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EVALUATION

Sudan Health Transformation Project
Phase II

End Of Project Performance Evaluation Report

July 2012

This publication was produced for review by the United States Agency for International Development. It was prepared by Jacob Hughes and Mohammed Ali, Management Systems International.

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South Sudan Services Under Program and Project Offices For Results Tracking (SUPPORT) Project

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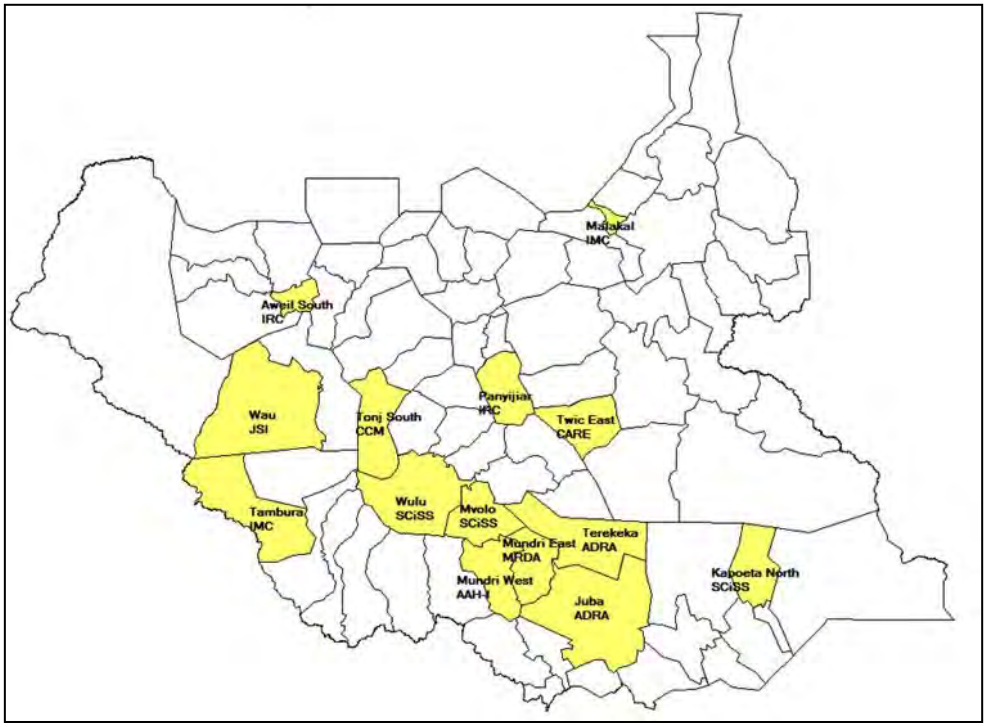
ACRONYMS

AAHI	Action Africa Help International
ACT	Artemisinin Combination Therapy
ADRA	Adventist Development and Relief Association
ANC	Antenatal Care
ARI	Acute Respiratory Infection
ARV	Antiretroviral
BCC	Behavior Change Communication
BEmOC	Basic Emergency Obstetric Care
BPHS	Basic Package of Health Services
BSF	Basic Services Fund
CA	Cooperative Agreement
CBD	Community Based Distributor
CBO	Community Based Organization
CBSO	Community Based Sanitation Officers
CCM	Comitato Collaborazione Medica
CCM	Community Case Management
CEmONC	Comprehensive Emergency Obstetrics and Neonatal Care
CHD	County Health Department
CHW	Community Health Worker
CIDA	Canadian International Development Agency
CLTS	Community Led Total Sanitation
CPR	Contraceptive Prevalence Rate
DFID	Department for International Development [UK]
DHIS	District Health Information System
DG	Director General
DPT	Diphtheria, Pertussis, and Tetanus
DPT3	Diphtheria, Pertussis, and Tetanus (third dose)
DQA	Data Quality Assessment
EmOC	Emergency Obstetric Care
EOP	End of Project

EPI	Expanded Program on Immunizations
FBO	Faith Based Organization
FHI 360	Family Health International +
FP	Family Planning
GFATM	Global Fund for AIDS, Tuberculosis, and Malaria
HBLSS	Home-Based Life Saving Skill
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome
HFMS	Health Facility Mapping Survey
HMIS	Health Management Information System
HR	Human Resources
HSDP	Health Sector Development Plan
HSS	Health Systems Strengthening
IEC	Information Education and Communication
IMC	International Medical Corps
IPT	Intermittent Presumptive Treatment
IRC	International Rescue Committee
JDO	Joint Donor Office
JDT	Joint Donor Team
JSI	John Snow, Incorporated
MCH	Maternal and Child Health
MCHW	Maternal and Child Health Care Worker
MDTF	Multi-Donor Trust Fund
M&E	Monitoring and Evaluation
MRDA	Mundri Relief and Development Association
MMR	Maternal Mortality Ratio
MOH	Ministry of Health
MOU	Memorandum of Understanding
MSH	Management Sciences for Health
MSI	Management Systems International
MTE	Mid-Term Evaluation
NGO	Non-Governmental Organization
PBC	Performance-Based Contracting/Contract

PHC	Primary Health Care
PHCC	Primary Health Care Center
PHCU	Primary Health Care Unit
PMP	Performance Monitoring Plan
PMTCT	Prevention of Mother to Child Transmission
PSI	Population Services International
RSS	Republic of South Sudan
RDT	Rapid Diagnostic Test
SBA	Skilled Birth Attendant
SCISS	Save the Children International South Sudan
SHTPI	Sudan Health Transformation Project Phase I
SHTPII	Sudan Health Transformation Project Phase II
SMOH	State Ministry of Health
SOW	Scope of Work
SSDP	South Sudan Development Plan
SSNBS	South Sudan National Bureau of Statistics
SHHS	Sudan Household Health Survey
TBA	Traditional Birth Attendant
TT	Tetanus Toxoid
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
USG	United States Government
VCT	Voluntary Counseling and Testing
WASH	Water, Sanitation and Hygiene

MAPS



SHTP II Supported Counties in South Sudan

EXECUTIVE SUMMARY

A. Overview

The United States Agency for International Development (USAID) and the South Sudan Ministry of Health (MOH) built on the successes of previous health programming with the South Sudan Health Transformation Project phase II (SHTP II). SHTP II was developed to strengthen local health systems and improve the delivery of services to patients while also increasing the local demand for services. The project ran from February 2009 to October 2012 with a total available funding of $58,497,880. SHTP II had three result areas: service delivery, health system strengthening, and demand increase. The project was designed to accelerate health system development by making the provision of essential health services compatible with the MOH's capacity to manage the service delivery system.

Management Sciences for Health (MSH) was contracted to manage SHTP II and provide support to 166 government-owned health facilities through performance-based contracts (PBCs) with lead agencies in each of the 14 focus counties. The seven high-impact services to be provided were based on the MOH's Basic Package of Health Services (BPHS), including: child health, nutrition, hygiene and sanitation, malaria, maternal health, family planning (FP), and prevention of HIV/AIDS. To underpin delivery of these essential services, SHTP II was designed to support the strengthening of South Sudan's health systems at the facility and county levels. Under SHTP II, emphasis was also put on involving the community and increasing its demand for health services. Midway through the project, USAID conducted a mid-term evaluation (MTE) to assess progress and make recommendations. The key findings and conclusions from the MTE centered on the availability of high-impact services, the number of quantitative performance indicators, and the validity of facility-based data and performance results. Following the MTE process, the number of SHTP II performance indicators was reduced and several activities were consolidated in order to maximize the results during the remaining project period.

Based on a series of specific research questions, the purpose of this End of Project (EOP) evaluation is to understand the strengths and weaknesses of SHTP II's approach to its three stated result areas in order to develop recommendations for new health program planning and for USAID's South Sudan health portfolio in general. The evaluation took place during May and June 2012 and relied on an extensive document review, key informant interviews, a rapid survey of sub-contracted partners, and field visits to a representative sample of health facilities.

B. Findings

Service Delivery: In the service delivery result area, the evaluation team sought to assess the extent to which the seven high-impact services were available, the strengths and weaknesses of the performance-based contracting (PBC) approach, and whether the project's data validation process was sufficient to ensure that reported results were reliable. The evaluation found that the SHTP II project achieved some encouraging results at the supported facilities such as: 96 percent provided five of seven high-impact services, four out of five pregnant women received some form of antenatal care (ANC) (nearly double the national average), and three out of four children under one year of age received the third dose of Diphtheria, Pertussis, and Tetanus (DPT3) vaccine. However, the availability of services was vulnerable to persistent supply and equipment shortages and lack of qualified health workers. Therefore, some critical services at the primary level of care relied upon referral to the secondary level, especially obstetrics and neonatal care, which were often hindered by long distances and lack of transportation. The evaluation also found that the PBC approach successfully motivated subcontracted partners to achieve their targets, but their motivation was not necessarily based on the financial component of the approach. Partners were also motivated by their reputation and the desire to be perceived as a "good performer" as well as other non-

monetary factors. The performance indicators used in the PBCs were predominantly quantitative and targets were not based on county or state planning. While MSH strongly believed that the PBC approach allowed much of the overall project accomplishments to be achieved in a shorter period of time, the MOH did not believe that value for money was objectively established for the approach. By basing data on achievement of performance targets and verifying facility data before making payments, the PBC approach did increase the overall focus on data quality. Subcontracted partners appreciated the data quality assessment (DQA) process and improved data quality was achieved during the project. However, there was a lack of consistent MOH participation in the DQA process, which was administered and led by MSH during field visits to subcontracted partner project sites, which casts doubt on its sustainability.

Health Systems Strengthening: In health systems strengthening, the evaluation assessed how the project responded to health system challenges at the facility and county levels. The process revealed that the very low baseline of national health systems posed significant implementation challenges for SHTP II and the sustainability of health services. The assumption was made during the design of SHTP II that certain health systems areas such as infrastructure, essential drugs, and human resources would be financed by other sources of funding. When these areas were not funded by other sources, they became major unplanned drains on project resources.

At the outset of the project, the health management information system (HMIS) was highly fragmented among the focus counties, and SHTP II addressed the problem by facilitating a harmonized approach to information collection. This effort contributed to improved overall availability of consistent tools, processes and information. However, the SHTP II transition to the new national HMIS system was slow and remained incomplete in about half of the focus counties. In the absence of a national quality assurance tool for service delivery, SHTP II deployed the Fully Functional Service Delivery Point tool, which was praised by subcontracted partners for its comprehensiveness, but found to be impractical to use in the current context. In response to the scarcity of skilled human resources, the project successfully scaled-up the training of community- and facility-based health workers, but its contribution to closing the workforce gap between the number of actual and the number of needed health workers was limited. More than half of the health workers in USAID-supported government health facilities were paid by the SHTP II project, which potentially enabled diverting government health spending and consumed scarce resources that could otherwise have been used to produce additional qualified health workers. Health infrastructure was a massive challenge for the implementation of SHTP II and the lack of appropriate facility space posed a major constraint to the availability of the high-impact services. In some cases the project was able to implement low-cost, local solutions by involving the community in addressing their own health needs. Finally, the availability of MOH-provided essential medicines was also a major challenge for all subcontracted partners, but resourceful project management and innovative supply chain management strategies were successfully used to mitigate shortages when they arose.

Increasing Demand for Services: The evaluation assessed the strengths and weaknesses of SHTP II to increase demand at the community level to identify, mobilize and address issues affecting the population's health. The findings were that the project successfully used standardized trainings to rapidly increase the number of trained community members, namely home health promoters and village health committees. By October 2012, over 12,000 community members will be trained in mobilizing the community to improve health practices. The training of community members resulted in successfully establishing or reestablishing village health committees at 80 percent of supported facilities. These committees became active in facility maintenance, oversight of drug deliveries, and in some cases renovation or construction of semi-permanent structures. However, although the number of home health promoters increased, they generally did not provide the expected services due to inconsistent motivation, low qualifications, unrealistic expectations and lack of supervision. The village health committees lacked ownership of project activities, which did not necessarily reflect their priorities.

Overall Approach: The evaluation sought to assess how the project balanced the result areas, what may have been the ramifications of focusing more on one area than another, and what lessons could be learned from the approach to achieving the three key results. The balance among the results was established by assigning performance indicators and targets to the result areas which dictated the allocation of resources. As the project progressed, the overall number of performance indicators was reduced and the majority of the remaining indicators were deliberately focused on service delivery (12 out of 17). The ramification was that the project emphasis was predominantly on facility-based services. Field visits confirmed that the high-impact services were generally available while community activities were only marginally functional and health system strengthening was constrained by the shortfalls in expected funding from other sources (e.g., health worker salaries). During evaluation interviews, subcontracted partners reiterated that the project activities prioritized service delivery over community mobilization and health systems strengthening. All partners reported increased communication and engagement by SHTP II project management, significantly improved implementation guidance, and an increased number of field visits as the project progressed. The main communications challenges experienced were the short-notice requests for information and delays in receiving feedback on information provided. The subcontracted partners also reported misunderstandings with the county health departments (CHDs) due to inadequate communication about which activities were included in the project. Although there was generally good communication among donors through development partner meetings, overlap and gaps were still evident in the support for service delivery. It was clear from the evaluation interviews that the project oversight committee fell short of providing the expected strategic direction, resulting in less national ownership. Finally, the shift from a cooperative agreement in the previous project to a contract modality in SHTP II potentially resulted in the perception of rigid project requirements that diminished responsiveness in an evolving context.

C. Summary of Recommendations

Service Delivery: USAID/South Sudan health programming should increase its advocacy and support for implementation of the National Reproductive Health Strategic Plan and improving the accessibility of life-saving health services. Support for integrated high-impact services should be bundled into a single contract per county and focused on serving a distinct catchment population. USAID health programming should diversify the selection and allocation of project indicators, include quality aspects, be better balanced among the results, and base performance targets for service-delivery on state and county planning. The performance targets should reinforce the non-monetary motivation partners have for achieving targets. USAID should discontinue the current form of performance-based financing and the pre-financing of service delivery requirement for implementing partners.

Health System Strengthening: Whenever MOH tools are developed, such as the Quality Supervision Checklist and new HMIS system, USAID health programs should move to quickly adopt them and train health system managers on how to use the tools and information as they become available. Counterparts at all levels should also be trained and supported to routinely verify the information provided by subordinate levels in the health system to improve data quality. In order to achieve the necessary mix of workforce skills, USAID should support the MOH to finalize and implement the National Human Resources for Health Policy and Strategic Plan. In-service training should be based on individual training needs and documented in individual human resource dossiers maintained at the county or state levels, and pre-service training should be supported when possible. Payment of incentives to health workers should be standardized, rationalized according to service delivery priorities, and increasingly transferred to the government. The USAID health portfolio should retain some budgetary flexibility to purchase essential drugs in case the central drug supply system fails, and MOH counterparts at all levels should be trained in efficient and transparent supply chain management. Future health systems support should also include technical assistance for development of health facility infrastructure standards, and USAID should prioritize, through whatever modality is most practical, the completion of new construction activities that were initiated under SHTP I.

Increasing Demand for Services and Project Approach Improvement: In the areas of community capacity-building and project approach improvement, USAID should join with other development partners and work with the MOH to develop a national community health services policy and strategy that defines the services to be provided at the community level and those responsible for providing them. Community-level health investments intended to compliment that policy should be based on community-identified priorities and increase the involvement of the community in their implementation. Strategies to increase the involvement of the MOH in USAID-funded health projects should be expanded especially in areas where the MOH demonstrates interest and initiative. Stakeholder orientation at all levels should be a featured activity at project start-up and be repeated at regular intervals thereafter to increase cooperation and minimize misunderstanding. Furthermore, USAID should maintain an open dialogue with its implementing partners about the need for flexibility in the South Sudan context and the extent to which flexibility exists within the project to respond to health needs as they arise.

I. BACKGROUND AND HEALTH CONTEXT

A. Background

After gaining independence on July 9, 2011, the Government of the Republic of South Sudan (RSS) is facing the daunting challenge of establishing the legal, policy, procedural and fiscal framework to underpin the world's newest nation. All areas of national development are in critical need of attention and investment, from peace and security and public infrastructure to the population's human development needs for education, good health and improved living standards. To address these needs, the new government has developed the South Sudan Development Plan 2011–13 (SSDP) to establish the priorities for national development. However, the escalating tension from internal ethnic clashes, on-going disputes with Sudan over oil, and other issues still unresolved following the 2005 CPA are posing new challenges for the government. Moreover, the South Sudanese returning from the Sudan are placing additional pressures on the health system, particularly in border areas, and the government is not in position to meet the need for basic services without significant development partner (DP) support. Therefore, as South Sudan celebrates the first anniversary of its independence, the situation is uncertain and DPs are preparing for a future that could include an expansion of humanitarian programming within a context of national development.

B. Demographics

According to the South Sudan National Bureau of Statistics, South Sudan has a total geographic area of 644,329 square kilometers and population density of just 13 people per square kilometer. According to the 2008 census, the population was 8,260,490 (48 percent male and 52 percent female), life expectancy was 59 years, and 51 percent of the population were below the age of 18. With an annual population growth rate of 2.2 percent, the return of South Sudanese from the diaspora and recent returnees from Sudan, the population of South Sudan is expected to nearly double by 2015. In 2008, the vast majority (83 percent) of people were living in rural areas. Three-fourths (78 percent) of households depended on agricultural activity (farming and livestock) as their primary source of income and more than half the population (51 percent) lived in absolute poverty. According to the Ministry of Education, in 2009 the literacy rate among men was 35 percent versus just 14 percent among women and only 27 percent overall. Thus, the population of South Sudan is predominantly young, rural, sparsely distributed, and rapidly increasing. There are more girls than boys, they lack opportunities for education, and they are reliant upon agricultural for their livelihood.

C. Health Status

Due to the inconsistent and fragmented data systems that existed during the long civil war and the nascent national HMIS, most of what is known about the health status of the population in South Sudan is based on national surveys conducted over the last several years. These surveys present a mosaic of health statistics across different disease areas, health services and time periods, and they provide only limited evidence of trends in the availability and utilization of services and the population's health status. Nevertheless, some generalizations are possible, and the preponderance of the available data indicates a very bleak health situation.

Table 1: Summary of Key Demographic and Health Information

Area	Status	Source
Population (2008)	8,260,490	SSNBS[1]
Female percentage of the population	52%	SSNBS
Percentage of the population below the age of 18	51%	SSNBS
Percentage of the population living in rural areas	83%	SSNBS
Life expectancy	59 Years	2010 SHHS[2]
Literacy rate	27% (women 14%)	SSNBS
Annual population growth rate	2.2%	2012 HSDP[3]
Total fertility rate	7.1	2010 SHHS
Maternal mortality ratio	2,054 per 100,000	2006 SHHS
Percentage of pregnant women attending one antenatal care (ANC) visit	47%	2010 SHHS
Percentage of deliveries within health facilities	12.3%	2010 SHHS
Percentage of deliveries by a Skilled Birth Attendant	15%	2010 SHHS
Percentage of girls pregnant or childbearing by age 18	35%	2010 SHHS
Contraceptive prevalence rate (CPR) (modern methods)	1.5%	2010 SHHS
Unmet need for FP	23.9%	2010 SHHS
Infant mortality rate	84 per 1,000	2010 SHHS
Under-5 child mortality rate	106 per 1,000	2010 SHHS
Percentage of fully immunized children (12–23 months)	1.8%	2010 SHHS
Under-5 children who received vitamin A supplement in the 6 months prior	6%	2010 SHHS
Under-5 children who had pneumonia 2 weeks prior	19%	2010 SHHS
Under-5 children who had fever-malaria 2 weeks prior	32.0%	2010 SHHS
Children 0–59 months with fever who received prompt and effective treatment within 24 hours	24%	2010 SHHS
Percent of women attending ANC who received two doses of preventative malaria treatment	22%	2010 SHHS
Women tested for HIV and who know their results	9.5%	2010 SHHS

Maternal and Reproductive Health: The 2006 SHHS found that the maternal mortality ratio (MMR) was 2,054 per 100,000 live births, among the highest in the world. While the 2010 SHHS report did not revise the MMR, it determined that less than half (47 percent) of all pregnant women in South Sudan received any

[1] South Sudan National Bureau of Statistics, "Southern Sudan Counts: Tables From the 5th Population and Housing Census, 2008," http://ssnbs.org/storage/SPHC 2008 tables.pdfand "Key Indicators for South Sudan," http://ssnbs.org/key-indicators-for-southern-su/

[2] Republic of South Sudan, Ministry of Health, Sudan Household Health Survey (SHHS), 2010.

