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ANNEX 2

to the Commission Implementing Decision on the financing of the individual measures in favour of the people of the Republic of the Sudan for 2023

Action Document for Primary Health Care provision for vulnerable populations affected by food insecurity and malnutrition - Sudan

ANNUAL MEASURE
This document constitutes the annual work programme within the meaning of Article 110(2) of the Financial Regulation, within the meaning of Article 23 of the NDICI-Global Europe Regulation.

1 SYNOPSIS

1.1 Action Summary Table

1. Title **CRIS/OPSYS business reference** **Basic Act**	Primary Health Care provision for vulnerable populations affected by food insecurity and malnutrition - Sudan OPSYS number: ACT-61530 Financed under the Neighbourhood, Development and International Cooperation Instrument (NDICI-Global Europe)
2. Team Europe Initiative	No
3. Zone benefiting from the action	The Action shall be carried out in the Republic of the Sudan to the benefit of the people of Sudan
4. Programming document	Individual measures (NDICI-Global Europe/East and Central Africa financial allocation)
5. Link with relevant MIP(s) objectives / expected results	N/A
PRIORITY AREAS AND SECTOR INFORMATION	
6. Priority Area(s), sectors	Health – 120 Population Policies/Programmes and Reproductive Health – 130 Water Supply and Sanitation – 140 Government and Civil society - 150 Other Social Infrastructure and Services – 160
7. Sustainable Development Goals (SDGs)	Main SDG (1 only): SDG 3 Good Health and well-being Other significant SDGs (up to 9) and where appropriate, targets: SDG 2: Zero Hunger SDG 5: Gender Equality (with a focus on Reproductive Health and Rights) SDG 6: Clean Water and Sanitation SDG 10: Reduced inequality through the focus on the most vulnerable groups in conflict-affected areas, such as IDPs, returnees, refugees, and host communities SDG 16: Peace Building

8 a) DAC code(s)	12110 - Health policy and administrative management 5% 12220 Basic health care 30% 12240 Basic nutrition 15% 12261 Health education 5% 13020 Reproductive health care 10% 13030 Family planning 5% 14030 Basic water supply and sanitation 5% 15190 Facilitation of orderly, safe, regular and responsible migration and mobility 10% 16010 Social protection 15%			
8 b) Main Delivery Channel	Third Country Government (Delegated co-operation) - 13000 International NGO – 21000 UNICEF - United Nations Children's Fund - 41122			
9. Targets	☐ Migration ☐ Climate ☒ Social inclusion and Human Development ☒ Gender ☐ Biodiversity ☐ Education ☐ Human Rights, Democracy and Governance			
10. Markers **(from DAC form)**	**General policy objective**	**Not targeted**	**Significant objective**	**Principal objective**
	Participation development/good governance	☐	☒	☐
	Aid to environment	☒	☐	☐
	Gender equality and women's and girl's empowerment	☐	☒	☐
	Trade development	☒	☐	☐
	Reproductive, maternal, new-born and child health	☐	☐	☒
	Disaster Risk Reduction	☐	☒	☐
	Inclusion of persons with Disabilities	☐	☒	☐
	Nutrition	☐	☐	☒
	RIO Convention markers	**Not targeted**	**Significant objective**	**Principal objective**
	Biological diversity	☒	☐	☐
	Combat desertification	☒	☐	☐
	Climate change mitigation	☒	☐	☐
	Climate change adaptation	☐	☒	☐

11. Internal markers and Tags	**Policy objectives**	**Not targeted**	**Significant objective**	**Principal objective**
	Digitalisation	☒	☐	☐
	digital connectivity digital governance digital entrepreneurship digital skills/literacy digital services	YES ☐ ☐ ☐ ☐ ☐	NO ☒ ☒ ☒ ☒ ☒	
	Connectivity	☐	☒	☐
	digital connectivity energy transport health education and research	YES ☐ ☐ ☒ ☐	NO ☒ ☒ ☐ ☒	
	Migration (methodology for tagging under development)	☒	☐	☐
	Reduction of Inequalities (methodology for marker and tagging under development)	☐	☒	☐
	Covid-19	☒	☐	☐
BUDGET INFORMATION				
12. Amounts concerned	Budget line (article, item): BGUE-B2023-14.020121-C1-INTPA. Total estimated cost: EUR 40 000 000 Total amount of EU budget contribution EUR 40 000 000			
MANAGEMENT AND IMPLEMENTATION				
13. Type of financing	**Direct management** through - Grants **Indirect management** with United National Children's Fund (UNICEF) and with Italian Agency for Development Cooperation (AICS)			

1.2 Summary of the Action

Half of Sudan's population remains without access to appropriate primary health care services. Maternal and child health indicators are extremely poor. In addition, in a context of drought, poor harvest and dire economic crisis, food insecurity is rising. Malnutrition among children is widespread. 38% of children under five are stunted and one in six children is acutely malnourished (wasting)[1]. This Action is part of the overall strategy of the EU in Sudan for 2022 focussed on support to basic services to the population. With its emphasis on nutrition the Action

[1] Global Health report 2021

complements the programme on food security and resilience, which aims at increased availability of nutritious food, as well as the school feeding activities of the Education programme.

The proposed Action aims at sustained delivery of essential health care and nutrition services for vulnerable populations among displaced and host communities in indicatively nine States of Sudan, including North, Central and South Darfur, South Kordofan, and the Eastern States (Red Sea, Kassala, Blue Nile, and Gedaref) as well as Khartoum peri-urban areas. Drawing upon lessons learnt from past EU funded projects and in reference to emerging health priorities, the proposed Action will support the local health care structures at Primary Health Care (PHC) level. These will include nutrition services, access to preventive and curative health care, retention of health workforce, ensuring the supply chain of essential drugs and the referral system. A participatory approach will address behaviour change interventions targeting nutrition and Water, Sanitation and Hygiene (WASH), Sexual Reproductive Health (SRH), Family Planning (FP), among others. This will be complemented by addressing financial barriers to accessing health care through bolstering National Health Insurance Fund (NHIF) subscriptions as well as through cash transfers to pregnant and lactating mothers. Active engagement and coordination of partners, beneficiaries, and local communities will be ensured, in line with the PHC model of care.

The proposed Action intends to contribute to the EU's priority of Human Development through sustainable universal access to quality health services within a resilient and responsive local health care system.

The **overall objective** of this Action is to contribute to improve the health conditions of vulnerable populations affected by extreme poverty, food insecurity and malnutrition in Sudan including IDPs, refugees and Host Communities. The overall objective reflects the EU commitment to SDG 3 (sub-target 8): Universal Health Coverage (UHC) and to UHC 2030 Health Systems Strengthening towards Universal Health Coverage. The **specific objective** is to increase sustainable access to and demand for quality Primary Health Care (PHC), nutrition and Water, Sanitation and Hygiene (WASH) services in targeted States, including for host communities, Internally Displaced Persons (IDPs) and refugees.

The outputs to be delivered by this Action, contributing to the corresponding Specific Objective are :

1. Primary healthcare, nutrition and Water, Sanitation and Hygiene (WASH) services at Primary Health Care (PHC) centre and community level improved, including for IDPs, refugees and host communities, with particular reference to women and girls and people with disabilities (PwD);
2. Management capacity and accountability of local health systems strengthened;
3. Socio-cultural behavioural and gender barriers to health and nutrition are reduced;
4. Financial barriers to maternal and child healthcare and Family Planning (FP) are reduced..

