process a number of policies and internal guidelines have been adopted and the SRCS Strategic Plan 2009-2012 has been developed. The main priority now is to translate policies into action. The plan for 2009-2012 is to establish new branches and improve branch operational capacities, financial and human resource management, program planning, monitoring, evaluation and reporting (PMER) at all levels of the SRCS[17].

Disaster Management, Health, Water and Sanitation, Organizational Development and Humanitarian Values are, according to the SRCS Strategy 2007-2011, the main programs of the organization.

Due to the fact that Sudan will be divided into two countries in July 2011, a process of separation within the SRCS has started and a new Red Cross NS in the South is in the making.

3.3 Overview of program

In 2005 a PAN Sudan health assessment was carried out jointly by representatives from the SRCS, the International Federation of Red Cross and Red Crescent Societies (IFRC) and representatives of other Movement partners in Sudan, to support the SRCS in identifying its role in the area of health and water and sanitation[18].

[16] The International Federation of the Red Cross and Red Crescent Societies (IFRC), The International Committee of the Red Cross (ICRC) and sister Red Cross/Red Crescent societies, such as the Norwegian Red Cross and the Swedish Red Cross

[17] Norwegian Red Cross Norad application 2009-2012

[18] The assessment was based on a policy document for health in post conflict Sudan, formed by Federal Ministry of Health (MOH), the 25 Years Strategic Plan for the Health Sector of MOH, Sudan's National Policy on the Voluntary Sector in Health, SRCS strategy 2005-2011, SRCS guide lines for community based health interventions, Sudan plan of action as well as other relevant documents. The team visited 12 out of 20 branches during the assessment period.

Following the recommendations from this assessment the National Community Health Volunteer Program was established in the following seven SRCS state branches in 2007; Red Sea, El Gadaref, El Gazera, Sennar, North Kordofan, Unity and Upper Nile. In 2009 the program was also initiated in Lakes state and program implementation started in Jonglei in 2010.

Currently the program is implemented in the following nine branches:
North Sudan: Red Sea, El Gadaref, El Gazira, Sennar and North Kordofan
South Sudan: Unity, Upper Nile, Lakes and Jonglei

The NCHVP attempts to build local capacities in order to deal with the most common health risks in targeted communities in Sudan. It seeks to empower people to take care of their own health and the management of SRCS volunteers plays a key role within the program.

Main activities in the NCHVP are training in prevention and control of prevailing infectious and endemic diseases with a focus on malaria and water borne diseases, the establishment of community-based action teams to respond to the needs of those affected by health emergencies and promotion of community-based action to reduce the risk of HIV/Aids transmission and stigmatization. The activities are carried out by SRCS volunteers through household visits, community awareness sessions and campaigns.

According to the ToR the overall goal of the programme is that: *"targeted communities are resilient to health risks, natural and man-made hazards and disasters, supported by an effective and efficient national society" .*

The main objectives of the program are as follows:

- Targeted communities are able to address basic health needs at house hold level through Community Based Health First Aid
- Targeted communities are well-informed and aware of communicable disease prevention and health promotion
- Targeted communities are able to mitigate and respond to large scale emergencies and communicable disease outbreaks
- Targeted communities are well informed and have capacities within HIV/Aids prevention, care and support
- Targeted communities are well informed and aware of hygiene and sanitation issues relevant for their environment
- Targeted volunteers at branch, locality and unit level have increased capacities

Support for the programme is currently received from the Norwegian Red Cross, the Swedish Red Cross, the Finnish Red Cross and the Canadian Red Cross. The Norwegian Red Cross and the Swedish Red Cross being the main contributors to the program, with financial support from the Norwegian Agency for Development Cooperation (Norad), the Norwegian Ministry of Foreign Affairs (MFA) and the Swedish International Development Cooperation Agency (SIDA). Funds from the Norwegian Red Cross are currently transferred directly to the SRCS (bilaterally), while funds from other partners are transferred through the IFRC (multilaterally). The Netherlands Red Cross contributed bilaterally to the program in 2007-2008.

The NCHVP program is managed by the SRCS National Coordinator for the NCHVP program and the Assistant NCHVP Coordinator in Khartoum. Additionally, there is a NCHVP Program Coordinator in the Secretariat in South Sudan. Field Health Coordinators in each of the program branches are responsible for the program at branch level, while volunteer supervisors are responsible for the program activities and for managing the volunteers at locality- and unit level.

4 Overall assessment

This chapter provides an assessment of the program along the defined review criteria of relevance, effectiveness, efficiency, outcome and sustainability.

4.1 Relevance

When assessing the relevance of the NCHVP the MTR team focused on the relevance of the programme vis-à-vis the Sudanese context, needs, policies and priorities, as well as SRCS- and partner's policies and strategies.

As documented in section 3.1 limited access to health services, clean water and adequate sanitary conditions are some of the main challenges in Sudan. Preventable diseases such as malaria, diarrhea and HIV/AIDS are widespread. The country is vulnerable to drought, floods and communicable disease outbreaks. Finally, the literacy rate is low indicating a general lack of education among the population. In the communities visited by the MTR team these challenges were confirmed by representatives of the Ministry of Health, the SRCS- staff and volunteers, as well as by community members spoken to.

The SRCS National Community Health Volunteer Program is addressing these challenges. A main focus in the program is on training of volunteers who again educate community members on the above mentioned issues. This is done through home visits where the volunteers, using available relevant education material, informs the community members about, among other things, the importance of hand washing, getting rid of garbage on a daily bases, the importance of using mosquito nets and to avoid having stagnant water in their homes in order to prevent malaria and other diseases. The NCHVP volunteers are also mobilizing the communities for regular clean up campaigns, they inform community members on how to avoid getting affected by HIV/AIDS and they focus on reducing the stigmatization of those affected. Based on the above the MTR team sees the NCVHP as highly relevant to the context.

The program is furthermore in line with Sudanese governmental policies as Sudan, being a member State of the United Nations (UN) and signatory to the 2000 Millennium Development Goals (MDGs), remains committed to the achievement of the MDGs[19], where *Goal 6: "Combat HIV/Aids, Malaria and other diseases"*, is in particular relevant to the NCHVP program. Likewise, the SRCS Strategy

[19] National Five-Year Strategic Development Plan (2007-2011), the Government of Sudan

2007 – 2011 guided by the MDGs, the Sudan Comprehensive National Strategy (SCNS) and the IFRCs Strategy 2020, is mentioning the below as one of its four strategic core areas:

> *SRCS is prioritizing various health services, community health programs (health education, sanitation, awareness campaigns and community based activities (first-aid and HIV/Aids) as well as response activities to the emerging diseases and epidemics. Drinking water and sanitation projects are also being carried out by SRCS in order to provide safe, adequate drinking water and sanitation facilities.*
> SRCS Strategy (2007 – 2011:12)

The program is furthermore in line with IFRC's Strategy 2020 and the international strategies of the Norwegian Red Cross, Swedish Red Cross, Finnish Red Cross and other partner NS' strategies.

It is also in coherence with policies of back donors such as the Norwegian Whitepaper no. 13 (2008-2009) "Climate, Conflict and Capital", as well as "Pluralism" - Policy for support to Civil Society in developing countries within Swedish Development Cooperation (2009).

Moreover, the NCHVP is placing a special emphasize on capacity building among its volunteers, which also is highly relevant to the SRCS Strategy 2007-2011.

As already mentioned, the NCHVP was established following the recommendations in the 2005 Pan Sudan health assessment. In addition to the many unmet health needs identified during this assessment, the SRCS was, according to the SRCS International Cooperation Director, at the time struggling to retain its volunteers as they were mostly involved in ad hoc projects. It was believed that participation in long term programs would contribute to retaining volunteers as it would mean that they would be kept busy in ongoing activities. At the same time, long term commitments from partners would also support the strengthening of selected SRCS branches and thus increase SRCS' capacities to support vulnerable groups.

During a workshop held for the SRCS Management and all SRCS Branch Directors it was thus agreed that a long term program focusing on volunteers and community based health would be developed. An IFRC Health delegate was recruited in order to support the NS in developing a program concept. It was decided that the NCHVP program would be piloted in seven branches as of 2007. The seven pilot branches were selected according to its poor health statistics and on the bases that they at the time were receiving limited, or none, external support. The Health delegate visited the selected program branches and in April 2007 a program document was developed based on discussions held with representatives of the SRCS at different levels and partner NS. Initial Plan of Actions for the program branches were developed during a one week workshop in Khartoum held for the FHOs from the pilot branches. According to interviews held with the different FHOs and Branch Directors in the visited branches, the program communities were selected by the branches themselves based on assessments carried out and in accordance with local authorities. It is the impression of the MTR team that the participation of representatives from different levels of the organization in developing the program has contributed towards ensuring the relevance of the NCHVP.

Additionally, during interviews with various stakeholders it was confirmed that local representatives of the Women's Union, the Youth Union, the Peoples Committee and religious leaders have been included in the planning and implementation of the program. These representatives are reflecting the population in the targeted communities, which again points to the relevance of the program as the needs of different groups are being considered.

In North Sudan it seems like most of the volunteers are women, while in the South it is the opposite. The team was told that the main reason for recruiting more women in the North is that most men are too busy to participate in volunteer activities. The limited number of female volunteers in the South might be due to the fact that most women in the South need written permission from their husbands or fathers in order to participate in SRCS activities. The FHOs spoken to did, however, say that this was in the process of changing.

Even though specific plans for the program are developed annually at branch level, the MTR team was informed about several cases of flexibility within the program. E.g. In Sennar state the SRCS wanted to provide CBFA training to a nomadic tribe. But, the nomads initially refused on the grounds that they did not have the time to stay in one place for several days. The SRCS then offered to send one of its volunteers travelling with them and train them while travelling. The tribe was still reluctant, but permitted the volunteer to follow them for one month. When one of the tribe members had an accident and was badly hurt, they discovered the importance of being able to perform First Aid and it made them appreciate the skills brought forward by the SRCS volunteer. The SRCS in Sennar made a big celebration ceremony for the members of the nomadic tribe who had been trained. Other nomadic tribes were also invited for this ceremony. After the ceremony, representatives of the other tribes requested the SRCS for First Aid training and they even offered to stay in one place for ten days in order to undergo the training, which was followed up by the SRCS. In Gadaref, there was an acute watery diarrhea outbreak in 2007 where the SRCS, in accordance with the MoH, managed to mobilize 1000 NCHVP volunteers in order to carry out water chlorination and awareness campaigns in communities. These two examples indicate that the program is capable of adapting to the context and to new emerging needs which again emphasizes the relevance of the program.

The NCHVP must be seen as highly relevant as it addresses major health challenges in the targeted communities. The activities of the program are consistent with the overall program goal and they are still seen as valid. It is also in coherence with national-, international- and Red Cross/Red Crescent policies and strategies. The program's inclusiveness' of different stakeholders in the planning and implementation process is further emphasizing the relevance of the program. Finally, its relevance is reinforced by its ability to adapt to emerging needs.

In spite of its high relevance there are also important issues which are not addressed thoroughly by the program.

Sudan has among the highest infant mortality rates and maternal mortality rates in the world. Although both the malaria and hygiene interventions in the NCHVP do contribute to improved Mother, Newborn and Child Health (MNCH), it is the impression of the MTR team that MNCH has not

been addressed as one of the priority areas in the program. Furthermore, according to SRCS staff, volunteers and community members, the mosquito nets distributed are not covering all households targeted by the program. It has also been a few years since the mosquito nets were distributed and the SRCS in the branches did not seem to know how to advocate for new nets.

The overwhelming lack of latrines in the communities visited by the MTR team is another issue which has not been sufficiently addressed by most of the branches in the program. Additionally, access to safe drinking water is mainly focused on through health education and through chlorination of water during disease outbreaks.

