

## **Annual Performance Report**

---

SHTP II

October 1, 2009 – September 30, 2010

This report was made possible through support provided by the US Agency for International Development, under the terms of Cooperative Agreement Number GHS-I-00-07-00006-00. The opinions expressed herein are those of the author(s) and do not necessarily reflect the views of the US Agency for International Development.

---

Sudan Health Transformation Project II (SHTP II)  
Management Sciences for Health  
784 Memorial Drive  
Cambridge, MA 02139  
Telephone: (617) 250-9500  
[www.msh.org](http://www.msh.org)



**USAID**  
FROM THE AMERICAN PEOPLE

**SUDAN**

**Sudan Health Transformation Project (SHTP II)**

**PERFORMANCE REPORT for FY 2010  
(1 October 2009 – 30 September 2010)**



Submitted to: Clifford Lubitz  
CTOR, SHTP II  
USAID/Southern Sudan

Report Type: Annual Task Order Performance Report  
Award No. GHS-I-00-07-00006-00 Task Order 4  
Period Ending: Sept 30, 2010

Prepared by

Management Sciences for Health  
784 Memorial Drive,  
Cambridge, MA 02139

The authors' views expressed in this publication do not necessarily reflect the views of the United States Agency for International Development or the United States Government

# Table of Contents

<b>ACRONYMS AND ABBREVIATIONS .....</b>	<b>ii</b>
<b>SUDAN HEALTH TRANSFORMATION PROJECT II – EXECUTIVE SUMMARY .....</b>	<b>1</b>
Background:.....	1
Qualitative impact: .....	1
Quantitative impact: .....	1
Project Administration.....	1
Fiscal Year 2010 work plan analysis (by result and activity) .....	2
<b>II. KEY ACHIEVEMENTS (QUALITATIVE IMPACT) .....</b>	<b>5</b>
<b>III. PROGRAM PROGRESS (QUANTITATIVE IMPACT) .....</b>	<b>9</b>
Lessons Learned .....	18
<b>V. NEXT QUARTER’S WORK PLAN .....</b>	<b>22</b>
<b>VI. FINANCIAL INFORMATION.....</b>	<b>22</b>
Cash Flow Report and Financial Projections (Pipeline Burn-Rate).....	23
<b>VII. PROJECT ADMINISTRATION .....</b>	<b>25</b>
Constraints and Critical Issues .....	25
Personnel.....	27
Changes in the Project .....	27
Contract Modifications and Amendments.....	28
<b>VIII. INFORMATION FOR ANNUAL REPORTS .....</b>	<b>28</b>
A. Estimated Budget Disaggregated by State .....	28
B. Earmark Expenditure Narrative .....	28
C. GPS Information.....	28
D. List of Deliverables.....	29
E. Summary of non-USG Funding.....	29
<b>ANNEXES &amp; ATTACHMENTS.....</b>	<b>29</b>
<b>ANNEX I: SCHEDULE OF FUTURE EVENTS.....</b>	<b>30</b>
<b>ANNEX II: SUCCESS STORIES .....</b>	<b>31</b>
<b>ANNEX III: LIST OF DELIVERABLE PRODUCTS.....</b>	<b>32</b>
<b>ANNEX IV: QUARTER 1 WORK PLAN.....</b>	<b>33</b>
<b>ANNEX V: QUARTERLY VARIATION IN ACHIEVEMENTS .....</b>	<b>39</b>
<b>ANNEX VI: VARIATION IN ACHIEVEMENTS ACROSS THE DIFFERENT COUNTIES FOR SELECTED CORE INDICATORS .....</b>	<b>41</b>

## Acronyms and Abbreviations

AAA	Arkanjelo Ali Association
AAH-I	Action Africa Help, International
ACSI	Accelerated Child Survival Initiative
ACT	Artemesinin-based Combined Therapy
ADRA	Adventist Development and Relief Agency
ANC	Antenatal Care
ARI	Acute Respiratory Infection
BCG	Bacilus of Calmette and Guarine
CCM	Comitato Collaborazione Medica
CCM	Community Case Management
CDD	Community Drug Distributor
CHD	County Health Department
CHMC	County Health Management Committee
CS	Child Survival
DPT	Diphthteria, Pertussis and Tetanus
EPI	Expanded Program on Immunization
FFSDP	Fully Functional Service Delivery Point
FP	Family Planning
GFATM	Global Fund for AIDS, TB and Malaria
GoSS	Government of Southern Sudan
HHP	Home Health Promoter
IMC	International Medical Corps
IRC	International Rescue Committee
JSI	John Snow, International
LLITN	Long Lasting Insecticide Treated nets
LRA	Lord Resistance Army
M&E	Monitoring and Evaluation
MCH	Maternal and Child Health
MCHW	Maternal and Child Health Worker
MoH	Ministry of Health
MRDA	Mundri Relief and Development Association
MSH	Management Sciences for Health
NID	National Immunization Days
OPV	Oral Polio Vaccine
PBC	Performance Based Contracting
PHC	Primary Health Care
PHCC	Primary Health Care Centre
PHCU	Primary Health Care Unit
PMTCT	Prevention of Mother to Child Transmission
PoU	Point of Use
PSI	Population Services, International
SBA	Skilled Birth Attendant
SCiSS	Save the Children in Southern Sudan
SCP	Subcontracting Partner

SHTP II	Sudan Health Transformation phase two
SIDF	Sudan Inland Development Fund
SRCS	Sudanese Red Crescent Society
STTA	Short Term Technical Assistance
TBA	Traditional Birth Attendant
TT	Tetanus Toxoid
VCT	Voluntary Counseling and Testing
VHC	Village Health Committee
WMC	Water Management Committee

## Sudan Health Transformation Project II – Executive Summary

**Background:** The second phase of the USAID-funded, three-year Sudan Health Transformation Project (SHTP II) is implemented in 14 counties across all 10 states of Southern Sudan. The overarching goal of the project is to, “*build on the decentralization of primary health care services to improve the health status of the Southern Sudanese people.*” To achieve this goal, SHTP II supports service provision in seven high impact areas: child health, nutrition, malaria, maternal health, family planning, water hygiene and sanitation, and HIV/AIDS within the primary health care system. We achieve our results through 10 Sub-contracting partners (SCPs) working in 14 counties through performance-based contracts (PBCs) that link performance to payments. Through these SCPs we increase access to health services, build capacity of the Sudanese government to manage the services, and increase demand.

**Qualitative impact:** during the year under review, SHTP II made significant progress in implementation of activities for all three expected results (ER), leading to major changes in health practices and improved access to quality services. SHTP II disseminated the national policies and guidelines for the seven high impact areas to all County Health Departments (CHDs) and health facilities in the catchment area. Staff members were trained in the use of these guidelines for the implementation of the Basic Package of Health Services (BPHS). SHTP II provided financial support to refurbish health facilities and to purchase equipment and supplies to improve BPHS facilities. SHTP II provided support to document drug consumption patterns and assisted with logistics to improve stocks of essential drugs and medical supplies. An RFA was issued, and sub-contracts were signed with 10 NGOs to support service provision in the 14 target counties. SHTP II provides technical oversight and capacity building to the SCPs and manages the sub-contracts using a performance scorecard linked to payments (PBCs). The SHTP II provides salary support to 65% of MOH health service staff that deliver all BPHS services. SHTP II provided support to strengthen the national monitoring and evaluation (M&E) system to: harmonize the frontline data collection tools; develop and disseminate operational guidelines to standardize M&E practices across the target counties; build the capacity of staff from the health facilities, County Health Departments (CHDs), and Subcontracting Partners (SCPs) in M&E; and develop a data quality assurance (DQA) system for ensuring the availability of high quality data. SHTP II printed and distributed frontline data collection tools such as registers, tally sheets, and monthly reporting forms, plus IEC materials and job aids for the facility level. More than 90% of all health facilities in SHTP II target counties sent in their monthly report within one month, a great improvement from baseline. SHTP II is finalizing operational guidelines for community participation to expand knowledge, demand and access to services. WASH activities extend into the community level.

**Quantitative impact:** During fiscal year (FY) 2010 SHTP II achieved or exceeded the targets for 69% (11/16) of the contractual indicators for the project. For all indicators there was a progressive increase in the proportion of the target that was achieved during successive quarters. Despite the slow start up and delays in finalization of the sub-contracts with the partners, during the past year significant progress was made towards the achievement of the three main objectives (expected results) of SHTP. At the end of this FY, SHTP II is poised to improve performance and achieve a greater percentage of its targets in FY 2011.

**Project Administration:** SHTP II has achieved much at the mid-point of the project, but we face significant administrative challenges. The first is a projected \$2,600,000 budget deficit by the End of the Project (EOP). The second is a high personnel turnover rate related to delayed approvals of staff and low salaries. The third is significant delays in USAID approvals that affect

many project activities ranging from personnel hiring, to procurement, to micro-grant implementation.

## **Fiscal Year 2010 work plan analysis (by result and activity)—requested by USAID**

### **Deviations from 2010 Work Plan**

SHTP II implementation has been influenced by many factors including issues related to project design, weather, social and political factors (presidential and parliamentary elections), and lack of recruiting a full complement of staff and other events. While the majority of our planned activities in the 2010 work plan have been completed, many factors have combined to delay accomplishment of planned project activities as described below. We had previously submitted an analysis of the full 2010 work plan achievements to USAID on October 20, 2010.

### **Result #1: Expanded access/availability of high impact services and practices**

MSH/SHTP II planned to disburse micro-grants to Civil Society Organizations (CSOs) for community-based activities as a complement to the PBCs in community-based activities. The SHTP II micro-grant manual was completed and sent to USAID for approval. There was a lengthy delay before USAID provided comments. After a recent review and comments by USAID, MSH is responding to USAID's comments and will resubmit the micro-grants manual for approval. The SHTP II Community Mobilization Advisor is now reviewing and revising the manual. We hope to start implementation of the micro-grants by the end of the first quarter of FY 2011.

Piloting of WASH approaches through SCPs or micro-grantees to develop recommendations for scale up is still in the initial implementation phase. This activity has been included in the PSI sub-contract as part of demand creation for sanitation. PSI began implementation of the pilot project last quarter, and will complete the pilot by the end of Dec 2010. Details of the pilot project are provided in the qualitative achievement section.

Development of technical guidelines for setting up basic WASH services in health facilities is pending finalization of an assessment of status and availability of WASH activities in health facilities. This activity will be accomplished in October 2010.

The plan to conduct three regional workshops for community and religious leaders and village health committees on the benefits of child spacing will be conducted after the training of trainers (ToT) and service providers training in family planning is completed as scheduled in October 2010.

The Fully Functional Service Delivery Points (FFSDP) was adapted for Southern Sudan in August, 2010, and training of the SCPs and CHDs was completed during the last partners meeting at the end of September. Eleven standards for the 7 high impact areas, as well as management standards were tested, and approved by the stakeholders (SCPs, CHD, and the State Ministries of Health (SMOH)). The roll-out plan in the counties is ready for implementation in the next FY.

Organization of a technical working group on HIV/AIDS for SHTP II and other partners was not completed. Instead, MSH appointed a focal point for HIV/AIDS within the technical team who is actively participating in the USAID PEPFAR prevention working group and other existing

HIV/AIDS forums within the MOH. The focal point coordinates all SHTP II HIV/AIDS activities, such as PMTCT training with the MOH and other partners.

Development and adaptation of training modules for Voluntary Counseling and Testing (VCT), Prevention of Mother-to-Child Transmission (PMTCT), and abstinence and be faithful (A&B) prevention activities was not completed. VCT and A&B deliverables are no longer relevant due to changes in HIV programming and indicators for the SHTP II. We will use the Ministry of Health, Government of Southern Sudan (MOH-GOSS) trainers, materials and guidelines for PMTCT training. Coordination between SCPs and the MOH for PMTCT training is included in the FY 2011 work plan.

**Result #2: Increased Southern Sudanese capability to deliver and manage services:**

Development of CSO capacity assessment tools, building on materials already in use in southern Sudan, with a field test in two SHTP II counties was not completed. Assessment tools were collected but not yet field tested. This activity is carried forward to fiscal year 2011. Relevant information and methodologies including program and training materials from agencies working with civil society in Southern Sudan will be used based on extensive existing experience and other USAID projects that build capacity of CSOs in S. Sudan.

Training subcontracting partners on the use of CSO assessment tools and finalizing the approach for working with CSOs (e.g., county-wide workshop vs. localized approach) was not completed. MSH planned to assess CSOs directly through the Community Mobilization Advisor/Coordinator. MSH has identified CSOs and well-organized Village health committees for micro-grants workshops. MSH has requested that Subcontracting partners include Community Mobilization focal points in their work plan for FY 2011 to advance this community approach in the next FY.

Providing support to subcontracting partners on the development of Capacity Building and Organizational Strengthening Plans for selected CSOs was not completed. Training workshops will be conducted to build capacity of CSOs to manage micro-grants as part of the FY 11 work plan.

Capacity building for Village Health Committees (VHCs) was not fully realized. MSH will complete a field assessment in focus counties to verify capacity, issues, and concerns with current VHC structures and approaches, seeking input from subcontracting partners, County Health Departments (CHDs), and communities. Orientation meetings will be conducted for SCPs to implement guidelines for VHC capacity strengthening plans in January through March. Following that, MSH will monitor capacity building activities by the SCPs.

Provision of capacity building activities for County Health Department staff was delayed, but is now actively progressing. The MSH Leadership Development Program (LDP) has started to improve the capacity of CHDs and SCPs to function as managers who lead. The first facilitators training workshop was completed in early October, 2010. MSH, with support of an experienced LDP facilitator, conducted LDP training for CHD and SCP Teams in October 2010, and will be followed up by focused trainings in selected counties in November, 2010.

SHTP II has gone to extraordinary lengths to assure availability of essential MOH policies and protocols at appropriate levels (county, Primary Health Care Center (PHCC) and Primary Health Care Unit (PHCU)), but there is one activity which was not completed as designed. The initial plan was to conduct review sessions of policy documents with CHDs and SCPs at the county

level. This activity was not completed at the county level, but undertaken through thematic presentations in quarterly partners' meetings. MSH will continue to conduct review sessions of policy implementation with CHDs and SCP at partners meetings.