2 RATIONALE

2.1 Context

General context

More than two years after the 2019 revolution and the signing of the Constitutional Document establishing a Transitional Government, Sudan remains politically fragile. Sudan's civilian-led transitional government had made great strides in ambitious reforms and macroeconomic policies to rectify decades of economic mismanagement. The Government reduced unaffordable energy subsidies, transitioned to a market-determined exchange rate and implemented fiscal consolidation to put the economy back on a sustainable path. A gradual increase in social expenditures was also planned. The military takeover of 25 October 2021 has put a sudden stop to the ongoing reform process of the transitional government which was dissolved and high-ranking officials arrested or replaced. The political developments in Sudan led to a disengagement of the major multilateral and bilateral donors. The country lost an estimated USD 4.4 billion in foreign assistance which was frozen as a result of the military takeover, and processes to relief the country of its USD 60 billion debt stalled. The economic recovery following the most painful macroeconomic reforms did not materialize as expected in 2021. Political unrest, port closures, disruption of transport links and supply chains weighed on the economic activity. The socio-economic situation of children and families, already precarious since early 2020, has deteriorated further amid a continued severe and acute economic crisis. Poverty is high and rising, estimated at 57.8% (World Bank), and disproportionally affecting rural areas. Inflation averaged 359% in 2021 and is expected to remain above 200% on

average in 2022. Hyperinflation combined with the end of subsidized goods led to huge erosion of purchasing power of the population, struggling to cater for basic needs of food, transport and shelter. The crisis was compounded by the effects of the COVID-19 pandemic.

While the country has ratified several international conventions (including ICCPR, ICESCR and CRPD)[2], implementing their provisions remains a major challenge. Weak institutional capacities obstruct the implementation of policies to protect human rights, especially the basic rights of women and children.

Marginalized groups of society remain vulnerable to being left behind, including women and girls, children, internally displaced persons (IDP), refugees, migrants, youth, and persons with disabilities (particularly women and girls). Many areas of the country that have historically been marginalized by successive central Governments, including Darfur, the East and the Two Areas (South Kordofan and Blue Nile), saw increased intercommunal conflict following the political crisis and ensuing security vacuum after October 2021. More than 3 million IDPs live in Sudan, many have for a long time been in camps and neighbourhoods with low access to communal infrastructure and schools.

Sudan is also facing a food crisis. The 2021/22 cereal crop harvest is expected to be more than 30% lower than the previous five-year average. According to the latest Comprehensive Food Security and Vulnerability Assessment (CFSVA) conducted in first quarter of 2022, 34% of the population in Sudan, amounting to over 15 million people, are food insecure, which constitutes an increase of 7 percent compared to the same time one year ago. With world cereal prices soaring due to the Ukraine war and a shortage of foreign exchange in Sudan, there is a risk that food consumption needs may not be fully met. This comes on the background of already widespread malnutrition among children. **Without progressive increase in the provision of basic social services, Sudan cannot escape the poverty trap.**

Specific sector context

The national health system in Sudan is three-tiered, consisting of federal, state and locality levels. The Federal Ministry of Health is responsible for setting standards, legislation and control measures, national policies and strategic planning, capacity building of state and local health systems, international relations, managing external aid, and for monitoring and evaluation. The States are responsible for operational planning, capacity building of human resources and providing secondary care. The Locality is responsible for the provision of primary health care, midwifery, mother and child services, environmental health, vector control and human resource management. Since 1993 Sudan has a National Health Insurance Fund (NHIF) and the 2016 National Health Insurance Act subsequently made health insurance compulsory for all residents, including for refugees. Medicines are supplied by the National Medical Supplies Fund (NMSF).

The weak performance of the country's health system and poor health status of the population are clearly expressed in the high neonatal mortality rate of 33 deaths per 1000 live births and the Under-5-Mortality rate of 68 deaths per 1,000 live births, with 55% of it due to malnutrition (MICS, 2014); only 77% of births in Sudan are delivered with the assistance of skilled health care providers whereas only 49% of women attend four or more antenatal care visits from skilled health personnel. Despite most maternal deaths being preventable, the country's maternal health indicator performance remains low at 295 deaths per 100,000 live births, of which many deaths due to home deliveries without the presence of skilled birth attendants and lack of emergency obstetric care at medical facilities (UN MMIEG). In addition, the contraceptive prevalence rate is 11.7%(19% urban and 8.7% rural) and the unmet need for family planning is 26.6%[3]. Twelve per cent of women were first married before age 15 and 38%before age 18, which leads to early childbearing[4]. The prevalence of female -genital mutilation in 2014 was 87% among women aged 15-49 and 32% among girls aged 0-14. Although there is a decrease in the younger cohort, about 40%of women report that they still have the intention to continue this practice to their daughters.

Health and nutrition indicators are worrisome, as they highlight poor and inequitable access to Reproductive Maternal Newborn and Child Health (RMNCH) services, with over 1.5 million women expected to have limited access to life-saving reproductive services, over 2 million children missing their routine vaccination doses, and

[2] Treaty bodies Treaties (ohchr.org).
[3] DP/FPA/CPD/SDN/7 (unfpa.org)
[4] DP/FPA/CPD/SDN/7 (unfpa.org)

over 3 million children suffering from severe malnutrition, of which 650,000 severe acute malnutrition according to Humanitarian Needs Overview (HNO) 2022.

The Sudanese context, in which large part of the population is deprived of a basic Human Right – *the right to health* – requires a response that spans across all its supply and demand side dimensions. On the one hand, support to decentralised health systems is critical to shore up resilience of the communities in protracted crises. As Sudan continues to face an increasing range and intensity of shocks and stresses – including conflict, economic pain, food and nutrition insecurity, and political uncertainty – the ability of decentralized systems to manage emergency preparedness and response at a local level will also be increasingly critical. On the other hand, with poverty on the rise, and with sustained socio-cultural barriers affecting health-seeking behaviours in the country, demand-side solutions should be sought, ensuring that knowledge and awareness, behavioural, as well as financial difficulties are addressed.

The need to support primary health care and nutrition at decentralised settings is consistent with EU priorities for Human Development. The Action is supporting and complementing the EU Flagship of Food security and nutrition in Sudan. Support to health care is an important enabler for this objective. It is targeting SDG 3 (Good Health and wellbeing) and contributes to a number of other SDG, notably SDG 2, 5, 6, 10 and 16. The Action is also contributing to the implementation of the Global Gateway strategy of the EU for Africa.

2.2 Problem Analysis

Short problem analysis: Sudan's health system struggles with both supply and demand-side challenges to health care access for its population. On the supply-side, severe underfunding, gaps in staffing, infrastructure, equipment, medicines, and supplies, lack of clarity over roles and weak management capacities at the locality level pose challenges to efficient service delivery. On the demand-side, poverty combined with high out-of-pocket expenditures on health and adverse traditional practices and believes hinder access to the health care services available.

These deficiencies leave 50% of people without access to appropriate primary health care services and 81% of the population lacking access to a functional health centre within two hours' walk from their homes. One fifth of the population does not have access at all to any health facility. Furthermore, healthcare financing deteriorated further due to the economic challenges arising from inflation and the impact of COVID-19. People residing in IDP and refugee camps with their host communities are still reliant on humanitarian actors to provide basic health services and support their communities with the needed medical supplies.

