CHALLENGES IN HEALTH TRANSFORMATION



Final Report of the Sudan Health Transformation Project (SHTP)

April 2004 to June 2009

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SHTP
Sudan Health Transformation Project

JSI
JSI Research & Training Institute, Inc.

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Acronyms

AAH	Action Africa Help
AMREF	African Medical and Research Foundation
ANC	Antenatal Care
BCC	Behavior Change Communications
BHC	Boma Health Committee
CBO	Community-Based Organization
CHC	Community Health Committees
CHD	County Health Department
CHW	Community Health Worker
CTO	Cognizant Technical Officer
DPT	Diptheria, Pertussis and Tetanus
EPI	Expanded Program on Immunization
FBO	Faith-Based Organization
GoSS	Government of Southern Sudan
HMIS	Health Management Information System
IHAA	International HIV & AIDS Alliance
IMC	International Medical Corps
INGO	International Non-governmental Organizations
IP	Implementing Partners
IRC	International Rescue Committee
JSI	JSI Research & Training Institute, Inc.
LLITN	Long-Lasting Insecticide Treated Nets
LMIS	Logistics Management Information System
M&E	Monitoring and evaluation
MCH	Maternal and child health
MMR	Maternal Mortality Rate
MoH	Ministry of Health
MRDA	Mundri Relief and Development Agency
NGO	Non-governmental Organizations
OFDA	Office of Foreign Disaster Assistance
OVC	Orphans and Vulnerable Children
PHC	Primary Health Care
PHCC	Primary Health Care Center
PHCU	Primary Health Care Unit
PITC	Provider-Initiated Testing and Counselling
PSI	Population Services International
RFA	Request for Application
RFP	Request for Proposal
RH	Reproductive health
RPHSD	Research, Planning and Health Systems Development
RTC	Regional Training Center
SHTP	Sudan Health Transformation Project
SIDF	Sudan Inland Development Foundation
SMoH	State Ministry of Health
SNGO	Sudanese Non-governmental Organization
SPLM	Sudan Peoples' Liberation Movement
USAID	United States Agency for International Development
VHC	Village Health Committees
WVI	World Vision International



Letter from the Chief of Party

The SHTP journey has come to an end. JSI and its partners have appreciated the opportunity to help make a difference in the lives of many of the most vulnerable Southern Sudanese mothers, children, families, and communities. It is heartening to note the progress made by the GoSS/MoH, particularly with respect to: the development of health sector norms, standards, and guidelines; counties and states developing their health systems; immunization coverage increases; bed nets distributed; and health care workers recruited and trained. We are pleased at the extent SHTP has been able to make a contribution. We wish our colleagues success with the enormous task ahead in further building and strengthening public health programs for the benefit of a strong and healthy population.

We thank the staff from JSI/Sudan and JSI/Boston, as well as our hard working partner NGOs and colleagues in the field. We appreciate the spirit of collaboration and help we received from the GoSS/MoH at national, state, and local levels and from other agencies in Sudan — collaborating NGOs, UNICEF, WHO, CDC, the Global Fund, and other organizations. Last, but far from least, we thank USAID and the dedicated U.S. Government staff who have helped and supported us along the way.

This report documents the challenges, achievements, and lessons learned of SHTP towards assisting to build a new health system in Southern Sudan. SHTP was a challenging project to implement – a direct reflection of the reality of moving a country from decades of civil war to a new beginning with all the difficulties of building Southern Sudan's health system from the ground up. This report also tries to emphasize the achievements and lessons learned that might be useful for public health professionals working in similar environments starting from relief and advancing to development. Although in its most early stages, the health sector in Southern Sudan is progressively developing and strengthening, and JSI is proud to have contributed towards making this happen.

While many actors contributed to the work of SHTP, and will continue to do so, this report is dedicated to the Sudanese themselves. Ultimately, it is the sometimes heroic efforts and courageous optimism of South Sudanese health professionals and community leaders which are responsible for gains to date. These individuals, institutions, and community groups are the key to future sustainable success.

