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## Mid-Term Performance Evaluation of Health Activities under the Integrated Service Delivery Project

**July 2015**

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# **MID-TERM PERFORMANCE EVALUATION OF HEALTH ACTIVITIES UNDER THE INTEGRATED SERVICE DELIVERY PROJECT**

**MONITORING AND EVALUATION SUPPORT PROJECT**

July, 2015

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## **DISCLAIMER**

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# ACRONYMS

ANC	Antenatal Care
BCC	Behavior Change and Communication
BEmONC	Basic Emergency Obstetric and Neonatal Care
CBO	Community-Based Organization
CDC	Center for Disease Control
CEmONC	Comprehensive Emergency Obstetric and Neonatal Care
CES	Central Equatoria State
CHD	County Health Department
CIP	County Implementing Partner
CMO	County Medical Officer
CMT	Community Mobilization Team
CTMC	County Transfer Monitoring Committee
CYP	Couple Years Protection
DFID	Department for International Development
DHIS	District Health Information Software
DPT	Diphtheria, Pertussis, Tetanus. A series of three vaccinations
EMF	Emergency Medicines Fund
EU	European Union
FBO	Faith-based Organization
FCR	Findings, Conclusions, Recommendations
GF	Global Fund for AIDS TB and Malaria
GRSS	Government of the Republic of South Sudan
HHP	Home Health Promoters
HIS	Health Information System
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome
HLA	Health Learning Assessment
HMIS	Health Management Information System
HPF	Health Pooled Fund
HRH	Human Resources for Health
HRIS	Human Resources Information System
HSDP	Health Sector Development Plan
HSSP	Health Systems Strengthening Project
ICCM	Integrated Community Case Management
IDSR	Integrated Disease Surveillance and Response
IMA	Interchurch Medical Assistance
ISDP	Integrated Service Delivery Project

JSI	John Snow Incorporated
M&E	Monitoring and Evaluation
MCHIP	Maternal and Child Integrated Health Program
MOFEP	Ministry of Finance and Economic Planning
MOH	Ministry of Health
MSF	Medicins Sans Frontieres
MSH	Management Sciences for Health
MSI	Marie Stopes International
NGO	Nongovernmental Organization
OF	Operational Framework
PEPFAR	US President's Emergency Plan for AIDS Relief
PFM	Public Financial Management
PHC	Primary Health Care
PHCC	Primary Health Care Centre
PHCU	Primary Health Care Unit
PMP	Performance Management Plan
PPH	Postpartum Hemorrhage
PSI	Population Services International
PSM	Pharmaceutical supply management
QA	Quality Assurance
QSC	Quantified Supervisory Checklist
RRHP	Rapid Results for Health Project
SBA	Skilled Birth Attendants
SBM-R	Standards Based Management and Recognition
SCM	Supply Chain Management
SHTP II	Sudan Health Transformation Project II
SIAPS	Systems for Improved Access to Pharmaceuticals and Services
SMOF	State Ministry of Finance
SMOH	State Ministry of Health
SSP	South Sudan Pound
SS	Supportive Supervision
TB	Tuberculosis
TOT	Training of Trainers
TO	Transition Objective
TPM	Team Planning Meeting
TWG	Technical Working Groups
UN	United Nations
UNFPA	United Nations Population Fund

UNICEF	United Nations International Children's Fund
UNOPS	United Nations Office for Project Services
USAID	U.S. Agency for International Development
VHC	Village Health Committee
WASH	Water Sanitation and Hygiene
WB	World Bank
WES	Western Equatoria State
WHO	World Health Organization

# EXECUTIVE SUMMARY

## Evaluation Purpose and Evaluation Questions

The purpose of the performance evaluation of the Integrated Service Delivery Program (ISDP) is to document the extent to which the project goals and objectives have been achieved and assist the USAID/South Sudan Health Office in reaching decisions related to mid-course corrections or modifications necessary to improve project implementation over the last half of the project life. The evaluation will also help the USAID/South Sudan Health Office in understanding the strengths and weaknesses of the present model and develop more informed future development programming in the health sector.

Although this evaluation focused on ISDP's work in CES and WES, the conclusions and recommendations may be used to inform program design and implementation with any subsequent USAID program that replaces ISDP, including, but not limited to, the Health Pooled Fund 2 health services and HSS activities. These evaluation recommendations may also be relevant and applicable to the health challenges in all South Sudan states, not just CES and WES, and may be used to construct new country-wide programs for all South Sudan states.

The evaluation addresses five main questions:<sup>1</sup>

1. What have been the results of USAID's health investments through ISDP, considering both targets established for these activities and unanticipated results?
2. How relevant is the project's work to both short and long-term development needs of health services delivery in South Sudan?
3. How effectively has ISDP coordinated with the Health Systems Strengthening Project (HSSP) activities and other South Sudan health stakeholders at the county and state levels to improve health services?
4. What are the advantages and disadvantages of the ISDP current model and approach?
5. What has been the impact of conflict and tenuous political situation on the ISDP project and how could future conflict and insecurity affect the project during its final two years?

## PROJECT BACKGROUND

ISDP commenced in June 2012 and is implemented by a consortium led by Jhpiego. The project end date is June 2017 with an approximate funding envelope of \$85 million. The goal of ISDP is to increase access to high-quality Primary Health Care (PHC) services for all people in Central Equatoria State (CES) and Western Equatoria State (WES), the two most populous states in South Sudan.

To achieve this goal, the project has two central expected results:

1. Standardized, functional, equipped, and staffed health facilities able to provide a minimum package of quality PHC services; and
2. An increase in access of information and services to the community.

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<sup>1</sup> During the April, 2 2015 meeting between MSI and USAID, modifications were made to the evaluation questions from the original SOW. The questions listed here were agreed to by all parties

The project is linked to USAID/South Sudan’s current Operational Framework (OF) through sub-Transition Objectives (TO) 1.2: Deliver critical services; 3.1: Maintain critical functions and indirectly; and 1:1 Facilitate community-led response.

## EVALUATION METHODS

The evaluation utilized both quantitative and qualitative data collection techniques with more emphasis on the latter. The data collection methods used included a focused document review. Both project indicator data and Ministry of Health (MOH) data from the District Health Information System (DHIS) were reviewed in detail. The evaluation also conducted 38 key informant interviews across all levels of the health system using structured interview guides. Additionally, a total of 18 focus group discussions were held with the beneficiaries and community workers. As part of the field work, the evaluation team visited a total of 15 facilities in nine different counties within both CES and WES. Table 1 summarizes the evaluation data collection effort.

Table 1: Evaluation data collection effort

Data collection activity	Interviews
Key informant interviews	38
Focus group discussions	18
Site / clinic visits	15

## KEY CONCLUSIONS AND RECOMMENDATIONS<sup>2</sup>

**Evaluation Question #1: What have been the results of the USAID/South Sudan’s health investments through ISDP, considering both targets established for these activities and unanticipated results?**

### Family Planning <sup>3</sup>

Evidence of the fragmented effort to supply commodities across counties and states is notable as more facilities are providing services but do not have adequate supplies to consistently provide the full set of services. Additionally, adequately trained providers are also a concern. While the departure of Marie Stopes International (MSI) only directly affects the subset of facilities the organization was supporting, it could have a larger effect on ISDP programming going forward. With limited flexibility<sup>4</sup> in budgeting, stretching to cover additional training does not seem realistic.

The new Health Management Information System (HMIS) format is very promising in providing improved measurement data and will be useful for overall program planning, including commodity

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<sup>2</sup> The Executive Summary contains only key conclusions and short term recommendations (for the remaining life of the ISDP project), full details and long term recommendations are found within each section of the full report. All recommendations are italicized in the following sections

<sup>3</sup> This question focuses on Family Planning, Child Health and Maternal Health – see the full explanation in the main report.

<sup>4</sup> Budget flexibility is discussed in greater detail under Question Two.

planning at the facility and county level. This new format also provides the opportunity to more accurately measure most of the health indicators including Couple Years Protection (CYP) and provide all partners with a better understanding of uptake and continued use.

ISDP should:

- Conduct short refresher trainings to fill skill gaps identified by supportive supervision, including reporting using the new HMIS format.
- Capture data using the new HMIS format; ISDP should ensure accurate reporting on CYP and promote data utilization by County Implementing Partners (CIPs) to better understand trends and performance as it relates to service provision and commodity tracking.
- Once the new HMIS format is rolled-out, ISDP should ensure that CIPs are further engaged in managing, reporting and checking the quality of data captured.

In order to maintain development gains, USAID should consider shifting resources or providing additional funds to ISDP to enable the project to cover gaps in conducting refresher trainings as well as reduce fragmentation in supply of Family Planning (FP) commodities by enhancing coordination with United Nations Population Fund (UNFPA) who supplies all FP commodities in South Sudan. As part of this, ISDP should continue conducting refresher trainings in long acting methods based on the identified gaps (including Behavior Change and Communication (BCC) and commodities) as they have been doing followed by supportive supervision in technical areas. Given the ongoing turnover in health clinic staffing, ISDP should continue regular refresher trainings throughout the life of the project.

## **Child Health**

ISDP has exceeded targeted performance for curative consultations, but met with more modest success for DPT3 vaccination. ISDP narrowed the performance gap (the difference between actual and targeted performance) in DPT3 vaccination from 17 percent in fiscal year 2013 to 10 percent in fiscal year 2014. However, performance on this indicator for the first and second quarters of 2015 have shown a leveling off in most counties, and the performance gap for the first two quarters of FY15 reverted to 16 percent (See figure 4.) Evaluation findings link this to cold chain disruption (vaccine fridges are poorly maintained and others have broken down for a while therefore disrupting immunization activities). Overall, findings also point to a need to increase support, motivation and supervision for vaccinators.

A key element to improve both vaccination coverage and rolling out of Integrated Community Case Management (ICCM) effectively will be related to the support from the project's community component. Micro planning at the county and Facility level before community vaccination activities are conducted, and involving the Home Health Promoters (HHPs) at the community level in the planning, will help improve coordination and performance and likelihood of reaching appropriate coverage levels.

ISDP/CIPs should:

- Implement refresher training for health workers in IMCI and HMIS based on noted skill gaps (where indicated by Supportive Supervision (SS) to ensure protocols are followed and documentation is improved.)
- Use better catchment area maps where necessary to improve outreach site selection and planning of service delivery especially where populations are very rural. More targeted and better planned outreach by facility staff can be conducted to improve routine immunization reach.
- Further document county level best practices and consider these practices in rolling out of training and supervision to Village Health Committee (VHCs) and Community Mobilization Team (CMTs).

- Diphtheria, Pertussis, and Tetanus (DPT I) is being captured at the facility but ISDP does not report it to USAID. ISDP should therefore report it to USAID. DPT I and DPT3 will help USAID monitor the dropout rate for children who got the first dose(s) of Penta and dropout before completion.

## Maternal Health

While SS assessments point to improved quality, performance data for maternal health indicators show limited or no improvement over project years. While small improvements can be attributed to community level demand creation and facility level improvements in staffing and infrastructure, significant barriers still exist. Key gaps still remain:

- Refresher trainings and continuous professional development of CMWs and Skilled Birth Attendants (SBAs) are needed. The majority of staff in these cadres has been trained but need a refresher to refresh their skills. Also, the issue of labor turnover means that those staff that might have received training in specific areas can be lost to other counties if recruited by a CIP offering better remuneration packages and consistency. Overall, there are still limited numbers of women accessing these key services at facilities; the BCC strategy has only been successful on a micro-level (with some CIP best practices or anecdotes).

Increasing the use and availability of uterotonics is an important step in preventing Postpartum Hemorrhage (PPH), while the data from the learning phase is promising, current project data is limited to tracking the number of uterotonics distributed.

ISDP should:

- Continue training and expanding PPH community coverage using the MCHIP model.
- Continue use of HHPs and VHCs for counseling, referrals and defaulter tracing for Antenatal Care (ANC) and delivery with a skilled birth attendant.
- Consider refresher trainings and continuous professional development for skills gaps identified in SS; mentoring by more experienced staff; brainstorming ways to provide more practicum experiences for SBA and CMW<sup>5</sup>.
- Consider use of facility staff for outreach — especially ANC staff for ANC services — to increase service access for women by bringing services to them. ANC staff should devote one day a week for outreach activities as part of ANC service provision.

USAID should ask ISDP to capture and report additional data and encourage CIPs to conduct facility level performance analysis:

- Additional data on deliveries — data on skilled, unskilled and deliveries in the community is currently captured at the facility level; however, ISDP only reports on skilled deliveries. Using this additional data USAID/ISDP should encourage CIPs to do facility level analysis with this data to better understand micro-level trends and where best practices are emerging. This would be especially crucial for counties that are beginning their community-based PPH prevention activities.
- Additional data on ANC by reporting first and second ANC visits (as is common in emergency settings) or other variations on ANC 1 and 4 only as it limits the nuances available for decision-

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<sup>5</sup> As noted in findings, ISDP is considering ‘catch-up’ trainings for BEmONC for next year’s work plan.

- making to help improve project implementation and performance.
- USAID should consider leading a collaborative effort to support a much broader BCC and advocacy campaign at the country level, The BCC strategy needs a major campaign with increase in funding to help change health service seeking behavior among women.

## **Evaluation Question #2: How relevant is the project’s work to both short and long-term development needs of health services delivery in South Sudan?**

The five key project assumptions described in the original project description have not held true thus far in the life of the ISDP project. Within the areas covered by the key project assumptions, there are both short and long term development needs across the health sector. ISDP is working to meet some of these directly while relying on the support of other actors for certain interventions.

- As assumptions about staffing were central to the original ISDP design, especially in-terms of the project’s planned Phase Three transition, the continued dependency of the MOH on ISDP paid salaries severely limited the flexibility of the project in responding to technical needs. In addition, inequities in salaries at the facility level created tensions and motivation issues for health workers.
- The assumption that commodities will be provided by other partners was unrealistic given that some partners may leave suddenly e.g. Marie Stopes, placing an additional burden on ISDP and limiting its ability to ensure quality and standardized services across facilities.

The assumptions no longer holding led to difficulties in meeting performance targets as well as overall project goals and objectives. At this stage, with both limited budget flexibility (due to the high percentage used for salaries) instead of other technical aspect of the program and limitations within the ISDP original design, the project were unable to be nimble enough to mitigate these faulty assumptions. In addition, reliance on other actors such as UNICEF, GAVI and MSI to fill those gaps has not been as successful as envisioned in the original design and reliance on other actors is a key disadvantage of the ISDP model.

USAID and ISDP should conduct a strategic planning session to determine how to move forward during the remaining project years in terms of coverage of technical areas within the current budget constraints, prioritizing technical areas while still meeting continued salary needs.

### **Salaries**

USAID should continue paying salaries at the current level through ISDP, but should work with ISDP to ensure that all CIPs are adhering to standards and best practices but also striking a balance to ensure a motivated workforce that would not be tempted to jump ship to other potential NGOs even though outside the ISDP.

### **Commodities**

ISDP/CIPs should continue to facilitate the transportation of commodities and supplies to Primary Health Care Unit/ Primary Health Care Centre (PHCU/PHCCs) but ensure coordination with monthly SS visits to reduce additional logistical or resource burden on the project.

### **Infrastructure (including WASH)**

ISDP, USAID, and USAID partners within the Health Pooled Fund 2 should prioritize infrastructure

support so that major transportation bottlenecks in all States that prevent the poor and extremely vulnerable, especially in rural areas, from accessing the BPHS. As part of this recommendation:

- ISDP should continue to work through VHCs – engaging them in upgrading facilities (action planning and leveraging support);
- ISDP should utilize CMTs (as they are rolled out) to consolidate community issues and prioritize at a Payam level;
- ISDP should continue to support CIPs in leveraging support of other actors such as local Community-Based Organization (CBOs), where possible for additional support; and
- As a critical point, USAID/ISDP should ensure functional water supply at every facility (especially at PHCCs) as this is an essential element of providing all other basic quality services.

### **Evaluation Question #3: How effectively has ISDP coordinated with the HSSP project activities and other South Sudan health stakeholders at the county and state levels to improve health services?**

Overall, there is significant overlap between ISDP and HSSP in terms of which actors the projects support in CES and WES, but as designed, there is limited duplication in terms of how this support is envisioned and what technical areas it covers. This is a significant strength in the design of the two projects and suggests a way forward for coordinating collaboration.

At this stage of implementation, however, there remain some areas of duplication (or potential duplication) as well as performance gaps, most notably:

- Gaps in support at the community level, for example, HSSP will not be able to support all VHCs in leadership and management training.
- Potential gaps will be created if there is segmentation of responsibility on management of drug stock-outs, but this is currently an activity that both projects are involved in (ISDP at the facility and HSSP at the CHD levels).

Positive examples of coordination and collaboration with other actors make it clear that there are some missed opportunities which could leverage outside resources, build community confidence in services, and improve performance.

ISDP should continue to participate in HSSP joint planning to support building technical capacity for Quality Assurance (QA) and management capacity for SS as well as ensuring that there are fewer missed opportunities and resources are maximized.

ISDP should work with USAID to consider the feasibility of co-location for CIPs and HSSP Hubs at this stage of the project.

ISDP should work with HSSP to create a plan for USAID's approval to maximize the reach of current resources that both projects have left for the community component, including prioritizing the setup of CMTs and using these entities as a resource for training VHCs. HSSP and ISDP should consider pooling funding to cover VHC trainings under ISDP.

### **Evaluation Question #4: What are the advantages and disadvantages of the ISDP current model and approach?**

#### **ISDP Community Focus**

ISDP has a strong emphasis on the community which is linked to the USAID/South Sudan Operational

Framework through its use of HHPs to deliver community-level services and supporting links to facility services, and the use of VHCs and CMTs to facilitate community-led responses to health related challenges. The community component has not yet been delivered as designed due to budget limitations, with only a few CMTs functioning, limiting the effectiveness of the Community Action Cycle process. While HHPs, VHCs and CMTs play a crucial role (according to the ISDP original Program Description) they are also outside of the government health system and this may pose a problem for sustainability when donor and NGO support is not available.

ISDP doesn't capture enough data on the performance of community activities and how this links to projects overall performance and support to reducing maternal mortality. Tracking the training and work of HHPs is important, but more from an accountability standpoint, rather than for understanding performance and results achieved with the community component. This is also an opportunity to collect and analyze more data related to gender differential participation and impacts at the community level.

USAID and ISDP should consider how best to continue the roll out of the CMTs and scale up the Community Action Cycle. There are potential cost savings in tasking CMTs to support training and supervision of VHCs and HHPs. In addition, further cost savings may be realized through the coordination of CMTs with other local actors. This is also an opportunity to reinforce the sustainability of this model for the future and consider a handover plan or exit strategy for ISDP.

ISDP should further utilize HHPs to collect data/information at the community level to better understand uptake and consistent use; HHPs can gather information and work with VHCs to develop better targeted plans. CMTs can support higher level issues and advocate.

ISDP should consider capturing additional data to better understand how the work at the community level contributes to the projects objectives. This could include indicators to track the functionality of VHCs (such as those used by HFP) or more qualitative measures that look at beneficiary satisfaction with services or gender differential participation or impacts.

### **Quality Assurance Model**

The QA approaches used by ISDP are clear evidence of a focus on quality and standardization of service delivery across counties (and country wide by working at the national level to have guidelines updated and approved) and are an improvement from the MOH Quantified Supervisory Checklist (QSC) tool in terms of full coverage of service delivery elements. The buy-in from the MOH is an important step and will allow for standardization beyond ISDP states. The effectiveness of this approach will be hindered by the complicated nature of the current modules as well as discouraging facilities that are unable to reach the 80 percent benchmark from continuing to work towards manageable goals. Manageable milestones and rewards would allow facilities to stay motivated while still progressively improving performance.

ISDP should continue with the support at the national and county/facility levels for development and roll out of standardized Standards Based Management and Recognition (SBM-R) modules and updated guidelines considering issues already encountered during initial roll out, such as: streamlining and designing mechanisms that reward facilities for improvement instead of setting the bar at 80 percent for recognition.

### **Disadvantages of the ISDP model**

ISDP was designed on the basis of assumptions that did not hold true (and are not likely to hold true during the life of the project. Though the assumptions are noted as problematic, the approach does not

include a contingency plan if any of the assumptions do not hold. As well, the phases of transition indicated in the ISDP original design assume transition of staff salaries and service delivery oversight to the government, but without a backup plan if this is not possible. This is problematic especially in the context of South Sudan, as even before the December 2013 crisis, South Sudan was a fragile working environment. These misaligned assumptions have had an impact on the project's performance and an impact on health outcomes. As noted earlier, the reliance on other actors to fill gaps and provide linkages has proven ineffective with key examples being challenges to supply chain and infrastructure. Support and linkages to secondary health care, though part of the original ISDP design and subsequent work plans, is also a gap where reliance on other actors has proven ineffective (with the exception of small scale solutions for specific facilities).

In addition, the CMT model, as part of the ISDP community approach, is quite complicated and takes time to implement, as indicated by the delays in rolling out this component thus far under ISDP. As mentioned earlier in this document, the CMT model is also outside of the MOH policy framework which makes its sustainability beyond ISDP support unlikely unless additional steps are taken.

Finally, as the ISDP approach concentrates at the community and facility levels, interactions with the CHD on a technical front are limited and CHDs are not demonstrating improved technical knowledge. While CIPs are sharing work plans with the CHDs, initiating coordination meetings, and quarterly reviews, CHD involvement on ISDP initiatives is still limited, which may threaten sustainability beyond the life of the project.

USAID should set up an oversight committee which includes representatives from the MOH, USAID and ISDP. This committee could be tasked with determining the best way forward in light of current circumstances and could focus on big picture issues as noted above as well as sustainability of ISDP initiatives.

#### **Evaluation Question #5: What has been the impact of conflict and tenuous political situation on the ISDP project and how could future conflict and insecurity affect the project during its final two years?**

Overall services only felt limited disruption in terms of service provision during conflict and use of services during and after, but challenges which can be identified are the under-utilization of local staff as well as the lower use of some facility services even beyond the crisis. The fact that ISDP was unable to complete technical activities slated for Year Two and has shifted these activities into the Year Three work plan, combined with the potential future risks noted above, suggest a significant possibility that ISDP will struggle to complete its Year Three work plan.

ISDP should continue with planned activities suggested for Year Three.

In addition, ISDP should work with Conflict Advisors to:

- Identify conflict sensitive areas/counties: Use 2013 national conflict assessment and staff interviews to identify one to three geographic areas of operations where social dynamics are serving as initial focus areas for conflict sensitivity planning.
  - Develop plans to understand local staff narratives surrounding service delivery and impact on social dynamics.
- Integrate conflict sensitivity into existing Quality Assurance, possible areas to explore:
  - Supervision Reports and SBM-R performance assessments and standards
- Consider contingency planning around likely risks to project implementation and performance going forward.

# EVALUATION PURPOSE & EVALUATION QUESTIONS

## EVALUATION PURPOSE

The purpose of the performance evaluation of ISDP is to document the extent to which the project goals and objectives have been achieved and assist the USAID/South Sudan Health Office in reaching decisions related to mid-course corrections or modifications necessary to improve project implementation over the last half of the project life. The evaluation will also help the USAID/South Sudan Health Office in understanding the strengths and weaknesses of the present model and reaching decisions related to future development programming in the health sector.

Although this evaluation focused on ISDP's work in CES and WES, the conclusions and recommendations may be used to inform program design and implementation with any subsequent USAID program that replaces ISDP, including, but not limited to, the Health Pooled Fund 2 health services and HSS activities. These evaluation recommendations may also be relevant and applicable to the health challenges in all South Sudan states, not just CES and WES, and may be used to construct new country-wide programs for all South Sudan states.

## EVALUATION QUESTIONS

There are five main questions that will be addressed in this evaluation.<sup>6</sup>

1. What have been the results of USAID's health investments through ISDP, considering both targets established for these activities and unanticipated results?
2. How relevant is the project's work to both short and long-term development needs of health services delivery in South Sudan?
3. How effectively has ISDP coordinated with the Health Systems Strengthening Project (HSSP) activities and other South Sudan health stakeholders at the county and state levels to improve health services?
4. What are the advantages and disadvantages of the ISDP current model and approach?

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<sup>6</sup> During the April, 2 2015 meeting between MSI and USAID, modifications were made to the evaluation questions from the original SOW. The questions listed here were agreed to by all parties

5. What has been the impact of conflict and tenuous political situation on the ISDP project and how could future conflict and insecurity affect the project during its final two years?

In addition, the evaluation team will (a) explore gender issues within the context of ISDP activities, and (b) identify any future gender issues that need to be addressed.

## PROJECT BACKGROUND

### CONTEXT

South Sudan became the world's newest nation in July 2011; however, decades of conflict and underdevelopment have left a devastating legacy. In the health sector alone, a majority of health related infrastructure has suffered significant degradation as a result of long-term and on-going armed conflict. This coupled with a massive exodus of skilled health personnel, has led to a substantial decline in the quality of health services delivered. Although the health status overall is poor, women have been most acutely impacted by this deterioration, evidenced by an exceedingly high maternal (and child and infant) mortality ratio, low access to skilled birth attendants, and an unacceptably low contraception prevalence rate. In fact, one out of seven women will die as a result of pregnancy or childbirth, representing a much needed intervention opportunity.

In response, the GRSS MOH set goals for the country's health sector in the Basic Package of Health Services (BPHS) directive. The BPHS identified a minimum package of integrated primary health care services. In an effort to coordinate coverage, international donors reorganized their commitments to ensure support for the BPHS in all ten states of the country. Beginning in 2012 and as a continuation of previous investments, USAID committed to an expansion of the BPHS in the two most populous states of CES and WES. To this effect, the MCHIP Project led by Jhpiego was awarded the ISDP to ensure coverage of the minimum package across all 16 counties in the two states.

In December 2013, violence broke out again in South Sudan, with continuing conflict in Juba, Jonglei, Upper Nile and Unity. Both ISDP and the BPHS were developed before the current civil conflict broke out and did not take into account the effects of ongoing violence and chronic population displacement. As a result, ISDP design assumptions did not factor in how limited the government capacity to deliver services and improve its health systems would be.

Due to these changed circumstances, in 2014, USAID undertook a review of its portfolio, and developed a new Operational Framework (OF) which integrated the on-the ground realities into the Transition Objectives (TOs). The OF integrated health service delivery (including ISDP) into various TOs and sub TOs including 1.2: Deliver critical services; 3.1: Maintain critical functions and indirectly; and 1:1 Facilitate community-led response. Under the new OF, USAID has placed greater emphasis on service delivery and will refocus to ensure provision of high-quality primary health care services.

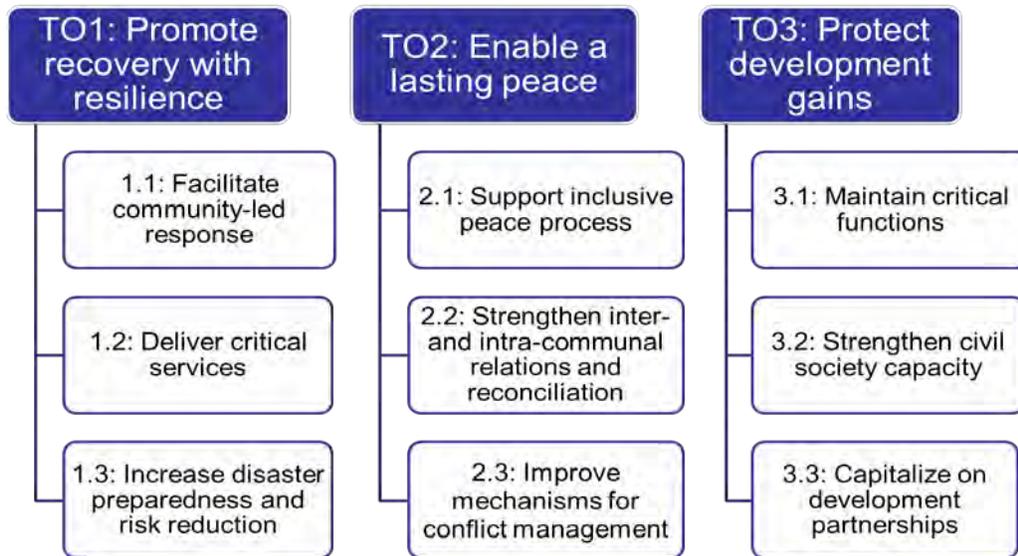


Figure 1: USAID/South Sudan Operational Framework

## Project Details

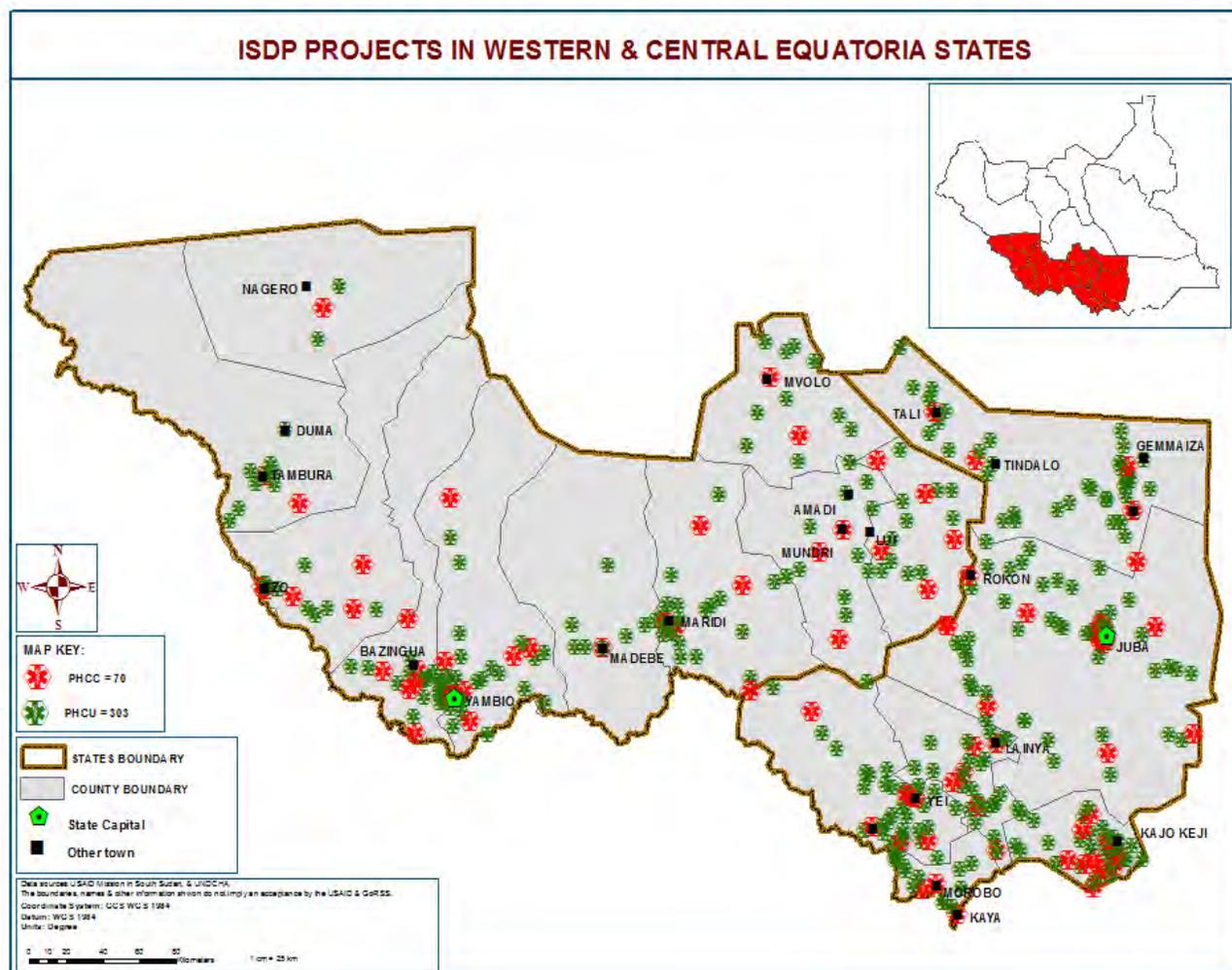
ISDP started in June 2012 and is implemented by a consortium led by Jhpiego. The project end date is June 2017 with an approximate funding envelope of \$85 million. The goal of ISDP is to increase access to high-quality primary health care (PHC) services for all people in CES and WES, the two most populous states in South Sudan.

