

The Sudanese Red Crescent Society (SRCS)

National Community Health Volunteer Program (NCHVP)

Final Evaluation Report

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ABBREVIATIONS

AIDS	Acquired-Immune-Deficiency Syndrome
ANC	Antenatal Care
ARI	Acute Respiratory Infections
AtB	Accountability to Beneficiaries
CBFA	Community Based First Aid
CBHFA	Community Based Health and First Aid
CBO	Community Based Organization
CDC	Communicable Disease Control
CHC	Community Health Committee
EAIIOI	East Africa and the Indian Ocean Islands
EPHS	Essential Package of Health Services
EPI	Essential Program of Immunization
FGD	Focus Group Discussion
FGM	Female Genital Mutilation
FO	Field Officer
GBV	Gender Based Violence
HAC	Humanitarian Aid Commission
HF	Health Facility
HE	Health Education
Hh	Household
HIV	Human Immuno-Deficiency Virus
HQ	Headquarters
IDP	Internally Displaced Persons
IGA	Income Generating Activity
IEC	Information Education Communication
IFRC	International Federation of Red Cross and Red Crescent Societies
IMCI	Integrated Management of Childhood Illnesses
INGO	International Non-Governmental Organization
ITN	Insecticide Treated Nets
KAP	Knowledge Attitude and Practice
KII	Key Informants' Interview
MCH	Maternal and Child Health
MoH	Ministry of Health
M&E	Monitoring and Evaluation
MOA	Ministry of Agriculture
MoE	Ministry of Education
MOU	Memorandum of Understanding
NCHVP	National Community Health Volunteer Programme
NGO	Non-Governmental Organization
NRC	Norwegian Red Cross Society
NS	National Society
ODK	Open Data Kit
PHAST	Preventive Health and Sanitation Training
PMER	Planning Monitoring Evaluation and Reporting

PNC	Post-Natal Care
RAMP	Rapid Mobile-Phone based data collection
PNS	Participating National Society
SRC	Sudanese Red Crescent
SRCS	Sudanese Red Crescent Society
STI	Sexually Transmitted Infection
TB	Tuberculosis
TOT	Training of Trainers
U5	Under Five years
U12	Under 12 months
UHC	Universal Health Coverage
UN	United Nations
UNICEF	United Nations Children's Fund
VC	Volunteer Coordinator
WASH	Water, Sanitation and Hygiene
Watsan	Water and Sanitation
WFP	World Food Program
WHO	World Health Organization

MAP OF SUDAN SHOWING PRESENCE OF NCHVP



EXECUTIVE SUMMARY

The social, economic and political context of Sudan is shaped by the over two decades of protracted civil war which ended in 2005. Although in the post-peace agreements phase and the separation of the South Sudan, Sudan still faces challenges related to the post-peace humanitarian, rehabilitation and development realities. The country is susceptible to natural disasters such as drought and floods.

Poor incomes, food insecurity in certain parts of the country, inadequate health services, low literacy, low access to clean water and adequate sanitary conditions are common challenges in Sudan contributing to national humanitarian needs.

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 2007.

Through National Community Health Volunteers Programme (NCHVP) the Sudanese Red Crescent Society (SRCS) has focused on engaging communities and most vulnerable groups in the search for solutions to persistent health problems, particularly in emergencies. At the fore front of this struggle are the SRCS volunteers working to make a difference in the lives of people. The national society through NCHVP is committed to promoting volunteering as a strategy to make meaningful contribution to improving the health and wellbeing of vulnerable people and to strengthen the resilience of communities. SRCS does this with the support of Red Cross/Crescent Movement partners through the International Federation of Red Cross and Red Crescent Societies (IFRC). The programme was initiated in 2007 focusing on Community Based Health and First Aid (CBHFA), Communicable Disease Prevention, Public Health in Emergencies, HIV and AIDS Prevention and Reduction of Stigma, and Water and Sanitation (Watsan).

NCHVP aimed to enable communities identify and solve their health problems in order to reduce mortality, morbidity, impact of disasters through enhanced access to care, and improved health seeking behaviour.

This final evaluation set out to assess: the relevance of NCHVP; the effectiveness of NCHVP implementation process; the impact of NCHVP; the extent to which the SRCS coordinate/collaborate with other humanitarian actors; and the participation of beneficiaries and sensitivity to diversity as well as document lessons learnt.

The evaluation applied a mixed methods design that included desk review, secondary analysis of household survey data, and qualitative approaches to data collection.

The key findings

A. Relevance of the programme:

The evaluation sought to determine the relevance of NCHVP to beneficiaries and volunteers' needs and priorities, as well as document the extent to which it built on existing capacities.

The programme intervention elements were consistent with the needs and priorities of beneficiaries and volunteers making it a major contribution to the improvement of health and wellbeing of households that were otherwise too far from health facilities. It tackled common health challenges such as diarrhoea, malaria and fevers identified by the June 2016 household survey as most common. In addition NCHVP trained volunteers and community members in first aid, disaster preparedness and management, and generally in primary health issues, improving their health seeking behaviour in normal times and in disasters, through home visits and campaigns.

NCHVP was capacity focused as it was built on existing resources of targeted communities such as available human resources (youth, leaders, community based resource persons like teachers); the tradition of helping neighbor and physical facilities to anchor activities (schools, health facilities). It also focused on capacity enhancement, building on local experience, skills, and workforce. A number of the volunteers became leaders and were also trained as trainers, thus making the capacity building task increasingly local and therefore self generating.

NCHVP was also built on the comparative advantage of the National Society as a leading grass roots voluntary organization, with a strong volunteer base.

Recommendations:

- Encourage exchange programme for volunteer coordinators and programme staff, on the basis of the ongoing regular activities, meetings to share success stories and scale up good practices.
- Strengthen the linkage of community based NCHVP with local health facilities to strengthen referral and technical support supervision.
- Use findings of the Sudanese Red Crescent Society Volunteers base line survey 2015- 2016 study to adjust their tasks by age, gender, motives and skills.

B. Effectiveness of implementation process and achievement of outputs and outcomes:

Supervision and management mechanisms were functioning well at all levels (Branch, HQ and IFRC), Monitoring and Evaluation framework was in place as the Planning,, monitoring, evaluation and reporting (PMER) system and the Department was established with systems, mechanisms and tools to support efficient implementation of NCHVP. The monitoring and evaluation framework was functioning from unit to Locality, to Branch and up to Headquarters based on plans. Information from all these levels feed into reports, monthly, quarterly and annually. PMER unit supported the branches in planning, monitoring, evaluation and reporting through field visits, technical training and regular meetings. Well trained volunteers were effective in increasing health service utilization as shown by the household survey, June 2016 that showed improvement in knowledge and practice with regard to immunization, hand washing and treatment of drinking water.

Apparent gap was in completeness of reporting at unit level because volunteers did not seem to be allocated specific households, it was not clear information would be received from all households and that some households would be reported by more than one volunteer.

Most of the reports indicated timely achievement of targets of the number of volunteers trained and certified in first aid, community members trained, first aid kits distributed, treated mosquito bed nets distributed.

Appropriate supportive supervision, technical support, on the job training, logistics, materials and supplies were provided by SRCS HQ and IFRC and the Swedish Red Cross to the Branches and through the branch personnel to localities and units, to ensure timely implementation of activities through regular visits.

Coordination of NCHVP with other SRCS Departments and within the Movement was reported to be smooth, with regular quarterly meetings held, with agenda circulated in advance and minutes well kept.

Recommendation

PMER is an excellent system, being rolled out. Volunteers should be assigned specific households in targeted areas to ensure that all households are catered for.

C. Impact resulting from the programme

NCHVP planted good health habits in hearts and minds of kids and communities, leading to permanent change in health seeking behaviour in villages and schools. It increased knowledge and practice on first aid; health seeking behaviour, and health risk reduction. First aid, home nursing, sanitation, malaria control, have become regular local activities.

The June 2016 household survey showed that almost all households (90%) in NCHVP areas were visited by volunteers and that their knowledge concerning vaccine preventable diseases as well as prevention of diarrhoeal diseases had improved (Household survey report June 2016).

Both volunteers and beneficiaries felt that First aid services became more available in communities and according to them morbidity and mortality among children reduced.

Ministry of Education has adopted many innovations from NCHVP such as competition in health knowledge and included them in routine national activities and competitions.

Recommendations

- Sharing success stories that reflect innovative initiatives should be acknowledged and replicated in other SRCS branches e.g. volunteer's graduation projects in Northern state, schools competitions on best hygiene practice and knowledge.
- Innovative approach to qualitative assessment of impact by stories, and testimonies change that were documented and disseminated is a good innovation to be replicated widely.
- Timely baseline population based survey is necessary to strengthen evidence on the impact of the programme.

D. Coordination/collaboration with Government and other external actors

NCHVP maximized its effectiveness and efficiency through effective coordination, throughout the project management process, being fully in line with SRCS, MOH and MOE health strategic plans. Vaccination campaigns were held in coordination with MOH; MOUs on TB and Malaria were signed, and SRCS units were established in schools and teachers and pupils trained.

Recommendation

There is a need for SRCS, NCHVP to articulate in their plans what engagement activities are planned for each level, in order to monitor the activities according to the plans.

E. Beneficiary participation

NCHVP involved communities in governance, leadership and management of activities. Communities through their leaders, and community based organizations, women groups were involved in planning as they suggested the health actions that were to be included in the annual plans.

Briefing and feedback took place regularly at meetings and community gatherings although complaint mechanism was not clearly stated by respondents. Accountability to Beneficiaries (AtB) with tools had been initiated to ensure adequate evidence based feedback from beneficiaries. Beneficiaries provided feedback on an ad hoc basis directly through the structure and hierarchy of the National Society from unit to branch. Others would go directly to desk officers, or contact them through phones. However elements of AtB were rarely mentioned by beneficiaries at focus group discussions. Often, satisfaction was indicated by gifts received from the community and "thank you" letters of appreciation, mostly to volunteers. Communication to beneficiaries occurred mostly through monthly community health committee and unit meetings, gatherings and reports as well as comments through local media.

According to beneficiaries and volunteers who were interviewed, attention had been given to gender balance in beneficiary identification for various initiatives to ensure equitable participation. In addition, there was sensitivity to gender and diversity in planning for volunteers and beneficiaries.

Most data available were disaggregated. Often gender distribution percentages were mentioned in reporting.

Lessons and recommendation

- Community involvement is gradually improving, can be accelerated and strengthened through AtB implementation,
- The Unit structure should be clearly organized by households taken care of by a particular volunteer to ensure that all households are covered, allocate households to volunteers.

Conclusion

With NCHVP SRCS has become a key community based health care provider in Sudan. It has strengthened the image and acceptance of the National Society at all levels in the provision of preventive and promotion of health services in local communities. It has also strengthened volunteers capacity and the volunteers management system of the National Society. Health activities of SRCS moved from project approach to long-term systematic program approach. NCHVP was well implemented through SRCS structures and systems and were well integrated with SRCS strategic programs including disaster management. The programme focused on upgrading the capacity and skills of the volunteers and encouraged voluntary work. There was emphasis of linking the NCHVP activities to social networks as a base to support volunteering. Volunteers played a key role in preparing communities under their care for timely response to disasters. Overall, the NCHVP program is extremely valuable and should be supported to expand to all 18 states in Sudan, given its relevance, quality and efficiency.

1 INTRODUCTION AND BACKGROUND

1.1 Background

Sudanese Red Crescent Society (SRCS) is working within a context acknowledged as a most demanding humanitarian situation, considering the protracted civil war which ended in 2005 and other socio-economic and political factors that characterize their context. Despite entering into the post-peace agreements phase and the separation of the South Sudan, Sudan still faces challenges related to the post-peace humanitarian, rehabilitation and development realities. Moreover, issues related to the conditions of the IDPs and mine actions still persist as challenges. During the dry season, pastoralists from Sudan herd their animals across the border into South Sudan which leads to tribal tensions. On top of the conflicts, Sudan is highly susceptible to natural disasters such as drought and floods which have led to increased food insecurity in certain parts of the country such as Eastern Sudan contributing to national humanitarian needs.

The population of Sudan is estimated as 36,787,000 with a population growth rate of 2.5% per annum and urbanization rate of 40% of total population. The infant mortality rate is 68.07 per 1,000 live births. The major causes of morbidity are communicable diseases such as food or waterborne diseases: bacterial and protozoal diarrhea, hepatitis and typhoid fever; vector borne diseases, malaria and respiratory infections as pneumonias and tuberculosis. Sudan has adopted its' quarter century National Strategy Plan (2007-31), which provides a framework for Sudanese Red Crescent Society (SRCS) planning, being auxiliary to the State. SRCS has continued to build its organizational capacity to effectively and efficiently render humanitarian assistance to the most vulnerable groups, supported by Movement partners. Presence across the 18 states has enabled the National Society to profile itself as leading humanitarian actor in Sudan.

1.2 Introduction

SRCS, International Federation of Red Cross Red Crescent Societies (IFRC) and other movement partners represented in Sudan together carried out a comprehensive assessment (PAN Sudan Health Assessment 2005) in order to support the National Society, in identifying its role in area of health and water-sanitation. The assessment team recommended the strengthening of the community based health first aid (CBHFA) approach by building the capacities of the volunteers and shift the focus from facility based primary health to community based primary health care in the communities. The assessment team observed that SRCS volunteers were trustworthy, reliable and can be called upon quickly to work in communities in addressing urgent needs. They were seen as neutral as they applied the movement principles. This situation assessment led to the National Community Health Volunteer Programme (NCHVP). It had the following interventions:

- Community Based Health First Aid (CBHFA)
- Communicable Disease Prevention (Malaria, Vaccination)
- Public Health in Emergencies
- HIV and AIDS Prevention and Reduction of Stigma

- Water & Sanitation using PHAST to encourage and empower communities to identify and solve health problems connected with water born disease and sanitation.

Through NCHVP the Sudanese Red Crescent Society focused on engaging communities and most vulnerable groups in the search for solutions to health problems, particularly in emergencies. At the fore front of this was the SRCS volunteers working at the frontlines of the struggle to make a difference in the lives of people. The national society was committed to promoting volunteering as a significant and positive contribution to improving the lives of the most vulnerable people and to strengthening the resilience of communities and civil society. More and more voluntary action was needed to meet the growing challenges facing Sudanese community today: armed conflicts, natural disasters, and silent disasters like HIV/AIDS Malaria and diarrhoeal diseases.

The National Community Health Volunteers Programme (NCHVP) started in 2007, addresses basic health care needs in targeted communities and empowers people to take care of their own health. Its design was based on lessons learned in the field and on recommendations made by the PAN Sudan Health Assessment Mission in 2005. The programme design was premised on a well-managed and trained network of Sudanese Red Crescent volunteers. A large proportion of the Sudanese population had poor access to health services. In addition government facilities were often not adequately resourced to provide the required health services. Thus, it was a priority for the SRCS to develop a network of local community based volunteers and equip them with basic skills in community based health care.

A stronger volunteer capacity was to enhance the community's resilience towards health hazards, both on a daily basis and in emergencies. The volunteers were to increase skills and awareness of members of the targeted communities on basic first aid, health action in emergencies and community disaster preparedness. Vulnerable people have a vital role to play in finding and implementing solutions to improve health status and hence the need to strengthen their capacity for effective participation in dealing with their own health problems.

Therefore the critical part of NCHVP was its skills transfer approach aimed at enabling communities to take preventive measures to commonly occurring illnesses as well as provide basic First Aid for minor accidents occurring at household level. This would contribute to building the resilience of the local communities in coping with disasters. The programme aimed to achieve the following outcomes:

Outcome 1: Reduce the number of deaths, injuries and impact from disasters through increased practice of first aid in target communities.

Outcome 2: Support delivery of health services to address ongoing community health concerns.

Outcome 3: Improve health care and well-being in selected urban and rural communities through responsive SRCS services in disease prevention and health risk reduction.

The NCHVP focused on addressing basic health care needs for targeted communities with emphasis on empowering people to take care of their own health, implemented in 11 states. The programme operated mainly in remote areas and the majority of the targeted population had low level of education, limited access to clean water, and in many cases lived far from health care

facilities. The overall goal was to improve the health status of targeted communities in Sudan, through building the community resilience in addressing basic health care needs of the most vulnerable communities and empower people to take care of their own health, in coping with disasters.