Most sincerely,



Dr. Margaret Itto
Chief of Party
Sudan Health Transformation Project
JSI Research & Training Institute, Inc.
June 16, 2009

I. SHTP: PROJECT HISTORY AND BACKGROUND

A. The Project

The Sudan Health Transformation Project (SHTP) was a five-year bilateral project supporting the Government of Southern Sudan (GoSS), funded by the United States Agency for International Development (USAID). The project was implemented by JSI Research & Training Institute, Inc. (JSI) in collaboration with the Government of Southern Sudan, Ministry of Health (GoSS/MoH), along with nine international non-governmental organizations (INGOs), and 16 Sudanese (or local) NGOs (SNGOs). The project began in April 2004 and was completed in June 2009.

B. The Context for SHTP

A series of events beginning with two civil wars destroying the country since 1955, a subsequent cease-fire agreement in January 2002, with a Comprehensive Peace Agreement in 2005, left the population of South Sudan debilitated, with widespread social and economic collapse. This was clearly evident from the collapsed infrastructure of schools, health facilities, roads, bridges and other social and administrative systems. The long period of conflict left the population of South Sudan with extremely low socioeconomic and health indicators, a high degree of illiteracy, extreme poverty, hunger and disease, and severe underdevelopment.



"Development is by the people and for the people" says the head of a Boma Health Committee in Aweil South.

The public health base in Southern Sudan from which SHTP began was exceptionally poor by any standards. Routine immunization was estimated at 10%. Home births accounted for 94% of all births. Modern family planning did not exist. Low birth weight accounted for 30-40% of all births. Exclusive breastfeeding rates were low, and vitamin A deficiency affected one of seven children. Protected water sources for drinking water were accessed by an estimated 30% of the population, and approximately 20% of the population had ever received any information about hygiene and sanitation practices. There was no health information system or any available socio-economic and health data upon which to build a health care system responsive to the needs of the population.

It was not until 2006 that valid data was obtained and officially disseminated through the Southern Sudan Household Health Survey. The information helped to reveal specific data on the extremely poor state of the country. According to the survey, 17% of primary school age children attended primary or secondary school. Over 90% of the population was living below the poverty line. Health service utilization indicators were among the worst in the world.

Table 1. Health Indicators for South Sudan, Relative to Other Sub-Saharan African Countries

Indicator	Average data for Sub-Saharan African countries* (source) [year of data]	Sudan (source) [year of data] **	South Sudan (source) [year of data]**
Life expectancy at birth (yrs)	48 (1) [2006]	58 (2) [2006]	42 (5) [2005]
Infant mortality rate (per 1000 live births)	93 (1) [2006]	62 (1) [2006]	102 (6) [2006]
Under five mortality rate (per 1000 live births)	151 (1) [2006]	89 (3) [2006]	135 (6) [2006]
Maternal mortality ratio (per 100,000 live births)	855 (1) [2006]	590 (4) [2005]	2,054 (6) [2006]
Fertility rate	5.1 (1) [2006]	4.2 (1) [2006]	6.7 (5) [2005]

** data compiled and averaged by Rajkotio et al (1) from World Bank, UNICEF, and WHO country data.*
*** year and source of data have been provided for each indicator as the situation in Sudan is changing rapidly and sources of data can be quite variable.*

Key health indicators in Table 1 illustrate the poor health status in Southern Sudan. In addition, when compared to either data from Sub-Saharan Africa (regional averages), or to aggregated data from Sudan as a whole (both North and South), the discrepancies are striking.

Given the situation, it is not surprising that the health system was completely dependant on international NGOs. The emerging GoSS was not yet fully prepared to take on the responsibility of providing health services to its population. The five years of SHTP provided the first steps for the transition from an inexperienced new government (with no established Ministry of Health and INGOs providing uncoordinated health services throughout Southern Sudan) to laying the foundation for a functioning health system. The transition from "relief to development" began to be a reality in 2004 in Southern Sudan. All key stakeholders (the nascent Government of Southern Sudan including the then-Health Secretariat; USAID Southern Sudan operations; and heads of the INGOs operating in Southern Sudan) were based in Nairobi. JSI initially set up its office in Nairobi so that it could work closely with these key stakeholders, while waiting for the upcoming peace agreement to be signed, and for improved security in Southern Sudan to be established.