To achieve this goal, the Program has two central expected results:

1. Standardized, functional, equipped, staffed health facilities able to provide a minimum package of quality PHC services; and
2. An increase in access of information and services to the community.

To achieve the two overarching results, Jhpiego envisioned three broad programmatic phases:

Phase 1: focus on ensuring the continuation of donor-supported existing primary health care services for a six-month period. Phase 2: awarding of competitive sub-grants to one implementing NGO per county for all 16 counties in the two states. This phase is focused on supporting the MOH, states and county health departments to standardize strengthen and expand primary health care activities in facilities and communities. Phase 3: focus on progressive transition of primary health care services to MOH support



over an 18-month period. In addition, ISDP incorporated cross-cutting initiatives of gender and Water Sanitation and Hygiene (WASH) into the programmatic framework.

The entire program further ensured the below three principles guided the intervention as a whole:

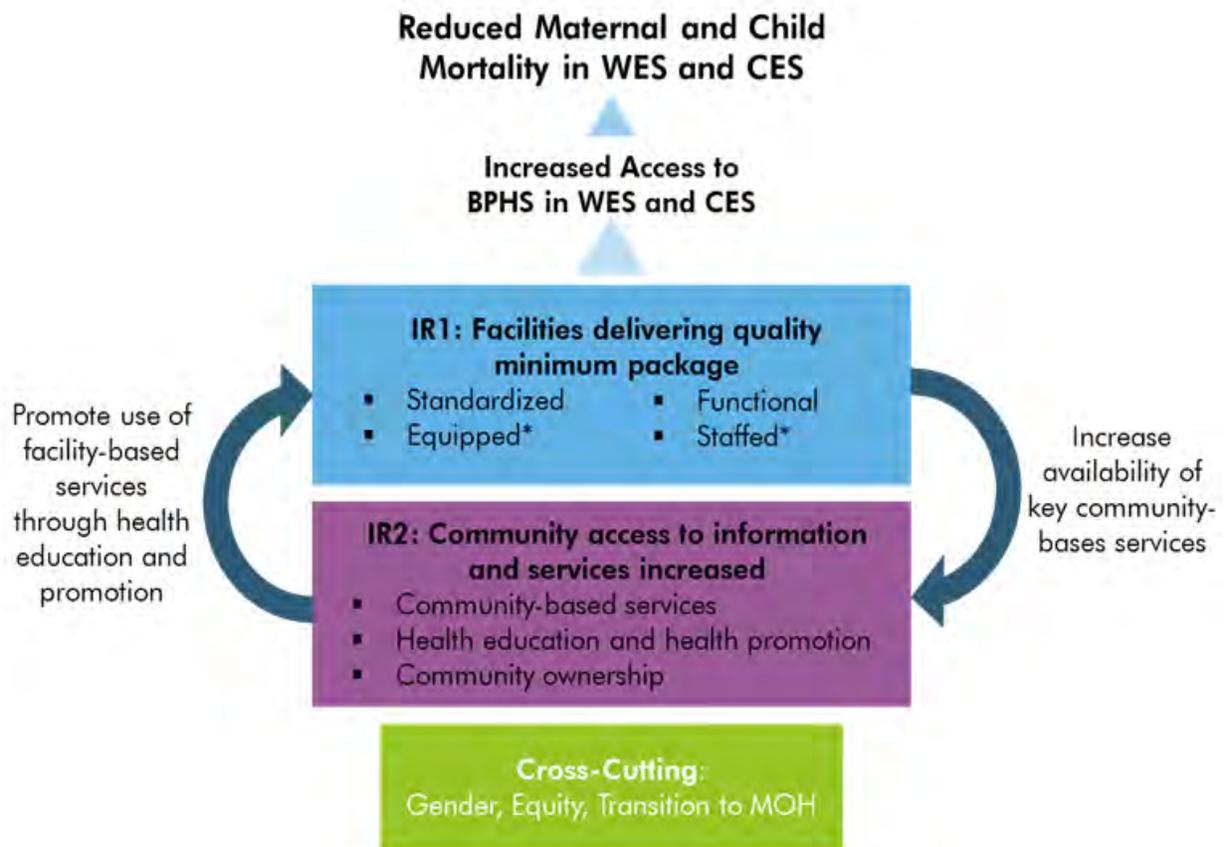
1. Collaboration with the GRSS at all levels
2. Standardization and equitable coverage
3. Lasting contribution to South Sudan’s health sector

### Development Hypothesis

The development hypotheses or theory of change underlying the ISDP activity can be expressed as follows:

*If the quality of basic primary health services is increased, and if community access to information and services is improved, then overall access to quality basic primary health services will be increased. This would result in reduced Maternal and Child Mortality in Western and Central Equatoria States. Thus, ISDP would have contributed to this goal.*

This development hypothesis is also demonstrated graphically below:



\*see key assumptions section

# EVALUATION METHODS & LIMITATIONS

To finalize the methodology to best evaluate ISDP, the team conducted initial orientation meetings and a Team Planning Meeting (TPM) attended by the evaluation team and representatives of MESP and USAID. The TPM offered an opportunity for the USAID South Sudan Health Office representatives to provide clarification on the objectives of the study and refine the evaluation questions. The evaluation team presented its inception report, which included a literature review and proposed methodology for the conduct of the evaluation and data collection tools.

The evaluation utilized both quantitative and qualitative data collection techniques with more emphasis on the latter. The respondents were purposively selected and snowball sampling techniques were used. Interview guides for primary questions allowed for a tailored approach — utilizing probing questions and flexibility. The data collection methods used included a focused document review of all relevant project-specific documents that included quarterly and annual progress reports, operational plans, field guides, and government strategies/policies. Both project indicator data and MOH data from the District Health Information System (DHIS) were reviewed in detail. The evaluation also conducted 38 key informant interviews across all levels of the health system and partners using structured interview guides. Additionally, a total of 18 focus group discussions were held with the beneficiaries and community workers. Observations were made on variables pertaining to practices and behavioral aspects in the visited sites.<sup>7</sup>

## SITE VISITS

The evaluation team visited a total of 15 facilities in nine different counties within both CES and WES. Sites were purposively selected by the evaluation team. Jhpiego and the USAID Health Office provided a facility sampling frame — “facility universe” — and collaboratively with the evaluation team established the criteria that were used to select facilities visited. Criteria considered in selecting counties and facilities were urban/rural sites, high/low volume facilities, international/local NGOs and sites implementing the community-based preventing post-partum hemorrhage (PPH) activities.

## DATA ANALYSIS AND TRIANGULATION

The evaluation team employed a systematic approach to record as well as analyzes the data gathered across various sources, using quantitative and qualitative analysis methods to arrive at conclusions and recommendations. The most frequent methods used in analyzing qualitative data were content, pattern and trend analysis to identify themes emerging from data collection and document review exercises; and response convergence/divergence analysis to determine where target groups exhibited similar or differing responses. For quantitative data on key performance indicators for health, measures of central tendency and variability were used in the analysis of continuous data. The main strength of the methodology was the triangulation of data collected from different sources which enhanced confidence in the findings.

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<sup>7</sup> A detailed list of documents reviewed, persons interviewed as well as data collection tools are provided in the annexes.

Before the completion of site visits, the team held a briefing with USAID to share some of the insights that had been gained from field visits. On April 4, a final debriefing with USAID South Sudan mission was held to present the preliminary findings, conclusions and recommendations of the evaluation. A subsequent presentation on April 5 was also conducted for a larger audience of stakeholders including representatives from ISDP, HSSP and the MOH.

## **LIMITATIONS**

Given the primary reliance on qualitative data for answering the majority of the evaluation questions, the evaluation team recognizes a number of associated limitations such as the possibility of recall bias among key informants and focus groups as well as the subjectivity of self-reported data. Additionally, the team's ability to visit one first choice site (Mvolo County) was curtailed due to insecurity.

The reliance on secondary data (MOH DHIS and ISDP project data) is also a potential limitation due to the quality of reported data as noted later in the body of the report.

# FINDINGS, CONCLUSIONS & RECOMMENDATIONS

Evaluation Question #1: What have been the results of the USAID/South Sudan's health investments through ISDP, considering both targets established for these activities and unanticipated results?

To answer this question, project performance in three key service areas (Family Planning, Child Health and Maternal Health) supported by ISDP were assessed. Moreover, these key service areas overlapped with common indicators reported by the Health Pooled Fund (HFP) activity in their recent Midterm Evaluation (MTE).<sup>8</sup> The analysis also involved establishing logical contribution or attribution of outputs delivered by ISDP to results achieved, considering reasons for achievement or non-achievement of targets and results. The discussion of the three service delivery areas is followed by a section on gender equity as it relates to ISDP performance.<sup>9</sup>

## Family Planning Service Delivery

### Findings

In both standard modern methods as well as long acting methods, ISDP is providing training for health workers, providing BCC materials, and is filling the gap created by Marie Stopes International (MSI) which stopped activities in CES in March 2015. MSI was responsible for training health workers (at facility and outreach sites) and supplying family planning commodities (in coordination with UNFPA) at a subset of facilities in CES. Though MSI support was focused on only a subset of facilities, the training and commodities supplied by the organization has affected ISDP going forward. According to ISDP, this is especially the case for training at outreach sites previously supported by MSI.

Performance data from ISDP shows an overall increase in the numbers of health facilities providing family planning services (including counseling services) from 53.4 percent of facilities in 2013 to 71 percent of facilities in 2014 (within the 367 facilities that ISDP supports). Each county (with the exception of Ezo County) showed an increase in facilities offering these services over the four quarters of 2014.<sup>10</sup> This performance data aligns with the overall picture of service uptake reported by the project in terms of new users or acceptors, which also shows an overall upward trend when looking at overall performance from the baseline in 2012 through the first quarter of 2015. ISDP has nearly met set targets across project years for this indicator and shows higher numbers than the national average (1.9% for ISDP program areas as compared to 1.4 percent nationally). Similarly, the HPF reporting on the new acceptors indicator show that they are likely to meet their December 2014 milestone (as of the writing of their midterm report) and reports a consistent upward trend in 2013 and holding steady throughout

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<sup>8</sup> Health Pooled Fund Midterm Evaluation Report

<sup>9</sup> This question focuses exclusively on a few key performance areas, Questions 2 and 4 give a broader picture of the project as a whole.

<sup>10</sup> ISDP Year 2 Annual report, PMP data by county

2014.

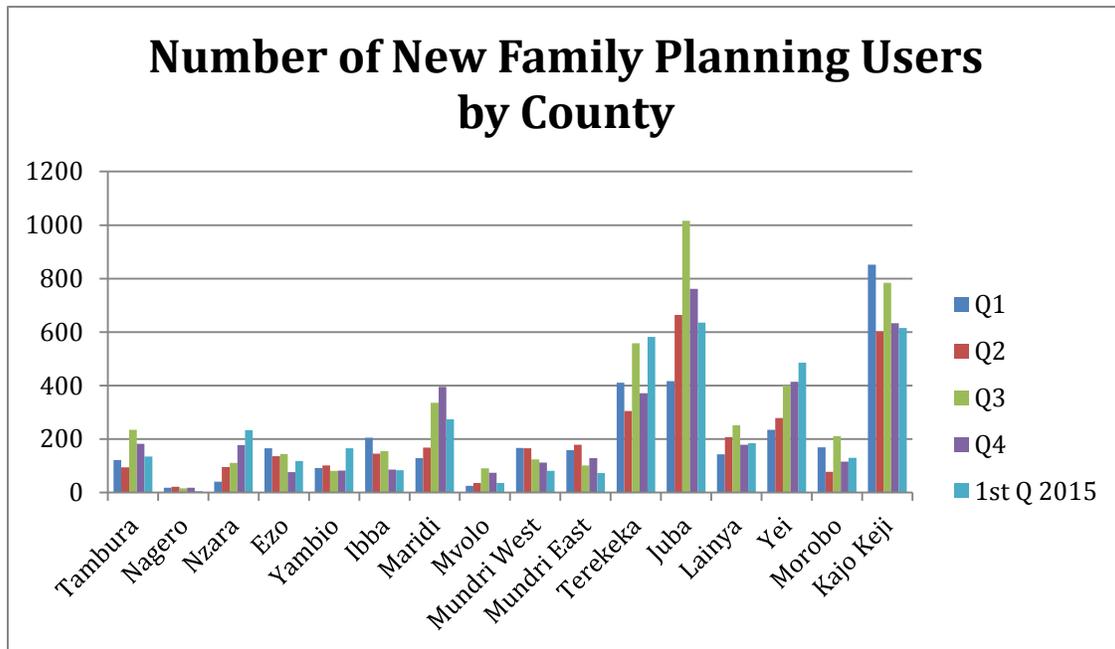


Figure 2: New Family Planning Users by County 2014 - 2015

As shown in Figure 2 above, however, when FP data is analyzed by county, there remain considerable variations. In addition, among sites visited, perceptions by FP clients who participated in FGDs about the success of family planning services varied and were not always consistent with reported performance data. For example, in Mundri East County, the perception was positive in terms of performance in family planning, while performance data (above) shows an irregular downward trend. On the other hand, in Nzara County, the data shows a steady increase in uptake which matched perceptions of the success of this service area as noted in site visits.

During evaluation field visits, drug/commodity shortages and stock outs were consistently mentioned, with different counties citing different sets of actors who supported them in supplying various commodities. The need for more training was also suggested across facilities, this included training for facility staff in improving documentation methods. Key findings related to family planning service delivery were:

- Providers suggested that there had been an increase in the uptake of long acting methods (Depo Provera in particular was cited) but that the commodities were inconsistently available to provide to clients
- One facility visited<sup>11</sup>, stated that since MSI left they have not provided family planning services to clients.

A recent reproductive commodity supply survey conducted by the United Nations Family Population Fund (UNFPA)<sup>12</sup>, which focused only on CES, noted similar inconsistencies by county, highlighting that a variety of actors were involved in supplying commodities across the counties and for different partners. The survey also indicated that there was no consistent way of measuring commodity quantities across

<sup>11</sup>Nyakaoron PHCC, Juba County, CES

<sup>12</sup> UNFPA Reproductive Health Commodity Supply in South Sudan: Case Study (2015) DRAFT

counties. In addition, the survey documented that while some partners felt that there were limited stock-outs or challenges with filling supply orders or gaps, other partners cited significant issues, such as:

- Receiving drugs that were about to expire;
- Non-reliable MOH kits in terms of timing or quantity;
- Inadequate kits for particular key drugs,
- Reproductive Health/Family Planning commodities which were not part of regular kits and were often stocked out.

In terms of available data to understand trends, the HPF midterm reports suggested that this indicator of “new acceptors” was not an appropriate indicator for understanding continued use of contraceptives (which is necessary for methods to be effective). Couple Years Protection (CYP) is a suggested indicator for HFP and ISDP (and is now a required indicator for USAID), but HPF has not reported any data and while ISDP does report data on this indicator, there is no baseline in the initial PMP. The new HMIS 2015 reporting format, which is not yet rolled-out, will enable CYP to be measured more consistently and accurately.

As stated above, ISDP was also mandated to provide BCC (materials and counseling) at the community level. Qualitative and anecdotal evidence from field work is noted below.

For example, at Lanyi PHCC (Mundri East County), it was noted during a focus group discussion that more women were interested in using Depo-Provera (a long acting method) in order to avoid issues with their husbands. It was also noted during interviews at this PHCC that many men were taking condoms for use with their extramarital partners but not to use with their wives. At the Kangai PHCC (KajoKeji County) during a focus group discussion, a service provider had this to say; “a man would not let his wife seek services due to misperceptions about the safety of family planning”. In Tambura PHCC (Tambura County), there has been an increase in the number of women seeking services since last year (*Source: service providers and beneficiaries, verified with facility registers*). This is attributed to steady sensitization activities by the VHC members. It was noted that the VHC members targeted men in these sensitization activities in order to educate and mitigate the prevalence of husbands not giving consent for their wives to seek services.

Another example in Tambura and KajoKeji County, it was noted that a significant gap existed in the family planning service support provided by ISDP to youth in terms of health education and access to services. This concern was highlighted in Tambura County and overall issues with early pregnancy and sexual transmitted diseases. At Kangai PHCC (KajoKeji County), the facility staff and county implementing partner (CIP) attempted to include special activities for youth in their sensitization activities, but limitations on funding have made it difficult to sustain these additional activities.

## Conclusions

In conclusion, evidence of the fragmented effort to supply commodities across counties and states is notable as more facilities are reported to be providing services but may not have adequate supplies to consistently provide the full set of services. While the departure of MSI only directly affects the subset of facilities the organization was supporting, it could have a larger effect on ISDP programming going forward. With limited flexibility<sup>13</sup> in budgeting, stretching to cover additional training and commodities

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<sup>13</sup> Budget flexibility is discussed in greater detail under Question Two.

does not seem realistic. This inconsistency must be addressed first as it will continue to cause potential (or already engaged) users to lose confidence in health services even when commodities are again available.

The new HMIS format is very promising in providing improved measurement and will be useful for commodity planning at the facility and county level. This new format also provides the opportunity to more accurately calculate CYP and provide all partners with a better understanding of uptake and continued use.

The significance of understanding cultural dynamics associated with the use of family planning cannot be understated and must be taken into account in order to provide BCC materials and education to men, women and youth. Anecdotes from sites visited highlight that these issues are currently being inadequately addressed by CIPs. It is also crucial to consider that generating demand without an adequately functioning supply side (providers, facilities and commodities) can cause additional challenges with uptake.

## **Recommendations**

### **Short term:**

ISDP should:

- Conduct short refresher trainings to fill skill gaps identified by supportive supervision, including reporting using the new HMIS format.
- Use data captured in the new HMIS format, ISDP should ensure accurate reporting on CYP and hold CIPs accountable for data analysis and utilization to better understand trends and performance improvements as it relates to service provision and commodity tracking. This should be mandated in ISDP sub-awards to CIPs going forward.
- Reinforce the use of the Community Action Cycle among community mobilization teams (CMT), VHCs and HPPs to understand barriers to health seeking behavior for family planning specifically. This new information can be used to tailor BCC interventions.
- Once the new HMIS format is rolled-out, ISDP should ensure that CIPs are further engaged in managing, reporting and checking the quality of data captured at the facility level.

### **Long term:**

- Utilizing the Technical Working Groups (TWG) already active in key areas (Family Planning, Reproductive Health, BCC), USAID and its development partners should consider an improved and harmonized approach to:
  - Collecting information about family planning uptake and continued use; and
  - Creating a clear, streamlined approach to family planning commodity supply across counties and states. <sup>14</sup>

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<sup>14</sup> A harmonized forecast document for RH/FP commodities for the Country for calendar year 2015 was being validated at the time of the evaluation but was not available to the evaluation team during data collection.

## Child Health Service Delivery

### Findings

In eight out of nine<sup>15</sup> counties visited by the team, increases in childhood disease diagnosis and routine immunization coverage were cited as project successes during FDGs; this was attributed to increased awareness, home health promoter's trainings and activities at the community level by participants.

### *Diagnosis and Treatment of Children under Five*

ISDP has rolled out Integrated Management of Childhood Illnesses (IMCI) in 15 out of 16 counties (not yet in Ibba County), with one training in 2013 for health workers in each county. No refresher trainings have been provided or were planned at the time of this evaluation. Training materials used by ISDP are aligned with World Health Organization (WHO) IMCI guidelines. In addition, the ISDP Child Health Advisor will be participating in the UNICEF-led process to adapt the WHO guidelines to the South Sudan context.

ISDP performance data for Under-Five Curative Consultations shows an increase in consultations per child from 2013 and then a leveling off towards the end of 2014, with similar trends for both states overall regardless of sex. These results, however, demonstrate that targets have not been met. See Annex 1 for achievement against target and Figure 3 for consultation by county. Similarly, the HPF MTE reports that the project has moderately exceeded its December 2014 milestone (as of September 2014) for fewer than five curative consultations, which has doubled (0.35 to 0.7 consultations to 0.73 to 1.38 per person per year).<sup>16</sup> In line with the ISDP performance data, HPF shows similar numbers for girls and boys.

When ISDP indicator data is reviewed at the county level (Figure 3 below), there are consistent 3<sup>rd</sup> Quarter spikes (reported by ISDP as due to EMF supplies being delivered in that quarter after delays in earlier quarters) and then a drop-off into the first quarter of 2015<sup>17</sup>. Staff turnover without retraining may be another reason for these inconsistencies (documented by ISDP). Interviews with ISDP staff suggested that the inconsistent reporting was also connected to the fact that there are currently two registers in use (MOH and IMCI specific). Often health workers only fill out the MOH register which is not well aligned with IMCI protocols or indicators.

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<sup>15</sup> Key informants in Mundri East did not cite child health or vaccinations as a project success

<sup>16</sup>HPF midterm report, page 18

<sup>17</sup> See Annex 5 for additional analysis on curative consultation indicators

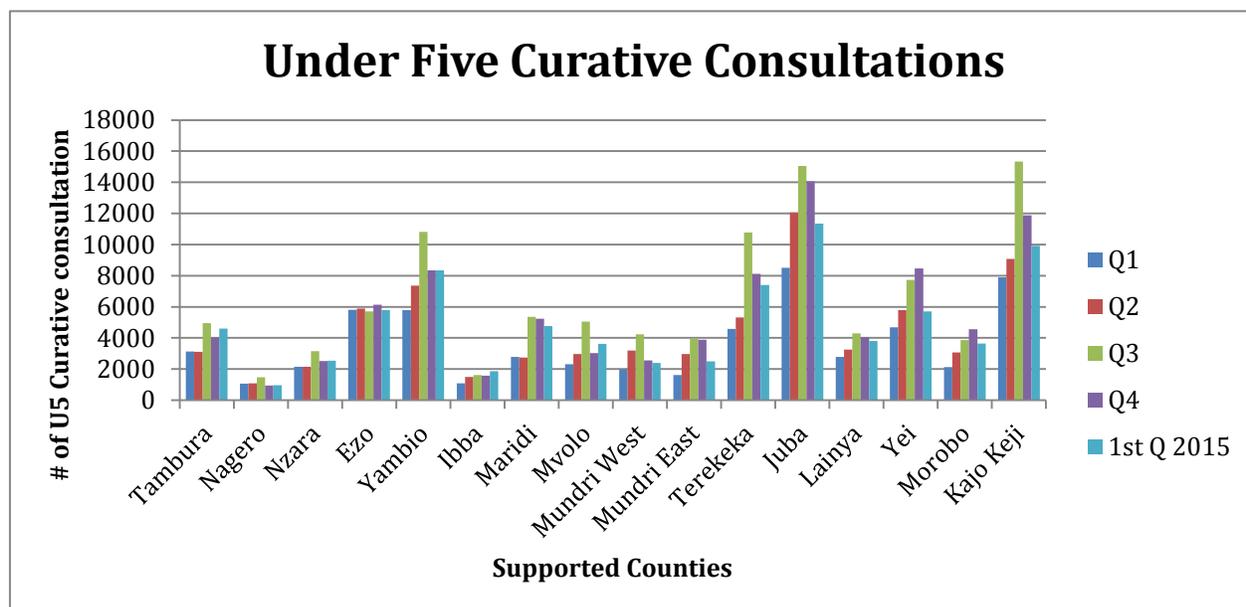


Figure 3: Under Five Curative Consultations

In addition to facility-based IMCI, ISDP is planning to roll out Integrated Community Case Management of Childhood Illnesses (ICCM) to enable services to reach children in more rural and harder to reach areas. At the time of this evaluation, ICCM had not been rolled out in any counties, but is planned to be piloted in Nzara and Nagero. Beyond these initial counties, ISDP plans to focus on counties where Population Services International has not trained or deployed Community Based Distributors (CBDs).<sup>18</sup> ISDP plans to use already engaged HHPs to carry out ICCM tasks as well.

Challenges in rolling out ICCM cited during interviews were concerns over the availability of commodities in enough quantities to provide full ICCM services at the community level. Currently, these are supplied through PSI (with Global Fund funding) but should ultimately be supplied through the CIPs (leveraged through the EMF) in each county where ICCM is rolling out.

While the ICCM strategy states that CBDs should be given only job related non-monetary incentives, all CBDs “should be given a package of key items (gum boots, t-shirt, umbrella, bar of soap, jerry can and a torch) as an incentive annually.” For activities where CBDs are asked to travel, “they should be given appropriate activity-related allowances.”<sup>19</sup> It was suggested during interviews that there was worry over CBDs being given salaries and HHPs being unhappy with their non-monetary incentives due to the comparison.

Based on documentation and interviews, it was not clear how closely aligned the roll out of ICCM is to the draft Strategic Plan for ICCM in South Sudan 2015-2021.<sup>20</sup> The draft Strategic Plan suggests that “key indicators to monitor and evaluate the ICCM program in South Sudan have been developed based on

<sup>18</sup> Strategic Plan for Implementation of Integrated Community Case Management of Childhood Illness in South Sudan, 2015-2021 - DRAFT

<sup>19</sup> Strategic Plan for Implementation of Integrated Community Case Management of Childhood Illness in South Sudan, 2015-2021 - DRAFT (pg 19)<sup>20</sup> Strategic Plan for Implementation of Integrated Community Case Management of Childhood illness in South Sudan, 2015 – 2021 -DRAFT

<sup>20</sup> Strategic Plan for Implementation of Integrated Community Case Management of Childhood illness in South Sudan, 2015 – 2021 -DRAFT

the global indicators for ICCM”.<sup>21</sup> At the time of this evaluation, there was no evidence that these indicators would be integrated as part of the ISDP Performance Management Plan (PMP).

### **Routine Vaccinations**

ISDP CIPs are also providing facility based routine vaccination services. Performance data on the number of children under one who received their third dose of the DPT3 shows an increase in coverage from 2013 to 2014, but still did not meet performance targets. (See Table I) When reviewed at the county level (See Figure 3) the majority of counties show plateaued data trends. In 2014, ISDP hired an EPI coordinator to better support the coordination of activities across counties and states as well as to provide more coverage for supportive supervision. Supportive supervision findings showed health workers knew how to maintain temperature charts for vaccine storage, how to use the shake test, and an overall improved management of vaccines; however, an interview with the coordinator suggested that current challenges in strengthening routine vaccination coverage still remain and are related to limited incentives for vaccinators (HHPs or those employed by the government), long travel due to the rural nature of South Sudan, lack of transportation support, and insecurity due to conflict.

An additional key issue cited was the poor quality of solar fridges for vaccines which often break down, disrupting the cold chain and significantly affecting the provision of routine vaccinations. The coordinator suggested a few recommendations based on these challenges, including:

- Finding support for maintaining the vaccine fridges outside of ISDP;
- Providing regular supportive supervision for vaccinators;
- Encouraging early and participatory micro planning for outreach; and
- Advocating for increased incentives, refreshments or other motivators for the vaccinators and community members to maximize community mobilization and coverage during outreach.