It is evident that the NCHVP program can not cover all community health needs, but there might be other ways to support communities in also meeting these needs. Advocacy towards the local authorities and towards other organizations could be one way of addressing such issues. Another possibility is to link up with ongoing SRCS Water- and sanitation (Watsan) projects with the aim to make use of technical resources within the organization to strengthen the NCHVP program. It could be considered to include simple components of latrine building and techniques for rainwater harvesting in the CBHFA trainings and/or in a separate workshop for all FHOs.

Recommendations:

1. The SRCS should approach local authorities and/or relevant humanitarian actors in country, as e.g. UNICEF, Oxfam or the Carter center, in order to advocate towards the construction of latrines and ensure access to clean water in communities were the NCHVP is implemented, and where such interventions are not covered by the SRCS. Synergies with SRCS Watsan program should also be sought by linking capacity building efforts of volunteers and staff in the two program areas. In line with this, it is recommended that a workshop is arranged with the aim to train Field Health Officers (FHOs) in how to construct simple latrines and how to harvest rainwater. According to discussions held with the Norcross Watsan delegate, who is based in Rumbek up till the end of 2011, he will be able to conduct such training.

2. The SRCS should consider a more strategic approach to malaria prevention based on the IFRC standards for malaria prevention and control. This includes ensuring high mosquito net coverage and proper usage of the nets in target areas. The possibility of receiving mosquito nets through the IFRC or from external organizations, which are distributing mosquito nets in Sudan, should be explored. If none of these requests are met, it should be considered including funds for mosquito nets in the NCHVP budget.

3. A more strategic approach to Mother, Newborn and Child Health (MNCH) could be considered in the program. This could be done by further emphasizing issues pertaining to MNCH during trainings, as well as by providing pregnant women with "safe home delivery kits".

4.2 Effectiveness

Assessing effectiveness, the team reviewed to which extent the NCHVP has been able to obtain its planned objectives. Main challenges affecting achievements were also identified.

Due to the fact that the reporting of the program has not been fully in accordance with the log frame developed in 2007 it has been a challenge to measure the effectiveness of the program. Another challenge is that concrete indicators were not set when the program started. E.g. the expected number of volunteers to be trained, the expected number of households to be visited and the percentage of target communities with access to safe water were not specified. The MTR team has thus only been able to assess the effectiveness of the program on the bases of available data, such as statistics presented in the annual plans of the branches for 2011, as well as through interviews with key stakeholders in the program.

Table 2 below shows the number of Trainer of Trainers (ToTs) trained and number of Community volunteers trained as of 2007 through 2009. As the annual report for the NCHVP program for 2010 was not finalized at the time of the review process, the numbers for 2010 are missing. Numbers from Jonglei and Lakes state are neither included in the below table as data was not available.

Table 2

	ToTs trained				**Community Volunteers trained**			
Year	2007	2008	2009	Total	2007	2008	2009	Total
Number	190	562	446	1.198	9.938	14.223	20.351	44.512

Numbers are based on the SRCS Plan of Action for each district branch for 2011. Figures for Lakes state and Jonglei state are not included.

Table 3

Activities 2007 – 2009			
Clean up campaigns	No. of home visits carried out	No. of people received health education	No. of mosquito nets distributed
578	50.176	196.535	37.050

Numbers are based on the SRCS Plan of Action for each district branch for 2011. Figures for Lakes state and Jonglei state are not included.

The above tables show the main outputs in the program up to 2010. As numbers are not yet available for 2010 it is safe to assume that the actual outputs are much higher than showed in table 2 and 3. The fact that the NCHVP has, among other things, during the period 2007-2009 trained 44.512 community volunteers and carried out 50.176 household visits, indicates effectiveness in program implementation. However, as the total number of households has not been registered in the program areas, and also due to the lack of indicators in the program documents, it has not been possible to comment on the degree of implementation against targets.

The NCHVP's degree of success in attaining its objectives is assessed in the matrix starting on the following page.

Main objectives	Status
Targeted communities are able to address basic health needs at house hold level through Community Based Health First Aid	50.176 household visits were carried out by volunteers from 2007 up to 2010. During these visits household members were, among other things, informed about hygiene issues, the importance of keeping the home clean, how to prevent malaria, how to treat burns, what to do if a child has diarrhea and how to manage safe drinking water. During interviews and discussions with the MTR team, volunteers in North and South Sudan and community members in North Sudan, clearly demonstrated knowledge about the issues they had been trained in. As examples, community members demonstrated knowledge in how to treat burns and other wounds in a hygienic way (some of the community members mentioned that prior to receiving the health education from SRCS volunteers they would put ash on a burn) and how to give a child sugar and salt solution if it has diarrhea. Community members asked, and who were in possession of mosquito nets, confirmed that the nets are being used. It was reported that in Upper Nile and Unity, one male and one female volunteer normally carry out home visits jointly. The experience is that this is facilitating communication with household members of both sexes; it is thus likely that this approach contributes to the effectiveness of the activity.
Targeted communities are well-informed and aware of communicable disease prevention and health promotion	In addition to the above mentioned home visits, 196.535 people received health education from 2007 up to 2010 and 578 clean up campaigns were organized. The MTR team did however not succeed in getting an overview of the total number of communities targeted. According to interviews with volunteers and community members people now regularly carry the garbage out of their houses and either burn it in confined places or place it on a garbage truck, if available. They also mention that they cover their water and food in order to protect it from flies and to prevent disease outbreaks. It is the impression of the MTR team that the combination of intimate- and larger scale methodologies (home visits, awareness campaigns, mobilization of clean up campaigns) applied in the NCHVP is important and can reinforce the messages conveyed and thus contributes to increase the effectiveness of the activities.
Targeted communities are able to mitigate and respond to large scale emergencies and communicable disease outbreaks	44.512 Community Volunteers and 1.198 ToTs were trained from 2007 up to 2010. Based on interviews with FHOs and Branch Directors all volunteers are registered with their contact details and the program branches are thus capable of mobilizing a large number of volunteers in a short time span to respond to emergencies and disease outbreaks. Examples: In Unity state SRCS volunteers have been mobilized in order to carry out malaria campaigns jointly with the MoH during the rainy season. Activities included health education, spraying and distribution of mosquito nets. Volunteers have also several times responded during clashes by giving First Aid to victims, provide victims with transport to hospital, as well as handling dead bodies. In the beginning of 2011, Sennar state received a large number of returnees (750 families) which were based in three camps. The NCHVP volunteers carried out First Aid training, health education and relief activities (food distribution etc.) in the camps. In 2007, in El Gadaref 1000 volunteers were mobilized to support the MoH in responding to acute watery diarrhea outbreak with awareness sessions and chlorination.
Targeted communities are well informed and have	The impression of the MTR team is that HIV/Aids is still not easily talked about in Sudan. The team did however observe large sign boards in market places in the bigger

capacities within HIV/AIDS prevention, care and support	towns aiming at informing about HIV/Aids. In some of the SRCS branches HIV/Aids IEC material was available and in use. The MTR team was informed by volunteers that People Living with HIV/Aids (PLWHA) is still to a great extent stigmatized. During most interviews HIV/Aids was not mentioned as a challenge, until asked about. Some of the volunteers also mentioned that they did not know any PLWHA. It is the impression of the MTR team that this component of the program needs to be strengthened in particular through awareness trainings. The team did, however, not have the opportunity to meet with any PLWHA or with major actors within HIV/Aids programming in order to gain a better understanding of the HIV/Aids situation, approaches and priorities in Sudan. A certain level of capacity has been obtained. E.g. When volunteers in El Gadaref met with the MTR team and they were asked to perform one of their theatre plays they use during awareness sessions, the volunteers chose to put on a play focusing on HIV/Aids prevention. The FHO from Sennar informed the team how volunteers visiting a family where one of the family members was affected by HIV/Aids had sensitized the family on the disease. Before the arrival of the SRCS volunteers in this household the other family members had refused to eat with the person affected and they did not seek his company. After the SRCS intervention the family had become comfortable with living with its affected family member and a sensitization session targeting the neighbors was held by the volunteers outside the home of the affected person. According to the FHO the life of the person living with HIV/Aids has been completely changed as his family is now eating with him, they sit with him and they are no longer ashamed of him. Home Based Care of PLWHA is currently not a component of the NCHVP program. It is not advisable to include this component in the program at this stage as it will require extensive human- and financial resources.
Targeted communities are well informed and aware of hygiene and sanitation issues relevant for their environment	Based on interviews and discussions with volunteers and community members it is evident that the informants have knowledge of hygiene and sanitation issues. They mention hand washing after visiting the toilet and before preparing food as important, they also mention the importance of not keeping stagnant water and how to cover water and food. The MTR team observed during visits in the communities in North Sudan that homes and compounds were fairly clean. Access to safe water and sanitation is addressed mainly through community education and support in water purification. However, in Upper Nile the SRCS volunteers are teaching communities to dig shallow latrines and in Unity they do the same and they also make slabs made out of cement donated by UNICEF. According to the FHO in Upper Nile, 66 volunteers were trained by Austrian Red Cross in latrine construction in 2010, the knowledge gained during this training is now integrated in the NCHVP program.
Targeted volunteers at branch, locality and unit level have increased capacities	The huge number of volunteers trained since the start of the program suggests that the capacity has increased among the volunteers. This is further confirmed by interviews with volunteers demonstrating knowledge within FA, disease prevention, water and sanitation and HIV/Aids. The team did, however, not participate in any of the trainings, nor did it have the opportunity to observe volunteers in action, consequently it has not been possible to comment on the quality of the training methodology or the performance of the volunteers.

According to the above matrix, the objectives of the NCHVP have to a certain extent been achieved. One of the main success factors to the achievements has been SRCS's ability to recruit and retain volunteers as well as its unique access to the communities through its volunteers.

The fact that the NCHVP is a long term program with ongoing activities has meant that the volunteers recruited have been utilized constantly. In interviews with volunteers this, in addition to trainings and the possibility to learn new skills and to help people, have been important to keep them motivated. The volunteers have mostly been recruited from within the communities they are working in, this coupled with the NCHVP's focus on managing volunteers have been an asset to the programme. This issue is further explored in section 4.3.

Challenges affecting achievement of the objectives
Transport was a challenge mentioned by almost all informants interviewed. Bikes and motorbikes are being used as means of transport in the program. In the North, and also in most places in the South, women are not allowed to ride bikes, or they do not feel comfortable riding bikes or motorbikes. Additionally, bikes and motorbikes are not suitable means of transport during the rainy season as roads are normally in a bad condition.

Another issue is the long distances. E.g. in North Kordofan, the most remote program community is 600 kilometers away from the branch office. According to the FHO in North Kordofan it takes a minimum of ten hours to travel this distance by car (Land Cruiser) when it is dry and up to 30 hours in the rainy season. Using motorbikes for monitoring and training of volunteers in the most remote areas is thus not feasible. In Northern Kordofan the FHO, originally being the only Master trainer in CBFHA, did however overcome this challenge by training four persons from two different localities in the most remote areas in order to enable them to conduct trainings and to carry out supervision visits. However, this example shows that monitoring and supervision in remote communities is a challenge due to lack of appropriate means of transport, which again might affect the effectiveness and the quality of the program. According to program staff there is not enough cars in the branches to carry out regular monitoring visits and there are not enough funds in the program to rent cars for such visits. All branch representatives talked to also mentioned that it was a challenge to maintain bikes and motorbikes as limited funds for maintenance were included in the budgets.

In all the program communities visited by the MTR team there was a striking lack of functional latrines. This was confirmed by SRCS volunteers, community members and representatives of the MoH. According to community members met, most people would go to the toilet in a public garbage area (women would go after dark). The team observed children using these public areas both as toilet and as play ground which poses a severe health risk. Teaching hygiene and sanitation might be contra productive when crucial facilities such as latrines are nonexistent. The MTR team was also informed that in communities where latrines are constructed it takes time to make people use them. In the South, some of the reluctance towards using latrines was reportedly related to the notion that the use of latrines is seen as an Arab custom.