II. SHTP: GOALS AND EVOLUTION

A. The Purpose of SHTP

As stated in USAID's Request for Applications (RFA), the primary purpose of SHTP was to:

"…obtain the services of an organization that will work with international PVOs and NGOs; Sudanese NGOs and Community Based Organizations (CBOs) and other stakeholders to implement expansion of Primary Health Care (PHC) interventions at the community level; provide institutional strengthening to the County Health Departments; and the Prevention/ Surveillance Division at the New Sudan Health Secretariat level; strengthen Sudanese (particularly Women's) capability to deliver and manage health services; increase demand for health services and practices; and improve access to safe water and sanitation. The above activities will contribute to achieving the results for Strategic Objective S07."

The RFA goes on to state that the project will work in five "…selected regions of southern Sudan (Eastern and Western Equatoria, Upper Nile, Southern Blue Nile, Bahr el Ghazal, and the Nuba Mountains)."

"Project activity will focus on assistance to two levels of the southern Sudan health care system – the Community and the County Health Department. The project will provide a package of high-impact PHC services; critical health systems; and will strengthen the capacity of the southern Sudanese to build and manage health services. The activities will include a significant degree of coordination, with … the SPLM Health Secretariat, USAID/Sudan, multilateral organizations, international NGOs/PVOs (INGOs), Sudanese NGOs (SNGOs) and other partners/stakeholders."

"A critical component of the Sudan HTP is an umbrella sub-grant/contract program for which PVOs and NGOs will compete. These sub-grants/contracts will finance decentralized, geographically-specific activities, focused on strengthening high-impact PHC services, and building Sudanese capacity to manage and implement health care services."

SHTP was intended to take on part of the then-existing grants program by the US Office of Foreign Disaster Assistance (OFDA) for health programs in Southern Sudan in which a variety of international NGOs were directly providing for health services (including HIV/AIDS) in individual counties during the war period in the complete absence of any government health services. USAID would not take on all OFDA counties and NGOs, but initially agreed on 20 counties.

As stated in the RFA: "The challenge faced by [SHTP] will be to build on and incorporate existing and past accomplishments of OFDA and other humanitarian organizations in Sudan, and utilize them for significant and lasting development of the health sector."

There is specific reference to the changes that the INGOs would be encouraged to make as they transitioned from OFDA funding to support of USAID's SHTP goals:

- "supporting routine immunizations instead of reliance on measles and neonatal tetanus campaigns;
- "supporting semi-annual vitamin A supplementation instead of annual distributions linked to polio and National Immunization Days;
- "promoting supervision of PHC structures by CHD staff, where feasible, instead of NGOs taking the lead."