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<sup>21</sup> Strategic Plan for Implementation of Integrated Community Case Management of Childhood illness in South Sudan, 2015 – 2021 -DRAFT pg 26

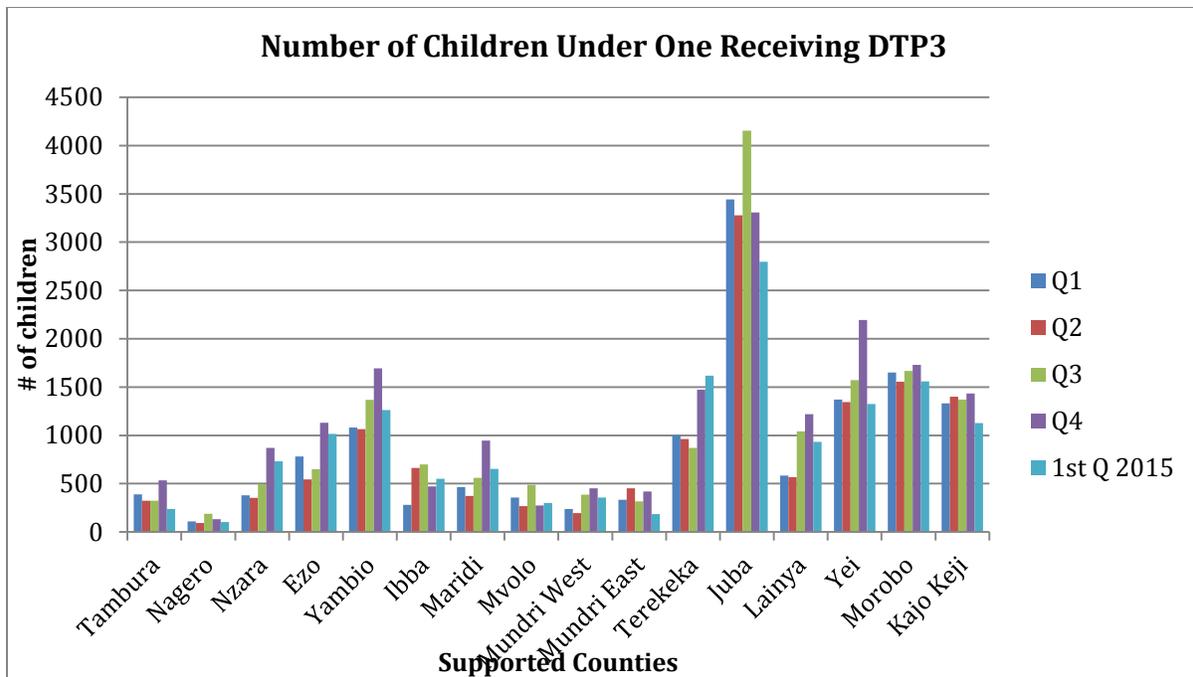


Figure 4: Number of Children under One Receiving DTP3

Annex 2 shows ISDP performance on all indicators across fiscal years, with the 2015 target pro-rated for two quarters of performance.

A few promising practices were also noted during site visits. In Kajo Keji County, local actors (CBO/FBOs) were engaged in defaulter tracing for vaccinations. In Mundri East County, mothers were given mosquito nets as incentives for bringing their child in for the final vaccination. Unfortunately, performance data viewed by county does not demonstrate an increase which might be attributed to these practices (as they may have recently introduced) and shows plateaued performance with a drop in the first quarter of 2015 with the exception of Terekeka County.<sup>22</sup>

Similar to ISDP, HPF performance data for DTP3 coverage shows steady improvement since HPF started service delivery, and the MTE report suggests that it will meet the project’s 2014 milestone, but performance has leveled off in the last two quarters suggesting that overall improvements will not be enough to ensure the end of project milestone will be reached.<sup>23</sup> The HFP MTE cited a number of challenges potentially linked to performance leveling off, including cold chain disruption, potentially incomplete data, limited outreach and community mobilization, poor maintenance, lack of knowledge of cold chain among health workers and conflict related issues.

## Conclusions

There have been moderate improvements in performance between 2013 and 2014, but performance has leveled off for both child health indicators. Evidence links this to cold chain disruption, a need to follow up with refresher trainings to fill-in skill gaps for documentation and prescriptions as well as increased support, motivation, and supervision for vaccinators. Data management and quality issues may be

<sup>22</sup> The team did not perform statistical significance testing for these data trends.

<sup>23</sup>HPF midterm report pg 23

partially attributed to documentation issues at the health worker/facility level, but findings indicate that this may be a larger issue.

ICCM has the potential to show dramatic improvements in curative consultations per child due to the rural nature of communities in South Sudan but has not yet been rolled out. Of the concerns raised, adequate drug supplies are important, as this could cause potential gaps in provision of services, for example, a situation where an HHP can only test but not provide treatment. Inclusion of appropriate indicators suggested in the strategic plan to measure successes of ICCM roll out are also a crucial step in showing how ICCM supports ISDP performance and improved health outcomes. Remuneration of HHPs is also a concern for appropriate roll out of ICCM.

A key element to improve both the routine vaccination coverage and rolling out of ICCM effectively will be related to the support from the project's community component. Micro improvements at the county level in both vaccination and curative consultations were attributed to community elements during county visits and further leveraging these strategically could be a way forward to ensuring continued improvements in performance and to facilitate reaching appropriate coverage levels.

## **Recommendations**

### **Short Term**

ISDP/CIPs should:

- Implement refresher training for health workers in IMCI and HMIS based on noted skill gaps (where indicated by SS) to ensure protocols are followed and documentation is improved.
- ISDP should complete its Strategic Plan for Implementation of Integrated Case Management of Childhood Illness in South Sudan, 2012-2015 by September 1, 2015.
- Start/continue roll out of ICCM in pilot counties by January 2016 and consider including a subset of the key indicators suggested in the ICCM strategy.
- Develop better catchment area maps where necessary to improve outreach site selection and planning of service delivery especially where populations are very rural. With improved maps, more targeted and better planned outreach by facility staff can be conducted to improve routine immunization reach.
- Capture DPT1 data, this is currently being collected as part of the MoH HMIS. This will help ISDP and USAID better understand vaccination issues on the demand side.
- Further document county level best practices and consider these practices in roll out of technical training and supervision to VHCs and CMTs.

### **Long Term**

USAID should provide leadership in coordinating at a national level with the key actors to ensure a harmonized approach in addressing issues with MOH data collection formats including key IMCI protocols and indicators.

ISDP should engage further with the ICCM TWG on ICCM rollout and best practices, especially in determining a way forward for the use of ICCM that addresses the large challenges of commodity supply and harmonized remuneration/incentive packages for HHPs/CBDs.

ISDP with support from other USAID partners should ensure cold chain issues (repairing fridges in particular) and improve coordination on outreach campaigns.

## Maternal Health Service Delivery

### Findings

To improve and standardize maternal health service delivery, ISDP provides training to facility staff in service provision as well as training to community health workers in promotion and referral. Key services supported by ISDP are ANC and facility deliveries by skilled birth attendants.

As demonstrated below, there has been limited improvement in performance against indicators related to these services across quarters. ISDP project reports indicate that there has been an increase in quality as a result of training and consistent supportive supervision, use of uterotonics as part of AMTSL, and equipping primary health care centers (PHCC) with midwives. This is mirrored in the team's findings from field work, where eight out of nine counties visited cited as a project success improved quality of maternal health services (ANC and delivery services) through training provided to skilled birth attendants (SBAs), midwives and other unskilled birth attendants.

### Antenatal Care Services

At all 15 facilities visited, ANC services were being provided, but cited a lack of adequate staff (availability and appropriately trained). ISDP has attempted to integrate ANC into outreach services to mitigate some of these challenges. Noted successes during field visits and interviews were the use of HHPs for counseling and referrals, including defaulter tracing for ANC; and HHPs going with women to facilities for services instead of just referring them to go on their own. In KajoKeji County, the team found evidence of the Community Action Cycle being used to support increased use of ANC, with HHPs gathering data and sharing this information with VHCs to engage in action planning.

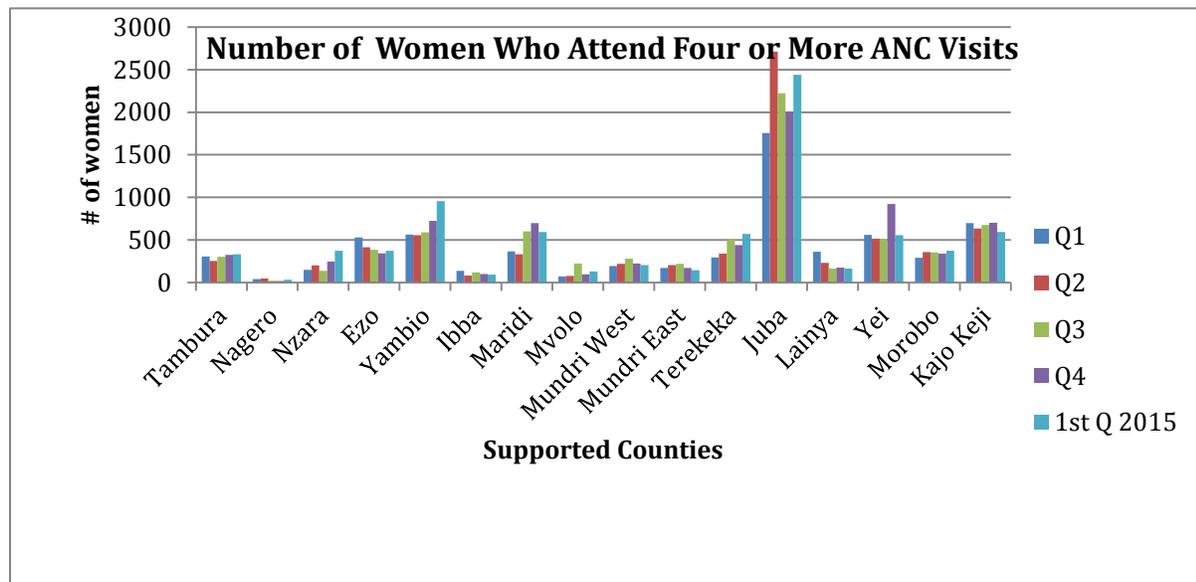


Figure 5: Number of Women Who Attend Four or More ANC visits

Overall, ISDP performance data for women attending four or more ANC visits shows a flat trend from 2013 into Q1 2015, with a dip in December 2013 due to the outbreak of violence, but followed by an

increase up to previous performance levels. On average, ANC4 attendance was higher in ISDP supported facilities when compared with data for all facilities (52.2 percent vs. 41.8 percent).<sup>24</sup>When looking at WES and CES individually, the trends remain the same. Looking at the most recent five quarters of data at the county level, shows nine counties trending relatively flat while five showing an overall increase and two showing decreases (see Figure 5 above). CES performance report states that slight increases in ANC for Q1 2015 in some counties can be attributed to HHP promotion and referrals for ANC in the community.

ISDP project data shows that on average of 41.8 percent of women who attend their first ANC visit drop-out before (or do not attend) their fourth visit. This holds true over the last five quarters of the project (see Figure 6 below) with minimal variation over project quarters. At the time of this evaluation, ISDP had not documented reasons for why ANC drop-out rate was so consistent across quarters and project years.

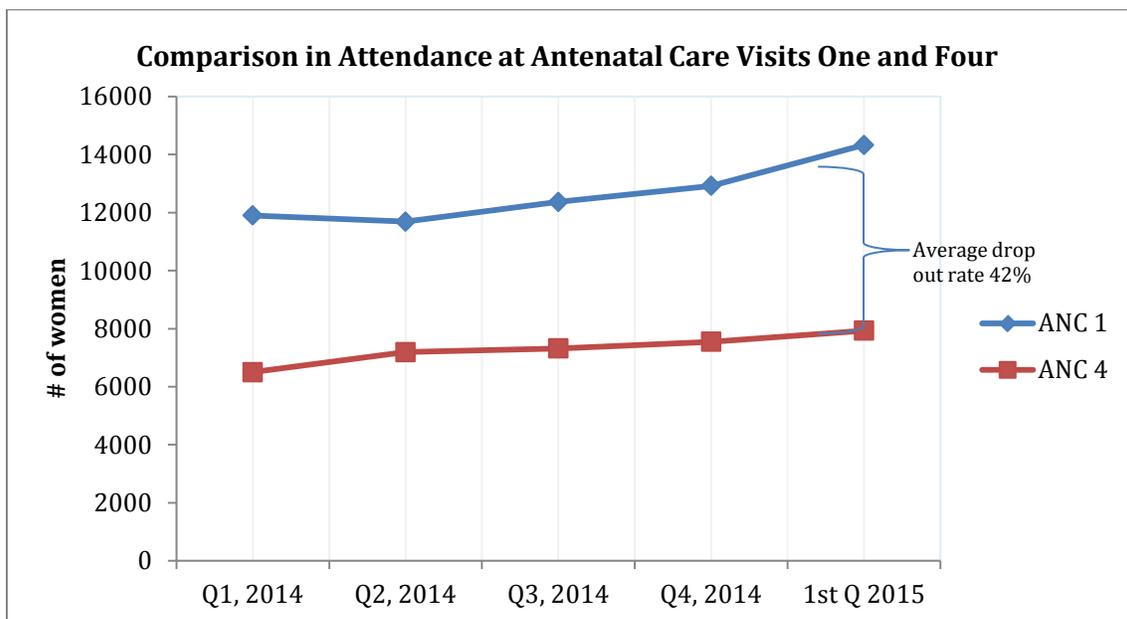


Figure 6: Comparison in Attendance at Antenatal Care Visits One and Four

### Deliveries with a Skilled Birth Attendant

In order to increase facility-based deliveries by skilled birth attendants, ISDP CIPs employ the majority of midwives (including community midwives) at facilities to ensure staffing levels are met.<sup>25</sup> Community midwives (CMW) are supported by the project but not recognized by the MOH as ‘skilled birth attendants’ (SBA) as they are considered to not have enough training. During Year One of the project, an additional indicator tracking deliveries by community midwives was reported by the project, but it is no longer included in the PMP. This data (including other information about deliveries in the facility catchment area) is captured at the facility level in MOH registers, but is not captured or reported on by ISDP or CIPs.

<sup>24</sup> ISDP reported data compared with DHIS data

<sup>25</sup> Further information was requested from ISDP on supported staff breakdowns by cadre and how their staffing support meets MOH guidelines – as of the submission of this report this additional information had not been received.

In addition, the project has provided training to midwives and SBA, including Basic Emergency Obstetric and Neonatal Care (BEmONC) training in both states for a total of 117 service providers and supervisors. Due to budget constraints initially planned Comprehensive Emergency Obstetric and Neonatal Care (CEmONC) needs assessments and training was postponed. Current plans are to conduct site assessments at Kajo Keji and Tambura Hospitals and develop a strategy for moving forward. Based on assessments and strategies, plans will include training doctors, aneshetists, midwives, and nurses from these two hospitals (as well as some staff from Yambio and Maridi hospitals). That said, ISDP does not currently provide support to secondary health care. The project has also engaged in community efforts through HHPs and VHCs to increase communitiy awareness of the importance of delivery at a facility with a skilled birth attendent. The project has also started the roll out of a community based model for the distribution and use of misoprostol to prevent post-partum hemmorage (PPH) for women who cannot get to a facility for delivery.

Despite these efforts, ISDP performance data indicated deliveries in facilities by SBA were low and the trend remained flat from 2013 through 2014<sup>26</sup> (when looking at aggregate project performance data) with an expected dip in December 2013 due to the outbreak of violence. However, a small increase back up to previous performance levels occurred after stabilization.

When reviewing data by county (Figure 7), a few counties (Yambio, Nzara and Morobo) showed continued increases in numbers of deliveries over the last five quarters. The team noted this during field visits in Nzara County and at Nzara PHCC; the team observed (confirmed during interviews and focus group discussions) that there had been significant improvements in the facilities' ability to provide quality delivery services, including some necessary renovations (increasing the beds available), staffing up with more clinical officers, and strengthened HHP outreach. Facility staff attributed an increase in the number of deliveries from two to twenty per month to the noted facility improvements.

Issues remain, however, and interviews with ISDP staff confirm that staff turnover since the intial BEmONC training have left many facilities without appropriatly trained staff. Catch-up trainings are planned for Year Four to fill gaps, but have not yet been conducted.

Additional barriers centered around logistical or transportation issues and infrastructure limitations: it was noted during site visits that logistical complications seemed to be exacerbated by cultural habits making it more difficult to persuade women to come to facilities for delivery. More specifically, in one example, midwives stated that one woman who lived directly opposite the facility delivered at home instead of coming to the facility.

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<sup>26</sup>Performance data for the HFP states shows a similar trend for this indicator from 2013-2014.

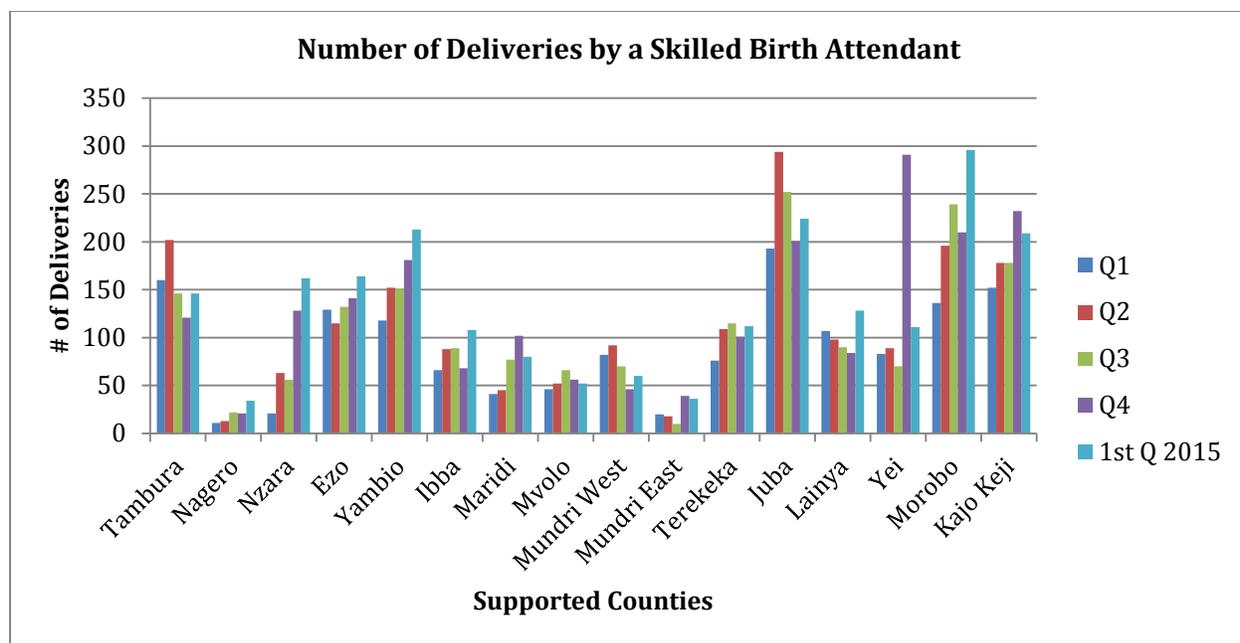


Figure 7: Number of Deliveries by a Skilled Birth Attendant

Infrastructure limitations were cited in all nine counties visited and a quick check by the evaluation team of a few key SBM-R infection control items indicated that no facility visited (out of 15) had a functional clean water source. Other infrastructure challenges noted during field visits were limited electricity (facility staff said they had to use mobile phone flash lights during deliveries in some cases) and non-functioning incinerators (all health facilities visited in Kajo Keji, Laniya and Ezo counties).

In an attempt to mitigate barriers to accessing services, some CIPs have been able to leverage additional support from other actors outside ISDP. In Ezo County, for example, the CIP coordinated with a local faith-based organization (FBO), the Camboni Sisters, to provide a motorbike ambulance to reduce the transportation barrier and improve referrals. Other CIPs leveraged outside or even community support to upgrade or construct needed maternity wards, and in all PHCCs visited, delivery rooms were well set up and had SBA to staff them.

### Scale up of community-based post-partum hemorrhage prevention activities

Post-partum hemorrhage (PPH) is considered to be one of the leading causes of maternal death in South Sudan. Prevention of PPH is crucial to reducing maternal death. Moreover, while facility deliveries have the benefit of uterotonics, where necessary, and skilled birth attendants based in the facility, the majority of women in South Sudan still deliver at home where they have no access to uterotonics, a key preventative tool for PPH or SBA. Community-based PPH prevention activities were not part of the original ISDP SOW, but these activities were incorporated into the project's 2014 work plan.

MCHIP is using its standard PPH prevention community based model adapted for South Sudan, which includes standard training modules, identification of focal persons and community mapping exercises. This was all done during the 2013 learning phase, which took place in Mundri East and was documented in an article published in the International Journal of Gynecology and Obstetrics. During the learning phase, out of 927 women with a reported birth, 787 were identified and counseled during pregnancy. All 787 accepted advance distribution of misoprostol at 32 weeks. Most women received their counseling and misoprostol from a HHP and more than half (57.5 percent) of these women then delivered at home. Among the women who delivered at a facility, 86.8 percent received an uterotonic

for PPH prevention. Among women who delivered at home, 98.9 percent took misoprostol. The study concluded (after a review of seven programs for PPH prevention) that the highest distribution and coverage rates are achieved by advance distribution late in pregnancy by a community agent during home visits for self-administration.

In 2014, the PPH prevention services were rolled out to communities in Mundri East and Mvolo Counties by HHPs trained by ISDP. The HHPs counseled women and their families and gave misoprostol to pregnant women after 32 weeks for self-administration. In November 2014, ISDP conducted a training of trainers (TOT) for new counties. Additionally, new HHPs were hired in Mundri East and Mvolo to fill gaps and increase activity coverage.

ISDP performance data indicates that the percentage of women receiving an uterotonic immediately after birth (this includes both facility and community deliveries) has held steady over project years up to the end of 2014. When comparing 2014 data with first quarter 2015 data in WES (where the community-based pilot was active in two counties in 2014), there was a spike in the use of uterotonics from about 1000/qtr to about 5000/qtr. Across the project, facility births have held steadily at low levels, with most births still taking place at home, but project data to support any conclusions based on this data is limited.

## **Conclusions**

While supportive supervision assessments point to improved quality, performance data for SBA and ANC 4 (as well as the ANC dropout rate) show limited or no improvement over project years. While small improvements can be attributed to community level demand creation and facility level improvements in staffing and infrastructure, significant barriers still exist in all of these areas. Key gaps still remain:

- Training and continuous professional development of CMWs and SBAs are needed. The majority of staff in these cadres does not have enough experience in real-life practicums of emergency deliveries. Such skills need to be practiced and also refreshed regularly.
- Overall, there are a limited number of women accessing these key services at facilities; the BCC strategy has only been successful on a micro level (with some CIP best practices or anecdotes).

Increasing the use and availability of uterotonics is an important step in preventing PPH, while the data from the learning phase is promising, current project data is limited.

## **Recommendations**

### **Short Term**

ISDP should continue:

- Training and expanding PPH community coverage using the MCHIP model.
- Use of HHPs and VHCs for counseling, referrals and defaulter tracing for ANC and delivery with a skilled birth attendant.

ISDP should conduct

- Refresher trainings and continuous professional development for skills gaps identified in SS; mentoring by more experienced staff; brainstorming ways to provide more practicum

- experiences for SBA and CMW<sup>27</sup>; and
- Use of facility staff for outreach – especially for ANC services – to increase service access for women by bringing services to them.
- USAID/ISDP should consider capturing first and second ANC visits (as is common in emergency settings) or other variations, to increase the nuanced data available for decision-making to help improve project implementation and performance.
- ISDP should capture and report additional data on deliveries (as in Year One) – skilled and unskilled including community (Traditional Birth Attendants) deliveries – which is being collected at the facility level already; and
- ISDP should encourage CIPs to do facility level analysis with this data to better understand micro-level trends and where best practices are emerging. This would be especially crucial for counties that are beginning their community-based PPH prevention activities.

### **Long Term**

USAID should coordinate with other development partners and government to:

- Look at more innovative ways of providing practicum experience to ensure delivery skills are maintained, e.g. placement of ISDP staff in hospitals or cross-state placements (e.g. to Nimule or Yambio hospitals which have higher numbers of deliveries) and may also want to consider support to pre-service institutions to fill in additional skills gaps.
- Continue to support PPH community based provision of miso beyond CES and WES using MCHIP model.<sup>28</sup>
- In considering future procurements, USAID should use collected data from HMIS (as outlined above) to identify and target key issues in getting women to use facility based services. In this vein, USAID should consider a dedicated BBC mechanism through a specialized technical partner.

## **Gender Equity as it relates to ISDP performance**

### **Findings**

The ISDP cooperative agreement speaks to the gender inequities in health and suggests that ISDP will use the USAID South Sudan 2010 Gender Assessment as a guide in project design and planning to promote gender equity and reduce barriers to service utilization. At the time of the evaluation, ISDP did not have a Gender Inclusion Strategy and admitted that the project struggles to adequately capture gender issues beyond disaggregation of person-focused indicators.

Through field visits and interviews, the team found that most facilities employ a majority of women, though men occupy the most senior positions. Out of the nine visited counties, only two of the CIPs had female program managers and these managers were all expatriates.

Other issues noted above have to do with unintended consequences of FP service provision, for example, at Lanyi PHCC (Mundri East County), it was noted during a focus group discussion that more women were interested in using DepoProvera (a long acting method) in order to avoid issues with their husbands. It was also noted during interviews at this PHCC that many men were taking condoms for use

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<sup>27</sup> As noted in findings, ISDP is considering ‘catch-up’ trainings for BEmONC for next year’s work plan.

<sup>28</sup> This is currently ongoing and ISDP has been instrumental in supporting the training and rollout.

with their extramarital partners but not to use with their wives. At the Kangai PHCC (KajoKeji County) during a focus group discussion, a service provider had this to say; “a man would not let his wife seek services due to misperceptions about the safety of family planning”. In Tambura PHCC (Tambura County), there has been an increase in the number of women seeking services since last year (*Source: service providers and beneficiaries, verified with facility registers*). This is attributed to steady sensitization activities by the VHC members. It was noted that the VHC members targeted men in these sensitization activities in order to educate and mitigate the prevalence of husbands not giving consent for their wives to seek services.

At the community level, HHPs and midwives were predominantly women, which fit with the projects focus on women’s health issues (child health as well is usually the sphere of women) and cultural dynamics which would make it very difficult for male HHPs or midwives to provide services to women. The 2015-2021 ICCM strategic plan suggests that “When possible, women should be selected as CBDs<sup>29</sup>. Implementation experience and operational research have shown that men are more likely to have other work outside of the home or to move away from the village . . . Additionally, mothers, who are the traditional caregivers of children, feel more comfortable going to the home of a female CBD and female CBDs have more experience providing care to children.”<sup>30</sup>That being said, there are still reasons to engage male HHPs and a few CIPs have done this. American Refugee Committee (ARC) in KajoKeji County is one example, and they have used the male HHPs to hold separate discussion groups for men related to the importance of family planning and ANC visits. It was suggested that this has improved service uptake for these areas, but performance data does not corroborate this statement (Figures 2 and 5).In Mundri East, the team noted that all the HHPs currently trained were women, but it became clear during focus group discussions that men were interested in becoming HHPs and have realized the benefit of the work. There is hope that in a future round of training these interested men could be engaged. One significant challenge, however, when recruiting more male HHPs is they are more likely to demand salaries instead of incentives, putting pressure on limited resources.

## **Conclusions**

ISDP has not documented gender differential participation or impacts on beneficiaries in its performance reports beyond sex-disaggregated data.

At the community level, ISDP CIPs have followed general best practices of recruiting mostly female HHPs where the focus is on maternal and child health. But the usefulness of male community agents to engage in particular community education issues and sensitization for men cannot be ignored. More evidence is needed to understand how to balance these two elements. Nevertheless it would be important to recruit both men and women HHPs.

## **Recommendations**

### **Short Term**

ISDP/CIPs should gather and analyze data related to gender differential participation or impacts. As part

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<sup>29</sup> CBDs are similar to HHPs in that they both provide community based counseling, referrals and services.

<sup>30</sup> Strategic Plan for Implementation of Integrated Community Case Management of Childhood illness in South Sudan, 2015 – 2021 -DRAFT

of this effort, ISDP should document the use of male HHPs to better understand the pros and cons, and determine if this should be something considered by all CIPs.

ISDP/CIPs should look for opportunities to provide additional support to current staffing (for example, HSSP L&M training, in-service technical training) and consider promotion from within to ensure that female staffs have equal opportunities for upward movement.

There is need to encourage recruitment of both qualified or junior female staff that will be mentored and coached to take up managerial positions at facility or program level. The intention is to groom more females at decision making levels who can influence better policies to support maternal child care.

Need for readily available ambulance for transporting emergency cases which cannot be handled in the PHCC or those mothers far from the PHCC/U so that they can be able to reach the facility for safe delivery

There is also need to provide means of transport like Bicycles to the HHPs to facilitate their movement in areas which are far away to reach with services to mothers and children in need

### **Long Term**

ISDP should comply with ADS 205 and create a Gender Inclusion Strategy which supports its integration, documents and plans measurement of gender differential access, and benefits to beneficiaries (including health facility staff and clients of PHCCs and PHCUs).

USAID should work with other key actors to ensure harmonization of HHP remuneration packages across South Sudan.

Evaluation Question #2: How relevant is the project's work to both short and long-term development needs of health services delivery in South Sudan?