According to interviews with volunteers and FHOs, the program is not providing enough First Aid (FA) kits. There are not available FA kits for all volunteers and in some of the branches not even for all the

ToTs. When speaking to volunteers and FHOs, it also became evident that a system for replenishment of First Aid kits does not exist. The volunteers did not know where to go in order to replenish their kits. Normally they resort to ad hoc solutions, such as buying items in the market. In the South, replenishment is sometimes provided by the ICRC. Some of the FHOs spoken to mention that replenishment of FA kits were not included in the NCHVP budget. The availability of functional FA kits is crucial to the effectiveness of trainings and to the level of response in emergencies.

SRCS staff members from seven of the NCHVP branches said that they would be able to fulfill their plans for 2011 provided that funding would be available and on time. Late transfers of funds have, however, been a major challenge in the program, an issue which is discussed further in section 4.3.

Recommendations:

1. The focus on the HIV/Aids component should be strengthened with regards to stigma and discrimination during trainings of volunteers and community members.

2. Expenses for maintenance of bikes and motorbikes should be included in the program budget. In order to enable monitoring visits to the most remote areas, expenses for renting cars should be considered included in the budgets in those branches where access to cars is a challenge.

3. A system for replenishment of First Aid (FA) kits should be implemented. The FHO in each branch should be responsible for the stock and all volunteers should be informed about who to address when refill is needed. In order to ensure that FA items are purchased and in stock, expenses for replenishment of FA kits should be included in budgets at branch level.

4.3 Efficiency

When analyzing the efficiency of the program, the team assessed to what extent resources were spent in a cost efficient and timely manner to deliver results. Different management factors important for delivery, such as monitoring, reporting, coordination, training, management of volunteers and security were also assessed.

The NCHVP is currently financially supported by the Norwegian-, the Swedish-, the Finnish- and the Canadian Red Cross[20]. It has been a challenge to obtain information on the exact amount each of the partners has contributed with. Although, the SRCS has provided the team with an overview of the total amounts transferred to the program in 2009 and 2010. Furthermore, funds received from Norcross are stated in the 2009 and 2010 Norcross/SRCS audit reports. See below tables.

[20] As it is not part of the TOR, this MTR does not include an assessment of the program accounts which in case would require a separate effort.

Table 4

Total transfers to the NCHVP program*				
2009		**2010**		**Total**
SDG	*NOK***	*SDG*	*NOK***	*NOK*
805.627	1.646.340	655.404	1.339.360	2.985.700

*According to transfer sheet received by the SRCS NCHVP Coordinator 08.05.2011

**According to Oanda Currency converter 20.05.2011

Table 5

Transfers to the NCHVP program from the Norwegian Red Cross				
2009		**2010**		**Total**
SDG	*NOK***	*SDG*	*NOK***	*NOK*
179.300	366.410	224.190	458.145	824.555

*According to Norcross/SRCS NCHVP Audit reports for 2009 and 2010

**According to Oanda Currency converter 20.05.2011

The total transfers to the programme in 2009 and 2010 are approximately[21] 2.985.700 NOK. It should be noted that the branches have not received equal amounts as they have been supported by different donors. However, when the total amount is divided on the nine program branches over a period of two years the average amount for each branch is 165.872 NOK annually. Although the actual amount for each branch will be less as the total amount transferred also cover salaries for the NCHVP team at HQ.

Considering the high number of activities carried out referred to in section 4.2, it is the view of the MTR team that the overall financial input is reasonable compared to the actual output. The program must thus be seen as cost efficient. According to informants, funds have mainly been spent on salaries and trainings, and to a lesser extent on equipment and incentives for the volunteers.

A main challenge in the program has been the delay in transfers of funds from partners. In 2010 the SRCS only received its first transfer of funds for the NCHVP in August. Additionally, some of the branches had at the time of the MTR team's visit in May 2011 not yet received any transfers for 2011.

The reasons for the delays are multifaceted. In 2010 financial irregularities were detected in one of the program branches. Although irregularities were not detected in relation to NCHVP funds, donors were reluctant to transfer funds until this issue had been fully resolved. According to the NCHVP team in Khartoum, the lack of continuity of desk officers in some of the partner NS' is another reason for the irregular transfers. Finally, a larger part of the program funds is channelled through the IFRC which operates with a working advance system. In other words, most of the funds transferred to all SRCS programs must be spent before a new transfer can be executed. Consequently, the NCHVP is dependent on the pace of implementation of other SRCS programs.

Interviews held with SRCS staff at all levels revealed that the delayed transfers were a major source of frustration. It was mentioned that staff had to go without salaries for several consecutive months which again affected their moral. The SRCS tried in some cases to solve this situation by inter

[21] Depending on exchange rate when funds were received.

borrowing from other programs, which is normally not accepted by donors and thus not a good solution to the problem. The unpredictability of transfers makes it difficult to plan. Branch directors and the FHOs spoken to reported that the irregular transfers had affected the timeliness of implementation of the activities. The purchase of important equipment such as First Aid kits and education material had, among other things, been hampered.

It is the view of the MTR team that the program would have been more efficient had funding been regular as it would have ensured predictability and it would have made it possible to implement program activities in a timely manner. In spite of the delayed transfers, program activities have to a certain extent been implemented on the ground, this is further discussed in section 4.5.

Monitoring

The salaries of the two program staff at HQ is covered 100% by the program. However, according to her own estimates, the National Coordinator for the NCHVP program is only spending 50% of her time on the program. This is related to the fact that she constantly has had to deal with emerging issues such as floods, the elections and the referendum, which has taken her focus off the NCHVP.

It was confirmed that the Assistant NCHVP Coordinator at HQ is visiting the branches on quarterly bases and that the NCHVP Coordinator in Juba since October 2010 has been visiting the four program branches in the South regularly. Monitoring is, according to the National Coordinator for the NCHVP also carried out through telephone and e-mails. Additionally, sometimes FHOs are visiting other program branches and provide monitoring reports to Khartoum, in this way monitoring and exchange of experience is achieved at the same time. Also, when someone from the HQ is going to a branch to follow up on other issues, the NCHVP program team at HQ asks them to follow up on NCHVP activities as well.

The monitoring system seems to be rather well functioning, but it is the opinion of the MTR team that the program would have been more efficient if the program staff spent all its time on the NCHVP. This would, among other things, have allowed the National Coordinator for the NCHVP to perform monitoring visits to the branches on regular bases.

Reporting

According to the FHOs, volunteers and the NCHVP team at SRCS HQ, one ToT (supervisor) at locality level will normally be in charge of a group of 10 volunteers who reports to her/him on weekly bases. The supervisor reports on monthly bases to the FHO in the State Branch, who again reports on quarterly bases to the HQ in Khartoum. The branches in the South are supposed to copy the NCHVP Coordinator in the Secretariat in Juba when reporting to Khartoum. The NCHVP team in Khartoum informed the MTR team that they give feedback on the reports received from the branches and this was confirmed by the seven FHOs spoken to. The SRCS HQ is supposed to provide partners with reports on quarterly bases.

It is the view of the MTR team that the reporting structure introduced by the NCHVP is efficient. The narrative reporting has according to stakeholders interviewed, been timely, statistics on activities carried out have been received on quarterly bases, but financial and narrative reporting has been unstructured due to the irregular transfers. The team notes that the reporting up to 2011 is focusing

on registering activities carried out and are not reflecting on why things happened or did not happen and what have been the challenges. Additionally, crucial information is missing. When the team spoke to volunteers, and was showed the reports they forward to the supervisor at locality level, it was detected that some important information gathered is getting lost on its way through the reporting chain. E.g. in El Gazera disease pattern in the households visited is registered by volunteers on weekly bases, but this information disappears when it is compiled by the supervisor at locality level. An important way to measure impact is to register the occurrence of different diseases within the program areas. If this information had been aggregated at HQ level it would have been possible over time to document trends related to the possible impact of the program activities. In addition, this could be an important source of information for the health authorities. This is thus a missed opportunity.

A new reporting system was implemented in the end of 2010 and according to the new system SRCS HQ is supposed to report to its partners on trimestriel bases. The reporting is to be in line with a revised program document and log frame finalized in autumn 2010. The first report according to the new system is due to be sent in May 2010 and was not available to the MTR team. It has thus not been possible for the team to assess the quality of these reports. However, the team observes that the new log frame is also missing measurable indicators. As mentioned in section 4.2., a considerable weakness pertaining to the reporting in the program is the fact that measurable indicators have not been specified in the program documents.

Furthermore, a baseline was not developed prior to the implementation of the program. Baseline questionnaires have however been prepared and a consultant has been hired to develop a baseline, but it is yet to be materialized.

Several important documents have been developed in the program, however the team notes that for some documents there are existing different versions and most documents are not dated. This includes the original program document and the revised program document.

It is the view of the team that the reporting structure put in place by the program is efficient, but the content and the quality of the reporting need to be strengthened.

Coordination

At a general level the SRCS is coordinating its services with other humanitarian actors, including ministerial agencies, UN and Red Cross Red Crescent Movement members working bilaterally and/or multilaterally in Sudan. SRCS is actively involved in most coordination fora at national and state levels. It maintains a regular contact with Humanitarian Aid Commission (HAC) of the Ministry of Humanitarian Affairs, and takes part in UN-led interagency task force meetings. Within the Red Cross and Red Crescent family in Sudan, coordination is managed through monthly cooperation, ad hoc and regular task force meetings. Coordination within the NCHVP is supposed to take place in a technical committee, including RC partners, but according to key informants, meetings in this committee have not taken place on regular bases lately. The RC partners within the NCHVP program have in addition to financial support contributed with technical support such as arranging workshops in Monitoring and Evaluation, in developing programme documents and in conducting monitoring visits.

In relation to the NCHVP program the different levels and departments of the MoH are the main external cooperation partners. The relations and cooperation with the local authorities in general, and the MoH in particular, seem to be very good. This impression was confirmed by interviews held with high level representatives of the MoH in El Gazera, El Gadaref and in Lakes state. The MoH is aware of the work carried out by the SRCS volunteers and they are e.g. often called upon during major immunization and malaria campaigns. Through the NCHVP the SRCS is also often cooperating with local authorities when arranging clean up campaigns: In some places the SRCS will mobilize community members while the authorities will provide tools and maybe trucks to transport the garbage. Representatives of the authorities are often invited to SRCS graduation ceremonies of volunteers who have graduated from trainings facilitated by the NCHVP. During one such graduation ceremony in El Gadaref, and where the MTR team participated, the Commissioner in El Fau was called to hand out the diplomas and to give a speech. The effect of having such a prominent person taking part of the ceremony and giving a speech which reinforces the message of the SRCS cannot be underestimated, as it both legitimizes the activities of the SRCS and it facilitates SRCS' access to the communities.

In El Gazera and in Lakes state it was confirmed that the SRCS is participating in MoH coordination meetings. While in El Gadaref the team was informed by the Minister of Health that coordination meetings are not taking place on regular bases, but the intention is to start arranging such meetings and the SRCS will be invited to participate. In the South the NCHVP Coordinator is normally not attending the Health cluster meetings which are taking place in Juba, the main reason mentioned for this was limited time to attend the meetings. However, it was emphasized that the SRCS in the South does collaborate with the MoH, for instance during disease outbreaks.

Recruitment and retainment of volunteers:
When deciding to implement the program in a community the SRCS starts by approaching the community leaders and offers them training in First Aid and Red Cross principles. The reason for this is that the community leaders will provide a smooth access to the communities, or with the words of one of the FHOs:

"If you train the chiefs they will be positive towards the programme and they will direct their communities".

Volunteers spoken to, say that they joined the SRCS because they wanted to participate in trainings, they wanted to contribute positively to their communities and/or because they had colleagues or friends in the SRCS. Some of the volunteers were recruited through other organizations such as the Youth Union or the Women's Union. In some branches, like in Upper Nile, the radio is also used to recruit volunteers.