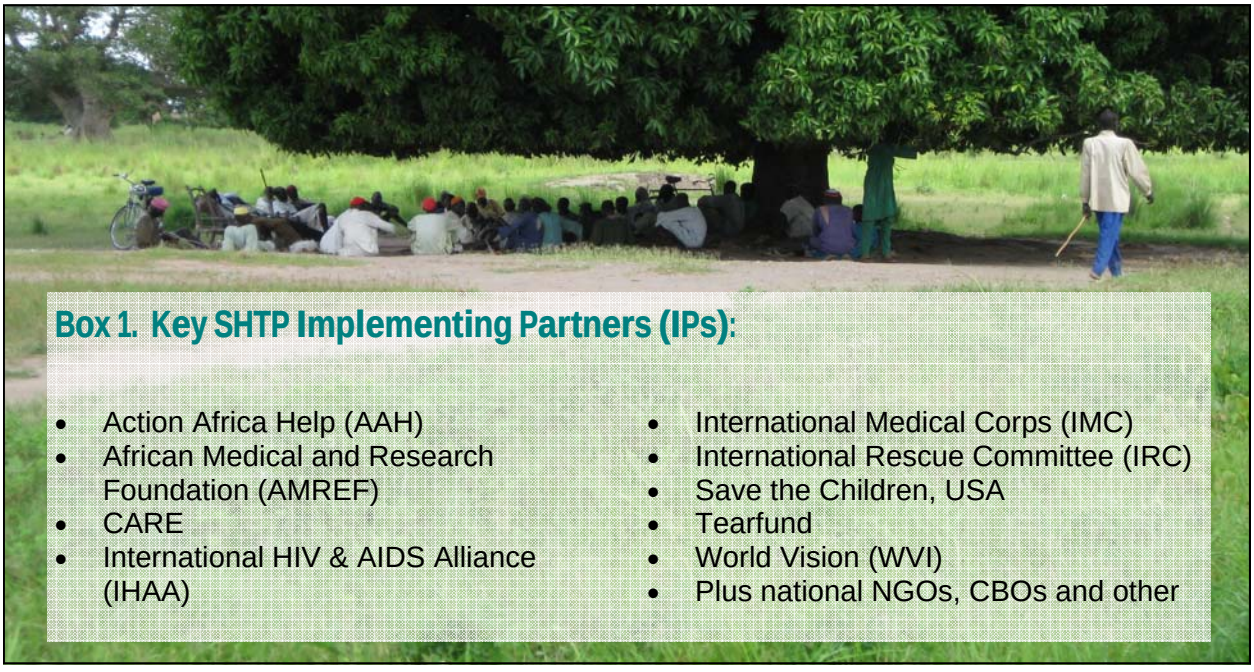
It is important to note that in spite of the clear purpose of SHTP, at the signing of the cooperative agreement (CA) it was made clear to JSI that the continuation of the OFDA grants, about to end, were the first priority of the new USAID SHTP. JSI was asked to begin this as quickly as possible so that the INGOs did not lose the momentum of their on-going work in Southern Sudan. Box 1 provides a list of the key SHTP implementing partners.

B. Specific Goals and Objectives

The specific goals and objectives of SHTP, as agreed in the cooperative agreement between JSI and USAID, were:

- Increased use of health, water, and sanitation services and practices (SO 7) through four intermediate results:

IR7.1: Increased access to high-impact services
IR7.2: Increased Sudanese, particularly women's, capacity to deliver and manage health services



Box 1. Key SHTP Implementing Partners (IPs):

- Action Africa Help (AAH)
- African Medical and Research Foundation (AMREF)
- CARE
- International HIV & AIDS Alliance (IHAA)
- International Medical Corps (IMC)
- International Rescue Committee (IRC)
- Save the Children, USA
- Tearfund
- World Vision (WVI)
- Plus national NGOs, CBOs and other

IR7.3: Increased demand for health services and practices
IR7.4: Increased access to safe water and sanitation

Expected specific results to be achieved were defined as:

1. Project beneficiaries will include at least 1.5 million people;
2. Expand PHC coverage from less than 30% to 60% coverage in USAID focus areas;
3. Rehabilitate/develop up to five CHW Training institutes;
4. Train up to 2000 CHWs, with 40% women using scholarships and incentives such as childcare to increase participation of women;
5. Basic public health systems in 20 County Health Departments established;
6. Increase immunization coverage from less than 10% DPT3 to 40% DPT3;
7. Provide 300,000 insecticide treated nets (ITNs) targeted for pregnant women and children under five;
8. Provide 2 million free or subsidized condom distributions through PHC facilities, the military and other outlets;
9. At least one SNGO from each USAID-assisted county, mentored over the life of the project, with capability to administer USAID funds appropriately by the end of the project.

Over the five year life of the project several modifications to the scope of work of the cooperative agreement required some adjustments to the direction of the project. In 2006 the original 20 counties were reduced to 6 counties (although never officially changed in the CA). This came at a time when the mission changed its focus to reflect USAID's then-new "fragile states strategy". This change reflected an emphasis on SHTP contributing toward building up the capacity of the GoSS, to enable GoSS to show its population that it could provide basic health services, thus improving GoSS' image as a viable government that kept the needs of its people at the forefront. Declaring the first two years of SHTP a success, USAID stated that a further new direction was to take lessons learned in the early phase of SHTP and making INGO partners more accountable for direct service delivery, while no longer requiring each INGO to partner with a local NGO.