NCHVP aimed to develop skills of volunteers, capacity of the branches and capacity of communities in preparedness and response to emergencies by providing targeted training and preparedness education on selected topics, while involving the communities at every stage of the programme in planning and implementation. Community capacities for participation were an important component of the programme.

1.3 The evaluation

1.3.1 Commissioning

The evaluation was commissioned by IFRC in compliance with its Evaluation Policy for final evaluations with the main purpose to generate evidence on good practices and lessons learned from intended and unintended impact of the programme. It was intended to unveil the change that has taken place in the lives of communities and SRCS volunteers. The results would enable and necessary adjustments for future SRCS-NCHVP interventions. Specifically, the evaluation was to determine the relevance, process effectiveness, impact, coordination and beneficiary participation in the NCHVP.

1.3.2 The purpose and scope

Purpose

The main purpose of the evaluation was to generate evidence-based good practices and lessons learned from intended and unintended impact/effects of the program and the target communities to inform the future direction and development of the NCHVP as well as the cooperation between the SRCS and partners, leading to adjustments and redirection of interventions. The evaluation was to determine the extent to which the strategic objectives of the NCHVP had been achieved, as well as the relevance of the program. To generate evidence on good practices, lessons, effects and change.

Scope

The evaluation was to cover NCHVP implementation in 11 states over a period of 3 years 2013 - 2015. It was to focus on 6 states (4 states Swedish Red Cross and 2 states Norwegian Red Cross) and the target was to be the targeted communities, community leaders and stakeholders in the areas, SRCS volunteers and staff in the localities and branches as well as SRSC Headquarters. The specific states purposively selected for inclusion were: North Kordofan, Sennar, El Geizira, Northern State, River Nile, El Gedaref.

1.3.3 Evaluation Questions and Objectives

The evaluation had the following objectives and questions as guiding criteria;

A. To assess relevance of program response from the point of view of the volunteers and targeted community members: Consistency with the needs and priorities of the intended beneficiaries and the extent to which the programme was built on existing resources and capacities of communities and were assessments of needs and capacities of the targeted beneficiaries carried out?

B. To assess the effectiveness of the implementation process of the program's support and to see if the program achieved planned outcomes and outputs: What M and E tools are in place to feed back in to implementation? Were there any gaps for further improvement; Activities timeliness, Achievement of objectives, outputs and outcomes on time; what was missing; what needed to be done differently next time? Were supervision and management mechanisms at all levels (Branch, HQ and IFRC) sufficient in relation to the project needs and expectations; Have lessons and recommendations from previous evaluations and reviews been considered and used; How effective was coordination/ collaboration between IFRC and SRCS and between SRCS's different Departments; What was the level and type of support provided by SRCS HQ and IFRC to the Branches implementing the activities? Was the support appropriate considering the Branches Capacities?

C. To assess the impact, positive and negative changes (intended or unintended) resulting from the programme: What was the stakeholders (beneficiaries and partners) viewpoint related to the performance and impact of the project? Were there changes in relation to the health knowledge, behaviour and attitude of the targeted beneficiaries and was the project able to strengthen SRCS presence and image in the community? If so, how?

D. To assess the Coordination of Programme support intervention with Government authorities, and other external stakeholders: How effective was the coordination with external actors and Government authorities?

E. To assess how beneficiaries participated in the programme planning, monitoring and implementation, considering gender and diversity: How were the beneficiaries involved in the different phases of the programme? Were beneficiaries able to provide feedback to SRCS on the programme? Has the programme considered gender and diversity in relation to design and planning of the program, the implementation of activities and the monitoring and evaluation of the programme? Are there Gender sensitivity of indicators and sex disaggregated data?

1.4 Evaluation Methodology

1.4.1 Design

The evaluation design used mixed methods design with narrative qualitative design as the dominant approach, complemented by desk review and secondary analysis of quantitative data, described by John Creswell (2013). Mixed design was found suitable to facilitate completeness in evidence required to evaluate program effectiveness on goals, impact and also generate evidence-based good practices and lessons learned from intended and unintended effects (Creswell 2003; Creswell & Clark 2011).

Sampling

For qualitative data was already undertaken by the Evaluation Management Team starting with a selection of branches and branch field officials, followed by a purposive selection of key informants, beneficiaries and community members ensuring gender and age coverage of respondents. Thus sampling was non-probability based, guided by how information rich a source was. Six out of eleven states implementing the program were purposively selected depending on logistics and security; two states funded by Norwegian Red Cross and four funded by Swedish Red Cross were selected. The sample size for each source was based on data saturation for each source as described by Creswell (2013) and targeted at 12 participants for FGDs as recommended by Guest (2006). See table 1 for selected branches.

Data collection

Two approaches were used according to the evaluation design: secondary sources of data and primary data collection. There were two main sources of secondary data, desk review of available documents and records and a household sample survey covering program implementation sites and non-implementation sites for comparison to improve validity in drawing conclusions linking effectiveness outcomes to program implementation.

Desk review was guided by a data extraction tool to standardize approach among observers as well as ensure completeness of data extraction. Documents reviewed included: program documents (including MSC), program proposals/document and or contracts (including budgets where applicable, etc); program progress reports (annual); and program evaluations.

Quantitative secondary data was provided by the program management. The quality of the data as a source for this evaluation was determined by reviewing the protocol describing the study population, the sampling design to evaluate both internal and external validity. Further the team reviewed the data collection process standard operating procedures to assess reliability of the data. The secondary quantitative data was obtained from data collected during May and June 2016 by SRCS with technical support from the IFRC country cluster in Nairobi. This was a household survey regarding health and hygiene knowledge, attitudes and behaviour conducted using Rapid Mobile-Phone based data collection (RAMP) as part of the National Community Health Volunteer Programme (NCHVP). The household survey was designed to incorporate both baseline and endline components (the questionnaire was identical) in various localities across 6 States:

- Endline: The NCHVP started in 2007. In communities where NCHVP activities had already been implemented, the data collected represented an ‘endline’ measure.
- Baseline: Since the programme’s inception, additional localities had been added to the NCHVP, covering 11 States (4 funded by the Norwegian RC and 7 funded by the Swedish RC). In communities where NCHVP implementation was yet to start, the data collected was to represent a ‘baseline’ measure.

Six out of the 11 States where NCHVP was implemented were randomly selected (two States funded by Norwegian RC and four funded by the Swedish RC). In five States, two localities were selected from each: one for endline and evaluation, and the other for baseline. In El Gedaref State, only one locality was selected for the endline. Therefore only 5 States were included for baseline data collection. Localities were randomly selected as clusters (by lottery).

The sample size was 254 households for baseline and 372 for endline survey, with proportional distribution according to number of households as shown in table 1.

Table 1: States and Localities for baseline and end line survey

Baseline			Endline		
State	Locality name	HH surveyed	State	Locality name	HH surveyed
El Geizira	Algirsh	45	El Geizira	Almanagil	43
North Kordofan	Omrowaba	87	North Kordofan	Sheekan	40
Northern	Dalگو	33	Northern	Muraoi	40
River Nile	Ubu Hamad	41	River Nile	Eldamar	125
Sennar	Reef Sennar	48	Sennar	Alsooki	70
-	-	-	El Gedaref	Basundaa	54
Total		254	Total		372

Magpi was used as a tool for data collection. SRCS volunteers were utilised as data collectors, and they were trained on the use of Magpi and the survey questionnaire. EpiInfo7 and Microsoft Excel were used for data cleaning, analysis and reporting.

Primary data collection was primarily qualitative involving Key Informants Interviews (KIIs) and Focus Group Discussions (FGDs), guided by interview guides, designed to permit free presentation of experiences by respondents telling their story about the program and its influence on their lives as described for narrative qualitative study design by Lincoln and Denzine (2011). Respondents included volunteers and beneficiaries at each of the selected evaluation Branches. In each selected Branch, an FGD was conducted with each of the following groups: volunteers, females, males and young beneficiaries. Participants to these groups were purposively selected based on ability to provide best representation of opinions. Homogeneity in groups was meant to enhance freedom among the respondents that would otherwise be inhibited by cultural norms and practices.

Table 2: Analysis of evaluation sites

No	State	Locality	Studytype	No	State	Locality	S.type
1	Northern	Marawi	Evaluation	4	North Kordofan	Sheikan	Evaluation
		Dulgo	Baseline			Umrawaba	Baseline
2	El Geizira	Almanagil	Evaluation	5	River Nile	Aldamar	Evaluation
		Algurashi	Baseline			Abu Hamad	Baseline
3	Sennar	Alsooky	Evaluation	6	El Gedaref	Basunda	Evaluation
		Rural Sennar	Baseline				

Key informant interviews (KIIs) were conducted with Program managers, locality commissioners, local community leaders, community health committee members and representatives of other key stakeholders as they were deemed to be information rich with regard to the evaluation questions. The respondents were guided by gentle probing carefully done not to influence responses, but to ensure completeness of narration as noted by John Creswell (2000). Table 3 presents the details of what data was collected to address evaluation questions.

Table 3: Assessment indicators and information source by questions and items

A. To assess the relevance, of NCHVP according to respondents

Assessment Items	Indicators	Data collection methods/Source
Consistency with the needs of volunteers and priorities of beneficiaries, based on assessment of needs	Needs assessment done Priorities	Desk review (plans, records, branch reports, project reports, minutes of management meetings), KII of Coordinators, Volunteers and staff
Building on existing resources and capacities of Communities	Knowledge, skills and behaviour / practices, structures utilization of services (service coverage), diverse groups of people, various backgrounds	Desk review of documents (Regular reports), Key Informant Interview of leaders, managers, FGD with communities (women, men, youth)
Assessment of needs and capacities of target	Whether VCA carried out, Gaps, suggested new approaches	Regular reports, Key Informant Interviews, FGDs

beneficiaries undertaken		
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B. To assess the Effectiveness of the implementation process of the Programme support and to see if the programme achieved planned outcomes and outputs

Assessment Items	Indicators	Data collection methods
Assess monitoring tools and feedback into implementation	M and E Frame in place Use of M and E Frame and results	Desk review of documents (Regular reports, minutes of meetings) Key Informant Interview
Timeliness of activities and achievement of objectives	Activities implementation, outputs, compared with targets	Desk review of documents (Regular reports) Key Informant Interviews
Adequacy of Supervision and management mechanisms at all levels (Branch, HQ, IFRC)	Support supervision mechanism in place, Support supervision undertaken, Adequacy of supervision by level	Desk review of documents (Regular reports) Key Informant Interviews
Timely technical and logistical support at all levels	Number and timing of supervisory visits Supervisory tool Supervision reports	Desk review (reports, records, mission technical reports, timeliness of feedback minutes of meetings, technical), Key informant interviews of Coordinators, Volunteers, and staff
Implementation of past recommendations from evaluations, lessons learnt	Examples of recommendations from past evaluations, implemented	Desk review of documents (Regular reports) Key Informant Interviews
The level and type of support by SRCS HQ, and IFRC to branches and appropriateness of the support based on Branches capacities	Support type, Timeliness, Adequacy and Appropriateness	Desk review of documents (Regular reports, minutes of meetings) Key Informant Interviews
Coordination / collaboration IFRC, SRCS, SRC, NRC, various Departments.	Coordination activities	Desk review of documents (Regular reports, minutes of meetings) Key Informant Interview

C. To assess the impact of intervention on target communities, positive and negative

Assessment Items	Indicators	Data collection methods
Stakeholders viewpoint (beneficiaries and partners) related to the performance and impact of the project	Views of communities Views of volunteers Views of partners	FGD communities, FGD Volunteers and KII Partners
Achievement of objectives, outputs and outcomes among target communities	Outcomes, Change in community KAP,	Desk review of documents (Regular reports, records), Secondary analysis of household sample survey.
Assess the Strengthening of SRCS in presence and image in communities.	Knowledge of NCHVP Experience with NCHVP Benefits of NCHVP	Desk review (reports, records, mission technical reports, minutes of meetings, testimonies and stories), Key informant interviews of Coordinators and partners, FGDs Volunteers, and Beneficiaries

D. To assess the Coordination of Programme Support, Intervention with Government Authorities and other Stakeholders:

Assessment Items	Indicators	Data collection methods
How effective has been the Coordination with External Actors and Government Authorities	Engagement with humanitarian partners Engagement with Government and local authorities. Roles and responsibilities of the different stakeholders Coordination mechanisms	Desk review of documents (Regular reports, meetings) Key Informant Interviews

E. To assess the participation of beneficiaries in Programme Planning, Monitoring and Implementation considering gender and diversity

Assessment item	Indicators	Data sources/methods
Beneficiaries involvement and participation In different phases of the programme	Availability and functionality of structures for community involvement Number of meetings in planning committees	Desk review (records, reports, minutes of meetings); Checklist of display and use of data on community information system, KII of community leaders, FGD of youths women and men
Accountability and transparency Feedback by beneficiaries to SRCS and to IFRC	Availability of feedback mechanisms Use of feedback mechanisms (no. using, response to feedback) by gender and age No. of complaints and or satisfaction	Desk review (plans, records, branch reports, project reports, minutes of meetings), KII and FGDs

Documentation of complaints/satisfaction.	documented Sharing of findings of M and E, participation in sessions	of Coordinators, Volunteers, and staff in charge of various units
Gender sensitivity in participation, Gender diversity in PIMEF Gender sensitivity of indicators and disaggregation of data	the extent to which the views of men, women, boys and girls are captured and how they have been able to influence the NCHVP	Desk review (plans, records, branch reports, project reports, minutes of meetings), KII and FGDs of Coordinators, Volunteers, and staff in charge of various units
Are there gender sensitive indicators and sex disaggregated data	Availability of disaggregated data, reports	Desk review (plans, records, branch reports, project reports), KII and staff in charge

1.4.2 Data processing and analysis

Quantitative analysis

Secondary data analysis of quantitative data from a household survey was undertaken on the basis of response options that would allow for comparison between sites and baseline and endline data sets. For instance, some response options were found slightly different for the baseline and endline survey components. Consequently, for Health behaviour change, only five variables: Respondents who would interact with people infected with HIV/AIDS, Households that could name at least 3 childhood diseases preventable by immunization, Households that could name at least 3 symptoms of tuberculosis (TB), Households that could name at least 3 symptoms of malaria, and Households that could name at least 3 ways to prevent acute respiratory illnesses (ARIs), could be compared. Similarly, only five variables could be compared for knowledge of common diseases and correct practice: interaction with HIV/AIDS infected persons, diseases preventable by immunization, TB, Malaria and ARI symptoms. On WASH practice, two variables were comparable: latrine use and Safety of drinking water.

Analysis of the household survey data was undertaken by a WASH and hygiene promotion consultant hired by the Swedish Red Cross. Only comparative analysis was undertaken involving variables that were comparable between baseline and endline data sets.

Qualitative analysis

Qualitative data were analyzed based on key themes emerging from the data, guided by evaluation questions and criteria, reflected on the data capturing tool, as described by Miles and Huberman (1994).

1.4.3 Evaluation Quality & Ethical Standards

The design and conduct of the evaluation ensured respect and protection of the rights and welfare of respondents and the communities of which they are members. It also ensured that the evaluation was technically accurate, reliable, and legitimate, conducted in a transparent and impartial manner, to contribute to organizational learning and accountability. Therefore, the evaluation team adhered to the evaluation standards and processes outlined in the IFRC Guidelines (2011).

Evaluation process was also designed to maximize achievement of acceptable levels of expectation regarding SRCS and IFRC commitment to Accountability to Beneficiaries (AtB) principles as vouched by the IFRC East Africa AtB minimum standards: The evaluation obtained beneficiaries opinions and information used to measure progress and inform conclusions and recommendations for programme improvement. To meet the minimum AtB standards during evaluation phase, the following was ensured:

- This Evaluation report includes a section on accountability to beneficiaries
- Beneficiaries were involved in evaluation, essentially in group discussions to ensure the community perspectives were included.
- The findings of evaluations will, hopefully, be shared back with communities.
- Learning from programmes will be documented and disseminated.

2 FINDINGS

2.1 Overall programme status

Overall the activities of NCHVP implemented by the Sudanese Red Crescent Society (SRCS) staff and volunteers in the targeted states, led to increased knowledge and practice of Community Based Health First Aid, Communicable Disease Prevention, Public Health in Emergencies, HIV and AIDS Prevention and Water & Sanitation in target communities. It has, addressed ongoing community health concerns through provision of responsive services in disease prevention and health risk reduction. In general, the implementation of the activities planned was satisfactory. The programme managed to improve the health status of targeted communities by addressing their primary health care needs in a coordinated participatory manner.