The Community leaders in El Gazera said that the volunteers are highly respected despite their young age as the community members know that they have been well trained. They also mentioned that the volunteers were trusted because they live in the community. This view was further confirmed by volunteers in El Gazera, by community members in Gadaref and by the FHOs interviewed from other

branches. Also, almost none of the volunteers asked, said that they had been denied visiting households. One exception was, however, mentioned by the FHO from Northern Kordofan, where people in one particular community initially had been reluctant to receiving home visits. In order to overcome this challenge the SRCS volunteers later returned to the community with education and multimedia material, which caught the attention of the community and paved the way for homes visits also here.

It is evident that the NCHVP volunteers have been a crucial entry point to the communities for the SRCS which again has contributed to increase the visibility and the image of the organization. As mentioned by one of the community leaders met in El Gadaref:

"before we thought that the SRCS was only working at the hospitals, now they are working in the communities and this has made us understand what the SRCS is all about".

It is the impression of the team that the SRCS volunteers were highly respected in the communities visited and that it gave a certain status to be a volunteer in the SRCS, which again contributes to the efficiency of the program.

The volunteers within the NCHVP are not being paid for their services, but they do receive incentives such as aprons, trainings, diplomas and sometimes a meal. Most of the volunteers met did not have SRCS T-shirts and none had caps, which were items repeatedly mentioned by the volunteers that they would like to have as it would help identifying them as SRCS volunteers.

Among the 67 volunteers met, the team observed that some of them did have ID cards, while many did not have any. In some branches all ToTs had ID cards, while in others it seemed more random who would have an ID card or not. The volunteers emphasized the importance of having an ID card so that they would be able to identify themselves, e.g. when following somebody to the hospital or when conducting home visits. Having an ID card also raises the status of the volunteers and it is thus a valuable incentive. It is furthermore important that the volunteers are able to identify themselves as it confirms the seriousness of the SRCS. Ensuring that all active volunteers have an ID card is not an expensive investment, but an important one.

The limited access to incentives was mentioned by several informants. The FHO from Unity state told the team that due to the late transfers they often had nothing to give to the volunteers, in such cases the SRCS staff would make private contributions so that the volunteers could get something to eat during campaigns etc.

A database of volunteers was established by the program in 2009. Each state branch has a computer and one person from each of the program branches have been trained in data entry. The data is forwarded to the SRCS HQ were it is compiled. It has been decided that the database will include data from all the SRCS branches. As all data has not yet been entered in the database, it was not possible to obtain the exact number of volunteers in order to confirm a possible increase in the number of volunteers since 2007. However, according to SRCS staff both at HQ and in the branches, there has been an increase of volunteers since the initiation of the NCHVP. Among a group of 21 volunteers, met by the MTR team in El Gadaref, 13 persons had become volunteers as of 2007. In

another group, also met in El Gadaref, 18 out of 24 volunteers had been recruited since the beginning of 2007. More than half of the volunteers in these two randomly selected groups had been recruited since the start of the NCHVP programme, which at least confirms an increased number of volunteers since the program started in El Gadaref.

Training/Capacity Building

One of the key elements for attracting and retaining volunteers is training. This was confirmed through interviews with SRCS staff and volunteers. It is likely that the high value placed on training is linked to the limited education opportunities in the program communities. In some communities the community leaders will suggest who should receive training and thus become SRCS volunteers, but in other places candidates come forward by themselves.

The way the trainings are arranged varies between branches. As an example, in Upper Nile a CBHFA training for regular volunteers will take place one to two hours daily during a 17 day period. In other branches more hours of training will be held over fewer days.

The volunteers have to pass a written exam after completing the training, but those who are illiterate have the possibility to graduate through an oral exam. If the exam has been passed successfully, the volunteer will receive a diploma during a graduation ceremony.

Among the volunteers trained some will, after passing an interview, be selected for ToT training. The FHOs in each state branch train 10-20 ToTs in each locality who again train the volunteers.

Refresher trainings from ToT to volunteers are taking place on quarterly bases and the FHOs are also seeking to provide refresher trainings for ToTs on quarterly bases. The FHOs, however, have only received refresher training 3 times since the start of the program and the need for such refresher trainings were mentioned by several informants. In order for the FHOs to carry out their jobs in the best possible and efficient way it is important that they are being regularly updated and motivated through trainings.

Sometimes when trainings are conducted in one state, participants from other branches will also be invited, which again provides for excellent opportunities of experience sharing.

The IFRC CBHFA manual is used when training the volunteers. Other training and educational material has been developed by the SRCS and some by the MoH (funded by UNICEF). It is the opinion of the MTR team that the training material is suitable to the context.

Security

According to discussions held with relevant SRCS staff in Khartoum, and representatives from Northern Kordofan, Sennar, El Gadaref and El Gazera, program implementation in the Northern part of Sudan has not been affected by security issues. However, the unstable security situation in the South is a recurring problem. According to the Deputy Director General for the SRCS Secretariat for South Sudan the security situation has affected the program somehow in all program branches. Planned trainings have, for instance, several times been cancelled due to conflict outbreaks

preventing the volunteers from travelling to the venue of the training. This has naturally affected the timeliness of the implementation of the activities and thus the efficiency of the program.

Recommendations:

1. Transfer mechanisms and communication regarding funding should be strengthened. In order to improve transfer mechanisms the SRCS should as soon as possible call for a meeting with all funding partners with the aim to make the partners agree on some common principles for transfers, this in order to ensure predictability in program implementation. The NCHVP branches should as far as possible receive funds at the same time as it will facilitate coordination and it will make it possible for the SRCS HQ to provide timely reports to its partners.

2. It is recommended that the content and quality of the reporting is strengthened. A few key core indicators should be selected for reporting in the NCHVP and reported on from all program areas independent of funding partners. The IFRC CBHFA Indicator guide, which is following the global standards of community health programming in the Red Cross Movement, could be used as support when selecting indicators.

3. A baseline for the nine program branches should be finalized as soon as possible.

4. It should be considered to increase the incentives for the volunteers. It is recommended that T-shirts and caps are provided for all NCHVP volunteers. As a minimum, ID cards for all volunteers should be included in the program budget.

5. In order to keep staff and volunteers updated and motivated, as well as to ensure a high level of quality of the activities, regular refresher trainings should be conducted for staff and volunteers involved in the program.

4.4 Outcome

When assessing the outcome of the NCHVP the team seeked to identify the medium term changes produced by the program.

As the NCHVP is ongoing and in some of the branches activities have just commenced, this MTR is not seeking to assess the impact of the program as impact is seen as the more long term changes due to an intervention[22]. Instead, this section will focus on the outcomes of the program, in other words the medium term changes produced by the program.

Through the fieldwork it became evident that the program has contributed to several changes in the targeted communities.

[22] "Result Management in Norwegian development Cooperation – a practical guide", Norwegian Ministry of Foreign Affairs

Firstly, community members demonstrated knowledge of crucial First Aid skills, which has been of particular importance to members of remote communities as they are now able to help themselves if, for instance, somebody has an accident and gets hurt. The community members are more likely to cope with such incidents today than before they received training from the SRCS. Considering the limited access to health services, it is likely that these skills have contributed to reduce vulnerability in the targeted communities.

Secondly, through home visits and awareness sessions the SRCS volunteers are advocating for immunization of children and they follow up that community members do take their children for vaccination. According to volunteers and community members spoken to, people are now much more aware of the importance of having their children vaccinated which again reportedly has increased the vaccination frequency of children in the targeted communities. In some communities, e.g. in Al Gazera, the community leaders mention that they believe that this has furthermore contributed to the fact that their children are less sick today than what was the case a few years ago. Due to the lack of a baseline for the program areas, it was not possible to confirm these assumptions with statistical material.

Thirdly, anecdotal evidence[23] suggests that awareness and attitudes around health and hygiene has improved in the targeted communities. Several representatives of the communities also mentioned that both the home visits and awareness sessions have contributed to improvements in hygiene behavior. Community members informed the team that regular clean up campaigns are now taking place, they are now regularly washing their hands before eating and after visiting the latrine, they cover their water containers and clean their cooking utensils. The FHOs from Unity and Upper Nile also reported on increased latrine usage by community members. It seems like these changes in behavior have led to cleaner communities. As an example, some of the community members pointed out that before there were a lot of flies in the communities, while now there were hardly any, an observation which was confirmed by the MTR team during its visits to program communities.

The team was also informed that those who have mosquito nets are using them and if they do not have nets for all family members, children and pregnant women are being prioritized. The MTR team was not in the position to confirm these statements through observation.

Furthermore, it was reported by volunteers and community members that incidences of diseases such as malaria and diarrhea had been reduced in the targeted communities. Adequate statistic material was not available in order to confirm this. Although statistics[24] received from the MoH in El Gadaref shows a decrease in malaria cases from 5331 in 2009 to 4830 in 2010. The cases of deaths related to malaria were 94 in 2009 while there were 76 cases in 2010. The Minister of Health in Gadaref informed the MTR team that watery diarrhea was widespread in 2007 and that many children died from it, but that no such cases had been recorded over the last two years. These data

[23] Community members, volunteers and FHOs

[24] Health statistics 2009 and 2010, El Gadaref state, Ministry of Health

may indicate that there has been a decrease in malaria and watery diarrhea in one of the nine program states, which are also in line with national tendencies[25].

The reported decrease in the above mentioned diseases is most likely a result of combined interventions carried out by the MoH and other humanitarian actors. It is, however, reasonable to assume that the NCHVP program has contributed towards the alleged improvements in the program communities.

An important outcome of the NCHVP is the fact that due to the implementation of a more comprehensive volunteer management system it is now possible to mobilize volunteers quickly in the program branches. The ability to mobilize a large number of volunteers within a short time, e.g. during a disease outbreak or a conflict situation, can, among other things, prevent further disease cases and it can contribute to save lives.

It is also the impression of the MTR team that the reporting structure introduced by the NCHVP has enabled the SRCS staff members to better structure themselves towards goals, which can be exemplified by a quote from one of the Branch directors:

"We were already doing many of the activities which are part of the NCHVP program before it became a program, but the difference now is that it is all more coordinated, we are operating within a framework, we work in a much more structured manner and this is much better as it makes our efforts more effective" .

The fact that the volunteers are visible in the local community and that they have proven skills have also, according to the informants, heightened the status of SRCS volunteers and improved the image of the SRCS. An indication of this is the appreciation of the SRCS/NCHVP activities by community members.

Finally, the program has contributed to the empowerment of community members, specifically youth, as most of the volunteers are quite young, and women as women are most often targeted during home visits. These groups are empowered in the sense that they have gained new and important knowledge through the NCHVP, which makes them more self reliable and less vulnerable when it comes to health challenges.

4.5 Sustainability

When assessing the sustainability of the NCHVP program the MTR team has focused on the extent to which the program activities will be able to continue after external financial and technical support have been withdrawn.

[25] Sudan Millennium Development Goals Progress Report (2010), The Republic of Sudan Ministry of Welfare & Social Security, National Population Council

A key premise for sustainability is the degree of ownership among relevant stakeholders in a program.

It is the opinion of the MTR team that the NCHVP to a great extent has managed to include relevant stakeholders in the planning and implementation of the program. As shown in section 4.1**,** branch directors and the FHOs at branch level have been included in the planning and implementation process. The branches were responsible for selecting the localities where to implement the program and community leaders were consulted prior to, and during, implementation. The fact that the program has been anchored at different levels in the organization and also in the targeted communities, as well as the positive attitude towards the program at the different levels in the SRCS and in the visited communities, indicate a high degree of ownership. It should also be mentioned that the SRCS Secretary General has taken a special interest in the program and as a consequence the NCHVP is normally on the agenda during the quarterly State Branch Directors meeting. Most likely this contributes to reinforce the interest and sense of ownership towards the program within the entire organization.