[3] Republic of South Sudan, Ministry of Health, Health Sector Development Plan (HSDP), 2012.

form of antenatal care and only 12 percent of deliveries occurred in a health facility, while 87 percent of deliveries occurred at home. Complicating the already desperate maternal health situation was the fact that 35 percent of girls had started childbearing or were pregnant with their first child before the age of 19. Only 4.5 percent of women married or in union used any form of contraception and 24 percent reported an unmet need for contraception.

Child Health and Nutrition: The 2010 SHHS reported an infant mortality rate of 84 per 1,000 live births and an under-five mortality rate of 106 per 1,000 live births. Pneumonia was the leading cause of child death and 19 percent of children had pneumonia symptoms in the two weeks prior to the 2010 survey. Malnutrition resulted in 30 percent of all children under-five being underweight (13 percent were severely underweight) and only six percent had received the recommended dose of vitamin A supplement in the six months prior to the 2010 survey. The Expanded Program of Immunization (EPI) coverage of children was difficult to ascertain during the SHHS because less than one percent of children had vaccination cards. However, the survey results found that only 1.8 percent of children between 12 and 23 months had received all eight recommended EPI vaccinations.

Major Communicable Diseases: The 2010 SHHS reported that one-third of children under-five years had a fever in the two weeks prior to the survey. Fifty-one percent of women who attend an antenatal clinic received preventative malaria treatment, but only 22 percent received the recommended second dose. Forty-two percent of women surveyed knew that HIV could be transmitted from mother to child but only twenty percent had knowledge of two HIV prevention methods. The HSDP estimated an annual incidence of tuberculosis at 140 per 100,000 people.

D. Service Delivery

In order to improve the health status of the population, the MOH developed the HSDP 2012–2016. The cornerstone of the HSDP is the BPHS, which contains a set of high-impact interventions aimed at reducing the leading causes of morbidity and mortality. The BPHS is designed to be provided at multiple levels in the health system, including at the village level, primary health care units (PHCUs), basic primary health care centers (PHCCs) and comprehensive PHCCs.[4]

At the primary care level, the BPHS includes village-level health promotion, active case finding and referral of pregnant women, treatment of children with simple diarrhea, acute respiratory infections (ARI) and fever, disease surveillance, and outbreak reporting. PHCUs are designated to serve a population of up to 15,000 people and provide additional preventive and curative services, including the EPI, information on disease prevention, personal hygiene, and nutrition, the provision of anti-malarial drugs, and sexual, reproductive and maternal health services including antenatal care.

Basic PHCCs serve as the first level of referral care for a population of up to 50,000 and, in addition to providing all of the services available at PHCUs, they offer a wider range of diagnostic and curative services with up to 15-bed in-patient capacity, laboratory services, stabilization of acute malnutrition, normal delivery and postnatal care, 24-hour basic emergency obstetrics and neonatal care (BEmONC), first aid and minor surgery for trauma, stabilization and referral where necessary.

Comprehensive PHCCs serve a population of up to 200,000 people. In addition to providing all of the services available at a basic PHCC, they offer up to 25-bed inpatient capacity as well as comprehensive emergency obstetrics and neonatal care (CEmONC), including full surgical obstetrics capacity for caesarean sections and other measures for severe uterine bleeding and safe blood transfusion. Where county hospitals are present, they are expected to function as comprehensive PHCCs.

[4] Basic Package of Health and Nutrition Services for Southern Sudan, Ministry of Health, 2009.

At the secondary level of referral care, county hospitals serve a population of up to 300,000 people and are intended to provide a wider range of referral level services than a comprehensive PHCC, but in reality most county hospitals provide similar services to PHCCs and most other secondary level services are only available at state hospitals and the national tertiary hospital in Juba.

Wulu County PHCC, Lakes State (USAID constructed and SHTP II Supported)

The 2011 Health Facility Mapping Survey (HFMS) identified 1,147 functioning health facilities in South Sudan, including 792 PHCUs, 284 PHCCs, and 71 hospitals (county, state, private and specialized).[5] About one-half of the functioning health facilities relied on donor-funded non-governmental or faith-based organizations (FBOs) for operational support. The HFMS also identified that three-quarters of the functioning health facilities were in need of repairs, 35 percent required total reconstruction, 85 percent lacked reliable cold chain refrigerators and less than 10 percent had all of the medical equipment necessary to provide the BPHS. Similarly to the widespread infrastructure challenges, although the health system had 14,667 workers at the time of the HFMS, 72 percent (10,561) were low-level cadres and administrative staffs; appropriately qualified staff occupied only 10 percent of all health facility positions.

[5] 2011 Health Facility Mapping of South Sudan Summary Report, Ministry of Health, May 2011.

II.INTRODUCTION AND DESCRIPTION OF THE PROJECT

A. Introduction

SHTP II was developed by USAID to strengthen county and community capacity to provide health services and to improve health practices by supporting 166 service delivery points in 14 focus counties across all 10 states of South Sudan. The project started in February 2009 and was scheduled to end in February 2012, but was extended an additional eight months until October 2012. The total funding for the three-and-a-half-year project was $58,497,880.

SHTP II was designed to build on the accomplishments of the original SHTP I, which was implemented through a cooperative agreement with John Snow, Incorporated (JSI) between 2004 and 2009. SHTP I focused on improving health facility infrastructure, providing basic equipment and supplies, strengthening the supply chain system, introducing standardized training**,** and developing reliable information and reporting systems.

Under SHTP II, MSH was contracted to lead the implementation, in partnership with performance-base contracted lead agencies in each of the focus counties. The table below indicates the distribution of SHTP II support by state, county and subcontracted partner.

Table 2: SHTP II Support by State, County and Sub-Contracted Partners

	State	County	Subcontracted Partner
1	Central Equatoria	Juba	Adventist Development and Relief Association (ADRA)
2	Central Equatoria	Terekeka	ADRA
3	Eastern Equatoria	Kapoeta North	Save the Children International, South Sudan (SCISS)
4	Lakes	Wulu	SCISS
5	Western Equatoria	Mvolo	SCISS
6	Western Equatoria	Mundri East	Mundri Relief and Development Association (MRDA)
7	Western Equatoria	Mundri West	Action Africa Help International (AAHI)
8	Western Equatoria	Tambura	International Medical Corps (IMC)
9	Upper Nile	Malakal	IMC
10	Jonglei	Twic East	CARE
11	Unity	Panyijar	International Relief Committee (IRC)
12	Northern Bahr el Ghazal	Aweil South	IRC
13	Western Bahr el Ghazal	Wau	John Snow, Incorporated (JSI)
14	Warrap	Tonj South	Comitato Collaborazione Medica (CCM)

B. Project Description

SHTP II was designed to accelerate health system development by making the provision of essential health services compatible with the MOH's capacity to manage the service delivery system.

In order to achieve this, the SHTP II project focused on the following three result areas:

1. Expanding access and availability of high-impact services practices;
2. Increasing South Sudan's capability to deliver and manage services; and
3. Increasing knowledge of and demand for services and healthy practices.

These three SHTP II result areas were expected to enable provision of seven high-impact services established by the MOH's BPHS:

- **Child health** – An EPI and the diagnosis and treatment of diarrheal diseases and acute respiratory infections;
- **Nutrition** – Exclusive breast-feeding, the promotion of infant and young child complementary feeding, and twice-yearly vitamin A supplementation;
- **Hygiene and sanitation** – household-level water, sanitation, and hygiene (WASH);
- **Malaria** – Prevention and control interventions, including the use of long-lasting insecticide-treated nets, intermittent preventive treatment for pregnant women, and management of active cases using anti-malarial medicines;
- **Maternal health** – Antenatal care, safe delivery and postnatal services;
- **FP** – Child spacing and FP information and services; and
- **Prevention of HIV/AIDS** – Prevention of Mother to Child Transmission (PMTCT) services established in selected primary-care facilities and behavior change promoted to reduce multiple-risk behaviors.

To support delivery of these high-impact interventions, SHTP II was designed to support strengthening South Sudan's health systems at the facility, county and state level. The intention was to improve the management of the health system by co-locating with CHDs, producing county health plans, developing county health budgets necessary for achieving project objectives, conducting joint supervision of health facilities, and strengthening drug forecasting.

Governance was also identified as an important area requiring support, and efforts were intended to focus on establishing and training village health committees and involving community organizations in mobilizing and increasing demand for health services. A micro-grants program was expected to fund community organizations to promote health awareness, knowledge, service utilization, and reductions in high-risk health behavior.

Human resources (HR) were to be strengthened through a strategy of continuous engagement that included formal training in seminars and workshops, and on-the-job coaching and mentoring. Finally, SHTP II was expected to ensure greater gender equity in the delivery of health services, household decision-making that affects healthy behavior, and the accessibility and utilization of health services. The project was also expected to ensure equitable participation of men and women in all health activities, and increased male involvement in FP and maternal health services.

C. Changes to the Project

Midway through the 36 month SHTP II implementation period, in October and November 2010, the then USAID/Sudan conducted a MTE to assess progress, identify challenges and recommend how project objectives could best be achieved in the remaining time available. The key findings and conclusions from the MTE centered on the availability of high-impact services, the number of quantitative performance indicators, and the validity of facility-based data, denominators used to establish catchment populations, and performance results. In light of the challenges experienced during the first half of the project, the MTE questioned among other things the feasibility of initiating the fully functional service delivery point tool, implementing PBC, proceeding with micro-grants to community-based organizations (CBO), and continuing to scale up PMTCT and other HIV-prevention activities. Following the MTE process, the number of SHTP II performance indicators was reduced from 25 to 17 and the proportion of indicators that were service delivery oriented increased to 70 percent, thereby increasing the emphasis on the availability of high-impact services. The expected number of PMTCT sites was reduced from 16 to four and the HIV emphasis shifted to increasing community awareness. The CBO micro-grant scheme was reprogrammed to support improving and expanding other community level activities such as working with village health committees and home health promoters to improve health awareness and behavior in local communities.

III. EVALUATION PURPOSE AND METHODOLOGY

A. Purpose

The purpose of the SHTP II end of project (EOP) evaluation was to help USAID understand the strengths and weaknesses of the project's approach to health service delivery and systems strengthening, especially relating to capacity-building, sustainability, and measurement and achievement of results. The EOP evaluation aimed to inform new program planning and provide information and recommendations to the USAID/South Sudan health portfolio in general by assessing implementation progress over the lifespan of the project, including the recommendations and changes made at the time of the MTE. The objectives of the evaluation were to:

1. Assess program performance in meeting targets and accomplishing its three key objectives.
2. Assess how the program has supported the transition from relief to development, specifically the systems strengthening component.
3. Assess the project's accomplishments, as well as challenges that remain, and areas that should be the focus of future activities.
4. Make recommendations to assist future programs, including identifying lessons learned and recommendations for future strategies.

Further to the objectives of the evaluation, the following series of specific research questions were posed in the Scope of Work (SOW) and became central to the EOP evaluation methodology.[6]

Table 3: SOW Research Questions

Research Area	Questions[7]
Result 1: Service Delivery	To what degree did the project succeed in providing all seven high impact standardized services at all facilities? What were the strengths and weaknesses of the PBC approach to service delivery, including the establishment and achievement of targets? Was the project's data validation process sufficient to ensure that reported results were reliable?
Result 2: Health Systems Strengthening	How has the project responded to health system challenges (HR, supply chain, HMIS, infrastructure, and limited functionality of management) at the facility and county levels?

[6] See Annex A: SHTP II End of Project Evaluation SOW

[7] Research findings are structured by project result area (as indicated in 'Research Area' column in above table), the overarching questions are dealt with last in sections D and E. Each section includes findings and conclusions. There is a final section for all recommendations

Result 3: Increasing demand	What were the strengths and weaknesses of the approach to building capacity at the community level (CBOs, village health committees, home health promoters, traditional birth attendant [TBAs] etc.) to identify, mobilize and address issues affecting the population's health?
Overarching	How did the project balance achieving the three key results of service delivery, community mobilization, and system strengthening, and what may have been the ramifications of focusing more on one area than another? What lessons can be learned from the approach to achieving the three key results of service delivery, community mobilization, and system strengthening? What can be learned by the project's approach to communication and management, including the use of tools, at all levels?

B. Methodology

Building on the SHTP I EOP evaluation and SHTP II MTE, this end of project evaluation took a holistic view of project design, implementation and outcomes with the intent of developing practical suggestions for future health programming in South Sudan. The methodology of the evaluation was predominantly qualitative in nature, with some supplementary quantitative information about service delivery. The evaluation took place during May and June 2012, with the in-country phase conducted from May 6 through June 9, 2012.[8] The evaluation team consisted of Jacob Hughes (team leader and independent consultant), Mo Ali (independent consultant) and Dominic Wadegu (Management Systems International [MSI]South Sudan).

The evaluation team conducted an extensive document review of all relevant project-specific documents, including the original Task Order (Task Order), annual Performance Monitoring Plans (PMPs), interim progress reports, and subcontracted partner contracts and reports, as well as MOH policies, strategies and guidance notes and other sector documents.[9] Key informant interviews were conducted using structured interview guides to ensure that the necessary information was captured.[10] Over 40 interviews were conducted across all levels of the health system, including with project beneficiaries, community members, and health facility staffs, government representatives, subcontracted partners, MSH, USAID and other external health actors.[11] As the evaluation could not include all facilities in all counties, a rapid survey was also conducted for all SHTP II supported counties that aligned with the evaluation research questions.[12]

[8] See Annex G:Evaluation Field Work Plan, p. 76.
[9] See Annex C: List of Reference Documents, p. 59.
[10] See Annex E:Interview Guides, p. 63.
[11] See Annex F:List of Key Informants, p. 73.
[12] See Annex B: SHTP II Evaluation Rapid Survey Results, p. 49.

In accordance with facility selection criteria established in the SOW the evaluation team visited a variety of facilities, both urban and rural, and hard-to-reach areas, including counties in Lakes, Western and Central Equatoria States. A total of four counties encompassing 11 health facilities were visited, providing direct evidence of the successes and challenges faced in SHTP II implementation. In all locations the relevant subcontracted partner and, where possible, the CHD were involved in facility visits. Care was taken to ensure that the experiences and opinions of facility staffs, communities and beneficiaries were actively solicited and accurately included in the findings. A meeting was conducted with the subcontracted partners, and separately with MSH, to validate findings and to ensure that all of information collected, conclusions, and findings were consistent with the stakeholders' experience during the project. It was especially important to confirm that the field observations were valid for all locations. After incorporating subcontracted partner and MSH feedback, the evaluation team conducted debriefing for USAID as well as for Development Partners and the MOH. An initial draft of this evaluation report was provided to USAID and MSH for comment. The evaluation team sought to introduce methodological rigor in the process by ensuring that the research questions were linked with project performance standards and indicators wherever possible and with the key informant information.[13] The process was guided by the MSI quality assurance process and USAID's Evaluation Policy.

Table 4: Project Performance Review Activities

Activity	Completed
Document Review	– All relevant project documents – Sector-specific documents – RSS documents (policies, strategies, guidance notes)
Field Visits	– 4 counties (Mundri East, Mundri West, Juba, Wulu) – 11 facilities (5 PHCCs and 6 PHCUs, including 1 non-SHTP II facility) – 4 sub-contracting partners (AAHI, MRDA, ADRA, SCISS) – 3 village health committees
Consultations	– 10 subcontracted partners (AAHI, ADRA, CARE, CCM, IMC, IRC, JSI, MRDA, Population Services International [PSI], SCISS) – 8 MSH – 4 development partners (Basic Services Fund[BSF], CIDA, [DFID UK], Joint Donor Team[JDT]) – 3 MOH (Director General(DG) of Community & Public Health, DG of Planning and Coordination, Acting DG of Training) – 2 CHDs (Mundri West and Juba) – 3 county commissioners (Mundri East, West and Wulu) – 4 USAID meetings (research areas, background, survey, HIV/AIDs) – 1 United Nations International Children's Fund(UNICEF) – 11 of 14 county survey results received
Validation and Debrief	– subcontracted partner validation

[13] See Annex D: Methods Matrix, p. 61.

Presentations	– MSH evaluation feedback – USAID debrief – Development partners and MOH final debrief

C. Limitations

The evaluation was primarily qualitative in nature, collecting subjective information surrounding the strengths and weaknesses. Thus, some of the limitations of this evaluation include:

- Heavy reliance on qualitative data and memory of past experiences (potentially leading to recall bias);
- Limited institutional knowledge among USAID and subcontracted partner staff (the majority of staff at all levels have not been involved since the beginning of the project); and
- Only a limited number of sites (four counties and 11 facilities) were visited, with first choice locations not possible due to accessibility in the rainy season and security considerations[14].

However, the team collected a large evidence base, using a systematic approach to recording and analyzing information across sources. This information has been triangulated against secondary sources so as to reduce any bias and cover gaps where they exist. The validation process was essential to confirm that field-observation generalizations were correct and the final debrief offered a chance for stakeholders to comment on the preliminary findings, conclusions and future recommendations. Circulating the draft report for comment ensured that wherever possible conclusions and recommendations were as accurate as possible and relevant to the context.

[14] The initial field-visit plan included Kapoeta North as a rural, hard-to-reach location; however, due to the start of the rainy season and subsequent inaccessibility, the visit was not possible during the evaluation period.

IV. RESEARCH FINDINGS

This section of the evaluation has been structured to respond to the research questions listed above in Section III, as well as to align the questions with the result areas of the SHTP II project, including service delivery, health system strengthening and increasing demand for services. The result areas are followed by an analysis of how those areas were prioritized and the ramifications to the project as well as findings on project management and communications. In Section V, recommendations related to the result areas are provided based on the findings in this section.

A. Service Delivery

In the Service Delivery result area, the evaluation team sought to assess the extent to which the seven high-impact services were available, the strengths and weaknesses of the PBC approach, and whether the project's data validation process was sufficient to ensure that reported results were reliable. These topics are addressed in sections A.1–A.3 below.

A.1 Availability of high-impact services

SHTP II was designed to support seven high-impact services derived from the MOH's 2009 BPHS, including: child health, nutrition, hygiene and sanitation, malaria, maternal health, FP and HIV/AIDS. Findings from facility visits corroborate information from interviews with subcontracted partners, the rapid survey and SHTP II project reports, which showed that 96% of the supported facilities were providing five of seven of the expected high-impact services.