2.2 Assessment of relevance of the Programme from the point of view of the volunteers and targeted community members

Evaluation question: A) To assess relevance of program response from the point of view of the volunteers and targeted community members:

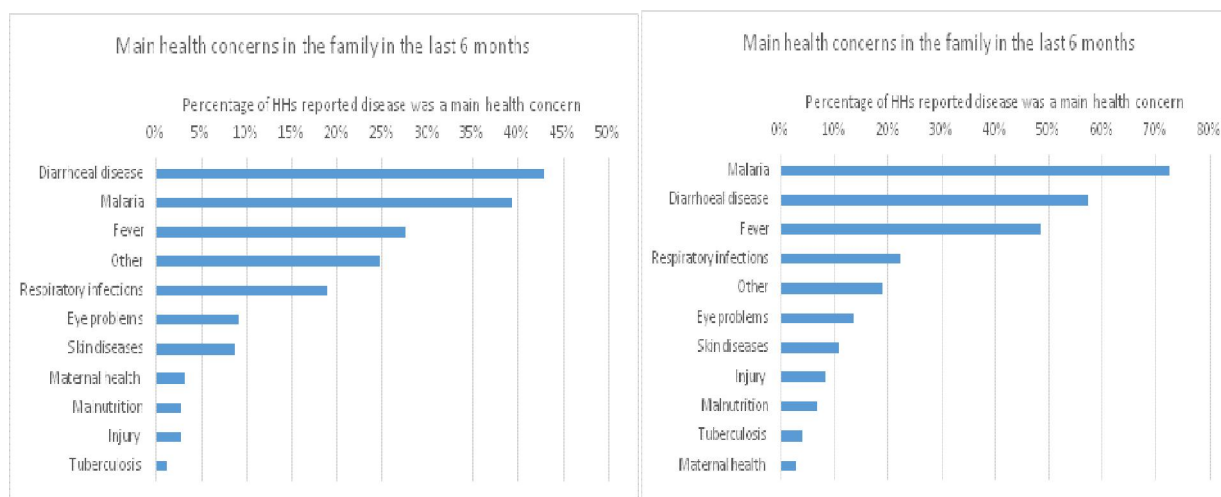
Has the programme built on existing resources and capacities of communities?

Has the programme been consistent with the needs and priorities of the intended beneficiaries?

2.2.1 Consistency with needs and priorities of intended beneficiaries

Respondents in focus group discussions representing the beneficiaries were in agreement that NCHVP was making a major contribution towards improving their wellbeing. Households were far from health facilities and hence the first aid, preventive and promotive services provided by volunteers through the NCHVP improved access to care considerably by health education, distribution of preventive materials such as insecticide treated nets, provision of first aid, and organizing targeted campaigns addressing the health priorities of the beneficiaries. The household survey confirmed the priority health issues being tackled by NCHVP such as diarrhoea, malaria and fevers, as demonstrated by result in both the NCHVP implementing and non implementing localities (see figure 1)

Figure 1: Main health concerns in last 6 months (a) Baseline, and b) Endline



Relevance to community health concerns

Other elements of NCHVP considered particularly relevant to the beneficiaries included school health activities, garbage collection, as well as engraving positive behaviour in communities with regard to personal hygiene and health care seeking.

Respondents considered establishing SRCS units in schools as particularly appropriate for long term culture of health and wellbeing as it engages the young people and through them their parents. Respondents explained the fact that NCHVP activities were not fixed for all sites, rather each community was able to pick and choose what they could implement based on their needs and resources. This flexibility ensured relevance of interventions to local contexts. Different activities could be added according to local context. This contributed to the success, in their view. All communities visited were satisfied that their health needs were being met by the programme.

The elements of NCHVP mentioned frequently by respondents included Health Education, IEC materials distributed, home visits done, and treated bed nets distributed, IEC materials in schools and training of volunteers and Governors. *"The programme is very necessary because it helps train community in disaster preparedness and management, communication and generally in primary health issues"* said a volunteer from El Geizira. Home visits had benefited the community a lot in terms of health education. Community capacity was built in terms of awareness of health issues and the presence of SRCS that was available to partner with them to enhance development for health, and preparedness for disasters.

The communities noted that their situations were characterized by lack of facilities. Health services were inaccessible due to either the remoteness of villages in relation to facilities location. This was worsened by the fact that some health facilities lacked essential drugs. So they needed a system that could enhance access to care or advocate on their behalf. A female FGD participant remarked:-

"the distance to health facility in the farthest areas would take one a full day of walking or five hours by public transport vehicles which are not guaranteed, or one hour on private car transport/ambulance which do not exist".

The support that communities needed was not forthcoming from responsible organizations including the government departments, because of distance and poor road network.

Another female participant in an FGD remarked, *"for this program (NCHVP), the volunteers are always with us and they have helped advocate for services to come to us, they have really changed our circumstances and so we like them so much" (female FGD participant in El Gedaref).* The volunteers have been instrumental in creating a system for communication between the community and government departments as well as partners. As FGD participants roundly echoed, *"Initially, there was just no way the community could communicate their grievances and problems for support. We knew nobody and so we would just die with our problems in the community, and yet there are partners who are willing to support communities like us"* a male FGD participant in El Gedaref.

Although the community had resources that they could mobilize and help themselves in cases of disasters such as floods, droughts and disease outbreak, they had no idea how to do it and therefore even simple problems would cause much harm to them. They had no knowledge of: common diseases affecting majority of the people, simple actions that they could take to avoid infections and initial actions in cases of accidents. A participant in an FGD remarked:

" In El Geizira, which is a huge state, PHC and knowledge was poor-besides households not having any strategy to work together.....but volunteers have created awareness and mobilized us to do something about our situation". Under this situation, respondents felt that they required someone to support them. Firstly, they noted that awareness regarding how to identify health related risks during floods and draughts. Secondly, they needed support to be able to appraise, identify and use local resources and available opportunities in mitigating against risks associated with floods, droughts and other risks. The volunteers under NCHVP had been instrumental in providing the support they needed, they recounted.

".....it is because of these many benefits from volunteers that I have encouraged all my children to participate and get more training from SRCS" said a male FGD participant in El Geizira

Relevance to disaster response

Of particular significance according to beneficiaries interviewed was health care in disasters that were quite frequent in many states. Preparedness for such disasters and timely response massively reduces the impact of the crises in terms of illness and death. Key elements mentioned by respondents included First aid to prevent morbidity and mortality through proper handling of people affected by injuries, or consequences of destruction that occur with disaster.

Respondents noted that many communities were prone to disasters ranging from floods, drought and disease outbreaks. In combating these risks, the communities had lacked required knowledge and skills to handle the situations of disasters when they occurred. *"...in fact a few weeks ago, there was a diarrhea outbreak.....and the floods situation is a rampant one during rainy seasons"* noted a Male FGD participant in El Geizira.



Volunteers wading through flood water to rescue families; El Geizira State, on 11th July 2016,

According to respondents Sudan was ranked 2nd worldwide in terms of disaster occurrences whether man made or natural. Therefore “*resiliency amongst communities is seriously needed to mitigate context of weak health system*” remarked a Male FGD participant in El Geizira. Supporting the urgent need for resilience were complaints of respondents about displacements during droughts especially among the nomads who have to move from place to place in search of pasture for their animals. Through these, several communities experienced violence as they scrambled for pasture.

2.2.2 Consistency with needs and priorities of volunteers

Many sources of information, the management, the beneficiaries and even the volunteers themselves, expressed strong consistency of NCHVP with the needs and priorities of volunteers. This was the view of all the volunteers that were interviewed as well as the managers and the partners. In addition, the programme continually integrated the needs of volunteers as identified during the assessment in 2014 (SRCS-NCHVP Volunteers & Community Baseline Assessment, 2014). The findings of this review showed that the NCHVP was uniquely suited to the needs and priorities of the volunteers. Volunteers existed in each state in Sudan and the SRCS management had a goal to have a volunteer in each village and eventually for every ten households countrywide to ensure access to essential care. When total coverage was achieved, they would ensure access to essential health care and thus contribute to the global agenda of universal health coverage. Volunteers made vital contribution to meeting health needs as they provided services such as home nursing, first aid, education in general and personal hygiene.

Volunteers themselves, expressed great appreciation for the program, indicating that their value to the community had been made perfect by training received from the program. As narrated by one volunteer *"My story started with one of my relatives that work as a midwife and I used to watch her giving injection one day while I'm at home my aunt came seeking for injection so I*

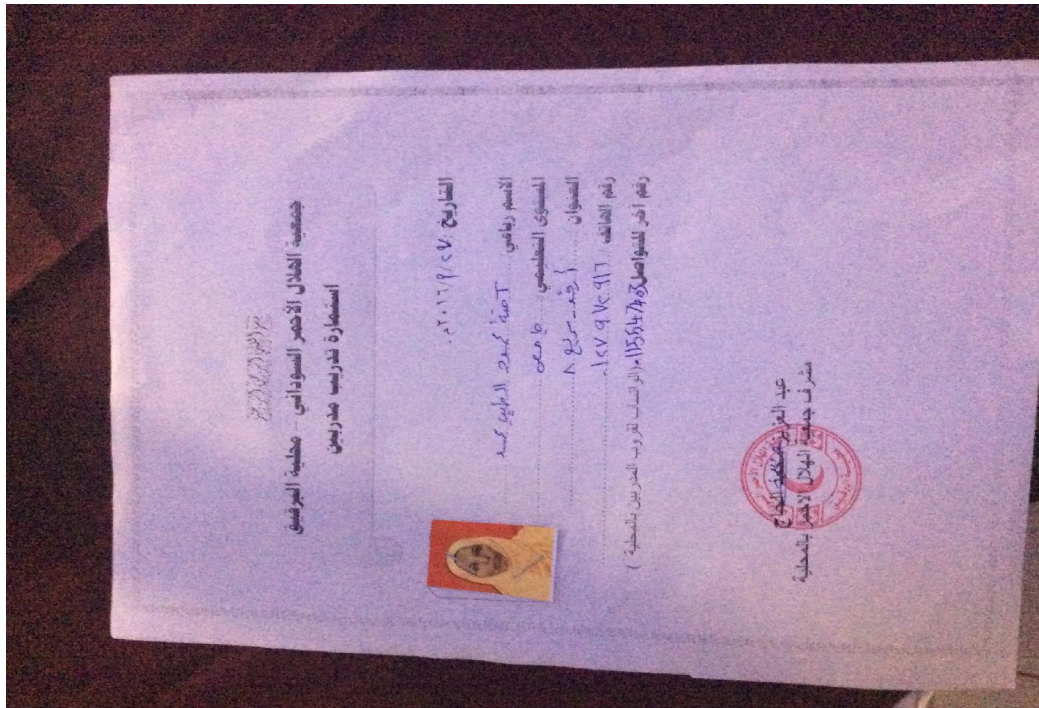
thought to give her the injection but unfortunately when finished we discover mistake after three or four days and felt guilt and sorry for causing pain to my aunt after that I decided to study with SRCs after hearing from one of my friend about SRCs So I started to study and completed the course and Started participated with them then I became trainer providing training to other which make me comfort and feel that I have a value regarding supporting and create happiness other." a Volunteer from El Geizira State Madany Locality.

Relevance of training to volunteers

The majority of volunteers were young and they found volunteering in SRCS a ladder towards eventual career. They gained not only knowledge and skills but also experience as they served their own communities, assisting in first aid in case of accidents, enhancing access to care by linking every household with a health facility. Volunteers expressed appreciation of the training they received which was regarded as standardized and high quality. The training covered a standard set of modules. Community Based Health First Aid (CBHFA) provided a standard training manual in First Aid, Community Health, Health Care in Emergencies, hence it assured quality of skills for which people received certificates. A volunteer had this to say *"Since we serve our own communities we contribute our very best"*.

Relevance to volunteer recruitment

NCHVP was considered a great means of recruitment of volunteers in which after First Aid and dissemination, CBHFA was covered to expand capacity for primary health care and was therefore great for volunteer training on First Aid and Home nursing following dissemination. Then certificates, aprons and cups were provided, all of which were for motivation. Certificates were standardized and were for PHC, home nursing and first aid. There was training of trainers for community in CBHFA and common diseases like malaria, diarrhea and vaccination.



Certificate to a volunteer in CBHFA training, Northern state – El-Borgige locality

In addition NCHVP contributed financially to volunteer activities. It made funds available to cover costs of transport and meals. It provided a volunteer development structure, and promoted volunteer management system and data base and hence strengthened volunteer management, which is a strong contribution to National Society development. It thus facilitated the implementation of the improved comprehensive plan for volunteers. It addressed issues of recruitment, training, and management of volunteers for maximum productivity.

Through NCHV activities, volunteers benefitted from exchange of experience with colleagues and learn from one another beyond the Branches that had funded activities. Similarly the programme supplied IEC and training materials, manuals, and even certificates were provided beyond the funded project sites. This contributed to volunteer motivation beyond the projects sites which volunteers appreciated immensely. NCHVP enabled the establishment of SRCS units in small communities.

Relevance to emergency response

According to respondents trained volunteers were able to manage refugees from South Sudan. Volunteers administered relief help on their own. They received new arrivals and distributed help. Volunteers and community members were satisfied. They valued supporting their people emphasizing that they had the time, especially the young people. *"We have some education and can learn skills fast but there was no source of information before NCHVP came"* added a young volunteer. The training they received as volunteers greatly added value to the education they already possessed. The comprehensive curriculum of the CBHFA helped the volunteers to shift their focus from regular activities to emergency activities during times of emergency. The focus on volunteers was capacity based in that it started with young people (at school), and that it was embedded in the culture and practice of service in the population.



Collecting data to inform evidence based action during flooding in the community of El Gedaref, on 4th August 2016

The program had increased their capacity to assess and direct their efforts to the deserving activities in the community such as First Aid to injured people, environmental cleaning, disease control and assisting people in disaster. *"Now we have found our role clearly cut out as the technical college in the locality. We have realized that we can make all schools safe environments for pupils and teachers, and so we have a plan to manufacture and distribute First Aid boxes to all schools (21) in our Locality"* said a Key Informant.

Relevance to community health

The CBHFA manual had a chapter on community organization and Community Participation and how to work with the community. Beneficiaries were also trained on Health Education, Communicable Diseases, Nutrition. The content was relevant especially in hard to reach areas. NCHVP gave volunteers capacity to contribute to the work of MOH and MOE, filling identified gaps. In some states it was the only project for the vulnerable. Volunteers expressed their ability to handle motor accidents well, give first aid before transfer to hospital, transporting the injured correctly to prevent harm, managing shock. These activities were very relevant and were appreciated by volunteers as functions needed to meet the needs of the community. As noted by a volunteer from Shendi locality, River Nile State

"Most of the people in the neighborhood knows that I am an active and well-trained volunteer and my door is open at any time even at midnight for anyone who needs first aid. I have started to organize health and sanitation campaigns, health awareness to the girls of my area and encouraging them to become volunteers. I do enjoy volunteering. I have become a volunteer leader in my community. I am no ignorant lady anymore"

They gave Health Education in schools, they run international day for hand washing and led in malaria control activities. They provided food baskets for the poor in Ramadhan supported by mobilizing community to produce the food basket. Volunteers were accepted by the community because of the services they rendered, and their good conduct. Examples were given by all communities visited. *"We managed to raise funds from the local community to implement and support expansion of the cleaning and chlorination activities in controlling water borne disease epidemics in community"* said a Volunteer FGD participant.

Volunteers were well prepared for their functions such as in Health awareness, PHC, home nursing, First Aid, School health, Community service, Hygiene, Garbage collection, WASH, Disaster preparedness and community capacity building and Assistance when needed especially during disasters. They gave Health Education in schools, they ran international day for hand washing, they distributed ITNs for malaria prevention in addition to removal of breeding sites. They had a leading role in distributing aid to the displaced people, IDPs. Volunteers were accepted by the community because of the services they render, and their good conduct. All activities are from community to community. Indeed, examples were given by all communities visited indicating instances where volunteers had demonstrated creativity and innovations in handling disasters and disease epidemics, such as fundraising from communities when funds to implement activities delayed or when funds were inadequate.

"We managed to raise funds from the local community to implement and support expansion of the cleaning and chlorination activities in controlling water borne disease epidemics in community" said a Volunteer FGD participant.