However, even though representatives met from the Secretariat in South Sudan acknowledge the importance of the program, they do not feel they have been properly included in the planning an implementation process. The impression of the team is that there has been a lack of clarity regarding the roles and responsibilities between the NCHVP team in Khartoum and the NCHVP Coordinator in the South.

The staff members met from the Secretariat in the South mention that their technical capacity has not been fully utilized in order to support the program branches in the South. For example, program visits from the Secretariat in Juba to the program branches in the South was not carried out on regular bases before 2010, as according to the NCHVP Coordinator in the South, funds for such visits was prior to 2010 not included in the program budget. This might be due to a misunderstanding as informants in Khartoum and in NorCross states that such monitoring visits were included in the budget. It is furthermore mentioned that they have not been sufficiently informed about the program as program branches in the South have reported directly to Khartoum. It is the impression of the team that this has affected the sense of ownership among staff members in the Secretariat in the South. However, as of autumn 2010 this situation has changed, as the NCHVP Coordinator in the South has since October 2010 paid each of the program branches at least two visits and the branches in the South are copying the secretariat in Juba on all correspondence regarding the NCHVP program.

As far as the MTR team was informed, the NCHVP is currently not receiving financial support from the Sudanese authorities at any level. However, according to observations made and interviews conducted with SRCS staff and volunteers, as well as with representatives of local authorities, the local authorities provide the SRCS with office space and furniture in some of the program branches. Some places the MoH is also providing technical support during trainings of volunteers. Furthermore, when volunteers are participating in immunization campaigns the MoH normally provides incentives, transport and food for the volunteers. These are important contributions to the SRCS, but it seems like the potential for receiving additional support from the local authorities has not been fully explored in all branches/localities. A continued close cooperation with the authorities might be an important factor for future sustainability of the program activities.

The focus on capacity building of volunteers and community members, confirmed by the high number of trainings carried out during the program period, reinforces the sustainability of the program. The fact that the volunteers are recruited from within the program communities, points in the direction that capacity built will remain in the communities also after funding has been phased out. All volunteers asked, confirm that they will continue to carry out activities even though there is no external financial support. In fact the delayed transfers of funds during the program period, e.g. in 2010 when funds were not received until August, confirms that activities, even though at a reduced level, have been ongoing independent of external funding. The reason for this must be contributed to committed volunteers who have a genuine dedication and wish to use their knowledge in order to make a difference in their communities.

Nevertheless, in order to keep the activities running in the future a certain level of funding will be needed at all levels of the organization; HQ level (Khartoum and Juba), branch level and locality/community level. Funds will, among other things, be required for salaries, FA kits, education material, diplomas, transport and incentives for volunteers. In order to ensure sustainability of the program activities it is important to start thinking of how these expenses are going to be covered in the future.

At HQ level, the program should in the future ideally become fully integrated in the SRCS Health department so that activities could be monitored and supervised by SRCS core staff, who also will be responsible for trainings of FHOs, who again will provide capacity building activities for volunteers.

It is important that future sources of income are established at branch level. Even though it is a challenge to establish viable Income Generating Activities (IGAs) in Sudan, several SRCS branches have been able to establish stable sources of income through renting out guest rooms and training halls. Some of the program branches have access to this kind of income. E.g. in El Gadaref the construction of a guest house and a training hall is in process and has been included in the NCHVP budget. According to the Branch director, the intention is that some of the income from the rent will be utilized in order to keep the program activities running after external funding is no longer available. It is the opinion of the team that the inclusion of funds for viable IGAs at branch level in the program budget is crucial in order to ensure sustainability and to secure a safe exit for the partners.

The Secretariat in the South is considering generating income through Commercial First Aid which will target NGOs, the UN, national authorities and the business community. The SRCS has already received requests from the UN and the national police in order to carry out FA trainings. Startup capital is needed in order to establish such a program, but the SRCS does have the main resource needed as it does have the knowhow through a pool of well trained FA trainers. Technical support in order to develop such a program could be sought from Kenya Red Cross which has a well functioning Commercial First Aid program. In order to ensure sustainability of the program in the South, partners could give financial support to a Commercial First Aid program under the precondition that some of the funds generated by the program will be fed back into the NCHVP activities.

The SRCS, both at national and state branch level, should look further into the possibility of attracting funds from relevant national actors, such as the MoH and private companies, as well as new

international partners. However, in order to attract such funding it is necessary to market the NCHVP program. Successful marketing efforts are depending on the ability to document results, which again is linked to the quality of the reporting system of a program. The need to strengthen the NCHVP reporting system is suggested earlier in this report. When the reporting system has been improved technical support for marketing the NCHVP could be sought from SRCS's partners. E.g. the Norwegian Red Cross does have the relevant expertise within its Marketing department. An exchange visit to Norway for a SRCS staff member could be facilitated, or a staff member from the Norwegian Red Cross Marketing department could conduct a workshop for relevant staff in Sudan and also support the SRCS in developing a marketing plan aiming at attracting national- and new international partners.

Recommendations

1. The SRCS should, together with its partners, start discussing exit strategies. It is recommended that the program branches develop realistic plans for viable Income Generating Activities (IGAs) and that funds are included in the NCHVP budgets for IGAs.

2. The SRCS should develop a more strategic approach towards national partners, such as the MoH and private companies, as well as new international partners, with the aim to attract funding for the NCHVP activities. A Marketing plan could be developed with the technical support of RC partners, for instance from the Norwegian Red Cross Marketing department.

4.6 Special issues pertaining to the NCHVP in South Sudan

The capacity of the SRCS in the South is lower than in the North. Most of the branches are in their infancy and only four out of ten branches are seen as fairly strong. Another challenge is the limited access to skilled people. For example, the position as SRCS FHO in Rumbek (Lakes state) and the position as IFRC Finance Officer in Juba, have been announced three times without success in recruiting candidates with the required skills. Both positions were announced for the fourth time when the MTR team left Sudan.

Several volunteers, as well as SRCS staff at the Secretariat in Juba, mentioned that using the Crescent as emblem sometimes is a challenge as many people in the South think that SRCS is a Muslim organization. This has represented a challenge at different levels, but normally volunteers and staff report that by taking their time to explain the mandate of the SRCS the organization is being accepted. This will no longer be a challenge when the new Red Cross society is established in the South.

As mentioned earlier in the report, the unstable security situation in parts of the South is sometimes affecting program implementation.

The SRCS Health Coordinator from Khartoum is in the process of relocating from the North to the South, this will contribute to strengthen the capacity of the Health team in the Secretariat in Juba and at the same time it might improve relations with MoH and other actors as it will make it possible for the SRCS to participate in Health cluster meetings and attend other important fora.

5 Summing up

There is no doubt about the relevance of the NCHVP program as it responds to crucial needs in Sudan and at the same time it contributes to strengthen the capacity of the SRCS, which further increases the ability of the organization to respond to the needs of vulnerable groups.

There is a strong commitment to the program both at HQ level and all the way down to the volunteers at community level. Evidence shows that the program has contributed to increase the image of the SRCS in the communities where it is implemented. The progress made and the positive outcomes mentioned in the report further confirm the importance of the NCHVP. It is thus the opinion of the MTR team that with some adjustments, following the recommendations in this report, it would be advisable to continue implementation in the program branches and furthermore to replicate the program in other branches. It is, however, suggested that the implementation in new branches is gradual in the sense that the various activities are scaled up over time. It is better to do one activity well than several activities at a low- or medium level. In this way it is more likely that the activities will have a real impact. The SRCS could also consider a more focused and scaled up intervention towards some key areas like MNCH and malaria. It might be wise to carry out assessments of key priorities within the six program components[26] in each state in order to decide on which components to focus on in the respective state branches.

The goal of the SRCS is to implement the program in all 15 states in the North and presumably in all 10 states in the South, depending on priorities of the new NS in the South. In fact, the SRCS has made plans for 2011 for implementation of the NCHVP in all branches in the North, in addition to four branches in the South. Even though funding is not secured for all branches, some of the program activities, such as trainings and the establishment of a volunteer database, are currently being implemented also in some of the branches that are not receiving external support.

The SRCS should in particular focus on improving its reporting system in order to be able to document its results, which again will make it easier to maintain the interest of current partners and also to attract new ones.

It is important that the SRCS starts developing plans for how to sustain the NCHVP activities after external funding has been withdrawn. Funds for IGAs should be included in the program and technical support for marketing the program should be considered by the partners.

The new NS in South Sudan will not be in a position to announce its priorities until the country has been separated and the NS is formally established. The future of the NCHVP in the South is thus depending on the interest of the new NS to continue with the program. The branches in the South which have been implementing the NCHVP since 2007 have made commendable progress. It is the opinion of the MTR team that the NCHVP program would be an asset to the new NS, as it responds to the needs in the South, as well as it focuses on much needed capacity building within the organization, both which will contribute to increase the profile of the new Red Cross society.

[26] CBHFA, Communicable diseases prevention, Health in emergencies, HIV/Aids prevention, Water and sanitation, Capacity building

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Annexes

Annex 1: Terms of Reference

Evaluation of the Sudan Red Crescent National Community Health and Volunteer Program (NCHVP)

Background of the program:
In Sudan local coping mechanisms are weak, undermined by poverty and chronic lack of basic services, health care, adequate sanitation, and safe water supply. Working within a challenging humanitarian situation, the Sudanese Red Crescent Society (SRCS) focuses on increasing its organizational capacity to effectively and efficiently render humanitarian assistance to the most vulnerable groups in the Sudanese society. It is a priority for SRCS to further develop the network of volunteers in the local communities and equip them with first aid skills, knowledge of prevention of common health risks and ability to do health promotion, to meet the needs of the communities.
This idea has been applied to the NCHVP, where the main objectives are:

Overall objective:

- Targeted communities are resilient to health risks, natural and man-made hazards and disasters, supported by an effective and efficient national society.

Specific objectives:

- Targeted communities are able to address basic health needs at house hold level through Community Based Health First Aid
- Targeted communities are well-informed and aware of communicable disease prevention and health promotion
- Targeted communities are able to mitigate and respond to large scale emergencies and communicable disease outbreaks
- Targeted communities are well informed and have capacities within HIV/AIDS prevention, care and support
- Targeted communities are well informed and aware of hygiene and sanitation issues relevant for their environment
- Targeted volunteers at branch, locality and unit level have increased capacities

Program components and activities:
Program components are implemented in the branches based on priorities and available funding. CBHFA is used as the basis and introduction of the program in all new branches.

- CBHFA

Conduct Training of Trainers (TOT) in CBHFA for volunteer team leaders from each locality in all the targeted states, the training will include RC/RC principles and mandate, community mobilization and community assessment.
Team leaders will train volunteers from each locality in CBHFA.
Volunteers will train members of the community in CBHFA
Procure first aid kits for the volunteers and for community posts
Replenish first aid material.
Print CBHFA certificates.

- Communicable diseases prevention

Conduct TOT on Malaria and other communicable diseases for two volunteer team leaders from each locality.
Train volunteers on prevention of malaria and other communicable diseases.
Conduct educational home visits to community members
Mobilize volunteers as primary advice providers on village level in priority areas. Minimum two malaria control sessions per month per volunteer
Disseminate health messages on malaria prevention
Distribute 5000 mosquito nets per state and treat and re-treat the bed nets
Assist MOH in insecticide spraying programs and vaccination campaigns
Identify mosquito breeding places.

- Health in emergencies

Conduct TOT in emergency response and health in emergencies for volunteer team leaders from targeted localities.
Volunteer leaders organize training by for volunteers in emergency response and health in emergencies.
Every volunteer will carry out trainings for members of the community in how to respond to emergencies.
Establish community committees in targeted communities.
Identify locally available resources in emergency response.
Community volunteers are participating in emergency response and/or communicable disease outbreaks.