In answering this question, the ISDP theory of change was examined in light of whether it addressed South Sudan's health services delivery needs. Findings and conclusions compare development needs with ISDP initiatives, highlighting those covered by ISDP and those not addressed by ISDP. Also examined, is the continued reliance on planning assumptions and ISDP's flexibility in responding to changing health service delivery needs.

The analysis undertaken below demonstrates where ISDP has been implementing activities to address basic development needs related to the areas highlighted in the assumptions and what performance has looked like. Gaps are also identified with recommendations provided.<sup>31</sup>

### **Findings**

The original Cooperative Agreement Program Description lays out a set of five key assumptions; four of these are taken directly from the previous project, Sudan Health Transformation Project II (SHTP II), where they did not hold true over that projects' life. The fifth key assumption was added by ISDP (see

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<sup>31</sup> Additional gaps are noted under Question four as part of the disadvantages of the ISDP model

text box below). All of these assumptions are caveated with this statement from ISDP which “recognizes that these assumptions, also critical to ISDP success, may once again not be met during the project due to external factors beyond the project’s control. Where these external factors represent challenges to project operations, MCHIP is fully committed to working closely with the GRSS and with USAID as necessary to creatively brainstorm solutions.”<sup>32</sup>

#### Original Design Assumptions:

1. Sufficient numbers of qualified national staff available to staff primary care facilities (e.g., certified community midwives) and HHPs trained and placed in the field in most counties
2. All commodities, including drugs, contraceptives and vaccines, consistently available through the MOH/GRSS commodity logistics system
3. Primary care facilities to be supported by the project need only minor repairs; infrastructure budget can be safely held to a minimum
4. Primary care facilities have clean water supplies and functioning sanitation infrastructure in place, including on-site hand washing facilities, latrines and proper arrangements for disposing of medical waste
5. Over the life of the project, the MOH will be able to transition staff paid by CIPs to MOH payroll.

### **Assumptions One and Five - Staffing**

ISDP addresses the short term needs related to staffing in terms of ensuring adequate numbers of staff at facilities based on the MOH staffing requirements, with CIPs paying salaries for facility employees and providing non-monetary incentives to community health workers (HHPs); each county covers a different percentage of staff salaries, this takes up about 40–70 percent of CIP budgets, depending on the level of salary support needed for each county.<sup>33</sup>

A different mix of cadres is covered by CIPs in each county and each facility as the goal was to fill gaps where they were evident.<sup>34</sup> This leaves the majority of SBAs on the CIP payroll which causes tension between CIP and MOH paid employees. Examples of tensions include MOH employees refusing to be supervised by CIP paid employees and MOH employees turning up for work late or not at all. In facilities that are solely staffed by MOH paid employees, facilities were sometimes closed as a result of staff absenteeism.<sup>35</sup>

While the MOH pays staff according to the MOH civil service salary scale, NGOs, on the other hand, are supposed to pay according to the NGO Harmonized Salary scale, not equivalent. According to ISDP,

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<sup>32</sup> Associate cooperative Agreement No AID-668-LA-12-00003, pg 19-20

<sup>33</sup> ISDP annual report 2014

<sup>34</sup> More specific information on staffing breakdown was requested from ISDP, but as of the drafting of this report the information had not been provided.

<sup>35</sup> From field work – Mundri site visit<sup>36</sup> South Sudan WASH cluster Mapping of WASH support actors, Accessed at: [http://reliefweb.int/sites/reliefweb.int/files/resources/wash\\_partners\\_may10\\_2015.pdf](http://reliefweb.int/sites/reliefweb.int/files/resources/wash_partners_may10_2015.pdf)

not all of their CIPs use this scale and some pay in USD instead of SSP, which causes some staff to seek employment with non-complying CIPs or other NGOs instead of the MOH or complying NGOs in order to be paid higher salaries.

ISDP has been rolling out standard packages of training, pre-determined during the initial phases of the project. Noted gaps still exist in qualified providers for the key service areas discussed within Question One (Family Planning, Child Health and Maternal Health) with the larger gaps noted for family planning and maternal health. In six out of nine counties visited, ISDP/CIP provided training was found effective with the caveat that training had only been provided at the beginning and was not ongoing. Challenges cited with this training model were staff turnover, the need for refresher trainings to fill skills gaps (indicated as a need for the three key service areas discussed in Question One), and ensuring new staff is adequately trained (four out of nine counties cited this specifically as a need).

ISDP supports identification and training of HHPs at the community level as well as VHCs at the Boma level. A limited number of CMTs have been engaged at the Payam level. Together, these actors make up the Community Action Cycle which is the central element of the project's community component. The community component will be discussed in more detail under Question Four.

Quality Assurance is also a critical element of ensuring that quality staff is available at the community and facility level in both the long and short term. ISDP has worked closely with the MOH to develop and roll out an improved set of standards (Standards-Based Management and Recognition – SBM-R); SBM-R has been endorsed by the MOH, and ISDP has rolled out a first module for Infection Control in all 16 counties supported by the project. The ISDP QI model is discussed in further detail under Question Four.

Additionally, another long term needs of the South Sudan health system will be the transition of staff to the MOH payroll. Phase Three, in the original project description, is described as a phased transition of health workers from the CIP to MOH payroll. While the MOH has put in place structures — such as the HRIS to map human resources across counties and the Infection Allowance to bring salaries of health care workers to match the NGO Harmonized Salary Scale — interviews and the PEST analysis conducted as part of the Health Learning Assessment, suggest that this transition will not be possible in the near future due to a number of outside factors. Interviews with ISDP and USAID suggest that the current funding envelop for ISDP will not cover the planned project period; this is attributed to the continued coverage of salaries into Phase Three. The MCHIP/ISDP Program Description states that it is committed to “brainstorming creative solutions” with its partners, but at the time of this evaluation, there was no evidence of any strategic contingency planning if this transition of salaries in not feasible.

A final long term health sector need is pre-service training to train new staff or significantly upgrade current cadres to meet needs. In the long term, this support will be needed to fill staffing gaps. This is outside of the ISDP original task order and current work plan.

### **Assumption Two: Commodities**

Short term needs in this area are related to limitations on space at CHD and facilities for drug storage and also challenges with the breakdown of the supply and cold chain (issues cited in Q1).

Best practice suggests that commodities should be transported to facilities during routine supervision which ISDP does jointly with the CHD. Currently, ISDP CIPs provide transport of drugs from the CHD to facilities. This places a logistical burden on the CIPs already limited budgets, especially when stock outs occur and drugs need to be transported between facilities outside of supervisory visits. Currently,

there is no systematic way for CIPs to review usage of commodities against disease burden, which limits the ability for facilities to plan ahead or ensure commodities are available when needed.

In the medium and long term, there are major drug shortages forecasted for the end of 2015 and a need for PSM support at lower levels, such as support for establishing a pull system between the CHD and facilities, improved storage, and cold chain for commodities. These tasks, however, are all outside of the ISDP current work plan and original task order.

### ***Assumptions Three and Four: Infrastructure and WASH***

Short terms needs in this area include renovations and upgrades to facilities so that they can deliver the full package of quality services outlined in the BPHS. It is within the mandate of ISDP to provide support in identifying needs (within facilities and with VHCs) as well as to provide funds for selected minor renovation projects. Through the Community Action Cycle it is assumed that renovation needs would be prioritized, but at the CIP and ISDP levels, there is no evidence of such prioritization.

As part of these minor renovations, ISDP has supported rehabilitation of WASH infrastructure at facilities, but is not mandated to put this type of infrastructure in place (other actors should be digging boreholes and putting in water pumps as well as providing for maintenance of these structures). Based on the current South Sudan WASH Cluster mapping (which indicates the number of WASH actors working in each county), WASH actors do not seem to be engaged in any of the ISDP supported counties in WES. In CES, there is limited support for a few counties (with the exception of Juba which shows seven to nine actors operating). This may only mean, however, that WASH support is fragmented and not well documented.<sup>36</sup>

Access to clean water was cited as an issue at all sites visited by the team. With the risk of cholera, access to clean water is a critical issue. Field observations show that when boreholes break down the repair process took an extended time as this was outside the scope of ISDP. In one location for example, the hand pump (also shared with the school) was broken for weeks. As a result, water was brought over from a distance every morning by the watchman.

Longer term needs, also beyond the initial scope and design of ISDP, are geared towards more intensive infrastructure support, including building entire facilities, new rooms (maternity wards), electricity supplies, and rehabilitated boreholes.

### **Conclusions**

As suggested in the original program description, the five key project assumptions have not held true thus far in the life of the ISDP project. Within the areas covered by the key project assumptions, there are both short and long term development needs across the health sector. ISDP is working to meet some of these directly (with a focus on short term needs with the exception of the support to QI), while relying on the support of other actors for certain interventions.

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<sup>36</sup> South Sudan WASH cluster Mapping of WASH support actors, Accessed at: [http://reliefweb.int/sites/reliefweb.int/files/resources/wash\\_partners\\_may10\\_2015.pdf](http://reliefweb.int/sites/reliefweb.int/files/resources/wash_partners_may10_2015.pdf)

- Assumptions about staffing were central to the original ISDP design, especially in-terms of the project's planned Phase three transitions, the continued dependency of the MOH on ISDP paid salaries limits the flexibility of the project in responding to technical needs. In addition, inequities in salaries at the facility level create tensions and motivation issues for health workers.
- Assumptions related to the availability of commodities place an additional burden on ISDP and limit their ability to ensure quality and standardized services across facilities.
- Unrealistic assumptions related to the degree infrastructure were already operational and in place has left a gap in quality of services provided and expectations due to the limited capacity.

At this stage, with both limited budget flexibility (due to the high percentage used for salaries) and limitations within the ISDP original design, the project was unable to be nimble enough to mitigate these faulty assumptions. In addition, reliance on other actors to fill those gaps has not been as successful as envisioned in the original design. This reliance on other actors is a key disadvantage of the ISDP model. Overall, these faulty assumptions have led to difficulties in meeting performance targets as well as overall project goals and objectives.

## **Recommendations**

### **Short Term**

. USAID and ISDP should conduct a strategic planning session to determine how to move forward during the remaining project years in terms of coverage of technical areas within the current budget constraints, prioritizing technical areas while still meeting continued salary needs. The strategic planning session should include consideration of whether to amend ISDP's scope to include basic WASH infrastructure items so as to maintain access to clean water.

### **Salaries**

USAID should continue paying salaries at the current level through ISDP, but should work with ISDP to ensure that all CIPs are adhering to standards and best practices.

USAID or its partners within the Health Pooled Fund 2 should conduct a mapping exercise in all South Sudan states to determine who is paying USD and SSP, including capturing any non-monetary compensation packages for VHC members and HHPs. Based on this information, USAID should set a policy statement of what implementing partners must do (e.g. stick to USD/SSP) in the current climate.

### **Training**

ISDP should consider follow up/refresher trainings based on SS findings, SBM-R assessments, or action plans which highlight identified needs or skill gaps.

At the community level, ISDP should use a cascade approach to training and supervision where feasible (CMTs to VHCs and HHPs) as this may provide some cost savings over the remaining life of the project.

### **Commodities**

ISDP/CIPs should continue to facilitate the transportation of commodities and supplies to PHCU/PHCCs but ensure coordination with monthly SS visits to reduce additional logistical or resource burden on the project.

ISDP/CIPs (in coordination with SIAPS) should review usage of commodities against disease burden to ensure the right commodities are transported; this will allow drugs to last longer in an environment

where supplies may run out.

USAID should coordinate with UNICEF/GAVI to provide further support for broken solar fridges.

### **Infrastructure (including WASH)**

ISDP, USAID, and USAID partners within the Health Pooled Fund 2 should prioritize infrastructure support so that major transportation bottlenecks in all States that prevent the poor and extremely vulnerable, especially in rural areas, from accessing the BPHS. As part of this recommendation

- ISDP should continue to work through VHCs – engaging them in upgrading facilities (action planning and leveraging support);
- ISDP should utilize CMTs (as they are rolled out) to consolidate community issues and prioritize at a Payam level;
- ISDP should continue to support CIPs in leveraging support of other actors where possible for additional support; and
- As a critical point, /ISDP should ensure functional water supply at every facility (especially at PHCCs) as this is an essential element of providing all other basic quality services. As necessary, USAID should consider expanding the scope ISDP during its remaining time to cover basic WASH infrastructure.

### **Long Term**

For any new design focused on service delivery, the following elements should be considered:

- Realistic assumptions should be considered at the start and periodically reassessed to ensure validity and feasibility of continued implementation.
- Training plans should include refresher trainings and follow up modules for needs identified during SS or other QA activities.

USAID should work with other donors to determine plans for supporting long term needs, areas for consideration would be:

- Feasibility of staff transfer to MOH due to the large impact on availability of funds for other work.
  - If staff transfer to the MOH is not feasible, stakeholders should consider the use of incentives to reduce the disparities between staff salaries and mitigate current motivation issues within facilities.
- A standard definition of SS should be agreed to by all stakeholders.
- Support to training institutions in terms of infrastructure capacity and technical capacity.
- Support for pharmaceutical supply chain management (PSM) at lower levels.
- Support for country-wide infrastructure initiatives which prioritize needs based on provisions of key services. Could be used to:
  - i. Meet B/CEmONC standards; and
  - ii. Address PSM issues.

Evaluation Question #3: How effectively has ISDP coordinated with the HSSP project activities and other South Sudan health stakeholders at the county and state levels to improve health services?

The response to this question examined the efficiency and effectiveness of ISDP's partnership strategy; especially in regards to its sister project, HSSP. The evaluation examined how ISDP has worked collaboratively in delivering initiatives where both projects have a mandate, as well as any gaps or duplication.

## **Findings**

The HSSP project is mandated to build the leadership/management at the county, community and facility levels. Similarly, ISDP supports a related set of actors by providing technical training to enhance service delivery. By design both projects have the mandate to:

- Support the CHD in SS to facilities.
- Support aspects of data collection and transmission.
- Support to HF staff and VHCs.

High level coordination between ISDP and HSSP takes place in the form of monthly meetings, but both parties have suggested that it was not clear if this is having a positive effect yet. Additionally, there is a joint training calendar between the two projects to ensure coordination of trainings and to reduce any duplication of effort.

### ***Interaction with the CHD and SMOH***

HSSP provides training and capacity building in leadership and management and also provides support for supervisory visits to facilities. ISDP CIPs share their work plans with the CHD and supports the CHD to provide supervision while focusing on the technical/medical supervision areas during joint visits. There are visitor's books at each PHCC which documents the purpose of visits and evidence of supervision. Findings from interviews suggest that CIPs often lead the supervisory visits on the technical areas where the CHD doesn't have expertise, but when the CHD doesn't participate, the CIP staff conducts the entire visit. HSSP provides support (vehicles, fuel) for the CHD to go on additional supervisory visits, but do not participate in the visits themselves.

Evaluation team findings suggest that while there is some overlap in support to the CHD which could be streamlined, in general, this support by both projects is really needed and appreciated by the CHD and facility staff. A key point here is that supervision is increasing and the CHD is more engaged.

HSSP has implemented a HUB model to bring HSSP technical advisors closer to the counties they support. The HUB model supports improved:<sup>37</sup>

- Communication support between the CHD and HSSP;
- Administrative support for planning activities and dissemination of information;
- Conflict resolution between the CHDs and other parties<sup>38</sup>;
- Reporting on drug stock-outs to the SMOH and CIPs;
- Communication among USAID partners: ISDP, HSSP, and SIAPS; and
- Provision of health systems strengthening programs in health finance, health governance and leadership and management, and health information.

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<sup>37</sup> Based on documents and interviews

<sup>38</sup>HUBs may be co-located with CIPs, but none are at the moment

ISDP performance reports and interviews indicate that Quarterly Review meetings (started by ISDP) in each state include the SMOH, CHD and CIPs; however, other service providers are not involved in these meetings— e.g. SAIPS HSSP. In addition, SMOH collaboration with ISDP is supported through regular program updates, joint supervision, state cluster meetings, CIP review meetings and taskforce meetings. Interviews with ISDP senior management suggested the co-location of CIPs with CHDs could enhance collaboration and mitigate any relationship challenges. ISDP also participates in technical working groups to support national level coordination.

### ***Interaction at facility and community levels***

At the facility and community levels, ISDP provides technical training at facilities and helps to identify and set up VHCs where they were not already functioning. HSSP, on the other hand, provides leadership and management training to facility management staff and VHCs. However, by projecting possible participant numbers, HSSP admits that they will not be able to train all VHC members in the program period.<sup>39</sup>

### ***Data Quality***

Both projects are responsible for data transmission and checks at various levels. HSSP is mandated to provide technical support for data transmission from the county upwards, including quality checks, while ISDP CIPs are responsible for actual data collection at facilities and reporting to the county.

In terms of data cleaning, HSSP has supported annual Data Cleaning Workshops in CES and WES led by the national MOH. ISDP CIPs have previously been invited to WES workshops but not in CES. The next round of state-wide data cleaning is in June/July 2015. HSSP also produces the HMIS bulletins. CIPs conduct data quality checks after HMIS reports are submitted at the facility level; checking between registers and reports (and ensuring correct MOH tools are being used). However, there is no formal procedure in place to ensure that data clean-up is harmonized, which may lead to discrepancies between the data reported by CHD and ISDP. As noted in Question One, during supportive supervision, concerns have been raised regarding staff's ability to accurately capture data related to services provided to clients at PHCCs and PHCUs.

In general, comparisons between ISDP reported and DHIS data at the county level were not useful in determining if data quality issues exist as ISDP only reports on the subset of facilities in each county supported by the project. However, as noted under Question One, there are concerns about data quality that impact its validity and reliability. This includes issues with data capture at the facility level by health workers (due to problems with reporting formats or limited training) as well as anomalies in reported data by ISDP, which shows inconsistencies in the continuum of care or discrepancies when compared to population projections. There is further discussion of these anomalies in the Performance Management section within Question Four.

### ***Supply Chain Support***

In addition to the discussion under Question Two about ISDP support for transporting commodities from the CHD to facilities, ISDP is also reporting drug stock-outs at the facility level while HSSP is mandated to report on drug stock-outs at the county level. There was no discussion of coordination

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<sup>39</sup>Interview Notes with HSSP

with Systems for Improved Access to Pharmaceuticals and Services (SIAPS) Program, which is the USAID-funded activity responsible for supply chain support.

### **Additional Collaboration**

There is no clear mechanism within the ISDP CIP model which supports coordination with other local actors, such as FBOs/CBOs and other implementing partner activities. However, a few examples of coordination and collaboration with actors outside of ISDP were documented, highlighting the potential to fill gaps in service delivery and improve service quality:

1. In Ezo County, support from a local FBO was useful in improving referrals to secondary facilities with motorbike ambulances.
2. In Ezo County, World Vision International was able to leverage additional funding to do construction at a PHCC where a new maternity ward was needed to provide services.
3. As of the first quarter of 2015 in CES, ISDP was prioritizing facilities for support from another USAID support UNOPs activity.

### **Conclusions**

Overall, there is significant overlap between ISDP and HSSP in terms of which actors the projects support in CES and WES, but as designed, there is limited duplication in terms of how this support is envisioned and what technical areas it covers. This is a significant strength in the design of the two projects and suggests a way forward for coordinating collaboration.

At this stage of implementation, however, there remain some areas of duplication (or potential duplication) as well as performance gaps, most notably:

- Support from HSSP and ISDP on data quality (transmission and cleaning) is not harmonized and significant anomalies and inconsistencies in reporting raise red flags,
- Gaps in support at the community level, for example, HSSP will not be able to support all VHCs in leadership and management training.
- Gaps are likely to be created if there is segmentation of responsibility on reporting drug stock-outs, but this is currently an activity that both projects are involved in (ISDP at the facility and both ISDP and HSSP at the CHD levels).

Positive examples of coordination and collaboration with other actors make it clear that there are some missed opportunities which could leverage outside resources, build community confidence in services, and improve performance.

### **Recommendations**

#### **Short Term**

- As part of ISDP Quarterly Meetings, HSSP and SIAPS should continue to participate to ensure improved coordination
- ISDP should continue to participate in HSSP joint planning to support building technical capacity for QA and management capacity for SS as well as ensuring that there are fewer missed opportunities and resources are maximized.
- ISDP should continue to notify HSSP of planned supervisory visits to CHDs to ensure coordination of supportive supervision tasks.

- ISDP should work with its CIPs; HSSP Hub managers, and USAID to implement co-location for CIPs and HSSP Hubs, and CHDs where feasible, at this stage of the project.
- ISDP collaborate with HSSP to resolve data quality issues
- USAID should require a full data quality assessment and any needed verification follow up to better understand facility level data issues.
- ISDP should continue to coordinate with SIAPS and EMF on all supply chain challenges
- ISDP should work with HSSP to create a plan for USAID’s approval to maximize the reach of current resources that both projects have left for the community component, including prioritizing the setup of CMTs and using these entities as a resource for training VHCs. HSSP and ISDP should consider pooling funding to cover VHC trainings under ISDP.
- HSSP should train CIPs (and VHCs) on proposal writing, ways to leverage funding, action planning, needs mapping as well as other potential areas of need which would be within the HSSP realm.<sup>40</sup>

### Long Term

USAID should emphasize in future designs:

- Support to CHDs to build SS teams (including management and technical focus) and consider embedded technical staff at CHD to lead supervision and create sustainability within the CHD for conducting supportive supervision visits.
- Joint work planning at the county level, including a mechanism to locate and leverage support from FBO/CBO local actors (as a further extension of learning that happens from short term recommendation above to conduct joint planning, mapping of actors, etc.).
- Mission level coordination with actors such as UNICEF who are providing support in particular counties in CES and WES to ensure strategic/coordinated roll-out.

Evaluation Question #4: What are the advantages and disadvantages of the ISDP current model and approach?

The response to this question looked at the project as a whole and then considers three major elements of the model (community activities, quality assurance and project performance management), looking at advantages and disadvantages in terms of performance and alignment. Disadvantages are noted in the main discussion of the model as well as described in a final section which brings in issues noted in findings and conclusions for earlier Questions.

The basic model was outlined during the 2011 Donor Harmonization workshop, which provided a platform for ensuring that ISDP was implemented using a harmonized approach with other donors and with the MOH’s Health Sector Development Plan 2012 – 2016 (HSDP). In line with this, the project’s overall focused on maternal and child health mirrors and supports the focus of the HSDP. The ISDP

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<sup>40</sup> This was previously agreed to by HSSP but at the time of the evaluation had not been organized or scheduled.

original project design indicates two results: (a) standardized service delivery and (b) a focus on the community. Two (out of three) objectives of the HSDP are to increase utilization and quality of standardized health services (with an emphasis on MCH), and to scale up health promotion and protection interventions so as to empower communities to take charge of their health.<sup>41</sup>

## ISDP Community Focus

### Findings

The alignment of ISDP to the HSDP is also highlighted in the community level focus. Additionally, this is clearly linked to the USAID/South Sudan Operational Framework, specifically TO 1.1: Facilitate community led response (see Figure 8).

**GOAL: Build the foundation for a more stable and socially cohesive South Sudan**

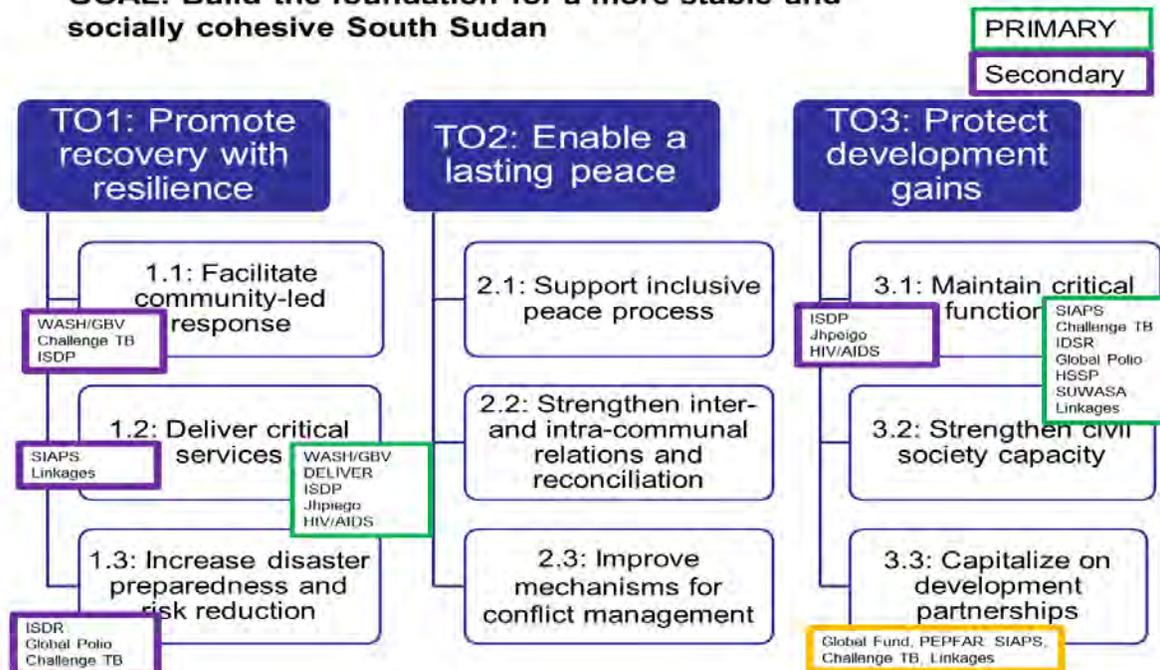
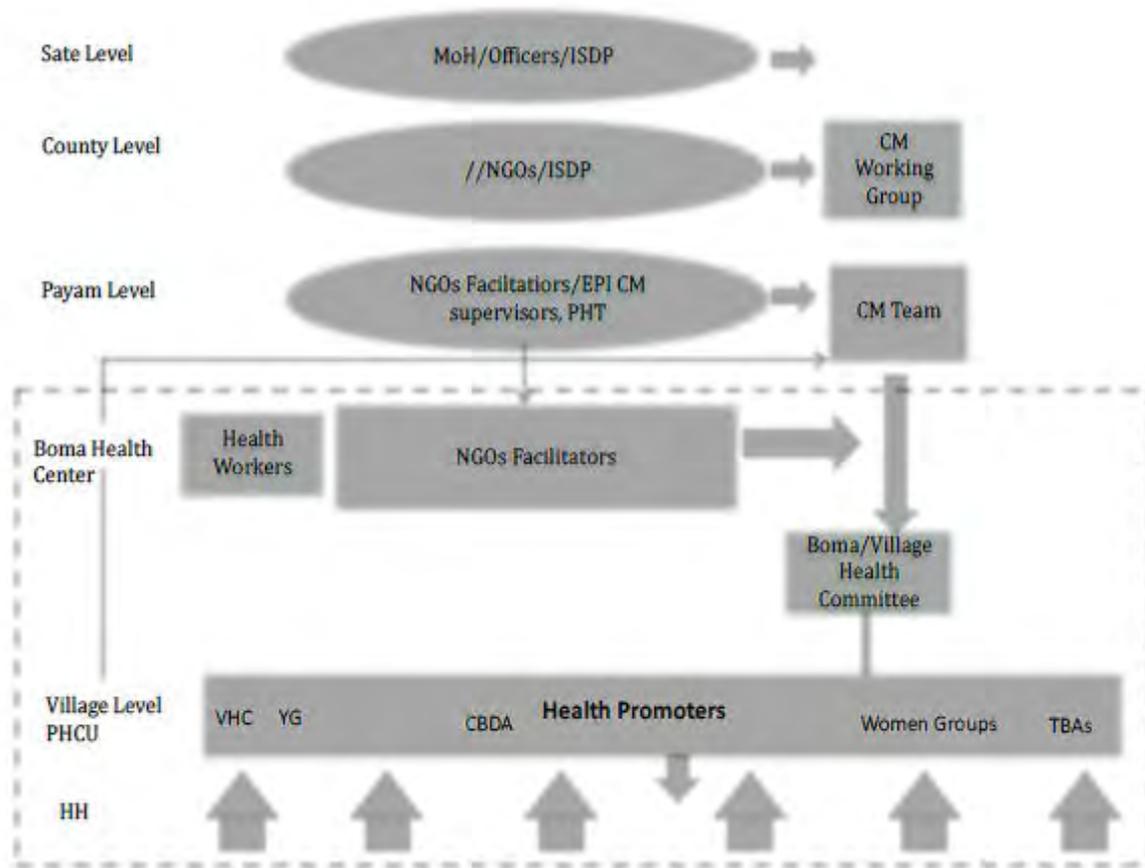


Figure 8: USAID South Sudan Operational Framework

To meet the community-focused objective of ISDP, the project has created training packages for key services, identified and conducted TOT, and cascaded trainings for HHPs. The project has identified and set up VHCs and trained these committees in identifying and assessing health issues in the community (hygiene, cleaning water sources, etc.). VHCs are also responsible for creating community action plans. ISDP reports that VHCs are functional in the majority of facilities.

<sup>41</sup> HSDP and ISDP cooperative agreements

A third layer of the community component is CMTs at the Payam level, per the following graphic.



CMTs are multi-sectoral teams which can roll out the community action cycle, a process which is intended to support community mobilization and prioritization of needs.<sup>42</sup> CMTs are also meant to support coordination with other local actors. There were a limited number of CMTs active at the time of the evaluation, but the evaluation team was able to speak with one active CMT in KajoKeji. The membership of this particular CMT was focused on representatives of local government and the CIP. The CMT members were able to state the key functions accurately during a meeting with the evaluation team, but there was no mention of coordination with other actors outside of ISDP structures or government institutions.