IDPs and refugees are among the most vulnerable groups with regard to access to basic services, healthcare and nutrition. More than 3 million IDPs live in Sudan, many have for a long time been in camps or in camp-like protracted situations with low access to communal infrastructure and health services. IDPs, refugees, and returnees as well as other internal migrants are particularly vulnerable to impacts of economic crisis, including loss of purchasing power and reduction in public service availability. Limited access of IDPs and refugees to land for farming as well as the 50% food assistance ration cut by the WFP in June 2022 for refugees who arrived more than 2 years ago risks to further exacerbate malnutrition for refugees and IDPs living in camps or outside camp settings. In addition, conflict-related sexual violence committed against women is widespread. Internally displaced women and girls face heightened risks of sexual violence in and around the camps, including while engaged in livelihood activities[5]

Since its inception, total coverage under the National Health Insurance Fund (NHIF) increased from 34.8% in 2014 to 81,3% by December 2020 while coverage among the poor has increased from 38.9% in 2014 to 71% in 2020. However, the number of accredited health units is not sufficient to cater for the needs of the population. Almost 67,38% of health expenditures are still "out-of-pocket". Despite the principle of free treatment (all NHIF members having unlimited access to a range of primary health services at public and private health facilities by using their NHIF card), less than 2% of the population receive free care and 92% pay for drugs.

[5] s_2021_312.pdf (securitycouncilreport.org)

The National Medical Supplies Fund (NMSF), in spite of its strong capacities in supply chain management at federal and state levels, has insufficient capacities to cover the "last mile" resulting in delays of delivery. Particularly in remote areas, availability of medicines is limited. Moreover, at facility level, inadequacies of current infrastructure affect the storage and management of vaccines and medicines. In 2020, essential medicines were accessible in only 43% of health facilities, while only 33% able to provide all main components of primary care, with services particularly limited in conflict-affected regions.

Additionally, Sudan is experiencing a shortage of health workers with an average ratio of only 0.76 health personnel (doctors, nurses and midwives) per 1,000 population, while the WHO target requirement for universal health coverage is 4.45 health personnel per 1,000 population (HNO 2022). The workforce has been depleted by severe brain drain, low staff retention and high emigration of healthcare workers. Unofficial surveys estimate that over half of Sudanese doctors' practice abroad due to political instability, low wages, and poor-quality training opportunities. Other health workforce challenges include an unbalanced skill mix and inequitable geographical distribution of workers. Despite over 70% of the population residing in rural areas, 70% of health workers work in the urban areas, with 38% working in the capital.

Women and children are disproportionally affected by Sudan's fragile health system given their - on average - greater need for care as well as the poor health policy mapping and system gaps impeding the implementation of quality reproductive, maternal, neonatal, and child health programmes in Sudan. Poor and inequitable access to Reproductive, Maternal, Neonatal and Child Health (RMNCH) services leaves an estimated 1.5 million women with limited access to life-saving reproductive services, and over 2 million children missing their routine vaccination doses (HNO 2022).

Meanwhile, the demand-side of Sudan's health system at decentralised level is adversely affected by a combination of factors including knowledge and awareness about health and nutrition, adverse traditional practices, and chronic poverty. The fact that people are not always aware when and how to seek the right kind of care, that – particularly women – on average tend to forego needed care during pregnancy, and the limited resources available to many families , affects behaviours among the population with negative impacts on their health and nutrition status. High out-of-pocket payments add to demand-side challenges to access care.

The States targeted under this Action all face significant challenges in terms of vulnerability levels as well as access to health and nutrition services and the inability of the State health systems to provide to them. Nearly all of the States targeted are affected by conflict and have largely rural vulnerable populations, often with vast distances between health facilities. The damage to facilities as well as lingering mis-trust between the population and the central government has meant over a decade of under-investment in primary care as well as health personnel in these States. The area of Khartoum State targeted is a long-neglected semi-urban locality outside of Khartoum city with large numbers of vulnerable residents, IDPs, and refugees. The 2022 HNO identified all targeted areas as being top severity score (4 of 5, the highest of any State) in the health sector, with at least 1 in 5 people in all targeted States unable to access basic primary health care services.

Table 1. Key demographic and health indicators in targeted states

STATE	# IDPs, refugees, Returnees	Total People in Need – Health & Nutrition	% People in Need among total population	% women who attended 4 ANC visits (target = 90%)	Global Acute Malnutrition Rate (by WHZ; 10% is emergency threshold)	# Skilled health personnel per 100,000 population	# Doctors per 100,000 population
Khartoum	305,684	432,840	27%	74.3	16.13	48	23
North Darfur	1,263,125	548,327	22%	40.19	19.46	62	17
Central Darfur	627,449	451,025	26%	42.28	15.28	16	3
South Darfur	1,031,265	1,014,428	27%	55.26	16.43	10	1

South Kordofan	389,762	585,029	30%	55.63	8.13	21	3
Red Sea	6,409	400,561	26%	42.94	17.84	31	13
Kassala	124,754	654,887	24%	52.6	8.12	51	12
Blue Nile	95,404	266,371	20%	45.51	6.40	20	4
Gedaref	53,514	561,292	23%	37.47	10.69	50	11
Source:	*UNHCR*	*HNO 2022*	*HNO 2022*	*S3M 2018*	*S3M 2018*	*HNO 2022*	*HNO 2022*

Increased frequency of droughts, increasing temperatures and high rainfall variability over the past few decades have already put stress on the region's rainfed agriculture and pastoralist systems, the dominant livelihoods in rural areas. The impact of climate change can be seen in the loss of productive land, pasture and water due to expanded desertification, limited access to water, crop failure or reduced yields, reduced available grazing lands and high livestock mortality have led to rural migration which expands slums and exacerbates health and sanitation concerns[6]. Sudan's National Adaptation Plan (2015) identifies public health as one of the sectors more impacted by climate change, as it exacerbate increasingly persistent health threats such as malnutrition, accelerated and extended spread of vectors/waterborne diseases.

This Action is aiming at selection of targeted States, beneficiaries and distribution of services so as to have a positive impact on and contribute to sustaining peace gains while supporting both development and resilience health and nutrition needs of the targeted population using eco-friendly approaches.

Identification of main stakeholders and corresponding institutional and/or organisational issues (mandates, potential roles, and capacities) to be covered by the Action:

The Action will be implemented by local/international NGOs, UN agencies, and/or EU Member States Agencies via direct and indirect management. So far, six potential implementing partners (IPs) have been tentatively identified. It includes the Italian Agency for Development Cooperation (AICS)[7] and United Nations International Children's Fund (UNICEF)[8], both via indirect management, and the NGOs GOAL[9], Save the Children[10], EMERGENCY[11] and International Rescue Committee via direct management.

The duty-bearers include Local Health Departments, National Health Insurance Fund (NHIF), National Medical Supply Fund (NMSF).

Regarding the rights-holders, the Action will work with community leaders (both men and women, elders) and local civil society, with solid background and experience in gender and human rights. CSOs of People with Disabilities (PwD) will be part of the consultation process and will be part of the righst-holders of the Action.

[6] Climate change risk profile of Sudan by USAID: Country fact sheet

[7] AICS: ongoing EU funded health project in North and South Darfur (HealthPro I, in full coordination with GOAL) while their health activities in Eastern States are ending mid-2022.

[8] UNICEF: ongoing Mother and Child Cash Transfer (MCCT) plus programme which addresses basic comprehensive **health and nutrition needs of children** during their **first 1000 days of life** and pregnant/lactating mothers.

[9] GOAL: ongoing EU funded health project in North Darfur (HealthPro I, in full coordination with AICS)

[10] Save the Children (SCI): ongoing EU funded projects in Education. SCI currently covers decentralised health related projects in 11 States in Sudan.

[11] EMERGENCY: ongoing EU funded project in Mayo with an acute needs to expand their ongoing health activities.