A strategy for integrating gender-based violence (GBV) policy into county health plans was not completed because the draft policy developed by the Ministry of Gender has not yet passed Parliament, nor has it been shared fully with SHTP II (despite our efforts). The policy is needed for us to ensure that GBV is appropriately integrated into county health plans. MSH will work with GOSS Ministries of Health and Gender on finalization of the GBV policy and will support counties to integrate a GBV policy into their County Health Plans.

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

Development of community intervention thematic groups among SCPs will be initiated at the November partners meeting, but it was not completed as planned in FY '10. MSH hopes to have USAID's approval of the micro-grants manual and will include a community-based intervention strategy to be shared with SCPs and CHDs at this meeting.

Collecting training curricula and guides being used to train Home Health Promoters (HHPs) and Community Based Distributors (CBDs) and the mapping of HHPs and CBDs by agency and location has not taken place as scheduled. However, initial information has been received from SCPs and we are in the process of collating them into one document. The SHTP II Community Mobilization Advisor will develop training strategies in all community-based technical areas, including training of HHPs.

The development of an SHTP II website in conjunction with the MOH was not completed and will be dropped as it is no longer a priority.

## II. KEY ACHIEVEMENTS (Qualitative Impact)

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

**Dissemination of National Policies and Guidelines:** Available national policies and guidelines that were developed by the MOH for the seven high impact areas were collated and distributed to all SCPs, the CHDs, and health facilities within our catchment area. This was complemented with extensive discussions and reviews of the guidelines during partners meetings, ensuring that all partners fully understand them and that they are used in the planning and implementation of services in their respective catchment areas.

**Facility refurbishment:** to ensure that health facilities meet the minimum standard that is required to provide services in the seven high impact areas, SHTP II provided financial support for the upgrading and refurbishing of facilities in five counties: Juba, Tonj South, Tambura, Malakal, and Wau.

**Support for distribution of drugs and medical supplies:** MSH worked with the MOH, the SCPs, and other stakeholders in the finalization of the list of health facilities and drug consumption patterns for each, to facilitate the distribution of drug kits and other medical supplies. To ensure that supplies are received on a timely basis, SHTP II also provided financial and logistical support to deliver these essential supplies to many counties and facilities within the respective districts. To assist in the prevention of future shortages, this medication and commodities list was handed over to the relevant department within the MOH to guide future planning. In addition to medications, for malaria prevention, SHTP II provided financial support for the distribution of 120,000 Long-Lasting Insecticide Treated Nets (LLITNs) to all of the counties that are supported by the project.

**FFSDP:** The Fully Functional Service Delivery Point (FFSDP) is a standards-based performance quality improvement methodology that will improve the quality of services in SHTP II supported facilities. MSH developed a supportive supervisory check list and tested it during the joint supportive supervisory visits. The check list was used to develop standards in 11 critical areas needed to achieve a fully functional service delivery point. Guidelines for use and a training program were developed, and the SMOHs, CHDs, and SCPs were trained in implementation and use of the FFSDP. It will serve as both an internal quality assurance (QA) tool for use by facility quality improvement teams, and as an external evaluation tool to improve the quality of supervision. In this next FY, the FFSDP will be rolled out to the facilities in each focus county and SHTP II will measure quality improvements over time.

**Financial support to sub-contracting partners:** Ten NGOs were selected and provided with financial support through performance-based sub-contracts to support implementation of the BPHS within the fourteen target counties. During the last quarter of FY 09, an RFA was issued soliciting proposals from NGOs to support the BPHS in these counties, and bids were received from multiple NGOs. Following a review of the proposals by a proposal review team, 14 awards were given to 10 NGOs. A significant amount of time was devoted in the first two quarters of FY 10 to negotiating sub-contracts and targets, agreeing on budgets, and developing the reporting and monitoring mechanisms with the SCPs. All sub-contracts were signed between November 30, 2009 and February 28, 2010. A standardized NGO scorecard to measure indicator achievement for each SCP was subsequently developed and is used as the basis for managing, monitoring, and payment of the SCPs, thus linking payments to performance.

**Distribution of IEC materials:** Over 15,000 pieces of IEC materials targeting Southern Sudanese citizens were printed by MSH and distributed to SHTP II-supported facilities (PHCCs

and PHCUs) through the SCPs. These materials provide information on malaria, HIV/AIDS, water, hygiene and sanitation, Expanded Program of Immunization (EPI), and family planning.

**Nutrition:** Activities were implemented in two broad areas of nutrition. First, SHTP II field staff assisted the MOH and other stakeholders in planning, organizing, and rolling out the National Immunization Days (NIDs) activities in focus counties, during which Vitamin A supplementation tablets are distributed to the majority of children under five years old. This strategy of using NIDs for vitamin A distribution is complemented by routine distribution at health facilities to persons who show evidence of vitamin A deficiency. Second, health education on good nutrition was provided to mothers, pregnant women, and children who visit SHTP II health facilities for services. Pregnant women were given information on the importance of eating a balanced diet using locally available foods. Lactating women were encouraged to continue breastfeeding their children until 2 years of age. Postnatal mothers were taught the importance of exclusive breast feeding.

### **Malaria prevention and treatment**

SHTP II contributes to the national efforts in malaria management by providing salaries for approximately 65% of MOH staff involved in implementing the BPHS, including malaria diagnosis and treatment, supporting prevention efforts, and building capacity of health workers and community members involved in malaria prevention and treatment. SHTP II shipped 120,000 long lasting insecticide-treated nets (LLITNs) to all 14 counties and provided intermittent preventive therapy (IPT) for malaria to pregnant women during antenatal visits. In addition, SHTP II supported capacity building activities in malaria management and appropriate case management of febrile illness for health care workers and community members. Service providers were trained in malaria prevention and treatment by SCPs using the national policies for distribution of LLITNs, integrated management of childhood illnesses, and malaria treatment guidelines using ACT. SHTP II facilities distributed LLITNs through MCH services outlets, such as antenatal care, EPI, and under-five clinics, in coordination with PSI and Global Fund (GF) BCC efforts.

### **Maternal health**

All SHTP II-supported health facilities offered ANC services to pregnant women who sought those services. In addition, through our community mobilization activities, women were sensitized on the importance of receiving ANC services and delivering at the health facilities under the supervision of a skilled attendant. During ANC visits, all pregnant mothers were provided with tetanus toxoid (TT) vaccinations, IPT for malaria, and nutritional supplements, such as ferrous sulphate and folic acid. Midwives and other staff at the facilities also educated pregnant women on good nutrition and appropriate self care during pregnancy. Assisted deliveries were conducted at both the health facility level and at the community level. Selected facilities provided HIV testing as part of PMTCT of HIV programs.

### **Family Planning**

MSH conducted a family planning (FP) workshop for SCPs and County Health Departments, using an MSH internationally-approved curriculum for FP services. GOSS MOH FP policy and guidelines and USAID FP compliance issues were presented and discussed. Contraceptives, both oral and injectables, were distributed to SHTP II facilities at the request of USAID. However, due to concerns about the poor quality of storage of these FP commodities, they have since been called back for quality testing before use. A TOT workshop is planned for October

and is currently ongoing. This will be followed by training of service providers. Cascade roll-out training will take place in respective counties. In addition, a memorandum of understanding was signed with UNFPA to ensure regular supplies of reproductive health and FP supplies and commodities pending verification of the quality of USAID-supplied FP commodities.

### **Water, sanitation, and hygiene**

An RFP was issued for WASH activities and a subcontract was awarded to PSI. The program implemented by PSI Sudan combines direct activities in the communities by the project teams in field offices and partner community-based organizations and women's groups. One of the main accomplishments under this high impact area includes the social marketing of the point of use water treatment (PoUWT) products, Water Guard and PUR, which is conducted through a network of wholesalers and retailers. During this FY, SHTP II worked on demand creation for WASH activities, using Community Led Total Sanitation (CLTS) training for staff members from the Ministry of Water Resource and Irrigation, SCPs, CSOs, and community members. Staff of the SCPs were responsible for conducting outreach sessions to disseminate appropriate messages on proper water treatment with Water Guard or PUR at the point of use, safe storage of water, hand-washing with soap at five critical times, and use of latrines for human excreta disposal.

**Support for medical waste management in health facilities:** SHTP II supports health facilities to ensure the following:

- Segregation of medical waste from general waste and appropriate disposal of the different forms of medical waste;
- Disinfection of all medical waste before disposal; and
- Tissue parts, blood, and sputum are disposed of in dry and lined pits to avoid contamination of water sources.

As a result of this activity health facilities are using safety boxes for the disposal of medical waste and sharps. There are also incinerators for burning the medical materials. Where there are no incinerators, medical waste is burned and buried. Management of incinerators is not up to standards in most areas. The SHTP II WASH Advisor is working with SCPs to improve medical waste management at different sites.

### **HIV/AIDS**

This was one of the most challenging areas for SHTP II during the FY under review. Less than 10% of the target for HIV prevention activities was achieved. The HIV program was not well defined, but this has been corrected by using MSH short-term technical assistance (STTA) in the last quarter of this FY to design more effective HIV/AIDS interventions. The BCC component of our HIV/AIDS program has been much better defined through this STTA, and will be more effectively implemented in the forthcoming year. SCPs have been asked to recruit community outreach staff to coordinate community activities in HIV/AIDS with a focus on improved BCC and counseling. PMTCT activities are supported by several donors, and reporting of PMTCT indicators goes to several agencies. We have identified the problem and have resolved it by simplifying the number of PMTCT sites supported solely by SHTP II and reported to the project on a quarterly basis. We will continue to use STTA to strengthen our HIV/AIDS program activities, provide supportive supervision to the counties and SCPs, emphasize community mobilization and behavior change communication around key messages for HIV/AIDS prevention, and strengthen a more limited number of PMTCT sites.

## **Result # 2: Increased knowledge of and demand for health practices**

The twin pillars of our technical approach in this result area are community mobilization and BCC activities. The SCPs provided support and training to VHCs, HHPs, and other community leaders for outreach and dissemination of key messages in key themes of FP, HIV/AIDS, malaria, maternal health, and WASH. We printed 15,000 copies of IEC materials in these key programs for dissemination in facilities and communities throughout the focus counties. WASH activities stressed a community-led educational process on the importance of good hygiene practices and PoUWT. In addition, the SCPs used community mobilization approaches such as puppetry to increase uptake into a number of the important BPHS services. These include EPI and National Immunization Days, Vitamin A distribution, maternal health services, including ANC and Intermittent Presumptive Treatment, 2<sup>nd</sup> dose (IPT2), malaria prevention through distribution and use of LLITNs, and WASH activities.

Delays in receiving USAID approval for the SHTP II micro-grants manual led to delayed implementation and award of small grants to CSOs to supplement this activity. Workshops were held in three counties to train CSOs in this process. Twelve proposals were received; 8 were selected for implementation. Once the micro-grant manual is approved, we will move forward with pre-award assessments of the CSOs and award of the grants. The micro-grants project when implemented should lead to an increase in the demand for services in all of the seven high-impact areas supported by the project.

## **Result #3: Increased Southern Sudanese capability to deliver and manage services**

One of the key accomplishments under this expected result is capacity building based on the national guidelines and curriculums of staff at all levels of the system including the MOH, the CHD, and at PHCU and PHCC service delivery points. In addition, many facilities were refurbished to bring them up to the minimum standards recommended by the MOH in the BPHS guidelines.

Significant training in priority high-impact BPHS service areas occurred with the SCPs, CHDs, and facility service staff. These included training in Family Planning (FP), HIV/AIDS, Expanded Program in Immunizations (EPI), Acute Respiratory Infection (ARI) and Diarrheal Disease Control (DDC) case management, prevention and treatment of malaria, good health and hygiene practices, and nutrition. Standardized training programs using government standards exist for EPI, ARI and DDC case management from the MOH, and for FP through MSH. SHTP II is in the process of standardizing the training in all remaining high impact areas and will make more progress in the next FY. This standardization process will include curricula, participants materials, trainers' manual, IEC materials and job aids. Job aids were developed in these key technical areas and posted in health facilities to support program implementation according to MOH guidelines. Policies and manuals were supplied to all facilities. In addition, effective management systems were introduced to improve the management and quality of services. CHDs/SCPs were trained in monitoring and evaluation using the HMIS, the FFSDP (described above) and leadership and management.

At the community level, VHC members received training in community mobilization, supervision of health activities in health facilities, allocation of resources in their various communities, and problem solving among their communities. Additionally, MSH organized a micro-grant workshop for VHCs and CSOs in three counties: Mundri, Mvolo, and Juba. The purpose of the workshop was to engage the VHCs and CSOs in the micro-grants application process and prepare them

for RFAs and the proposal development process. This process will be expanded to other counties once the micro grant manual is approved by USAID.

### **III. PROGRAM PROGRESS (Quantitative Impact)**

During FY 10, SHTP II made significant strides toward achieving our overall goal: *“to build on the decentralization of primary health care service to improve the health status of Southern Sudanese people.”* Based on a cut-off point of 80% to define whether the target for any indicator has been achieved, the project achieved or exceeded sixty-nine percent (11/16) of the targets for the contractual indicators. The data also showed a progressive increase in the proportion of the targets that were achieved during successive quarters, reflecting the initiation and expansion of services provided through our SCPs during the year. A significant amount of time was spent during the first and second quarters finalizing sub-contracts and negotiating targets with the SCPs. This section describes the key numerical achievements of the project against the indicators for each of the three key expected (intermediate) results: expanded access and availability of high impact health services; increased knowledge and demand for services and health practices; and increased Southern Sudanese capacity to deliver and manage services.