The Principal of Industrial vocational training school showing sample of First Aid kit of the first 21 boxes manufacture by students to install in all schools in the locality as a result of NCHVP training, Gedaref, on 17th October 2016

Participants noted that, while they had clearly demonstrated the practice of helping one another, initially, they had lacked the knowledge, skills and competence that would optimize satisfaction to the person being assisted. That the program had sharpened their capacity to assess and direct their efforts to most community deserving services, such as First Aid to injured people, environmental cleaning, disease control and assisting people in disaster.

"Now we have found our role clearly cut out as the technical college in the locality. We have realized that we can make all schools safe environments for pupils and teachers, and so we have a plan to manufacture and distribute First Aid boxes to all schools (21) in our Locality" said a Key Informant.

The programme utilized various facilities in the community as communication platforms and channels, including mosques, community leadership structures, markets, local radio and TV stations. Mosques were used for mobilizing volunteer recruits, awareness creation and disseminations; community leadership structures mainly used for community mobilization, meetings convening, and dissemination of information to the community; markets, radio and TV stations were used mainly for awareness creation and information dissemination.

Community Health Committees (CHCs) had representation from the community leaders (including village and clan leaders, administrators and religious leaders) and volunteers that

made them gender balanced. It was the structure that facilitated community needs assessment, and developed plans. They also directly supervised implementation of activities by volunteers in the community. In some instances they went as far mobilizing community to raise more resources for activities that SRCS or Government did not have sufficient funds for but yet considered critical by the community. CHCs also carried out monitoring and reporting to Locality SRCS volunteer structure.

"We feel greatly valuable to the community when we undertake needs assessment and planning for health activities and solving problems that appear priority, which occupies the community's day to day life" said a CHC chair in a Locality.

Relevance to school health

Competition among schools on health issues reinforced positive behaviour e.g. personal hygiene, within community and during holidays, to maintain 1 class by painting as part of health promotion. Training people in first aid made them happy and relieved pressure on hospitals. These activities were very relevant and were appreciated by volunteers as functions, needed to meet the needs of the community.



A volunteer spraying facilities, in Northern State, on 28th September 2016

2.2.3 Extent to which program builds on existing resources and capacities

The respondents explained how the program was founded on capacities and not just needs of the Community. The participatory approach in the initiation of the NCHVP in a new area required the assessment of resources and capacities of the communities such that the programme interventions in any area was to be built on existing resources and capacities of communities.

Built on human resource

The main resources were people who volunteer to become governors of the programme or be trained in service delivery. The human resources were available in households and communities (youth, leaders, community based resource persons like teachers). Respondents identified local leaders such as religious leaders, local administration and community and clan leaders as resources that had benefited the NCHVP in making it more responsive to community pressing needs and priorities.

"The training we have received from this (NCHVP) program has enhanced our value to the community, because now we are tackling the real problem of the people, otherwise we acted more as custodians of systems rather than serving the people" [KII, CHC chair in Medani Locality]

The community identified local volunteers as a resource that had been underutilized. The communities expressed pride that NCHVP enabled them to develop otherwise unskilled labour into a trained and skilled labour serving vulnerable households and the community more effectively.

"...we are happy, now the SRCs has trained our young people and they have become very wise and innovative in handling disasters as well as accidents along the road passing through our town, initially, it was guess work in support granted to injured persons, nowadays the volunteers take lead and coordinate everyone involved with clear instructions that have prevented further injuries to accident victims" said a Female FGD participant in Sennar.

In its design NCHVP focused on capacity enhancement which ensures lasting capacity development in the community on a long term basis. Skills transfer was a major element of the programme, strengthening knowledge and skills of local people for activities that they were already trying to do, in order do them better. The primary beneficiaries of skills transfer were the volunteers that were part of the community. Capacity enhancement enabled them to play leadership roles in their communities. In addition some of them were trained as trainers, thus making the capacity building task part of the community and therefore self sustaining.

Built on culture and tradition

It was also built on the culture of reciprocity, helping one another in such a way that everyone contributes to the welfare of the others and everyone gets an opportunity to benefit. This was the tradition of helping neighbor. Culture and religion are reservoirs of values and therefore, practices. The leaders and communities concurred that in their traditions, they have for a long time practiced "Nafir", which is a practice to pool effort for a bigger task. Events in which the practice has been used range from house building to communal work for the common good. They now noticed that their Nafir practice would be utilized to advance communities vision for health and resilience in disasters. Under this culture, each cohort starting from adolescents, young people, young adults, adults and elders, each had clearly their roles cut out and hence

functions to play under different situations. It is in line with this that some communities have structured their volunteer development plan starting from school (primary, high school, colleges and universities) to adulthood in their communities.

"We noticed how important everybody is to an effective behaviour change process and support that to the community in event of disasters, and so we have structure our volunteer trainings to start in primary schools. Among our volunteers, you will find all age groups, because each of these groups is critical. For instance, when we conducted general clean up in schools, we needed the practice and behaviour for cleanliness maintained, and so at the level, primary school volunteers are responsible to sustaining the practice. Out of this we see very encouraging results in schools, markets and communities" said a volunteer coordinator.

Thus NCHVP simply rejuvenated and expanded the value of culture applied to health where it was needed. Training, organizing volunteers in coordinated groups, under community health committees (CHC) provided opportunity for greater strengthening. Volunteers were able to advocate with authorities, learn how to manage disasters and environmental issues, before any outside support could be sought for additional inputs. This had expanded into entrepreneurial group formations that were engaged in economic initiatives.

"....through Nafir our community practices the culture of pooling labour for major tasks in the community that require collective efforts such as when disasters happen or even building houses where one person cannot manager by themselves.....our religion and culture promotes this"
[Volunteer FGD participant]

Built on local structures and institutions

It was also anchored on physical facilities and institutions in the communities such as in schools and health facilities. Examples were witnessed in North Kordofan, Sennar, and El Geizira.

The programme utilized local institutions such as government offices - Ministry of Health (El Geizira State, Madany), schools (Sennar State), colleges (El Gedaref State), hospitals (Sennar State) and mosques (Sennar State) for office space for volunteers, as training halls and meetings venues. Furthermore, States had contributed land on which SRCS offices were built. Government officers were vocal on the value of the program and hence they would not hesitate to support in any way possible including offices. Other resources utilized included community meeting halls (El Gedaref State) and markets and community open grounds (all States) for meetings of volunteers and community activities.



Using local community venues for training & Hospital space for meetings;-a) The Baseline survey questionnaire in Gaderef (Algallabat-Kassab locality), on 18th April 2013; b) Abu-Hojar locality Hospital, on 18th October, 2016

Further NCHVP was built on the comparative advantage of National Society as a leading grass roots voluntary organization, utilizing existing resources, organizing the volunteer base. *"The program is very relevant to all the states. NCHVP is the only program that fits all, even States that are usually excluded from project can be included. And therefore those excluded from it complain a lot"* said by a Branch Director. It would appear that since NCHVP was based on volunteers, and on First Aid that are core concepts of the Red Crescent, all interested Branches qualify to implement the programme.

The program also utilized national and local government systems to promote its agenda. For instance, senior government officers in the ranks of Locality Commissioners were aware of and support the NCHVP in their areas of jurisdiction. They remarked that the program endeared itself to the government leaders due to its major contribution to combating disasters and disease outbreaks. The political system recognized contribution of the program as having reduced the impact of disasters to their communities and they themselves regard it as a mechanism that has made service to the needy population more effective.

"I have known the volunteer program from my last station, and although am just a few months here in this State, the first thing I wanted to know was if there are SCRS volunteers in the Locality. In fact in the meeting we have just completed with Locality HODs, we were strategizing on how to use the volunteers more effectively in disease prevention and disaster mitigation" said a Locality Commissioner.

The community members in many instances supported program activity implementation by raising funds especially when resources had not been adequate or when need for scope expansion was necessary. . Community members contributed through actual funds raising and also through donations of supplies such as food stuff. *"As volunteers in my area I had organized a mission to*

support poor households with cloths and food stuff during the Eid holidays. My plan as a volunteer in the village was to support just one household. When the community noticed what I was doing, they approached me and asked me to call for the whole community to raise more donations. This we did, and I tell you we were able to provide clothing and food stuff for eight families" [Volunteer, Sennar] said a Locality Commissioner.

2.3 Effectiveness of the programme implementation process, outputs and outcomes

Evaluation question: B) To assess the effectiveness of the implementation process of the program's support and to see if the program achieved planned outcomes and outputs:

Have the activities been undertaken in a timely manner? Were objectives achieved on time?

Were assessments of needs and capacities of the targeted beneficiaries carried out? :what was missing; what can we do differently next time?

Were the supervision and management mechanisms on all levels (branch, HQ, and IFRC) sufficient in relation to the project needs and expectations?

Have lessons and recommendation from previous evaluations and reviews been considered and used?

What monitoring tools were in place to feedback into implementation? Were there any gaps for further improvement?

How effective was the coordination/collaboration between IFRC and SRSC and between SRSC's different departments?

What was the level and type of support provided by SRSC HQ and IFRC to the branches implementing the activities? Was the support appropriate considering the branches' capacities?

2.3.1 Activities timeliness, Achievement of objectives and outputs

There was evidence of timely implementation, covered by reports indicating achievement of targets and supported by respondents during key informant interviews and group discussions.

Branches reported on first aid kits distributed, community volunteers trained, and community members trained. Reports also documented the number of meetings with health actors (MOH, CBOs, NGOs), number of vaccination campaigns, number of households visited, IEC materials distributions, number of bed nets distributed, Training of trainers (TOTs) on PHAST, Community environmental sanitation, garbage cleaning and disposal. Health awareness raising in the community leading to health campaigns, improved vaccination coverage. Volunteers were trained in PHAST; HH visits, Media Campaigns, school health, Branch Governance and management training. Efforts were made to build branch capacity on volunteer management data base. Networking meetings and celebrations were held to maintain improvement momentum.

Sennar and Northern Branches were trained on AtB standards and tools. Emphasis was made on access to care particularly in conflict situations, SRCS facilitated provider protection, impartiality. The volunteer's manual was reviewed and edited, 500 copies printed and distributed. Existing institutional policies and regulations were reviewed and refined to ensure

they meet recognized standards of good practice. SRCS updated branch laws, policies and regulations.

SRCS volunteers reached large numbers of beneficiaries as documented in periodic and annual reports, disaggregated by gender. This was achieved through implementation of activities aimed to increase knowledge and practices on first aid and address priority health concerns of the target community. SRCS partnered with communities to disseminate and raise awareness on health with the support from leaders, communities and local authorities. SRCS reported strong relationship with communities in the implementation of activities. Many of the activities overshot the targets, because of the support from local authorities. Volunteers carried out community based health activities, Community Based Health and First Aid (CBHFA) services.

NCHVP reached the targeted population in the eleven states, achieving the targeted indicators, increased knowledge and practice on first aid, addressing priority health concerns of community, provision of disease prevention and health risk reduction. For instance, results of comparison of indicators between endline and baseline survey showed improved health knowledge and behaviour, knowledge of common diseases and correct practice in water and sanitation among households in the program implementing areas. The main achievements of the programme was the training of a large number of volunteers on CBHFA, home nursing and health care in emergencies, water and sanitation and HIV/AIDS prevention, reaching a large number of beneficiaries through home visits, health education and first aid. The well trained NCHVP volunteers provided evacuation and emergency Health care services to internally displaced people from South Kordofan following the armed conflict in late 2013. During floods that hit many parts of Sudan in the previous years, including the most recent of August 2016, the volunteers played a major role in responding to the needs of the affected communities. The volunteers helped in the evacuation of the affected households members to safer higher grounds, provided first aid services and health education and support distribution of the non- food items.

The program conducted training workshops on CBHFA for schools teachers and students and established SRCS units in the same schools. Volunteers & communities were trained on First Aid, and they conducted Community Health media campaigns. They managed to respond actively to the needs of the flood affected people. NCHVP procured and equipped the volunteer's leaders with Community Based Health First Aid (CBHFA) manuals, in addition to distribution of posters of different health messages. The eleven Branches trained trainers (TOTs) for CBHFA. Volunteers and community members were trained as first Aiders. Health committees comprising of representatives from the local community, health focal persons, volunteers leaders and others were established. In addition volunteers were trained on HIV/AIDS prevention and stigma reduction. More people were reached through multi media campaigns on health and care messaging (TV & radio shows).

The volunteers were equipped with first aid kits as well as protective tools. TOT training were also held on PHAST, leading to awareness sessions on PHAST in the local communities. Cleaning campaigns were organized, coordination meetings conducted for the emergency action teams in target communities. Distribution of ITNs for pregnant women and children under five was undertaken. Printed manuals and PHAST manuals, and hygiene kits for SRCS volunteer leaders and volunteers were distributed. Certificates were printed and distributed to trained

volunteers together with first aid booklets. Volunteers conducted household visits to provide health education and referrals for sick people. They also held sessions to promote vaccinations of children under 5 years in the community, and to educate households on HIV/AIDS prevention and stigma reduction. Table 4 gives analysis of output indicators and their level of performance between 2013 and 2015 implementation years.

Outcomes 2 and 4 areas had all their output indicators reported on progress between 2013-2015 years of implementation. In outcome 1, all indicators performed well as reported except Output 1.1: Community first aid posts are established and/or supported (equipped) - there was no record reported in progress reports 2013-2015 period. Similarly, Branches visited did not mention them. Outcome 3 had Output 3.3: Community action groups leading regular community hygiene and watsan activities were also missing in the reports, and not mentioned by respondents in visited Branches. In outcome 5, although reports did not show explicitly record of Output 5.5: Arrange quarterly meeting for field officers and NCHVP staff, volunteers' leader; Output 5.6: Celebrating for May 8; and Output 5.8: Base\ End line survey and mid-term review, there was evidence that all the three output indicators had been realized by the time of this evaluation.

2.3.2 Assessment of needs and capacities of the targeted beneficiaries

Respondents described processes that were routinely undertaken to identify needs and capacities of beneficiary communities to guide programme activities. Tools such as the People first impact methodology (Pfim) were used in community engagement, listening to communities as they expressed not only what was important to them but also to formulate solutions to their challenges based on their own resources and experience. This ensured that programme activities addressed the most pressing needs in which beneficiaries were willing and able to invest their own time, available skills and resources. These tools are available in the IFRC VCA tool box available to the National Society.

According to the respondents the needs and capacities process undertaken contributed greatly to the relevance of NCHVP activities to beneficiary communities. The communities gained greater understanding of their own environment in relation to risks and hazards as well as greater realization of their own capacities to cope with the risks and hazards identified. The process facilitated an agreement between the community, volunteers and local authorities on the one hand and NCHVP personnel on the other hand concerning what actions are needed to prevent or reduce the effects of risks and hazards. This guided programme interventions, focusing on prevention, preparedness and risk reduction, and enhanced ownership by the beneficiaries and volunteers.

2.3.3 Adequacy in supervision and management mechanisms at all levels

Respondents noted that technical and logistical support were both timely and, adequate at all levels enabling delivery of services to target communities. Monitoring visits to project sites and meetings were conducted regularly, attended by SRCS, IFRC, SRC and NRC , particularly the Swedish Red Cross and to a lesser extent the NorCross, to follow up on the volunteers and the planned activities. The NCHVP staff and volunteers, senior staff at SRCS, SRC and IFRC joined these meetings. During the year IFRC technical staff, in country and region/zone, provided technical and management support that included the introduction of frameworks and tools in 2015, such as accountability to beneficiaries (AtB) to improve the management of programme implementation. They also carried out training to build the capacity of the National Society to implement the new framework and tools. As part of the capacity building for SRCS to implement NCHVP the SRC introduced the PMER to strengthen evidence based decisions and planning as well as support the volunteer management. According to respondents the support was appropriate and timely to each Branch considering varying Branch Capacities.

The support by SRC and IFRC consisted of support supervision, technical input, on the job training, logistics, materials and supplies. Branch directors were responsible for programme implementation supported by field officers. Thus the support supervision chain was in place and functioning (HQ to Branch, to Locality and to Units). There was SRCS volunteer committee and CHC at unit level, to supervise volunteers. Volunteer coordinators at locality level, alongside SRCS field officer supervising CHC, and VCs. FO supervisors the locality volunteer coordinators. All responsible officers reported every month, quarterly and annually. Localities had programme offices with supervisors, who were all working according to plan.