- **Child Health:** The evaluation team found that the EPI was available at all health facilities visited either through fixed services or outreach services using mobile EPI teams. Of the six PHCUs visited, only four had cold chain equipment. In three of those facilities the equipment was not functioning and the subcontracted partners had not been successful at getting the state-level cold chain repair expert to visit the facility. Therefore, subcontracted partner mobile outreach teams provided EPI services on a monthly basis to five of six PHCUs.

- **Nutrition:** Project documents indicate that SHTP II has consistently exceeded the annual PMP targets for vitamin A and is on track to exceed the 2012 annual goal of 50 percent of the target population of under-fives. The evaluation field visits found vitamin A available in all facilities; however subcontracted partners and facility staff reported experiencing a prolonged national vitamin A stock-out in 2011, indicating that the target was potentially too low.
- **Malaria:** Malaria is a leading cause of morbidity and mortality in South Sudan, and its prevention and control was one of the most important high-impact services. In addition to other malaria services, the SHTP II 2010 and 2011 annual targets (50 and 60 percent respectively) for Intermittent Presumptive Treatment (IPT2) were both met and the project was on track to achieve the 75 percent target for 2012. However, in addition to Artemisinin Combination Therapy (ACT) and Rapid Diagnostic Test (RDT) shortages, there have been recurring shortages of bed nets in South Sudan and only a few of the SHTP II supported facilities visited during the evaluation had nets available for distribution.

- **Hygiene and Sanitation:** SHTP II documentation indicates that access to improved drinking water supply was achieved and exceeded the target (about 25% of the target population) for improved drinking water supply through provision of point of use water treatment products. However, facility latrines were poorly maintained, and while most PHCCs had some form of waste disposal, piles of waste near PHCUs were common. At the community level, Community Based Sanitation Officers (CBSOs) were incentivized by PSI but were not necessarily assigned to communities with an SHTP II supported facility.
- **Maternal Health:** In the face of 87 percent home-based deliveries and one of the highest maternal mortality rates in the world, SHTP II project data indicates that ANC targets were generally met and, encouragingly, in the final year of SHTP II it is likely that 80 percent of the expected number of pregnant women will have made at least one ANC visit. Moreover, half of all pregnant women who made one ANC visit returned for at least three additional ANC visits. Uptake was much higher at appropriately staffed PHCCs than PHCUs, which generally lacked a skilled birth attendant. Project data indicates that although the relative frequency of skilled attendance at birth doubled from six to 12 percent during the project period (below the revised target of 15 percent), the overall percentage and absolute number of pregnant women who delivered in a health facility remained extremely low.
- **FP:** The evaluation team found that FP counseling and basic commodities were available at all facilities visited. According to SHTP II project documentation, the number of FP counseling visits has progressively increased throughout the project implementation period and the target for the final year (30,000 visits) is on track to being accomplished. Nevertheless, uptake of FP services remained extremely low in SHTP II supported counties and South Sudan in general. The reasons for the low uptake were attributed to complex psycho-social factors. However, uptake at the PHCUs was also limited by a lack of appropriate space for counseling and because injectable contraception was only available at PHCCs and higher-level facilities.
- **HIV/AIDS:** At the EOP, SHTP II documentation indicates that performance targets were met in terms of increasing numbers of individuals who participated in a community-wide event and the number of pregnant women with known HIV status. Comprehensive PMTCT services were available in the expected four locations (originally 16). USAID-funded FHI 360 was supporting VCT services, but the awareness, counseling and testing services were not consistently coordinated, leaving one subcontracted partner to ask the question, "Why bother to raise awareness if testing is not available, and why bother to test if the anti-retrovirals (ARVs) are not available?"

Although the high-impact services were found to be generally available, the availability of services was vulnerable to persistent supply shortages. Some key services at the PHCU, such as some aspects of FP and maternal health, were dependent upon patient referral to the nearest PHCC. However, referral was often unreliable or impossible due to distance, cost, and time away from home. Maternal health services were the most affected by weak referral due to the enormous shortages in skilled birth attendants (SBAs) in PHCUs.

A.2 Strengths and weaknesses of the PBC approach

In order to increase SHTP II progress toward service delivery performance targets, a PBC scheme was implemented between MSH and subcontracted partners.[15]The PBC scheme was based on a financial incentive to achieve performance targets, coupled with a financial penalty for failing to do so.[16] The evaluation found that partner motivation was successfully linked to achievement of targets. However, motivation was not universally based on the financial component of the PBC scheme. All subcontracted partners reported having been motivated by the PBCs to achieve the targets, but the reasons why they were motivated varied among the organizations from reputation (i.e., being perceived by USAID and NGO peers as a "good performer" versus a "bad performer") to the financial necessity of the monetary bonus to cover operating costs.

During the standardized interviews conducted with all SHTP II implementing subcontracted partners, it was apparent that large international partners with substantial private funds and very large country programs were less motivated by the financial bonus to achieve targets. In some cases they were able to achieve their targets by using private resources to supplement SHTP II activities and their motivation was largely based on the importance they assigned to being a credible international health agency in South Sudan. For example, one subcontracted partner reported using private funds to conduct regular EPI outreach in distant communities in a campaign-like approach in order to achieve its DPT3 target, indicating that the financial outcome was secondary to achieving the target itself.

Other international organizations that also assigned high importance to the reputation factor, but without significant private resources, relied upon complementary contracts with other sources of funding, such as the BSF, to pay for costs not covered by SHTP II. When asked whether services were perceived to be of better quality under SHTP II funding versus another source of funding, the organizations consistently reported that the source of funds (and therefore the PBC component) made little difference in the quality of programming because the organizational approach to service delivery transcended project funding and many organizational staffs were funded by multiple projects. Most subcontracted partners reported that the performance bonuses were usually not paid to SHTP II project staffs. Instead, they were typically used for general program purposes, which may or may not have been SHTP II related.[17] It is noteworthy that no subcontracted partner reported providing any portion of the performance bonus to facility-based health workers or to incentivize community-based volunteer workers, which might have motivated an increase in proactive service delivery.

In both instances above, with or without private funds, the driver of good performance was the importance the organizations placed on reputation. However, because the SHTP II PBC scheme originally included a penalty for failing to achieve at least 80 percent of the performance targets, another group of subcontracted partners was indeed motivated by the financial component of the PBC because those incentives covered an important part of their operating costs. Subcontracted partners in this group typically had only one health project and had little or no private funds with which to cover penalties assigned by SHTP II.[18] One such subcontracted partner reported that the financial penalty reduced their operating capacity and exacerbated their already failing performance, which was due to many factors, stating, *"For several quarters we were unable to achieve the performance target due to persistent vehicle problems. When we finally met the target, we used the bonus to repair the vehicles."*[19]

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[15] The PBC approach was not used between USAID and MSH.

[16] The financial penalty ended in January 2012.

[17] One subcontracted partner reported using the SHTP II bonus to build a drug warehouse in a non-SHTP II supported county.

[18] Near the end of the SHTP II implementation period the financial penalty was dropped from the PBC scheme.

[19] SHTP II Interview Notes, May 16, 2012.

After submitting the quarterly indicator results report, the PBC process included a data validation exercise (described in the next section) before bonuses were paid. By linking data to performance and correcting subcontracted partner's reported facility data before making PBC payments, the PBC process increased the overall importance of data quality.

Under SHTP II, targets were proposed by MSH and approved by USAID for the entire project in terms of population percentages and absolute figures. The target percentages were then transferred to the respective subcontracted partners and the county in which they were working. Many partners felt that the targets they were required to achieve were not representative of the communities being served and that a "one-size fits all" approach to establishing targets did not reflect the varying levels of development, geography and demographics – the characteristics of the counties being supported. MSH expressed a similar concern during an SHTP II evaluation interview, in which this issue was discussed, stating, "It's painful to see some subcontracted partners get a bonus when only one facility is causing achievement of the entire county target."[20] To ensure these partners did not focus on only a small number of facilities, a PBC indicator was added to monitor the percent of facilities that received a supervisory visit. Another weakness was the pre-financing and reimbursement requirement whereby subcontracted partners were expected to conduct activities using their own funds and be reimbursed after data validation. Partners stated that it routinely required four to five months from expenditure to reimbursement. For small organizations this constituted a major barrier to participating in SHTP II and to successful fulfillment of contract terms, especially to the only indigenous subcontracted partner involved in SHTP II.

While the PBCs were effective in focusing attention on key aspects of the high-impact services, motivating partners and increasing the importance of data quality, they emphasized immediate results and targets achieved by subcontracted partners instead of measurable health systems strengthening (HSS) improvements involving the MOH. For example, "number of community members trained with USG funds" was a PBC indicator for health system strengthening, but it had no link to whether the trained community members (home health promoters and village health committees) were active and accomplishing anything. Moreover, the performance indicators and targets were quantitative and did not prioritize quality aspects of the services to be provided. For example, "number of children less than 12 months of age who received DPT3 from USG supported programs" was a PBC indicator between MSH and subcontracted partners, as well as a performance indicator of SHTP II between MSH and USAID. This indicator and the associated target motivated subcontracted partners to conduct mobile outreach EPI activities (in some instances to populations outside of their facilities' catchment communities) to achieve the target, but without prioritizing the quality aspect of educating mothers about child health and the importance of immunization. As one subcontracted partner stated: "When the priority is achieving the target, the mother does not know why immunization is important. We want the mother to bring the child to the facility knowing that vaccination will save the child's life."[21] This point was especially significant in light of the 2010 SHHS finding that less than 1 percent of children 12-23 months had vaccination cards.

During EOP evaluation interviews, the MOH at both the county and national levels stated that they did not know how the PBC approach worked because they were not involved in its management. The central MOH said that the value for money attained by SHTP II PBCs was not determined by objectively comparing the results between PBC and non-PBC supported areas, factoring for the administrative management of the PBCs as well as the actual bonuses paid (or withheld) and determining the cost of the potential increased productivity. The MOH was particularly concerned about the (perceived) high cost of managing PBCs. The central MOH went on to say, "Until MOH systems are developed, it would be better to stay away from performance-based work. When systems are developed, it may be possible for the CHD to verify the work of subcontracted partners."

[20] SHTP II Interview Notes, M&E meeting with MSH, May 14, 2012.

[21] SHTP II Interview Notes, May 21, 2012.

Ultimately, the MTE anticipated the potential challenges of the PBC approach and therefore explicitly recommended that it not be implemented, "It is not recommended that an incentive-based PBC system be started if the project has only one year of additional implementation time remaining. Greater emphasis should instead be given to improving the quality and timely reporting of performance indicators."[22] MSH was asked during the evaluation why, in contradiction to the MTE recommendation, the PBC approach was implemented and their response was that the contract with USAID included a specific requirement to use performance-based financing with subcontracted partners to achieve the results described in the Task Order (Task Order). MSH stated that they "believe very strongly that the PBC approach compressed achievement of key indicators into one year that normally would have taken 2–3 years and that is the reason that [they] continued to use the PBC approach."[23] Moreover, they said PBCs were implemented with the full knowledge of USAID, who could have amended their contract to remove PBCs if they felt that the approach did not add value.

A.3 Sufficiency of the data validation process

The original SHTP II Task Order specified that the contractor would be expected to collaborate closely with the CHD to establish improved quality assurance. In the initial stages of SHTP II, the HMIS was very fragmented with no emphasis on data quality. As such, SHTP II had to develop a system to rapidly improve the data quality for those counties in which it operated. The DQA process was initiated in 2010 across all focus counties and a DQA checklist and operating procedures were developed that covered the seven high-impact services.[24] The methodology focused on comparing health facility registers to the subcontracted partner reports, after which MSH debriefed the partners about any issues and made recommendations. A sample review of the DQA assessment reports found that common recommendations were:

- Continue with or improving regularity of CHD-subcontracted partner joint supervisions;
- Provide training and mentoring for health facility staff to reduce basic register misunderstandings and errors;
- Provide updated registers and discontinue use of old versions/substitute use of notebooks; and
- Correct misunderstandings on SHTP II reporting requirements.

At the MTE, concerns were raised about the validity of the data being collected. This led to a recommendation for SHTP II staff to conduct quarterly data validation checks and subcontracted partner staff to visit all facilities at least once a month, with more frequent visits to facilities with a history of reporting problems.[25] In 2011, additional emphasis was placed on improving data quality, including training of all subcontracted partners and CHDs, development of DQA database and a joint assessment of information by USAID and MSH. The joint assessment found that the data quality was generally good, but that further strengthening was needed to improve field site support as well as joint subcontracted partner-MSH health facility staff training.[26] Thereafter, MSH did increase the frequency of DQA visits, but it was not possible to visit all subcontracted partners each quarter, so improvements in data quality were not monitored over time for either the subcontracted partners or the facilities visited.

In addition to the DQA process, the Fully Functional Service Delivery Tool quality assurance tool included one standard specifically for reporting (Standard 9), and the MOH Quantified Supervision Checklist also included two sections relating to data quality, which, if they had been routinely used, might have eliminated

[22] SHTP II Mid-Term Evaluation Report – Public Document, page 48, recommendation 17.

[23] MSH comments on the First Draft of the End of Project Evaluation Report, June 2012.

[24] Management Sciences for Health, *Draft Protocol and Checklist for Data Quality Assurance*, August 2010.

[25] SHTP II Mid-Term Evaluation Report. Management Systems International. January2011.

[26] SHTP II Annual Progress Report for FY 2011.Juba, MSH, October 2011.

the need for dedicated DQA visits.[27] Review of DQA reports found that the most common data errors identified during DQA visits were arithmetic (simple counting) errors that could have been identified and corrected locally. Other data errors should have been noticed immediately, such as sudden increases or numbers incorrectly written against the data element, by the subcontracted partner rather than requiring verification by a field visit from MSH. MSH acknowledged that ideally DQA should take place during routine supervision, as partners and CHDs were trained to do, but as the DQA was not being done it was necessary for MSH to conduct DQA outside of routine supervision.[28]

The overall findings from the EOP evaluation interviews and field visits were that the standardized MSH data verification process responded to the Task Order and the SHTP II MTE in terms of instituting regular and independent facility data verification. The DQA methodology was appreciated by subcontracted partners and improved data quality has been achieved during the project. However, there was a lack of consistent MOH participation in the process, which was administered and led by MSH during subcontracted partner visits.

B. Health Systems Strengthening

According to the Task Order, the principal objective of USAID/South Sudan's involvement in health systems strengthening was to ensure that the MOH at the county and state level was able to manage the delivery of high-priority health services. Working through subcontracted partners, it was considered essential that SHTP II develop an assessment-based approach to strategically identify requirements for system strengthening in each county. Likely areas that would require support included health systems management, governance and human resources. Strategies such as co-location with counterparts, county planning, improved community governance, and health worker training were envisaged. However, at the outset of the project, the very low baseline of national health systems posed significant implementation challenges for SHTP II and for the sustainability of health services. Moreover, the expectation was made during the design of SHTP II that certain health systems areas, such as infrastructure, essential drugs and human resources, would be financed by other sources of funding. When these areas were not funded by other sources, such as payment of health worker salaries, SHTP II tried to be responsive by supporting what it could, but these areas became major unplanned drains on project resources.

B.1 Health Management Information Systems

The SHTP I final assessment report was critical of the lack of harmonization of tools and poor monitoring processes at USAID-supported health facilities.[29] However, the SHTP II Task Order did not specifically require the establishment of a harmonized HMIS system and the performance standard for information systems was simply that 80 percent of supported health facilities submit their monthly HMIS reporting form within one month of the reporting month.

At the beginning of SHTP II, MSH addressed the poor information tools and monitoring problem by facilitating a harmonized approach to information collection among partners. This harmonization involved bringing together all of the subcontracted partners and the MOH to review all of the tools being used and to develop a consensus on what SHTP II would use during implementation. MSH then implemented the HMIS system in the focus counties by providing forms, training, collecting reports, and compiling and verifying data. The performance target was achieved within the first year of implementation and maintained

[27] fully functional service delivery point Draft Assessment Report, Juba, May 2012, Standard 9.

[28] MSH comments on the First Draft of the End of Project Evaluation Report, June 2012.

[29] SHTPI Assessment Report. Washington, DC: IT Shows, Inc. 2008.

thereafter. However, the MTE highlighted deficiencies in the capacity of health facility staff to use the HMIS tools, especially the registers.

Subsequent to the MTE, the MOH developed a new national HMIS system, accompanied by the supportive supervision tool (Quantified Supervision Checklist), monthly reporting format, updated registers and software. The finalization workshop for the national HMIS system was held in February 2011 involving all major stakeholders and official endorsement of the tools and software occurred in April 2011.[30] MSH maintained that because no resources were provided by the MOH to rollout the new national HMIS, it was an unfunded mandate for which SHTP II did not have the resources and that the system that did not collect data related to gender that was required by USAID. Nevertheless, SHTP II did print and distribute the new HMIS forms and registers and incorporated training of trainers on HMIS into the SHTP II training schedule.[31]

However, the transition to the national system by SHTP II was slow and remains incomplete. At the EOP evaluation in May 2012, only 50 percent of the subcontracted partners were using the new national HMIS system.[32] Of the partners using the system, most were doing so because of pressure from government counterparts to move to the new national system. One partner stated, "MSH wanted us to submit reports using the older version of tools while MOH/CHD also wanted us to submit reports using new District Health Information System (DHIS) tools. This has caused us many problems over the past year."[33] The other 50 percent of subcontracted partners were starting the transition to the national HMIS system in May 2012, but health facility staffs in most cases were not yet trained. The split between reporting systems was apparent during the evaluation team's facility visits, where two counties were using the old system and two were implementing the new national system. Also, a variety of different registers (both new and old versions) were being used in the different field visits.

Fully functional service delivery point: Under the Task Order, the performance standard for supervision was to ensure that 80 percent of county health departments in the focus counties conduct joint, routine facility monitoring and supervision visits with subcontracted partners. Although this standard was not included as a performance indicator in SHTP II annual performance management plans, it was used as a PBC indicator between MSH and subcontracted partners. All subcontracted partners and CHDs interviewed during the EOP evaluation reported that joint supervision between partners and the CHD occurred at least quarterly and in several cases on a monthly basis. At the beginning of SHTP II there was no standard supervisory tool used by either the government or subcontracted partners. Therefore, the fully functional service delivery point tool was introduced, covering 11 standards for health facility activities: infrastructure, equipment and supplies, service delivery, HR, referral, IEC/BCC, community support, quality of care, HMIS, drugs and management.

While the fully functional service delivery point captured a large amount of information, it also took a large amount of time to conduct and collected information that was not relevant for most locations, especially for PHCUs, which constitute 75 percent of the SHTP II supported health facilities. The large amount of information being collected led one subcontracted partner to state that they didn't see the point of collecting data on issues that were not intended to be addressed by SHTP II, such as infrastructure, "The fully functional service delivery point tool identified gaps that the project was unable to resolve – the gap remained a gap." During interviews, all partners stated separately that they felt the tool was not appropriate for the South Sudan context and collectively they confirmed that point during the validation meeting with one partner stating, "SHTP II is collecting information which is in a "nice to know" category rather than in an essential "need to know" category."

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[30] MOH, Endorsement Letter for Health Management Information Systems and Tools Rollout, April 2011.

[31] MSH comments on the First Draft of the End of Project Evaluation Report, June 2012.

[32] SHTP II: Final Evaluation Sub-Contracting Partner Rapid Survey. May 2012.

[33] Final Evaluation Subcontracted Partner Interviews, May 2012.