Table 1 shows the overall performance of the SHTP II against the key indicators and targets for the year. In order to reflect the changes in the indicators that occurred during the fiscal year as a result of USAID Amendment 4, this table is divided into three sections. Section A shows the current contractual indicators that will be carried over to subsequent fiscal years. Section B shows indicators that are reportable for the current fiscal year, but will no longer be used beginning in FY 11. Section C contains a list of indicators that are currently being negotiated with USAID. The table also provides a brief description of reasons for under and over achievement, defined as achievements above or below 10% of the stated targets. A more detailed breakdown of the project achievements across the different counties and during each quarter can be found in the tables in Annexes V and VI of this report.

Table 1: key achievements against the key indicators of the project

Indicator	FY10 Target	FY 10 achievements			% of target achieved	
		Males	Females	Total		
<b>Section A: Contractual indicators</b>						
1. Number of children less than 12 months who received DPT3 in a given year from USG supported programs MSH/SHTP II	20,750	9,227	5,826	15,053	72.5	Target was set higher later in the FY, more than is required to achieve 20.8% coverage in the population.  Target was increased without a corresponding increase in the coverage for indicator 2.  Delayed start-up by some SCPs delayed the EPI program, but by the last quarter the project achievement was at projected target level.
2. Percentage of children less than 12 months who received DPT3 in a given year from USG supported programs MSH/SHTP II	20.80%	34.6	23.5	29.2	139.1	Potential population in some counties is higher than initially projected. While the numerical target for DPT2 was increased during the year, the % coverage was not.
3. Number of children under 5 years of age who received vitamin A from USG-support programs MSH/SHTP II	30,400	n/a	n/a	66,523	284.3	There may be some duplicate reporting as some children may have received more than one dose during the FY.  Much of this is achieved during the NIDs, but Vit. A distribution also occurs through facilities.
4. Percentage of children under 5 years of age who received vitamin A in the last six months in areas currently assisted with USAID funds MSH/SHTP II	45%	n/a	n/a	51.4	114.2	The high level of achievement noted in Target # 3 resulted in a higher % of children receiving Vit. A.
5. Percentage of pregnant women who receive IPT2 during the reporting period MSH/SHTP II	50%	n/a	n/a	56.3	112.6	Training on the importance of IPT 2 has led to success; good supplies of Fansidar exist in the facilities.
6. Percentage of women with one ANC visit MSH/SHTP II	65%	n/a	n/a	52.7	81.1	Delayed start up by some SCPs  Target level was achieved by fourth quarter
7. Percentage of women with at least 4 ANC visits MSH/SHTP II	20%	n/a	n/a	18.0	90.0	SCPs have had success in stimulating 4 visits, but more work needs to be done to increase ANC attendance.
8. Percentage of deliveries with a skilled attendant at birth in USG-supported programs MSH/SHTP II	15%	n/a	n/a	7.0	46.6	Lack of skilled birth attendants at primary care level  Under reporting of home and hospital deliveries
9. Percentage of deliveries by trained traditional birth attendant (TBA) or Maternal and Child Health Worker (MCHW) in USG supported counties MSH/SHTP II	40%	n/a	n/a	22.9	57.3	Under reporting of home deliveries supported by TBA & MCHW. This category of health care personnel is no longer officially recognized by the MOH and therefore not well supported, although they still exist.

Indicator	FY10 Target	FY 10 achievements			% of target achieved	
		Males	Females	Total		
10. Number of counseling visits for FP/RH as a result of USG assistance MSH/SHTP II	15,000	n/a	n/a	4035	26.9	Uncertainty with regards to approach to FP during the early part of the FY and shortage of supplies. Inadequate monitoring system in early part of the FY
11. Liters of drinking water disinfected with USG-supported point-of-use treatment products MSH/SHTP II	140,000,000	n/a	n/a	189,558,420	135.4	Reflects success of the social marketing program done through the sub-contract to PSI responsible for this activity.
12. Number of individuals reached through community outreach that promotes HIV/AIDS prevention through abstinence and/ or being faithful	150,000	n/a	n/a	21,353	14.2	Strategy not well developed during this FY, both facility staff and communities not clear on messages and approach. Increased emphasis on this activity next FY.
13. Number of health personnel trained with USG support in the different program areas MSH/SHTP II	1,690	n/a	n/a	1559	92.3	Good success with training of HCWs by SCPs using their own training programs and trainers. Increased emphasis next FY on standardizing training approaches.
14. Number of community members trained with USG support in the different program areas MSH/SHTP II*	2500	269	134	2286	91.4	Same comment..
15. Percentage of clinics and health facilities that provide at least 5 of the 7 high impact services using the MoH approved standards MSH/SHTP II	93.6%	n/a	n/a	77.3	82.2	Many facilities were reporting on an irregular basis at the start of the FY and staff were poorly trained in data collection and reporting. Shortage of data collection and reporting tools, which is now corrected. Improved data collection will improve this indicator performance (see below). In addition, increased training and mentoring of health facility staff will increase number and types of services provided.
16. Percentage of USG supported health facilities that submit their HMIS monthly reporting form within one-month of the reporting month MSH/SHTP II	90%	n/a	n/a	94.4	104.9	
<b>Section B: Indicators which are reportable in FY 10 but will be retired at the end of the fiscal year</b>						
17. Number of LLITNs distributed through USG-support	151,698	n/a	n/a	36,349	24.0	120,000 LLITNs were sent to the counties but the distribution rate is slow as SHTPII supports distribution through MCH clinics and does not do mass distribution.

Indicator	FY10 Target	FY 10 achievements			% of target achieved	
		Males	Females	Total		
18. Number of people trained in malaria treatment or prevention with USG funds	150	n/a	n/a	286	445.0	In preparation for program roll out intensive training was done by the new SCPs for LLITN distribution, IPT2, and the use of ACT treatment.  Repeat training will be necessary to deal with the high turn-over rate of staff next FY.
19. Number of Individuals trained in good health and hygiene practice	520	n/a	n/a	647	124.4	In preparation for program roll out, intensive training was done by the new SCPs  Repeat training is necessary to deal with the high turn-over rate of staff
20. Number of health personnel trained in immunization, diarrhea, and ARI management	150	n/a	n/a	691	423.3	DDC is emphasized by SCPs and PSI, as is IMCI that also includes EPI and ARI management.
<b>Section C: Indicators that are currently being negotiated</b>						
21. Number of pregnant women with known HIV status (includes those who were tested for HIV and received their results)	None set	n/a	n/a	1591	n/a	
22. Number of HIV-positive pregnant women who received antiretrovirals to reduce the risk of mother-to-child transmission of HIV	None set	n/a	n/a	22	n/a	
23. Number of individuals from target audience who participated in community wide event	150,000	n/a	n/a	21,353	14.2	Improved performance is expected next FY with the redefinition of this indicator.

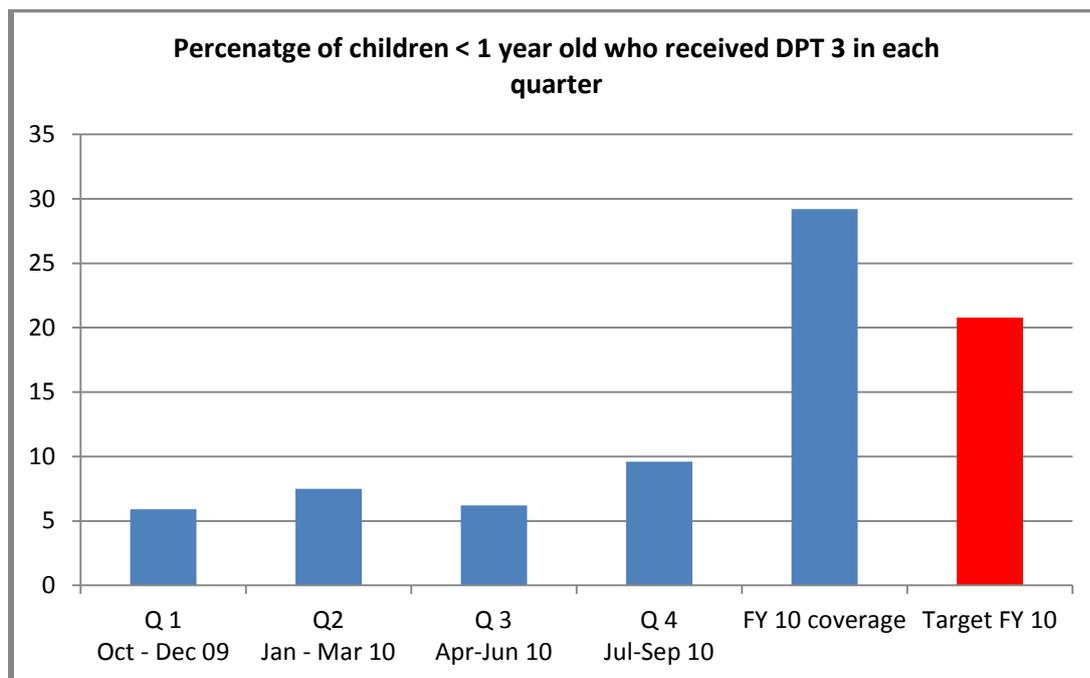
**\*Number of males and females do not add up to the total as sex disaggregated data were not available for some training**

**Quantitative achievements for ER 1 (expanded access to high impact services) & ER 2 (increased knowledge and demand for services):**

**A. Child health:** during the fiscal year under review, slightly more than 15,000 children younger than one year received DPT 3 vaccination through SHTP II services. Using data from the Census Bureau on the estimated population of children less than one year old in the target counties during this period, this achievement corresponded to an overall DPT 3 coverage rate of 29.2%, which exceeds the target (20.8% coverage) that was set for this indicator. As shown in Figure 1 below, there was a progressive increase in the proportion of children vaccinated during each quarter throughout the year, increasing from 5.9% during the first quarter to 9.6% in the fourth quarter with a slight reduction during the third quarter. This overall increase may be explained by the fact that all of the SCPs did not become fully functional until the second half of the year. The slight reduction noted in the third quarter corresponds to the rainy season, which made services inaccessible in many parts of the country during this period. In addition, insecurity in some areas due to inter-tribal conflicts and concerns during the period leading up to and after the elections led to a reduction in the utilization of health services during the third quarter.

As shown in Annex VI, the coverage level in nine counties was higher than the target with varying levels of coverage across the different counties. The exceedingly high coverage in Panyijar and Mundri West may be attributed to different factors that are operating at the community level. First, it is possible that there may have been some shifts in the population in those counties leading to the actual population being much higher than was captured in the census figures. Secondly, in Panyijar, SHTP II supports service delivery in three Payams only and it is possible that persons from the other Payams may be utilizing the services of SHTP II facilities. Thirdly, it is likely that there may be issues related to the quality of data reported from facilities in these counties. SHTP II will work with the SCPs in those counties to address this issue and to identify the reason(s) for this high coverage and share lessons learned with other SCPs at our quarterly meetings. The exceedingly low reported coverage in Kapoeta North is related to low staffing levels, heavy rains, under reporting, and poor record keeping.

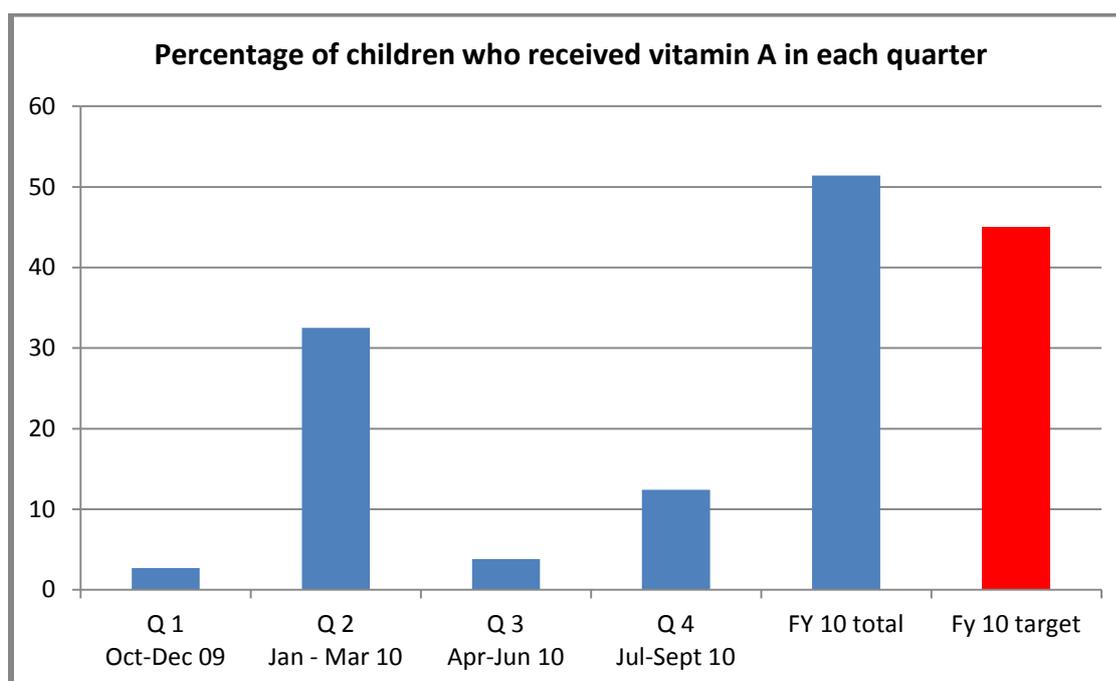
**Figure 1: DPT 3 coverage during FY 10**



**B. Nutrition:** nutritional coverage in the target counties is measured by the number and percentage of children under five years who received Vitamin A through a USG-

supported program. Vitamin A supplementation is given to children under five years old either when they visit a health center for other services and display any evidence of deficiency, or during the NIDs campaigns organized by the MOH and implemented at the community level by staff working at facilities supported by SCP staff paid by the SHTP II. Despite a number of challenges, SHTP II was able to exceed the target that has been set for vitamin A distribution and coverage among children less than five years old. The quarterly variation in vitamin A uptake that is shown in figure II below is due to the fact that the NIDs campaigns were held during the second and fourth quarters. In addition to the quarterly variation, the table in annex II illustrates that there are variations in coverage with vitamin A supplementation in children less than five years old across the different counties. SHTP II will work closely with the SCPs and the MOH to address these discrepancies. We will also work with the SCPs to determine the reason(s) for the high coverage in some counties such as Panyijar, Mundri West and Malakal. SHTP II will identify best practices and disseminate them to other counties during our quarterly partners' meeting.