Table 4: Consolidated output by outcome area

	2013	2014	2015	Total
Outcomes I: Reduce the number of deaths, injuries and impact from disasters				
Output 1.1: Community first aid posts are established and/or supported (equipped):				
Output 1.2: First aid kits and CBHFA DVD are provided to volunteer leaders.	-	-	1,150	1,150
Output 1.3: Targeted community volunteers are trained as trainers for first aid .	600	540	350	1,490
Output 1.4: Community and volunteers members are trained and certified in first aid.	-	-	20,000	20,000
Outcome 2: Support delivery of health services to address on-going community health				
Output 2.1: Community health committee established and/or support:	33	23	20	76
Output 2.2: Coordination and partnership with health actors (MoH, CBOs, NGOs).	46	64	144	254
Output 2.3: Vaccinations campaign are provided in coordination with state MOH and the participation of the community	8	4	32	44
Output 2.4: Malaria prevention a household mosquito bed nets and usage instruction provided to the communities	4,000	4,000	5,283	13,283
Outcome 3: Increased community awareness of Hygiene, water and sanitation				
Output 3.1: Targeted community volunteers are trained as trainers for PHAST trainings:	-	-	97	97
Output 3.2: Community environmental sanitation conducted with target communities.	844	96	388	1,328
Output 3.3: Community action groups leading regular community hygiene and wat san activities.				
Output 3.4: Garbage disposals and cleaning material (tools) in regular use	-	-	600	600

Outcome 4: Increased community awareness of basic health issues and practices				
Output 4.1: Community volunteers are trained as trainers for basic community health:	600	540	350	1,490
Output 4.2: Community members are trained in community health	2,880	5,567	13,642	22,089
Output 4.3: Household visits conducted by community health volunteers.	54,552	10,250	39,063	103,865
Output 4.4: Community health media campaign conducted (radio, road signs, newspaper, TV, posters / leaflets, community youth clubs, sporting events, religious places).	39	-	7	46
Output 4.5: School classroom health presentations and lessons.	404	-	508	912
Output 4.6: Branch governance, staff, and volunteers are trained in community health.	9,030	6,100	16,505	31,635
Output 4.7: Branch governance, staff, and volunteers are trained in RCRC Principles, Values, Code of Conduct, and IHL.	9,030	6,100	16,505	31,635
Outcome 5: Build the capacity of SRCS branches to implement the National Community Health Volunteers Programme				
Output 5.1: Branch governance is trained in volunteer management:	20	-	-	20
Output 5.2: Branch staff and volunteers leaders are trained in volunteer database management.	30	30	80	140
Output 5.3: Branch staff and volunteers leaders are trained in project management.				
Output 5.4: Inter-Branch activities are coordinated to share knowledge and experience.	102	40	75	217
Output 5.5: Arrange quarterly meeting for field officers and NCHVP staff, volunteers' leader.				
Output 5.6: Celebrating for May 8.				
Output 5.7: Celebrating for 5 December International Volunteer Day.				
Output 5.8: Base\ End line survey and mid-term review				

2.3.4 Use of lessons and recommendations of previous evaluations

Previously, two major assessments and reviews conducted included the NCHVP Mid-term Review in 2011 and NCHVP Volunteers and Community Baseline Assessment conducted in 2014. Broadly, seven types of recommendations were made by previous evaluations. These included recommendations on fundraising to expand the scope of services, scale up and sustainability of NCHVP; volunteer incentives; volunteer capacity building; collaboration/linkage with health facilities; monitoring and evaluation - considering content and quality of indicators as well as baseline information; community involvement; and service package and delivery. A detailed analysis of the status of implementation of specific recommendations made in the previous reviews is as shown in table 5.

One key lesson learnt and documented was on teamwork dominating in the program at all levels, smooth communication and bi-directional flow of information to promote similarity in the planning, implementation processes and achievements across levels and States. Evidence indicated that the programmes continued to utilize lessons learnt and recommendations to improve NCHVP performance. For instance, under fundraising, SRCS has continued to increase and strengthen collaborations with partners to expand funds generation portfolio, strengthening activity tracking meetings and foreseeing delays in funds disbursements where various innovative mitigating mechanisms were developed and pursued.

On volunteer incentives, the comprehensive volunteer assessment in 2014, and the establishment of the volunteers data base and office were major efforts to address volunteer concerns. On

capacity development, manuals were developed and used, refresher training were conducted as needed. Collaborations and linkage with health facilities was already underway and many States already created linkage (eg in the case Sennar and North Kordofan). Recommendations on M&E were fully implemented and there are several tools and frameworks already introduced in the program, such as AtB, Indicator tracking and establishment of a department to steer the function (PMER). Community was being strengthened currently through committees and representations of various categories of people. On service delivery, more efforts were demonstrated to integrate all health issues affecting the communities including Malaria and maternal, newborn and child health interventions. HIV/AIDS prevention and First Aid were strengthened in Branches.

Table 5: Summary of previous recommendations and actions

Category	Specific	Progress
1. Fundraising	<p>Service/package definition: <i>- Service analysis and the operational strategies to determine gaps where the governments and donor community can support, by NCHVP Volunteers & Community Baseline, Assessment conducted in 2014</i></p> <p>More collaborations: <i>-SRCS use local authorities and/or relevant humanitarian actors in country, to increase scope of service offered by NCHVP Mid-term Review Report, 2011</i></p> <p>Improve transfer mechanisms <i>-Transfer mechanisms and communication regarding funding should be strengthened, by NCHVP Mid-term Review Report, 2011</i></p> <p>Strategic approaches: <i>-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 by NCHVP Mid-term Review Report, 2011</i></p>	<p>Through annual reviews determining gaps and accordingly design and integrated in annual plans.</p> <p>Program liaise, work closely and maintain good partnership with State offices/ government line ministries, Social Welfare and other NGOs (other humanitarian actors), through bilateral agreements and joint approaches to conduct community based activities</p> <p>Now monthly and quarterly meetings track and follow up routinely</p> <p>Now utilizing collaboration and joint planning meetings. Can further be strengthened based on existing opportunities of good image</p>
2. Volunteers	<p>Development plan/PDPs: <i>- Prioritize a comprehensive volunteers' development plan.</i> <i>-To develop 'best practice' models for humanitarian services eg completing Personal Development Plans (PDPs), NCHVP Volunteers & Community Baseline, Assessment conducted in 2014</i></p> <p>Encourage youth Reward, recognition: <i>- Encourage young/ youth in the schools and peer education programs, NCHVP Volunteers & Community Baseline, Assessment conducted in 2014</i></p> <p>Diversify by characteristics: <i>- Diversify quality/skills of the volunteers introducing a well-defined to start the process, NCHVP Volunteers & Community Baseline, Assessment conducted in 2014</i></p> <p>Expense coverage:</p>	<p>Now SRCS established unit for volunteers development to work on this, Study completed with strategies</p> <p>Study completed with strategies</p> <p>Now establishment of SRCS units in the schools & universities, training for teachers and the students in program components, classes time table included the messages of the program, as annual operational plan elements</p> <p>A lot work done at youth level, eg senior volunteers is 3% by baseline. Can do more at adults focusing on strength of expertise</p>

	<p>- Maintenance of bikes and motorbikes should be included in the program budget, <i>NCHVP Mid-term Review Report, 2011</i></p> <p>Motivation/Incentives (eg T shirts): - Increase the incentives for the volunteers, <i>NCHVP Mid-term Review Report, 2011</i></p>	<p>Running cost allocated for the branch to cover this activities</p> <p>Now SRCS rules and regulations on volunteers incentives require including in all activities as an integral part in the program budget. The incentives include financial and material kinds. The financial one normally covers food and transportation costs while the material includes certificates, t-shirt etc</p>
3. Capacity	<p>Volunteer - community mobilization skills: - Community mobilization techniques among volunteers strengthening community mobilization, cooperation and increase community ownership, <i>NCHVP Volunteers & Community Baseline, Assessment conducted in 2014</i></p> <p>Exchange visits: - Exchange program to identify success stories and lessened on means to attract and keep quality volunteers, diversify means of volunteer recruitment (i.e. first aid courses is one of the successful means still there are others related to media programs, dissemination, radio drama...etc), <i>NCHVP Volunteers & Community Baseline, Assessment conducted in 2014</i></p> <p>Refresher training: - Regular refresher trainings should be conducted for staff and volunteers involved in the program, <i>NCHVP Mid-term Review Report, 2011</i></p>	<p>Refresher trainings and AtB tool introduction, strengthened CHCs for role</p> <p>Annual meetings for the FOs (discussing Community mobilization techniques, Volunteers organization, recruitment and retentions, PMER), unit of volunteers updated the volunteers manuals for recruitment, structure code of conduct, Established pages in ALL social media(Whatsapp, face book), used public media TV/broadcast channels and new pap, Youth camps at national and state level, NCHVP produced manuals and IEC materials, peer to peer program for the volunteers with the Norwegian Red Cross</p> <p>Now refresher training frequently conducted, various approaches to motivation adopted</p>
4. Collaboration/linkage	<p>MOH HF linkage: - Networking: SRCS volunteers, local health facility and health workers- for support and guide, <i>NCHVP Volunteers & Community Baseline, Assessment conducted in 2014</i></p>	<p>Volunteers are part of the CHCs taking responsibility of supervising the health facility, linkage, MOH conducting trainings for SRCS volunteers, referral to health facilities from household visits by volunteers</p>
5. M&E	<p>Appropriate indicators Content & quality: - Content and quality of the reporting is strengthened, <i>NCHVP Mid-term Review Report, 2011</i></p> <p>- Improve monitoring approaches for wash and other hygiene techniques through identifying appropriate updated change indicators and behavior outcomes e.g. WASH behavior change indicators, <i>NCHVP Volunteers & Community Baseline, Assessment conducted in 2014</i></p> <p>Finalize baseline: - A baseline for the nine program branches should be finalized, <i>NCHVP Mid-term Review Report, 2011</i></p>	<p>Now program coordinate with WASH section who applied 14 Standard guidelines and different manuals for all WASH component in addition to that the WASH section used PHAST</p> <p>Now baseline done and outcome indicators focusing on appropriate indicator</p>
6. Community involvement	<p>Action group formation: - Exit strategies, through program branches developing realistic plans for viable IGAs and that funds are included in the NCHVP budgets for IGAs, <i>NCHVP Mid-term Review Report, 2011</i></p> <p>- Strengthen in community engagement approach as</p>	<p>Now project designed to empower targeted families, women groups and the entire involved communities to undertake and engage in activities that are self-sustaining after the initial investment in HR and technical support. The program uses locally available material and service and adapted small-scale technology which is accepted and can be maintained by the target group</p> <p>Currently IEC material and school program for community</p>

	<i>main approach for Hygiene promotion and community appropriate IEC material, NCHVP Volunteers & Community Baseline, Assessment conducted in 2014</i>	engagement, as focus
7. Service delivery	<p>Integrate with livelihoods/IGAs: - Linking WASH with livelihoods</p> <p>Expand coverage/scope for effective control eg Malaria: - Consider a more strategic approach to malaria prevention based on the IFRC standards for malaria prevention and control</p> <p>MNCH interventions: - Strategic approach to Mother, Newborn and Child Health (MNCH) in the context of HS, <i>NCHVP Mid-term Review Report, 2011</i></p> <p>HIV/AIDS strengthening: - <i>HIV/Aids component strengthening with regards to stigma and discrimination during trainings of volunteers and community members, NCHVP Mid-term Review Report, 2011</i></p> <p>First Aid kit replenishment system strengthen: - <i>System for replenishment of First Aid (FA) kits should be implemented, NCHVP Mid-term Review Report, 2011</i></p>	<p>Various activities on livelihood including formation of microcredit office to support poor families selected within various programs</p> <p>Annual targets for mosquito net distribution, and use as outcome through baseline</p> <p>Now collaboration with MOH, eg safe home delivery kits provided by MOH</p> <p>Training was done in all the program states</p> <p>Now budget incorporated into Branch budget</p>

2.3.5 What M and E framework, and tools are in place to feed back into implementation

A Planning, monitoring, evaluation and reporting (PMER) unit was established in SRCS as the Monitoring and evaluation (M&E) mechanism, to enhance the capacity of SRCS to monitor and analyze trends in humanitarian indicators for informed decisions and planning. This provides a framework for the monitoring and evaluation of NCHVP to feedback into its implementation. With the support of SRC the PMER department was established as a major effort to institutionalize the framework for planning, monitoring, evaluation and reporting with standardized tools to be used at all levels and programmes including NCHVP and evidence from data used to influence management decisions. NCHVP met once a year for PMER for monitoring, evaluation decisions and planning. Reporting was done from unit to locality, to Branch and up to Headquarters, based on plans and at each level. There was monthly reporting at Unit and Locality levels, and quarterly reporting by Branches and all of these fed into annual reports.

The reports documented mainly the efforts and numbers that were reached against targets that were critical for accountability that the expected effort was being put into programme implementation. SRCS HQ and branches developed and disseminated PMER tools targeting all reporting officers. The unit also conducted field visits and technical support at the branches. PMER conducted a training course for participants from all the branches. Branch and Coordination staff had capacity and competency in the management and supervision of the NCHVP, being enhanced by PMER. The field officers in each state conducted regular monitoring visits and discussed with the volunteer leaders and community the implemented activities. Volunteer management information, and accountability to beneficiaries (AtB) framework, that were more recently established will further strengthen the monitoring and

evaluation of the programme. Accountability to Beneficiary (AtB) consists of satisfaction form, complaint box and indicator tracking tools.

PMER unit supported the branches on planning, monitoring evaluation and reporting through field visits and technical training. PMER staff participated in the Open Data Kit (ODK) training organized by the IFRC EAIOI office. ODK is a software for electronic data capture that increases the efficiency of data collection, transmission and processing. They also conducted one training workshop on accountability to beneficiaries (AtB). In addition volunteer data base System was introduced to identify the actual number of volunteers in SRCS disaggregated by gender, experience and qualifications across Sudan. It aimed to organize and distribute the opportunities for volunteers in capacity building in addition to unifying all the existing data base systems at the level of the branches in to one integrated system that connected all states and HQ on-line. The NS demonstrated the capacity to monitor and analyze trends in humanitarian indicators using the PMER.

2.3.6 Coordination / collaboration between IFRC, SRCS and different departments

NCHVP was a flagship project of SRCS which was well coordinated with other departments, given that it was dealing with core activities of the National Society such as Volunteer recruitment, training, and management and First Aid training. This made it mandatory for NCHVP to work closely with the other departments of SRCS such as Volunteer Management, First Aid and Disaster preparedness and response. There were regular meetings to share in planning, monitoring and evaluation. There was also collaboration in sharing resources such as training and educational materials. NCHVP also facilitated coordination among movement partners such as SRCS, IFRC, SRC and NRC as they were all involved in various aspects of it implementation. Regular meetings, already described above ensured teamwork and mutual support at all levels which has led to the outstanding achievements of the programme.

2.3.7 The level and type of support provided by SRSC HQ, IFRC and SRC.

All levels, the headquarters, the Branches and the Localities of SRCS had the required capacity to manage programme implementation . This was because they had been given intensive management training, which was sustained by regular supportive supervision. The programme coordinators had responsibility for programme implementation and they demonstrated capacity as evidenced by quarterly and annual reports. Branch and Coordination staff displayed impressive competence in the management and supervision of the NCHVP, while continuously improving their skills in new initiatives such as PMER. Frontline implementers of NCHVP were well trained volunteers. They were effective in increasing health service utilization through change in the knowledge and health seeking behaviour of the population.

The challenge mentioned at the Branch level was inadequate inputs especially the budget which the Branch Directors interviewed said always came late and was too little for the required activities, made worse by inflation that was very high. The delay in funds disbursement was reflected repeatedly in regular programme reports. A number of Branches had problems with communication and transport, leading to service delays sometimes for 3 to 6 months due to inadequate logistics. In their view equipment such as computers, tables, furniture were

inadequate and needed to be improved. According to respondents, documentation was undermined by resources, such as computers for capturing and storing information.

Management training continued and needed to be continued, particularly for volunteers. The IFRC and SRC provided technical and management support throughout, introducing new approaches, skills and techniques in programme management and accountability. This included support on capacity building of the SRCS staff, particularly in financial management, AtB, epidemiological surveillance to combat new and emerging diseases, as well as PMER, that was provided by the SRC to improve evidence based management NCHVP.