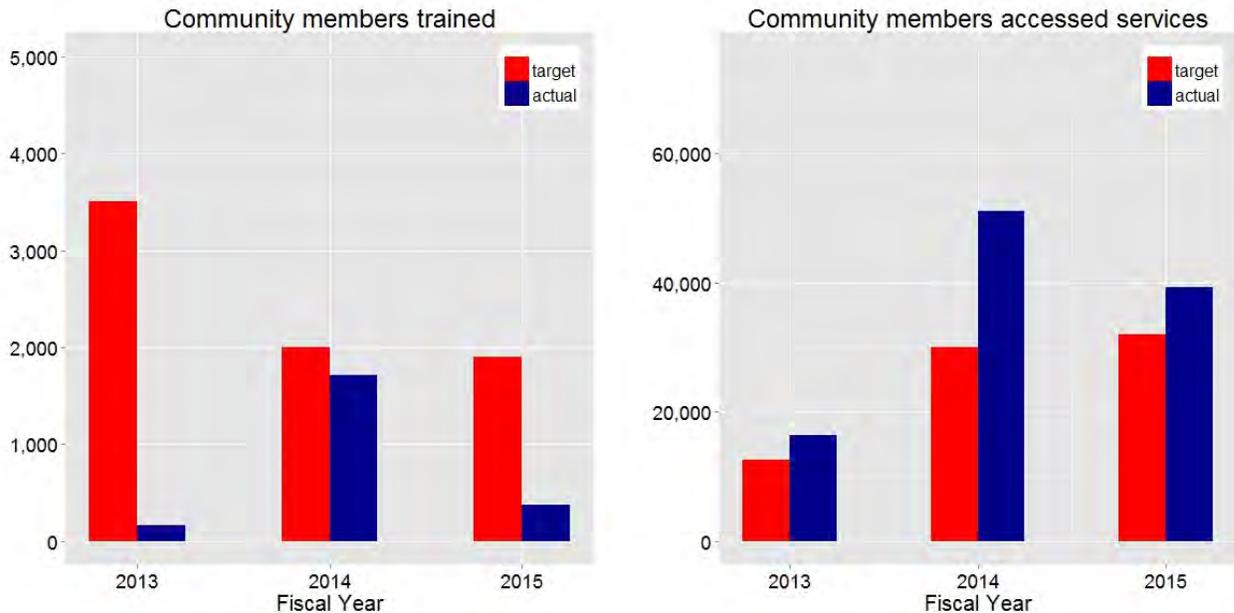
ISDP has recently hired a new Community Mobilization advisor to provide overall guidance. In addition, CIPs are using modified supervision checklists to monitor community activities, which include some integrated coaching and tools useful for continuous self-assessment aimed at VHCs and HHPs.

Information presented through Question One indicates the importance of the community model and ISDP/CIP community health actors. Notable positives are the use of VHCs to engage in community action planning as well as the mobilization and training of HHPs to provide education, referrals and

<sup>42</sup> ISDP Year I Annual Report, ISDP cooperative agreement

community based services. Gaps remain in the identification and set up of CMTs (needed to coordinate the community action cycle at the Payam level) and in demand creation for facility-based maternal and child health services.

Currently, ISDP only measures two indicators related to the community component, both are related to the training and work of HHPs.



While performance on community members trained is seriously lacking, performance on enabling citizens to access services far exceeds targets. While informative, these indicators do not capture information related to health outcomes or community-based services provided.

## Conclusions

ISDP has a strong emphasis on the community which is linked to the USAID/South Sudan Operational Framework through its use of HHPs to deliver community-level services and supporting links to facility services, and the use of VHCs and CMTs to facilitate community-led responses to health related challenges. The community component has not yet been delivered as designed, with only a few CMTs functioning, limiting the effectiveness of the Community Action Cycle process. While HHPs, VHCs and CMTs play a crucial role (according to the ISDP original Program Description) they are also outside of the government health system and this may pose a problem for sustainability when donor and NGO support is not available. This is a disadvantage of the community model.

ISDP does not capture enough data on the performance of community activities and how this links to the projects overall performance and support to reducing maternal mortality. Tracking the training and work of HHPs is important, but more from an accountability standpoint, rather than for understanding performance and results achieved with the community component. This is also an opportunity to collect and analyze more information related to gender differential participation and impacts at the community level.

## Recommendations

### Short Term

ISDP should consider how best to continue the roll out of the CMTs and scale up the Community Action Cycle. There are potential cost savings in tasking CMTs to support training and supervision of VHCs and HHPs. In addition, further cost savings may be realized through the use of CMTs in coordination with other local actors. This is also an opportunity to reinforce the sustainability of this model for the future and consider a handover plan or exit strategy for ISDP.

ISDP should further utilize the community component to better understand uptake and consistent use; HHPs can gather information and work with VHCs to develop better targeted plans. CMTs can support higher level issues and advocate.

ISDP should consider capturing additional data to better understand how the work at the community level contributes to the projects objectives. This could include indicators to track the functionality of VHCs (such as those indicators used by HFP) or more qualitative measures that look at beneficiary satisfaction with services or gender differential participation or impacts.

### Long Term

For any new service delivery project design, USAID should consider:

1. Continuing to support the Community Action Cycle, but ensuring buy in from the government CMT structure and the incorporation of lessons learned to utilize these structures to their fullest potential.
2. Use additional data suggested above to ensure community activities are designed in a way to maximize results and gender equity.

## Quality Assurance Model

### Findings

In addition to staffing and training, ensuring quality services is also part of ISDP's mandate. A clear gap in the MOH Quantified Supervisory Checklist (QSC) was that it did not cover quality of care. ISDP has led the introduction of a new quality improvement tool which has closed this gap, Standards-Based Management and Recognition (SBM-R), which has been endorsed and adopted for country-wide use.<sup>43</sup>

### ISDP supports for national level Quality Assurance Standards

Nationwide performance standards approved for use are:

- Infection prevention
- FANC
- Normal labor, post-partum care
- BEmONC

Updating service delivery guidelines with SBM-R standards

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<sup>43</sup> ISDP Year 2 Annual Report

Currently, ISDP has rolled out specific standards associated with infection control to all 16 counties,<sup>44</sup> an area that the MOH Health Facility Survey identified as a critical gap in PHCUs and PHCCs.<sup>45</sup> Currently, other modules are being finalized and considered for roll out.

ISDP CIPs have conducted SBM-R assessments for infection control in 45 facilities, developed action plans around the assessment findings and conducted SS to ensure that action plans are implemented. SS is conducted jointly with the CHD, but the technical areas are led by the CIP. The CHD is not involved in the SBM-R assessments. ISDP is working with MOH to determine reward and recognition models at the state level; it is also planned that CIPs will develop their own models for county level.

Based on a few selected infection controls, SBM-R standards, the team observed that only six out of fifteen facilities visited had functional incinerators to dispose of waste and only six had appropriate waste containers. All facilities visited had appropriate sanitation facilities. Infection control standards are an important step in improving quality of services and overall functioning of health facilities.

A key finding from ISDP performance reports is that most facilities assessed do not meet the current benchmark of achieving 80 percent or above of the SBM-R module standards. In light of this fact, ISDP is considering a review of modules to streamline more lengthy modules (ANC for example) or review requirements in terms of a milestone approach to reward progress and improvement rather than only rewarding meeting the 80 percent benchmark. In addition, the SMB-R tool requires a lot of training and would be difficult for the CHD to implement without ISDP technical assistance during assessments and supervision.

In addition to the SBM-R assessments, ISDP CIPs coordinate supportive supervision with the CHD. Findings from field work suggest that while there are increased and more consistent supervisory visits, there are still challenges to ensuring that supportive supervision has its intended effect of improving quality and standardization.

Specific issues cited were:

- Lack of technical capacity of CHD;
- Lack of clear definitions of what makes up supportive supervision;
- Limited understanding by the CHD and facility staff regarding the purpose of supportive supervision exercises; and
- Overlap/duplication of efforts with HSSP (discussed more fully under Question Three).

## **Conclusions**

The QA approaches used by ISDP are clear evidence of a focus on quality and standardization of service delivery across counties (and country wide by working at the national level to have guidelines updated and approved) and an improvement from the MOH QCS tool in terms of full coverage of service delivery elements. The buy-in from the MOH is an important step and will allow for standardization beyond ISDP states. The effectiveness of this approach will be hindered by the complicated nature of the current modules as well as discouraging facilities that are unable to reach the 80 percent benchmark from continuing to work towards manageable goals. Manageable milestones and rewards would allow facilities to stay motivated while still progressively improving performance.

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<sup>44</sup> HSSP Year Two Annual Report, USAID HSSP, 2014

<sup>45</sup> Rapid Health Facility Survey, MOH, 2013

## Recommendations

### Short Term

Continue support at the national and county/facility levels for development and roll out of standardized SBM-R modules and updated guidelines considering issues already encountered during initial roll out, such as: streamlining and designing mechanisms that reward facilities for improvement instead of setting the bar at 80 percent for recognition.

ISDP should be given the mandate to fix and maintain a functional hand washing stations and incinerators at health facilities as necessary to insure infection control standards are met.

### Long Term

In future procurements, USAID should consider MOH capacity to implement the QA approach without the current level of ISPD (and HSSP) support. It may be necessary to embed staff within the CHD to ensure that the approach is carried forward and that the appropriate technical expertise is available to conduct the assessments and follow-up.

USAID should coordinate with other development partners and governments to ensure there is standardized implementation of QA across the country (including a clear definition of what supportive supervision covers).

## Management and Performance Management

### Findings

#### County Implementing Partner Model

The ISDP CIP model was meant to provide simplified coordination at the county level and provide continuity from the SHPT II implementation. CIPs were carried over initially and then ISDP conducted a competitive bidding process to ensure poor performing CIPs were replaced. In addition, ISDP conducts annual performance reviews of partner performance, looking at targets set and results achieved, which includes representatives from ISDP, the CHD, and SMOH. This feeds into decisions to keep or replace partners based on consistent performance. When low performance is identified, partners are given time to show improvement, but if this does not happen in a timely fashion, a competitive process is

undertaken to find a new partner for the county. Factors considered in selecting a new partner, include: past performance (if already an ISDP partner), experience with primary health service delivery and existing or recent activities within the appropriate state. It was suggested in interviews with ISDP, CIPs and the MOH that a key weakness of this model is its inability to effectively pair CIPs and CHDs in terms of capacity needs. An additional weakness is that the

Selected Infection Control Standards	Yes	No	Total
Facilities with clean water source	0	15	15
Facilities with fully functioning hand washing stations	8	7	15
Facilities with appropriate waste containers	6	9	15
Facilities with appropriate sanitation	15	0	15
Facilities with incinerators	6	9	15

Figure 9: Selected Infection Control Standards

contracting mechanism used by ISDP to subcontract with CIPs only allows for limited control over staffing policies and management.

At the time of this evaluation, a number of new partners had taken over activities in counties as recently as March 2015. Based on interviews, documentation and other field work, it was understood that each CIP and county has its own unique circumstances and particular strengths and weaknesses. As a result, it was not possible to attribute specific performance issues to CIP characteristics. Instead, the team found that CIPs who were the most successful in terms of performance results for various implementation areas were those which found unique or outside the box solutions to performance challenges.

### **Performance Management**

The ISDP PMP includes a mix of indicators that matches the project’s activity mix (PHC, HSS and Community), but overall (as mentioned above), the set of indicators for the community component is limited.

There are inconsistencies and anomalies with reporting of targets and results for certain indicators, such as:

Indicator	Recommendation
Percent curative consultations for children under five.	Consultations should be measured as a rate, the number of visits per child per year which suggests that reported figures should be .35 or .7 consultations per person per year (as reported by HPF). The ISDP PMP records results as 55.06 percent and 62.8 percent for years one and two, respectively.
DPT3 vaccination	The ISDP PMP includes indicators that capture both raw number and percentage. This is unnecessary as both will be based on the raw number of vaccinations
IPT2 and ANC4	Current targets for these indicators are the same, but as IPT2 should be given in the 2nd and 3rd trimester <sup>46</sup> targets for IPT2 should be set higher than ANC4. It would also be important to consider the most appropriate denominator the IPT2 indicator, either total pregnant population or out of women who attend ANC first visit.

There are several targets set as percentages, and then the progress noted against targets is documented as a percentage as well. This is confusing as it suggests that targets are raw numbers.

### **Conclusions**

The one implementing partner model per county was useful as geographic simplification was the key in the initial design; however, looking forward, it may be useful to consider that not all counties and CHDs are the same. Some have more capacity than others and may be able to take on more or less as a result. This is disadvantage of the CIP model in the current implementation environment.

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<sup>46</sup>[http://www.who.int/malaria/mpac/sep2012/iptp\\_sp\\_erg\\_meeting\\_report\\_july2012.pdf](http://www.who.int/malaria/mpac/sep2012/iptp_sp_erg_meeting_report_july2012.pdf)

There are best practices and lessons learned over the life of ISDP and previous mechanisms that would be helpful to document and share, in terms of CIP contracting, government involvement and CIP unique solutions for potential scale up.

Inconsistencies and anomalies in indicator reporting call into question the overall quality of data reported by ISDP.

## Recommendations

### Short Term

- ISDP should continue to document lessons learned through the competitive bidding and performance review process to ensure they are captured for future contracting.
- ISDP should document CIP solutions more fully and assess whether they are appropriate for scaling up to other CIPs (some solutions may be too specific). Those that may be appropriate for roll out in other counties should be included as best practices for other CIPs to try in their next work plan cycle.
- During the remaining time under ISDP, USAID should address the level of government involvement (a key part of the project design) across CES and WES counties and consider piloting a different contracting method in some more advanced counties, such as contracting-in CHDs similar to what IMA World Health has done under Rapid Results Health Project or supervisory grants as in HSSP.<sup>47</sup>With RRHP the PR contracts the CHD, and the CHD contracts their staffs and the health facility staffs, and the CHD pay salaries of health workers and incentives the IPs supervise the process and provide logistical, financial and technical support to the CHD, the CHD takes charge of all the affairs of the health facilities and they are the forefront.
- Data Quality Assessments should be conducted for key ISDP indicators (including those mentioned above) to ensure that methods and reporting formats meet quality requirements and best practice standards. Data verification exercises should also be conducted as follow up to assessments where indicated.

### Long Term

- For any new service delivery procurement:
  - USAID should consider best practices and lessons learned documented by ISDP
  - USAID should consider a heavier focus on data quality. Beyond the standard M&E plan, USAID should request additional data verification plans or data quality assurance requirements.

## Disadvantages of the ISDP model

### Conclusions

ISDP was designed on the basis of assumptions that did not hold true (and are not likely to hold true) during the life of the project. Though the assumptions are noted as problematic, the approach does not include a contingency plan if any of the assumptions do not hold. As well, the phases of transition

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<sup>47</sup> IMA Presentation on RRHP Harmonization 2013

indicated in the ISDP original design assume transition of staff salaries and service delivery oversight to the government, but without a backup plan if this is not possible. This is problematic especially in the context of South Sudan, as even before the December 2013 crisis, South Sudan was a fragile working environment. These misaligned assumptions have had an impact on the project's performance and an impact on health outcomes. As noted earlier, the reliance on other actors to fill gaps and provide linkages has proven ineffective with key examples being challenges to supply chain and infrastructure. Support and linkages to secondary health care, though part of the original ISDP design and subsequent work plans, is also a gap where reliance on other actors has proven ineffective (with the exception of small scale solutions for specific facilities).

In addition, the CMT model as part of the ISDP community approach is quite complicated and takes time to implement, as indicated by the delays in rolling out this component thus far under ISDP. As mentioned earlier in this document, the CMT model is also outside of the MOH policy framework which makes it's sustainability beyond ISDP support unlikely unless additional steps are taken.

Finally, as the ISDP approach concentrates at the community and facility levels, interactions with the CHD on the technical front are limited and CHDs are not demonstrating improved technical knowledge. While CIPs are sharing work plans with the CHDs, initiating coordination meetings and quarterly reviews, CHD involvement on ISDP initiatives is still limited, which may threaten sustainability beyond the life of the project. The limited interaction with CHDs may also be responsible for the differing data between ISDP/MOH.

## **Recommendations**

### **Short Term**

- USAID should set up an oversight committee which includes representatives from the MOH, USAID and ISDP. This committee could be tasked with determining the best way forward in light of current circumstances and could focus on big picture issues as noted above as well as sustainability of ISDP initiatives.

### **Long Term**

For any new service delivery procurement, USAID should consider:

- An oversight mechanism (as suggested above) to ensure buy in from the MOH and future sustainability
- Continued alignment of project approaches to current MOH policy frameworks

Evaluation Question #5: What has been the impact of conflict and tenuous political situation on the ISDP project and how could future conflict and insecurity affect the project during its final two years?

For this question the evaluation team focused on the impact of the December 2013 conflict on the project, also looking at the response to the cholera outbreak and effect on programming. Recommendations focus on how the project and USAID might incorporate a conflict-sensitivity lens in project planning moving forward (within ISDPs remaining years or in future activities).

## Findings

Localized conflict has affected 11 of the 16 counties where ISDP operates. Conflict and conflict dynamics are critical cross-cutting issues that require explicit attention and approaches in order to improve ISDP service delivery.<sup>48</sup> Findings from evaluation field work point to three main categories of conflict-related implementation and performance issues:

1. **Access to Resources:** Due to insecurity there was significant difficulty in transporting commodities from Juba's central store to other states and counties in order to re-supply the CHD and facilities. In some cases, it was impossible to do anything to help this situation, but CHDs were able to use whatever drugs they had in stock (also at the facility level) and CIPs supported this where possible.

2. **Quality of services:** Many service providers couldn't make it to their posts and service delivery had to rely on local or community level health workers to keep services going. In addition, expatriate staffs from CIPs were evacuated, leaving gaps in management and technical support, including technical elements of supportive supervision.

According to interviews in WES counties, the current situation is not affecting the CIPs in WES and services are back to normal. One CIP, however, stated that additional pressures could mean that national level CIP staff will have to take on an extra burden, slowing support, during peak crisis periods.

As described in more depth within Question Two, there are no plans for transitioning health workers currently on the ISDP payroll to the government payroll.

3. **Access to Services:** During the conflict project performance data shows dips in service statistics (especially in Maternal Health services as noted in the Question One discussion).

ISDP was unable to complete a number of technical activities slated for Year Two. Activities pushed to Year Three include CEmONC and newborn care activities, finalization and roll out of additional SMB-R modules, additional staff training for IMCI and routine vaccination as well as additional recruitment of vaccinators, ICCM rollout and additional training for HHPs. Reasons for delaying these activities included:<sup>49</sup>

1. Delays due to violence starting in December 2013;
2. Delays due to budget constraints and limited flexibility;
3. Delays in approval from the MOH.

The project currently has a plan in place (according to its year three work plan<sup>50</sup>) to implement a number of additional activities to ensure preparedness in the event of future shocks (conflict-related or otherwise). These are:

- Incorporate the Local Capacities for Peace Project's, Do No Harm framework in its community component.
- Ensure participation of a broad sector of community members in the selection of HHPs, community mobilization teams (CMTs), B/VHCs, reward and recognition.
- Initiate a community inclusive quality improvement approach—Partnership Defined Quality

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<sup>48</sup> ISDP Year 2 annual report

<sup>49</sup> ISDP Year 2 annual report

<sup>50</sup> October 2013 - September 2014 Annual Report

- (PDQ)—which will promote closer interaction between community members.
- CIPs will be encouraged to exhibit positive working attitudes to promote unity and peace in the community.
- Use 2013 conflict assessments and staff interviews to select areas to better understand service delivery and impact on social dynamics.

The cholera epidemic of 2014, which affected Juba, KajoKeji and Yei, was an example of an unexpected disruption to implementation. Through interviews, the evaluation team learned that the project was able to immediately conduct a rapid WASH Assessment for affected areas based on USAID guidance. The information was used to ensure appropriate supplies were available by strategically redirecting resources. Due to this quick action there were limited effects on other services. There may be lessons here which could be useful for conflict-sensitive planning going forward.

### **Future Risks**

- As a result of the increased inflation, there are reports of increased pressures on NGOs to pay health workers' salaries in USD, with some already having made the transition.<sup>51</sup>
- The Internally Displaced Persons camps will remain, which means health risks associated with a camp setting will continue, possibly affecting ISDP, such as disease outbreaks.
- Increased violence, particularly due to ethnic conflict, could decrease access and health seeking behavior of the population. It could also alienate certain group's access to health services based on ethnicity or tribe and endanger the CIPs, HHPs and CMTs.
- As robbery and violent crime increase, risks to all health workers and health centers will also increase as they could be viewed as potential revenue and looting sources.

### **Conclusions**

Overall services only felt limited disruption in terms of service provision during conflict and use of services during and after, but challenges which can be identified are the under-utilization of local staff as well as the lower use of some facility services even beyond the crisis. The fact that ISDP was unable to complete technical activities slated for Year Two and has shifted these activities into the Year Three work plan, combined with the potential future risks noted above, suggest a significant possibility that ISDP will struggle to complete its Year Three work plan (especially when considering project assumptions which did not hold true as discussed under Question Two).

The cholera outbreak of 2014 is a useful example of reaction to a sudden change in circumstances, though a much simpler situation than the 2013 conflict, which can highlight some useful techniques and tools, such as rapid assessments and strategic redirection of resources, to carry forward in planning to ensure procedures are in place to mitigate the effect of sudden shocks to project implementation and results.

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<sup>51</sup>Letter from MOLPSHRD, Clarification on Circular No 8/2012, September 2014

## Recommendations

### Short Term

- ISDP should continue with planned activities suggested for Year Three related to preparedness for possible future shocks (conflict-related or otherwise).
- ISDP should enhance its security measures.

ISDP should work with Conflict Advisors to:

- Identify conflict sensitive areas/counties: Use 2013 national conflict assessment and staff interviews to identify one to three geographic areas of operations where social dynamics are serving as initial focus areas for conflict sensitivity planning.
  - Develop plans to understand local staff narratives surrounding service delivery and impact on social dynamics.
- Integrate conflict sensitivity into existing Quality Assurance, possible areas to explore:
  - Supervision Reports and SBM-R performance assessments and standards
- Consider contingency planning around likely risks to project implementation and performance going forward.

### Tips for Integrating Conflict-Sensitivity

#### Increase collaboration/coordination:

- Coordinated multi-actor regional meetings (Skype or phone conference)
- Using joint planning for activities
- Prioritize IDSR reporting

#### Task Shifting to local staff and actors:

- Task shift/training from expat to local staff
- Incremental shifting of responsibilities to community and government actors
- Enhanced focus on Community Mobilization

### Long Term

For future designs, USAID should consider:

- Using data gathered to determine best approaches for ensuring equity, specifically:
  - Using data from SS checklists, supervision reports, and performance assessments that have integrated conflict sensitivity elements;
  - Undertaking a comprehensive Conflict Analysis looking at government service delivery and impacts on social cohesion by USAID and other actors such as OFDA and the DRG conflict resolution team;; and
  - Standardization of the equitable delivery of services and supplies.

Considering some practical ways to ensure projects and their staff are more prepared to respond to shocks:

- Emergency budget line to respond quickly and effectively to shocks;
- Induction pack for emergency and existing staff providing mandate, logistics, and check list of responsibilities;

- Strategy for remote supervision and communications during times of crisis;
- Shorter work plan periods to provide more flexibility and adjustments to needs on the ground; and an
- Action plan to assess risks and guide staff in times of crisis and violence.

The following table captures short and long term recommendations across all evaluation questions.

What have been the results of the USAID/South Sudan's health investments through ISDP, considering both targets established for these activities and unanticipated results?		
Program area	Short term	Long term
Family planning service delivery	Conduct short refresher trainings to fill skill gaps identified by supportive supervision, including reporting using the new HMIS format.	Utilizing the Technical Working Groups (TWG) already active in key areas(Family Planning, Reproductive Health, BCC), USAID and its development partners should consider an improved and harmonized approach to: <ul style="list-style-type: none"> <li>• Collecting information about family planning uptake and continued use; and</li> <li>• Creating a clear, streamlined approach to family planning commodity supply across counties and states.</li> </ul>
	Use data captured in the new HMIS format, ISDP should ensure accurate reporting on CYP and hold CIPs accountable for data analysis and utilization to better understand trends and performance improvements as it relates to service provision and commodity tracking. This should be mandated in ISDP sub-awards to CIPs going forward.	
	Reinforce the use of the Community Action Cycle among community mobilization teams (CMT), VHCs and HPPs to understand barriers to health seeking behavior for family planning specifically. This new information can be used to tailor BCC interventions.	
	Once the new HMIS format is rolled-out, ISDP should ensure that CIPs are further engaged in managing, reporting and checking the quality of data captured at the facility level.	
Child health service delivery	Implement refresher training for health workers in IMCI and HMIS based on noted skill gaps (where indicated by SS) to ensure protocols are followed and documentation is improved.	USAID should provide leadership in coordinating at a national level with the key actors to ensure a harmonized approach in addressing issues with MOH data collection formats including key IMCI protocols and indicators.
	ISDP should complete its Strategic Plan for Implementation of Integrated Case Management of Childhood Illness in South Sudan, 2012-2015 by September 1, 2015.	ISDP should engage further with the ICCM TWG on ICCM rollout and best practices, especially in determining a way forward for the use of ICCM that

		addresses the large challenges of commodity supply and harmonized remuneration/incentive packages for HHPs/CBDs.
	Start/continue roll out of ICCM in pilot counties by January 2016 and consider including a subset of the key indicators suggested in the ICCM strategy.	ISDP with support from other USAID partners should ensure cold chain issues (repairing fridges in particular) and improve coordination on outreach campaigns.
	Develop better catchment area maps where necessary to improve outreach site selection and planning of service delivery especially where populations are very rural. With improved maps, more targeted and better planned outreach by facility staff can be conducted to improve routine immunization reach.	
	Capture DTPI data, this is currently being collected as part of the MoH HMIS. This will help ISDP and USAID better understand vaccination issues on the demand side.	
	Further document county level best practices and consider these practices in roll out of technical training and supervision to VHCs and CMTs.	
Maternal health service delivery	Training and expanding PPH community coverage using the MCHIP model.	Look at more innovative ways of providing practicum experience to ensure delivery skills are maintained, e.g. placement of ISDP staff in hospitals or cross-state placements (e.g. to Nimule or Yambio hospitals which have higher numbers of deliveries) and may also want to consider support to pre-service institutions to fill in additional skills gaps.
	Use of HHPs and VHCs for counseling, referrals and defaulter tracing for ANC and delivery with a skilled birth attendant.	Continue to support PPH community based provision of miso beyond CES and WES using MCHIP model.
	Refresher trainings and continuous professional development for skills gaps identified in SS; mentoring by more experienced staff; brainstorming ways to provide more practicum experiences for SBA and CMW	In considering future procurements, USAID should use collected data from HMIS (as outlined above) to identify and target key issues in getting women to use facility based services. In this vein, USAID should consider a dedicated BBC mechanism through a specialized technical partner.
	Use of facility staff for outreach – especially for ANC services – to increase service access for women by bringing services to them.	
	USAID/ISDP should consider capturing first and second ANC visits (as is common in emergency settings) or other variations, to	

	increase the nuanced data available for decision-making to help improve project implementation and performance.	
	ISDP should capture and report additional data on deliveries (as in Year One) – skilled and unskilled including community (Traditional Birth Attendants) deliveries – which is being collected at the facility level already.	
	ISDP should encourage CIPs to do facility level analysis with this data to better understand micro-level trends and where best practices are emerging. This would be especially crucial for counties that are beginning their community-based PPH prevention activities.	
Gender equity	ISDP/CIPs should gather and analyze data related to gender differential participation or impacts. As part of this effort, ISDP should document the use of male HHPs to better understand the pros and cons, and determine if this should be something considered by all HHPs.	ISDP should comply with ADS 205 and create a Gender Inclusion Strategy, supports its integration, documents and plans measurement of gender differential access and benefits to beneficiaries (including health facility staff and clients of PHCCs and PHCUs).
	ISDP/CIPs should look for opportunities to provide additional support to current staffing (for example, HSP L&M training, in-service technical training) and consider promotion from within to ensure that female staffs have equal opportunities for upward movement.	
	There is need to encourage recruitment of both qualified or junior female staff that will be mentored and coached to take up managerial positions at facility or program level. The intention is to groom more females at decision making levels who can influence better policies to support maternal child care.	
	Need for readily available ambulance for transporting emergency cases which cannot be handled in the PHCC or those mothers far from the PHCC/U so that they can be able to reach the facility for safe delivery	
	There is also need to provide means of transport like Bicycles to	

	the HHPs to facilitate their movement in areas which are far away to reach with services to mothers and children in need	
<b>How relevant is the project's work to both short and long-term development needs of health services delivery in South Sudan?</b>		
Program area	Short term	Long term
	USAID and ISDP should conduct a strategic planning session to determine how to move forward during the remaining project years in terms of coverage of technical areas within the current budget constraints, prioritizing technical areas while still meeting continued salary needs. The strategic planning session should include consideration of whether to amend ISDP's scope to include basic WASH infrastructure items so as to maintain access to clean water.	<ul style="list-style-type: none"> <li>• Realistic assumptions should be considered at the start and periodically reassessed to ensure validity and feasibility of continued implementation.</li> <li>• Training plans should include refresher trainings and follow up modules for needs identified during SS or other QA activities.</li> </ul>
		<ul style="list-style-type: none"> <li>• Feasibility of staff transfer to MOH due to the large impact on availability of funds for other work. <ul style="list-style-type: none"> <li>○ If staff transfer to the MOH is not feasible, stakeholders should consider the use of incentives to reduce the disparities between staff salaries and mitigate current motivation issues within facilities.</li> </ul> </li> <li>• A standard definition of SS should be agreed to by all stakeholders.</li> <li>• Support to training institutions in terms of infrastructure capacity and technical capacity.</li> <li>• Support for pharmaceutical supply chain management (PSM) at lower levels.</li> <li>• Support for country-wide infrastructure initiatives which prioritize needs based on provisions of key services. Could be used to: <ul style="list-style-type: none"> <li>iii. Meet B/CEmONC standards; and</li> <li>iv. Address PSM issues.</li> </ul> </li> </ul>
Salaries	USAID should continue paying salaries at the current level through ISDP, but should work with ISDP to ensure that all CIPs are adhering to standards and best practices.	