**Figure 2: Vitamin A coverage among children less than five years old in the target counties**

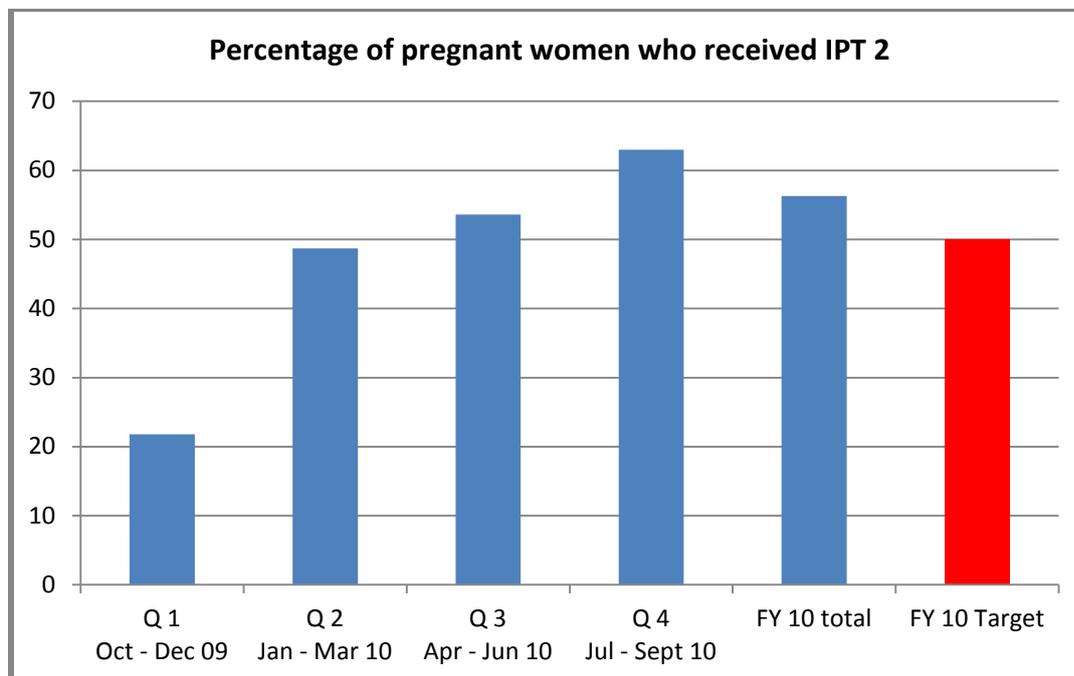


**C. Malaria:** GOSS has a comprehensive malaria control program which includes surveillance, prevention, treatment, and capacity building of health care workers and members of the community for effective case management of malaria in Southern Sudan. SHTP II contributes to the national efforts in malaria management by providing salaries for approximately 65% of staff involved in malaria diagnosis and treatment, supporting prevention efforts, and capacity building for health workers and community members. In the area of malaria prevention, SHTP II is involved in the distribution of LLITNS and the administration of IPT for malaria to pregnant women during antenatal visits. In addition, SHTP II supports capacity building activities in malaria management for health care workers and community members. SHTP II efforts in malaria management are tracked by measuring the “percentage of pregnant women who received their second dose of (IPT2) during ANC visits.” This indicator is defined as the total number of women who received IPT 2 expressed as a percentage of the number of women who had one ANC visit. During the period under review, fifty-six percent of all pregnant women in the areas served by SHTP II received their second dose of IPT with USG support. This achievement exceeds the target level of 50%. As shown in figure 3 below, there was a progressive increase in IPT 2 coverage among

antenatal women during successive quarters, rising from 21.8% in the first quarter to 63.0% during the fourth quarter. Much of this increase may be related to the slow start up and delay in getting all of the SCPs on board. We anticipate that this upward trend in performance will be maintained during the new fiscal year.

Except for Kapoeta North, approximately 50% of all pregnant women in the other counties received IPT 2 during the fiscal year. SHTP II plans to work with the SCP, the County Health Department (CHD), and the MOH to ensure that IPT 2 coverage among antenatal women in Kapoeta North is significantly increased and the coverage level in the other counties is maintained.

**Figure 3: Quarterly variation in IPT 2 coverage among antenatal women**



In addition, we reached 80% of the target for distribution of LLITNs to the counties, but only 34% of the target for distribution through maternal and child health services. We will intensify activities in this next FY to ensure that pregnant women and children under five years receive and use LLITNs appropriately for malaria prevention.

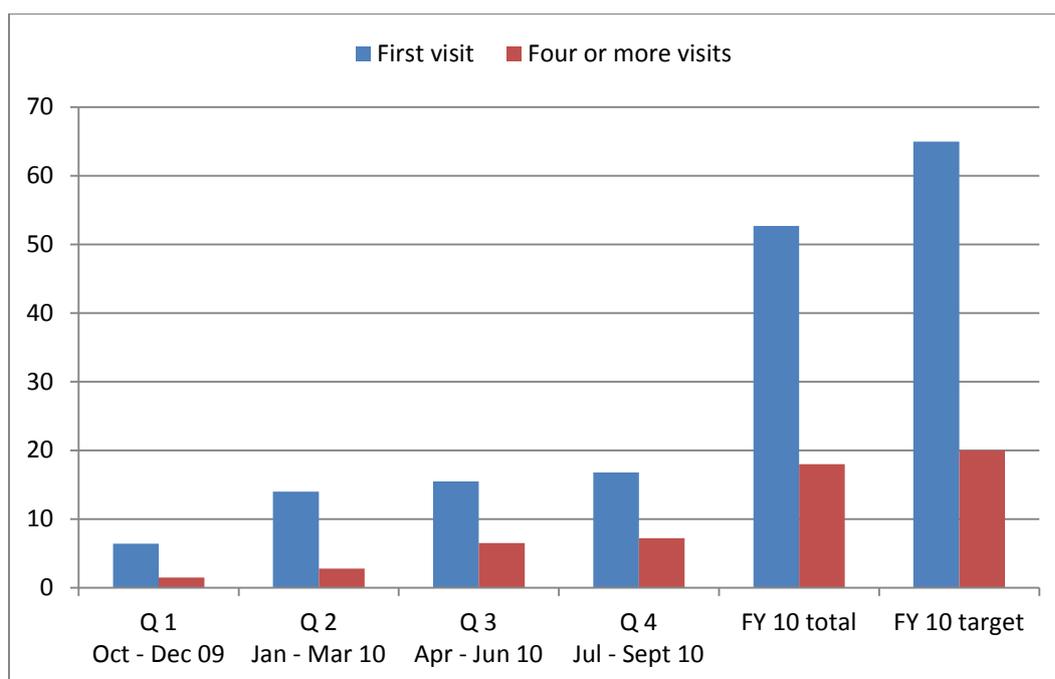
**D. Maternal Health:** In this strategic high-impact area, SHTP II supports the provision of high quality ANC to pregnant women, assistance during delivery, refurbishment of facilities to provide services, capacity building for appropriate staff, and community mobilization efforts to increase demand.

**Antenatal care:** Our efforts in antenatal care are tracked by measuring the “percentage of pregnant women who had one ANC visit” and “the percentage of pregnant women who had at least four ANC visits.” A little in excess of one-half (52.7%) of the estimated number of pregnant women in the target counties had one ANC visit while approximately one-fifth (18.0%) had four or more ANC visits during pregnancy. This reduction between one and four ANC visits may be due to a variety of factors, principal among them being cultural and environmental factors that affect access to ANC in Southern Sudan. Traditionally women do not present for their first ANC visit until very late in their pregnancies and as do not have enough time to complete four visits. SHTP II will intensify our community mobilization activities through the SCPs to reduce this gap by promoting earlier access to ANC. Despite the drop off in access to services between the first and fourth ANC visits, there has been a

noticeable increase in the proportion of pregnant women who accessed ANC care during consecutive quarters. The proportion of women who had one ANC visit increased from 6.4% during quarter one to 16.8% during the fourth quarter. For those who had four or more visits the percentage increased from 1.5% in the first quarter to 7.2% during the fourth quarter (see Figure 5 below). SHTP II was attained 81.1% and 90.0% of the respective targets for these indicators. We anticipate that performance will continue to improve in the next fiscal year as our community outreach activities intensify.

The available data in annex V indicate that there are wide variations in the proportion of pregnant women who access ANC across the different counties supported by SHTP II. Our supportive supervision visits to the SCPs and CHDs will focus on those low performing counties to increase utilization of ANC services.

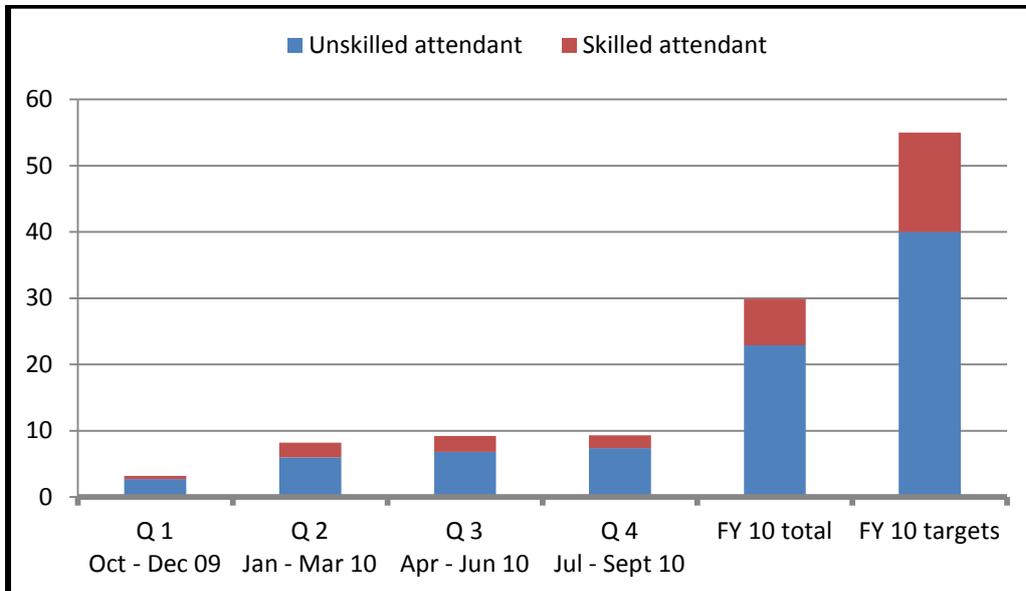
**Figure 4: Quarterly variation in the percentage of pregnant women who had one and four or more ANC visits**



**Assistance at delivery:** our efforts in this area are tracked through two indicators: “the percentage of deliveries that are assisted by a skilled attendant,” and “the percentage of deliveries that are assisted by a trained TBA or Maternal and Child Health worker (MCHW).” The first indicator tracks delivery assistance by skilled attendants (community midwives with at least 18 months training). The second indicator tracks delivery assistance by unskilled attendants as a proportion of the estimated total number of expected deliveries. Only 7% of all deliveries were attended by a skilled birth attendant in the target counties; 22.9% were attended to by an unskilled attendant. The achievement for both of these indicators was approximately one-half of the targets set for SHTP II. These achievements should be interpreted very cautiously however, as they are based only on reports of deliveries that occurred at facilities supported by SHTP II, or were supported by staff attached to these facilities. It is highly likely that many deliveries may have been assisted by a skilled birth attendant but were not reported, e.g., births in hospitals whereas the ANC was provided in the health center. Home deliveries attended by either a skilled attendant, trained TBA, or MCHW who were not attached to one of the SHTP II facilities would not be captured in the data reported. Due to cultural practices in Southern Sudan and the security situation, which causes many of the primary care facilities to be closed after dark, many women will deliver their babies at home. The SCPs have been trained on tracking and registering births that occurred outside of health centers that provided the ANC to try and capture as much

information as possible about the type of birth attendance. As shown in Figure 5, one encouraging sign was the progressive increase in the reported proportion of deliveries that were assisted by either a skilled or unskilled attendant during consecutive quarters. However, the lack of skilled birth attendants in S. Sudan is a severe constraint on improving this indicator.

**Figure 5: proportion of deliveries that were assisted by different categories of attendants**



**E. Hygiene and sanitation:** for this high impact area, SHTP II supports the treatment of water at the point of use through the distribution of water treatment products at outlets, such as retail shops, pharmacies, and drug stores. Through our sub-contract with PSI, distribution of the point-of-use treatment is complemented by an elaborate and proactive social marketing campaign targeting the population. During the period under review, sufficient point-of-use products were distributed to disinfect approximately 190 million liters of water (see annex V) which is approximately 35% higher than the target that was set for this indicator. Based on the internationally recognized norms that each person requires two liters of water daily, this quantity of water was sufficient to meet the needs of about 260,000 persons.

**F. Family planning:** The FP program in Southern Sudan is still in its infancy and there is considerable debate on the best approach for introduction of FP services in the counties. Cultural beliefs lead to low acceptance and utilization rates. During the past fiscal year, there were considerable shortages of FP commodities. The FP efforts of SHTP II are measured by counting the number of counseling visits for FP/RH services. We were only able to achieve about one-quarter of the target for this indicator. This low achievement is mainly due to the absence of a well-developed FP program coupled with a high degree of under reporting. The MOH data collection and reporting tools do not collect data for this indicator. It was only during the latter part of the year that a separate tool was developed by MSH to collect this data. During this FY, SHTP II completed intensive training of MOH, CHD, and SCP staff in FP programming and assisted each county in developing an action plan to improve FP coverage. We anticipate increased achievement of this indicator in the next FY. Supplies of FP commodities remains an issue, since the USAID supply of contraceptives that was distributed has been called back due to poor storage conditions that may have lead to deterioration of the quality of the product. We have activated an MOU with UNFPA to receive additional FP commodities starting in November for distribution. This improved supply of contraceptives will stimulate increased utilization of FP counseling and services.