- HIV/AIDS prevention

Conduct ToT for 20 key volunteers from each locality on HIV prevention.
Train 20 volunteers from each locality on HIV/AIDS transmission and prevention
Raise awareness in the general population and risk groups on HIV prevention through the following activities:
- community awareness sessions
- group discussion
-home-to-home visits
-video shows and drama activities
-Print and distribute information and education materials
Conduct one-day orientation and information training to state level key stakeholders (policy makers and community leaders) on HIV prevention
Implement health education activities to young people in schools, including dissemination of HIV messages through focus group discussions, sessions, wall magazine and video shows.

- Water and sanitation

Conduct TOT in PHAST for 10 volunteers team leaders from each locality
Train community volunteers in PHAST methodology
Conduct PHAST sessions in the targeted communities
Distribute chlorine tablets in targeted communities
Conduct awareness raising campaigns on maintenance and use of latrines
Conduct cleaning up campaigns in the local environment
Promote composting centralized garbage disposals at household/village level

- Capacity building

Establish and maintain a volunteer data base program in all branches for registration and mobilization purposes.
Conduct volunteer management trainings for members of staff from SRCS HQ and branches, both at administrative and governance levels.
Construct and equip training rooms where needed
Arrange quarterly branch officers meet for reporting, follow up, revising of plans and general exchange of experience.
Rehabilitate and equip locality offices
Carry out training for staff and volunteers in RC/RC principles and laws and International Humanitarian Law

Support to the NCHVP

The Norwegian Red Cross, together with Swedish Red Cross, Finish Red Cross and Canadian Red Cross, are currently support in the SRCS NCHVP. In 2009, the program was implemented in five states in the North (Red Sea, Gedaref, El Gezira, Sennar and North Kordofan) and two in the South (Unity and Upper Nile). In 2010, activities were also implemented in, Malakal, Unity and Lakes State. In addition, the Canadian Red Cross started supporting a small part of the program in Sennar State in 2010.

In 2011, plans are made for all branches in the North in addition to four branches in the South, awaiting funding from new or existing donors. The goal is to implement the program in all 15 states in the North, and finally in all 10 states in the South, depending on new plans made in the South.

2009[27]:

NORAD (Red Sea, Gedaref, Upper Nile and Unity, HQ support)

SIDA (North Kordofan, Sennar, El Gezira, personell costs Juba branch, HQ support/Secretariat support)

2010:

NORAD: (Red Sea, Gedaref, HQ support)

MFA: (Lakes State, Unity, Upper Nile, Secretariat support)

SIDA: (North Kordofan, Sennar, El Gezira, HQ support/Secretariat support)

Canadian RC: (Small support to Sennar)

Finnish RC (Jonglei, Secretariat support)

Main objective of the evaluation:

The aim of the evaluation is to do a midterm review the NCHVP, to be used when considering further support to the program in the North. The review will also serve as back ground for a possible continuation of a revised NCHVP in South Sudan, perhaps in cooperation with ICRC.

Specific objectives of the mid term review:

Relevance

To what extent has the NCHVP been relevant according to the priorities and policies of the target group, recipient and donor:

Are the objectives of the program still valid?

Are the activities and outputs of the program consistent with the overall goal and the attainment of its objectives?

Are the activities and outputs of the program consistent with the intended impacts and effects?

Effectiveness

To what extent have the objectives of the NCHVP been achieved / are likely to be achieved?

What were the major factors influencing the achievement or non-achievement of the objectives?

Efficiency

During the evaluation, it will be important to measure the outputs of the NCHVP, in relation to the inputs.

Have activities been cost-efficient?

Have objectives been achieved on time?

Has the program been implemented in the most efficient way compared to alternatives?

[27] No information on which branches that were financed by Sweden or Norway, regarding Unity, Upper Nile and Juba branch.

Output/outcome
Has the program reached its output/outcomes?
How many people have been affected?

Sustainability

This should be focused on after project finalization, but could also be considered in a mid term review. One aspect to consider is: What are the major factors which have been influencing the achievement or non-achievement of sustainability of the program?

Participants in the Evaluation:

Team leader Trude Bang, Consultant

- Marianne Monclair, Health Advisor Norwegian Red Cross
- Federation Program Coordinator Khartoum, Aisha Maulana
- Representatives from Sudan Red Crescent Society(To be decided):

Evaluation methodology:

- Document review (project documents, budgets, reports, evaluations)
- Interviews of beneficiaries, Sudan Red Crescent Society volunteers and employees, the Federation, donors, Ministry of Health, other relevant stake holders
- Field visits to see/experience implementation of program activities

Plan of Action for evaluation

1. Meetings at HQ Oslo with Program Coordinator Sudan and Health Advisor, to plan the evaluation
2. Approximately 12 days field visit in North and South Sudan to: Khartoum, Gedaref, El Geezira, Juba and Malakal.
    - Meetings and interviews in Khartoum and Juba with SRCS HQ and Secretariat staff who are responsible for the program. What are their experience with the program, the progress and outcomes? Relationship with branches, beneficiaries, volunteers, donors etc. Benefits and challenges. In Juba, what is their opinion on which changes should be included in the program outline for South Sudan to allow for contextual differences between the North and South, which focus should the program have in the South?
    - Meetings in Khartoum with NorCross Country Representative and representative from the Federation. Their opinion on the program, progress, cooperation with SRCS etc.
    - Meetings with Sudanese health authorities and other relevant organizations /stakeholders. What are their experiences with the program, cooperation with SRCS, health needs in their area etc.
    - Visit to Gedaref, El Geezira and Malakal to interview and meet with beneficiaries (community members in targeted societies), SRCS volunteers involved in the program and branch staff. What are their experiences with the program, the outcomes, benefits and challenges. In Malakal: focus on changes/revisions that should be done to adjust the program to South Sudan context.
    - Participants form Red Sea and Sennar will meet with the evaluation team in El Gezira and Gedaref. Participants from Unity and Lakes State will meet with the evaluation team in Malakal and Juba.
3. Write evaluation report

Deliverables:

1. Evaluation report (responsible Team leader):
    - Evaluation of the program
    - Recommendations related to continued NORAD support to NCHVP in North Sudan
    - Recommendations related to a revised version of NCHVP in South Sudan.
2. A briefing at HQ on achievements, challenges and recommendations (responsible Team Leader)

Key stakeholders:
The following key stakeholders must be considered during the whole project. Communication and coordination with key stakeholders should be discussed with Norcross HQ in Oslo and/or the Norwegian Red Cross country rep in Khartoum

- Sudan Red Crescent at all levels (staff and volunteers)
- Beneficiaries in targeted communities
- Donors: Norwegian Red Cross, Swedish Red Cross and Finnish Red Cross
- Back donors: NORAD, SIDA
- The Federation in Sudan

Reporting line:
The consultant reports to Program Coordinator Sudan, Anna Hamre

Length of assignment:
A total of 26 working days from 12th of April to 3rd of June 2011.

Oslo, April 20th 2011

Annex 2: Evaluation Criteria

Explanation of the OECD/DAC Criteria for Evaluating Development Assistance used in this report:

Relevance
The extent to which the aid activity is suited to the priorities and policies of the target group, recipient and donor. In evaluating the relevance of a program or a project, it is useful to consider the following questions:
To what extent are the objectives of the program still valid?
Are the activities and outputs of the program consistent with the overall goal and the attainment of its objectives?
Are the activities and outputs of the program consistent with the intended impacts and effects?

Effectiveness
A measure of the extent to which an aid activity attains its objectives. In evaluating the effectiveness of a program or a project, it is useful to consider the following questions:
To what extent were the objectives achieved / are likely to be achieved?
What were the major factors influencing the achievement or non-achievement of the objectives?

Efficiency
Efficiency measures the outputs -- qualitative and quantitative -- in relation to the inputs. It is an economic term which signifies that the aid uses the least costly resources possible in order to achieve the desired results. This generally requires comparing alternative approaches to achieving the same outputs, to see whether the most efficient process has been adopted.
When evaluating the efficiency of a program or a project, it is useful to consider the following questions:
Were activities cost-efficient?
Were objectives achieved on time?
Was the program or project implemented in the most efficient way compared to alternatives?

Impact
The positive and negative changes produced by a development intervention, directly or indirectly, intended or unintended. This involves the main impacts and effects resulting from the activity on the local social, economic, environmental and other development indicators. The examination should be concerned with both intended and unintended results and must also include the positive and negative impact of external factors, such as changes in terms of trade and financial conditions.
When evaluating the impact of a program or a project, it is useful to consider the following questions:
What has happened as a result of the program or project?
What real difference has the activity made to the beneficiaries?
How many people have been affected?

Sustainability
Sustainability is concerned with measuring whether the benefits of an activity are likely to continue after donor funding has been withdrawn. Projects need to be environmentally as well as financially sustainable.
When evaluating the sustainability of a program or a project, it is useful to consider the following questions:
To what extent did the benefits of a program or project continue after donor funding ceased?
What were the major factors which influenced the achievement or non-achievement of sustainability of the program or project?

Sources: The *DAC Principles for the Evaluation of Development Assistance*, OECD (1991), Glossary of Terms Used in Evaluation, in 'Methods and Procedures in Aid Evaluation', OECD (1986), and the *Glossary of Evaluation and Results Based Management (RBM) Terms*, OECD (2000).

Annex 3: Evaluation matrix

The Sudanese Red Crescent (SRCS) NCHVP Program

The team will use OECD-DAC evaluation criteria for the assessment.
Key instruments will include key information interviews, focus group discussions and observation of ongoing activities.

Evaluation criteria	Key evaluation questions	Informant	Method
A) Relevance			
1	Is the program relevant to the given context	Partners, volunteers, beneficiaries, local government representatives, project staff	Focus group discussions; key informant interviews
2	Are the program outputs relevant to the community needs (what are the main needs?)	Partners, volunteers, beneficiaries, local government representatives, project staff	Focus group discussions; key informant interviews. Assessment also in relation to other ongoing activities in the area
3	How is the program corresponding with governmental, SRCS, RC/RC- and donor strategies?	Partners, project staff, PNS, RC representatives (IFRC/ICRC?)	Key informant interviews
4	Who was involved in developing the program?	Partners, volunteers, beneficiaries, local government representatives, project staff	Focus group discussions; key informant interviews
5	How well has the program adjusted during implementation to new emerging needs (examples?)	Partners, volunteers, beneficiaries, local government representatives, project staff	Focus group discussions; key informant interviews. Assessment also vis-a-vis context
B) Effectiveness			
1	To what extent have the objectives of the NCHVP been achieved/likely to be achieved*	Partners, volunteers, selected beneficiaries, local government representatives	Focus group discussions; key informant interviews
2	Does the project meet identified needs of the community	Partners, volunteers, beneficiaries, local government representatives, project staff	Focus group discussions; key informant interviews. Assessment also vis-a-vis context
3	Are the committees formed representative of the community	Volunteers, beneficiaries, project staff	Focus group discussions; key informant interviews
4	How inclusive of women, youth and the vulnerable is the project planning and implementation processes	Partners, volunteers, beneficiaries, project staff, government representatives	Focus group discussions; key informant interviews
5	Which activities have been most successful and why	Partners, volunteers, beneficiaries, project staff, government representatives	Focus group discussions; key informant interviews
6	What has been the main challenges	Partners, volunteers, beneficiaries, project staff, government representatives	Focus group discussions; key informant interviews