It is a priority for the SRCS to continue developing the network of local community based volunteers and equip them with basic skills in community based health care. A stronger volunteer capacity will enhance the community's resilience towards health risks, both on a daily basis and in emergencies. The programme improved preventive and promotive services in local communities and strengthened volunteer management system of the National Society. The health activities of the SRCS moved from project to systematic long-term programme approach.

NCHVP carried out annual meetings in different implementing states, to promote peer exchange and learning with the participation of all field officers, and accountants from all project states. Accountants participated to discuss linking the program activities to financial reporting and to connect the accounts and field activities. During the three years 2013 to 2015 SRCS monitored and reported on the activities of the NCHVP and PMER with support from the IFRC and SRC technical staff in country and region/zone and the Swedish Red Cross and Norwegian Technical advisors. The NCHVP staff and volunteers, senior staff at SRCS, SRC and IFRC joined these meetings. However, branches field officers and PMER HQ staff conducted monitoring visits to the health operational sites. In addition there were implementation visits to all states to follow up the activities.

NCHVP program plans and activities annual meeting for field officers were conducted in December of every year for reviewing the program progress and sharing of experience and best practices between field officers. Existing institutional policies and regulations were reviewed and refined to ensure they meet recognized standards of good practice. SRCS updated branch laws, policies and regulations. To strengthen volunteer effectiveness, the volunteer's manual was reviewed and edited and under the volunteering development, prints of 500 copies of volunteers' manual in Arabic version to be distributed to the branch offices was accomplished.

The volunteering development office managed to arrange for experience sharing exchange visits for volunteers by branches with participation of volunteers. The aim was to enhance experience sharing and learning among volunteers and to build their leadership skills. The major areas of experience exchange were volunteer database management, volunteer mobilization using social media, volunteers recruitment techniques and community mobilization and ownership. Volunteering development office conducted a two-day annual planning session in coordination with NCHVP since 56% of volunteers' focal persons are NCHVP officers as well. The Staff demonstrated capacity to monitor, analyse and use trends in humanitarian indicators in their operations.

Lessons and Recommendations

- Establishment and development of PMER, AtB tools and Volunteer Data base were positive moves to strengthening the management of the programmes, their implementation should be accelerated.
- In terms of M&E, improvement is needed to ensure completeness of reporting at unit level by assigning households to volunteers so that every household is covered and is reflected in reporting by the responsible volunteer. This would enable assessment of population coverage by preventive activities. There is need for refresher training for NCHVP field officers with the emphasis on community participatory approaches, evidence based dialogue as part of the PMER process.
- There was no mention of First Aid posts and Community action groups and leadership training although these exist in the plans, neither were they evident at Branches visited.
- Provide opportunities for the field officers to exchange experiences through attending external training and workshops, such as project management, leadership and advocacy skills, Nationally and regionally.

2.4 Impact, positive and negative changes resulting from the programme

C) To assess the impact, positive and negative changes (intended or unintended) resulting from the programme:

What was the stakeholders (beneficiaries and partners) viewpoint related to the performance and impact of the project?

Has there been changes in relation to the health knowledge, behaviour and attitude of the targeted beneficiaries ?

Has the project able to strengthen SRCS presence and image in the community? If so, how?

2.4.1 The views of the stakeholders (beneficiaries and partners)

From interviews and discussions with a variety of respondents Community capacity for health action has improved in normal times and in crises (care seeking, care provision, coverage by services). Environmental cleanliness improved and many respondents believed that mortality, and morbidity have reduced due to disease prevention, risk reduction and first aid efforts. In addition some negative cultural practices such as female genital mutilation (FGM) have been abandoned in some States as a result of the work of the NCHVP. There is increasing gender sensitivity in many states such as Sennar, Gedaref, and Northern state.

2.4.2 Changes in the health knowledge, behaviour and attitude of beneficiaries

Results from the June 2016 baseline and endline survey showed that the presence of SRCS volunteers was more frequent in NCHVP implementation areas than non programme areas. There was a difference of up to 66% between households within the project area and those without, with up to 89% households reporting having been visited by a SRCS volunteer in the past 12 months within project area compared to only 23% households outside of the project area, table 6. Furthermore, a high proportion of households (72%) reported that a family member had participated in SRCS CBHFA activities in the past 12 months within project area as compared to only 46% of households outside of the project area, a difference of 27%.

Table 6: Presence of SRCS volunteers

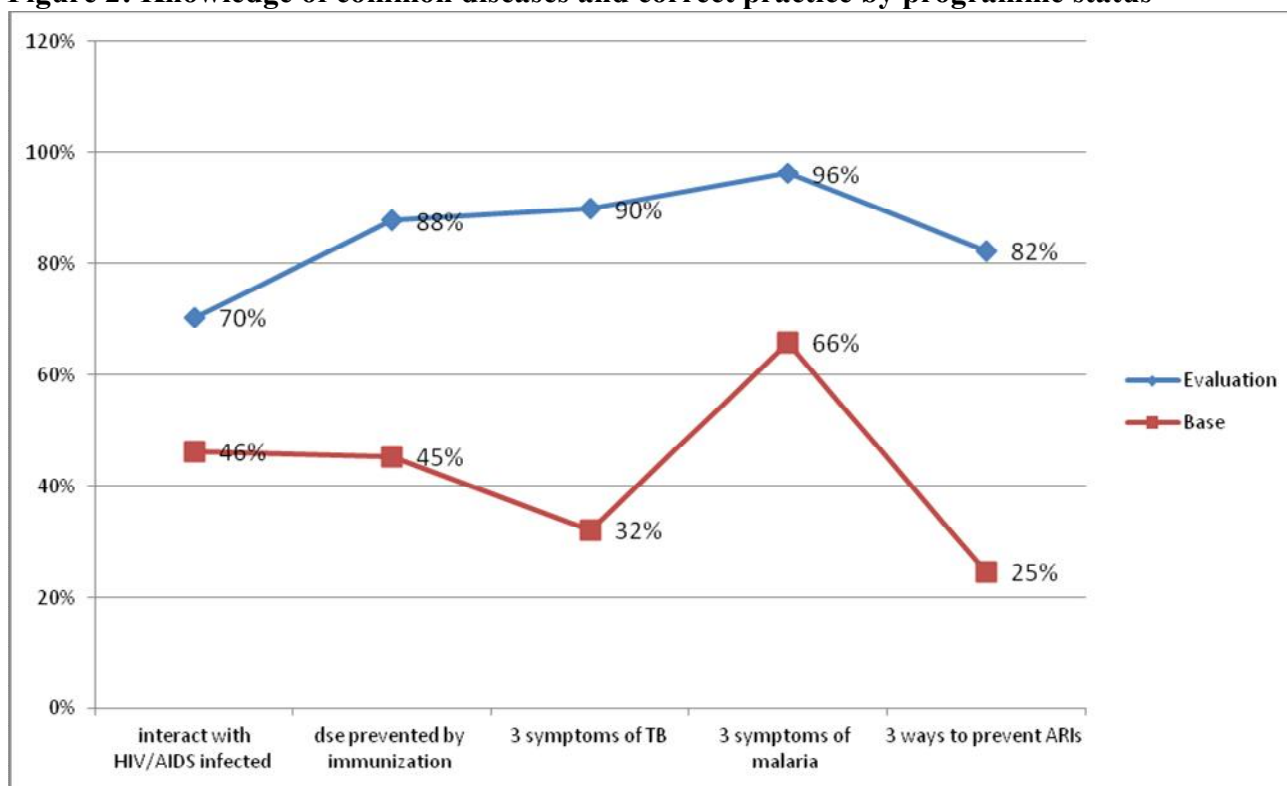
Branch	Households visited by SRCS volunteer			Households with member participated in SRCS CBHFA activities		
	Eval.	Base	Variance	Eval.	Base	Variance
El Geizira	91%	49%	42%	65%	42%	23%
North Kordofan	93%	24%	68%	78%	51%	27%
Northern	63%	21%	41%	78%	33%	44%
River Nile	93%	15%	78%	74%	46%	27%
Sennar	84%	6%	78%	79%	56%	22%
Overall	89%	23%	66%	72%	46%	27%

Knowledge about and behaviour regarding common diseases was more and better in NCHVP programme than non-programme areas (table 7 and figure 2).

Table 7: Health behaviour by programme status

	Evaluation	Base	Variance
Respondents who would interact with people infected by HIV/AIDS	70%	46%	24%
Households that can name at least 3 childhood diseases that can be prevented by immunization	88%	45%	42%
Households that can name at least 3 symptoms of tuberculosis (TB)	90%	32%	58%
Households that can name at least 3 symptoms of malaria	96%	66%	30%
Households that can name at least 3 ways to prevent acute respiratory illnesses (ARIs)	82%	25%	58%

Figure 2: Knowledge of common diseases and correct practice by programme status



The knowledge of childhood diseases that can be prevented by immunization was also higher in areas implementing NCHVP as compared with non implementing areas by as wide a margin as 39% for whooping cough and 32% for polio as shown on table 8. The level of community members who would not have response for the question on knowledge on disease also reduced drastically in implementing areas. This implies that the NCHVP has had an impact on increasing the knowledge level among the community on childhood diseases.

Table 8: Knowledge of childhood disease that can be prevented by immunisation

Percentage of respondents who could name the childhood disease that can be prevented by immunisation			
Disease	baseline	endline	Difference
Measles	70%	92%	22%
Polio	56%	88%	32%
Tuberculosis	47%	74%	27%
Tetanus	18%	20%	2%
Whooping cough/Pertussis & Diphtheria	42%	81%	39%
Don't know	15%	6%	-9%

Regarding disease prevention, the project area recorded higher proportion of respondents with "Good level of knowledge" for hand washing (individuals that could identify at least 3 correct critical times for hand washing to prevent diarrheal disease) at 94% compared with 57% for non project area households. However, to prevent malaria, mosquito net ownership and use was slightly higher at 59% against 56% between non project area households and project area households respectively (table 9).

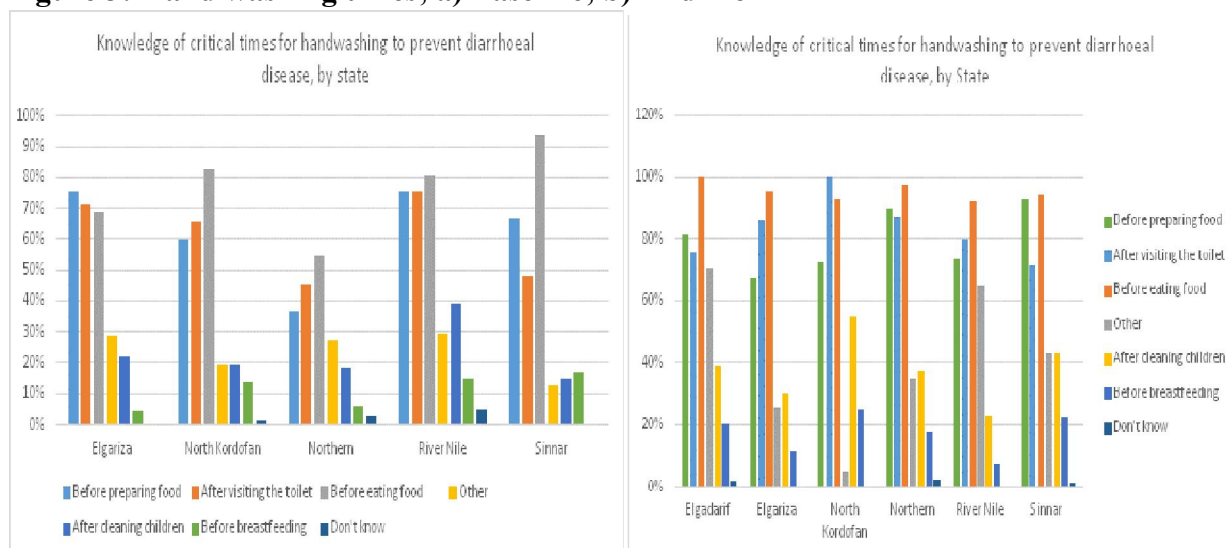
Table 9: WASH practice by programme status

	Evaluation	Base
<i>Latrine use:</i>		
Family members defecate in a latrine	90%	81%
Family members defecate in the open or declined to respond	10%	19%
<i>Safety of drinking water:</i>		
Households who reported that they or a family member does something to treat drinking water	66%	45%
Reason for not treating drinking water - It's clean already	77%	36%
Reason for not treating drinking water - Don't know how	8%	21%
Reason for not treating drinking water - Don't have the means	11%	24%
Reason for not treating drinking water - Other	4%	18%

Project areas recorded higher proportion (90%) of households whose members used latrines for defecation as compared to 81% for non project areas. Similarly, more households (66%) in project areas reported doing something to treat drinking water, as shown in table 9.

While both sites most commonly identify critical times for hand washing to prevent diarrheal disease as before preparing food, before eating food and after visiting the toilet, results show higher proportions of households who cited these moments in NCHVP implementing sites compared with non implementing sites as shown on figure 3. In general, after cleaning children and before breastfeeding were the two critical times for hand washing least identified by respondents, however they were more frequently reported for at implementing sites compared to non implementing sites.

Figure 3: Hand washing times; a) Baseline; b) Endline



Results show that NCHVP had positive effect on increasing level of awareness for childhood diseases that can be prevented by immunization and knowledge on symptoms of diseases such TB, malaria, acute respiratory illnesses (ARIs). The levels of awareness and knowledge was higher in areas where the project had been implemented compared with non project areas with as high variation as 58% for TB and ARIs, and the lower variance for respondents who would interact with people infected with HIV/AIDS between the two different area types at 24%. Similarly, NCHVP showed effect on improving health seeking behaviour on latrine use and water safety measures in households. A high proportion of households in both areas used ITNs.

Their capacities were built in malaria, first aid, health in emergencies, vaccination, and many have been trained as trainers. Volunteers carried out CBHFA activities in the 11 states, addressing basic health care needs of the most vulnerable communities, empowering them to take care of their own health, in coping with disasters, achieving the targeted indicators, e.g. increased knowledge and practice on first aid; health seeking behaviour, and health risk reduction. Volunteers and other beneficiaries increased their capacity for First aid, Home nursing, sanitation, malaria control, these became local habits. Some communities have abandoned FGM. For instance, Magasir Island in Northern State was one of the targeted areas with FGM/C prevention intervention. SRCS volunteers visited the Island and explained the negative impact FGM/C had on women's lives using different ways for conveying the health messages, conducting the health awareness sessions through public sessions, and focus group discussions. They did home visits, talking to different family members including wives, grandmothers, and youth. Volunteers also talked to the religious and community leaders. Following the concerted effort, communities of the island become more aware of the negative consequences of the FGM practices for the their young girls. They made up their minds to abandon the habit of performing FGM/C on young girls, through a Community declaration.

Other practices that were internalized by communities as a result of NCHVP included CBHC activities, garbage collection, malaria prevention, reinforced by the fact that volunteers originated from the communities in which they are active, they work in own communities.

The difference in knowledge and behaviour was demonstrated by the difference in households reporting having been visited and their members having participated in the NCHVP activities. Areas where the program had been, recorded higher proportions of households that were visited as well as household members participating in program activities as compared to non program implementing areas. In the program implementing areas potential modifiers were the increased awareness activities by volunteers and community ownership that improves acceptability for behaviour changes, as shown by empirical studies. For instance, the renewed interest in community participation in health care (WHO 2004) is attributable partly to the perceived failure of conventional health education and primary health care to deliver substantial health benefits (Bryce, et al 2003). The NCHVP program emphasized gender sensitivity and accountability to beneficiaries. It has been shown that in many countries, local-health committees have had little accountability to their communities, and the level of representation of beneficiaries such as women has been low (Manandhar M 1996; Sepehri and Pettigrew 1996). Beneficiaries themselves can be passive in the face of service bureaucracies (Rifkin S, 1986, 1988&90) because of an absence of local ownership and different perceptions of priorities.

2.4.3 Strengthening of SRCS presence and image in the community

NCHVP strengthened SRCS presence at different levels and in different places. The Government officials, literally in all states visited, described NCHVP as a great program, that had helped them and more so at the level of the Localities in their efforts to improve health status. EPI programme drew a lot of support in all campaigns, because volunteers were spread across the states. They were proud of the programme and SRCS. Volunteers were ever present in disasters of all kinds, in schools, and in communities, engaging with MOH, MOE, HAC, MOA (El Gedaref), and they were responsive when called upon by MOH and Local Authorities.