**G. HIV/AIDS:** less than 10% of the target for this indicator was achieved as the HIV program was not well defined. Under the BCC component of HIV, SCPs did not recruit staff to coordinate community activities in time, there was a delay in training of peer educators by the SCPs, and as a consequence, poor and sporadic outreach activities for HIV/AIDS. In the case of PMTCT, some SHTP II partners (IMC in Tambura, MRDA in Mundri East, and AAH in Mundri West) were implementing PMTCT activities under different funds and as such were reporting to different agencies, UNICEF, WHO, etc. In this FY, SHTP II provided intensive HIV/AIDS training during our FP workshops and stressed community mobilization and outreach in HIV/AIDS preventive messages. In this next FY, SHTP II will provide intensive STTA in HIV/AIDS to the counties through our PHC advisors and implement an intensive BCC strategy developed with the assistance of MSH STTA in 2010. We are working with USAID to identify new PMTCT sites based on the prevalence of HIV, linkage to ART sites, and ANC attendance and will continue coordinating with USAID to secure and distribute HIV test kits.

### **Achievements for ER 3 (increased Southern Sudanese capability to deliver and manage services)**

The interventions under this third ER are aimed toward the **strengthening of the health system** in Southern Sudan and are measured by tracking the training of health care workers and community members, service provision at the health facilities, and submission of HMIS reports by facilities.

#### **H. Health systems strengthening:**

**Training of health personnel:** Training of health personnel is done by both MSH/SHTP II as well as the SCPs. As shown in table one above, a total of 1559 health personnel received in-service training in different program areas during the fiscal year. This achievement represents 92.3% of the target that was established for this indicator for the period under review. Annex I and II provide additional details of the program areas in which the training was provided and counties from which the trainees were drawn.

**Training of community members:** during the current fiscal year a total of 2,286 community members were trained in different program areas with support from SHTP II. This represents 91.4% of the target that was set for this indicator.

**HMIS reporting:** Significant progress was made in obtaining reports from the health facilities. The percentage who submitted their reports within one month of the reporting period increased from a very minimal level in the first quarter, to 70% in the second quarter, to 94% by the end of the reporting period (see annex V). At the beginning of the year, the SHTP II target was to ensure that at least 90% of the health facilities provided their HMIS reports within one month of the end of the reporting period.

**Service provision by facilities:** By the end of the fiscal year approximately three-quarters (77.3%) of the health facilities were providing at least five of the seven high impact services. This is about 20% below the anticipated target. In this next FY, performance will improve as more health facilities receive support from the CHDs and SCPs and the quality of the data reported continues to improve.

### **Lessons Learned**

#### **1. Good coordination between SCPs, SMOH, and CHDs contributes to improved project outcomes**

The SHTP II project is, in reality, a public-private sector partnership. The central MOH establishes policies and guidelines that determine all project activities and services. The SMOH and CHDs represent the more local levels of the MOH and are responsible for service delivery at the facility level and monitoring and oversight at the county and state levels. In this fiscal year, MSH completed sub-contracts with 10 NGOs to help build capacity at the county and facility level to support implementation of the BPHS. However, the SCPs also played a key role in BPHS provision, since the SHTP II provides salary support to 65% of staff within the facilities through employment contracts with the individuals involved. This partnership thrived this year, with multiple joint activities implemented. These include training activities conducted by MSH that involve the SMOH, CHDs, and SCPs, joint supervisory visits, and implementation of improved management systems, such as the monitoring and evaluation system, the FFSDP, and the Leadership Development Program. While these are just beginning to be rolled out in the counties to the facilities, over the course of this next year we will see improved management and technical leadership in implementation of the BPHS.

## **2. Community mobilization and participation is fundamental to the success of BPHS implementation in the SHTP II.**

Formation of VHCs, increased community mobilization, and community participation in implementing project activities and achieving the deliverables has produced significant results already. The International Rescue Committee (IRC) in Aweil south reported that in the course of implementation of the SHTP II program they have shown that empowering the VHCs can make a significant difference in community-based health care service provision and increased utilization of services. Involvement of the VHCs and local leaders (payam chiefs) can be linked to increased demand for and ownership of the services provided. Additionally, TBAs played an active role in increasing the use of institutional deliveries by addressing the concerns of pregnant women with cultural sensitivity and bringing them into facilities for delivery by a skilled birth attendant. Increased emphasis will be placed on community mobilization efforts in this next year due to their overall importance in increasing access to services.

## **3. Joint supervisory visits by USAID, MSH, SCPs, SMOH and CHDs leads to better implementation of the project**

Joint supervisory visits emphasize the public-private partnership that is the foundation of SHTP II and allows all partners to understand progress made and the challenges for implementation. Frequent supervisory visits provide opportunities to mentor staff at the county and facility level, and also to provide feedback to project managers so that program activities can be adjusted to meet the real needs of the MOH.

## **4. Systems Development to support SHTP II/MOH/SCP activities takes time in a post-conflict environment where very few standardized systems exist to support expansion of the BPHS.**

A functional monitoring and evaluation system is essential to all effective PHC programs, but especially important to SHTP, II which relies on PBCs for implementation. At the end of the second year, we have now established an effective project-wide M&E system and trained the counties, SCPs, and facility staff in implementation. It is functioning and provides data that can be used to support decision making, but additional work is required on improving the quality of the data. It will take another year, or longer, to ensure that the quality of the data increases. It took the first year of the SHTP II to establish effective PBCs with the

SCPs to support and provide services at the county and facility levels. The PBCs are now fully functional and our results show significant improvements in services in successive quarters during this past year. We expect that this improved performance will continue into the next fiscal year, especially since performance on a group of key indicators has now been linked to the quarterly payments received by the SCPs. Quality assurance is important in any program of scale up of the BPHS, and it took us a year to adapt the FFSDP to Southern Sudan norms and standards based on MOH policies and guidelines. The FFSDP training has occurred and roll out will continue over this next year. We will be able to demonstrate quality improvements over the course of the next FY. The MSH LDP has now been started; training has started and roll-out to the counties will occur over this next year. Training standardization for all the counties has begun in key areas, but much more time will be needed to ensure this occurs in all seven high impact BPHS areas. Management systems are also needed to support the CHDs and SCPs. By Year 3 of SHTP II, these systems will produce significant improvements to both the quantity and quality of services provided, leading to significant improvements in health status. But, starting these systems from scratch has taken time, and they need time to mature to maximize the impact.

#### **5. SHTP II program activities need to be linked to available resources.**

One of the SHTP II core indicators is the percentage of deliveries attended by a skilled birth attendant, yet precious few community midwives are present in Southern Sudan. Neither SHTP II, nor any other parallel project, has funds to support increasing the supply of midwives trained in an approved 18 month program. The BPHS requires a consistent supply of essential medications to function, and these medications are provided by the MOH. SHTPII and SPS have collaborated this year to improve the pharmaceutical management system. However, stock outs of key medications occur at the facility level, leading to an inability to provide essential medications to clients in need and demoralization of the staff when they cannot meet the BPHS treatment guidelines. This is especially true in family planning, where the SHTP II is underperforming. The lack of contraceptives at the facility level is a major factor quoted by staff as to why they do not effectively promote FP services. If they cannot provide the appropriate FP method to the client, why spend the time in a busy day to counsel them?

#### **6. Lack of experienced human resources in health in the post-conflict environment in Southern Sudan has hindered recruitment of a full SHTP II staff and increased our costs due to the need to supplement with external STTA**

There is a limited pool of experienced public health professionals in Southern Sudan. We advertised for three months for PHC advisors and only received two applicants, whose skills were not up to standards for the position. Lengthy delays in USAID approval of staff salaries and low salaries eventually approved have contributed to a high turnover rate of key personnel within SHTP II, compounding the recruitment problem. As a result, in order to accelerate progress in program implementation, we have relied on STTA by experienced MSH personnel. This STTA has produced a surge in program activities, but has significantly increased our personnel expenses.

#### **7. Procurement of essential equipment for the BPHS is important for successful delivery of the BPHS, yet delays in approvals have significantly delayed purchase and delivery of important equipment.**

Our equipment purchase orders are still pending USAID approval.

## **V. MONITORING**

For FY 2010, the M&E Unit made significant progress toward the collection and reporting of high quality data for tracking overall project achievements, monitoring the performance of the

sub-contracting partners, and reporting to USAID, the Ministry of Health and other stakeholders. In doing so, SHTP II continued to support the principle of building one M&E system for Southern Sudan. Key achievements of the M&E Unit included:

**Finalization of the reporting requirements of the project:** Project staff worked closely with USAID mission staff to complete the performance management plan (PMP) for SHTP II. During this process, a core group of indicators that adequately reflects the activities of the SHTP II were selected as the basis for monitoring project performance. All but one of these indicators were consistent with those that are being tracked by the MOH of GOSS.

**Harmonization of data collection tools:** Building on the findings of the mini-assessment of the M&E system conducted during the first year of the project, the M&E Unit worked with staff of the MOH, the CHD, and the SCPs to ensure the frontline data collection tools, which record patient level data, capture sufficient information to meet the reporting needs of the MOH. An initial analysis was conducted at a workshop held in the first quarter of the fiscal year to assess gaps in the existing tools. The findings were sent to the MOH and other stakeholders providing support to the MOH in this area, and all of the frontline tools were subsequently revised to ensure that all required data are collected. The revised tools were pretested with the support of SHTP II staff. This process has led to the development of standardized frontline tools such as registers and tally sheets for recording patient data and submission of monthly reports. SHTP II supported the printing and dissemination of these tools to facilities in those counties that are supported by SHTP II, incurring significant additional expense in this process.

**Capacity building in monitoring and evaluation:** During the fiscal year, SHTP II conducted two workshops for the training of staff from the SCPs, the CHDs, and the MOH on issues related to M&E. Some of the broad topics that were covered in the training included basic issues in M&E, data quality assurance, reporting requirements of the project, indicator definition and measurements, use of the frontline tools and data analysis and reporting. This classroom type training was complemented by one-on-one mentoring visits for M&E staff at the SCPs and service staff who work at the health facilities (PHCCs and PHCUs).

**M&E Guidelines:** SHTP II developed and distributed standard operational guidelines for M&E for the sixteen core indicators of the project to the SCPs. These guidelines provided clear details on the definition and meaning of the indicators, methodology for data collection and reporting, and clarified key concepts and definitions related to the indicators. Prior to widespread dissemination, the first draft of the guidelines was tested at the second M&E workshop and then revised. We are working with the M&E Unit at the MOH to expand these guidelines to include all of the national level indicators.

**Data quality assurance system:** The project developed a protocol and guidelines for data quality assurance in Southern Sudan. The first draft was pretested in a small number of facilities before it was finalized. Following the finalization of this protocol, a sample of facilities was visited by teams comprised of representatives of the MOH, the SCPs, the CHDs, and USAID. The tool was used to assess M&E practices, and the quality of data that are reported. The findings were shared with staff at each facility, and quality improvement plans were developed for each facility. The data are currently being entered into a database, after which they will be analyzed and the findings will be shared with the MOH, the SCPs, the CHDs and other stakeholders during the second quarter of FY 11. Discussions are currently being held with the MOH to expand the range of this protocol to include other indicators of interest to them and GOSS. SHTP II will subsequently adapt the protocol as the national DQA protocol.

**Data management:** SHTP II worked with the MOH to standardize the different monthly reporting tools, and these were printed and disseminated to all facilities supported by the project. SCPs provide service delivery reports for each facility on a monthly basis. They are reviewed by M&E Unit staff and feedback is provided. To facilitate internal data management, SHTP II developed an access-based database into which all data are stored and analyzed.

## V. NEXT QUARTER'S WORK PLAN

Annex IV contains the detailed workplan for the next quarter. A revised work plan for FY '11 was submitted to USAID on October 20 for review and comment. Key features of both plans are summarized below:

- Continue to manage the subcontracts
- Assess utilization and need for M&E tools and distribute to health facilities in need
- Continue joint supervisory visits to counties and develop a schedule for another round of supervisory visits for the next quarter, targeting low performing counties as identified in the Annex,
- Continue with DQA visits to areas where reviews have not been held recently
- Conduct back to back FP, ToT, and services providers training for 45 people selected from subcontracting partners, CHD, and facility staff
- Conduct micro-grants workshops in the remaining counties and award micro-grants to the identified CSOs pending approval of the micro-grant manual from USAID
- Review the micro-grant manual, develop a robust community mobilization strategy, and award micro-grants to selected CSOs
- Carry out the capacity-building training and activities for CHDs/SCPs. An experienced MSH LDP facilitator will conduct leadership development program (LDP) training for CHD and SCP teams in October, 2010 at the central level, and in November, 2010 at the state/regional levels.
- Develop a standardized training approach for different technical areas to build the capacity of the subcontracting partners, CHDs, and service providers in the 14 counties to implement the high-impact interventions on a county-by-county basis
- Roll out the FFSDP tool at the country and facility level as the SHTP II standards-based quality improvement technical approach
- Review, negotiate, and sign sub-contracts with all current SCPs for the next year
- Develop and train CHDs and SCPS in a standardized approach for community mobilization and participation in the BPHS and SHTP II activities
- Implement WASH activities in selected counties that were delayed during the FY 10 work plan

## VI. FINANCIAL INFORMATION

At the end of the FY 10 work plan, the MSH pipeline analysis indicated a \$2,600,000 deficit. A detailed budget analysis has been provided to USAID with our FY 11 work plan and a costed activity budget will be provided with this annual report as required by USAID. The \$2.6M deficit is found in the following line items:

1. Salaries: \$745,696—this is due to the need to use external staff to fill in for unfilled local hire positions
2. Overhead: \$461,873—this is a direct percentage of salary costs
3. Training: \$723,678—the increased need for training of all staff on the BPHS and management systems using an SHTP II standardized approach has increased costs
4. Equipment: \$1,893,811—the number of health facilities covered has increased and the overall equipment needs are greater than expected
5. Other Direct Costs: \$701,748—these costs reflect the higher cost of doing business in Southern Sudan, and include costs for vehicle maintenance and transportation, shipping of commodities, printing, and rent.