Evaluation criteria	Key evaluation questions	Informant	Method
7	How effective are capacity building initiatives for volunteers, beneficiaries and for SRCS staff	Volunteers, beneficiaries, project staff, local government representatives	Key informant interviews
C) Efficiency			
1	Are the financial inputs for the program reasonable compared to the outputs	Project staff	Key informant interviews
2	How well are the financial inputs being managed	Project staff	Key informant interviews
3	Are project activities on time, according to work-plans and at planned cost?	Project staff	Key informant interviews
4	How appropriate, inclusive and flexible is the projects M&E and reporting system (What is it like?) - Any challenges? (relationship partner NS, SRCS HQ, branches)	Volunteers; selected beneficiaries, project staff	Key informant interviews
5	How are volunteers recruited and retained	Volunteers; project staff	Focus group discussions; key informant interviews
6	What is the level of cooperation with other agencies working in the same sector and area	Volunteers; selected beneficiaries; project staff; local government representatives	Focus group discussions; key informant interviews
7	How has the security situation affected project planning and implementation	volunteers; selected beneficiaries; project staff	Focus group discussions; key informant interviews
8	Has the program been implemented in the most efficient way compared to alternatives	Volunteers; project staff, selected beneficiaries, local government representatives	Key informant interviews
9	Added value of partner NS?	Volunteers; project staff	Key informant interviews
D) Sustainability			
1	What is the level of support from relevant authorities	Volunteers; selected beneficiaries; project staff; local government representatives	Key informant interviews
2	Are project supported activities in tune with prevailing socio-cultural values and norms	Volunteers; selected beneficiaries; project staff; local government representatives	Key informant interviews
3	How suitable are capacity building activities in relation to sustaining facilities and activities that have been initiated	Volunteers; selected beneficiaries; project staff; local government representatives	Focus group discussions; key informant interviews

Evaluation criteria	Key evaluation questions	Informant	Method
4	What are the chances that the activities will be carried out after the program funding has been phased out?	Volunteers; selected beneficiaries; project staff; local government representatives	Focus group discussions; key informant interviews
5	Are operational (exit) plans in place and appropriate	Volunteers; selected beneficiaries; project staff	Focus group discussions; key informant interviews
6	Will funds be available to support activities beyond the life of the project/program	Volunteers; selected beneficiaries; project staff; local government representatives	Focus group discussions; key informant interviews
7	To what extent are lessons learnt being documented, communicated and acted upon	Volunteers; selected beneficiaries; project staff	Focus group discussions; key informant interviews
E) Outcome			
1	What changes are being realized as per expected program objectives*****	Volunteers; beneficiaries; project staff	Focus group discussions; key informant interviews
2	Are the facilities and services established by the project being used by the target beneficiaries	Volunteers; beneficiaries; project staff; local government representatives	Focus group discussions; key informant interviews; observations
3	Positive/negative changes in the communities Any unintended changes?	Volunteers; beneficiaries; project staff; local government representatives	Focus group discussions; key informant interviews
4	What impact has the project had specifically on women, youth and vulnerable in the communities	Volunteers; beneficiaries; project staff; local government representatives	Focus group discussions; key informant interviews
5	Any changes in behavior due to the program activities? What do you know/do now that you did not know/do before/What have you learnt? What do you know about hygiene issues, malaria, HIV/AIDS? (breastfeeding, washing hands, using latrines etc…? + are people less sick in your family, in general?)	Beneficiaries, volunteers; local government representatives	Focus group discussions; key informant interviews
6	How many people have been affected (available statistics?)	Government representatives, project staff, PNS, IFRC	key informant interviews

*** Program Objectives:**

Targeted communities are able to address basic health needs at house hold level through Community Based Health First Aid

Targeted communities are well-informed and aware of communicable disease prevention and health promotion

Targeted communities are able to mitigate and respond to large scale emergencies and communicable disease outbreaks

Targeted communities are well informed and have capacities within HIV/AIDS prevention, care and support
Targeted communities are well informed and aware of hygiene and sanitation issues relevant for their environment
Targeted volunteers at branch, locality and unit level have increased capacities

Annex 4: Program in Sudan

Draft Program: Evaluation of NCHVP – Trude Bang & team (updated 04.05)

Date	Action	Participants/field level	Comments
01.05	Meetings at SRCS HQ: AbuBaker, Imad, John Lobor Aida, Osama Evaluation Team North: Trude, Aisha, Sami		Pick up at hotel 0830
02.05	Travel Khartoum – Gezira		Approx 3 hours drive. Overnight stay in Gezira
02.05	Meeting with SRCS Branch, Ministry of Health NCHVP activities & Community members.	Branch Director NCHVP Field officer	
03.05	Meeting with NCHVP Field officer Sennar and North Kordofan		
03.05	Meeting with NCHVP Field officer Sennar and North Kordofan		
03.05	Travel Gezira-El fau		Approx 1:30 hours drive
03.05	El Fau locality, Gedaref. NCHVP activities; Clean up Campaign and Household visit. Graduation ceremony, first aid training	Branch Director NCHVP Field officer	
03.05	Meeting with El Fau Governor, Meeting with Ministry of Health. Community members		
03.05	Travel El Fau – Gedearef		
03.05	Meeting at SRCS Branch	Branch Director NCHVP Field officer	Overnight stay in Gedaref
03.05	Meeting with NCHVP field officer Red Sea		
04.05	Meeting with SRCS Branch, Ministry of Health. NCHVP activities & Community members.	Branch Director NCHVP Field officer	
04.05	Travel Gedearef –Khartoum		Approx 5 hours drive
05.05	Meetings at SRCS HQ, Federation, Norwegian Embassy		Norwegian embassy at 1400
06.05			FRIDAY
07.05	Travel Khartoum – Rumbek		Trude arr from Khartoum Marianne Monclair from Nairobi
08 + 09	Meetings with SRCS Branch, Volunteers and community members. Meeting with Ministry of Health., Meeting with Norcross del	Branch Director	Note: Sunday & Monday
10.05	Travel Juba- Rumbek		
11.05 & 12.05	Meetings /interviews with Secretariat, NCHVP field officer Malakal & Bentiu Federation, Ministry of Health		Additional organizations?
12.05	Meeting with ICRC		
13.05	Travel – Juba – Nai – Oslo		

Annex 5: List of people and institutions consulted

	Name	Position	Organization, location
1	Anna Hamre	Programme Coordinator Sudan	The Norwegian Red Cross
2	Torild Næss	Country Representative Sudan	The Norwegian Red Cross
3	Abu Baker El Tigani Mahmoud	International Cooperation Director, HQ	The Sudanese Red Crescent Society
4	Imad Abdelrahmin (imad@srcs.sd)	Director Program, HQ	The Sudanese Red Crescent Society
5	Osama Mustafa Suleiman	Assistant NCVHP Coordinator, HQ	The Sudanese Red Crescent Society
6	Aida Said	National Coordinator for the NCHVP programme (HQ)	The Sudanese Red Crescent Society
7	John Labour	Deputy Director General, Secretariat South Sudan (Juba)	The Sudanese Red Crescent Society
8	Bakry Ahmed Mohamed	FHO, Al Gazera	The Sudanese Red Crescent Society
9	Wasira Abdelagir	Admin and Finance Officer, Al Gazera	The Sudanese Red Crescent Society
10	Sameer Osman	Hiv/Aids coordinator, Al Gazera	The Sudanese Red Crescent Society
11	Sharaf Ahmed	IT and Hiv/AIDS Coordinator, Al Gazera	The Sudanese Red Crescent Society
12	Kamil Elfadil Elgak	Deputy State EPI[28] Manager	Ministry of Health, Al Gazera state
13	Mohi Eldin Hassan	Mid Zone EPI Coordinator	Ministry of Health, Al Gazera state
14	Halima Ibrahim Malik	Chief Nurse	Ministry of Health, Al Gazera state
15	Babekr B. Elmalah	Anasthsiologist	Ministry of Health, Al Gazera state
16	Amal Modawi Ramhi	Assistant Chief Nurse	Ministry of Health, Al Gazera state
17	Ahmed El Bashir Abdullah	Director General	Ministry of Health, Al Gazera state
18	Osama Osman Dalaha	Branch Director, Al Gazera	The Sudanese Red Crescent Society
19	Esam Jama	FHO, Sennar	The Sudanese Red Crescent Society
20	Abdelwahid Mohammed Elnour	FHO, North Kordofan	The Sudanese Red Crescent Society
21	Adam Yusuf Ali	Commissoner, El Fau locality, Gadaref	Sudanese Authorities
22	Dr. Elsadig Yousif Mohamed	Minister of Health, Gadaref	MoH, Gadaref
23	Dr. Ali	General Director, Gadaref	MoH, Gadaref
24	Yasin Mohamed Mohammed	FHO, Gadaref	The Sudanese Red Crescent Society
25	Sharafadin Ahmed Mohammed	Branch Director, Gadaref	The Sudanese Red Crescent Society

[2828] EPI (Expanded Programme for Immunization)

26	Osman Gafr Abdalla	Secretary General	The Sudanese Red Crescent Society
27	Sami Mahdi Adam	Volunteer Coordinato, HQ	The Sudanese Red Crescent Society
28	Gordon Cien Dhiacie	Branch Director, Lakes State	The Sudanese Red Crescent Society
29	Dr. Acuf Acur Madhiot	Director General, Lakes state	MoH, Lakes
30	James Majok	Finance and Admin Manager, Lakes state	The Sudanese Red Crescent Society
31	Fidelus Chulu	Watsan delegate, Lakes state	The Norwegian Red Cross
32	Arthur Agany Poole	Director General, Secretariat South Sudan (Juba)	The Sudanese Red Crescent Society
33	Jane Amal	NCHVP Coordinator, Secretariat South Sudan (Juba)	The Sudanese Red Crescent Society
34	Jos Miesen	Senior Health Delegate	The Netherlands Red Coss
35	Gunnar Strøm	Head of Sub Office, Juba	IFRC
36	Manana Burtikashvili	Regional Finance delegate	The Netherlands Red Coss
37	Shohreh Naghcbandi	Cooperation delegate, Juba	ICRC
38	Glenys Ewans	Health delegate, Juba	ICRC
39	Yasir Gafar Eldow	FHO, Unity	The Sudanese Red Crescent Society
40	Garang William Wol	FHO, Upper Nile	The Sudanese Red Crescent Society

Groups met

Type of group	Location	No of females	No of males
Community leaders	Maringan, Al Gazera	1	4
Volunteer leaders (ToTs)	Maringan, Al Gazera	3	6
Volunteers (ToTs)	El Fau, Gadaref	2	2
Volunteers (ToTs)	El Fau, Gadaref	11	10
Community members (household – 8 persons)	El Fau, Gadaref	1	1
Community members (household – 8 persons)	El Fau, Gadaref	1	1
Community leaders	El Fau, Gadaref	2	3
Volunteers	Gadaref-, Gadaref Center-, Guraisha locality	14	10
Volunteers	Lakes state		9
Community members	Lakes state	25	10
Total		**60**	**46**

Annex 6: Map of Sudan

Annex 7: Overview of SRCS branches involved in the NCHVP

RED SEA	
The Red Sea State Red Sea state is located in North-Eastern Sudan, bordering Egypt, Kassala, River Nile and the Red Sea to the east. The state has an area of 218,887 km² and the population is estimated to be 800,216. Port Sudan is the capital of the state and this is also Sudan's main harbor. Red Sea state is divided in to 11 localities (Port Sudan, Rural Port Sudan, Suakin, Sinkat, Haya, Derudeb, Toker, Halaib, Ageeg, Osafe and Gebiet Al-Maaden). Red Sea state is characterized by different, distinct geographical attributes, which divides the state into three parts; the coastal area, the hills and the flat western plains. The state is primarily inhabited by Beja pastoralists and agro-pastoralists, although a wide variety of ethnic groups can be found in the state capital Port Sudan, especially Hausa, Fallata, Nuba and other northern and southern Sudanese populations. More than the 60% of the population lives in Port Sudan	**The SRCS in Red Sea** The Sudanese Red Crescent Red Sea state branch was established in 1972. The branch started up with traditional RC/RC Movement activities and eventually expanded through its involvement in major relief operations in the mid-eighties. Since then, the branch has shifted its focus to development activities through project co operations with other Red Cross societies such as the Norwegian, Danish and British Red Cross with other partners such as the WFP. The cooperation with WFP includes food for recovery and food for work programs. The Red Sea branch has a governing board of 8 members and 16 paid staff, which is placed in Port Sudan and in the four sub-divisions of the branch in Sinkat, Gebeit, Haya, Derudeb and Tokar. There is an extensive and well established network of 5000 to 10000 volunteers in all localities of Red Sea State. The branch's activities include: • Disaster response • Volunteers capacity building • Establishment and rehabilitation of water sources • Livelihood support, establishment of communal farms • Support to health infrastructure and services • Support to women development including education These involvements has given the branch good experience in handling both emergency relief and development activities, while at the same time raising the credibility of SRCS in the communities and among the NGOs and government departments in the area . The Norwegian, Danish and Netherlands Red Cross Societies have long-standing bilateral relations with the Red Sea branch food security, community development and health programs. Some of the bilateral relationships have been going on for more than 20 years. Red Sea state is one of the seven pilot states of the program that started in 2007.