	<p>USAID or its partners within the Health Pooled Fund 2 should conduct a mapping exercise in all South Sudan states to determine who is paying USD and SSP, including capturing non-monetary compensation packages for VHC members and HHPs. Based on this information, USAID should set a policy statement of what implementing partners must do (e.g. stick to USD/SSP) in the current climate.</p>	
Training	<p>ISDP should consider follow up/refresher trainings based on SS findings, SBM-R assessments, or action plans which highlight identified needs or skill gaps.</p>	
	<p>At the community level, ISDP should use a cascade approach to training and supervision where feasible (CMTs to VHCs and HHPs) as this may provide some cost savings over the remaining life of the project.</p>	
Commodities	<p>ISDP/CIPs should continue to facilitate the transportation of commodities and supplies to PHCU/PHCCs but ensure coordination with monthly SS visits to reduce additional logistical or resource burden on the project.</p>	
	<p>ISDP/CIPs (in coordination with SIAPS) should review usage of commodities against disease burden to ensure the right commodities are transported; this will allow drugs to last longer in an environment where supplies may run out.</p>	
	<p>USAID should coordinate with UNICEF/GAVI to provide further support for broken solar fridges.</p>	
Infrastructure	<p>ISDP, USAID, and USAID partners within the Health Pooled Fund 2 should prioritize infrastructure support so that major transportation bottlenecks in all States that prevent the poor and extremely vulnerable, especially in rural areas, from accessing the BPHS. As part of this recommendation</p> <ul style="list-style-type: none"> <li>• ISDP should continue to work through VHCs – engaging them in upgrading facilities (action planning and leveraging support)</li> </ul>	

	<ul style="list-style-type: none"> <li>• ISDP should utilize CMTs (as they are rolled out) to consolidate community issues and prioritize at a Payam level</li> <li>• ISDP should continue to support CIPs in leveraging support of other actors where possible for additional support</li> <li>• As a critical point, /ISDP should ensure functional water supply at every facility (especially at PHCCs) as this is an essential element of providing all other basic quality services. As necessary, USAID should consider expanding the scope ISDP during its remaining time to cover basic WASH infrastructure.</li> </ul>	
How effectively has ISDP coordinated with the HSSP project activities and other South Sudan health stakeholders at the county and state levels to improve health services?		
Program area	Short term	Long term
	As part of ISDP Quarterly Meetings, HSSP and SIAPS should continue to participate to ensure improved coordination	Support to CHDs to build SS teams (including management and technical focus) and consider embedded technical staff at CHD to lead supervision and create sustainability within the CHD for conducting supportive supervision visits.
	ISDP should continue to participate in HSSP joint planning to support building technical capacity for QA and management capacity for SS as well as ensuring that there are fewer missed opportunities and resources are maximized.	Joint work planning at the county level, including a mechanism to locate and leverage support from FBO/CBO local actors (as a further extension of learning that happens from short term recommendation above to conduct joint planning, mapping of actors, etc.).
	ISDP should continue to notify HSSP of planned supervisory visits to CHDs to ensure coordination of supportive supervision tasks.	Mission level coordination with actors such as UNICEF who are providing support in particular counties in CES and WES to ensure strategic/coordinated roll-out.
	ISDP should work with its CIPs; HSSP Hub managers, and USAID to implement co-location for CIPs and HSSP Hubs, and CHDs where feasible, at this stage of the project.	
	ISDP collaborate with HSSP to resolve data quality issues	
	USAID should require a full data quality assessment and any needed verification follow up to better understand facility level data issues.	

	ISDP should continue to coordinate with SIAPS and EMF on all supply chain challenges	
	ISDP should work with HSSP to create a plan for USAID's approval to maximize the reach of current resources that both projects have left for the community component, including prioritizing the setup of CMTs and using these entities as a resource for training VHCs. HSSP and ISDP should consider pooling funding to cover VHC trainings under ISDP.	
	HSSP should train CIPs (and VHCs) on proposal writing, ways to leverage funding, action planning, needs mapping as well as other potential areas of need which would be within the HSSP realm.	
What are the advantages and disadvantages of the ISDP current model and approach?		
Program area	Short term	Long term
ISDP community focus	ISDP should consider how best to continue the roll out of the CMTs and scale up the Community Action Cycle. There are potential cost savings in tasking CMTs to support training and supervision of VHCs and HHPs. In addition, further cost savings may be realized through the use of CMTs in coordination with other local actors. This is also an opportunity to reinforce the sustainability of this model for the future and consider a handover plan or exit strategy for ISDP.	Continuing to support the Community Action Cycle, but ensuring buy in from the government and the incorporation of lessons learned to utilize these structures to their fullest potential.
	ISDP should further utilize the community component to better understand uptake and consistent use; HHPs can gather information and work with VHCs to develop better targeted plans. CMTs can support higher level issues and advocate.	Use additional data suggested above to ensure community activities are designed in a way to maximize results and gender equity.
	ISDP should consider capturing additional data to better understand how the work at the community level contributes to the projects objectives. This could include indicators to track the functionality of VHCs (such as those indicators used by HFP) or more qualitative measures that look at beneficiary satisfaction with services or gender differential participation or impacts.	
Quality assurance model	Continue support at the national and county/facility levels for development and roll out of standardized SBM-R modules and updated guidelines considering issues already encountered during	In future procurements, USAID should consider MOH capacity to implement the QA approach without the current level of ISPD (and HSSP) support. It may be

	initial roll out, such as: streamlining and designing mechanisms that reward facilities for improvement instead of setting the bar at 80 percent for recognition.	necessary to embed staff within the CHD to ensure that the approach is carried forward and that the appropriate technical expertise is available to conduct the assessments and follow-up.
	ISDP should be given the mandate to fix and maintain a functional hand washing stations and incinerators at health facilities as necessary to insure infection control standards are met.	USAID should coordinate with other development partners and governments to ensure there is standardized implementation of QA across the country (including a clear definition of what supportive supervision covers).
Management	ISDP should continue to document lessons learned through the competitive bidding and performance review process to ensure they are captured for future contracting.	<ul style="list-style-type: none"> <li>• For any new service delivery procurement, <ul style="list-style-type: none"> <li>○ USAID should consider best practices and lessons learned documented by ISDP</li> <li>○ USAID should consider a heavier focus on data quality. Beyond the standard M&amp;E plan, USAID should request additional data verification plans or data quality assurance requirements.</li> </ul> </li> </ul>
	ISDP should document CIP solutions more fully and assess whether they are appropriate for scaling up to other CIPs (some solutions may be too specific). Those that may be appropriate for roll out in other counties should be included as best practices for other CIPs to try in their next work plan cycle.	
	During the remaining time under ISDP, USAID should address the level of government involvement (a key part of the project design) across CES and WES counties and consider piloting a different contracting method in some more advanced counties, such as contracting-in CHDs similar to what IMA World Health has done under Rapid Results Health Project or supervisory grants as in HSSP <sup>52</sup> with RRHP the PR contracts the CHD, and the CHD contracts their staffs and the health facility staffs, and the CHD pay	

<sup>52</sup> IMA Presentation on RRHP Harmonization 2013

	salaries of health workers and incentives the IPs supervise the process and provides logistical, financial and technical support to the CHD, the CHD takes charge of all the affairs of the health facilities and they are the forefront.	
	Data Quality Assessments should be conducted for key ISDP indicators (including those mentioned above) to ensure that methods and reporting formats meet quality requirements and best practice standards. Data verification exercises should also be conducted as follow up to assessments where indicated.	
Disadvantages of ISDP model	USAID should set up an oversight committee which includes representatives from the MOH, USAID and ISDP. This committee could be tasked with determining the best way forward in light of current circumstances and could focus on big picture issues as noted above as well as sustainability of ISDP initiatives.	An oversight mechanism (as suggested above) to ensure buy in from the MOH and future sustainability
		Continued alignment of project approaches to current MOH policy frameworks
What has been the impact of conflict and tenuous political situation on the ISDP project and how could future conflict and insecurity affect the project during its final two years?		
Program area	Short term	Long term
	ISDP should continue with planned activities suggested for Year Three related to preparedness for possible future shocks (conflict-related or otherwise).	Using data gathered to determine best approaches for ensuring equity, specifically: <ul style="list-style-type: none"> <li>• Using data from SS checklists, supervision reports, and performance assessments that have integrated conflict sensitivity elements;</li> <li>• Undertaking a comprehensive Conflict Analysis looking at government service delivery and impacts on social cohesion by USAID and other actors such as OFDA and the DRG conflict resolution team;; and</li> <li>• Standardization of the equitable delivery of services and supplies.</li> </ul>
	ISDP should enhance its security measures.	Emergency budget line to respond quickly and effectively to shocks;
	Identify conflict sensitive areas/counties: Use 2013 national conflict	Induction pack for emergency and existing staff

	<p>assessment and staff interviews to identify one to three geographic areas of operations where social dynamics are serving as initial focus areas for conflict sensitivity planning.</p> <ul style="list-style-type: none"> <li>• Develop plans to understand local staff narratives surrounding service delivery and impact on social dynamics.</li> </ul>	<p>providing mandate, logistics, and check list of responsibilities;</p>
	<p>Integrate conflict sensitivity into existing Quality Assurance, possible areas to explore:</p> <ul style="list-style-type: none"> <li>• Supervision Reports and SBM-R performance assessments and standards</li> </ul>	<p>Strategy for remote supervision and communications during times of crisis;</p>
	<p>Consider contingency planning around likely risks to project implementation and performance going forward.</p>	<p>Shorter work plan periods to provide more flexibility and adjustments to needs on the ground; and an</p>
		<p>Action plan to assess risks and guide staff in times of crisis and violence.</p>



investments, USAID committed to supporting expansion of the minimum package in the two most populous states of CES and WES. To this effect, the MCHIP, led by Jhpiego, was awarded ISDP to ensure coverage of the minimum package across all 16 counties in the two states.

Since 2010, ISDP has also provided technical assistance to the MOH to strengthen family planning, RH and human resources. Building on this investment, ISDP provided key strategic support to the GRSS and supported operationalization of the South Sudan Development Plan 2011–2013 by expanding access to the minimum package through the ISDP. ISDP was steered by the following three guiding principles:

- (1) *Collaboration with the GRSS at all levels*
- (2) *Standardization and equitable coverage*
- (3) *Lasting contribution to South Sudan’s health sector*

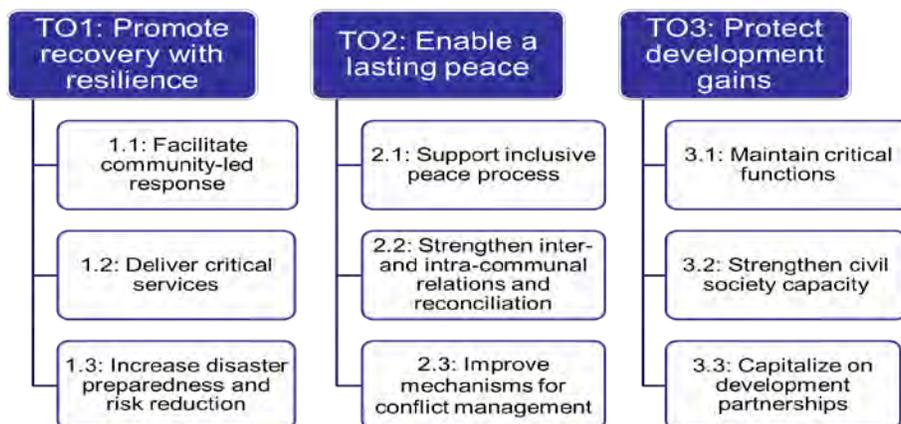
Under the ISDP, Jpiego envisioned three broad programmatic phases to ensure the delivery of existing services during the transition from SHTP II to ISDP:

- Phase 1—Maintain existing services
- Phase 2—Standardize, strengthen and expand services
- Phase 3—Consolidate and transition services to MOH

However, the ISDP and the minimum package were developed before the current civil conflict broke out and did not take into account the ongoing violence and chronic population displacement. Further, the current conflict has severely affected the Government’s capacity to deliver services and improve its health systems. To compound these challenges, no DHS was conducted this year and future plans to conduct the DHS have been put on hold due to the conflict. Thus, the most recent available data is from the 2010 Sudan Household Health Survey (SHHS), weakening the veracity and effectiveness.

In light of the ongoing violence and instability in South Sudan, in 2014, USAID undertook a review of its portfolio, and developed a new Operational Framework focused on the following transition objectives (TOs) to guide new activities and re-orient existing activities:

Fig. 1: Operational Framework



Health service delivery is directly linked to 1.2: *Deliver critical services* and 3.1: *Maintain critical functions* and indirectly to 1.1: *Facilitate community-led response*. Under the new operational framework, USAID will

place greater emphasis on service delivery and will refocus to ensure provision of high-quality primary health care services.

## 2. Development Hypothesis

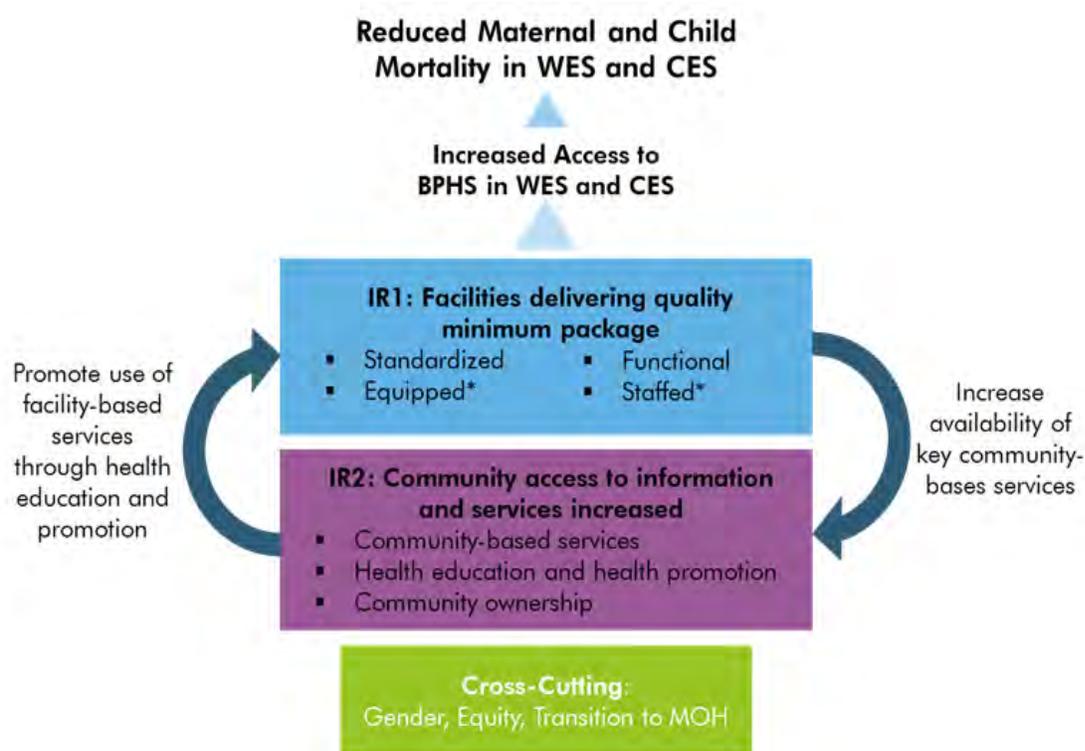
The development hypotheses or theory of change underlying the ISDP activity is embedded in the project’s Results Framework below. Stated as hypothesis and intended results, the ISDP activity’s theory of change can be expressed as follows:

**If** quality minimum package of health services are delivered, and **if** community access to information and services is increased, **then** access to basic primary health services will be increased.

This would result in reduced Maternal and Child Mortality in Western and Central Equatoria States.

Thus, ISDP would have contributed to this goal.

This development hypothesis is also demonstrated graphically below:



\*see key assumptions section

## 3. Existing Background Documents

There will be a range of project background documents for the evaluation team to consult one week before the actual work begins. The documents include:

- ISDP project document/procurement (AID-668-LA-12-00003)
- ISDP work plan document (s)
- Partner work plan guidance
- Work plan request for extension if any
- Performance Management Plan (PMP)
- Reports quarterly and Annually

- Any other related documents

## EVALUATION RATIONALE

### 4. Evaluation Purpose, Audience, and Intended Uses

The performance evaluation of ISDP activities will assist the USAID/South Sudan Health Office to reach decisions related to any mid-course corrections or modifications necessary to improve project implementation over the last half of project life. It will also help the Health Office in reaching decisions related to future development programming in the health sector. The evaluation will also help the Mission to document the extent to which the project goal and objectives have been achieved. And further, the Mission will understand the strengths and weaknesses of the present model and approaches to health service systems and delivery while also documenting lessons learned.

#### Audience and Intended Uses

The main audience of the evaluation report will be the USAID Mission in South Sudan, specifically the Health Team who will use the evaluation to review their investment in South Sudan's health sector and the Implementing Partners who will use the evaluation to take corrective measures. The partners and their counterparts will study and collaborate regarding strengths and weaknesses. This will help the Government and the Implementing Partners adjust to any future project approaches and management strategies. The evaluation findings will also help partners to assess the effectiveness of the approaches in delivering and increasing access to the minimum health package services in South Sudan, evaluate the geographic approach (limiting USAID service delivery to two states), and make decisions on whether or not to continue with separate service delivery and health systems strengthening projects in the future. The USAID/South Sudan Mission, specifically the Health Team, USAID/Africa Bureau, and the Government are also interested in determining if the project is achieving its project goals; and to document lessons learned and best practices for informing future health projects and implementing partners.

### 5. Evaluation Questions

There are six main questions that will be addressed in this evaluation study. These broad evaluation questions will be unpacked during TPM sessions for the consultants to get to know what the Mission expects to find out using these broad questions:

1. What have been the results of the USAID' health investments thorough ISDP, considering both targets established for these activities and unanticipated results?
2. How relevant is the project's work to both short and long-term development needs of health services delivery in South Sudan?
3. How effectively has ISDP coordinated with the HSSP project activities and other South Sudan health stakeholders at the county and state levels to improve health services?
4. What are the advantages and disadvantages of the ISDP current model and approach?<sup>53</sup>
5. How have the multiple demands placed on the sparsely staffed state and country health units by USAID programs (ISDP) been addressed and mitigated?<sup>54</sup>

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<sup>53</sup> New language agreed to during April 2 2015 meeting with USAID; old language: What has been the impact of conflict and tenuous political situation on the ISDP project and how could future conflict and insecurity affect the project during its final two years?

## 6. Gender Disaggregation and Gender Differential Effects

USAID/South Sudan’s health team expects the evaluation team to disaggregate finding by sex in terms of gender differential effect: (a) explore gender issues within the context of ISDP activities, and (b) identify any future gender issues that need to be addressed. The table below identifies USAID’s initial expectations for the integration of gender differential effects into answers to assessment questions; the evaluation team will be expected to expand this section as they unpack the six evaluation questions.

<b>Evaluation Questions</b>	<b>Disaggregate by Sex (M/F)</b>	<b>Examine Gender Differential Access/ Participation</b>	<b>Examine Gender Differential Results and/or Benefits</b>
<b>Question 1:</b>	<b>X</b>	Gender equity in access to project support services, participation in project support activities	Gender equitable results of project supported services and activities (looking at outcome and higher level indicators)
<b>Question 2:</b>		Differing issues of access and participation in the health sector may be relevant for men vs. women	Differing results may be necessary for men and women
<b>Question 3:</b>			
<b>Question 4:</b>			
<b>Question 5:</b>		Differing effects of the conflict and political strife on women vs men may change access and participation	Differing effects of the conflict and political strife on women vs men may change results or benefits
<b>Question 6:</b>			

## 7. Evaluation Design and Methodology

This evaluation will utilize mixed methods approaches. However, USAID/South Sudan Health Team expects the evaluation consultant to propose a suitable methodology for this assignment, which will then be approved by USAID. It is recommended that any methodology that will be adapted should utilize both primary and secondary data from multiple sources. This will allow for triangulation of data to inform findings, conclusions, and recommendations. The Mission encourages collection of both quantitative and qualitative data as part of this evaluation.

### Evaluation Methods – Data Collection

<sup>54</sup> Question dropped during April 2 2015 meeting with USAID

The evaluation team will start work by reviewing project documents as soon as they are commissioned. At this stage, the evaluation team will also start working on data collection tools to be used for collection of primary data. However, the tools will be further discussed at the TPM when the teams arrive in Juba. During the TPM session, USAID and other parties involved will unpack the evaluation questions to clearly show what the USAID expectations are regarding the broad evaluation questions. Although the Mission reserves the right to shape the final look of the evaluation tools, the Mission will seek the opinions of the consultants before reaching any final decisions. Respondents to this evaluation will include but are not limited to the following:

- USAID Mission staff, including relevant members from the Front Office, Health/WASH Team, and the Program Office;
- Prime Recipient Management and Technical/Financial Officers;
- Subcontractor Management and Technical/Financial Officers in Juba and the field;
- Government of South Sudan Ministry of Health at National and State levels;
- Commissioners, local government authorities, Payam and Boma authorities;
- County Health Departments officers;
- Staff at health facilities (PHCCs, PHCUs);
- Village Health Committees, influential elders, members of parliament at National, State and Town council levels and Mayors;
- Counterpart Agencies and Projects (WHO, Health Pooled Fund, World Bank, UNICEF, PSI, etc.); and
- Beneficiaries (using customer satisfaction survey if possible).

The table below shows some possible data collection methods for various evaluation questions

Data Collection Methods	Evaluation Questions
Desk Review	1, 3, 4 & 5
Existing Data Series	1, 2, 3, 4 & 5
Key Informant Interviews (KI)	1, 2, 3, 4, 5 and 6
Individual/Group Interviews	1, 2, 3, 4, 5, and 6

### Evaluation Methods – Data Analysis

The evaluation team will recommend an analysis plan based on the general direction presented in this SOW (below). Review of project documents will reveal what is already known from existing data sources about answers to each evaluation question, and what are the gaps that need to be filled. Document review will be done in line with the table shown below.

Evaluation Questions	Desk Review Findings	Gaps to Fill from Field Work
1.		
2.		
3.		
4.		
5.		

It is recommended that the evaluation team disaggregate findings by gender where applicable. Further disaggregation of findings by state and by counties would also be expected when useful. The table below summarizes some possible data analysis methods for each question.

Data Analysis Methods	Evaluation Questions
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Descriptive (trend analysis, Content/Pattern analysis of qualitative data and analysis of effectiveness etc.)	1, 2 & 5
Comparatives (or normative) analysis	2, 3 and 6
Integrated Mixed Methods Analysis of overlapping data points/Findings Synthesis	1, 2, 3, 4 & 5
Cause-and-effect and gap analysis	1, 5 & 6

**8. Methodological Limitations**

This health evaluation comes at a time when South Sudan is facing increasing security challenges, coupled with poor infrastructure, creating logistical challenges in some areas and safety concerns. As a result, some of the potential site locations may not be reachable by the evaluation team. All these can be limitations that may affect representativeness and reliability of the assessment findings, conclusions, and recommendations. However, the Mission expects that the team to use both random and purposive sampling with replacement of site locations.

Other limitations beyond this are constraints placed on the evaluation team by outside factors. Strong gender norms and cultural values as related to gender are evident across South Sudan; this is an anticipated limitation as it may hinder free and open participation by women to freely provide genuine information to the evaluation team during data collection. Thus, the evaluation team will propose clear strategies of how to mitigate anticipated limitations during this assessment exercise.

**9. Deliverables**

USAID/South Sudan Health team expects the following deliverables from the evaluation team:

**(a) Pre-Field Work Briefing and Report**

The team will present the inception report and approaches detailing the evaluation design to USAID in an oral PowerPoint presentation and review meeting in which USAID and other parties involved in the evaluation may raise questions and issues and request adjustments, if necessary, to that plan prior to the start of field work. This meeting will be held within 1 work day after the submission of the team’s inception report detailing the following:

1. A summary of the key findings that emerged from the team’s review of existing documents organized to answer each evaluation question. Bullet points of clearly identified gaps that the team will fill through field data collection and analysis.
2. A detailed description of the evaluation design, including:
  - a. Any suggestions from the evaluation team about changes in the methodological approach proposed in the SOW
  - b. A detailed description of the methodological approach and tools by evaluation question proposed, and a detailed data analysis plan – a detailed description of data analysis methods in relation to the evaluation questions and the specific data collection methods.
  - c. A draft work-plan that includes the timeline for the study as well as scheduled field location visits and interviews is a required element of the detailed design

The COR will approve or request adjustments of the team's inception report within 1 - 2 work days after this meeting is held.

### **(b) Post-Field Work Review**

This briefing and oral presentation/review will serve as a checkpoint on the completeness of the evaluation data and analysis on each of the evaluation questions and on the clarity of the flow of the team's presentation of its findings, conclusions and recommendations. The document required, may take the form of a set of PowerPoint slides, and should present team's findings on each question in bullet points to demonstrate how findings lead to the conclusions and recommendations it intends to present. This briefing will be held after field work and the bulk of its data analysis have been completed; but before drafting of evaluation report commences. Any gaps identified at this review or gaps in the logic of the flow from findings to conclusions to recommendations will need to be addressed before drafting report.

### **(c) Draft Report**

The full draft of the evaluation report will be prepared in accordance with USAID's How to Prepare and Evaluation Report guidance in Annex I of USAID's evaluation policy. The report will be based on USAID's evaluation report template. The evaluation team is encouraged to self-score its evaluation against USAID's evaluation review checklist before delivering this document to USAID: [http://transition.usaid.gov/policy/evalweb/evaluation\\_resources.html](http://transition.usaid.gov/policy/evalweb/evaluation_resources.html)

### **(d) Debriefings**

The second debriefing with a wider audience that include, USAID team, implementing partner(s), government invitees, and any other interested stakeholder(s). The Mission reserves the right to request the team to omit all findings of sensitive nature during presentations to wider audience. After the debriefing all quantitative and qualitative data set including debriefing slides will be transferred to USAID health team.

### **(e) Final Report**

The evaluation team is required to produce 2 versions of the report. The first report will be for the sole use of USAID mission. And the second version of the report will be shared with wider stakeholders: Implementing Partner(s), government of the Republic of South Sudan, and any other interested South Sudanese stakeholder. Any potential procurement-sensitive information will be omitted from the second version of the report before the report is submitted. The final evaluation report is due in 5 working days after the evaluation team receives USAID comments - see levels of effort.

The final version of the evaluation report will be submitted electronically. And the report format is restricted to font I I Garamond, but heading and sub-headings is required to be in Gill sans MT 12. Page limit for this evaluation, excluding the Executive Summary and Annexes, be in the range of 27 - 30 pages.

## **10. Report Requirements**

USAID requires that evaluation, assessment and special studies reports are 27 – 30 pages maximum and arranged as follows:

1. **Executive Summary:** concisely state the most salient findings and recommendations (2pages);
2. **Table of Content:** (1 page);
3. **Introduction:** Purpose, audience and Questions:(1 page);
4. **Background:** brief overview of the project, strategies, and activities (2 page);
5. **Methodology:** describe assessment methods, including detailed limitations, constraints and gaps(1 page);
6. **Findings/Conclusions/Recommendations (FCR):**organized FCR by questions, highlighting data quality, and reporting as bases for verification of spot checks, issues, and results as applicable (17–20pages);
7. **Issues:** Provide list of key technical and/or administrative, if any (1 page),
8. **Lessons learnt and future directions:** (1page);
9. **References:** (including bibliographical documentation, meetings. Interviews and focus group discussion);
10. **Annexes:** annexes that document the assessment SOW, tools, schedules, and interview lists, and list of tables/charts.

## 11. Team Composition

The evaluation consultants will conduct the ISDP evaluation, and the team will consist of three main team members; Team Leader, and two Technical Experts. In addition, representatives of the Government, implementing partners, and USAID staff may also join the team. However, USAID representatives will participate on a part-time basis and in selected trips. The Team Leader will take full responsibility for managing the team, organizing its work, and ensuring quality control and delivery of a final report acceptable to USAID standards.

**Team Leader:** A senior Evaluation/Evaluation Specialist should have a postgraduate degree in Public Health, International development or any related Health Systems Strengthening/Health Systems Management, qualifications. S/he must have at least 10 - 15 years' experience – 5 of which should be working in a developing country context especially in the Monitoring and Evaluation of Primary Health Care activities and programs. The candidate should also have analytical and good report writing skills. S/he must have experience leading large scale studies. A sound knowledge of understanding USAID programming approaches and methodologies will be an added advantage.

**Technical experts:** Technical experts with extensive experience ranging from 7 – 10 years. The technical experts should have postgraduate degree in Public Health, Health Economics, Evaluations, development studies or any other relevant Primary Health Care qualifications. The individual should have experience in research and demonstrated knowledge of conducting qualitative studies. The two technical experts will have complementary skills. Local experience as well as experience in Africa or/and other similar setting will be an added advantage. Female consultants are encouraged to apply. Further, South Sudanese are especially encouraged to apply.