The tool was rolled out to subcontracted partners at about the same time that the MOH Quantified Supervision Checklist supervision tool. Even after the latter supervision tool was approved in April 2011, the fully functional service delivery point tool continued to be used and updated guidelines were introduced as late as November 2011.[34] When asked about the duplication of the fully functional service delivery point with the MOH Quantified Supervision Checklist tool during the evaluation, MSH responded that the rollout of the former tool began several months before the Quantified Supervision Checklist rollout, and MSH believed that they were contractually obliged to continue to use the tool. They also maintained that the fully functional service delivery point tool was revised to incorporate Quantified Supervision Checklist aspects when it was released so that the "subcontracted partners could implement the Quantified Supervision Checklist, or the fully functional service delivery point, or both, giving maximum flexibility."[35]

In terms of its effectiveness, baselines were established using the fully functional service delivery point tool at about 30 of the 40 PHCCs supported by the SHTP II project. After more than one year of using the tool, the Fully Functional Service Delivery Point Draft Assessment Report produced in May 2012 reported on results at 17 PHCCs according to a varying number of standards. For some facilities, three result areas were reported and for others as many as six result areas were reported, making comparison among facilities difficult. Among the varying result areas, there was not a clear trend towards improvement and no comparison was made to non-SHTP II facilities in order to benchmark the tool's impact. Ultimately, although use of the tool was fundamentally an effort to improve quality at the health facilities, its benefits to health system strengthening were not evident during the EOP evaluation.

B.2 Human Resources

As the SHTP II Task Order from 2009 explicitly notes, "The capacity of human resources is the greatest challenge in Southern Sudan."[36] SHTP II intended to prioritize human resource strengthening through a strategy of "continuous engagement," especially at the community and county levels. At the community level, human resource strengthening was directed to training Community Health Workers (CHWs), and Maternal Child Health Workers (MCHWs), and home health promoters. At the state and county levels, the priority was to build their capacity to plan and manage the health sector. Observers concluded after the MTE that, due to a slow scale-up of the training aspect, the project might be best served by dropping the expectation to link with the regional training centers and focusing on scaling-up training for the high-impact services, which was then enacted.

At the EOP evaluation, the target number of 2,750 health workers to be trained had nearly tripled since the first year of the project (1,000) and was on track to being achieved. Similarly, the target number of community members to be trained more than doubled from 2,500 to 6,200. Key training priorities such as refresher trainings for midwives, obstetrics training for MCHWs and child health training for all cadres were conducted and an extensive home health promoter curriculum was developed and disseminated among subcontracted partners, although it has not yet been approved by the MOH. The standardization of training was a major strength of the SHTP II project that enabled scale-up of training for the high-impact services.

An area of concern identified during the evaluation was that individual human resource records of health worker qualifications, training needs and trainings received have not been systematically kept beyond the number, gender and type of health workers trained by topic area. Establishing county-level human resource files that include individual health worker qualifications and training history could be done with relative ease and, coupled with using HMIS data for decision-making, could form the basis for improved workforce investments in the future.

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[34] SHTP IIQuarterly Report October 1, 2011 to December 31, 2011. Juba, MSH, January 2012.

[35] MSH comments on the First Draft of the End of Project Evaluation Report, June 2012.

[36] SHTP IITask Order, USAID, 2009.

While the number of trained community members and existing health workers who received refresher training both increased rapidly during the second half of the project, the decision not to link SHTP II to pre-service training institutions had quite a profound impact on the project. The EOP evaluation identified only one instance in which community-identified women, five in total, were supported in attending midwifery school. The evidence indicates that this was the main contribution SHTP II made to producing additional skilled health workers and closing the workforce gap in the focus counties between the number of actual health workers and the number needed. MSH reported that after the MTE the project worked very hard to increase the number of midwives. Indeed, the number of midwives employed by the subcontracted partners increased about 40 percent from around 100 to over 140. However, most of these new midwives were previously employed by other NGOs rather than being additions to the workforce.

In order to retain health workers, partners paid incentives to health workers according to the MOH-approved staffing patterns, but the amount paid was not closely regulated. This led to competing salary levels among partners and with NGOs funded by other donors, contributing to health worker migration and escalating incentive costs. Paying incentives had an immediate benefit to the availability of health services; estimates were that up to 60 percent of health workers in SHTP II-supported facilities were paid by USAID. Ironically, in one county where the subcontracted partner was unable to recruit and pay health workers due to a budgetary misunderstanding, the State Ministries of Health (SMOH) assumed responsibility for assigning health workers to the subcontracted partner-supported facilities, including at least one skilled professional at each facility.[37] While this subcontracted partner's experience was an isolated case, in the current context of the Government of South Sudan's revenue shortfalls, serious consideration should be given to USAID's willingness to pay health workers and the potential enabling effects that might have on government budgetary allocations for health.

At the CHD level, human resource gaps forced partners to step in and fulfill some CHD function, e.g., facility supervision. When this occurred, a staff person was usually employed to work for the partner rather than for the CHD, as opposed to what happened at the facility level, where health workers were recruited and paid by the partner to work for the facility. One CHD medical officer pointed out this contradiction, "The subcontracted partner program managers and supervisors should be based here in the CHD office and work as a member of the CHD team."[38]

In order to increase the capacity at the county, state and national levels, leadership development program was instituted to improve the quality of leadership and planning. The program includes four modules: scanning, planning, aligning (mobilization), and results. It focuses on management and leadership rather than specific technical areas. The aim is to develop problem-solving skills by working through the process, develop action plans, and then roll out the changes. An Arabic version was also developed. Participants from subcontracted partners, CHDs, PHCCs, village health committees and the central MOH were enthusiastic about the leadership development program. Anecdotal comments made during the evaluation suggested that the methodology was effective, but at the end of project the future sustainability of the program was uncertain.

B.3 Infrastructure

Health infrastructure was a massive challenge for all subcontracted partners during the implementation of SHTP II. According to the 2010 health facility mapping survey, which included SHTP II focus counties, 57 percent of health facilities in South Sudan were non-permanent structures.[39] In general, whether permanent or non-permanent, PHCCs had better infrastructure than PHCUs, which did not have adequate space to

[37] SHTP II Interview Notes, May 26, 2012.

[38] SHTP II Interview Notes, Juba CHD Meeting, May 22, 2012.

[39] Ministry of Health, Republic of South Sudan.(2010). Rapid Health Facility Assessment Report.

provide the necessary services. Lack of appropriate delivery space was an obvious shortcoming of all PHCUs, but also lacking was appropriate inpatient space to conduct FP counseling and HIV/AIDS counseling. The EOP evaluation interviews found that communities linked infrastructure with quality of services. Therefore, a lack of appropriate facility space was a potential deterrent to uptake of high-impact services. The original SHTP II Task Order did not include specific infrastructure activities and SHTP II budgets (MSH and subcontracted partner) only included the resources necessary to make minor renovations and perform facility maintenance.

Although it recognized that SHTP II budgets were totally inadequate to address infrastructure needs, the MTE recommended conducting a rapid facility infrastructure assessment at SHTP II facilities "to provide a clear picture of current infrastructure deficiencies and suggest strategies for remedying deficiencies."[40] A subsequent rapid infrastructure assessment was conducted in accordance with the MTE recommendation. The assessment results covered only eight of the 14 counties and the cost for renovating a single PHCU ranged from $4,635 to $50,000. The estimate to meet the essential infrastructure needs across the eight counties was $2.1 million, including the cost of completing a number of SHTP I facility construction projects that were unfinished. For example, in Wulu County, Lakes State, a new health facility construction project initiated under SHTP I was not completed, and now a skeleton structure with an expensive roof still intact stands as a reminder to the community and local government that USAID did not complete the facility construction it started. In the interim, the current fully-staffed PHCU has been functioning out of one room in the local payam office.

Incomplete construction at Nukta Manga PHCU, Wulu County, Lakes State

In some encouraging instances, one subcontracted partner collaborated with active village health committees by matching community-provided support for construction of PHCUs. At a cost of just $2,500, the partner was able to provide the hardware materials and skilled labor necessary to transform community-made bricks into a low-cost PHCU structure.

[40] SHTP II Mid-Term Evaluation Report – Public Document, page 47, recommendation 6.

B.4 Supply Chain

The availability of essential medicines in South Sudan was a major challenge for all subcontracted partners during project implementation. The national drug procurement system was managed by the MOH with financial support from the Multi-Donor Trust Fund (MDTF), which was coming to an end at the time of the evaluation. The mechanism was described as a "push system" whereby provision of drugs by the MOH was not based on consumption patterns and morbidity trends, due to lack of information. A standard quantity of drugs and materials, reflecting consumption patterns during the war, was provided by the MOH to all equivalent health facilities under SHTP II. Because the quantity was standard, many facilities suffered chronic stock-outs of some essential drugs and over-supply of others, especially Ringers lactate solution, bandages, and other items that were used in greater quantity during the war.

Although the SHTP II contract did not provide for the procurement of essential medicines, the Task Order called for improving the logistics system to allow a regular supply of drugs to stock health facilities. The performance standard was that 80 percent of CHDs could effectively conduct aggregate forecasts of their pharmaceutical and commodities consumption. The evaluation team found that SHTP II consistently supported the transportation of drugs either from the national, state or county levels to facilities. At the national level, MSH managed shortfalls in MOH-provided drug kits on behalf of the subcontracted partners, and was repeatedly credited during the evaluation by subcontracted partners for the effort made in 2011 to overcome a national shortage of ACT for malaria. Subsequently, CHDs were trained by SHTP II in drug forecasting to improve the future availability of ACTs. At the facility level, stock-outs were dealt with on a case-by-case basis by redistributing drugs among facilities. When redistribution of drugs was not a viable solution, subcontracted partners reported borrowing drugs from other projects, such as the BSF, to meet shortfalls. Most PHCUs were using precious facility space to store huge quantities of bulky items (e.g., Ringers lactate solution) that continued to be provided by the MOH and large quantities of oversupplied drugs that had expired.

In an innovative approach to the over/under drug supply problem, one partner found that supporting the CHD to establish a county drug depot was an effective, low-cost strategy to minimize stock-outs and over-supply of drugs. It worked by simply unpacking the MOH drug kits provided for each facility in the county into an organized space for management of drug supply at the county level. The existing facility stock cards were used to keep track of inventory and complementary, on-the-job training was provided to both CHD and health facility staffs on how to request drugs according to consumption. When the EOP evaluation findings were validated with all subcontracted partners, many of them reported using this technique in other non-SHTP II focus counties where they had more funds available than under SHTP II to establish the drug depot.

C. Community Demand for Services

Community level activities were central to the design and implementation of the SHTP II project. Given the lack of skilled health professionals in PHCUs and in the community, the Task Order envisaged that at the primary health care level CHWs, MCHWs, TBAs, traditional healers, and home health promoters would be the focus of capacity-building. The expectation was that the seven high-impact services relied upon these cadres of community workers and volunteers to be delivered. The Task Order also imagined community-based organizations (CBOs) would be central to mobilizing the community demand for the high-impact services. Therefore SHTP II was expected to invest in training and supporting village health committees as well as to identify opportunities to work with and strengthen the involvement of non-health civil society groups, non-governmental organizations (NGOs), faith-based organizations (FBOs), and CBOs.

C.1 Community Level Training

One particularly notable strength of the SHTP II project was the use of standardized trainings (as described above in Section B.2) to rapidly increase the number of trained community members, namely home health promoters and village health committees. According to the USAID's 2012 PMP for SHTP II, the target number of community members to be trained during the entire project period was 12,700 and at the time of the evaluation SHTP II was on course to achieve that target. Scale-up of community member training resulted in establishing or reestablishing village health committees at 80 percent of supported facilities that were involved in facility maintenance, oversight of drug deliveries and in some cases renovation or construction of semi-permanent structures.[41] However, although the number of home health promoters increased, they generally did not provide the expected services due to inconsistent motivation, low qualifications, unrealistic expectations and lack of supervision. The MOH prohibited paying community level volunteer health workers, which facility staffs are expected to be supervise, because the MOH cannot sustain the cost in the future at the expense of other priority cadres.

Lack of geographic and activity-based coordination among donors and NGOs meant that in many areas where home health promoters were meant to be active, other community-level workers were active and were being incentivized and supervised directly by NGOs - creating confusion and undermining home health promoter motivation. The evaluation found that other donors were funding several SHTP II subcontracted partners to implement a community case management (CCM) of malaria, pneumonia and diarrhea project that used community-based distributors (CBDs) within the catchment population of SHTP II supported facilities. These CBDs were given incentives (e.g., cash equivalents such as kilograms of sugar, clothing, flashlights), trained to provide CCM, supervised directly by the partner, and reported their patient contacts outside of the SHTP II HMIS systems. Yet these partners also reported CBDs under SHTP II as trained and functioning home health promoters. When questioned how this was justifiable, they maintained that the home health promoter curriculum was modular and therefore being trained in just two or three areas did not disqualify the CBDs from being considered home health promoters, nor did they see a problem with providing incentives and special supervision. The problems with this approach are: (1) the MOH will never know the skills and services being provided by home health promoters unless they are trained consistently according to a standard curriculum; (2) the MOH repeatedly stated during the evaluation that they had no intention of paying incentives to volunteer workers; (3) inconsistent provision of incentives to community volunteers discourages the non-incentivized volunteers; and (4) reporting CBDs who are trained and supported by another project as home health promoters is inaccurate. A major cause for concern is that in nine of the 16 counties in which USAID expects to provide future support to health service delivery, other donors will fund the CBD approach, creating a high probability of continued confusion in the area of community health services.

Finally, the draft curriculum of home health promoters is remarkably similar to the curriculum of CHWs, which the MOH banned from production in 2009. The curriculum includes over 50 modules and requires more than six months of training for individuals who are intended to be a volunteer cadre of health worker. Several stakeholders acknowledged that the creation of the home health promoter cadre was one way of getting around the MOH prohibition of training further CHWs. The MOH stated that prohibition of training further CHWs was put in place to a large extent because of the disproportionate investment in training low-level health workers, resulting in a workforce that was overwhelmingly unskilled.[42]

[41] SHTP II: Final Evaluation Sub-Contracting Partner Rapid Survey. May 2012.

[42] SHTP II Interview Notes, MOH meeting, May 21, 2012.

C.2 Community Involvement

The involvement of community-level non-health civil society groups and local NGOs, CBOs and FBOs through micro-grants for community initiatives did not materialize as envisioned in the Task Order. Because the micro-grant scheme had not yet started, the MTE, recommended that SHTP II should focus instead on improving community health awareness by increasing the funding available to subcontracted partners to train home health promoters and village health committees. As there was little more than one year remaining in the project, this would be an expeditious strategy to maximize results by the end of the project period in terms of the number of community members trained.

Village Health Committee, Kotobi PHCC, Mundri West County

Through interviews with subcontracted partners and village health committees, the evaluation found that not involving CBOs and funding for community initiatives had a negative effect on community ownership. Social development methodologies of working with communities to identify and address their own needs were not incorporated into community level activities and as a result the communities had little ownership over the project activities. This perspective was validated by subcontracted partners during the validation meeting, and field visits showed that village health committees seemed to require motivation in the form of refreshments in order to convene a meeting. Ultimately, community-level activities were conducted according to the performance-based indicator (number of community members in home health promoter and village health committee trained with USG support), instead of addressing issues identified by communities, such as working with women doing home-based deliveries, which was suggested by one community leader in Wulu County.

D. Balance among the Results and Ramifications

The SHTP II result areas of service delivery, sustainability and increasing demand were not mutually exclusive. Work in one result area was intended to have an improving effect on the other result areas. Strengthening human resources (e.g., health systems) was intended to have an impact on service delivery, just as improving service delivery was expected to stimulate community demand.

Assigning performance indicators and targets to the result areas, which determined the allocation of resources (time and money), established the balance among the results to be achieved. Originally, the SHTP II health system strengthening and community mobilization results had nine performance indicators assigned across areas of management, governance, health policy dissemination, and human resource capacity. As the project progressed, the overall number of performance indicators was reduced and the majority of the remaining indicators were deliberately focused on service delivery (12 out of 17).[43] Just two performance indicators each were allocated to community mobilization and health systems strengthening, and the final indicator focused on water disinfection. The prioritization among results was also evident in the PBC scoring calculations, in which seven of 11 performance indicators were directly linked with health services.

[43] USAID SHTP II Performance Monitoring Plan. (2012). Please note that an indicator was removed from 2011 version relating to assisted deliveries by a trained traditional birth attendant (TBA or MCHW).

The ramification of the balance among the results was that the project emphasis was predominantly on facility-based services. Evidence for this finding was rooted in the SHTP II Task Order, the rapid survey, and the 2012 semi-annual SHTP II progress report. Field visits confirmed that the high-impact services were generally available whereas the original community demand-increasing activities involving local NGOs, CBOs and FBOs were not implemented, home health promoters were only marginally functional, and village health committees were facility-focused instead of actively mobilizing community demand. In terms of health systems sustainability, the project information and monitoring systems were vertical, opportunities were missed for low-cost quick wins in improving supply chain management, and refresher training of health workers was the main measureable health system strengthening accomplishment. Not surprisingly, subcontracted partners repeatedly stated that the project activities focused on service delivery rather than on either community mobilization or strengthening health systems.[44]

E. Communication and Management

E.1 Communication

The SHTP II MTE report highlighted that subcontracted partners wanted increased communication, more implementation guidance and more field visits from SHTP II project management. A clearer understanding of roles and responsibilities was needed for successful implementation and shared ownership of the project, and stakeholder orientation and active engagement was needed at all levels. The EOP evaluation team found that the quarterly partner meetings recommended in the MTE had been conducted and all partners reported increased communication and engagement by SHTP II project management in the form of significantly improved implementation guidance and an increased number of field visits. The main communications challenges they subsequently experienced were short-notice requests for information and delays in receiving feedback on information provided. For example, several subcontracted partners referred to the extremely short period of time (about three days) allowed for developing the SHTP II extension period budget and then a lack of feedback on the budget for three to four months.

The subcontracted partners' main MOH partners were the county health departments, which had varying levels of functionality and project understanding.[45] They consistently reported miscommunication and additional demands from the CHDs due to their misunderstanding which activities were included in the project. CHDs as well as SMOHs expected activities outside of the project to be implemented, such as drug procurement and infrastructure improvements. Several partners therefore developed a memorandum of understanding (MOU) with the CHD to define expectations, mutual responsibilities and proposed budgets, so as to minimize confusion and unrealistic requests. One partner held a one-day workshop to jointly develop an MOU with the CHD, which proved very successful in ensuring clearer understanding and improved joint ownership of the project.

The evaluation found that regular meetings occurred between donors such as CIDA, DFID, USAID and the World Bank at the Health Sector Partner Group, however overlap and gaps were still evident in the services delivered.[46] For example, as stated in Section C.1 above, there was inadequate activity-based coordination among donors of community-level activities and the various types of community volunteers. As another example, subcontracted partners reported that for facilities to be handed over from SHTP II to the future World Bank project, there was no clear information about handover timing and the activities that the World Bank would support. Discussions and plan development have occurred between SHTP II, BSF

[44] Final Evaluation Subcontracted Partner Interviews, May 2012

[45] Please note that the relationship between the project and the county commissioner's office was not systematically explored. However it is worth pursuing in the next project inception period, due to its local oversight role for use of the Constituency Development Fund (CDF) and the potential advocacy opportunity for targeted health funding for areas such as health infrastructure.

[46] Final Evaluation Development Partner Interview (BSF, DFID, JDO), May 2012

and relevant implementing partners for the Health Pooled Fund. So the lack of clarity may mainly have occurred in the World Bank supported areas of Upper Nile and Jonglei States. The management agents hired by different donors to manage activities could have had more systematic meetings so that lessons learned and practical ideas could be routinely shared to improve management and harmonization of support for health services.