With no quantitative requirements specified, revised results that JSI would be responsible for according to Modification 6 (September 2006) were:

<u>SO 09: Avert and Resolve Conflict</u>

- Development of malaria and MCH/RH policies and guidelines
- Development of an M&E project database that can be used by the MoH

<u>SO 10: Promote Stability, Recovery and Democratic Reform</u>

- Higher utilization rate of PHCU/Cs in the USAID supported areas
- Increased number of functional community health committees taking ownership of PHC needs and awareness
- Increased number of long-lasting insecticide treated nets (LLITNs) distributed to pregnant women and children under five

- EPI coverage increased
- Equipped functioning PHC facilities
- Improved quality of care provided at PHC facilities
- Trained staff working at these facilities
- Increased number of PHC facilities providing seven high impact indicators
- In the SHTP counties, an LMIS established and staff trained using comprehensive, efficient and standardized tools to ensure the availability of quality of essential drugs and supplies at the PHC facilities
- Decrease in number of PHC facilities in program areas reporting stock out of essential drugs
- Increased number of health practitioners trained and placed at PHC facilities
- Five Regional Training Centers selected, renovated and equipped
- Development of training curricula for nurses and laboratory technician cadres
- Number of health practitioners recruited and trained
- Pre-existing decentralized government health institutions strengthened through training, sharing of materials, and collaboration with NGOs through regular meetings
- Improved proportion of population who adopt appropriate health seeking behavior
- Increase utilization rate of PHC facilities in USAID supported areas
- Non-functional water points rehabilitated
- New water points at all PHC facilities
- All health facilities have reliable water points
- Water management committees are functional
- Number of latrines available increased
- Increased percent of community members who use latrines

SO 11: Program Support Objective

- Each SHTP supported county will have PHCC and PHCU staff trained in HIV prevention, treatment, care and support
- CHMC and/or other relevant community based groups will provide leadership to increase HIV awareness in the community
- BCC materials developed and disseminated
- Public awareness campaigns carried out in SHTP counties

Modification 10, dated 26 September 2007, later reversed Modification 6 by stating that INGO partners would be required, as per the original CA, to select a local Sudanese partner organization

"SHTP's early contributions to the Secretariat Health – equipment, tools, computer training, were enabling factors in support of the Secretariat's preparations to the establishment of GoSS Ministry of Health in Juba."

Dr. Samson Baba, Director General of External Assistance and Coordination of GoSS/MoH

(NGO) with which to implement project activities. The two new results in this Modification were:

- Increased number of FP/maternal health workers, mothers, and health workers trained in Home Based Life Saving Skills
- Comprehensive and sustainable plan for distribution of Water Guard to the urban communities developed, Water Guard distributed and used

Most significantly, Modification 10 states:

"Based on lessons learned in implementing SHTP over the past three years and the current health system in Southern Sudan, which is evolving though slowly after its first year of operation, SHTP will focus mainly on two primary areas: A) Service delivery to be implemented through sub-grants to INGOs both at primary health care facilities (PHCC and PHCU) and community levels to increase access to PHC services; B) Collaboration with MoH to build its health systems and institutional capacity at the county, state and national levels."

SHTP's scope of work was in constant flux for all stakeholders: USAID, JSI, and even the new GoSS MoH. This was a result of rapid changes on the ground (e.g., waiting for the Peace Agreement to be signed; moving the national capital from Rumbek to Juba; changes in designated counties; availability of Sudanese staff and NGOs; etc.). The learning curve for all concerned was reflected by this constantly changing and dynamic environment that was present in Southern Sudan at the time.