MSH has submitted a pipeline and budget for the rest of the project to USAID that keeps all costs within the original ceiling. To do this, we have proposed cuts of \$3,597,048 to sub-contracts and \$825,000 to the micro-grants. At the beginning of the project, MSH was asked

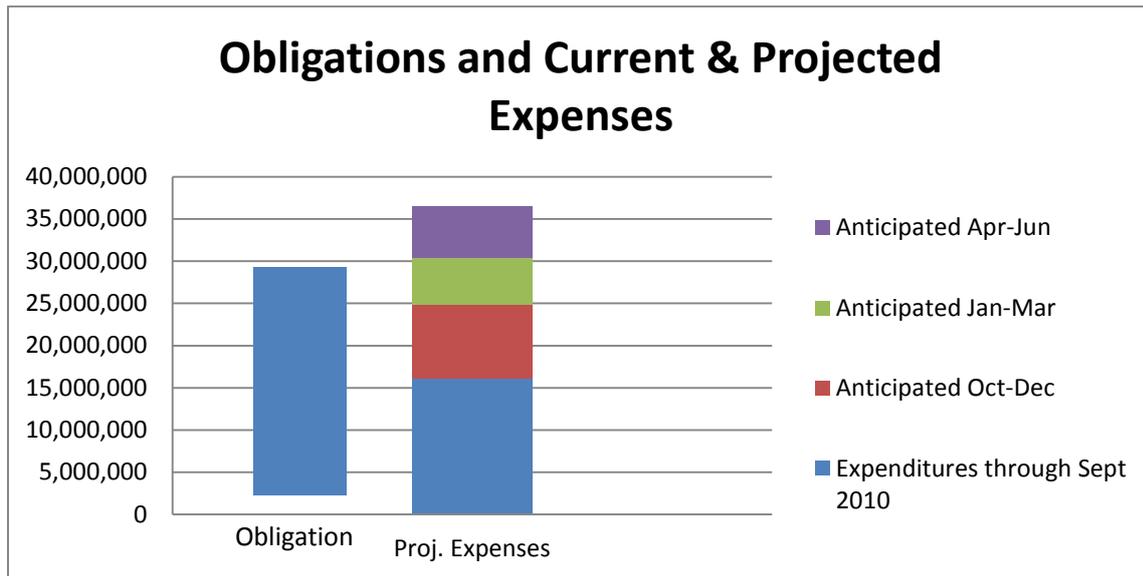
to absorb additional costs that were not anticipated in our original budget and have never been addressed. These include \$2,700,000 in MOH salary support for service providers through the SCPs and \$3,000,000 for the PSI sub-contract.

Constraints placed upon the project during the design and funding phases are the largest challenges that we are facing. Specifically, the funds earmarked for Water, Sanitation, and Hygiene that have been used to fund this program are significantly greater than those envisioned during the RFTOP / proposal phase. This funding allocation has forced the project to dramatically decrease the funds going to provide Primary Health Care in the 14 counties, even as we have been asked to 1) expand the number of counties; 2) set aside significant funds for needed equipment and supplies for the PHCCs and PHCUs, as well as for the SCPs' management costs; 3) continue to provide salary support to PHCC / PHCU staff; and 4) scale up and standardize training across the partners to help move S Sudan along the trajectory from relief to development. MSH underestimated some of the costs of doing business in Southern Sudan during the proposal, but also has been asked to take on substantial costs that were originally to be borne by the GOSS, such as logistics costs for LLITNs and pharmaceuticals. The final area that has been a major challenge financially is related to the difficulties faced in recruiting appropriate staff from Southern Sudan, due to a dearth of qualified technical staff and significant delays in salary approvals, due to contractual limitations, challenges in garnering appropriate paperwork from candidates, and some early salary decisions that have skewed the scale.

Discussions are ongoing with USAID to mitigate the impact of the issues above. Two areas have been flagged for potential cuts or shifts in the remaining months: Equipment for the SCPs is being procured by MSH, rather than directly by the SCPs to ensure that all of USAID's equipment is appropriately inventoried and approved prior to purchase, which shifts significant funds from the "Subcontracts" line to the "Equipment" line in MSH's books. With the delays in grant startup and limited absorptive capacity of the CSOs in Southern Sudan, MSH has recommended a decrease in the funds available for microgrants – fewer, smaller, but targeted grants are more likely to provide the desired health impact than larger grants in less-vital areas.

### **Cash Flow Report and Financial Projections (Pipeline Burn-Rate)**

6. Chart 1: Obligations & Current and Projected Expenditures



	Obligation	Actual Expenditures prior to July 2010	July-Sept 2010 Actual Expenditures	2nd Quarter Projected Expenditures	3rd Quarter Projected Expenditures	4th Quarter Projected Expenditures
	24,535,000	14,214,849	1,875,014	8,825,220	5,513,350	6,055,810
<b>01. Salaries and Wages</b>		1,287,195	367,866	318,025	289,114	346,936
<b>02. Consultants</b>		71,756	15,049	35,000	7,394	14,788
<b>03. Overhead</b>		854,270	205,884	190,646	173,314	207,977
<b>04. Travel and Transportation</b>		325,051	75,575	102,641	62,258	74,709
<b>05. Allowances</b>		300,257	44,815	54,252	49,320	59,184
<b>06. Subcontracts</b>		9,196,718	809,304	7,100,465	4,129,102	4,542,012
<b>07. Training</b>		66,671	89,945	134,917	202,376	303,564
<b>08. Equipment</b>		1,030,971	10,186	496,989	247,877	0
<b>09. Grants</b>		0	0	0	50,000	150,000
<b>10. Other Direct Costs</b>		666,315	186,290	173,213	157,467	188,960
<b>Subtotal Expenses</b>		13,799,203	1,804,913	8,606,150	5,368,221	5,888,131
<b>10. Fee Income</b>		415,645	70,101	219,071	145,128	167,679
<b>TOTAL EXPENSES</b>		14,214,849	1,875,014	8,825,220	5,513,350	6,055,810

Budget Notes (Listed below are assumptions, major changes, estimations, or issues intended to provide a better understanding of the numbers)

01. Salaries and Wages	Salaries in the October – December quarter will be slightly below July – September due to departure of a few staff and lower salary of replacement staff.
02. Consultants	Consultants are high in the second quarter as we wrap up the Family Planning TOT
03. Overhead	This fluctuates as a direct percentage of the salaries.
04. Travel and Transportation	Travel and transportation is expected to be high through the end of December with the significant STTA and arrival of new international staff, curtailed through the referendum and thereafter, and will then pick back up in February / March.
05. Allowances	Tied to international staff and STTA.
06. Subcontracts	Best estimate for when invoices will be received and processed. Several long-outstanding invoices will clear in October / November.
07. Training	SHTP II's heaviest period of training is the coming year, with significant increases anticipated each quarter. There will be a period from mid-December through mid- or late January when training will be curtailed for security reasons.
08. Equipment	SHTP II eagerly awaits permission to procure equipment for the SCPs. Costs have been split across quarters 2 and 3 based on best estimate of how much will be delivered in each period, assuming approval.
09. Grants	The microgrants program should get under way in the October – December quarter, but we expect to process the first payments following the referendum.
10. Other Direct Costs	Other Direct Costs are expected to fluctuate based on the level of activity, with occasional bumps due to shipping costs for program materials, printing costs, etc.
10. Fee Income	Fee varies as a percent of applicable costs incurred.

## VII. PROJECT ADMINISTRATION

### Constraints and Critical Issues

The project operations have been influenced by many factors including issues related to contract design, weather, social, political (presidential and parliamentary elections), USAID approval processes, and other events.

### **SHTP II design issues affecting project implementation**

**Assumptions pertaining to commodities:** SHTP II depends on the national procurement system and other donor sources for drug supplies, FP and reproductive health commodities (contraceptives, delivery kits, etc.) and LLITNs. Lack of such commodities and supplies hampers delivery of services.

**Infrastructure:** As SHTP II builds on SHTP I, a major assumption was that SHTP I had resolved most of the infrastructure issues. Hence, the project only planned to perform minor refurbishments instead of undertaking major infrastructural activities to accommodate all BPHA services, but especially institutional deliveries. However, major structural challenges remain at health facilities in every county, and some are barely functional due to the lack of an adequate structure in which to provide services.

**Staff salaries/availability:** Health facility staff (not SCP employees) in Terekeka went on strike due to salary delays, which led to interrupted service delivery in health facilities. Deliveries with skilled birth attendants is a core deliverable in SHTP II project, but there is general lack of skilled birth attendants in southern Sudan. This affected achievement of this indicator.

**Payment of MOH salaries at county and facility level:** The SHTP II pays 65% of the MOH staff salaries in the focus counties. This was an unanticipated expense at the start of the project and is contrary to the official MOH policy. However, discussions with USAID indicate that the amount of payments involved, which totals \$2.7M according to a USAID report completed in August, 2010, would cause a major shock and possible collapse of the PHC system if discontinued. For now, we have agreed to continue these payments while supporting ongoing discussions with the MOH to assume an increasing role in paying their own staff salaries.

**“75% Rule”:** Both in the RFP, and in the contract, MSH is required to utilize 75% of the funds available for services through NGOs and CSOs. This meant that only 25% of the funds were available for project management. As the financial analysis indicates, experience has shown this is not enough money to manage the SHTP II effectively, nor is it enough to address the high cost of doing business in Southern Sudan. MSH is now experiencing a significant deficit that must be made up somehow if no additional funds are made available.

**Assumptions regarding availability of local hires and experienced staff were incorrect:** To balance the budget with the remaining 25% of the funds, it was originally planned that much of our staff would be Sudanese. However, experience has shown that both technical and administrative staff with sufficient experience to function in a complex project are hard to recruit. We advertised for a PHC advisor for three months and only received two applicants, and neither is satisfactory for the position. This has led to two problems for our staffing: 1) we have had to import expatriate staff to fill in the gaps for the short term, and 2) we have experienced a high turnover of staff due to a high number of jobs available in Southern Sudan and staff leaving for higher paying positions.

## **Environmental, social and political factors**

**Insecurity:** Lords Resistance Army attacks in May and June led to closure of several health facilities and burning of one of the PHCUs in Tambura County. Other incidents of insecurity due to tribal and inter-clan fights were reported in other counties.

**Elections:** During the quarter in which elections were held, we show a decrease in service utilization, perhaps related to an unwillingness to travel to access health services. During the post-election period, some areas experienced insurgency, but SHTP II project areas were not affected much. The much-anticipated forthcoming referendum will undoubtedly introduce an element of uncertainty that will affect SHTP II overall performance. The potential for violence is present around the time of the referendum.

**Weather situation:** During periods of heavy rain, many roads are flooded and access to health facilities is limited, inhibiting delivery of commodities and medications, supervisory visits, and technical assistance to facilities.

**Significant delays in USAID approvals:** The MSH contract requires approvals from the USAID contracts officer in key activities. Significant delays have occurred in the following areas:

- **Personnel approval:** Some staff have been waiting up to six months for salary approvals and when the salaries are approved, they are often approved at a level that is not acceptable to the candidates involved. This has contributed to a high rate of

personnel turnover. Staff not approved for long periods of time leave for more secure positions, and staff approved at a salary level lower than the market rates leave as soon as they find another position.

- **Procurement:** Request for approvals of our equipment purchases has now been pending for almost three months. This has caused delays in purchasing and delivering essential equipment to the health facilities, and raised the overall costs. Vendors will not hold their quoted prices over 90 days.
- **Micro grants manual:** The SHTP II micro-grants manual was submitted for approval in April. In early October, we received comments after a USAID review from the contracts office. We are now in the process of responding to those comments and will soon resubmit the manual for approval. However, the whole micro-grants process has been delayed more than six months due to this protracted approval process.

## **Personnel**

Despite significant challenges in recruitment, momentous progress was made on the Human Resource front. The recruitment and hiring process for PHC Advisors, M&E Officers, and other programs and operations staff resulted in a total staffing level of 20 by the fourth quarter, including two M&E Officers and a Logistics Coordinator who were awaiting approval for employment. From October 2009 to September 2010, 18 STTA visits from MSH Headquarters and regional consultants provided support to SHTP II in programmatic areas including support to M&E, FP, HIV/AIDS, LDP, FFSDP, malaria, and mentoring of senior staff in technical and management areas. Nevertheless out of the 20 staff hired, 8 left the project for other jobs. The last to leave is the COP, who resigned on October 14.

High personnel turnover has been a consistent problem for SHTP II this year. We have implemented several interventions as a result. First, every departing staff member is interviewed by an MSH regional HR representative based out of our Nairobi office. The most consistent reason for leaving is for another, higher paying position. Two have left for personal reasons unrelated to the job. The MSH Regional HR Partner, Helen O'kongo, traveled to Juba in September and spent a week talking with individuals privately to identify key issues that we need to address to improve the work climate. Second, we have used an LDP technical approach called the Work Climate Assessment (WCA) with the staff. This is an anonymous score sheet that ranks multiple parameters required for an effective work climate on a scale of 0 (nothing exists) to 5 (the best there is). We expected to score poorly, but, in fact, our average score was 3.5. Deficiencies were noted in some leadership, decision making and team building areas, which we are working on. We also started implementing the Leadership Development Program within the SHTP II team, prior to rolling it out to the CHDs. Following right on the heels of the WCA, the LDP afforded a good opportunity to work on the weaknesses identified in the WCA. All staff report that the WCA and the LDP were highly productive and effective in improving our MSH/SHTP II team dynamics. However, one important staff person resigned several weeks after implementing all these interventions, stating that waiting six months for USAID approval was too insecure for her and she accepted another position in another donor funded project.

## **Changes in the Project**

The main issue affecting SHTP II implementation is the \$2.6M deficit that we are facing this year. We are addressing this issue with USAID and have been instructed to develop a budget within the current ceiling. This means that we need to cut this amount out of our budget. We have proposed cuts in the SCP budgets and micro-grants. While cutting the micro-grants will have negligible effect on the project, since it is too late in the project to implement the full amount budgeted for that line item, cuts in the SCP budgets will effect

implementation, especially since the SHTP II pays 65% of MOH salaries in the focus counties. Significant cuts in other line items will be equally painful, since we will have to choose between staff, training, and equipment purchases. If no additional funds are forthcoming from USAID, the next year will see significant cutbacks in services provided.