E.2 Management

The original Task Order anticipated that USAID and national MOH representatives would form a Core Group Management Committee to provide oversight during project implementation, review progress, and recommend changes on a quarterly basis.[47] It was clear from the evaluation interviews that the oversight functions fell short of providing strategic direction to SHTP II, resulting in less national ownership over the project and potential exacerbation of the imbalance between service delivery, building national health systems and increasing demand. In the end, although the project results have been consistently presented to the MOH and the MOH has regularly participated in quarterly review meetings, one MOH official said, "The concept of working together is not about presenting the results or findings of an evaluation, it is about being partners in determining the need, the design, the implementation, and the supervision. The counties should also be involved in this process."[48]

As described above in Section I, "Background and Health Context," SHTP II was intended to accelerate health system development by balancing the provision of essential services while increasing the capacity of the MOH at county and state levels to manage the service delivery system. According to evaluation interviews with USAID, the project management approach changed from a cooperative agreement under SHTP I to a contract under SHTP II in order to give USAID more control over the direction and priorities of the project. The Task Order established objectives and expected results for the project and annual PMPs were used as a tool to influence prioritization of activities without having to revise the contract.

The end of project evaluation found that although the shift from a cooperative agreement to a contract was intended to increase USAID's ability to influence project implementation, the contract mechanism imposed a rigid framework of requirements that diminished the responsiveness of the project in an evolving context. An example of this was the Task Order requirement to award PBCs to the lead agencies in the counties previously supported under SHTP I in order to achieve the project results.[49] In addition to predetermining which organizations should receive contracts, the SHTP II contract included an arbitrary requirement of MSH to provide 75 percent of contract funds to the subcontracted partners and retain 25 percent for contract administration, which was insufficient to effectively administer the project.[50] MSH reported that another example of the effect of using a contract agreement were the delays in approving staff by the USAID contract office, which contributed to SHTP II being only 50-percent staffed at the time of the MTE.[51]

In terms of SHTP II sub-contract management, the issue of long delays in sub-contract awards noted in the MTE was not resolved. The majority of partners found sub-contract negotiations very challenging, and several reported long delays in the sub-contract finalization for the extension period. At the time of the EOP evaluation, one partner reported that they had not yet received a signed sub-contract and another reported that it had only just been received.

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[47] SHTP II Task Order, USAID, 2009.

[48] Final Evaluation, MOH Representatives Interview, May 2012

[49] Task Order Section C.3, Lead Agencies and Local NGOs/CBOs, page 8.

[50] USAID eventually changed that requirement which allowed MSH to hire more staffs for quality improvement activities, such as data quality assurance and field supervision.

[51] MSH comments on the First Draft of the End of Project Evaluation Report, June 2012.

V. RECOMMENDATIONS

A. Recommendations to Improve Service Delivery

1. **USAID health programming should increase its advocacy and support for implementation of the National Reproductive Health Strategic Plan.**

In the face of unavoidable shortages in the necessary number of SBAs, a very strong cultural preference for home-based delivery, and ineffective emergency referral, it is imperative to improve maternal health services in order to begin to reduce the extremely high maternal mortality in South Sudan. Therefore USAID health programming should increase its advocacy and support for implementation of the National Reproductive Health Strategic Plan, which includes:

- Formulating and implementing strategies for making services more accessible, especially for hard-to-reach populations living in rural areas, which could be accomplished by increasing the type, number and deployment of community-based SBAs.
- Encouraging and supporting community and home-based initiatives to reduce maternal and neonatal mortality, such as home-based life-saving skills initiatives , that have been shown to be effective in similar contexts.
- Providing kits for safe delivery and incentives for increasing facility-based deliveries (such as mother-baby kits) as well as incentives for continuing to increase ANC attendance.

In discussions with the MOH, they indicated that the strong cultural preference for home-based deliveries warranted priority formulation of the strategy for making services more accessible in rural areas, while increasing investment in pre-service training to increase the number of SBAs. Therefore, and as anticipated in the BPHS, USAID and other development partners should discuss with the MOH the feasibility of resuming limited MCHW training with emphasis on selected simple reproductive health care interventions until a sufficient number of SBAs have been produced.

2. **Support for integrated high-impact services should be bundled into a single contract and focused on the same catchment areas.**

The vertical implementation of high-impact services such as hygiene and sanitation, and HIV/AIDS has undermined the cohesion of services at the facility level. Instead of contracting multiple providers to deliver services (such as PMTCT and WASH), support for high-impact services should be bundled together into a single contract per county or catchment area in order to reduce costs, increase cohesion, and improve the overall quality of services.

3. **The selection and allocation of project indicators should be diversified, include quality aspects, and be better balanced among the results.**

Clear evidence exists that the number of performance-based indicators established the balance and prioritization of the results to be achieved. Therefore, the selection and allocation of project indicators (performance or otherwise) should be diversified and be better balanced among the results to be achieved. Quality of care indicators should be included to improve the likelihood that the right services are correctly provided and make the best use of the resources available in order to satisfy patients.

4. **Health programming should use performance targets for service-delivery that are based on state or county planning.**

The use of targets was successful at motivating subcontracted partners to increase the availability and uptake of high-impact services. This target-based strategy should be retained, but with an emphasis on establishing and achieving state- or county-level targets in order to increase cohesiveness, ownership and sustainability of the services being provided. Wherever possible, targets should be based on local health system planning done with the CHDs and other stakeholders as appropriate, and cover areas such as micro-planning to increase EPI coverage, human resource planning according to workload, and planning to improve referral systems for obstetrics and other emergencies. In areas that lack functional CHDs, SMOHs should be supported to establish aggregate state health system targets that are in line with national priorities, disaggregated by county.

5. **Reinforce the non-monetary motivation partners have for achieving targets and discontinue the current performance-based financing approach.**

Ample evidence was found that the financial component of PBCs was not the only motivation of partner performance and in at least one case it exacerbated already poor partner performance (see Strengths and weaknesses of the PBC approach, p17). Therefore USAID should discontinue the current form of performance-based financing and increase the use of non-monetary means of motivating partners to leverage the intrinsic importance many of them place on being perceived as a credible health organization. Publication of national health facility accreditation results based on either lot quality assurance (LQA) methods or blanket health facility assessment has been used in similar contexts to rank providers, acknowledge performance and inform future funding decisions.[52]

6. **Discontinue the pre-financing of service delivery requirement for implementing partners.**

The SHTP II approach of requiring not-for-profit organizations to pre-finance the functioning of the government health system in South Sudan discriminated against smaller organizations that could not afford to subsidize government health services and caused a negative impact on services. Therefore, the pre-financing requirement should be discontinued and future subcontracted partners should be advanced the necessary program funds to encourage local NGO involvement, foster competition during bidding processes and minimize the negative impact that the financing modality has on health services.

B. Recommendations to Improve Health System Strengthening

7. **Use MOH tools, such as the Quantified Supervision Checklist, as soon they become available.**

The fully functional service delivery point tool was praised its comprehensiveness, but it was found to be too cumbersome and detailed to be used for routine supervision, especially at PHCUs. Moreover, investing in rolling out the fully functional service delivery point tool was at the expense in of rolling out the MOH's supervision tool in USAID supported counties. The MOH's Quality Supervision Checklist has been widely adopted by other development partners in South Sudan and should be adopted by USAID health programs. However, one point worth exploring is the possibility of adapting the SHTP II comprehensive fully functional service delivery point concept into a national facility accreditation tool (as mentioned in recommendation 5), with variations according to the type of facility, which could be used to assess health facilities on an annual or bi-annual basis.

8. **Support for health service delivery should rely the national HMIS system and include training of health system managers to use the information that is available to them.**

[52] Cleveland et al., "Introducing health facility accreditation in Liberia," Global Public Health, 2010.

HMIS data is the most important information health system managers have and it is essential that health system managers know how to use the data for decision-making in order for the system and sustainability to improve. Relatively simple calculations to determine staff and facility workload, based on complete HMIS data, can have a profound impact on improving the allocation of resources and should be the foundation for basic health system planning. Therefore, USAID support for health service delivery should rely on the national HMIS system and include training of health system managers on how to use the information that is available to them in order to increase efficiency, effectiveness, and equity in health services.

9. **MOH counterparts at all levels should be supported to verify data provided by subordinate levels in the health system during routine supervision.**

Data verification should continue because the process was successful at improving data quality. However, responsibility for the process should be transferred to MOH counterparts at all levels, as each level has a role to play in verifying the information being provided by subordinate levels in the health system. The central MOH Monitoring and Evaluation (M&E) Department should verify data submitted by state ministries of health, which should verify data received from counties. Within the county health system, data verification should be integrated into routine supportive facility supervision, in accordance with the Quantified Supervision Checklist. Facility data verification should go beyond correcting arithmetic errors and increase the health worker's understanding of using registers and adhering to protocols through providing one-on-one guidance at the facility level.

10. **In order to achieve the necessary skills mix, USAID should support the MOH to finalize and implement the National Human Resources for Health Policy and Strategic Plan.**

A better balance is required between training additional community level volunteers, strengthening the existing workforce, and increasing the overall number of skilled providers. Investments should be balanced among the priority services to be delivered at each level of the health system, in accordance with a HR Policy and Strategic Plan. Priority should be given to ensuring that while gap-filling measures are being implemented, such as training MCHWs to administer misoprostol, investment is also being made in the training of additional skilled birth attendants and upgrading the skills of the existing workforce. The goal should be to close the workforce skills gap as quickly and efficiently as possible. Multiple strategies are possible, including directly supporting pre-service training institutions and linking them to USAID support for service delivery, supporting tuition for students selected from focus counties, or establishing small-scale local training programs to upgrade the skills of critical cadres in the counties in which they are working.

11. **In-service training should be based on individual training needs and documented in individual human resource dossiers maintained at the county or state levels.**

Basic records of health worker training, qualifications, employment status and salary payments, which are currently being kept by subcontracted partners, should be expanded into individual HR dossiers at the county or state level. Along with HMIS data, this is the basic health system information required to plan, redeploy and strengthen the workforce in focus counties. Scarce training resource investments should target skills gaps in critical groups according to individual training needs analyses, rather than blanket training of the workforce. Ideally, on-the-job training provided either through direct observation during supervision or by temporary reassignment to a training facility would be adapted according to individual health worker needs. This approach will free up resources for producing the necessary additional health workers mentioned in the recommendation above.

12. **Payment of health worker incentives should be standardized and increasingly transferred to the government.**

Unregulated payment of health worker incentives consumes precious resources needed to produce additional skilled health workers and can potentially undermine government ownership and accountability to pay the health workforce (see B. 2 Human Resources, p23). Therefore, incentives should be standardized and the responsibility gradually transferred to the government. The process should begin by supporting development of a national salary scale for health workers that takes into account hardship factors, in order to increase the incentive to work in underserved rural areas, and that prioritizes incentive levels according to service delivery needs (such as SBAs in rural areas). The human resource dossiers described above will facilitate this process and ensure that only essential, qualified staffs are supported where they are needed.

13. **Duplication of health system managers should be minimized and resources shared among subcontracted partners and CHDs.**

The cost of duplicating functions between the subcontracted partner and CHD is unnecessary and unsustainable. When the partner is obliged to support the recruitment of technical officers such as facility supervisors, M&E officers, and supply chain managers in order to satisfy the needs of USAID health programming, these officers should be seconded - to the extent possible - to the CHD counterpart office and gradually transferred onto the government payroll as described in the recommendation above. Several have successfully implemented this approach under SHTP II as well as by some NGOs under the MDTF project, and should become the norm with exceptions being made on a case-by-case basis (e.g., in the absence of a functioning CHD). Constraints such as lack of CHD office space are not reasons to avoid having to pool scarce resources to manage the county health system.

14. **Retain some budgetary flexibility to purchase essential drugs in case the central drug supply system fails.**

The MDTF-financed central drug supply system will end in 2012. If the government is unable to replace the resources currently being provided by the MDTF, health programs should retain some budget flexibility to purchase essential medicines to fill gaps as they arise. In the case that government revenues do return to normal levels but remain insufficient to finance all areas of the health system, priority should be given to transferring donor-funded health workers onto the government payroll rather than prioritizing a government-financed drug supply. International partners are much better positioned to provide high-quality, low-cost drugs than government, and having to pay for the workforce is an incentive for government to keep it lean and efficient.

15. **Train facility staff, county health departments and state health authorities in the fundamentals of supply chain management.**

Irrespective of who pays for drugs, there is huge potential for making low-cost, high-impact improvements to the efficiency of the supply chain in South Sudan that would begin the gradual process of moving from a "push" to a "pull" drug system. Efficiencies can be realized at all levels by including modest resources into budgets for training and for the decentralized storage of drugs - starting with reinforcing rational drug prescription to reduce over prescription of drugs, facility-based drug requisitioning according to consumption, and county, state, and national level stock management and forecasting. USAID should also discuss with other development partners and the MOH the merits of developing a national supply chain master plan to guide all stakeholders in this process and ensure transparent, efficient participation.

16. **Future health systems support should include technical assistance for development of health infrastructure standards for space, materials, design, energy and safety.**

In the health system reconstruction process, many actors, including subcontracted partners, identify private resources for the construction or renovation of health facilities. Without basic standards, health infrastructure will become increasingly fragmented in terms of design and functionality, and threaten to be

of a potentially deteriorating quality. A relatively low-cost, but worthwhile health system strengthening activity is to support the development of health infrastructure standards for space, material, design, energy and safety. These basic standards can guide government, subcontracted partner, and community-built facilities that will increasingly be built in South Sudan. Special attention should be paid to avoiding development of mere blueprints for expensive facilities - infrastructure standards are not blueprints. Notwithstanding the constraints on construction of new health facilities that existed under SHTP II, USAID should prioritize, through whatever modality is most practical, the completion of new construction activities that were initiated under SHTP I.

C. Recommendations to Increase Demand for Services

17. **Support development of a national community health services policy and strategy that defines the services to be provided at the community-level and who will provide them.**

Lack of guidance by the MOH about community-level health services is causing general confusion at the community level among all stakeholders. USAID should coordinate with other development partners, either as a health system strengthening activity or as a service delivery activity, and support the MOH in developing a national community health services policy and strategy that defines the health services to be provided at the community level, who will provide them, how providers will be motivated and supervised, and how much investment should be made at this level of the health system. Until such a policy and strategy is in place, blind investment of scarce resources in unapproved, uncoordinated, and volunteer cadres are an unwise choice.

18. **Community-level health investments should be based on community-identified priorities and include the involvement of the community in their implementation.**

All health investments to compliment the community health policy should be based on sound social development plans, in which community-identified health needs are gradually addressed with the involvement of the community to increase their sense of ownership and its sustainability. If this is a USAID and MOH priority activity, the village health committee is an obvious entry point for working with communities to plan how they can meet their own health needs. The small-grant scheme envisaged under SHTP II could also be implemented with village health committees for community co-funded health projects, such as local construction of PHCUs.

D. Recommendations to Improve the Approach

19. **Opportunities should be maintained for involvement of the MOH in oversight of USAID-funded health projects and be expanded where possible.**

It is important that the Core Group Management Committee approach be strengthened in the next phase to increase ownership and accountability, to improve the alignment of USAID health programs with broader health system priorities, and to improve overall health system planning and management. Other opportunities for MOH involvement, if the initiative and motivation exist, should also be created, such as increasing the MOH involvement in quarterly and annual subcontracted partner meetings, which should be framed in the context of county and state progress rather than individual partner performance.

20. **USAID should maintain open dialogue with its implementing partners about the need for flexibility in the South Sudan context.**

Although contractual agreements can be modified and priorities can be established through annual work plans, contracts are perceived to be less flexible by implementers than a cooperative agreement between USAID and its implementing partners. In an evolving context such as South Sudan, it is essential for

USAID and its implementing partners to maintain a consistent, open dialogue about shifting priorities and the legal flexibility that exists within the project to respond as required. Similarly, partners must be vocal about the challenges they are experiencing during implementation and how flexibility on USAID's part could increase the overall project responsiveness and improve the results achieved.

21. **Stakeholder orientation at all levels should be a featured activity at project start-up and be repeated at regular intervals thereafter.**

Subcontracted partners consistently reported miscommunication and additional demands from the communities, facilities, CHDs and SMOHs due to misunderstanding about which activities were included in the project. Several of them therefore developed a memorandum of understanding with the CHD to inform expectations, mutual responsibilities and proposed budgets, so as to minimize confusion and unrealistic requests. However, this need not be done on a case-by-case basis among partners. It is clear that stakeholder orientation at all levels should be a featured activity at project start-up and be repeated at regular intervals thereafter.

22. **In addition to donor coordination, periodic meetings should be required between management organizations for USAID and other donor-funded projects to share lessons learned and improve harmonization.**

Although funding for health is supported by a relatively large number of international donors, including CIDA, DFID, the European Union, the Global Fund for AIDS, Tuberculosis, and Malaria (GFATM), USAID, and the World Bank among others, the number of management organizations working for these donors to manage support for service delivery across most of South Sudan's territory may be as few as three. In addition to continued donor coordination, management organizations for USAID and other donor-funded projects should be required to demonstrate how they cooperate and share lessons learned to improve the overall efficiency and effectiveness of the health system.

ANNEX A: SHTP II END OF PROJECT EVALUATION SCOPE OF WORK

I. Background - Project Identification

1. Project Title: Sudan Health Transformation Program II (SHTP II)
2. Project Number: GHS-I-00-07-00006-00
3. Project Dates: February 11, 2009 to October 10, 2012
4. Project Funding: $58,497,880
5. Implementing Organization: Management Sciences for Health
6. Evaluation Dates: o/a April 23-May 23
7. Contracting Officer's Technical Representative (COTR):
   Anna Hoffman
   Deputy Health Team Leader, USAID/South Sudan
   ahoffman@usaid.gov

II. Background – Development Hypothesis

The main objective of SHTP II is to enhance the decentralization of primary health service to improve the health status of the South Sudanese people. SHTP II aims to achieve the following key results:

Result 1: Expanded access/availability of high-impact services and practices;

Result 2: Increased South Sudanese capability to deliver and manage services; and

Result 3:Increased knowledge of and demand for services and healthy practices

To achieve these results, SHTP II focuses on service delivery and community mobilization as well as health systems strengthening.SHTP II directly contributes to the USAID Investing in People Objective through the provision of the following seven high-impact services and practices, including: child health, nutrition, malaria, hygiene and sanitation practices, maternal health, family planning and prevention of HIV/AIDS.

SHTP II States, Counties, and Subcontracting Parties			
S/N	**State**	**County**	**Subcontracting Partner**
1	CentralEquatorial	Juba	Adventist Development and Relief Association
2	CentralEquatorial	Terekeka	Adventist Development and Relief Association
3	Eastern Equatorial	Kapoeta North	Save the Children
4	Lakes	Wulu	Save the Children
5	WesternEquatorial	Mvolo	Save the Children
6	WesternEquatorial	Mundri East	Mundri Relief and Development Association
7	WesternEquatorial	Mundri West	Action Africa Help International
8	WesternEquatorial	Tambura	International Medical Corps
9	Upper Nile	Malakal	International Medical Corps
10	Jonglei	Twic East	CARE
11	Unity	Panyijar	International Relief Committee
12	Northern Bahr El Ghazal	Aweil South	International Relief Committee
13	Western Bahr El Ghazal	Wau	John Snow, Incorporated
14	Warrap	Tonj South	Comitato Collaborazione Medica

SHTP II is managed by Management Sciences for Health.Its start date was February 11, 2009 and its end date is October 10, 2012. It partners with the International Relief Committee (IRC) and subcontracts with nongovernmental organizations (NGO) for delivering health services in 14 counties in all ten states of Southern Sudan.Table 1 shows SHTP II's subcontracting partners (subcontracted partner) and their geographic locations.