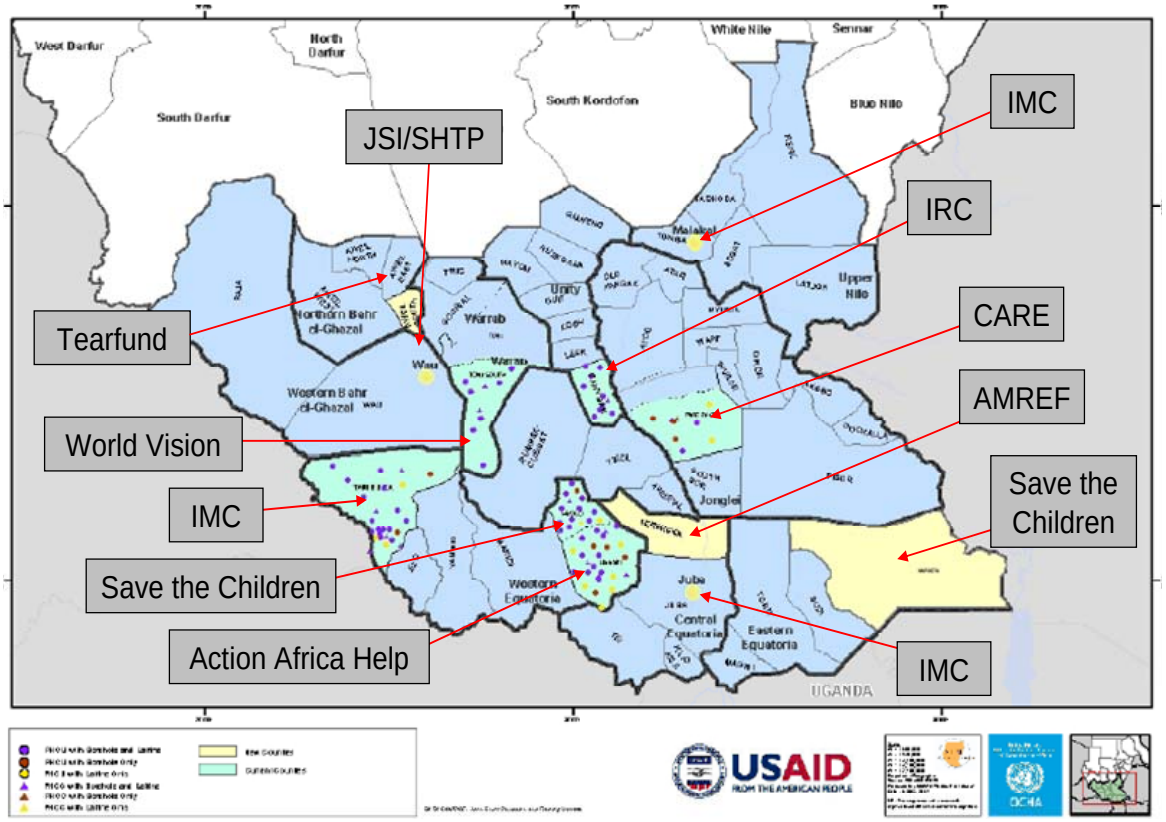
III. SHTP: ACHIEVEMENTS

A. Overview

This review of SHTP achievements is based on comparing the requirements of the cooperative agreement, and its several modifications (see section above), with the actual achievements of the project during its five-year life span. Achievements are grouped by the Intermediate Results (IRs), specific results, and by each county/urban area of SHTP as they relate most to actual public health goals. In mid-project, Strategic Objectives 9, 10, and 11 were introduced to reflect USAID's then-new "fragile states strategy". For Southern Sudan the intent was to strengthen the credibility of the Government of Southern Sudan (GoSS) through: (1) averting and resolving conflict (SO 9), and (2) promoting stability, recovery and democratic reform (SO 10). While very important goals for USAID's overall work in the country, the two primary focus areas defined in Modification 10 (service delivery and building MoH health systems and institutional capacity at the county, state, and national levels) best capture events that directly impact on public health goals of the MoH.

A map of SHTP-supported counties and implementing partners is shown in Figure 1.

Figure 1. Map of SHTP Implementing Partners and Counties



Tables 2a. (Years One-Three) and 2b. (Years Four-Six) show the timeline of major project activities and results by quarter.