## 12. Management of the Evaluation

Management Systems International (MSI) will provide overall management and support to the evaluation team. This support will include overall technical guidance to the team, coordinating and arranging teams meetings with key stakeholders; other logistical arrangements e.g. travel, housing in Juba and in the field, etc.; and coordination of Juba visitations and other meetings as identified during the course of this

evaluation. But MSI will pay for government representatives. In addition, MSI will also provide, for the evaluation team, office and meeting space, as needed, at MSI's Juba Office Compound where the team can access internet, printing and photocopying documents including any other technical support as deemed appropriate.

### 13. Schedule

The specified period of performance for this evaluation exercise is proposed to be approximately 6 weeks.

Task/Deliverables		Estimated Duration/LOE in days		
		Team leader	Technical Specialist 1	Technical Specialist 2
1	Travel to South Sudan	2	2	2
2	Preparatory work and initial document review	3	3	3
3	Preparation of inception report (literature review, methodology & tools development)	4	4	4
4	Debrief USAID/South Sudan	1	1	1
5	Incorporate comments from the debrief with USAID	1	1	1
6	Data collection exercise	12	12	12
7	Data analysis & draft evaluation report writing	6	6	6
8	Debrief meetings with USAID	1	1	1
9	Debrief with partners and key stakeholders	1	1	1
10	Team incorporate feedback/comments and complete draft evaluation report and submit to USAID	1	1	1
11	Depart South Sudan	2	2	2
12	USAID & partners provide comments on draft Report (out of country) due ten days after			
13	Team revises draft report and submits final to USAID(out of country)	4	2	2
14	USAID completes final review			
15	Team Leader/MSI do final revisions and edit/brand final report for submission to USAID	4		
<b>Total Estimated LOE</b>		<b>48</b>	<b>36</b>	<b>36</b>

A six-day work is authorized when working in country. And additional LOE may be for the Team Leader to meet any further requirements as deemed fit.

## Criteria to Ensure the Quality of the Evaluation Report

### APPENDIX I CRITERIA TO ENSURE THE QUALITY OF THE EVALUATION REPORT

- The evaluation report should represent a thoughtful, well-researched and well organized effort to objectively evaluate what worked in the project, what did not and why.
- Evaluation reports shall address all evaluation questions included in the scope of work.
- The evaluation report should include the scope of work as an annex. All modifications to the scope of work, whether in technical requirements, evaluation questions, evaluation team composition, methodology or timeline need to be agreed upon in writing by the technical officer.
- Evaluation methodology shall be explained in detail and all tools used in conducting the evaluation such as questionnaires, checklists and discussion guides will be included in an Annex in the final report.
- Evaluation findings will assess outcomes and impact on males and females.
- Limitations to the evaluation shall be disclosed in the report, with particular attention to the limitations associated with the evaluation methodology (selection bias, recall bias, unobservable differences between comparator groups, etc.).
- Evaluation findings should be presented as analyzed facts, evidence and data and not based on anecdotes, hearsay or the compilation of people's opinions. Findings should be specific, concise and supported by strong quantitative or qualitative evidence.
- Sources of information need to be properly identified and listed in an annex.
- Recommendations need to be supported by a specific set of findings.
- Recommendations should be action-oriented, practical and specific, with defined responsibility for the action.

## ANNEX 2: ISDP PERFORMANCE DATA TABLE, LIFE OF PROJECT THROUGH Q2 FY15

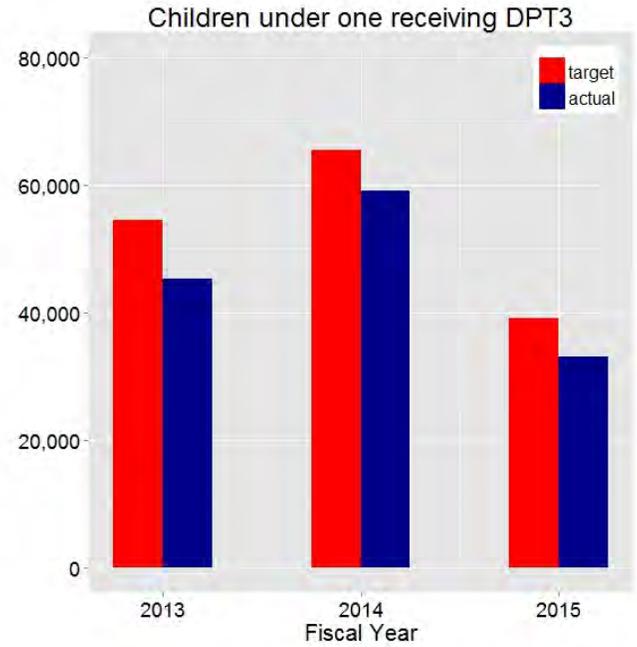
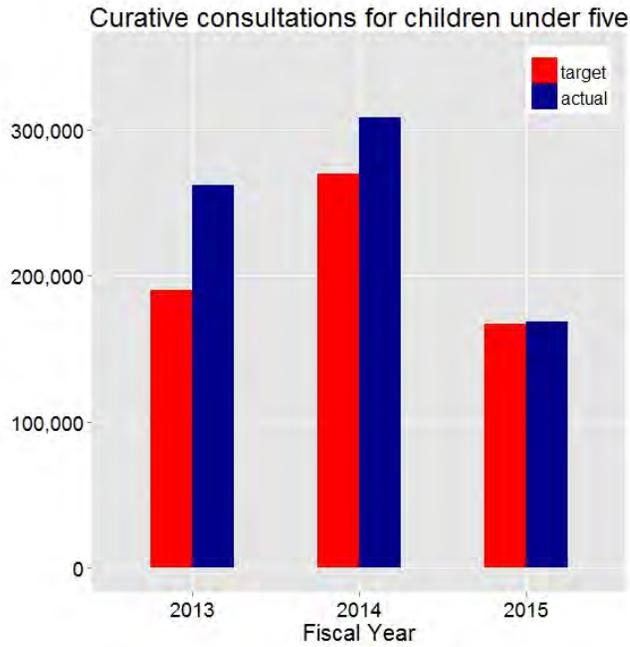
Intermediate Result	Indicator	FY2013		FY2014		FY2015*	
		Target	Actual	Target	Actual	Target	Actual
Child Health	Percentage of curative consultations for children less than 5 years	0.40	0.55	0.55	0.63	0.65	0.53
Child Health	Number of curative consultations for children less than 5 years	190,620	262,464	269,967	309,108	333,545	168,562
Child Health	Number of children less than 12 months of age who received DPT3 from USG supported programs	54,463	45,306	65,445	59,050	78,194	33,033
Child Health	Percentage of children less than 12 months of age who received DPT3 from USG supported Counties	0.60	0.50	0.7000	0.6320	0.8000	0.5100
Child Health	Number of children less than 12 months of age who received measles vaccine from USG supported programs			65,445	76,233		
Nutrition	Number of children under 5 years of age who received Vitamin A from USG-supported programs	194,000	62,459	194,000	95,534		40,223
Family Planning	Number of new users/acceptors of modern FP methods	8,020	10,048	16,830	15,373	16,910	7,640
Family Planning	Couple years of protection (CYP) in USG supported programs	12,470	18,267	20,110	4,031	4,434	
Focused ANC	Percentage of women with one ANC visit	0.65	0.33	0.5000	0.3590	0.5500	0.4210
Focused ANC	Number of women with one ANC visit	82,602	42,143	65,447	47,062	53,758	27,255
Focused ANC	Percentage of women with at least 4 ANC visits during pregnancy in USG supported Counties	0.40	0.25	0.4000	0.2150	0.4500	0.2390
Focused ANC	Number of women with at least 4 ANC visits during pregnancy in USG supported Counties	50,832	31,461	52,357	28,153	43,984	15,479
Focused ANC	Percentage of pregnant women who received IPT 2nd dose.	0.60	0.30	0.4000	0.4190	0.5000	0.5230
Focused ANC	Number of pregnant women who received IPT 2nd dose.	49,561	25,058	26,179	27,487	26,880	18,952
Safe and Hygienic Delivery	Percentage of delivery in facility assisted by skilled birth attendant	0.20	0.05	0.1000	0.0490	0.1500	0.0680
Safe and Hygienic Delivery	Number of delivery in facility assisted by skilled birth attendant	25,416	5,736	13,089	6,431	14,661	4,157

Safe and Hygienic Delivery	Percentage of women receiving a uterotonic immediately after birth	0.40	0.27	0.3000	0.2100	0.2200	0.1890
Safe and Hygienic Delivery	Number of women receiving a uterotonic immediately after birth	5,790	4,261	14,220	9,955	10,458	6,212
Malaria	Number of insecticide treated nets (ITNs) purchased / received in an fiscal year that was distributed in reported fiscal year with USG funds					90,000	35,669
HIV/AIDS (PMTCT)	Percent of antenatal clients tested for HIV (in targeted facility).	1.00	1.02	1.0000	1.2700	1.0000	0.6850
HIV/AIDS (PMTCT)	Number of antenatal clients tested for HIV (in targeted facility).	9,000	10,932	10,100	12,854	14,140	6,028
HIV/AIDS (PMTCT)	Percent of antenatal clients who collects (HIV test) results	1.00	1.00	1.0000	0.9970	1.0000	0.9900
HIV/AIDS (PMTCT)	Number of antenatal clients who collects (HIV test) results		10,452	10,100	12,815	14,140	5,970
HIV/AIDS (PMTCT)	Percent of antenatal clients testing HIV positive (new case; (in targeted facility)	0.03	0.04	0.0360	0.0240		0.0270
HIV/AIDS (PMTCT)	Number of antenatal clients testing HIV positive (new case; (in targeted facility)	270	345	480	304		163
HIV/AIDS (PMTCT)	Percent of HIV-infected pregnant women who received antiretroviral prophylaxis to reduce the risk of mother-to-child-transmission	0.30	0.55	0.5000	0.9080	0.5000	1.0700
HIV/AIDS (PMTCT)	Number of HIV-infected pregnant women who received antiretroviral prophylaxis to reduce the risk of mother-to-child-transmission	87	189	240	276		201
HIV/AIDS (Testing and Counseling)	Number of individuals who received Testing and Counseling (T&C) services for HIV and received their test results.	34,300	25,219	40,000	39,095	44,915	18,557
Health System	Number of (facility) managers in USG supported facilities who received performance written feedback (after a supportive supervision) from implementing agency	0.75	0.47	0.80	0.67	0.85	0.59
Health System	Percentage of (facility) managers in USG supported facilities who received performance written feedback (after a supportive supervision) from implementing agency	268	450	294	836	312	395
Health System	Percentage of targeted facilities achieving 80% of performance standards						
Health System	Percent of USG-assisted service delivery sites providing family planning (FP) counseling and / or services.	0.85	0.53	0.70	0.71	0.85	0.76

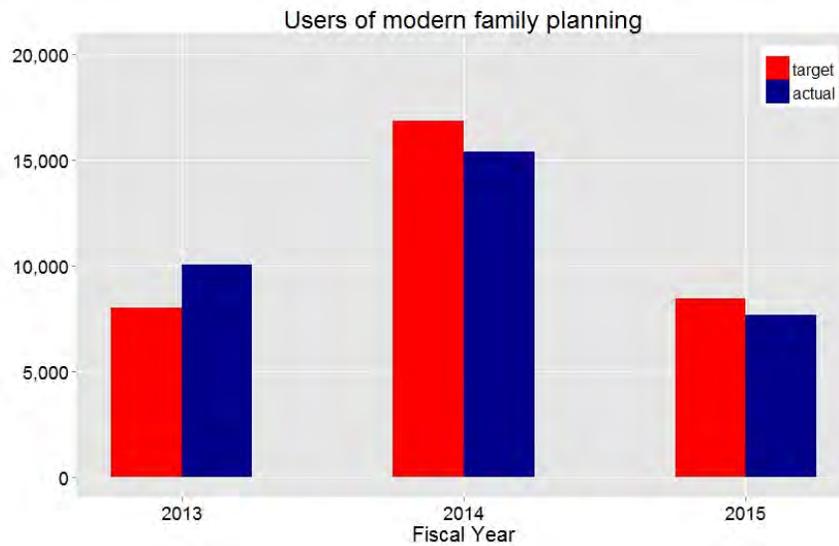
Health System	Number of USG-assisted service delivery sites providing family planning (FP) counseling and / or services.	304	439	257	898	312	525
Health System	Number of health personnel trained with USG support in the different program areas	2,750	1,585	2,250	1,145	1,500	412
Health System	Number of people trained in family planning/reproductive health (FP/RH) with USG funds	400	295	400	476	300	223
Health System	Number of people trained with USG funds in malaria treatment or prevention	425	124	480	294	500	58
Health System	Number of health workers trained in intermittent preventive treatment in pregnancy (IPTp) with USG funds	78	35	100	248	200	53
Health System	Number of people trained in good health and hygiene practices	450	956	500	501	500	195
Water Sanitation and Hygiene	Number of individuals reached with WASH promotion activities	70,900	48,877	70,900	122,105	140,420	80,227
Community Mobilization	Number of community members (e.g. HHPs) trained with USG support in the different program areas	3,500	157	2,000	1,712	3,800	376
Community Mobilization	Number of clients who received community-based services delivered through HHPs	12,545	16,307	30,000	51,146	63,933	39,317
MCHIP	Number of improvements to laws, policies, regulations or guidelines related to improve access to and use of the services drafted with USG support	6	6	4	4		
MCHIP	HIV Sentinel Surveillance survey report completed	1	1	0	0		
MCHIP	HIV/AIDS Division annual report compiled	1	1	1	1		

### ANNEX 3: ISDP PERFORMANCE, FISCAL YEAR 2013 THROUGH TWO QUARTERS OF FISCAL YEAR 2015.

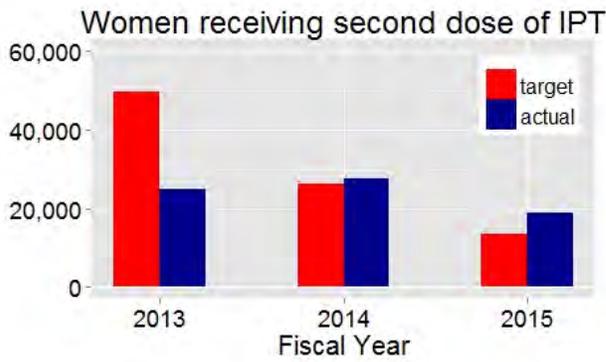
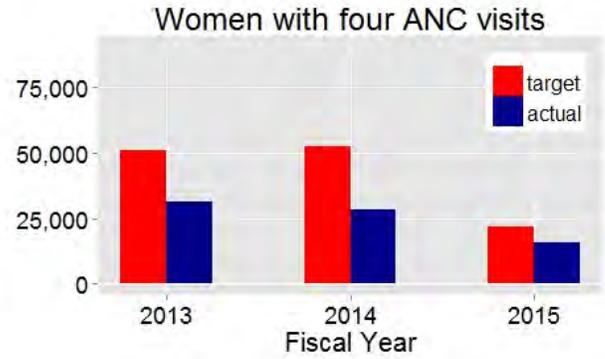
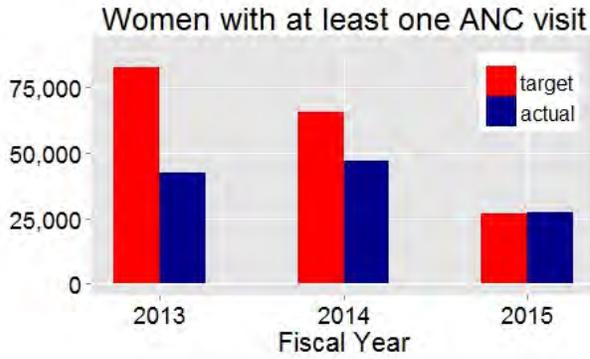
#### Child Health



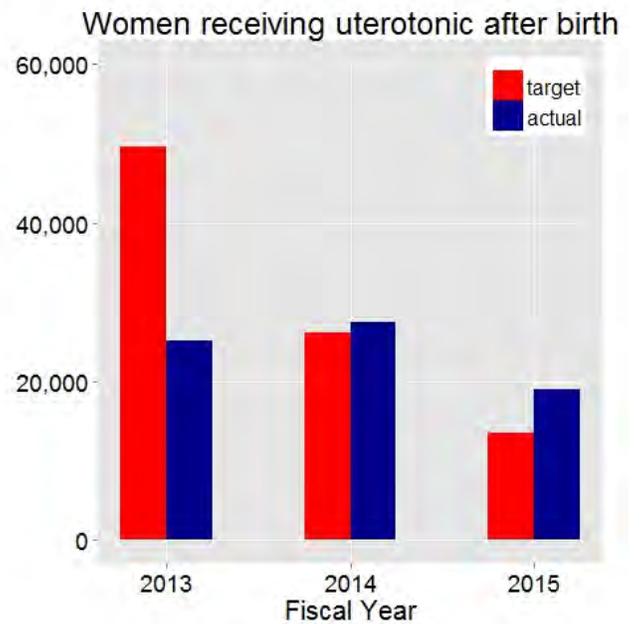
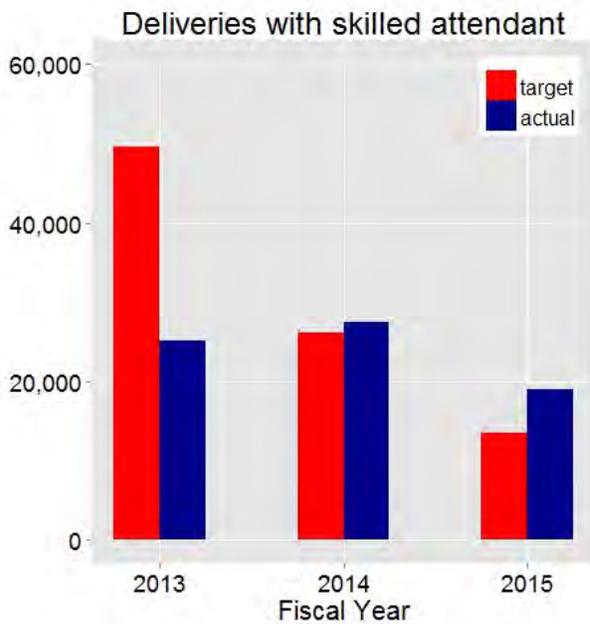
#### New users of modern family planning



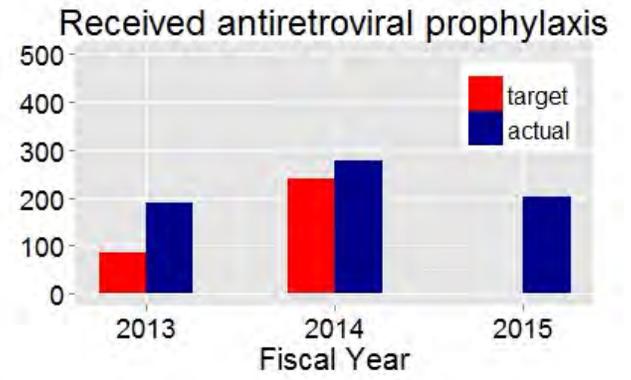
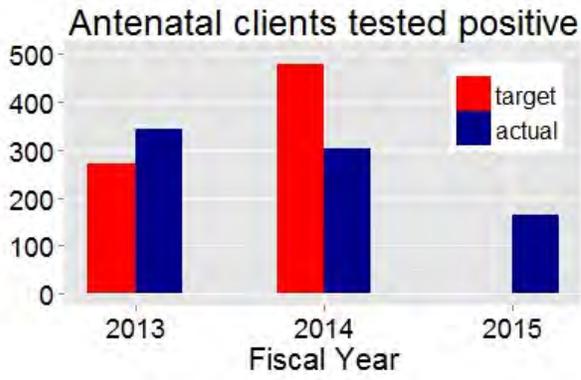
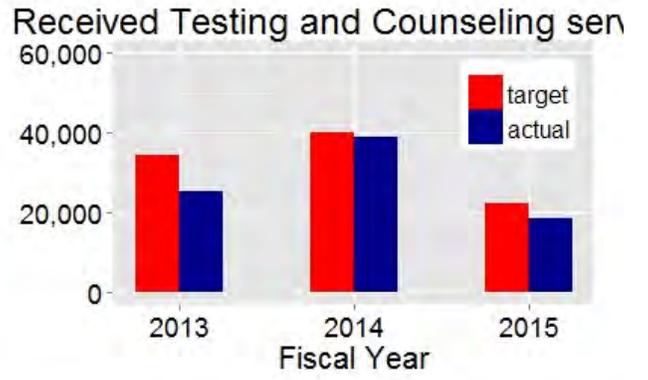
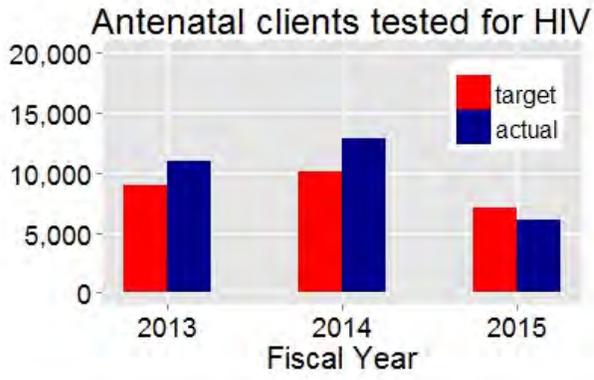
Antenatal Care



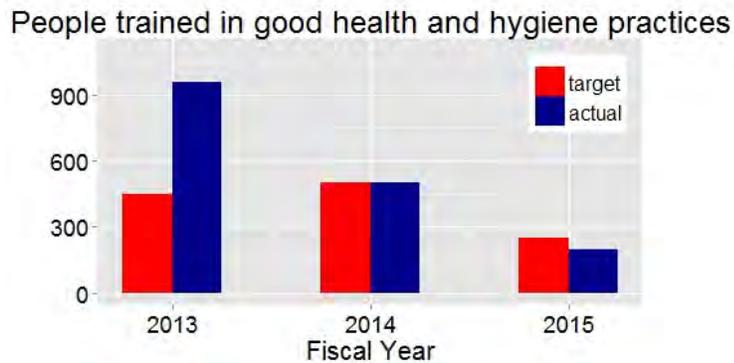
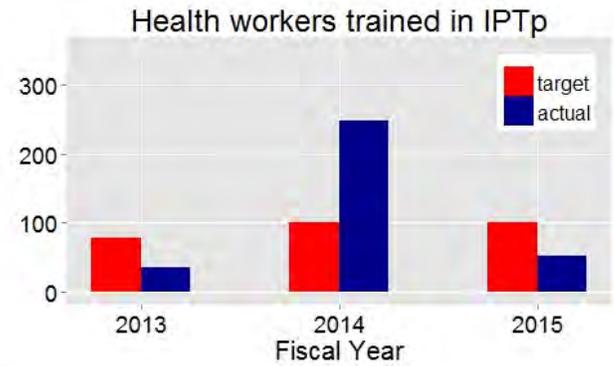
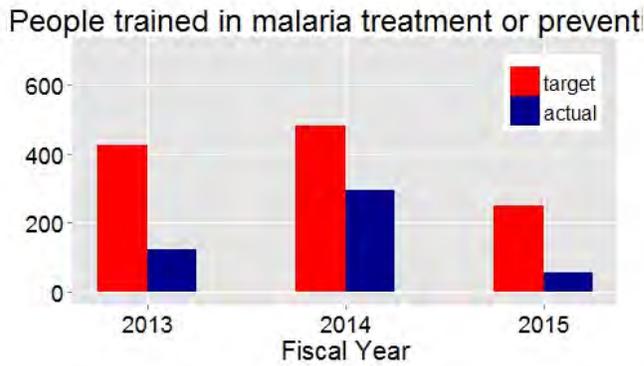
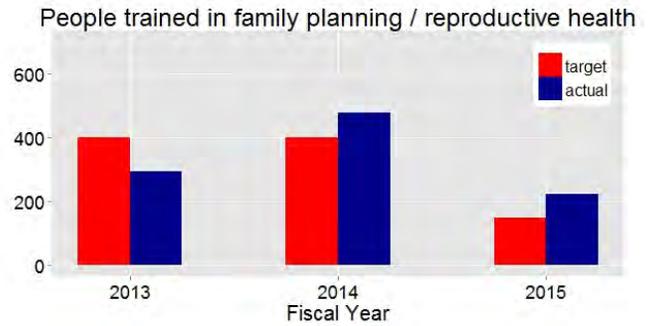
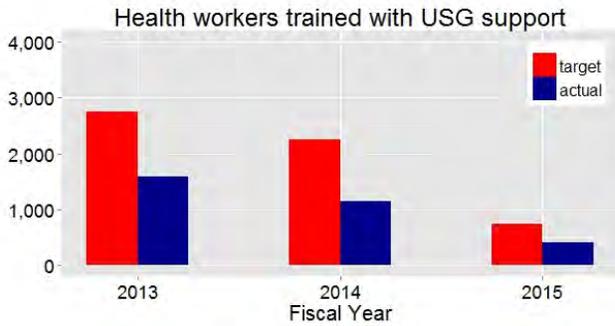
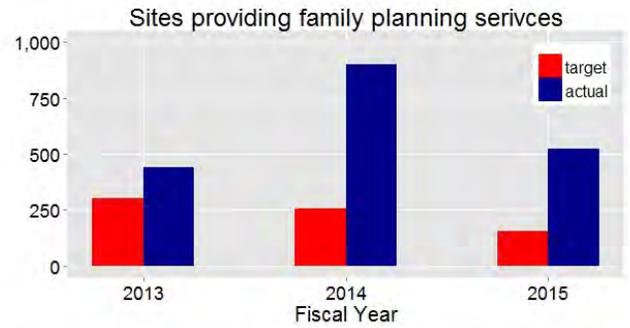
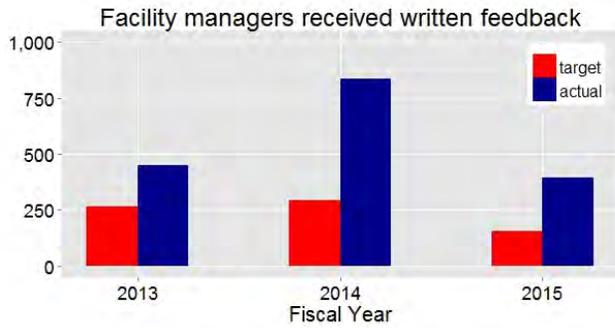
Safe and Hygienic Delivery



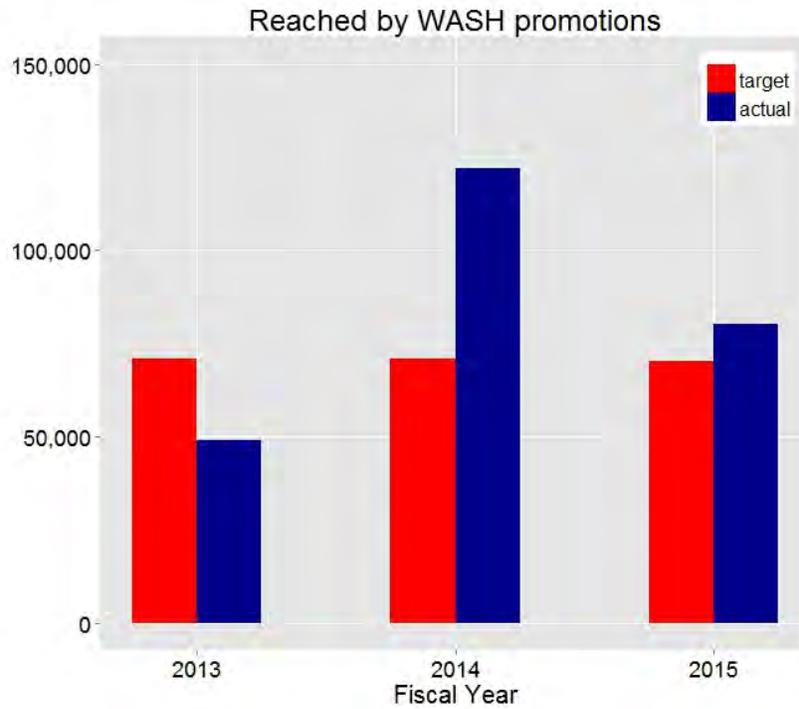
HIV/AIDS



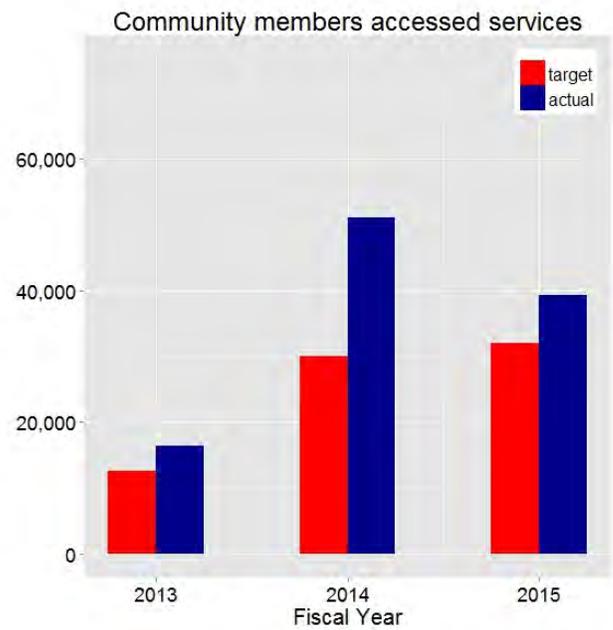
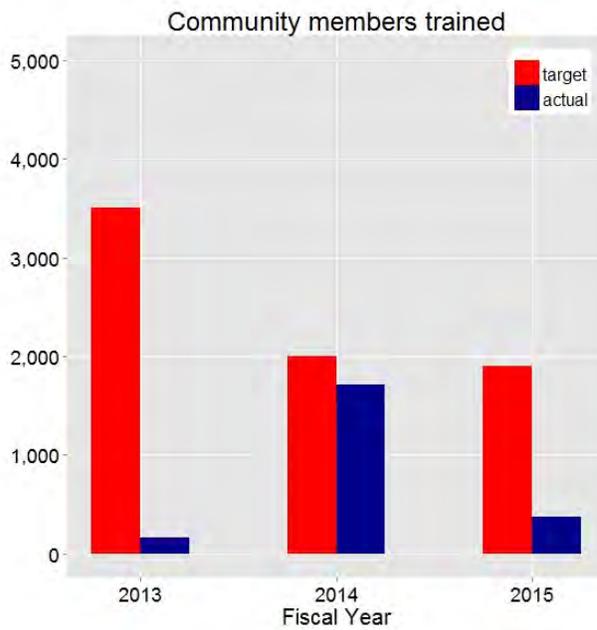
Health System