III. Background Information: Existing Information

The SHTP II project developed a performance monitoring plan for this effort and routinely produced quarterly reports documenting the status of the project on its performance indicators. The projects performance monitoring plan and quarterly reports will be provided to the evaluation team by e-mail upon selection of the team.

In addition, in October 2010, USAID, with support from MSI, conducted an independent MTE. Findings from the MTE were incorporated into subsequent work plans and project activities. A copy of this evaluation will be made available to the evaluation team with the performance monitoring plan and report described above. USAID/South Sudan will provide the entire team with additional key documents before the start of in-country work for their review. Background documents will include:

- SHTP II MTE
- Quarterly and annual reports
- Project PMP, targets, and quarterly data
- Relevant field trip reports
- DQAs

IV. Evaluation Purpose

The purpose of this performance evaluation of SHTP II is to help USAID understand what have been the strengths and weaknesses in the current approach to health service delivery and systems strengthening, especially as they relate to capacity-building, sustainability, and measurement and achievement of results.This information will inform a new program planning, as well as provide information and recommendations to the health portfolio in general. Evaluation findings will inform the design of work plans for the follow-on project, as well as USAID/South Sudan's overall health strategy. Findings will be shared widely with other stakeholders, including the Ministry of Health and other donors, so that other health interventions may benefit from the findings and conclusions of the evaluation.

To support this purpose, the evaluation is expected to:

1. Assess program performance in meeting targets and accomplishing its three key objectives.

2. Assess how the program has supported the transition from relief to development, specifically the systems strengthening component.

3. Assess the project's accomplishments, as well as challenges that remain, and areas that should be the focus of future activities.

4. Make recommendations to assist future programs, including identifying lessons learned and recommendations for future strategies.

V. Evaluation Questions

Consistent with the evaluation's purpose, main research questions will focus on the project's successes and challenges in the areas of capacity-building, sustainability, and measurement and achievement of results. The following questions will be addressed:

Research Area	Research Areas
Overarching	How did the project balance achieving the three key results of service delivery, community mobilization, and system strengthening, and what may have been the ramifications of focusing more on one area than another? What lessons can be learned from the approach to achieving the three key results of service delivery, community mobilization, and system strengthening? What can be learned by the project's approach to communication and management, including the use of tools, at all levels (fully functional service delivery point)?
Results	To what degree did the project succeed in providing all seven high impact standardized services at all facilities (effectiveness of fully functional service delivery point tool)? What were the strengths and weaknesses of the PBC approach to service delivery, including the establishment and achievement of targets? Was the project's data validation process sufficient to ensure that reported results were reliable (effectiveness of DQA tool)? **[Result 1: Service Delivery]**

Sustainability	How has the project responded to health system challenges (HR, supply, HMIS, infrastructure, and limited functionality of management) at the facility and county levels? **[Result 2: Health Systems Strengthening]**
Capacity Building	What were the strengths and weaknesses of the approach to building capacity at the community level (CBOs, village health committees, home health promoters, TBAs, etc.)to identify, mobilize and address issues affecting the population's health?**[Result 3: Increasing demand]**

These questions represent the main interests of USAID. However, the evaluators may be flexible to modify the interview protocol as the evaluation progresses based on input from key informants and questions that they believe are also relevant.

VI. Evaluation Questions – Gender Considerations

USAID expects that in answering each of the questions above the evaluation team will disaggregate data by sex on all questions involving people. Methods used to collect and analyze data pertinent to the questions above, and the manner in which the evaluation presents its findings, should make it clear whether and how men and women differed in their participation in project activities, ability to access services, and benefits received from the project. Information about differential participation in and benefits to men and women is important for designing future projects in ways that produce equitable results.

VII. Evaluation Methods – Evaluation Design and Data Collection and Analysis Methods

The evaluation team will have an opportunity in its team planning meeting (TPM) at the start of the evaluation to develop its design and data collection and analysis plan for this evaluation. Sound social science methods should be used to address each evaluation question, and there should be a clear match between questions and the methods the team proposes to use to address them. The team should employ methodologies that collect primarily qualitative information, though some quantitative information about service provision at health facilities would be useful. In designing the methodology, the team should consider how the evaluation questions will be investigated, data availability and quality, the rigor of the proposed methodology (validity and reliability of method, tools, sampling procedures), and any potential for bias. These considerations should be documented during the design process.

The team members will have an initial meeting and map out a detailed implementation plan. Team members will then produce quantitative and qualitative interview instruments and schedule and organize the field visits. The evaluation team is expected to keep the USAID/South Sudan Health Team informed about its election of data collection methods in advance of field-work and of progress and issues during the field work period. Among the methods USAID anticipates the evaluation team will propose are:

A. A desk review from which the team will extract and summarize, before field work begins, which questions can be fully or partially answered with existing information the team is given
B. A survey of NGOs involved in the project to understand their experiences in implementation, and follow up interviews with NGOs involved in-service delivery under SHTP II
C. Key informant interviews that include but are not limited to:
    a. Current and former USAID mission staff, including relevant members from the Front Office, Health/WASH Team, and the Program Office
    b. Prime recipient management and technical/financial officers
    c. Subcontractor management and technical/financial officers in Juba and the field
    d. Government of South Sudan Ministry of Health
    e. County health departments in selected SHTP II counties
    f. Village health committees in selected SHTP II counties
    g. Counterpart agencies and projects (BSF, UNICEF, PSI)
    h. Project beneficiaries
D. Field Visits

Field visits will be conducted in a sample of counties where SHTP II has activities; the counties will be chosen collaboratively with USAID and MSI. USAID expects that purposive sampling methods will be used that include criteria for selection that will ensure that data collection takes in at least two counties in Western and/or Central Equatoria (the two states that will be USAID's future area of concentration in

health) as well as in at least one difficult-to-access county. Choices of counties should also provide an opportunity to see counties that are considered "successful," as well as those considered to be poor performers. The team will not be expected to visit all project sites; however, the team should try to make contact (through a written questionnaire and follow up meetings or phone calls, where possible) with all nine of the sub-contracting NGOs that support facility-based activities.

In addition to these methods, the team is expected to propose other methods that would help to strengthen the credibility of answers to evaluation questions. Accordingly, such tools as mini-surveys of beneficiaries and other methods should be considered and incorporated into the final data collection plan the evaluation team prepares during and immediately following its TPM.

While still in country and after data collection, the evaluators will conduct a stakeholders meeting. This meeting will present initial findings and seek input from participants. Stakeholders will include representatives from Ministry of Health, NGOs, donors, and UN agencies. Prior to this meeting, the team will meet and discuss the presentation with USAID.

VIII. Evaluation Methods – Data Analysis Plan

Given the qualitative nature of the document review, key informant interviews, and field visits suggested above, the evaluation team will need one or several qualitative data analysis techniques, including content analysis, to transform raw field notes into useful information from which conclusions can be drawn. For each question the evaluation team will address, the team's pre project plan should explain how evaluation data will be analyzed.

IX. Evaluation Methods – Strengths and Limitations

This evaluation will be primarily qualitative in nature. As there is no baseline information about the project, evaluators will be collecting primarily subjective information about successes and challenges. Thus, some of the limitations of this evaluation include:

- Heavy reliance on qualitative data and memory of past experiences (potentially leading to recall bias)
- Limited institutional knowledge among USAID and NGO staff (the majority of staff at all levels have not been involved since the inception of the project)
- Small number of sites visited, meaning that generalizations may not be valid
- Heavy reliance on key informants

X. Deliverables

1. Evaluation materials (topic list, data gathering tools, list of geographic areas and field sites, and list of respondents)
2. Interview notes and completed surveys
3. Stakeholder's meeting PowerPoint presentation (one electronic copy, as well as hard copies for distribution during the stakeholders meeting)
4. Draft report (two hard copies and one electronic copy)
5. Final report (including recommendations) (one electronic copy)
6. All data/documents to be left with MSI

The consultants will utilize MSI support to develop the final report, as well as any PowerPoint presentations. The draft report will be due on departure day of the evaluation team from Juba. USAID will provide comments within 10 work days. The Team Lead will respond to the comments within 10 workdays.

Upon final approval of the content by USAID/South Sudan, MSI will be responsible for editing and formatting the final report, which takes approximately 30 days. The final report in both hard and electronic format will be submitted to USAID/South Sudan and approval given before submission to the Development Experience Clearinghouse (DEC).

XI. Team composition – Expertise Required

The team leader is expected to work with other team members and USAID to develop a plan for conducting the evaluation, including interview guides or other tools as necessary, and a schedule for its timely completion. The core team members are expected to develop the deliverables, including taking responsibility for writing the report.

Qualifications for the team leader:

- At least fifteen years of experience assessing or evaluating USAID-supported health projects
- Previous experience serving as a team leader on a USAID-supported health project
- Previous experience working in Africa
- Experience in facilitation and providing leadership in collaborative and participatory evaluations with multiple stakeholders
- Excellent verbal and writing skills
- Ability to produce preliminary and final reports on time

Qualifications for other team members:

- At least ten years of experience with USAID-supported health projects
- Previous experience in assessment and/or evaluation of USAID-supported health projects
- Previous experience working in Africa
- Excellent verbal and writing skills

XII. Team Composition – USAID and Partner Involvement

The review will be carried out by a team of two researchers, one of whom will be identified as the team leader. In addition, a counterpart from the Ministry of Health may join the team. Officers from USAID, the World Bank, and the Basic Services Fund might also join the evaluation team; however, these participants would be observers only and should not impact the outcomes of the evaluation.

XIII. Schedule and Logistics

The evaluation is scheduled to take place in May and June 2012.The in-country phase of the review will be conducted over a period of up to 30 days with a desired start date around May 7, 2012. USAID, in conjunction with MSI, will arrange some initial interviews and meetings, and will make recommendations for site visits. Once the team is in country, they will be responsible for working with MSI to set up additional interviews, meetings, site visits and debriefings. Field visits will take place in at least two counties in Western and/or Central Equatoria (the two States that will be USAID's future area of concentration in health) as well as in at least one difficult-to-access county.

XIV. Period of Performance

Below is an illustrative list of the specific tasks to be accomplished by the team, with an estimated level of effort for each task. Field work is to be carried out over a period of approximately 4 weeks, beginning on or about (o/a) April 15, 2012 and concluding o/a May 15, 2012.A six-day work week is authorized for South Sudan.

XV. Reporting Requirements

The report must:

- Distinguish clearly between findings, conclusions (based strictly on findings) and recommendations (based clearly on the evaluation findings and conclusions);
- Comply with all instructions of the SUPPORT Projects "Evaluation Special Study Quality Management Guide" and meet the specific requirements of the "Evaluation Report Review Score Sheet," contained therein;
- Comply with USAID Evaluation Policy;
- Be submitted to the DEC after finalization;
- Include a table of contents, a list of acronyms, an executive summary of no more than three pages; a section describing the project to be evaluated and purpose of the evaluation; a section on the methodology employed, a section discussing the findings and conclusions, a section on recommendations and a Lessons Learned section;
- Annexes: Vital source documents consulted and any other relevant materials that cannot be part of the body of the report, including: this SOW; tools/data; sources cited.

ANNEX B: SHTP II EVALUATION RAPID SURVEY RESULTS

SHTP II End of Project Evaluation Rapid Survey

The purpose of the rapid survey is to identify subcontracted partners and county-specific experiences as well as commonalities related to service delivery, health system strengthening and community mobilization during the implementation of the SHTP II project. One survey should be completed for each county supported under the project. If a subcontracted partner supports two or more counties, separate surveys should be completed for each county. Survey responses will remain confidential.

1. Result area one: Expand access and availability of high-impact services

1.1 To what extent are the relevant seven high-impact services available at the levels your organization is supporting:

High-impact Service (median used)	Levels					
	Community			Facility		
	Not at all	Partially	Fully	Not at all	Partially	Fully
Child Health (F/F)	1	3	5	1		10
Nutrition (P/F)	1	7	2	1	2	8
Hygiene and Sanitation (P/F)		6	4		4	7
Malaria (P/F)	1	4	5	1		9
Maternal Health (P/F)	1	4	5	1	1	8
Family Planning (P/P)	1	8	1	1	5	4
HIV/AIDS / PMTCT (P/P)	1	8	1	1	9	1

(Mark "X" where appropriate.)

1.2 During the last joint-facility supervision visit by MSH and your organization, what facility supervision tool was used?

All MSH-subcontracted partner joint supervisions used the fully functional service delivery point tool.

1.3 During the last joint-supervision visit by your organization and the CHD, what facility supervision tool was used?

MOH Quality Supervision Checklist [6], fully functional service delivery point [3], DQA [1]

1.4 How would you rate the usefulness of the fully functional service delivery point tool for:

	fully functional service delivery point Usefulness [average survey result]	1	2	3	4	5
A	Improving the management of health facilities? [3.8]	1		1	6	2
B	Serving as a tool for communicating priorities? [4.0]			1	8	1
C	Improving the availability of health services? [3.9]	1		3	5	1
D	Improving the quality of service delivery? [3.9]		1		8	1
E	Comparison among health facilities? [4.0]			3	4	3
F	Improving community mobilization? [3.4]		1	5	3	1
G	Identifying training gaps? [3.8]			3	6	1

(1 = Very Poor to 5 = Excellent)

1.5 How would you rate performance-based contracting in the following areas:

	PBC Areas	1	2	3	4	5
A	To what extent did the existence of a performance indicator affect prioritization of an activity? [3.5]	1	1	3	4	2
B	To what extent did the number of community level indicators impact on prioritization of community level activities? [3.3]	1	2	2	5	1

(1 = Not at All to 5 = Very Much)

1.6 What were the strengths and weaknesses of the PBC approach to service delivery?

Strengths:

The most common strengths were, supporting focus towards a common target [7], increasing motivation of the organization or staff members [4], encouraging improved monitoring/data management [2].

Other strengths included: supporting standardization of services [1], the bonus allows reinvestment in the project [1], results are felt in a short time frame [1], encourages innovation [1], improves accountability [1], and can help to improve coverage [1].

Weaknesses:

The main comments towards weaknesses surround the approach to targets [4] and the flexibility of the contract [4].

In terms of the setting targets, respondents thought that not all relevant targets were part of the performance calculations [3], and there was too much focus on quantitative targets [2], which may also mean ignoring activities outside of targets [1].One respondent also noted the lack of focus on quality in targets [1]. Targets themselves were also noted as being too high [2] or not appropriately calculated for the specific location context [1]. It was also stated that it becomes difficult to strike a balance between achieving targets and making sure there is a sustainable approach to health interventions [1].

The contract issues were around flexibility [4] for changing resource/budget allocations [3] as well as any external factors changing the situation [1] or lack of ability to change for different requirements from the community [1].

Other respondents noted that there were no systems in place to implement PBC [1], the bonus payment ("package") did not reach the individual [1], and there is an increased workload [2] due to the strict reporting schedule [1]. Finally one respondent stated that there is too much emphasis on software side (i.e., service delivery) with little support on infrastructure [1].

1.7 How would you rate the SHTP II data collection process against the following:

	[survey result]	1	2	3	4	5
A	Ease of collecting data for SHTP II data requirements. [3.2]		3	3	5	
B	Your organization's ability to quickly detect errors before submitting data. [3.8]			3	7	1

(1 = Difficult and 5 = Easy)

1.8 How often do you receive feedback from MSH on the data submitted by your organization? (monthly, quarterly, semi-annually, annually)

Most commonly cited response for receipt of feedback is quarterly [7] with others stating monthly [5].

During quarterly meetings, the data is printed at for discussion [1] and detailed feedback and analysis received [1]

Monthly feedback involved clarifications [1], corrections/verification [1], and confirming receipt of monthly data [1]

One agency has had some issues with receiving regular feedback from MSH [1], and another has stated that they do not receive constructive feedback but it constituted pointing out errors [1]

2. Result area two: Increase sustainability through health systems strengthening

2.1 How would you rate the experiences you had in the following health system areas during project implementation?

	[survey result]	1	2	3	4	5
A	Service delivery (e.g., accessibility, infrastructure) [3.3]		2	4	5	
B	Leadership and governance (e.g., gaps in policy) [3.4]		1	5	5	
C	Drugs and equipment [2.7]		3	8		
D	Human resources for health (e.g., staffing gaps) [2.5]	2	3	4	2	
E	Information systems (e.g., reporting) [3.7]		2	2	6	1

(1 = Difficult and 5 = Easy)

2.2 What have been the main health systems challenges confronted by your organization and how did you overcome them?

Challenges	Solutions Implemented
Infrastructure: • Poor infrastructure of health facilities [5] • Lack of space [2] including space for deliveries [1] • Lack of waste management facilities [2] and WASH facilities [2] Human Resources • Not enough qualified health professionals [6] • Lack of funding for long term/pre-service training [1] • Salary payments not done by government [1] • Retention of qualified health professionals [2] unless additional benefits given, e.g., housing [2] • Lack of funding for complete salary package for community based health staff (i.e., additional benefits covered by subcontracted partner) [1] HMIS • Issues with tools [3] often changing [2] and many different tools [1] • Insufficient registers for health facilities [1] • Introduction of new tools to cover additional information needs [1] Supply Chain and Equipment	Infrastructure: • Use of other donor funding to construct permanent facilities [1] Human Resources • Recruitment of qualified professionals from other areas [2] • Provide improved benefits (e.g., accommodation) [2] or high wages [1] • In-service training on existing health facility staff [1] • Lobby donors, including SHTP II for funding pre-service training, with no success[1] • Engaging with MOH to adsorb health staff, with no success [1] HMIS • Regular supportive supervision/on the job training to help improve knowledge [2] • Collection of additional registers from MSH in Juba [1] Supply Chain and Equipment

• Delayed/irregular MOH drug supplies [3] • Inadequate equipment [1]	• Reliance on MSH supported additional drug procurement [1]

2.3 Is the DHIS being consistently used at the facilities supported by your organization?

Yes = 5 No = 5 Don't know = 1

2.4 What challenges are you experiencing with the DHIS, if any? What are you doing to overcome these challenges?

Challenges	Solutions Implemented
Need more training of health facility staff/no orientation of health facility staff [4] DHIS is being used only by the CHD [3], in one county only one person trained [1] Data quality is an issue [2] DHIS implementation only recently started [2] DHIS rolled out a few months ago at the health facilities [1] There are insufficient paper tools/registers [1] CHD does not have the IT equipment needed [1] Submitting old forms [2] (up until April 2012) [1]	DHIS training course implemented for health facilities [2] and positive results seen [1] Supportive supervision [2] and regular feedback to the health facility [1] DQA is helping to partly overcome data quality issues [1]

2.5 In the table below, please indicate the frequency at which supportive supervision field visits occurred (weekly, monthly, quarterly, annually):

Supervisor	Supervisee			Comment
	subcontracted partner	Health Facility	Home Health Promoter	
MSH	Quarterly	Quarterly	Semi-annual	
Joint subcontracted partner-CHD	N/A	Quarterly	Quarterly	
subcontracted partner	N/A	Monthly	Monthly	
Health facility	N/A	N/A	Bi-Weekly	

3. Result area three: Increase demand by capacity-building at the community level

3.1 In order to identify what proportion of health facilities are linked to trained, community-level structures, please list the community-level trainings your organization has carried out during SHTP II - indicate the category of participants and number of facilities they represented.[Add rows as required.]