3 DESCRIPTION OF THE ACTION

3.1 Objectives and Expected Outputs

The Overall Objective (Impact) of this Action is to contribute to improve the health conditions of vulnerable populations affected by extreme poverty, food insecurity and malnutrition in Sudan including IDPs, refugees and Host Communities.

The Specific Objective (Outcome) of this Action is:

To increase sustainable access to and demand for quality Primary Health Care (PHC), nutrition and Water, Sanitation and Hygiene (WASH) services in targeted States, including for host communities, Internally Displaced Persons (IDPs) and refugees.

The Action is contributing to the integration of migrants, IDPs and refugees. They will benefit, together with their host communities, from the improvement of health care services in order to do no harm to the cohesion within the communities. Interventions will focus on localities with a high incidence of IDP and migrant population. In some areas IDPs make up the quasi totality of the resident population, such as in two camps in El Fasher, North Darfur, as well as in the Mayo neighbourhood at the periphery of Khartoum.

The Outputs to be delivered by this Action contributing to the corresponding Specific Objective (Outcome) are:

1. Primary healthcare, nutrition and Water, Sanitation and Hygiene (WASH) services at Primary Health Care (PHC) centre and community level improved, including for IDPs, refugees and host communities, with particular reference to women and girls and people with disabilities (PwD);
2. Management capacity and accountability of local health systems strengthened;
3. Socio-cultural behavioural and gender barriers to health and nutrition are reduced;
4. Financial barriers to maternal and child healthcare and Family Planning (FP) are reduced.

Final selection of States will take place in consultation with the EU and partners implementing the programme. Suggested selection criteria; vulnerability, feasibility to deliver impact, local presence and experience, convergence with existing programming by implementing partners, incidence of migrant population and value for money.

3.2 Indicative Activities

Activities relating to Output 1

1.1. Strengthen Primary Health Care (PHC) infrastructure including Water, Sanitation and Hygiene (WASH) through the construction of communal latrines and ensuring access to safe drinking water.
1.2. Procurement of essential medical drugs and supplies and guidelines availability at targeted PHC facilities.
1.3. Support public health disease surveillance, including early warning and response capacity at PHC/local level.
1.4. Strengthen referral mechanisms between community, PHCs and rural hospitals (supported with critical services including quality of Emergency Obstetric Care (EmOC))
1.5. Monitoring and Evaluation.

Activities relating to Output 2

2.1 Strengthen capacity at State and Local level on (i) budgetary planning, management and monitoring of health and nutrition programmes; (ii) supply chain management; (iii) Human Resource (HR) management, (iv) and physical capacity of Local Health Departments (LHD).
2.2 Build a local Health Information System.
2.3 Strengthen and formalize Health Community Committees, promoting the participation of women and girls and PwD.

Activities relating to Output 3

3.1 Assessment of awareness-raising and Socio-cultural Behaviour Change (SBC) needs, including men, elderly women,IDP and refugee populations with an integrated approach (emphasis on impacts of climate change among other topics).
3.2 Develop and implement awareness raising gender and human rights sensitive SBC strategies and awareness raising programmes on key preventable diseases.
3.3 Train key frontline staff and volunteers while support SBC coordination and advocacy at local and State levels.

Activities relating to Output 4

4.1 Promote National Health Insurance Fund (NHIF) subscription with subsidized NHIF premiums for the poorest.
4.2 Cash transfer to pregnant and breastfeeding mothers at Primary Health Care (PHC) level following a financial support model which aims at improving health and nutrition status of children (first 1,000 days of life).
4.3 Research and learning.

3.3 Mainstreaming

Environmental Protection & Climate Change

Outcomes of the EIA (Environmental Impact Assessment) screening (relevant for projects and/or specific interventions within a project)

The EIA (Environment Impact Assessment) screening classified the action as Category B (not requiring an EIA, but for which environment aspects will be addressed during design).

Outcome of the CRA (Climate Risk Assessment) screening (relevant for projects and/or specific interventions within a project)

The Climate Risk Assessment (CRA) screening concluded that this action is no or low risk (no need for further assessment)

Much of the planned activities are not expected to have a significant negative environmental and social impact. However, environmental safeguarding instruments will be prepared for any intervention where safeguard is deemed necessary. Furthermore, this project harnesses environmental opportunities such as solar energy for PHCs in a number of states as well as recycling of waste water and waste management in a way that is least harmful to the environment, including management of medical waste. Community sensitization on the benefits of an open-defecation free environment will be conducted in selected states as well.

Gender equality and empowerment of women and girls

This Action responds as well to Sustainable Development Goal 5 of achieving gender equality and empower all women and girls, gender equality. While the Action interventions are designed to be accessible to all community members (girls, boys, women, and men), women comprise the majority of individuals in need of services and will therefore be the primary right-holders of this action.

Interventions directly targeting women, for instance women of reproductive age who face life-threatening complications, related to pregnancy, birth, sexually transmitted infections (STIs) and Sexual and Gender-Based Violence (SGBV) due to limited access to quality reproductive health (RH) services in these areas will be part of this action. The Action will furthermore contribute to gender equality through social behavior change (SBC), awareness-raising, skills-building efforts and financial support designed to increase empowerment of women and girls, increase their decision-making power within families and communities, and optimize their health-seeking behaviours as well as access to Primary Health Care (PHC) centres.

Gender bottlenecks and barriers will be identified and addressed to ensure that women and girls' access to and availability to participate in project interventions are not hindered. This will include designing interventions that embed transformative and solution-oriented approaches to social norms restricting women and girls' freedom of movement, their greater domestic responsibilities and limited availability of time and their sense of safety and security, as well as cultural and traditional practices that may affect health-seeking behaviours. Partners will work with men and boys to challenge gender socialisation norms; the role of fathers in parenting; and the hegemony of masculinity. This Action will also aim to address harmful traditional practices of female genital mutilation and

child marriage, building on its decade-long community engagement approach to promote positive social norms and the empowerment of adolescent girls in their families and communities.

Further, financial support provided through cash transfers to mothers who are pregnant or have young children aims to further reduce barriers in accessing health care. Cash transfers, particularly when linked to other interventions, have proven to contribute to human capital development and in particular influence positively girls' empowerment, enabling them to stay in school longer and delaying child marriage. The cash transfer component places more prominence on the role of women in social support and resilience.

Human Rights

The proposed action is designed to help move Sudan closer to fulfilling the Right to Health, which is essential for a life in dignity, for the people of Sudan, including IDPs, refuges and migrants. Furthermore, the Action centres a rights-based approach throughout design, assessment, implementation and evaluation phases to ensure community ownership and hold duty bearers, including implementing partners, accountable.

Refugees and IDPs face multiple challenges: insufficient access and language barriers when seeking healthcare, lack of information on their rights to healthcare services and limited knowledge of modalities of the healthcare system. The proposed action will have an inclusive awareness raising and outreach approach to indiscriminately provide the services to the refugees, IDPs and host communities through promoting access and enabling culturally sensitive healthcare services in native languages.

Disability

As per OECD Disability DAC codes identified in section 1.1, this Action is labelled as D1. This implies that this action adopts a rights-based approach to equitable healthcare access for all, including people with disabilities (PWDs) who are often the most socio-economically marginalized. Opportunities to engage PWDs in meaningful work (through health systems strengthening, and governance including disability-inclusive planning processes for Local Health Department (LHD) infrastructure and financing etc) will be leveraged. Any rehabilitated or new infrastructure will take the needs of PWDs into account, physical accessibility, among other needs. Health care workers will be oriented to the needs of these groups. The comprehensive Social and Behavioural Change communication strategy includes components mitigating social norms and narratives inhibiting the participation of PWDs in daily life (e.g. Narrative of PWDs as dependants) and will take into account communication needs of PWDs.