### **Contract Modifications and Amendments**

Contract modifications and amendments are to be noted in this section, if any took place.

Three contract modifications were received during this year:

- Modification Two, which formalized that host government staff could not be paid by the project.
- Modification Three, which provided incremental funding of \$14,235,000.
- Modification Four, which amended and approved the SHTP II PMP.

## **VIII. INFORMATION FOR ANNUAL REPORTS**

### **A. Estimated Budget Disaggregated by State**

Sum of Amount	Expenditures by State through Sept 2010
<b>STATES</b>	<b>Total</b>
Central Equatoria State	6,717,826.19
US	731,065.09
Tonj South	469,114.12
Northern Bahr el Ghazal	331,502.06
Western Equatoria State	2,722,069.14
Aweil South	107,985.62
Unity	910,021.53
Eastern Equatoria State	668,536.39
Jonglei	825,812.56
Lakes (Mvolo/Wulu)	622,412.57
Panyijar	1,497,771.56
<b>Grand Total</b>	<b>15,604,116.83</b>

### **B. Earmark Expenditure Narrative**

Sum of Amount	Expenditures by Earmark through Sept 2010
<b>Funding Area</b>	<b>Total</b>
AIDS	1,031,280.27
Child	2,392,110.97
H2O	1,293,832.15
MCH	2,434,475.45
Other	5,505,431.58
POP	1,297,950.36
WASH	1,649,036.05
<b>Grand Total</b>	<b>15,604,116.83</b>

### **C. GPS Information**

GPS information has not been obtained from clinics. This will be obtained from OCHA since they have health facility map.

#### **D. List of Deliverables**

Quarterly and Annual Reports

STTA Trip Reports

Joint supervisory trip reports to counties

Training curricula, manuals, IEC materials and job aids for M&E, FP, Malaria, HIV/AIDS, FFSDP and LDP trainings.

#### **E. Summary of non-USG Funding**

This project does not have non-USG funding.

#### **Annexes & Attachments**

## Annex I: Schedule of Future Events

Date	Location	Activity
Nov.1-30	Juba	Reviewing, revising, and negotiating budgets and work plans with SCPs
Nov. 17-19	Juba	SMOH/CHD/SCP meeting
Oct./Nov/Dec	Various Counties	Joint Supervisory Visits
Nov. 29-Dec.12	2 States	Regional LDP training for counties

STTA Information:

Monitoring and Evaluation: Kip Eckroad, Oct. 1-Dec. 31, 2010

Sr. MSH Management Visit: Dr. Jonathan Quick, CEO/Pres. MSH, Nov.29-Dec. 4 (not funded by SHTP II)

Support to the Acting COP: Bud Crandall, COP, Ethiopia HCSP

Leadership Development Program training: Dr. Morsey Mansour, Nov. 26-Dec.12

Community Mobilization: Melissa Brill, Oct. 10-Dec. 15

WASH: Samuel Gonzaga, Oct. 1-Dec.15

Training Plan and Standardization: Dan Nelson, Oct. 6-Nov. 6

Monitoring and Evaluation: Oct. 15-Oct. 30

Finance and Grants: Matt Iwanowicz, Oct. 5-Nov. 5

Finance and Grants: Gerhard Combrink, Nov. 3-24

Acting COP: Fred Hartman, Oct. 17-Nov. 20

## Annex II: Success Stories



**USAID | SUDAN**  
FROM THE AMERICAN PEOPLE

### 1. Point of Use Outreach in Wau

Eliveria Isaac is a 41 year-old mother of three and an active member of the Seventh Day Adventist Church in Wau Town. During a support visit by MSH to Wau, MSH visited Eliveria's home to discuss her thoughts on the safe water and hygiene promotion program being implemented by PSI Sudan. In her own words, Eliveria explained the impact that point of use (PoU) water treatment has had on her life.



*Eliveria Isaac – PoU Outreach Success Story*

"It is my first time to attend a session on PoU conducted by PSI staff in the church where I pray, the result of the PUR demonstration was a great attitudinal change to me and the community. I came to believe that the water we are drinking is contaminated from the source. I was impressed and bought the product from a shop in the town. I took the initiative of demonstrating it to my people in Ngongba village. My fellow community members were also impressed and convinced to treat their water before drinking to reduce the incidences of water borne diseases. They asked me where the product can be found; then I told them in the shops and pharmacies in the town.

The church loves all people and respects their cultures without any discrimination of color and race. We are willing to conduct community education on PoU, hygiene, and sanitation in the communities as volunteers so that mothers know how to protect themselves and their children from diarrhea and cholera.

Good health brings development. People are living without knowledge on health education and it is the biggest gap in life. Therefore, this work of PSI should not stop."

### Success Story 2: *Bring Immunization services closer to the Pager community*

Pager PHCU is in Lobonok Payam, one of the 16 payams of Juba County. In Lobonok Payam, Lobonok PHCC and Pager PHCU are the only health facilities supported by the SHTP II project. Routine immunization activities other than national immunization days for polio or accelerated immunization campaigns have not occurred. Through the SHTP II project, ADRA supported the two health facilities in this area. ADRA worked with the EPI/SMOH to install EPI cold chain equipment in Lobonok PHCC and ensure the supply of vaccines every month. This enabled the Pager health workers to collect vaccines from Lobonok PHCC and give routine immunizations. Mothers are eagerly waiting for their children to be immunized.



*Mothers and their babies wait for vaccination in Pager*

## **Annex III: List of Deliverable Products**

- Data quality assurance protocol
- Database for managing project data
- FFSDP standards and guidelines for implementation
- Family Planning training curriculum, TOT manual, IEC materials and job aids
- HIV/AIDS, malaria, and WASH IEC materials
- HIV/AIDS BCC plan
- Leadership Development Program materials, “Managers Who Lead” manual
- Trip Reports for all STTA
- Quarterly and Annual Reports
-

## Annex IV: Quarter 1 Work Plan

	Activity	Responsible person	Oct	Nov	Dec
<b>Result #1: Expanded access/availability of high impact services and practices</b>					
<b>1.1 Support implementation of Fully Functional Service Delivery Point (FFSDP)</b>					
1.1.1	Refine FFSDP Assessment Tool based on Workshop with SCPs end of September and circulate	TD	X		
1.1.2	Consolidate SCPs rollout plan for FFSDP across all facilities	TD & Tech Team	X	X	
1.1.3	Roll out training in FFSDP to SCPs, CHDs, SMOH	TD & Tech Team		X	X
<b>1.2 Award &amp; implement performance based primary health care subcontracts</b>					
1.2.1	Review FY 11 workplans, M&E plans, and budgets from SCPs	Tech Team, M&E Team, and Finance Team		X	
1.2.2	Negotiate with SCPs on budget and work plans	COP, TD, and DFG		X	
1.2.3	Modify all subcontracts to reflect enhanced emphasis on performance	Contract Officer		X	
1.2.4	Sign all modifications	Contract Officer		X	X
1.2.5	Monitor subcontract performance against performance indicator targets defined in subcontract.	M&E team & Tech Team	X	X	X
1.2.6	Improve provider capacity through joint supportive supervision using an approved supervisory check list	Joint supervisory team (MSH, MOH, USAID)	X	X	X
1.2.7	Collect/Receive subcontractor performance reports (service data and progress on defined indicator targets)	M&E Team	X	X	X
1.2.8	Conduct technical assistance to low performing counties on specific needs identified through performance assessment	Tech Team, M&E	X	X	X
1.2.9	Verify quarterly achievements against performance-based financing indicators	Tech & M&E Teams			X
<b>1.3 Manage Point of Use Water, Sanitation &amp; Hygiene subcontract to PSI</b>					
1.3.1	Monitor PoU water, sanitation and hygiene activities against targets defined in subcontract.	WA, M&E	X	X	X
1.3.2	Adapt existing IEC materials to SHTP II needs	WA		X	
1.3.3	Support approval of the IEC materials by MOH-GOSS and disseminate to SCPs/CHDs	WA		X	X
1.3.4	Ensure implementation of the "Impact of Water Treatment, Hygiene and Sanitation Promotion Programs" Survey by PSI	WA	X	X	
1.3.5	Share approved IEC materials, survey results, and lessons learned with SCPs	WA			X
1.3.6	Monitor progress on sanitation demand creation activities and increase utilization of WASH services	WA	X	X	X
<b>1.4 Develop technical guidelines for setting-up basic WASH services in health facilities</b>					
1.4.1	Finalize result of assessment on status and availability of WASH services in Health Facilities and communities in SHTP-II Counties and SCPs	WA	X	X	

	Activity	Responsible person	Oct	Nov	Dec
	capacity in area of implementation				
1.4.2	Develop & share technical guidelines towards set-up/improvement of WASH practices in health facilities and communities	WA		X	X
<b>1.5 Pilot WASH approaches through Micro Grantees to develop recommendations for scale up</b>					
1.5.1	Test/pilot approach for demand creation for sanitation with micro grants with experience and capacity for implementation	WA			
<b>1.6 Disburse Micro-grants to CSOs</b>					
1.6.1	Solicit applications for micro-grants (\$5,000-\$10,000) from community-based organizations on a county-by-county basis	DFG, CMA		X	X
1.6.2	Establish county panel for subgrantee selection	COP, DFG, CMA	X	X	X
1.6.3	Make selection of grantees among applicants	TD with County Panel	X	X	X
1.6.4	Do pre-award survey on selected grantees	Finance Team		X	X
1.6.5	Request and receive USAID approval of grants (in batches)	DFG		X	X
1.6.6	Determine appropriate mechanisms to transfer funds to grantees	DFG, COP, TD		X	X
<b>1.7 Provide logistical and technical support to National Immunization Weeks (As scheduled)</b>					
1.7.1	Assistance to be provided as activities are scheduled	PHC Advisors, SCPs	X	X	X
<b>1.8 Expand Family Planning/Child Spacing Services</b>					
1.8.1	Conduct three regional workshops for Community and Religious Leaders and VHCs on the benefits of child spacing	PHC, CA		X	X
1.8.2	Train CHD, PHCC, Nurses, Clinical Officers and doctors in selected family planning methods	STTA, CA	X	X	
1.8.3	Assess training methodology to inform strategies for future trainings	STTA & TD		X	
1.8.4	Train CHWs, MCHWs, and HHPs on methods of Family Planning and counseling in 14 counties	SCPs			X
1.8.7	Support provision of FP supplies to service delivery points (CHDs, PHCCs, PHCUs)	PHC, SCPs	X		
1.8.8	Ensure FP services at service delivery points	PHC, SCPs	X	X	X
<b>1.9 Expand HIV/AIDS services</b>					
1.9.1	Submit to USAID performance reports that reflect the NGI	PHC Advisor, TD	X		
1.9.4	Coordinate PMTCT training by MOH and UNICEF for health facility staff in remaining SHTP II focus counties	PHC, SCPs, MOH, UNICEF	X	X	X
1.9.7	Provide guideline to SCPs for systematic HIV reporting	PHC Advisor, M&E Tech Advisor		X	
1.9.8	Monitor HIV/AIDS services by all SCPs	Tech and M&E Team	X	X	X
<b>1.10 Expand and improve the quality of high priority technical programs</b>					

	Activity	Responsible person	Oct	Nov	Dec
1.10.1	Adapt and or develop standardized training program and identify priority maternal and child health services and malaria prevention and treatment programs	Tech Team, STTA		X	X
<b>1.11 Improve rational distribution of pharmaceuticals to the county level</b>					
1.11.1	Participate in fora related to pharmaceutical and vaccine management	Tech Team	X	X	X
1.11.2	Training of SCPs, CHDs, and Health Facility staff on rational Drug Supply Management in collaboration with SPS	TD, SPS			X
1.11.3	Advocate for effective pharmaceutical supply system at central and state level	TD, SCPs	X	X	X
<b>Result #2: Increased Southern Sudanese capability to deliver and manage services</b>					
<b>2.1 Provide capacity building for Community Based Organizations</b>					
2.1.1	Collate information, methodologies, program and training materials from agencies working with civil society in Southern Sudan	CMA, Tech team, DFG	X		
2.1.2	Revise CSO capacity assessment tools incorporating feedback and lessons learnt from field testing	CMA, Tech team, DFG	X		
2.1.3	Conduct preaward CSO capacity assessment for microgrants	CMA, Tech team, DFG		X	X
2.1.5	Adapt organisational / institutional strengthening materials for CSOs	CMA, Tech team, DFG	X	X	X
<b>2.2 Provide Capacity Building for Village Health Committees</b>					
2.2.1	Complete field assessment in counties of implementation to verify level, issues and concerns with current VHC structure and approach seeking input from Subcontracting Partners, CHD and communities	CMA, Tech team	X		
2.2.2	Adapt existing materials in use by Subcontracting Partners related to working with VHCs	CMA, Tech team	X	X	
2.2.3	Standardize guidelines for training of VHCs	CMA, Tech team		X	X
2.2.4	Conduct a meeting with MOH and Subcontracting Partners to discuss and approve the guidelines	CMA, Tech team			X
<b>2.3 Provide capacity building for County Health Department staff and specified partners</b>					
2.3.1	Complete assessment of CHD capacity	TD, PHC Advisor	X		
2.3.2	Use leadership development program to improve capacity of CHD to function better as managers who lead	TD, STTA	X	X	X
<b>2.4 Conduct leadership and management training for CHDs and specified partners</b>					
2.3.1	Organize Leadership Development Program for CHD and SCP Teams	COP, STTA	X		
2.3.2	Adapt MSH's training modules to Sudanese context	STTA	X		
2.3.3	Support CHD team to roll out LDP	TD & Tech Team		X	X
2.3.4	Conduct a focused LDP training in a selected State(s)	Tech Team, STTA		X	X
<b>2.5 Improve supportive supervision systems and capacity</b>					
2.5.1	Finalize supportive supervision check list	TD, Tech team	X		
2.5.2	Develop quarterly joint supportive supervisory visit schedule with the counties	TD, Tech team	X		