Name of Training Course	Category of Participant (e.g., village health committee, home health promoter)	Number of facilities represented by the training[53]
Facility management & community mobilization	village health committee	70
village health committees	village health committee	14
Community mobilization	village health committee	14
FP	village health committee	14
WASH	village health committee	14
Malaria	village health committee	23
Community case management of malaria, diarrhea and pneumonia	home health promoter	11
HIV peer education	home health promoter	26
Maternal health training	home health promoter	51
Child health	home health promoter	44
Malaria	home health promoter	33
CLTS / WASH	home health promoter	26
FP	home health promoter	15
EPI	home health promoter	22
Community Mobilization	home health promoter	28
Maternal health	TBA	13

3.2 At what percent of the facilities you support are these community structures are actively functioning?

Community Level Activities [Median]	0%–20%	21%–40%	41%–60%	61%–80%	81%–100%
Trained village health committees [61-80%]	1	1	1	2	4
Trained home health promoters [61-80%]	1		2	2	3

3.3 In your estimation, to what extent have promotion and marketing of improved drinking water products served to increase demand for improved drinking water?

N/A = 5, 3*3

[53] For example, if community mobilization training was done for village health committees, give the number of facilities that those trained-village health committees represent.

(1 = None and 5 = Significantly)

4. Overarching

4.1 How would you rate the priority your organization has given the result areas of the SHTP IIproject:

Result Area [survey result]	1	2	3	4	5
Result area one: Expand access and availability of high-impact services [4.5]		1		2	7
Result area two: Increase sustainability through health systems strengthening [4.2]			1	7	3
Result area three: Increase demand by building capacity at the community level [4.5]				5	6

(1 = None and 5 = Significant)

4.2 How would you rate the priority USAID/MSH has given the result areas of the SHTP II project:

Result Area [survey result]	1	2	3	4	5
Result area one: Expand access and availability of high-impact services [4.2]		1	1	3	5
Result area two: Increase sustainability through health systems strengthening [4.1]			3	3	4
Result area three: Increase demand by building capacity at the community level [4.2]			1	6	3

(1 = None and 5 = Significant)

4.3 What factors determined the priority rating given to the result areas above (i.e., the amount of resources allocated, quantity of time allocated, number of indicators monitored., etc…)?

The most commonly cited criteria for prioritizing the result areas was the number of performance indicators [6], followed by the time spent on the work [5], and the resources provided in the budget [5].

Other criteria cited include the amount of procurement done, the implementation sequencing (later versus earlier in the project), amount of technical backstopping provided by MSH and the RSS contribution to the result area.

4.4 How would you rate the communication between your organization and MSH:

		1	2	3	4	5
A	Quality of communication? [3.8]		2	1	5	3
B	Frequency of communication? [3.9]				7	3
C	Timeliness of communication (last minute?)? [3.2]	2		3	5	1
D	Feedback received?[3.7]	1	1		7	2

(1 = Very poor and 5 = Excellent)

4.5 How would you rate the communication between your organization and the CHD:

		1	2	3	4	5
A	Quality of communication? [4.3]				7	3
B	Frequency of communication? [3.9]			1	4	5
C	Timeliness of communication (last minute?)? [4.2]			2	4	4
D	Feedback received? [3.9]		1	3	2	4

(1 = Very poor and 5 = Excellent)

4.6 Have there been any particular communication challenges? If so, what were they and how do you overcome them?

Challenges	Solutions Implemented
MSH's program related information requests are high [4]. The requests are often over short deadline [3], can be a large amount of information [2], or MSH request information already submitted [1]. Contract negotiations with MSH have been very challenging [2] because the subcontracted partner had to communicate with MSH's head office, which does not fully understand the context [1]. An subcontracted partner reported long delays with budgets/contract confirmations [1] Lack of office internet facilities at the office as MSH /USAID removed it from the purchase list [1], and another subcontracted partner suffers from breakdown of internet services [1] Communications are going on well [2]	Explaining to MSH why the delays in information are occurring for MSH's additional information requests [1] Use of modems and internet café to solve the issue of no office internet facilities [1]

4.7 How frequently does your organization participate in a formal project-related meeting with the following: (weekly, monthly quarterly, annually, never).

USAID?	Annual [2], Quarterly [6], Never [3]
MSH?	Quarterly [9]
MOH?	Monthly [8] Quarterly [1]
MOH?	Monthly [5], Quarterly [1], Never [4]
CHD?	Weekly [2], Monthly [6] Often [1]
Facilities?	Weekly [6], Monthly [4]

4.8 Upon review of the questionnaire and considering your organization's experience implementing the SHTP II project, are there any priority lessons learned in the areas of service delivery, health systems strengthening and community capacity-building?

Community Mobilization

- x Many health facilities do not have a community health component because they are inadequately staffed [1]
- x There is a need for better awareness raising at the community to (a) ensure pregnant mothers come to the facility earlier if they are having complications and (b) dispel misconceptions of delivering at the facility (e.g., a laboring mother going to facility for delivery has a higher chance of still birth) [1]
- x There is a need to put in place a continuous community mobilization exercise [1]
- x The messages communicated to members of the community should also address the local belief and practice [1]
- x Further work is needed to explore linking the WASH community outreach with the routine community based work [1]

- ✓ Community outreach activities have helped improve demand for service delivery [3] especially in reproductive health indicators [1].
- ✓ Mothers are travelling long distances to attend ANC/PNC and family planning/ child spacing visits. Some mothers, who do not have access to health care services have spent a night on route, so as to reach the nearest health facility [1].
- ✓ The use of community outreach members (WASH) is effective for increasing knowledge about the importance of safe drinking water to reduce diseases, and to increase demand for water treatment products [1]
- ✓ The community demand for preventive services and improved care, while health seeking behavior has increased [1]
- ✓ Community based "Child Health Days" have helped to bring services into the community [1]
- ✓ Working with home health promoters and village health committees is pivotal in improving service delivery [1]

Service Delivery

- ✓ Many communities are remotely situated in relation to the health facility, therefore the only way of extending services is an integrated community outreach [1]
- ✓ Placing a midwife in the PHCU allows maternal health services to be expanded to the community level [1]
- ✓ Integrating ANC services into outreach programs could help increase services in remote locations [1]

Communication/Management:

- x The project needs to strengthen quality supervision across the program, going beyond the performance targets [1]
- x The project needs to develop improved systems across the country [1]
- x There have been delays in transferring funds from MSH-subcontracted partner which have stalled the project implementation [1]

- ✓ It is important to ensure a good working relationship with local authorities especially the

CHD and SMOH throughout project implementation [1]

- ✓ The project has supported monitoring and improvements both monthly and quarterly, as well as sharing lessons learnt across the subcontracted partners [1]
- ✓ Performance targets are an excellent way to increase coverage across health programs [1]

Human Resources

- x There are gaps in the number of qualified health staff across South Sudan [4]
- x Part of the project should focus on increasing the number of qualified staff in order to meet the demand [1]
- x The MOH needs to absorb the health staff into the government systems to ensure sustainability [1]
- x Motivation and turn-over of staff is a challenge due to competing salaries and non-standard packages [1]
- x The short duration of initial training for CHWs or equivalent affects the quality of health services, and their capacity to absorb in-service training is a cause for concern [1]
- x Lack of appropriate teaching, reading materials and reference books in local language ia a barrier in efforts to build CHW/local level capacity [1]
- x Trainings of health facility staff has been very helpful, but on-going refresher training and mentoring is needed [1]

- ✓ Building the capacity and collaborating with village health committees and home health promoters can make a tremendous impact on the demand for quality service delivery, increase ownership and the sustainability [1]

Infrastructure:

- x Developing health infrastructure will support improvements in demand [1]

Balance of Priorities:

- ✓ To attain quality standards, service delivery, health systems and community mobilization have to be improved simultaneously [1]

Other:

- x The project should have an emergency preparedness and response aspect, for the more insecure areas, to ensure there can be a response and the project objectives are continued [1]
- x Additional logistical support is required in terms of an additional vehicle so as to cover a large health service coverage area [1]
- x IGSM helps expand and stabilize POU water treatment product availability at recommended retail prices [1]
- x There needs to be improved advocacy with Ministry of Education at appropriate levels to allocate school budget for maintenance of latrines, hand-washing stations and water treatment products [1]

ANNEX C: LIST OF KEY DOCUMENTS REVIEWED

1. Basic Package of Health and Nutrition Services for Southern Sudan, Ministry of Health, 2009
2. Cleveland et al., 2010 "Introducing health facility accreditation in Liberia"
3. Draft Basic Package of Health and Nutrition Services in Primary Health Care, Ministry of Health, 2011
4. Draft Home Health Promoter Curriculum Outline, Ministry of Health, 2011
5. Draft Implementation Guide for Community Based Management of Malaria, Pneumonia and Diarrhea, Ministry Of Health, 2009
6. Draft National Reproductive Health Policy, Ministry of Health, 2011
7. Draft National Reproductive Health Strategic Plan, Ministry of Health, 2011
8. Draft Protocol and Checklist for Data Quality Assurance, Management Sciences for Health, 2010
9. Endorsement Letter for Health Management Information Systems and Tools Rollout, Ministry of Health, 2011
10. Fully Functional Sservice Delivery oint Draft Assessment Report, Management Sciences for Health, 2012
11. Final Community Health Worker Trainers Manual, Ministry of Health
12. Functioning Health Training Institutions in the Republic of South Sudan, Ministry of Health, 2011
13. Guidelines for the Quantified Supervision Checklist Southern Sudan, Ministry of Health, 2011
14. Handover Guidelines, Ministry of Health, 2011
15. Health Management Information Systems Manual, Ministry of Health, 2011
16. Health Policy for the Government of Southern Sudan, 2006-2011, Ministry of Health, 2007
17. Health Sector Development Plan 2012-2016, Ministry of Health, 2012
18. Health Service Delivery Project Final, USAID, 2012
19. Health Systems Strengthening Project (HSSP) Request for Applications, USAID, 2012
20. LQAS Community-based Survey, Ministry of Health, 2011
21. M&E Trainings conducted by MSH December 2009 – May 2012, Management Sciences for Health, 2012
22. Operational Guidelines for Reporting on SHTP II Core Indicators, Management Sciences for Health, 2011
23. Performance Management Plan for Health, USAID/Sudan, 2011
24. Performance Monitoring Plan 2012 for Sudan Health Transformation Project II, USAID, 2012
25. Rapid Health Facility Assessment Report, Ministry of Health, 2010
26. SOW for Sudan Health Transformation Project II Extension, USAID, 2011
27. South Sudan Global Fund Implementation Matrix, PSI, 2011
28. South Sudan Transition Strategy 2011-2013, USAID, 2011
29. Sudan Health Transformation Project (SHTP) Assessment Report, IT Show Inc., 2008
30. Sudan Health Transformation Project II (SHTP II) Performance Report for FY 2010 Management Sciences for Health, 2010
31. Sudan Health Transformation Project II (SHTP II) Construction and Refurbishment Estimates, Management Sciences for Health, 2011
32. Sudan Health Transformation Project II (SHTP II) Project Monitoring and Evaluation Plan February 2009 –February 2012, Management Sciences for Health, 2010
33. Sudan Health Transformation Project II (SHTP II) Task Order, USAID, 2009
34. Sudan Health Transformation Project II (SHTP II): Final Evaluation Sub-Contracting Partner Rapid Survey, Management Systems International, 2012.
35. Sudan Health Transformation Project Ii: Leadership Development Program Mid-Term Evaluation Report, Management Sciences International, 2011

36. Sudan Health Transformation Project Phase II (SHTP II) Mid-Term Evaluation Report – Public Document, Management Systems International, 2011
37. Sudan Health Transformation Project II, Semi-Annual Progress Report, Fiscal Year 2012 (October 1, 2011 to March 31, 2012), Management Sciences for Health, 2012
38. Sudan Health Transformation Project (Phase Two) Fully-Functional Service Delivery Point Tool Standards 1-11, Management Sciences for Health, 2010
39. Sudan Household Health Survey (Southern Sudan Report), Government of Southern Sudan, 2006
40. Summary of Findings of Southern Sudan Household Survey 2010, Government of Southern Sudan, 2011
41. USAID South Sudan: Sudan Health Transformation Project II (SHTP II) Quarterly Report October 1 2011 to December 31 2011, Management Sciences for Health, 2012
42. USAID Sudan: Sudan Health Transformation Project II (SHTP II): Annual Progress Report for FY 2011, Management Sciences for Health, 2011
43. USAID Sudan: Sudan Health Transformation Project II Quarterly Report April 1 to June 30 2011, Management Sciences for Health, 2011
44. Variety of routine monthly data submitted by SHTP II subcontracted partners

ANNEX D: METHODS MATRIX

Evaluation Questions	Type of Answer/ Evidence Needed	Methods for Data Collection		Sampling or Selection Approach,	Data Analysis Methods
		Method	Data Source		
1. To what degree did the project succeed in providing all seven high-impact standardized services at all facilities?	• Description • Statistics	• Document reviews • Rapid survey • Field observations • Interviews	• Project documents • HMIS reports • MOH documents • Subcontracted partner survey results • Facility Staffs & patients • Subcontracted partner interviews • MSH interviews	• Purposive sampling	• Trend analysis • Content analysis
2. What were the strengths and weaknesses of the performance-based contracting (PBC) approach to service delivery, including the establishment and achievement of targets?	• Description	• Document reviews • Rapid survey • Interviews	• Project reports • Subcontracted partner survey results • Subcontracted partner interviews • MSH interview •	• Purposive sampling	• Content analysis
3. Was the project's data validation process sufficient to ensure that reported results were reliable?	• Description	• Document review • Rapid Survey	• Project documents • Subcontracted partner assessment reports • MOH documents • Subcontracted partner survey results • MSH Interviews	• Purposive sampling	• Trend analysis • Content analysis
4. How has the project responded to health system challenges at the facility and county levels?	• Description	• Document review • Rapid	• Project documents • MOH documents • Subcontracted partner	• Purposive sampling	• Content analysis

Evaluation Questions	Type of Answer/ Evidence Needed	Methods for Data Collection		Sampling or Selection Approach,	Data Analysis Methods
		Method	Data Source		
		survey • Interviews	survey results • Subcontracted partner interviews • MOH interviews • MSH interviews		
5. What were the strengths and weaknesses of the approach to building capacity at the community level?	• Description	• Document review • Rapid survey • Interviews	• Project documents • MOH documents • Subcontracted partner survey results • Subcontracted partner interviews • Village health committee interviews • MOH interviews • MSH interviews • Donor interviews	• Purposive Sampling	• Content Analysis
6. How did the project balance achieving the key results of service delivery, community mobilization and system strengthening and what may have been the ramifications?	• Description • Comparison (across results areas)	• Document review • Field observations • Interviews	• Project documents • Field observations • Health facility staff interviews • Village health committee interviews • Subcontracted partner interviews • MOH interviews	• Purposive sampling	• Content analysis
7. What lessons can be learned from the approach to achieving the three key results of service delivery, community mobilization,	• Description	• Document review • Rapid survey	• Project documents • Subcontracted partner survey results • Subcontracted partner	• Purposive sampling	• Content analysis

Evaluation Questions	Type of Answer/ Evidence Needed	Methods for Data Collection		Sampling or Selection Approach,	Data Analysis Methods
		Method	Data Source		
and system strengthening?		• Interviews	Interviews • MOH Interviews • Donor Interviews • USAID		
8. What can be learned by the project's approach to communication and management?	• Description	• Document review • Rapid survey • Interviews	• Project documents • Subcontracted partner survey results • Subcontracted partner interviews • MOH interviews • MSH interviews	• Purposive sampling	• Content analysis

ANNEX E: INTERVIEWS GUIDES

Interview Guide: Meetings with Sub-Contracted Partners

Introduction to evaluation team and summary of the SHTP II evaluation

What has been your experience of working in SHTP I and SHTP II projects?

I. Service Delivery

1. To what extent did the project succeed in providing all seven high-impact standardized services at all facilities? (Child Health, Nutrition, Malaria, WASH, Maternal Health, Family Planning and Reproductive Health, Prevention of HIV/AIDS)
2. What has been your organization's experience of the PBC model? Has it proved useful in terms of prioritizing activities, motivation or continued achievement of results?
3. Has your organization found the fully functional service delivery point tool useful? Has it supported improvements in management and communication? Are there any examples?
4. Do you think there has been balance between the three key result areas of service delivery, health systems strengthening and community mobilization? Have certain areas been prioritized more than others?

II. Sustainability (Health Systems Strengthening):

5. What challenges are you facing in the drug supply chain and what solutions have you found?
6. How often do you conduct supervision visits? How often is it jointly conducted with CHD? What tools are used and are they effective?
7. What tools are you using to collect health facility information? What frequency? Is the MSH DQA process helpful?
8. What challenges are you facing in staffing, and what solutions have you found?
9. What training courses are you providing home health promoters/village health committees/health workers/CHD?
10. What challenges are you facing in terms of health infrastructure and what solutions have you found?

III. Community Level Capacity-building:

11. To what extent do you consider home health promoters functional and are facility staff partnering with them to provide seven high-impact services at the community level?
12. What other types of community-based health workers are active and who is supporting them?
13. What proportion of village health committees are trained and functional and what types activities they are implementing

Interview Guide: Meetings with County Health Departments

Introduction to evaluation team and summary of the SHTP II evaluation

I. Overarching:

1. What has been your experience of working in the SHTP I and SHTP II projects?
2. What is your opinion on priorities given to service delivery, HSS and community mobilization? Have certain areas been prioritized more than others?
3. What do you know about the Performance Based Contracting model? What do you think the strengths and weaknesses have been to the approach?

II. Sustainability:

4. What challenges are you facing in the drug supply chain and what solutions have you found?
5. How often do you conduct supervision visits? What proportion of the supervision visits are done with the subcontracted partner? What tools are used and are they effective?
6. Which tools do you use to collect information from health facilities? Are you having issues such as data quality or completeness? How are these being solved?
7. What challenges are you facing in staffing, and what solutions have you found?
8. To what extent have you been involved with the training of home health promoters/village health committees/health workers?
9. What challenges are you facing in terms of health infrastructure and what solutions have you found?

III. Community Level Capacity-building:

10. To what extent do you consider home health promoters functional across the county? Has the CHD been involved with decisions about home health promoters or equivalent community level workers?
11. What other types of community-based health workers are active and who is supporting them?
12. To what extent do you consider the village health committees functional? Has the CHD been involved with strengthening village health committees (e.g., selection, training, supervision, resource decisions, etc…)?

Interview Guide: Meetings with Health Facility Staffs

Introductions to evaluation team and verbal summary of the SHTP II evaluation

1. Please describe the size of catchment population? Hours open? Number of patients per day? Deliveries? What are the referral linkages? Where?

I. Service Delivery

2. What child health services do you provide? All child immunization? Diarrhea/malaria/ pneumonia treatment?
3. Does your facility provide Vitamin A supplementation and nutrition education for children?
4. Do you provide prevention, diagnosis and treatment of malaria? How do you diagnose malaria?
5. Is sanitation and hygiene education provided? How often?
6. Are antenatal services provided in the facility? How often should women be seen for antenatal services? Do women typically have more than one antenatal visit in your facility? Are women provided Intermittent Preventative Treatment for malaria (IPT-2)?
7. Are women coming to the health facility to delivery or do they prefer to deliver at home? Are postnatal care services provided?
8. What family planning services are provided at your facility? What type of FP commodities?
9. Does your facility offer HIV counseling and testing?