Democracy

To speak to SDG 16 of promoting peaceful, inclusive societies for sustainable development and providing access to justice for all, this project aims to provide more equitable opportunities for communities. By targeting vulnerable groups and communities to open up for greater access to basic services, establish mechanisms for redress when there has been injustice, build capacity, awareness and monitoring for accountability.

Conflict sensitivity, peace and resilience

The Action will have an inclusive and transparent approach throughout its design and implementation, ensuring equitable access to health services in all locations despite tribal or other background. Prioritisation of target populations and geographic areas will be grounded in an understanding of the local context and done in consultation with all relevant stakeholders considering tribal, ethnic, gender, age and other criteria.
Assistance will be delivered based on needs and vulnerability based on a robust needs assessment and verification process, not status.

Strong community engagement is one of the core components of this project. This includes engagement of all segments of society across various age, gender and occupational groups. Conflict sensitivity will cover in particular:

- **Resource transfers**: a well-designed, conflict sensitive programming, including through a community-based participatory approach that would inform the specific risks and local/organisational solutions.
- **Neutrality**: Careful selection and vetting of local implementing partners as well as training on key humanitarian and development principles.

- **Communication**: ensuring that two-way communication platforms are in place so that all key stakeholders and local communities understand the scope and objectives of the programme, targeting criteria, timeline and exit strategy.

Disaster Risk Reduction
It is mainstreamed into the central approach of this action, namely through health systems and household resilience. Vulnerable populations continue to be disproportionately impacted by disasters. Integrated into the activities are the improvement of locality surveillance systems, including disease outbreak early warning systems.

Further, risks of undernutrition can be managed by optimising infant and young child feeding, improving food security and ensuring access to health care. This action integrates all into its central approach, with the added benefit of unconditional cash designed to shore up resilience of the most vulnerable households.

Other considerations if relevant
N/A

3.4 Risks and Lessons Learnt

Category	Risks	Likelihood (High/ Medium/ Low)	Impact (High/ Medium/ Low)	Mitigating measures
External environment	Security situation impacts pro-gramming (e.g. Darfur, Kassala, Blue Nile)	Medium	High	Frequent liaison with UN DSS, as well as in-house Security Advisors to mitigate security issues and to ensure continuous access to programme areas. Mitigation strategies already in place in some States.
External environment	Natural disasters (e.g. flooding during rainy season) render some target areas inaccessible, and cause disease outbreaks	Medium	Medium	Disaster Risk Reduction (DRR) is integrated into the approach of this Action. However, in the case of natural disasters, partner approaches to emergency response including pre-positioning, leveraging emergency funding and liaison with local authorities like the Humanitarian Aid Commission to facilitate access permit might also be needed.
Planning, processes and systems	Funds leakages due to corruption and weak budget controls	Medium	High	Implementation of robust tools for management and monitoring of funds flows. Rigorous programme monitoring, including internal monitoring as well as Third party Monitoring and Post-Distribution Monitoring to reinforce accountability, provide feedback for programme improvement, and identify potential risks.

Lessons Learnt:

Primary Health Care (PHC), health and nutrition services

- Engaging **with different sectors at the technical level** is working as an effective entry point for developing a **multisectoral approach** to addressing health and nutrition challenges in Sudan.

- The establishment of a **buffer reserve of ready-to-use therapeutic food** (RUTF) has been crucial to maintain an intact supply pipeline.

Sustainability and accountability at local level

- **Ensure Integrated, cross-cutting health systems interventions** for greater impact: particularly on the Health Information Systems (HIS), social accountability, and monitoring and reviews of health service delivery for all health facilities (not only the project supported ones) across the targeted localities ensuring broader impact on the decentralized health system.
- **Infrastructure development at Local Health Departments (LHDs)** proved to be a key factor which particularly significant impact where LHDs are weak and attractive incentives are provided.
- Health system decentralization can be built by **shoring up capacities of LHDs**, targeted support to health facilities, and community-based interventions to promote social health insurance and strengthen accountability mechanisms.

Socio-cultural barriers

- Socio-cultural barriers express themselves in behaviors that are deeply ingrained in people's conditioning and therefore require continuous community engagement over extended periods of time. For Social Behavioral Change communication to be effective, it must be designed in a way that it is able to address highy sensitive topics respectfully and carefully, taking the respective local thinking into close account.

Financial barriers to accessing health care

- **Evidence shows that the establishment of linkages** between the provision of cash as the platform for convergence on the one hand, and health and nutrition services as well as social behavioral change communication on the other, is a model that is able to deliver results that are greater than the sum of individual interventions, with sustainable impact that can break intergenerational cycles of poverty, poor health and food insecurity. Providing such interventions during a cricitical window in an individuals life increases the likelihood of achieving the aforementioned results and impact.
- To optimize synergies with other ongoing and planned programming, it is important to coordinate efforts with other cash actors (eg. Emergency Safety Net Project for Sudan, implemented by the World Bank through WFP).
- The National Health Insurance Fund (NHIF) alone has not been able to address financial barriers to accessing health care in Sudan. NHIF subscriptions must therefore be accompanied by measures to reduce out-of pocket expenditures on health.

3.5 The Intervention Logic

The underlying Intervention logic for this action is that better access to Primary Health Care (PHC) and nutrition services, strengthening of health care structures, and removal of behavioural and financial barriers to health services will contribute to improve the health conditions of vulnerable populations affected by extreme poverty, food insecurity and malnutrition in Sudan. This will be achieved through four key pathways (outputs to be delivered):

If PHC service providers are strengthened in service delivery, patient-friendly outreach and public health surveillance *and* Health and Nutrition-focused community networks take an active role in monitoring, referring and awareness raising through strong linkages to client-friendly PHCs *and* strong referral mechanisms between community, PHCs and rural hospitals (supported with critical services) are functioning well, then **healthcare and nutrition services at PHC centres and community level have sustainably improved to meet growing need (output 1)**.

If Health Community, WASH and other Committees are strengthened/trained and linked to service providers for better information sharing, referral pathways and integrated into joint planning processes with locality and State ministries *and* health information management systems are strengthened to support evidence-based decision making and analysis *and* locality and State health ministries can coordinate inclusive and well-planned health and nutrition programmes in suitable facilities (PHC and LHD) supported by improved local supply chain management, then **local health systems will be strengthened, rendering them more sustainable with clear accountability structures (output 2).**

If social and behaviour change strategies are designed, informed by socio-behavioural assessments addressing key barriers to the uptake of critical health and nutrition services *and* the strategy is mainstreamed and implemented throughout the collective action to ensure as wide a reach as possible and act as an "impact multiplier" *then* **socio-cultural and behavioural barriers to health and nutrition will be reduced (output 3).**

Lastly, if a proven financial model to support pregnant and breastfeeding mothers at PHC centres is scaled to address the growing need in Sudan *and* action research underscores the viability of this model for a further scale in dynamic, protracted crises, *then* financial barriers to **maternal and child healthcare will be reduced (output 4).**

The outputs are interdependent and complementary to one another. A reduction of barriers (output 3 and 4) rely on functioning health systems, able to absorb higher service demand from communities.

Assumptions

1. No major change in the political, economic and/or security situation that renders access, human resource availability and population needs beyond the action ability to serve targeted population;
2. No further catastrophic deterioration in the nutritional situation beyond planning figures which can further worsen food security and nutritional status;
3. The banking system remains with adequate liquidity;
4. All project partners will continue operating as per status quo.