First aid training helped the community manage scorpion bites in Northern state. They also could manage nose bleeding and burns, then refer, if necessary, after giving first aid. They were also confident that they could manage highway road traffic accidents (RTAs) with first aid and could safely transport the injured. They were involved together with the MOE in planning School health activities. Most teachers were trained in first aid and were supplied with First Aid kits.

In the case old wells that often break up and flood the communities, SRCS volunteers were usually the first to arrive. They could also rehabilitate the wells before they reached the stage of flooding. Communities had also acquired knowledge on disaster preparedness, prevention, response, and communicable diseases that were common in such situations. NCHVP worked with women groups and were therefore engaged in their development. Women respondents from Northern state expressed the support of the programme beyond health including teaching them on cooking, as well as enabling them to access modern ovens.

It was noted that SRCS governing structures cater for many programmes beyond the health sector, hence the strengthening of the presence and image of SRCS. The driving force continued to be to complement other structures of Government. Thus, SRCS has positioned itself as a major provider of community health care through the PHC model based on the volunteers as the

backbone. NCHVP encouraged youth in the schools and peer education programs were organized and implemented in all branches by ensuring knowledge and skills development among teachers and pupils. NCHVP enabled branding of materials such as T-shirts. It has strengthened SRCS presence at different levels and in different places. The auxiliary partnership role of the national society was strengthened by reaching out to a large number of Members of Parliament across the country to disseminate their auxiliary role.

Governance structures were established, volunteers leaders had trained in RCRC Principles, Values, Code of Conduct, and IHL, as well as in volunteer database management. Volunteers' leaders shared knowledge and experience across localities. SRCS volunteers played a major role in responding to the needs of affected communities in targeted areas such as the Red Sea, White Nile, River Nile and El Gedaref by evacuating affected families, giving health education and first aid to the needy, and giving as well as helping in the mobiles clinics run by the SRCS in collaboration with MOH. In addition to the floods, SRCS in White Nile State was partially involved in providing some services in Refugees camps. In order to prevent water borne diseases, trained SRCS volunteers distributed aqua tabs to the vulnerable population and conducted health information dissemination session and awareness campaign. Volunteers participated in vaccination campaigns. The role included community mobilization, organization and giving vaccines.

Based on information from respondents from the government and from beneficiaries, NCHVP has done communities great service. Volunteers stood out as the best in response to and readiness for disaster, whenever there was one. Due to their being ever present and in fact being always the first whenever disasters happened, they made all partners to notice their position and all partners praised them for their effectiveness. MOH uses them without any further trainings for activities in the disaster areas but also in WASH and community health activities, including even in hospitals, their training is highly trusted. MOH have greater trust in the SRCS volunteer. MOH is in fact using them without any further training for activities in the disaster areas but also in WASH and community health activities, including even in hospitals. The CBHFA training they had undergone was great training.

Lessons, Recommendations:

- Promote the use of documentation and dissemination of community stories and testimonies of change. These are good particularly when learnt by others to replicate.
- Sharing success stories that reflect innovative initiatives should be acknowledged and replicated in other SRCS branches e.g. volunteer's graduation projects and schools competitions on best hygiene practice and knowledge in Northern state.
- That there is potential in NCHVP to accelerate improvement in uptake of health seeking behaviour among communities. Advocate for the scaling up of NCHVP countrywide.

2.5 Coordination of Programme with Government authorities, and other stakeholders

D) To assess the Coordination of Programme support intervention with Government authorities, and other external stakeholders: *How effective was the coordination with external actors and Government authorities?*

According to government respondents, SRSC through the NCHVP worked with government better than any other partners. They maintained strong collaboration with authorities and enjoyed good partnership with them. Volunteers participated in all activities by the Government to which they were invited at the community, village and locality levels. Indeed, they made sure that at each locality, a volunteer was a member on any committee at locality level. In addition there were monthly meetings from which they presented reports and received feedback to help plan activities at each level. The Government and local authorities had contacts of all volunteers at their ministry and unit levels and SRCS planning data was provided to the government partners. *"We have just been in MOH meetings discussing issues of water contamination and they have been seriously mentioning SRCS volunteers"* said a field officer. Vaccinations campaigns provided in coordination with state MOH and the participation of the community numbers, ensured achievement of high level of coverage.

According to government officials and community leaders interviewed SRCS in partnership with communities through NCHVP, with the support from communities leaders and local authorities, excelled in providing quality services. The work was recognized by the MoH, NGOs, INGOs, CBOs, and HAC. NCHVP has maximized efficiency through effective coordination, throughout the project management process, being fully in line with SRCS, MOH and MOE health strategic plans. In addition SRCS coordinated its humanitarian services with other actors within and beyond the Movement, with IFRC playing facilitator role. For example vaccination campaigns were held in coordination with MOH.

Memoranda of understanding (MOUs) were signed with the MOH on TB and Malaria. Engagement in such agreements with MOH for joint action enabled NCHVP volunteers to support the MOH in TB case finding and defaulter tracing (El Geizira, and North Kordofan), in Malaria integrated control, LLTN and IRS (Sennar, El Geizira) and in management of malnutrition, in which volunteers used mid upper arm circumference (MUAC) to identify malnourished children (North Kordofan and El Gedaref) and refer them for care. There was also engagement in cleaning and vaccination campaigns to improve health status in all States. NCHVP was linked to local health facilities.

To support delivery of health services to address on-going community health concerns Community health committees were established in each programme state with a minimum of 60% participation of women. The program distributed mosquito nets to households and gave instruction on usage in collaboration with targeted communities. Volunteers were always included in Community health committees (CHCs) that were involved in the management of health facilities, ensuring acceptable performance of health facilities, and supporting health personnel to ensure their retention.



Madany Locality office, El Geizira, on 16th October 2016

Additionally there was partnership with the Ministry of Education (MOE) as well as other relevant entities, filling identified gaps, with materials and other resources provided. Through NCHVP, SRCS established units in schools and trained teachers and pupils. Capacity building in schools targeted teachers and pupils with first aid, personal hygiene, watsan, and maintenance. In schools, NCHVP assisted with maintenance, checked on cleanliness, latrines, provided first aid training and kits to teachers and pupils after training. There was regular engagement with Humanitarian Assistance Commission in disaster awareness, and preparedness including timely relocation of affected populations.

Emergency health activities were implemented in cooperation with partners. Coordination meetings were conducted with health partners (Ministry of health, CBOs, UNHCR, Unicef and NGOs at States and at the headquarters levels. Awareness sessions on HIV prevention and stigma, focusing on schools, youth clubs and sports were undertaken in addition to programs in the World AIDS Day using TV, Radio, Newspaper, singing and mobile theatre. Many activities were in partnership with organizations working in similar activities in the same areas.

There were coordination meetings, M and E meetings, with MOH nutrition department. The MOH nutrition department used volunteers to carry out activities, the same with vaccinations department. There was coordination in planning from Branch office to localities to units in

implementation of activities. Head of Nutrition and Director of Emergencies had great relationship with NCHVP since it harmonized with MOH priorities, enabling excellent participation of SRCS in National campaigns at all levels, and in emergencies. SRCS is major stakeholder, involved in planning implementation M and E in all relevant MOH programmes.

From the information we obtained from many stakeholders representing government ministries and NGOs we can conclude that coordination was excellent at all levels. The MOH gave the community management of acute malnutrition as an example of an initiative accomplished in collaboration with NCHVP. Volunteers identified cases in the community using measurement of mid upper arm circumference and referred them to treatment centres.

Representatives of government, community leaders and senior SRCS staff expressed the view that NCHVP is critical and should be continued by involving more local donors and fund raising activities. Main need is technical support not material or financial according some respondents. Others suggested that SRCS should have an investment scheme. Volunteers and beneficiaries vowed to bring the programme to completion. *"We will invest all we can until we lift everyone out of vulnerability"* Beneficiaries from the Northern State.

The NCHVP program kept a good coordination with many partners including the MOH, Ministry of education at both levels (HQ and Branches). There were coordination meetings with MOH - TB department regarding working with them on the drop out of tuberculosis patients and how to convince them to continue the treatment and with education department regarding facilitating SRCS school activities. As a result Cooperation agreements were signed: Agreement with MOH TB program in several states where the volunteers were trained by MOH to carry out awareness session in community, as well as monitoring tuberculosis patients and how to convince them to continue the treatment. Co-operation with Malaria control department in MoH and SRCS where the department agreed to train SRCS volunteers to provide part of vector control tools and IEC material to the volunteers.

Another agreement facilitated establishment of SRCS school units for training and health promotion in corporation with Ministry of Education. Governmental health services and their staff were important collaborators in training, as advisors and referral partners, in epidemics and in social mobilization in improving immunization coverage.

Lessons and recommendation

- It was noted that coordination and collaboration of NCHVP with government departments was strongest at Locality level, where all government departments recognize the significant role of volunteers to their work in the community. The coordination and partnership gets blurred and weak as it progresses towards national level. There is need for SRCS to articulate in their plans what engagement actions are planned for each level, and monitor execution of actions along with other planned activities.

2.6 Beneficiaries participation and sensitivity gender and diversity

Evaluation question E) To assess how beneficiaries participated in the programme planning, monitoring and implementation, considering gender and diversity:

How were the beneficiaries involved in the different phases of the programme?

Were beneficiaries able to provide feedback to SRCS on the programme?

How was information given to beneficiaries?

Has the programme considered gender and diversity in relation to design and planning of the program, the implementation of activities and the monitoring and evaluation of the programme?

Are there Gender sensitivity indicators and sex disaggregated data?

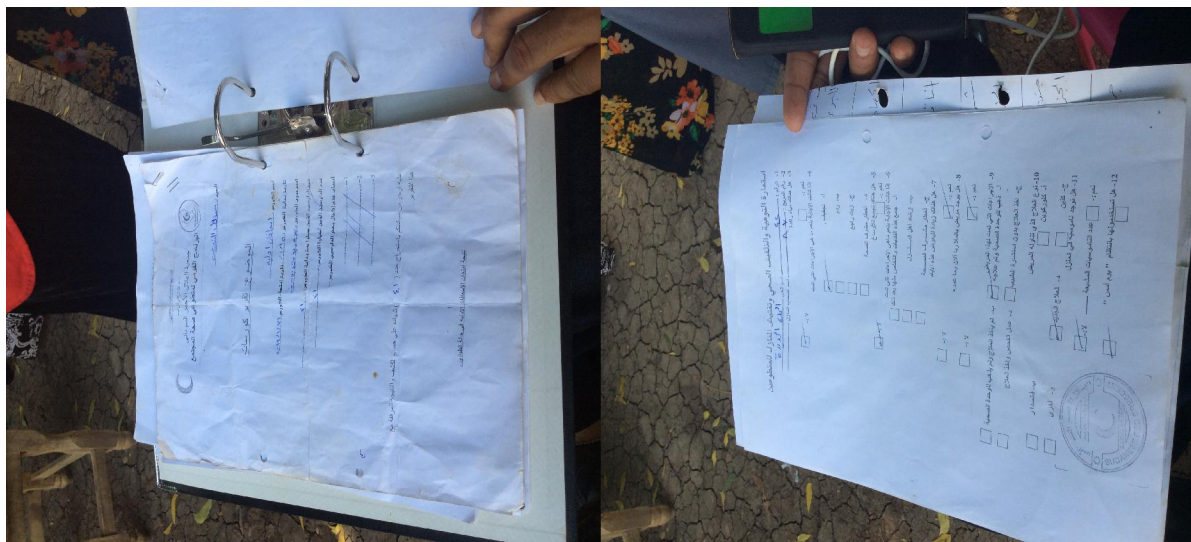
2.6.1 Involvement of beneficiaries involved in the different phases of the programme

NCHVP involves community participation in governance, leadership and management from the community level anchored to health facilities and schools, through the sub-branch to branch and to Headquarters. This is an innovative approach to build social accountability mechanisms at the different levels. Communities were consulted on annual plans. Plans had to belong to communities, and had to be locally approved by the community and by the ministries at the local levels. Formal comments had to be received from various gender based and diverse stakeholders such as women groups, youth groups, CHCs and local authorities.

Communities had to suggest health actions that get included in the annual plans for example in Northern state and North Kordofan School teachers were engaged in planning school health activities. Women groups also brought suggestions that were included into plans based on the planning framework and cycle.

On participation, Branches indicated that communities views were included for planning through representation committees (village health committees) and ad hoc feedback from community members to the volunteers.

Volunteers provided another link for participation. They were represented in CHCs that were responsible for the running of the Health Facility on behalf of the community.



Copies of volunteer reports, Madany Locality, Elhila Elgadida village , 15th October, 2016

Participatory approaches were deployed in identifying target communities and specific actions. Desk reviews were used to map out trends and gaps in humanitarian needs of target communities in addition to community group discussions, key informant interviews with key stakeholders amongst other appropriate participatory approaches. The trend of community and local authority support was promising in terms of participation through investment of financial and material resources. SRCS maintained partnership at the local community and authority level. NCHVP maintained close cooperation with local authorities and line ministries. Often, local communities were able to support community health services, even when funds for activities delayed. Some activities were supported by the local authorities and community leaders.

2.6.2 Beneficiaries feedback to SRCS on the program

The most common feedback avenues and channels between the programme and beneficiaries was direct face to face communication in ad hoc meetings, telephone conversations. These were the most commonly mentioned means of communication. However, both the volunteers and community members noted that they had enough information about NCHVP through regular updates, trainings and briefs in meetings.

Regarding feedback and complaints, volunteers explained that they undertook collection and reporting on complaints from community level from time to time. NCHVP was in the process of strengthening mechanisms of capturing complaints from volunteers and beneficiaries through the accountability to beneficiary framework. A lot is being done to address complaints raised, such as establishment of a unit for volunteers development to spearhead innovative ways of supporting volunteers and the recent Sudanese Red Crescent Society Volunteers base line survey 2015- 2016.

Beneficiaries were able to provide feedback but it was ad hoc usually directly to the SRCS officers through the chain of command, or through phones but there was no mention by

beneficiary respondents in FGDs, of regular mechanisms such as complaints boxes or regular meetings for the purposes of feedback from beneficiaries. Accountability to Beneficiaries (AtB) with its tools (complaints, telephone, meetings, satisfaction) had been initiated in some branches such as Sennar and Northern state since 2015 to ensure adequate evidence based feedback from beneficiaries, but there was no evidence that it had become a routine mechanism to influence feedback. Mention was made of AtB Certificates from schools, and from community leaders, approving satisfaction with various services but these were few. Positive feedback on garbage collection improvement was received from a few areas but use of complaint box was even more rare. *"Feed back mechanism is mainly through the structure and hierarchy from unit to branch, we can go direct to desk officer, or can phone, through report. Both male and female can complain"* expressed at a focus group discussion with beneficiaries

Respondents believed that AtB would strengthen the ownership principle among the local community. Satisfaction and feedback questionnaires had been designed, printed, distributed but their analysis and decisions made based on evidence was yet to become a common feature in the programme. Feedback tended to continue to be through community meetings and reports. These traditional approaches may not ensure equity in voice, ensuring that all beneficiaries have opportunity to be heard.

Governance structures, committees and meetings were designed to enhance beneficiary voice. In addition it was found necessary to train community leaders and community organizations on how to hold meetings that create space for the vulnerable to be heard. Beneficiaries and communities appreciated efforts being made. They also gave appreciation, to volunteers and allowed them in their houses, and often gave them a letter of thank you.

2.6.3 Gender and diversity in relation to design and planning of the programm

Inclusivity in terms of age and sex was considered important by beneficiary respondents for ownership and sustainability. Special attention was given in supporting gender mainstreaming in beneficiary identification for various initiatives ensuring equitable participation, as well as gender and diversity sensitivity in relation to design and planning for volunteers and beneficiaries. The programme has been sensitive to gender more consciously than it is with other forms of diversity such as age and disability, in its design and planning, implementation of activities and the monitoring and evaluation. At the level of volunteers, women are more numerous. A lot of effort has gone into making women participation possible and acceptable. Sennar Branch, for example tried to recruit volunteers from schools to make opportunities for both age and gender equitable. There was effort through the mosques to make women participation in volunteer programmes more acceptable. Respondents from Northern State confirmed sensitivity to gender as they insisted that in their setting women get heard more.

At organizational level, accountability to community was embedded in the vision for NCHVP, staff were recruited through community advertisement, local schools and mosques. They were briefed on issues of diversity and made to sign a code of conduct requiring maximum sensitivity to gender and diversity. .