II. Systems Strengthening

10. How reliable is the drug supply? How frequent are shortages of critical drugs? What do you do when shortages occur? How long does it take to replenish supplies?
11. How often does the NGO visit the facility? What do they do when they visit? How often does the CHD accompany the NGO?
12. Does your facility have an action plan? Did anyone help to produce it?
13. Which reporting tools are used (weekly, monthly, quarterly)? Who collects them and do you receive feedback on the reports you submit?
14. What staffs are working at the health facility? Who pays the staff? Are there any staff vacancies? Are there any major HR challenges?
15. What training is provided for health facility staff?
16. What infrastructure improvements have been made to your facility by the project? What are the unmet priorities?

III. Community Level Capacity-building:

17. What services are home health promoters providing at the community level?
18. Are there other types of community-based health workers active? Who is supporting them?
19. Is there a trained, functioning village health committee? How often do they meet?
20. What activities do the village health committee implement? Do village health committees help to increase utilization of health services?

Interview Guide: Meetings with Community

Below is a brief provided to the translator for the meeting. Any narrative in () is not to be stated in the translation, but is a potential aspect for answers.

Introductions

Summary of SHTP II Evaluation:

We are a team of 3 people (Jacob Hughes, Dominic Wadegu, Mo Ali). We are evaluating the government health services supported by USAID looking at (1) the work done in health facilities (2) also the work done at the community level.

The evaluation aims to support improvements for the future health activities in South Sudan. We are very interested in the support received at the community level. We have questions that we would like to ask you, to get a better understanding of what is happening. And there is time at the end for you to ask us questions.

1. Does the NGO meet with the community? Do you know the NGO staff with us today?
2. Does the CHD meet with the community? How often do they come?
3. Do you have a village health committee? Who is on the Village Health Committee?
4. What activities does the village health committee do?
5. What support does the village health committee receive from the NGO/CHD (e.g., training, transport, other, etc…)?

Home Health Promoters

6. Do you have home health promoters in your village?
7. Does the Village Health Committee support or supervise the home health promoters?
8. Do you know how many they are in your area?
9. What specific services do the home health promoters provide in your area?
10. What training have the home health promoters received?
11. Who supervises the home health promoters (e.g., NGO, CHD or health facility staff, etc…)?
12. If there are home health promoters in this community meeting today, does someone from the health facility help you? If so, how (e.g., supervision, services, coaching, etc…)?

Heath Facilities

13. Are you satisfied with the services at this facility? If not, why not (e.g., not open, not enough staff, no drugs, etc…)?
14. Are the health workers at the facility courteous? Are staffs and drugs available? Is it kept clean?
15. How do you think we can improve the number of people coming to health facilities?

Questions from community members and closure.

Interview Guide: Meeting with the Ministry of Health

Introduction to evaluation team and summary of the SHTP II evaluation SOW

I. Overarching

1. What has been your experience with the SHTP II project?
    a. How effective did the Core Team between USAID, MSH and RSS function?
    b. Was the MOH involved enough in oversight of implementation?
    c. Were they any communication challenges?
2. The project has three result areas: service delivery, HSS and strengthening the community level. Which areas do you think SHTP II has performed well and what is your opinion on prioritization among the three areas?
3. What do you know about the performance-based contracting model being used by MSH? What do you think the strengths and weaknesses have been to the approach, or any similarities or differences to the World Bank model?
4. The project has placed a major emphasis on increasing the utilization of services at the community level by reinvigorating village health committees and training volunteer home health promoters.How would you respond to a CHD concern about the practicality of an unpaid workforce cadre and the government's ability to sustain extensive community-level investments?
5. Please explain the MOH policy position on TBAs, skilled attendance at birth and facility based-deliveries.
6. How does the central MOH verify the quality of services provided by CHDs and NGOs? Through the SMOHs? Are there any plans in the works for annual M&E/verification?
7. The 2009 BPHS included the following cadres of community level health workers: CHWs, CHEWs, home health promoters, MCHWs, and VMWs. Do the cadres named in the 2009 BPHS remain valid or has the 2011 HSDP and draft 2011 BPHS deliberately excluded these cadres and they are not sanctioned by the MOH?
8. Has the community child survival program been approved by the MOH? Is the CDD an approved cadre of health worker?

Interview Guide: Meeting with DG for Planning and Coordination

Introduction to evaluation team and summary of the SHTP II evaluation

Management/Communication

1. What has been your experience of working with the SHTP II project?
2. How effective has the SHTP II Core Team been in providing oversight to the project? How can the management be improved for the future?
3. How effective do you think approaches such as the performance-based contracting of SHTP II or similar schemes can work in South Sudan?

Policy Development

4. In your opinion, has SHTP II supported the development policies? How has it helped and which policies/guidelines have they helped with?

Human Resources

5. What is the Ministry's vision for the future workforce in terms of the balance to be struck between:
    a. Skilled and unskilled health workers (facility versus community)?
    b. Pre-service (schools) and in-service (workshops) training investments?
6. SHTP II has run leadership development program training courses for the central ministry. How useful has the MOH found this?
7. Do you have any questions for the evaluation team?

Interview Guide: Service Delivery Meeting with Management Sciences for Health

I. Service Delivery

1. Please describe MSH oversight of SHTP II service delivery and assuring quality services?
2. How has SHTP II been coordinating its service delivery activities within county, state and national-level RSS?
3. To what degree did the project succeed in providing all seven high-impact standardized services at all facilities:
    a. Child health?(Increase vaccination rates (DPT3) for children <1 yr. to ≥ 50%?)
    b. Nutrition? (Percent of <5 ys who received vitamin A ≥ 50%?)
    c. Malaria? (75% IPT2 during ANC?)
    d. Water sanitation and hygiene?
    e. Maternal health (skilled attendance at birth 20%?, ANC-1 80%? - ANC-4 45%)?
    f. Family planning and reproductive health - clinical standards used ≥ 80%?
    g. Prevention of HIV/AIDS?
        i. Integration of family planning services at HIV/AIDS and PMTCT programs?
        ii. Availability of PMTCT services?
4. What do you believe have been the major service delivery accomplishments of SHTP II?
5. Have certain health interventions been particularly successful?
6. How has the project been generating greater demand for the utilization of health services?How well attended are the facilities (utilization figures or rate)?
7. What has been the project's approach to BCC and community-based outreach activities?
8. Functionality (%) of village health committees (training village health committees, meetings, decisions on resources)?
9. Functionality of home health promoters to provide growth monitoring, nutrition, sanitation, and health promotion services for infants and children?

II. Sustainability (Health Systems Strengthening):

13. Frequency of facility supervision and by whom (MSH, subcontracted partner, CHD)? Tools used?
14. Health systems challenges faced and solutions found: Drug supply? HRH?
15. Have standardized training materials and procedural manuals been developed by the project? Facility level? Community level? Which ones and are they being used?

IV. Overarching:

16. Factors affecting prioritization of service delivery, HSS and community mobilization?
17. Usefulness of performance-based contracting?
    a. Influence on prioritization?
    b. Impact on motivation?
    c. Continued achievement of results?

Interview Guide: Data Quality (M&E)

Briefly describe the tools used to monitor the SHTP II project and who uses the tools. (2010/ 2011/ 2012)

Is it possible to see the data that is submitted from subcontracted partners? (Changed in 2010/11/12.)

I. Service Delivery

1. What service delivery indicators do you monitor (monitor more than PBC/PI?)
2. How do you monitor the number of high-impact standardized services delivered in a facility?
3. How is the data quality assessed? Who is involved in DQA? Any changes in approach in 2010/11/12?
4. How were baselines developed for the project? At state/county/facility? Service delivery areas, training, number of services available, use of SHTP ISHTP I, use of MOH data?
5. How were catchment populations estimated, per facility?

II. Sustainability (Health Systems Strengthening)

1. How do you monitor the HMIS/DHIS reports received within a monthly report submission?(Is it a measurement of reporting to CHD or to the subcontracted partner)?
2. What data to you collect from subcontracted partners on training, per course?
3. What do you do with the data when you see there is a health issue? (e.g., drugs, disease burden increase)
4. How would you rate the reliability of the data?
5. How does the SHTP II monitoring system fit with the HMIS/DHIS?
6. What support do you provide to the subcontracted partners or CHDs (i.e., quality improvement teams)?
7. What challenges have you faced in implementing monitoring systems?
8. What training have you provided to improve data quality (subcontracted partners/CHDs/HF)?

III. Community Level Capacity-building

1. What data do you collect on outreach activities?

IV Overarching

18. What lessons can be learned from how the project has monitored the results (MoH Systems, burden on subcontracted partners/MSH/MOH)?
19. With whom do you communicate the results (e.g., CHD/HF/subcontracted partners/SMOH/RSS)? How often?

Interview Guide with MSH: Leadership Development Program Program

1. Description of the (leadership development program) process?
2. Modules of the leadership development program (Service Delivery, Systems Strengthening, Community?
3. Were any needs assessments carried out before the start of the leadership development program?
4. The 2011 Annual Report refers to "A rapid survey of CHD officials and subcontracted partners." Is it possible to get a copy of this? Was this linked with the leadership development program?

I. Service Delivery

1. To what extent has the leadership development program improved the number of high-impact services available? Examples? Locations?
2. As a result of the leadership development program, to what extent are facility staffs partnering with home health promoters to provide these seven services in the community?

II. Sustainability (Health Systems Strengthening)

1. Training courses provided to CHDs (counties and number trained)?
2. Training courses provided to Health Facilities (counties and number trained)?
3. Training courses provided to SMOH/RSS (states, and number trained)?
4. Refresher and follow up provided (HF, county, SMOH/RSS)?
5. Evidence of how the leadership development program course has supported problem solving in the areas of health systems strengthening (drug Supply, HRH, Health Facility, village health committee)?

III. Community Level Capacity-building

1. Evidence of supporting the increase in outreach activities?
2. Evidence of improving activities of the village health committees (e.g., resources, priorities, etc…)?

IV. Overarching

1. To what extent was service delivery, health systems or community mobilization prioritized in the leadership development program?
2. What are the main successes of the leadership development program?
3. How was the progression of participants monitored?
4. How could the leadership development program process be improved?
5. Evidence towards improving communication (with subcontracted partner, CHD, HF, community, or other)?

Interview Guide: Fully Functional Service Delivery Point with Management Sciences for Health

Related Research Questions

What can be learned by the project's approach to communication and management, including the use of tools, at all levels (role of the fully functional service delivery point)?

To what degree did the project succeed in providing all seven high-impact standardized services at all facilities (role of the fully functional service delivery point tool)?

Questions for discussion:

1. Describe the tool and the components of the tool. (Reference Annual Report 2010, and 11 sections of tool)
2. How often is the information collected?
3. Who uses the tool? Who is trained on the tool?
4. How are the results presented
5. What happens with the results?
6. How is the follow-up conducted?
7. What information is provided to the health facility/NGO/CHD/USAID/SMOH/RSS?
8. Has the tool changed over the period of the project?
9. How has it helped to improve the seven high-impact services?
10. Is there any data available of how many health facilities are using the tool and the results it has produced?
11. What have been some challenges with the use of the tool?

Interview Guide: Final Follow-Up Questions with MSH

1. In the MTE a rapid infrastructure assessment was strongly recommended and in a previous meeting with MSH it was confirmed that this assessment was completed. Please describe the process and outcomes of the infrastructure rapid assessment?
2. We have noticed several different types of posters in SHTP II supported health facilities. Please describe the work that has been done in the area of IEC/BCC.
3. What were the linkages between SHTP II and the regional training centers or pre-service training institutions?
4. Were there any activities that MSH would have considered not implementing that were requirements under their contract with USAID?

ANNEX F: LIST OF KEY INFORMANTS

Organization	Title	Surname	First Name
AAH-I	MCH/HIV Technical Advisor	Waigi	Jemimah
AAH-I	PHC Coordinator	Dr Mohamed	Omar
AAH-I	M&E Specialist	Mustafa	Sebit
AAH-I	Senior Programme Manager	Innocent	Asminu
AAH-I (Kotobi PHCC)	Assistant Nurse	Olive	Vivien
AAH-I (Kotobi PHCC)	Clinical Officer	Semira	Loice
AAH-I (Kotobi PHCC)	Community Midwife	Elisa	Charity
AAH-I (Kotobi PHCC)	CHW/Store Keeper	Vole	Bennet
AAH-I/MOH (Wandi PHCC)	In-Charge	William	Charles
AAH-I/MOH (Wandi PHCC)	MCHW	Joseph	Esther
ADRA	PHC Coordinator	StanlyBiga	Adruga
ADRA	Programs Director	de Graff	Rebecca
ADRA	SHTP II Coordinator	Mahmud	Gaznabi
ADRA	Project Manager	Okdwoku	Rafael
ADRA	Country Director	Ogillo	Awadia
ADRA (Kadiba PHCC)	Clinical Officer	Gidan	Kenneth
ADRA/MOH (Munuki PHCC)	In-Charge	Luate	Juluis
ADRA/MOH (Nyakuron PHCC)	In-Charge	Ouyon	Celestian
BSF	Team Leader	Louwes	Kate
BSF	Finance Manager	Janssen	Allard
CARE	Assistant Country Director	George	Jacqueline
CARE	Assistant Country Director	Avenell	Peter
CCM	Country Representative	Montanari	Alessia
CCM	Desk Officer	Gulino	Daniela
CCM	M&E Officer	Daniel	Lai
CIDA	Deputy Head of Cooperation	Delany	Caroline

Organization	Title	Surname	First Name
DFID	Health Advisor	Bagaria	Jay
Doso PHCU	TBA	Mary	Mama
IMC	Project Director	Dr Baktiar	Mohammed
IRC	Grants Coordinator	Lovett	Ashleigh
IRC	Deputy Director Programs	Taerber	Wendy
JDT	Senior Health Advisor	Timmermans	Dia
John Snow, Inc	Project Medical Director	Ama	Morris
Local Government	Commissioner, Wulu County	Thiang	Ezekiel
Local Government	Director, Wulu County	Manga	Zakaria
MOH (CHD Juba)	Deputy County Medical Officer	Lado	Caeasar
MOH (CHD Mundri East)	Deputy Executive Director	Night Wilson	Vance
MOH (CHD Mundri West)	PHC Supervisor	Ismail	Wilson
MOH (CHD Mundri West)	County Medical Officer		Lawrence
MOH (RSS Juba)	DG for Comm. and Public Health	Dr Baba	Samson
MOH (RSS Juba)	Acting DG for Training and PD	Arop	Kuol
MOH (RSS Juba)	HRM Technical Advisor	Etenyi	Josephine
MOH (RSS Juba)	DG for Planning and Coord.	Dr Riek	Lul
MRDA	Director	Wilson	Light
MRDA	Health Coordinator	May Kenneth	Lextion
MRDA/MOH (Kadiba PHCC)	Senior Medical Assistant	Manu	Gibson
MRDA/MOH (Kadiba PHCC)	Head of Nurses	Brown	Lamsudan
MSH	Communications	Polich	Erin
MSH	PHC Advisor	Lukudu	David
MSH	MNCH Advisor	Luka	Edward
MSH	MNCH Advisor	David	Victoria
MSH	MNCH Advisor	Ochieng	Isabella
MSH	COP	Rumunu	John
MSH	Deputy COP	Mohammed	Jemal

Organization	Title	Surname	First Name
MSI	Health M&E Specialist	Wadegu	Dominic
MSI	WASH Advisor	Teffera	Wondwossen
National Government	MP	Hon. Mulual	Simon
PSI	Global Fund M&E Manager	Dale	Martin
PSI	Acting Country Representative	Walton	Jason
SCiSS	SHTP-11 Programme Manager	Tamirat	Kassahun
SCiSS	Health Coordinator	Dr Tadesse	Derebe
SCiSS	In-Charge		Moses
SCiSS	MCHW		Susannah
SCiSS	In-Charge		Phillip
UNICEF	Chief of Health and Nutrition	Mkerenga	Romanus
USAID	Maternal Child Health Specialist	Armbruster	Deborah
USAID	Health Specialist	Swaka	Martin
USAID	Health Specialist	Denis	Mali
USAID	Deputy Health Team Leader	Hoffman	Anna
USAID	Health Specialist	Modi	Basilica
Village Health Committee (Kadiba PHCC)	Chairperson	Khormis	Samson
Village Health Committee (Kotobi PHCC)	Payam Administrator		Hezekkiah
Village Health Committee (Kotobi PHCC)	Village Health Committee Member	Zakago	Silivano
Village Health Committee (Kotobi PHCC)	Village Health Committee Member	Fakir	James
Village Health Committee (Tonji PHCU)	Village Health Committee Member	Deng	William
Village Health Committee (Tonji PHCU)	Village Health Committee Chairperson		Maridine
Village Health Committee (Tonji PHCU)	Village Health Committee Member	Majok	Futur
Village Health Committee (Wulu PHCC)	Village Health Committee Chairperson	AjonPajalla	Manyang
Village Health Committee	Village Health Committee	Manuela	Jor

Organization	Title	Surname	First Name
(Wulu PHCC)	Member		
Village Health Committee (Wulu PHCC)	Chief of Village	Malual	Majak

ANNEX G. EVALUATION FIELD WORK PLAN

Activity	Loc.	May																							June							
		M	T	W	T	F	S	M	T	W	T	F	S	M	T	W	T	F	S	M	T	W	T	F	S	M	T	W	T	F	S	
		7	8	9	10	11	12	14	15	16	17	18	19	21	22	23	24	25	26	28	29	30	31	1	2	4	5	6	7	8	9	
MSI evaluation procedures orientation	Juba	x																														
USAID for evaluation briefing	Juba		x																													
USAID first Interview	Juba		x																													
Meet other development partners	Juba			x																												
Introductory meeting with MSH	Juba			x																												
Develop Inception Report and Survey Tool	Juba				x	x																										
Conduct one-to-one meetings with MSH	Juba					x		x																								
Develop semi-structured interviews	Juba						x	x																								
Finalize work plan and meeting plans	Juba				x	x																										
Finalize the travellogistics W Equatoria	Juba				x	x	x	x																								
Meeting with USAID/MSI survey tools	Juba							x																								
Distribution of final survey tool to subcontracted partners	Juba							x	x																							
Travel to Mundri Town	Mun								x																							
Meet Mundri East CHD in Kedi'ba	Mun								x																							
Meeting with MRDA	Mun									x																						
Meeting with AAH-I	Mun									x																						
Facility visits in Mundri West	Mun										x																					
Meet with CHD Mundri West	Mun										x																					
Facility visits Mundri East & return to Juba	Mun											x																				
Confirm Juba visit for following week	Juba											x																				

Writing up field visit surveys	Juba												x																			
Deadline for Survey Tool response	Juba													x																		
Meeting with MOH	Juba													x																		
Facility Visits Juba County &Adra meeting	Juba														x																	
Subcontracted PartnerMeetings	Juba													x	x	x	x															
Synthesize data	Juba																	x	x													
Midpoint meeting with USAID	Juba																	x														
Update work plan & finalise survey results	Juba																		x													
Travel to Rumbek, travel to Wulu	Wulu																			x												
Facility Visits Wulu, and meet SCiSS/CHD	Wulu																				x											
Travel to Juba	Juba																					x										
Interview and field visit synthesis	Juba																						x	x	x							
Prepare Subcontracted PartnerPresentation	Juba																								x							
Validation of information from subcontracted partner	Juba																									x						
Presentation to USAID health team	Juba																											x				
Wider partners' presentation	Juba																													x		
Drafting of evaluation report	Juba																									x	x	x	x	x		
Team submits the report draft, ET depart	Juba																															x