3.6 Logical Framework Matrix

This indicative logframe constitutes the basis for the monitoring, reporting and evaluation of the intervention.
On the basis of this logframe matrix, a more detailed logframe (or several) may be developed at contracting stage.
In case baselines and targets are not available for the action, they should be informed for each indicator at signature of the contract(s) linked to this AD, or in the first progress report at the latest. New columns may be added to set intermediary targets (milestones) for the Output and Outcome indicators whenever it is relevant.

- At inception, the first progress report should include the complete logframe (e.g. including baselines/targets).
- Progress reports should provide an updated logframe with current values for each indicator.
- The final report should enclose the logframe with baseline and final values for each indicator.

The indicative logical framework matrix may evolve during the lifetime of the action depending on the different implementation modalities of this action.
The activities, the expected Outputs and related indicators, targets and baselines included in the logframe matrix may be updated during the implementation of the action, no amendment being required to the Financing Decision.

PROJECT MODALITY (3 levels of results / indicators / Source of Data / Assumptions - no activities

Results	Results chain: Main expected results (maximum 10)	Indicators: (at least one indicator per expected result)	Baselines (values and years)	Targets (values and years)	Sources of data	Assumptions
Impact	Improved health conditions of vulnerable populations affected by extreme poverty, food insecurity and malnutrition in Sudan, including IDPs, refugees and Host Communities.	1 Prevalence of malnutrition in Sudan (weight for height >+2 or <-2 standard deviations from the median of the WHO Child Growth Standards) among children under 5 years of age, by type (wasting and overweight), by sex and migratory status (GERF 1.25 SDG 2.2.1) 2 Universal Health Coverage (UHC) index (GERF 1.27 SDG 3.8.1) 3 Maternal mortality ratio in Sudan, by migratory status	1. TBD 2. TBD 3. TBD	1. TBD 2. TBD 3. TBD	1. International organisation data portals and reports 2. International organisation data portals and reports 3. UN Maternal Mortality Interagency Group (UNMMIEG)	*Not applicable*
Outcome 1	To increase sustainable access to and demand for quality Primary Health Care (PHC), nutrition and Water, Sanitation and Hygiene (WASH) services, including for host communities, Internally Displaced Persons (IDPs) and refugees.	1.1 Percentage of the population in target locations with access to health and nutrition services, disaggregated by sex, age and migratory status 1.2 Number of new WASH facilities at PHC 1.3 Outpatient Department (OPD) utilization rate in target locations 1.4 Percentage of users by sex and age reporting satisfaction with the provided PHC services 1.5 Number of women of reproductive age, adolescent girls and children under 5 reached by nutrition-related	1.1 TBD 1.2 TBD 1.3 TBD 1.4 TBD 1.5 TBD	1.1 TBD 1.2 TBD 1.3 TBD 1.4 TBD 1.5 TBD	1. Programme evaluation 2. Facility records 3. Post distribution monitoring (PDM) 4. Client Exit Survey on Satisfaction of services at PHC 5. Annual Sudan Country Level Implementation Plan	1. No major disruption to service delivery (conflict, political instability, natural disasters) 2. No major further deterioration in economic situation.

		interventions supported by EU (GAP III indicator)			(CLIP) /GAP III report	
Output 1 relating to Outcome 1	Primary healthcare, nutrition and Water, Sanitation and Hygiene (WASH) services at Primary Healthcare (PHC) centre and community level improved, including for IDPs, refugees and host communities, with particular reference to women and girls and people with disabilities (PwD).	1.1.1 Number of PHCs in target locations with improved healthcare, nutrition and WASH infrastructure and equipment 1.1.2 Number of beneficiaries in communities with improved access to WASH facilities 1.1.3 Number of PHC staff trained, disaggregated by sex 1.1.4 Number of PHCs with availability of Ready-to-use therapeutic food RUTF 1.1.5 Number of PHCs with availability of essential drugs 1.1.6 Number of clients referred to rural hospitals for health services, by sex, age and migratory status 1.1.7 Status of scorecard mechanisms in place	1.1.1 TBD 1.1.2 TBD 1.1.3 TBD 1.1.4 TBD 1.1.5 TBD 1.1.6 TBD 1.1.7 TBD	1.1.1 TBD 1.1.2 TBD 1.1.3 TBD 1.1.4 TBD 1.1.5 TBD 1.1.6 TBD 1.1.7 In place	1. Programme evaluation 2. PDM 3. Project internal monitoring	No deterioration of staff retention and human resource management among all implementing partners throughout the lifecycle of the programme.
Output 2 relating to Outcome 1	Management capacity and accountability of local health systems strengthened.	1.2.1 Number of Local Health Department (LHD) staff trained, by sex 1.2.2 Number of LHDs with improved infrastructure and equipment	1.2.1 TBD 1.2.2 TBD 1.2.3 TBD 1.2.4 TBD 1.2.5 TBD	1.2.1 TBD 1.2.2 TBD 1.2.3 TBD 1.2.4 TBD 1.2.5 TBD	1. Training attendance registers 2. Health Management Information System	1. Willingness of facility and LHD staff to apply and practice new knowledge acquired through programme intervention

		1.2.3 Proportion of health facilities submitting monthly health reports 1.2.4 Number of PHCs with a scorecard mechanism in place 1.2.5 Number of community committees active			(HMIS) reporting 3. Project monitoring	
Output 3 relating to Outcome 1	Socio-cultural and behavioural and gender barriers to health and nutrition are reduced.	1.3.1 Number of danger signs principal caregivers are able to identify 1.3.2 Percentage of principal caregivers by sex with knowledge about malnutrition treatment services 1.3.3 Percentage of mothers exclusively breastfeeding	1.3.1 TBD 1.3.2 TBD 1.3.3 TBD	1.3.1 TBD 1.3.2 TBD 1.3.3 TBD	1. Programme evaluation 2. Surveys	1. Cultural sensitivity is applied in design of interventions. 2. Communities open and receptive to implement knowledge shared in their everyday lives.
Output 4 relating to Outcome 1	Financial barriers to maternal and child healthcare,Family Planning (FP) are reduced.	1.4.1 Number of pregnant or lactating women provided with a cash transfer 1.4.2 Number of households by sex (female-headed households) with a National Health Insurance Fund (NHIF) subscription	2.4.1 TBD 2.4.2 TBD	1.4.1 TBD 1.4.2 TBD	1. Programme reports 2. NHIF registers	1. Financial support provided will be used for the intended

4 IMPLEMENTATION ARRANGEMENTS

4.1 Financing Agreement

In order to implement this action, it is not envisaged to conclude a financing agreement with the partner country.

4.2 Indicative Implementation Period

The indicative operational implementation period of this action, during which the activities described in section 3 will be carried out and the corresponding contracts and agreements implemented, is 60 months from the date of adoption by the Commission of this Financing Decision.

Extensions of the implementation period may be agreed by the Commission's responsible authorising officer by amending this Financing Decision and the relevant contracts and agreements.

4.3 Implementation of the budget support

N/A

4.4 Implementation Modalities

The Commission will ensure that the EU appropriate rules and procedures for providing financing to third parties are respected, including review procedures, where appropriate, and compliance of the action with EU restrictive measures[12].

4.4.1 Direct Management (Grants)

Grants: (direct management)

(a) Purpose of the grant(s)

The grant will implement the specific objective of the programme: Increased sustainable access to and demand for quality Primary Health Care (PHC), nutrition and Water, Sanitation and Hygeine (WASH) services in targeted States, including for host communities, Internally Displaced Persons (IDPs) and refugees.