EL GADAREF	
El Gadaref State El Gadaref state is located in the eastern part of Sudan and borders Ethiopia and Eritrea in the east, Kassala state in the north, El Gazera state in the west and Sennar state in the south. Most of the 2,700,000 inhabitant are farmers, and the state is divided into 9 localities: El Gadaref east, El Gadaref west, El Gadaref north, El Fashaga, El Faw, El Rahad east, El Rahad west, El Galabat north and El Galabat south.	**The SRCS in El Gadaref** The branch was established in 1997 and has more than 30,000 volunteers, of them 10,000 active. The branch activities focus on training of volunteers in first aid, Primary Health Care (PHC), home nursing, prevention of HIV/AIDS and emergencies. 80% of the volunteers are women. Most of the activities are carried out by volunteers. The branch has started to create a standardized volunteer manual for all trainers, to avoid different focus and level of the trainings of community members. The branch has a governing board of 17 members. El Gadaref is one of the seven pilot states of the program that started in 2007.
EL GAZERA	
El Gazera State El Gazera State is located in the central part of Sudan, bordering Khartoum, Sennar and El Gadaref States. It has an area of 35,000 km2. The state population is estimated to be 3,177,413. Madane is the capital of the state. The state is divided into 7 localities (Madani El Cobra, El Managel, South Elgazera, Eastern Elgazera, El Hasahesa, Um Elgora and El Kamleen).	**The SRCS in El Gazera** Sudan Red Crescent Society (SRCS) El Gazera State Branch was established in 1992. The branch is focusing on traditional, community- based RC activities, which include: • First aid • Primary Health Care (PHC), home nursing • Disaster response • Dissemination of RC/RC principles and values • Volunteer capacity building • In collaboration with the Netherlands RC, the branch is running a HIV/AIDS program (focusing on peer education) in three localities. • In cooperation with Ministry of Health (MOH) El Gezira branch supports the management of some hospitals in El Gazera state, including support to patients without resources to pay for health services. The branch is also running 4 health centres in collaboration with the community. All activities are carried out by volunteers. There are a few paid employees in El Gezira branch, who support the volunteers to run high quality and well coordinated activities.

	The El Gazera branch has an elected governing board of 10 members, and has a well established network of volunteers (27,000) in all localities. The volunteers are all trained in first aid, 10,000 in home nursing, 5,000 in PHC, 2,000 in disaster management, 2 members of the staff in Participatory Hygiene and Sanitation Transformation (PHAST) and 4,000 in HIV/AIDS. El Gazera is one of the 7 pilot branches where the NCHVP started in 2007.
LAKES	
Lakes State Lakes state is located in South Sudan, bordered to the north-west by the states of Unity and Warrab, to the east by Jonglei State, to the south-east by Baher El Jabel and to the south and west by Western Equatoria and Central Equatoria. The population of the state is 695,730. The state has 8 counties; Rumbek Center, Cuibeit, Wulu, Rumbek North, Rumbek East, Yirol west, Yirol east and Awerial. The table below shows an overview over infrastructure within the eight counties in Lakes State. The information was collected during team leader training on community mapping.	**The SRCS in Lakes state** With the signing of the Comprehensive Peace Agreement (CPA) in 2005, the Sudanese Red Crescent Society (SRCS) could access former Sudan People's Liberation Army (SPLA) controlled areas, thus expending its humanitarian and development activities in the south. In 2008, SRCS established branches in five new state branches in the south, including Lakes state. The branch was established in July 2008, with headquarters in Rumbek and a sub branch in Yirol. So far there are only two staff members in the branch; a branch director based in Rumbek and an area coordinator based in Yirol. The NCHVP program started in Lakes state in 2009.
NORTH KORDOFAN	
North Kordofan State North Kordofan state is one of the largest states in Sudan, with three million inhabitants. The state is bordering Northern State, Northern Darfur, Southern Kordufan, White Nile and Khartoum State. North Kordofan has 10 localities, inhabited mostly nomads and farmers; ShiKan, UmRoaba, Bara, Sodery, Hamra Elshiekh,	**The SRCS in North Kordofan** The Sudanese Red Crescent North Kordofan State Branch has more than 40,000 volunteers and an elected governing board of 10 members. All the activities are carried out by volunteers. There are a few paid employees in North Kordofan branch, who supports the volunteers to run high quality and well coordinated activities. The branch's activities include:

Abu Zabad, Gubiesh, Alnihood, Gabrah and Wad banda.	• In cooperation with the Ministry of Health, contribute to general health services in North Kordofan state. • Primary Health Care (PHC), health education and cleaning (chlorination) of water. • The branch was running one health centre in collaboration with the community. The centre was funded by the Netherlands Red Cross from 1991 – 2000). North Kordofan is one of the 7 pilot branches where the NCHVP started in 2007.
SENNAR	
Sennar State Sennar State is located in the central -eastern part of Sudan, bordering El Gazera, Wight Nile and El Gadaref states. It has an area of 40,680 km2. The state population is estimated to be 2,000,000 and Senga is the capital of the state. The state is divided into 7 localities: Singa, Sennar, East Sennar El Soky, Daly wa Mazmom, Abo Hojare and El Deinder.	**The SRCS in Sennar** The Sudanese Red Crescent Sennar State Branch was established in 1997 and has more than 42,200 volunteers and around 220 units. This branch is focusing on traditional, community-based RC activities, which include: • First aid • Primary Health Care (PHC), home nursing • Dissemination of RC/RC principles and values • Disaster response • Volunteer capacity building • Support to poor school children and patients without resources to pay for health services. • The branch, in cooperation with Ministry of Health, also supports health infrastructures and services in the state. All the activities are carried out by volunteers. There are a few paid employees in Sennar branch, who supports the volunteers to run high quality and well coordinated activities. The branch has an elected governing board of 6 members and has a well established network of volunteers in all localities. Sennar is one of the 7 pilot branches where the NCHVP started in 2007.
UNITY	
Unity State Prior to the 2005 Interim Constitution of Southern Sudan, Unity state was part of the former province of Upper Nile in accordance	The SRCS in Unity The branch was established in 1996 following the adoption of the decentralization policy by the SRCS General Assembly. Headquarters of the branch is located in the city of Bentiu. The branch implements all activities through a network of nearly 3,700 volunteers, deployed in the six counties of Leer,

with the boundaries of 1956. Upper Nile Province consisted then of Upper Nile, Jonglei and Unity. The 2005 Interim Constitution divided Southern Sudan into 10 states, among them Unity state. Unity borders to South Kordofan to the North, Warrap to the West, Lakes to the South and Upper Nile and Jonglei to the East, separated by the White Nile as a natural border. Unity State is subdivided into 9 counties/localities, and the counties into 73 payams which are subdivided into more than 100 bomas. The counties/localities are: Rubkona, leer, Abiemnom, Mayom, Koch, Ruweng/Pariang, Guit, Mayiendit and Panyijar. The capital of the Unity state is Bentiu.	Rubkona, Gut, Faryanq, Mian-det and Myom. All activities are carried out in cooperation and coordination with different state departments, civil authorities and relevant institutions. The staff, consisting of 3 employees and 2 supporting staff, has a fixed office. To be able to implement program activities, the Unity branch depends financially on the support of SRCS headquarters and partnerships with the International Committee of the Red Cross (ICRC), Swiss Red Cross, Austrian Red Cross, the Norwegian Red Cross and World Food Program. In addition, the branch receives income from lease of premises (three shops and a guest house). The branch carries out various activities and all activities are carried out by volunteers. Unity is one of the seven pilot states of the program that started in 2007.
UPPER NILE	
Upper Nile State Upper Nile state is located in South Sudan, bordering to the North by the White Nile and Sinnar states, to the East by the Blue Nile State, to the South-east by Ethiopia, to the South by Jonglei state and to the West by Unity and Southern Kordofan**.** Upper Nile has an approximate land area of 77,723 km sq, with a population of 1,300,000 inhabitants. The community structure is a mixture of tribes, the major ones being: Shuluk, Nowair, Denka and Mundari**.** The main trades in the state are agriculture, farming (cattles) and fishing.	**The SRCS in Upper Nile** The Upper Nile branch of Sudan Red Crescent Society (SRCS) was established in 1972, following the signing of the peace agreement in Addis Ababa. Headquarter is located in the city of Malakal. The approximately 2,000 volunteers are deployed in 12 counties (Malakal, Venica, Melut, Renk, Mapan, Maywood, Lonkachio, Manga, Nasser, Olanc, Palit and Fachoada). All SRCS activities are implemented in close cooperation with state departments, civil authorities and relevant institutions. There are four employees in the branch, and they have a proper and equipped office. Upper Nile branch is dependent of financial support from the SRCS headquarters, from partnerships with the International Committee of the Red Cross and the World Food Program. In addition, the branch runs some small scale income generating activities, as for instance lease of premises (rooms, restaurants and shops). The branch has various activities and all activities are carried out by volunteers.

The state has 12 counties: Malakal, Venica, Melut, Renk, Mapan, Maywood, Lonkachio, Manga, Nasser, Olanc, Palit and Fachoada. The branch has 2,000 volunteers; approximately 70% of them are within the NCHVP: 1,385 program volunteers (1,303 volunteers and 82 team leaders).	Upper Nile is one of the seven pilot states of the program that started in 2007.
JONGLEI	
Jonglei State Jonglei is the largest state in South Sudan; approximately 122,479 km^2. The state borders to Upper Nile and North Kordofan in the north, Unity, Lakes in the west, Central Equatoria and Eastern Equatoria in the south and Ethiopa in the east. Its population is estimated to be 1,358,602 and Bor is the capital. Jonglei State is divided into 10 counties/counties: Duk &Twic East, Bor, Akobo, Nyirol, Uror, Pibor, Pochalla, Ayod, Pigi and Fangak.	**The SRCS in Jonglei** With the signing of the Comprehensive Peace Agreement (CPA) in 2005, the Sudanese Red Crescent Society (SRCS) could access former Sudan People's Liberation Army (SPLA) controlled areas, thus expending its humanitarian and development activities in the south. The Sudanese Red Crescent Society (SRCS) initiated community based volunteer activities in Jonglei state in 2009, an initiative that represented the beginning of SRCS Jonglei branch. The same year, it was recruited a SRCS focal person in the state. His key responsibilities is to represent the National Society in the state, liaise with authorities and other actors in the humanitarian field, volunteer mobilization and recruitment, and initiate and monitor activities. From 2010, there has also been a NCHVP field officer in Jonglei. Land has been cleared and slabs prepared to install two container offices for SRCS Jonglei branch. However, due to conflicts related to cattle rustling, the security situation in Jonglei state is very difficult and unpredictable. With the funding from Finnish Red Cross, the National Community Volunteer Health Program (NCVHP) & Emergency Preparedness & Response (EP&R) kick started volunteer mobilization and recruitment in 2009. The program started in Jonglei in 2010.

A summary of the NCHVP Branch plans for 2011.