## Water Sanitation and Hygiene

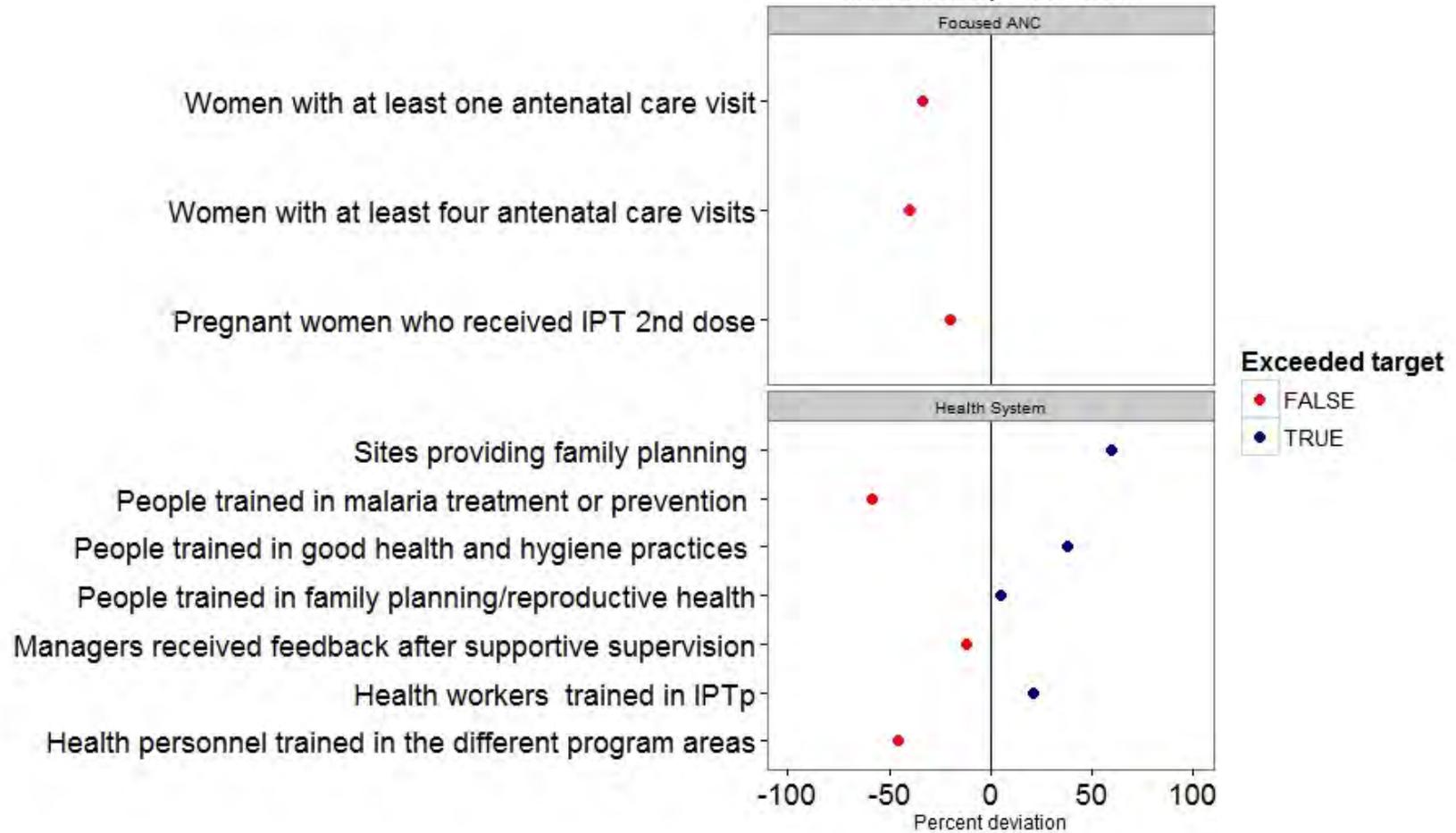


## Community Mobilization

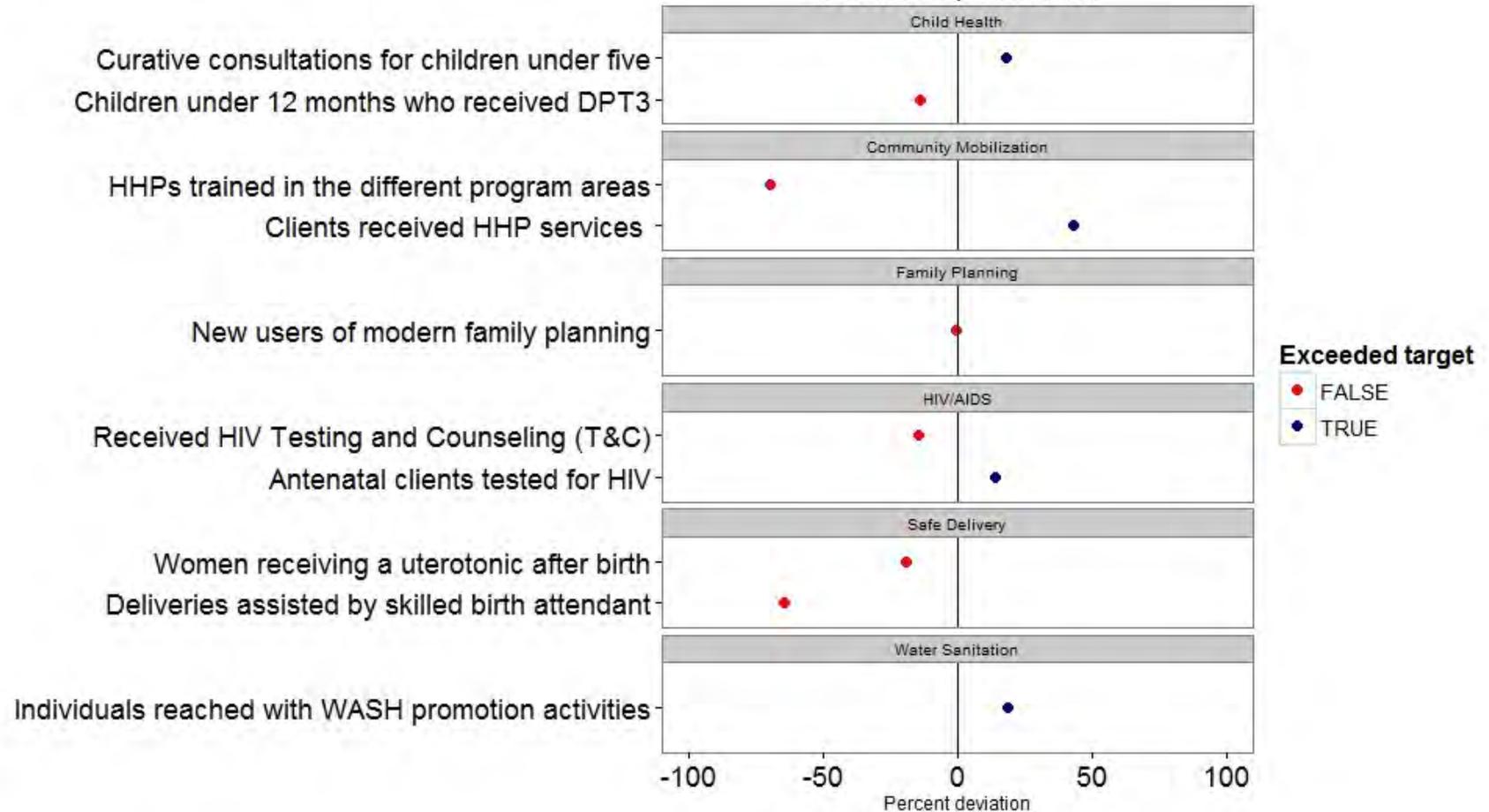


Overall percent deviation from target

### ISDP percent deviation from target FY2013-Q2 FY2015



### ISDP percent deviation from target FY2013-Q2 FY2015



## ANNEX 4: LIST OF KEY DOCUMENTS

1. 2013 EmONC Assessment, Central Equatoria Factsheet, MOH, 2013
2. 2013 EmONC Assessment, Western Equatoria Factsheet, MOH, 2013
3. Advance distribution of misoprostol for the prevention of postpartum haemorrhage in South Sudan”, Smith et al., 2014
4. Annual IDSR Report: Year 6, USAID, 2014
5. Annual Report for IDSR Project in South Sudan – FY2014 (1<sup>st</sup> October 2013-30<sup>th</sup> September 2014), USAID, 2014
6. Baseline Assessment Report Central and Western Equatoria States, HSSP, 2013
7. Central Equatoria State Strategic Plan 2012/13 – 2014/15
8. Common Salary Scale for Primary Healthcare Workers in South Sudan, Ministry of Health, 4<sup>th</sup> April 2015
9. Deliver EMF Project Report, Bradley, September 2014
10. Democracy, Human Rights, and Governance Assessment Revisited: 2012-2015, USAID, April 2015
11. Designing and Operating Grant for Primary Health Care Centers, Presentation given to the Health TWG Working Session, 26<sup>th</sup> March 2015
12. Emergency Medicines Fund Fact Sheet, USAID, 2014
13. Ezo County Health Department Work Plan for 2015, State Ministry of Health Western Equatoria, 2015
14. Guidelines for County Planning and Budgeting for Fiscal Year 2013-2014, Ministry of Finance and Economic Planning
15. Handover Roadmap for MSF supported services in Yambio State Hospital, MSF, July 2014
16. Health Pooled Fund South Sudan Mid Term Evaluation Report, Cammack et al, January 2015
17. HSSP Work Plan for Year 1, USAID HSSP, 2012
18. HSSP Work Plan for Year 2, USAID HSSP, 2013
19. HSSP Work Plan for Year 3, USAID HSSP, 2014
20. HSSP Year One Annual Report, USAID HSSP, 2013
21. HSSP Year Two Annual Report, USAID HSSP, 2014
22. HSSP Hub Based Approach (PowerPoint presentation), 2015
23. HSSP Organization Chart, HSSP, 2015
24. HSSP Task Order, USAID, 2012
25. Innovative Financing in Early Recovery: The Liberia Health Sector Pool Fund, Hughes, Glassman, Gwenigale, 2012
26. Introduction of New common Salary Scale/Infection Allowances for Primary Healthcare Workers, Letter from MoH to SMOHs, 10<sup>th</sup> March 2015
27. ISDP Annual Report October 2013 – September 2014, USAID/Jphiego, 2014
28. ISDP Quarterly Report April 1 – June 30, 2014
29. ISDP Quarterly Report January 1 – March 30, 2014
30. ISDP Quarterly Report October 1 – December 31, 2013
31. ISDP Annual Report October 2012 – September 2013, USAID/Jphiego, 2013
32. ISDP Quarterly Report April 1 – June 30, 2013
33. ISDP Quarterly Report January 1 – March 30, 2013
34. ISDP Quarterly Report January 1 – December 31, 2013
35. USAID/South Sudan Semi-Annual Portfolio Review Project Implementation Report (PIR) April – Sep, 2013
36. ISDP Monitoring Plan Year 1
37. ISDP Monitoring Plan Year 2
38. ISDP Normal Labor, Childbirth and Immediate Newborn Care Assessment Sheet 2014

39. ISDP Post-Partum Care Assessment Sheet 2014
40. ISDP Basic Emergency Obstetrics and Neonatal Care (BemONC) Assessment 2014
41. ISDP Community Activities by County 2015
42. ISDP Focused Antenatal Care Assessment Sheet 2014
43. ISDP Infection Prevention Assessment Sheet 2014
44. Standards Based Management and Recognition (SBM-R) Facilities Protocol (Implementing Infection Prevention) 2015
45. South Sudan Quality Assurance Recognition Strategy
46. Standards Based Management and Recognition: A field Guide 2005
47. ISDP Task Order, USAID, 2012
48. ISDP Year 2 Implementation Plan October 2013 – September 2014, Jphieigo, 2013
49. Note from Health LSS meeting, MOFEP, 26<sup>th</sup> March 2015
50. Letter from Ministry of Health to Ministry of Finance and Economic Planning: Realignment of 27.5m from Operating to Transfers Chapter, MoH, 22<sup>nd</sup> May 2014
51. Letter from Ministry of Health to Ministry of Finance and Economic Planning: Realignment of 37m from Operating to Transfers Chapter, MOFEP, 29<sup>th</sup> May 2014
52. Pooled Funding to Support Service Delivery: Lessons of Experience from Fragile and Conflict-Affected States, Commins et al, 2013
53. Quarterly Performance Report Nov 2014 – Jan 2015 – Technical Assistance for sub-national capacity building in payroll and PFM in South Sudan, Ecorys/EU, March 2015
54. Review on the Health Training Institutions in South Sudan to identify areas of support, July 2014, Health Pooled Fund
55. Scaling up Mid-level Health Cadre Strategy Paper, MOH, November 2014 (Draft)
56. SIAPS Quarterly Report, Project Year 3, Quarter 4, USAID/SIAPS, 2014
57. South Sudan Conflict Assessment, USAID, February 2013
58. South Sudan Health Rapid Results Project Implementation Report, World Bank, December 2014
59. South Sudan Health Sector Development Plan 2012-2016, MOH, 2012
60. South Sudan Humanitarian Response Plan 2015, OCHA South Sudan, December 2014
61. South Sudan Operational Plan Report FY 2013, PEPFAR, 2013
62. Standards Based Management and Recognition Field Guide, Jhpeigo, 2007
63. State and Local Government Health Sector Planning, Budgeting and Reporting Guidelines for Fiscal Year 2014/15, Ministry of Health
64. State Coordination Meeting of the Ministry of Health, Central Equatoria, Conducted on Friday 20<sup>th</sup>, March 2015, Ministry of Health Central Equatoria, 2015
65. Sudan Health Transformation project Phase II End of Project Performance Evaluation Report, Hughes & Ali, MSI, 2012
66. Summary of the November 2011 Donor harmonization Workshop, MOH, November 2011
67. USAID / South Sudan strategic exercise (Feb-June 2014) strategy document to support re-entry, USAID, June 2014
68. USAID/South Sudan FY 2013 Full Operational Plan Report, 2013
69. USAID/South Sudan FY 2014 Full Operational Plan Report, 2014
70. USAID/South Sudan Strategy Document to Support Re-entry, MSI/USAID, 2014
71. USAID/South Sudan PEPFAR Report (Jhpieigo) for APR, 2014

## ANNEX 5: LIST OF INTERVIEWEES

List of persons consulted in facility visits, semi-structured interviews and focus group discussions, by location

Name	Position	Program/Organization
<b>KajoKeji County, Central Equatoria</b>		
Jacqueline Maina	CIP Management Team	ARC
Anet Gune	CIP Management Team	ARC
Peter Adiga	County Health Director	CHD KajoKeji
Julius Taban Lowani	Clinical Officer in Charge	Kangayi PHCC
Beneficiaries (19)	Beneficiaries	Kangayi PHCC
HHPs (12)	Home Health Promoters	Kangayi PHCC
BHC (9)	Boma Health Committee	Jalimo
Beneficiaries (15)	Beneficiaries	Jalimo PHCC
Health Staff (8)	Health Staff	Jalimo PHCC
<b>Lainya County, Western Equatoria</b>		
Amondi Dellah	Program Manager	SSUHA
Dr. Morbe Taban	Health Management Staff	Lainya Hospital
Dusman Clara Simon	Health Management Staff	Lainya Hospital
County Health Director	County Health Director	CHD Lainya
Cosmos Agrey Janda	Clinical Officer In Charge	Limbe PHCC
HHPs (8)	Home Health Promoters	Limbe PHCC
Acting Clinical Officer in Charge	Acting Clinical Officer in Charge	Lora PHCC
Registered Midwife	Registered Midwife	Lora PHCC
<b>Terekeka County, Central Equatoria</b>		
Taban John	Acting Program Manager	ADRA
Paulino Pitian	County Health Director	CHD Terekeka
Chaplain Laido	Clinical Officer In charge	Terekeka Central Hospital
James Tambura Michael	Clinical Officer in Charge	Digala PHCC
HHP (1)	Home Health Promoters	Digala PHCC
<b>Juba County, Central Equatoria</b>		
Joe Asobasi	Acting Program Manager	ADRA
Veronica Ageno	Clinical Officer in Charge	Lologo PHCC
Linda Oliver	Acting Medical Officer In Charge	Munuki PHCC
<b>Yambio, Western Equatoria</b>		
Taban Mark John	Acting Program Manager	World Vision
HHPs (13)	Home Health Promoters	Bazungua PHCC
Health Staff (5)	Health Staff	Bazungua HPCC
<b>Ezo County, Western Equatoria</b>		
Taban Mark John	Program Manager	World Vision
Moses Girish	County Health Director	CHD Ezo
Health Staff (12)	Health Staff	Naandi PHCC
HHP (9)	Home Health Promoters	Naandi PHCC
<b>Nzara County, Western Equatoria</b>		
Moses Lodu Moses	Program Manager	IMC
Richard Benty Bagbolo	Community Outreach Officer	IMC
Midwife (1)	Midwife	Nzara PHCC

ANC Beneficiaries (16)	ANC Beneficiaries	Nzara PHCC
HHPs/BHC (12)	Home Health Promoters/Boma Health Committee	Yabua HPCU
Tambura County, Western Equatoria		
Charles Vongevo	Acting Program Manager	Johannitor
Angelo Edward	Pharmacist	CHD Tambura
John Nyisi	Chairman	Village Health Committee
Health Staff	Health Staff	Tambura PHCC
Mundri East, Western Equatoria		
Mary Rose	PPH Focal Person	CUAM
Minor Janga	County Health Administrator	CHD Mundri East
HHPs (13)	Home Health Promoters	Lainyi PHCC
Health Staff (5)	Health Staff	Lainyi PHCC
Beneficiaries (18)	Beneficiaries	Lainyi PHCC
George Kenyi	Community Health Worker/Officer in Charge	Wandi PHCU
HHPs/Community leaders (18)	Home Health Promoters/Community Leaders	Wandi PHCU
Beneficiaries (34)	Beneficiaries	Wandi HPCU
National		
Dr. Felix Ladu	M&E Director	Jhpiego
Dr. Victor Guma	Program Manager	Jhpiego
Dr. T Morris	Technical Director	Jhpiego
Patricia McLaughlin	Chief of Party	Jhpiego
Dr. Samson Baba	Director General – Primary Healthcare	South Sudan Ministry of Health
Michael Odong	Community Engagement Advisor	
Basilica Modi	AOR Integrated Service Delivery Project	USAID

## ANNEX 6: DATA COLLECTION TOOLS

### ISDP Mid Term Evaluation: Key Informant Interview Guide

THIS INTERVIEW GUIDE HAS BEEN PREPARED TO GET INFORMATION FROM DIFFERENT RESPONDENTS, INCLUDING CIP MANAGERS, CHDS, MOH OFFICIALS, MIDWIVES AND HEALTH FACILITY MANAGER. THE RESPECTIVE RESPONDENTS PER QUESTION IS SHOWN IN FRONT OF THE QUESTION ITSELF.

Interviewee Name	Organization
Location	Position
Email Contact	
Interviewer	Date

#### Results of USAID Health Investments through Integrated Service Delivery Program

1. How familiar are you with USAID-Maternal and Child Health Integrated Program Model?
2. In your opinion, what's the level of performance of Integrated Service Delivery Program to date? (Give reasons for your Response).
3. What can you say is the level of scale up of Post-Partum haemorrhage prevention activities?
4. Are you familiar with QI approach used by MCHIP SBM-R? What are some of its features?

*(Chief of Party JHPiego, Program Managers, County Health Department Directors, Director General-PHC-Ministry of Health, CoR ISDP-USAID)*

#### Relevance of Projects work to both short and long term development needs of Health Service Delivery in South Sudan

1. The political situation when the project was developed was not the same as now, in your view can the development activities be effective considering the current political crisis?
2. How has ISDP-MCHIP addressed short and long term needs of health System in terms of what the project was designed to do? (Staff support, Technical Support & Specific Services to reduce Maternal Mortality)
3. Do you think the Govt will be in a position to take over services under ISDP-What mechanisms does MoH have in place to manage such a transition?

*(Chief of Party JHPiego, Program Managers, County Health Department Directors, Director General-PHC-Ministry of Health, CoR ISDP-USAID)*

#### ISDP Coordination with HSSP Project Activities

1. How is USAID approach of working to strengthen communities being effective?
2. In your view, where does the mandate of Health System Strengthening and ISDP differ? At what level?
3. HSSP build leadership/Management at county level, are responsible for managing service delivery at the county level, but this is also the role of ISDP-How does this happen?
4. It's envisioned that county health officers with training would provide supportive supervision to facilities where ISDP is working to address issues that are inhibiting service delivery. How will this Happen?

*(Chief of Party JHPiego, Program Managers, County Health Department Directors, Director General-PHC-Ministry of Health, CoR ISDP-USAID)*

### **Advantages and disadvantages of ISDP Current Model & Approach**

1. ISDP is a community level health project, there is a community mobilization aspect that was initially put on hold but it's now underway. This aspect overlaps with HSSP, are there issues with that?
2. Is it possible for NGOs to effectively handover some services to the government i.e. (Staff payment)
3. How effective is ISDP approach to training of health workers (Considering NGOs paid workers & Government Paid Workers)

*(Chief of Party JHPiego, Program Managers, County Health Department Directors, Director General-PHC-Ministry of Health, CoR ISDP-USAID)*

### **Impact of Conflict and Tenuous Political Situation on ISDP Project-How Future Conflict and Insecurity could affect the project in its Final 2 years?**

1. What did ISDP have to deal with due to conflict and Stability? How did they respond?
2. Due to Cholera outbreak ISDP had to shift resources and this had an effect on immunizations and other project activities. How did this impact on delivery of other services? How did ISDP handle it?
3. What can the project do to mitigate future issues using conflict sensitive programming?
4. Based on implementation and learning on experience that has occurred over the previous project years, how can USAID help ISDP Partners on Conflict Sensitive Programming?

*(Chief of Party JHPiego, Program Managers, County Health Department Directors, Director General-PHC-Ministry of Health, CoR ISDP-USAID)*

### **Partnerships**

1. Who are your partners in this program?
2. How are partnerships working within the ISDP arrangement?
3. Do they have meetings and how do they handle the resolutions passed from those meetings?
4. How can the partnership arrangements be strengthened for better results?
5. What is your opinion on the Strength and Weaknesses of various implementing partners in general?  
How do you balance the management of the partners?

*(Chief of Party JHPiego, Program Managers, County Health Department Directors, Director General-PHC-Ministry of Health, CoR ISDP-USAID)*

### **Gender issues**

1. Do you consider gender issues in ISDP activities?
2. How are gender issues involved during important activities like hiring of staff, training etc.?

*(Chief of Party JHPiego, Program Managers, County Health Department Directors, Director General-PHC-Ministry of Health, CoR ISDP-USAID)*

## ISDP Mid Term Evaluation Focus Group Discussion Guide

THIS FGD GUIDE HAS BEEN PREPARED TO GET INFORMATION FROM DIFFERENT RESPONDENTS, INCLUDING HHPs, V/BOMA HEALTH COMMITTEES, NURSES, MIDWIVES AND LAB TECHNICIANS. THE RESPECTIVE RESPONDENTS PER QUESTION IS SHOWN IN FRONT OF THE QUESTION ITSELF.

Name of group (HHP, etc.)..... State, County, Site of FGD.....  
 Number of participants..... Note-taker.....  
 Date..... Start time..... End time.....

Sample Checklist for all FGDs	Complete
Facilitator	
Flip charts	
Organize setting	
Refreshments	

### Draft prompts:

Ante Natal Clinic (ANC), PMTCT, Postpartum Hemorrhage (PPH), Family Planning, Help Baby Breath, and Maternal interventions, Newborn interventions, Child health interventions, Immunization, SBM-R, Partnerships, Supervision, and ISDP

### Draft FGD Questions: HHP

**Introductions (FG Facilitators and participants)**

**Brief description of purpose of FGD**

**Ask if there are any questions/clarifications**

What have been the results of the USAID's health investments through ISDP, considering both targets established for these activities and unanticipated results?

*(Midwives, Nurses, HHPs, B/Village Health Committees, Counselors)*

1. What has been the Maternal and Child Health situation in the county?
2. What kind of supervision do you get from the PHCCs?
3. What have you learned from ISDP that has made the most significant improvement in your work? Give examples.
4. What training have you received from the Maternal and Child Health Integrated Program? **(Also probe on the PPH prevention activities being received by the pregnant women)?**

How relevant is the project's work to both short term- and long-term development needs of health services delivery in South Sudan?

*(Midwives, Nurses, HHPs, B/Village Health Committees, Counselors)*

1. Do you think the training was relevant in your work?
2. What services do you offer in the communities **(also probe on the PPH prevention activities being offered to pregnant women and FP services, is this what the community needs)?**

What has been the impact of conflict and tenuous political situation on the ISDP project and how could future conflict and insecurity affect the project during its final two years?

*(Midwives, Nurses, HHPs, B/Village Health Committees, Counselors)*

1. What problems have you experienced OR experiencing in your work?

2. What are the most significant obstacles/barriers? *Probe on the conflict situation*
3. What are some of your suggested sustainable solutions to those problems and challenges?
4. In the event that the Partner Organization that you are working with pulls out, what do you think you can be able to do to continue to unveil the same services that you have been offering?
5. Do you have any recommendations on how the program can be more effective in offering the services?

**Thank the respondents for coming!**

### **ISDP Mid Term Evaluation Focus Group Discussion Guide For Beneficiaries**

Name of group (HHP, Beneficiaries etc.).....  
 State, County, Site of FGD.....  
 Number of Participants and the Sex.....  
 Moderator.....  
 Note-taker.....  
 Date.....  
 Start time.....  
 End time.....

<b>Sample Checklist for all FGDs</b>	<b>Complete</b>
Facilitator	
Flip charts	
Organize setting	
Refreshments	

**Draft prompts:**

PMTCT  
 Integrated Management of childhood illness (IMCI)  
 Postpartum Hemorrhage (PPH)  
 Family Planning  
 Help Baby Breadth  
 Maternal interventions  
 Newborn interventions  
 Child health interventions  
 Immunization  
 ISDP

**Draft FGD Questions: Beneficiaries**

***Introductions (FG Facilitators and participants)***

***Brief description of purpose of FGD***

***Ask if there are any questions/clarifications***

What have been the results of the USAID’s health investments through ISDP, considering both targets established for these activities and unanticipated results?

1. What has been the Maternal and Child Health situation in the county?
2. What kind of support do you get (get) from (to) your partners during pregnancy? **(Probe on ANC visits etc.)**.
3. What services are making the most difference in your lives? Give examples.

How relevant is the project's work to both short term- and long-term development needs of health services delivery in South Sudan?

1. What **services** are you receiving from the Maternal and Child Health Integrated Program? (**Also probe on the PPH and FP services and are these what you would require to meet your needs?**).
2. Do you think the services are relevant in meeting your Maternal and Child Health Needs?

What has been the impact of conflict and tenuous political situation on the ISDP project and how could future conflict and insecurity affect the project during its final two years?

1. What problems have you experienced OR experiencing in accessing Maternal and Child Health Services?
2. What are the most significant obstacles/barriers to your accessing these health services efficiently?  
**Probe on the conflict situation**
3. Do you have any recommendations on how the program can best serve your maternal health needs?

**Thank the respondents for coming!**

### **ISDP South Sudan Mid Term Evaluation Facility Checklist**

1. What is the number of clinical staff members at the facility disaggregated by sex:  
Male..... Female.....
2. Number of clinical staff with salaries paid by  
NGOs..... Government.....
3. MNCH services offered by the facility i.e. (ANC, VCT, Deliveries, PPH, Malaria, Family Planning, Integrated Management of childhood illness (IMCI), EPI, Laboratory etc.)
4. What is the monthly number of patients/clients by gender accessing the above-mentioned services?
5. What is the facility's catchment area population?
6. Does the facility have a water source?
7. Number of monthly supervisory visits from the County Health Directorate?
8. Does the facility have an SBM-R management protocol (*request to see a copy*)?
9. Number of clinical staff trained in (ANC, VCT, Deliveries, PPH, Malaria, Family Planning, Integrated Management of childhood illness (IMCI), EPI, Laboratory etc.).
10. Frequency of drug stock outs at the facility in the last three months.

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