(b) Type of applicants targeted

Implementers with in-depth experience in Health, nutrition and Water, Sanitation and Hygiene (WASH) services at health facilities in Sudan, strong implementation capacities including for inputs delivery, infrastructure works and procurement components, solid capacities and representation in the field at states and locality level. Furthermore, implementers need to have specialized experience with empowerment of vulnerable groups, such as Internally Displaced Persons (IDPs) and refugee communities, women and youth and people with disabilities. A consortia approach of several specialised organisations would be encouraged when appropriate.

(c) Justification of a direct grant

[12] https://www.sanctionsmap.eu/#/main.

Under the responsibility of the Commission's authorising officer responsible, the grant may be awarded without a call for proposals to international NGOs or a consortium of NGOs: GOAL, Emergency, Save the Children International (SCI) and International Rescue Committee (IRC). A prior approval will be encoded in OPSYS/CRIS.

GOAL: will draw upon its experience in designing and implementing primary health care services in North Darfur and South Kordofan, at facility and community level enhancing governance mechanisms and strengthening District Health Information System. GOAL will also leverage experience in Nutrition Impact and Positive Practice approach which is a unique community-based methodology that links humanitarian and development programming, improving adoption of positive practices.

EMERGENCY: Provides free, high-quality healthcare to victims of war, poverty and landmines, alongside building hospitals and training local medical staff. In Sudan EMERGENCY has been operating since 2004; at present, EMERGENCY runs a Centre of Medical Excellence for cardiac surgery in Khartoum (The Salam Centre for Cardiac Surgery), as well as three Paediatric Centres in Mayo (Khartoum), Nyala (South Darfur) and Port Sudan (Red Sea State). The EMERGENCY Paediatric Centre in Mayo (EPC) has been open since 2005, and up until now it has offered almost 300,000 free of charge outpatient consultations to children 0-14, as well as more than 50,000 midwife consultations to women.

Save the Children International (SCI): works across 14 states, 10 of them are common operational areas and three are emergency response areas covering multiple sectors - Health, Nutrition, WASH, Food Security and Livelihood, Child Rights Governance, Child Protection, and Education. During the past two years, SCI has implemented over 66 projects with funds from major donors, including European Union (ECHO and EU). During the COVID-19 pandemic, SCI managed Isolation Centers, running awareness-raising campaigns, and working with all stakeholders to strengthen overall programming. SCI regularly collaborates and coordinates with the Government at both state and national levels, UN Agencies, I/NGOs, CBOs and local community groups on assessments and project implementation. In all its programming, SCI focuses on supporting the most marginalized and vulnerable groups, prioritizing girls' and women's specific protection needs.

International Rescue Committee (IRC): In Sudan, IRC provides essential services such as primary health care, including reproductive health, child health, nutrition and mental health, supports environmental health services, including water, sanitation and hygiene, rebuilds health systems, including information, quality assurance and governance systems, conducts research and monitoring to enlarge the evidence base on global health. IRC provides essential facilities and resources to communities to prevent disease, increase personal safety and improve food security. Its local partners are working to expand family planning coverage in conflict-affected communities, deliver care for common childhood illnesses such as malaria, diarrhea, and pneumonia. IRC has a track record in treatment for acute malnutrition through in-patient and out-patient care, and integration of mental health and psychosocial support into primary health programs while strengthening community support systems.

Under the responsibility of the Commission's authorising officer responsible, the recourse to an award of a grant without a call for proposals is justified because of the possibility to use flexible procurement and grant procedures in crisis situations as defined by the Financial Regulation (Article 195(a)) provided that they are valid at the time of the attribution.

4.4.2 Indirect Management with a pillar assessed entity

4.4.2.1 Indirect management with Italian Agency for Development Cooperation (AICS):

A part of this action may be implemented in indirect management with AICS. This implementation entails: Output 1: Primary healthcare, nutrition and WASH services at PHC centre and community level improved;

Output 2: Management capacity and accountability of local health systems strengthened;
Output 3: Socio-cultural and behavioural barriers to health and nutrition reduced;

The envisaged entity has been selected using the following criteria:

- Implementer with extensive experience and track record in implementing health programmes in Sudan particularly on Primary Health Care (PHC) and Maternal and Child Health Care (MCHC)
- Implementer with in-depth experience in designing and implementing primary health care services at facility and community level, through enhancing governance mechanisms and strengthening District Health System
- Implementer with experience in addressing food security as linked to Nutrition
- Implementer who maintained a positive relationship with government actors at both state and national levels, and have acquired acceptance from all stakeholders, including other implementers and local communities

AICS has extensive experience in implementing health programmes in three states of East Sudan (Red Sea, Kassala, Gedaref) and North and South Darfur states, particularly on Primary Health Care (PHC) and Maternal and Child Health Care (MCHC), including with EDF funding through Delegated Cooperation. It is currently implementing the EU funded projects "Strengthening resilience for refugees, IDPs and host communities in Eastern Sudan" and "HealthPro in North and South Darfur states" on the same intervention sector: this is expected to create strong synergies with the proposed programme. Moreover, AICS has built trust and consensus among authorities' at all institutional levels: Federal, State, localities and community thanks to its long presence in the country and particularly in the target areas.

4.4.2.2 Indirect management with the United Nations Children's Fund (UNICEF)

A part of this action may be implemented in indirect management with UNICEF. This implementation entails:

Output 2: Management capacity and accountability of local health systems strengthened;

Output 3: Socio-cultural and behavioural barriers to health and nutrition reduced;

Output 4: Financial barriers to maternal and child healthcare reduced

The envisaged entity has been selected using the following criteria:

- Implementer with extensive experience and track record in implementing health programmes in Sudan particularly on Primary Health Care (PHC) and Maternal and Child Health Care (MCHC)
- Implementer with in-depth experience in designing and implementing primary health care services at facility and community level, through enhancing governance mechanisms and strengthening District Health System
- Implementer with experience in addressing food security as linked to Nutrition
- Implementer who maintained a positive relationship with government actors at both state and national levels, and have acquired acceptance from all stakeholders, including other implementers and local communities

UNICEF plays a distinct and important role in the development and delivery of basic health care and nutrition services in the States concerned with longstanding experience and good working relations in the states as well as sufficient implementation capacities, allowing them to quickly and efficiently start project

implementation. It has developed the innovative Mother and Child Cash Transfer plus (MCCT+) programme that it will replicate under the current Action.

4.4.3 Changes from indirect to direct management mode (and vice versa) due to exceptional circumstances (one alternative second option)

- If indirect management with the EU Member state implementing agency (AICS) or the international organisation (UNICEF) cannot be concluded due to circumstances outside of the Commission's control, that part of this action may be implemented in direct management with an international or national NGOs, in accordance with the qualification criteria identified in section 4.4.1, point (b).
- If direct management cannot be concluded due to circumstances outside of the Commission's control (for instance if negotiations for a direct award fail or the access to the country becomes difficult for international NGOs), that part of this action may be implemented in indirect management with an EU Member state implementing agency or an international organisation, in accordance with the qualification criteria identified in section 4.4.2

4.5 Scope of geographical eligibility for procurement and grants

The geographical eligibility in terms of place of establishment for participating in procurement and grant award procedures and in terms of origin of supplies purchased as established in the basic act and set out in the relevant contractual documents shall apply, subject to the following provisions.

The Commission's authorising officer responsible may extend the geographical eligibility on the basis of urgency or of unavailability of services in the markets of the countries or territories concerned, or in other duly substantiated cases where application of the eligibility rules would make the realisation of this action impossible or exceedingly difficult (Article 28(10) NDICI-Global Europe Regulation).