3 CONCLUSION

In conclusion NCHVP is uniquely relevant to SRCS, its volunteers and beneficiaries and has provided a niche for the NS to be a key community health care provider in Sudan. The programme has been well managed and has made good progress towards its goal and objectives, with a lasting impact on access to services as well as health knowledge and seeking behaviour. It has strengthened the image and acceptance of the National Society at all levels focusing on its core mandate of first aid and disaster preparedness and response through well prepared and well managed volunteers. By strengthening volunteers capacity and the volunteers management system it has strengthened the National Society as a whole.

The NCHVP activities of SRCS moved from project approach to long-term systematic program approach which is ready for scaling up nationwide. The introduction of new approaches to improve its management, such as the planning, monitoring, evaluation and reporting, accountability to beneficiaries, and volunteers data base are critical to the scaling up phase of the programme. As they further improve the systems and structure that were found to be well functioning in the delivery of NCHVP interventions that are well integrated within the strategic programmes of SRCS including disaster management, while being well coordinated with Government Ministries of Health and of Education.

Key recommendations

1. Overall, the NCHVP program is extremely valuable and should be supported to expand to all 18 states in Sudan, given its relevance, quality and efficiency.
2. The development of PMER, AtB and Volunteer Data base and management are all urgent for the Society and should be carefully implemented in terms of consistency and intensity to ensure uptake at all levels. Adequate, timely technical support and mentorship will be required for some time.
3. Quantitative assessment of the outcomes of NCHVP can be improved by undertaking actual baseline and end-line household surveys. Specific indicators, beyond knowledge, should include immunization coverage, morbidity (e.g. diarrhoea) rates based on two week recall and nutritional status among children under five based on mid upper arm circumference or weight for age.
4. Since coordination and collaboration appear to be essential to the success of the programme, SRCS should consider establishing coordinating structures at national and branch levels that would plan, implement, monitor and evaluate, applying the PMER framework to joint initiatives to drive continuous improvement in joint identified health problems (malnutrition, maternal health, tuberculosis, vaccine preventable diseases and community resilience).

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ANNEXES

Annex 1: Terms of Reference (TOR) for National Community Health Volunteer Program in Sudan

1. Summary

1.1. Purpose: The main purpose of the evaluation is to generate substantive evidence-based knowledge by identifying good practices and lessons learned from intended and unintended impact/effects of the program.

1.2. Audience: The Sudanese Red Crescent Society (SRSC), the IFRC Sudan Country office and partners

1.3. Commissioners: This evaluation is being commissioned by IFRC in compliance with its Evaluation Policy for final evaluations.

1.4. Reports to: Asjad ALI (IFRC) and Nagat Malik (SRCS)

1.5. Duration: The consultancy will take place over a period of approximately 32 days

1.6. Timeframe: The evaluation will tentatively take place during May 2016

1.7. Methodology summary: The evaluation will include gathering qualitative data in various field locations and analysing the quantitative data from a household survey.

1.8. Location: SRSC and IFRC office in Khartoum, as well as selected localities in North Kordofan, Sennar, Gezira, Northern State, River Nile and Gedaref states.

2. Background

During the last decade new knowledge about illnesses and disease patterns, new technology, previous unknown diseases, new life styles and intensive travelling have changed our understanding of health and how it affects people. It has become evident that antibiotics will not keep people healthy, insecticides will not eradicate malaria and pesticides might have a negative impact on human beings, animals and vegetation. Politicians and professional medical staff have realised that the solutions to health problems are not to be found in more specialised hospitals, bigger clinics or expensive drugs. The interest has therefore grown towards health promotion and prevention and to raise the capacity of local communities to deal with their own health problems.

SRCS, IFRC and movement partners represented in Sudan together carried out a comprehensive assessment (PAN Sudan Health Assessment 2005) in order to support the National Society, in identifying its role in area of health and water-sanitation. The assessment team recommended the strengthening of the existing community based first aid (CBFA) approach by building the capacities of the volunteers and shift the focus from facility based primary health to community based primary care in the communities.

The assessment team observed that SRCS volunteers are trustworthy, working in communities, reliable and can be called upon quickly. They are seen as neutral in all regions visited. As expected they apply the movement principles. They are strongly recognized by MOH and other organizations involved in health care service delivery.

The team recommended SRCS to implement with the volunteers the following interventions

- Temporary assistance to returnees and Internally displaced persons (IDP's) in facility based or community based programs
- Emergency health services

- Build SRCS capacity and profile in community health and public health in emergencies through volunteers. Special focus should be on primary health care, public health in emergencies preparedness and scaling up HIV / AIDS interventions.

Besides lack of access to health services for the main part of the population, the government facilities are often understaffed, not adequately resourced and unable to provide comprehensive services. Interest has therefore grown to develop a network of volunteers in the local communities and equip them with basic skills in first aid, prevention of common health risks and health promotion.

Program Overview: The program focuses on addressing basic health care needs for the targeted communities and empowering people to take care of their own health through The NCHVP started in 2007 and is currently implemented in 11 state (4 funded by the Norwegian RC and 7 by the Swedish RC).

Program Objective: To build the community resilience in addressing basic health care needs of the most vulnerable communities and empower people to take care of their own health, in coping with disasters through community based health and care initiatives and enhanced capacity of the Sudanese RC to address humanitarian needs.

Program Core areas of intervention:

1. CBHFA (Community Based Health First Aid)
2. Communicable Disease Prevention (Malaria, TP, Vaccination)
3. Public Health in Emergencies
4. HIV and AIDS Prevention and Reduction of Stigma
5. Water & Sanitation using PHAST to encourage and empower communities to identify and solve health problems connected with water born disease and sanitation.

3. Evaluation Purpose & Scope

The main purpose of the evaluation is to generate substantive evidence-based knowledge by identifying good practices and lessons learned from intended and unintended impact/effects of the program. This evaluation is intended to unveil the nature of the change that has taken place in the lives of communities, SRCS volunteers and on sustainable well-being of the local communities.

The results from this exercise will be highly useful to enable any adjustment/redirection that may be necessary for future SRCS-NCHVP interventions.

The evaluation will determine the relevance, effectiveness, impact and beneficiary participation of the NCHVP.

The evaluation is concerned with the NCHVP, implemented in 11 states. The evaluation will cover the 3 year period of 2013 - 2015 for 6 states (4 state Swedish Red Cross and 2 state Norwegian Red Cross) and the target group will be the SRCS volunteers and staff in the localities and branches as well as SRSC HQ, members of the targeted communities, community leaders and stakeholders in the area.

Due to limitations in terms of budget, security and accessibility the following 6 states have been selected: North Kordofan, Sennar, Geizira, Northern State, River Nile, Gedaref.

4. Evaluation Criteria – Objectives - Questions

A. To assess relevance of program response from the point of view of the volunteers and targeted community members.

- To which extent has the programme built on existing resources and capacities of communities?
- Has the program been consistent with the needs and priorities of the intended beneficiaries?

B. To assess the effectiveness of the implementation process of the program's support and to see if the program achieved planned outcomes and outputs.

- Have the activities been undertaken in a timely manner? Were objectives achieved on time?
- Were assessments of needs and capacities of the targeted beneficiaries carried out? : what was missing; what can we do differently next time?
- Were the supervision and management mechanisms on all levels (branch, HQ, and IFRC) sufficient in relation to the project needs and expectations?
- Have lessons and recommendation from previous evaluations and reviews been considered and used?
- What monitoring tools were in place to feedback into implementation? Were there any gaps for further improvement?
- How effective was the coordination/collaboration between IFRC and SRSC and between SRSC's different departments?
- What was the level and type of support provided by SRSC HQ and IFRC to the branches implementing the activities? Was the support appropriate considering the branches' capacities?

C. To assess the impact, positive and negative changes (intended or unintended) resulting from the programme.

- What is the stakeholders' (beneficiaries, partners) viewpoint related to the performance and impact of the project?
- Has there been changes in relation to the health knowledge, behaviour and attitudes of the targeted beneficiaries?
- Has the project been able to strengthen SRSC presence and image in the community, if so how?

D. To assess the coordination of program support intervention with the government authorities and other stakeholders.

- How effective has the coordination with external actors and government authorities been?

E. To assess how beneficiaries have participated in the programme planning, monitoring and implementation, considering gender and diversity.

- How were beneficiaries involved in the different phases of the program?
- Were beneficiaries able to provide feedback to SRSC on the program?
- How was information given to beneficiaries?

- Has the programme considered gender and diversity in relation to design and planning of the program, the implementation of activities and the monitoring and evaluation of the programme?
- Are there gender sensitive indicators and sex disaggregated data?

5. Evaluation Methodology

The evaluation will include gathering qualitative data and analysing the quantitative data from a household survey. The methodology should at least include the following elements:

1. Document review of program documents (including MSC)
2. Review of secondary data, including from the household survey
3. Beneficiary interviews and focus group discussions
4. Interviews with key stakeholders
5. Focus group discussions with volunteers involved in the program

SRSC and IFRC are committed to Accountability to Beneficiaries (AtB) and follow the AtB minimum standards:

Monitoring, Evaluating and Learning: We will ask beneficiaries about their opinions and we will use this information to measure progress and inform programmes.

To meet the minimum accountability to beneficiaries standards in the evaluation phase, programme managers must ensure that:

- Evaluation reports include a section on accountability to beneficiaries
- Beneficiaries are involved in evaluations to ensure the community perspective is included.
- The findings of evaluations are shared back with communities.
- Learning from programmes is documented and disseminated.

As part of the deliverables of the assignment the consultant will propose a methodology for the evaluation, based on the above.

6. Deliverables (or Outputs)

The evaluator/evaluation team is responsible to submit the following deliverables:

1. **An inception report**, including the proposed design and methodology. The inception report should outline detailed scope, evaluation questions; methodology; sampling, field visit timing, data collection methods, timeline for activities and submission of deliverables. The inception report should also include initial data and findings based on the document review. This report will be used as an initial point of agreement and understanding between the EMT and the evaluator/evaluation team. A draft will be shared in advance for comments, and approved by the EMT.
2. **Draft Final evaluation report in English** to be submitted after completion of the data collection field visits.
3. **Final Evaluation Report in English** to be submitted after receiving consolidated comments and feedback from EMT and key partners.
4. **A power point presentation in English** summarizing the quantitative and qualitative findings of the evaluation using text, charts and diagrams.

The Evaluation report should systematically answer the key evaluation questions posed. It should fairly and clearly represent the views of the different actors/stakeholders. It should clearly give the conclusions and recommends in a way that is substantiated by evidence.

7. Proposed Timeline (or Schedule)

The evaluation will tentatively start at the beginning of May 2016.

8. Evaluation Quality & Ethical Standards

*The evaluators should take all reasonable steps to ensure that the evaluation is designed and conducted to respect and protect the rights and welfare of people and the communities of which they are members, and to ensure that the evaluation is technically accurate, reliable, and legitimate, conducted in a transparent and impartial manner, and contributes to organizational learning and accountability. Therefore, the evaluation team should adhere to the evaluation standards and specific, applicable process outlined in the **IFRC Framework for Evaluation**.*

*The **IFRC Evaluation Standards** are:*

- 1. **Utility:** Evaluations must be useful and used.*
- 2. **Feasibility:** Evaluations must be realistic, diplomatic, and managed in a sensible, cost effective manner.*
- 3. **Ethics & Legality:** Evaluations must be conducted in an ethical and legal manner, with particular regard for the welfare of those involved in and affected by the evaluation.*
- 4. **Impartiality & Independence;** Evaluations should be impartial, providing a comprehensive and unbiased assessment that takes into account the views of all stakeholders.*
- 5. **Transparency:** Evaluation activities should reflect an attitude of openness and transparency.*
- 6. **Accuracy:** Evaluations should be technical accurate, providing sufficient information about the data collection, analysis, and interpretation methods so that its worth or merit can be determined.*
- 7. **Participation:** Stakeholders should be consulted and meaningfully involved in the evaluation process when feasible and appropriate.*
- 8. **Collaboration:** Collaboration between key operating partners in the evaluation process improves the legitimacy and utility of the evaluation.*

*It is also expected that the evaluation will respect the seven **Fundamental Principles of the Red Cross and Red Crescent**: 1) humanity, 2) impartiality, 3) neutrality, 4) independence, 5) voluntary service, 6) unity, and 7) universality. Further information can be obtained about these principles at:*

www.ifrc.org/what/values/principles/index.asp”

Annex 2: Program of work

Proposed schedule for evaluators of the NCHVP 8 October until 30 October 2016			
Date	Activity	Time	Comments
8 Oct Sat	Travel from Nairobi to Khartoum	1 day	Ethiopian Airline at 5.00 A.M from Nairobi arrive in Khartoum 11.35 A.M,
9 Oct Sun	Briefing with SRSC, IFRC	1 day	SG brief + Imad plus IFRC HoD
10-11 Oct	Development of inception report, desk review of secondary data/information, development of qualitative data collection instruments	2 days	
	Travel for 4 states Charles Wafula and Osama Mustafa Suliman		River Nile,
12 Oct Wed	Travel to the field River Nile, qualitative data collection, meeting with key partners in the field.	1 day	Osama informs all the branches
13 Oct Thu	River Nile	1 day	
14 Oct Fri	Travelling from River Nile to Al Gezeira	1 day	
15 Oct Sat	Al Geizera	1 day	
16 Oct Sun	Al Geizera	1 day	Evening travel to Gedaref (3 hrs)
17 Oct Mon	Gedaref	1 day	
18 Oct Tue	Gedaref	1 day	Travel to Sennar 5 hrs
19 Oct Wed	Sennar	1 day	
20 Oct Thu	Sennar	1 day	
21 Oct Fri	Sennar plus travel back Khartoum	1 day	Travel back to Khartoum (5 hrs)
22 Oct Sat	Preparation for briefing in Khartoum	1 day	
23 Oct Sun	Briefing	1 day	Departure for Nairobi Ethiopian Airlines flight 18.45 P.M from Khartoum arrive Nairobi 1.20 A.M Return to Nairobi
Travel for Dan Kaseje consultant by flight to North Kordofan and Northern State			
10 oct	Arrival of Dan Kaseje		

11 -12Oct	Development of inception report, desk review of secondary data/information, development of qualitative data collection instruments	2 day	
13 Oct Wed	Travel to Northern State	1 day	Team member Ali Hussein alt. Nagat Malik (PMER) accompany the consultant
14 Oct Thu	Northern state	1 day	
15 Oct Fri	Northern state	1 day	
16 Oct Sat	Northern state	1 day	
17 Oct Sun	Travel to Khartoum	1 day	
17 Oct Mon	Travel to North Kordofan	1 day	
19 Oct Tue	North Kordofan	1 day	
19Oct Wed	North Kordofan	1 day	
20 Oct Thu	Travel back to Khartoum	1 day	
21-22 Oct Fri-Sat	Khartoum	2 days	Prepare for briefing
23 Oct Sun	Briefing in HQ- workshop	1 day	Ethiopian Airlines flight 18.45 P.M from Khartoum arrive Nairobi 1.20 A.M Return to Nairobi
24-28 Oct	Report writing (1 st draft)	5 days	
29-30 Oct	Report writing (final draft)	2 days	
	Total:	23 days	10 days in the field

Annex 3: Interviews conducted

s/n	Participant	Tool			
A	HQ				
A1	Officers:-				
A1.1	Programs Director (also Ag. SG)	T2/KII			
A1.2	Director of PMER	T2/KII			
A1.3	Program Coordinator (IFRC)	T2/KII			
A1.4	Program Coordinator (SRCS)	T2/KII			
A1.5	Swedish RC Rep	T2/KII			
A1.6	Locality volunteer leaders	T1/FGD			
A2	Stakeholders:-				
A2.1	MOH	T3/KII			
A2.2	WHO	T3/KII			
B	Branch (Generic - see annex for each)				
B1	At each of the 5 Branch (El Geizira, Gedaref, Sennar, North Kordofane and Nothern States): the following interviews conducted				
B11.	Officers:-				
B11.1	Branch Director	T2/KII			
B11.2	Health Field Officer	T2/KII			
B12	Stakeholders:-				
B12.1	Commissioner of locality	T3/KII			
B12.2	Community leader	T3/KII			
B12.3	CHC - Chair/Secretary	T3/KII			
B12.4	MOH	T3/KII			
B13	Beneficiaries:-				
B13.1	Females	T1/FGD			
B13.2	Males	T1/FGD			
B13.3	Young people	T1/FGD			
B14	Volunteers	T1/FGD			