	Activity	Responsible person	Oct	Nov	Dec
2.5.3	Conduct supportive supervisory visits with SCPs, MOH, and USAID	TD, PHC, USAID, SCPs	X	X	X
2.5.4	Review progress of joint supervisory visits and adjust materials as needed	TD, PHC, M&E			X
<b>2.6 Ensure availability and use of essential MOH policies and protocols at appropriate levels</b>					
2.6.1	Confirm availability during supervisory visits	Tech Team, M&E	X	X	X
2.6.2	Review essential policies implementation and adjust as needed in technical meetings with central MOH	Tech Team, M&E	X	X	X
2.6.3	Conduct review sessions of policy implementation with CHDs and SCP at partners meetings	Tech Team, M&E			X
<b>2.7 Ensure integration of GBV strategy into county health plans</b>					
2.7.1	Work with GoSS ministries of Health and Gender on finalization of GBV policy	TD, STTA	X	X	X
<b>Result #3: Increased knowledge of and demand for services and healthy practices</b>					
<b>3.1 Ensure implementation of project strategy for community based interventions</b>					
3.1.1	Secure USAID's approval of microgrant's manual and community based interventions strategy	COP		X	
3.1.2	Coordinate with MOH on key health messages and reproduce and distribute BCC materials	CMA & Tech Team	X	X	X
3.1.3	Develop standardized approach for support and training of VHCs and CSOs	CMA & Tech Team		X	X
3.1.4	Train SCPs/ CHDs to provide support to VHCs and CSOs to deliver key health messages	CMA & Tech Team			X
3.1.5	Provide supportive supervisory visits to SCPs/CHDs to monitor progress of support to VHCs and CSOs to delivery key messages	CMA, Tech & M&E teams			X
<b>3.2 Adapt HIP's WASH Improvement Training Package for the Prevention of Diarrheal Disease for Southern Sudan context</b>					
3.2.1	Duplicate and distribute WASH IEC materials for SCPs or Micro Grantees for use by outreach workers	WA	X	X	
3.2.2	Pilot HIP's WASH Improvement Package for the Prevention of Diarrheal Disease	WA, SCPs		X	X
3.2.3	Conduct sporadic validation visits by Joint Assessment Team	WA, M&E, Joint Team		X	X
3.2.4	Evaluate performance against Monitoring and Evaluation indicators	TD, WA			X
<b>3.3 Develop job aids on the seven high impact priority interventions</b>					
3.3.1	Finalize and reproduce job aids in collaboration with MOH	TD & TEAM, TWG		X	X
<b>3.4 Develop training modules for SCPs/CHDs to train HHPs and CBDs</b>					
3.4.1	Collate training curricula and guides used by SCPs and other partners (e.g. GF ATM Rd 7)	CMA & Tech Team	X	X	
3.4.2	Develop draft training modules for high impact interventions for HHPs	CMA & Tech Team		X	X
3.4.4	Review and finalize training modules with MOH and SCPs	Tech Team & STTA			X
<b>SHTP II Management and Quality Assurance</b>					
<b>Area 4: Project Administration/Quality Assurance</b>					
<b>4.1 Human Resources</b>					
4.1.1	Finalize hiring of personnel including Chief of	HR, Acting	X	X	X

	Activity	Responsible person	Oct	Nov	Dec
	Party	COP			
<b>4.2 Complete development of essential project documents and submit to USAID and MOH</b>					
4.2.1	Complete development of and submit Quarterly Report	TD, COP	X		
4.2.2	Complete development of and submit Annual Report	TD, COP	X		
4.2.3	Complete development of and submit STTA Plan	COP	X		
4.2.5	Complete development of and submit Training Plan	COP		X	
4.2.6	Complete development of and submit Annual Workplan & Budget	COP	X		
<b>4.3 Conduct, coordinate and participate in meetings</b>					
4.3.1	Conduct quarterly core team meetings	F&G, TD, COP		X	
4.3.2	Conduct quarterly sub-contracting partners meeting	F&G, TD, COP		X	
4.3.3	Participate in relevant technical working groups, task forces, and health fora	COP, Tech and M&E Team	X	X	X
4.3.4	Support mid term evaluation		X	X	
<b>Area 5: Monitoring and Evaluation</b>					
<b>5.1 Finalize the requirements and guidelines for monitoring and reporting for SHTP II</b>					
5.1.1	Complete STTA Plan for M&E in year 2	M&E, COP	X		
5.1.3	Develop a system to track the characteristics of persons who are trained with SHTP II support	M&E; STTA			X
<b>5.2 Provide valid data to guide program monitoring and decision making</b>					
5.2.1	Conduct regular data quality assessments in facilities working through (building capacity) SCPs and CHDs	M&E, Data Validation Team	X	X	X
5.2.3	Prepare and disseminate monthly and quarterly reports of project outputs	M&E	X	X	X
5.2.4	Develop and implement a training database for tracking training activities and participants	M&E		X	X
5.2.5	Identify, develop and implement other information systems to improve project management	M&E			
<b>5.3 Enhance the capacity within the Subcontracting Partners , SHTP II, CHD, CSOs, PHCC and PHCU for collecting, collating and reporting data</b>					
5.3.1	Mentoring staff at CHD, PHCC, PHCU, HHP, VHC, CSO in monitoring and reporting and DQA	M&E	X	X	X
5.3.2	Mentor staff at SCPs, CHD, SDPs CSO, VHC and HHP in use of tools for data collection and reporting	M&E	X	X	X
5.3.3	Conduct regular joint supportive supervision by SHTP-II, MOH/GOSS, USAID, SCPs and CHDs	M&E, TD	X	X	X
5.3.6	Participate in M&E Reference Group and support national level M&E system	M&E; STTA	X	X	X
5.3.7	Work with SCPs to ensure the CHDs receive, use and send programmatic data to the state level	M&E	X	X	X
<b>5.4 Submit quarterly performance monitoring reports</b>					
5.4.1	Submit quarterly performance report to COP & TD no later than the 20th of the month following the end of the quarter	M&E	X		
<b>5.5 Monitor microgrant progress</b>					
5.5.1	Visit microgrant sites to monitor progress	M&E, F&G,		X	X

		<b>Activity</b>	<b>Responsible person</b>	<b>Oct</b>	<b>Nov</b>	<b>Dec</b>
			TD			
	5.5.2	Pay micrograntees swiftly upon proof of achievement	F&G		X	X
<b>5.6 Submit quarterly financial reports</b>						
	5.6.1	Quarterly Accruals Report due to USAID no later than the 15th of the final month of the quarter	F&G			X
<b>5.7 Submit monthly success stories to USAID</b>						
	5.7.1	Submit at least one success story to USAID each month	COP	X	X	X
<b>5.8 Support GOSS in the preparation and conduct of GOSS Health Assembly</b>						
	5.8.1	Help prepare and conduct GOSS Health Assembly	COP	X		
<b>5.9 Submit semi-annual performance monitoring report</b>						
	5.9.1	Submit semi-annual performance monitoring report (combined with quarterly report) in October and April	COP, TD, M&E, F&G	X		

## Annex V: Quarterly variation in achievements

Achievement against targets for key indicators, FY 2010							
Progress on Indicator Targets	Target FY 10	Period				FY 10 Year-to-date achievement	% of FY 10 target achieved
		Q1 (Oct–Dec 2009)	Q2 (Jan–March 10)	Q3 (April–June 10)	Q4 (July - September 10)		
<b>Section A: Contractual indicators</b>							
1. Number of Children <1 year who received DPT3	20,750	2,941	3,898	3,228	4,986	15,053	72.5
2. Percentage of children less than <1 received DPT3 **	20.8%	5.9	7.5	6.2	9.6	29.2	139.1
3. Number of children under 5 years of age who received Vitamin A in areas currently assisted with USAID funds	30,400	3,452	42,065	4,915	16,091	66,523	284.3
4. Percentage of children under 5 years of age who received Vitamin A in areas currently assisted with USAID funds	45.0%	2.7	32.5	3.8	12.4	51.4	114.2
5. Percentage of pregnant women who receive IPT2 as part of the ANC visit	50%	21.8	48.7	53.6	63.0	56.3	112.6
6. Percentage of pregnant women with one ANC visit	65%	6.4	14.0	15.5	16.8	52.7	81.1
7. Percentage of pregnant women with at least four ANC visits	20%	1.5	2.8	6.5	7.2	18.0	90.0
8. Percentage of deliveries with a skilled attendant at birth in USG-supported counties	15%	0.5	2.2	2.4	1.9	7.0	46.6
9. Percentage of deliveries by a trained traditional birth attendant (TBA) or Maternal and Child Health Worker (MCHW) in USG supported counties	40%	2.7	6.0	6.8	7.4	22.9	57.3
10. Number of counseling visits for FP/RH	15,000	0	85	961	2937	3983	26.6
11. Liters of drinking water disinfected with USG-supported point-of-use treatment products	140 million	37,454,820	28,258,800	92,359,600	31,485,200	189,558,420	135.4
12. Number of health personnel trained with USG support in the different program areas	1690	37	85	495	942	1559	92.3
13. Number of community members trained with USG support in the different program areas	2500	0	215	1445	626	2286	91.4

Achievement against targets for key indicators, FY 2010							
Progress on Indicator Targets	Target FY 10	Period				FY 10 Year-to-date achievement	% of FY 10 target achieved
		Q1 (Oct-Dec 2009)	Q2 (Jan-March 10)	Q3 (April-June 10)	Q4 (July - September 10)		
14. Percentage of all health facilities that provide at least 5 of the 7 high impact services using the MoH approved standards	94%	n/a	n/a	72.0	77.30%	77.3	82.2
15. Percentage of USG supported health facilities that submit their HMIS monthly reporting form within one-month of the reporting month	90%	n/a	70.0	82.0	94.40%	94.4	104.9
<b>Section B: Indicators currently being negotiated</b>							
16. Number of pregnant women with known HIV status (includes those who were tested for HIV and received their results)	None set	0	0	491	1100	1591	n/a
17. Number of HIV-positive pregnant women who received antiretrovirals to reduce the risk of mother-to-child transmission of HIV	None set	0	0	0	22	22	n/a
18. Number of individuals from target audience who participated in community wide event	150,000	n/a	n/a	n/a	n/a	n/a	n/a
<b>Section C: Indicators that will no longer be used beginning in FY 2011 (data for these indicators are provided for FY 2010 but will not be used from FY 2011 onwards)</b>							
20. Number of ITNs distributed to USG-supported counties	151,698	886	16,277	6,382	12,804	36,349	24.0
21. Number of people trained in malaria treatment or prevention with USG funds	150	0	49	114	123	286	445
22. Number of Individuals trained in good health and hygiene practice	520	18	347	70	212	647	124.4
23. Number of Health Personnel Trained in Immunization, diarrhea and ARI management	150	53	16	335	287	691	423.3
24. Number of USG-assisted service points experiencing stock-outs of specific tracer drugs	35	0	0	21	70	-	
25. Percentage of USG-assisted service delivery points that experiencing stock-outs of specific tracer drugs	48.0	n/a	n/a	21.0	42.9	42.9	89.4 (111.9)

## Annex VI: Variation in achievements across the different counties for selected core indicators

	Mvolo/ Wulu	Kapoeta North	Panyijar	Mundri West	Aweil South	Tambura	Juba	Malakal	Twic East	Wau	Tonj South	Mundri East	Terekeka	MSH/ SHTP II	Total
<b>Child Health</b>															
Number of children < 1 year old who received DPT 3	803	310	1261	1704	1127	1564	1786	2045	1278	777	581	849	968		15053
% of children < 12 months old who received DPT 3	22.1	7.4	189.1	122.6	37.3	69.1	13.4	39.5	36.6	16.1	16.4	43.0	24.8		29.3
<b>Nutrition</b>															
Number of children < 5 years old who received Vitamin A	3952	7676	2583	6927	6584	382	960	17855	2101	39	6401	10402	661		66523
% of children < 5 years old who received Vitamin A	43.6	72.8	154.8	199.4	87.3	6.7	2.9	138.1	24.1	0.3	72.3	210.5	6.8		51.7
<b>Malaria</b>															
Number of pregnant women who received IPT 2	1564	60	789	1073	1243	2298	1289	1018	843	1138	1062	581	439		13397
Percentage of pregnant women who received IPT2	127.4	4.9	58.6	66.3	70.7	74.8	40.5	53.2	47.3	42.8	48.3	58.0	53.5		56.3
<b>Maternal Health</b>															
Total number of women with one ANC visit	1228	1221	1347	1618	1759	3071	3182	1913	1782	2660	2197	1001	820		23799
% of women with 1 ANC visit	38.7	33.1	229.1	133.1	66.6	154.9	27.3	42.3	58.3	62.8	70.9	57.9	24.0		52.9
Total number of women with at least four ANC visit	396	49	237	771	823	779	2539	502	541	616	390	268	250		8161
% of women with 4 ANC visit	12.5	1.3	40.3	63.4	31.2	39.3	21.7	11.1	17.7	14.6	12.6	15.5	7.3		18.1
Total number of deliveries assisted by a skilled attendant	212	115	91	393	48	763	271	270	138	105	321	108	277		3112
Percentage of deliveries assisted by a skilled attendant	6.7	3.1	15.5	32.3	1.8	38.5	2.3	6.0	4.5	2.5	10.4	6.2	8.1		6.9
Total number of deliveries assisted by TBA or MCHW (unskilled attendant)	1067	448	654	871	1019	1499	494	368	1507	256	767	654	683		10287
Percentage of deliveries assisted by TBA or MCHW	33.6	12.1	111.2	71.6	38.6	75.6	4.2	8.1	49.3	6.0	24.7	37.8	20.0		22.8
Total number of health personnel trained	52	93	61	109	55	325	71	108	79	25	85	98	260	112	1533
Total number of community members trained	602	614	0	11	202	323	17	11	15	0	0	5	279	42	2121