4.6 Indicative Budget

Indicative Budget components	**EU contribution (amount in EUR)**
Implementation modalities – cf. section 4.4	
Specific Objective: Increased sustainable access to and demand for quality Primary Health Care (PHC), nutrition and Water, Sanitation and Hygiene (WASH) services, including for host communities, IDPs and refugees; composed of:	**40 000 000**
Output 1. Primary healthcare, nutrition and Water, Sanitation and Hygiene (WASH) services at Primary Healthcare (PHC) centre and community level improved; composed of	**17 700 000**
Grants (direct management) – cf. section 4.4.1	14 400 000
Indirect management – cf. section 4.4.2	3 300 000

Output 2: Management capacity and accountability of local health systems strengthened; composed of	**7 300 000**
Grants (direct management) – cf. section 4.4.1	4 300 000
Indirect management – cf. section 4.4.2	3 000 000
Output 3: Socio-cultural and behavioural barriers to health and nutrition reduced; composed of	**4 600 000**
Grants (direct management) – cf. section 4.4.1	2 200 000
Indirect management – cf. section 4.4.2	2 400 000
Output 4: Financial barriers to maternal and child healthcare reduced; composed of	**10 400 000**
Grants (direct management) – cf. section 4.4.1	1 400 000
Indirect management – cf. section 4.4.2	9 000 000
Grants – total envelope under section 4.4.1	22 300 000
Evaluation – cf. section 5.2 **Audit** – cf. section 5.3	may be covered by another Decision
Totals	**40 000 000**

4.7 Organisational Set-up and Responsibilities

A Programme Steering Committee (SC) will be established and will comprise representatives at senior management level of each Implementing Partner and other stakeholders, as appropriate. The Steering Committee will supervise the strategic direction and implementation of the programme. It shall guide the work of the programme and review work plans and budgets. The Steering Committee shall meet at least quarterly or more frequently if needed and/or decided.

As part of its prerogative of budget implementation and to safeguard the financial interests of the Union, the Commission may participate in the above governance structure set up for governing the implementation of the action.

5 PERFORMANCE MEASUREMENT

5.1 Monitoring and Reporting

The day-to-day technical and financial monitoring of the implementation of this Action will be a continuous process, and part of the implementing partner's responsibilities. To this aim, the implementing partner shall establish a permanent internal, technical and financial monitoring system for the Action and elaborate regular progress reports (not less than annual) and final reports. Every report shall provide an accurate account of the implementation of the Action, difficulties encountered, changes introduced, as well as the degree of achievement of its results (Outputs and direct Outcomes) as measured by corresponding indicators, using as reference the logframe matrix. Likewise, all monitoring and reporting shall assess how the Action is taking into account the human rights-based approach (including vulnerable groups, disability, migration status etc.) and gender equality. Indicators shall be disaggregated at least by sex.

Joint baseline and endline surveys will be conducted by independent consultants recruited by the implementers during the inception and closure phases of their individual contract.

The Commission may undertake additional project monitoring visits both through its own staff and/or through independent consultants recruited directly by the Commission for independent monitoring reviews.

Roles and responsibilities for data collection, analysis and monitoring:
The arrangements for monitoring and reporting on indicators of the logframe matrix, including the collection of baseline data are of the responsibility of the Commission and implementers. Arrangments and details will be agreed upon at contracting level.

5.2 Evaluation

Having regard to the importance of the action, mid-term and final evaluations may be carried out for this action or its components contracted by the Commission.

The mid-term evaluation will be carried out for problem solving and learning purposes, in particular with respect to coordination and coherence of different implementers and strategic lessons for a possible subsequent phase of the Action.

The final or ex-post evaluation will be carried out for accountability and learning purposes at various levels (including for policy revision), taking into account innovations in programme design, such as the cash transfer component and its central approach.

The Commission shall inform the implementing partner at least one month in advance of the dates envisaged for the evaluation missions. The implementing partner shall collaborate efficiently and effectively with the evaluation experts, and inter alia provide them with all necessary information and documentation, as well as access to the project premises and activities.

The evaluation reports may be shared with the partners and other key stakeholders following the best practice of evaluation dissemination. The implementing partner and the Commission shall analyse the conclusions and recommendations of the evaluations and, where appropriate, apply the necessary adjustments. The financing of the evaluation may be covered by another Decision.

In addition, all evaluations shall assess to what extent the Action is taking into account the human rights-based approach (including vulnerable groups, disability, migration status etc.) as well as how it contributes to gender equality and women's empowerment. Expertise on human rights and gender equality will be ensured in the evaluation teams.

5.3 Audit and Verifications

Without prejudice to the obligations applicable to contracts concluded for the implementation of this Action, the Commission may, on the basis of a risk assessment, contract independent audit or verification assignments for one or several contracts or agreements.

6 STRATEGIC COMMUNICATION AND PUBLIC DIPLOMACY

The 2021-2027 programming cycle will adopt a new approach to pooling, programming and deploying strategic communication and public diplomacy resources.

It will remain a contractual obligation for all entities implementing EU-funded external Actions to inform the relevant audiences of the Union's support for their work by displaying the EU emblem and a short funding statement as appropriate on all communication materials related to the Actions concerned. This obligation will continue to apply equally, regardless of whether the Actions concerned are implemented by

the Commission, partner countries, service providers, grant beneficiaries or entrusted or delegated entities such as UN agencies, international financial institutions and agencies of EU member states.

However, Action documents for specific sector programmes are in principle no longer required to include a provision for communication and visibility Actions promoting the programmes concerned. These resources will instead be consolidated in Cooperation Facilities established by support measure Action documents, allowing Delegations to plan and execute multiannual strategic communication and public diplomacy Actions with sufficient critical mass to be effective on a national scale.

Appendix 1 REPORTING IN OPSYS

An Intervention (also generally called project/programme) is the operational entity associated to a coherent set of activities and results structured in a logical framework aiming at delivering development change or progress. Interventions are the most effective (hence optimal) entities for the operational follow-up by the Commission of its external development operations. As such, Interventions constitute the base unit for managing operational implementations, assessing performance, monitoring, evaluation, internal and external communication, reporting and aggregation.

Primary Interventions are those contracts or groups of contracts bearing reportable results and respecting the following business rule: 'a given contract can only contribute to one primary intervention and not more than one'. An individual contract that does not produce direct reportable results and cannot be logically grouped with other result reportable contracts is considered a 'support entities'. The addition of all primary interventions and support entities is equivalent to the full development portfolio of the Institution.

The present Action identifies as;

Action level		
☒	Single Action	Present Action: all contracts in the present Action
Contract level		
☒	Single Contract 1	Humanitarian Development Peace Nexus: Strengthening a Decentralized Health System for protracted displaced population (HealthPro II) in Al-Fasher (North Darfur), Nyala (South Darfur) and Al-Fashega and Basonda localities (Gedaref State)
☒	Single Contract 2	Humanitarian Development Peace Nexus: Strengthening a Decentralized Health System for Protracted Displaced Population (HealthPro II) in North Darfur and South Kordofan States, Sudan
☒	Single Contract 3	Case for expanding Mother and Child Cash Transfers Plus (MCCT+) in Sudan
☒	Single Contract 4	Providing Equitable, Sustainable Access to Primary Healthcare Services in Selected Priority States
☒	Single Contract 5	Mayo Paediatric Centre
☒	Single Contract 6	Integrated And Sustainable Health, Nutrition, and Wash Programming