Table 2a. SHTP Major Activities and Results <u>Years One-Three (2004-2006)</u>

Time Period			Major Activity	Results, Implications & Other Activities	Ongoing			
Relief: Reliance on INGOs to build health sector	Year I; 2004	Q1	CA awarded		Instability, difficulty with travel, security issues			
		Q2		Workshop: defining priorities of Secretariat of Health (SOH				
		Q3	Annual workplan developed	Capacity building for S0H: methods for implementing project activities				
		Q4	RFA's issued & evaluated for initial 6 counties	Capacity building of Health Secretariat/MOH: how to review proposal submissions				Renovations for CHDs underfunded; 20 counties re-assessed
			Vehicle procurement for Secretariat of Health					
Rehabilitation: Technical assistance and equipping facilities	Year II; 2005		Comprehensive Peace Agreement	Database established to track finances; with financial guidelines distributed to INGOs				
		Q1	RFA's awarded initial 6 counties	Computers, communications, server installed in Rumbek offices	Policies and guidelines established for MOH: MCH, RH and malaria	Six county grants, 3 HIV/AIDS grants, 2 curriculum development grants awarded		Drugs required to purchase for PHCs finalized; delays from USAID due to high costs
			Staffing process underway; salary issues delay local staff recruitment	Sub grants finalized for INGO partners for start up of 6 counties				
		Q2	Transition workshop	Establishment of warehouses in Rumbek and Loki				
			JSI HQ established in Rumbek	All 6 counties rec'd funding and visits by SHTP partners				LLTNs bidding final
				Construction of JSI offices				
		Q3	Assessment completed for additional 10 counties	Remaining 14 counties visited for assessment for planning				
			TBA training materials available; first course completed	RFAs for 10 counties ready-delayed due to new mandate				
			Ministry of Health established (Nairobi)					
		Q4		National nurses training development				
	Year III; 2006	Q1		Workshop on teamwork: SHTP partners/improving service delivery				
		Q2		Maternal health technical assistance: assessments, task force, policies under development			Behavior change & awareness materials developed, for malaria, HIV/AIDS, women's groups sensitized	Management systems set up: Monitoring & data collection, procurement, training, transport, budget and supervisory systems
			UNICEF MICS Household Survey results disseminated	Improvements in 5 regional training centers				
			USAID changes to 'fragile states' strategy	Changes criteria for selecting pilot counties				
		Q3	MOH moves from Nairobi to Juba	Move delays authorizations of activities				Delivery delays of USAID-funded drugs hampered progress
			Decrease in SHTP covered counties from 20 to 6	INGOs no longer req'd to work w/ local partner				
		Q4	Addition of HIV/AIDS component	Renovations of health facilities completed for original 6 counties				
			USAID and JSI offices move to Juba from Rumbek	Renovations of 5 regional training centers completed				
				Water points increased, 54 total constructed/rehabilitated		HIV/AIDS training; BCC activities; VCT sites opened		

Reporting on outcome data is complex for SHTP. Several factors limit the ability of the project to report on specific achievements:

- Obtaining initial baseline data was difficult to impossible for SHTP. No NGO or county had baseline information at the beginning of SHTP, and with many based in Nairobi for the first years of the project, generating this important information was extremely difficult.

Table 2b. SHTP Major Activities and Results <u>Years Four-Six (2006-2009)</u>

Time Period			Major Activity	Results, Implications & Other Activities	Ongoing		
Rehabilitation: Technical assistance and equipping facilities	**Year IV; 2007**	**Q1**			Policies and Guidelines established for MOH; MCH, RH, malaria	HIV/AIDS training; BCC activities; VCT sites opened	
		Q2					
		Q3	Increase in SHTP covered counties from 6 to 12	INGOs still required to work w/ local partner			
		Q4	Added family planning				
Development: transfer of skills to government	**Year V; 2008**	**Q1**	USAID assessment	Staffing recruitment completed			
		Q2	New SHTP leadership	LLITNs mass distribution in 5 counties	Quarterly core group partners meetings		Increased CHD training; over 400 health workers trained
				Joint MOH-SHTP-USAID supportive field visits begin			
				Workplan updated with new performance milestones			
		Q3		Regular drugs supply for all sites			
		Q4		Technical consultants seconded to PHC Directorate; BCC for national events			
			SHTP scales-up to include 3 'urban' areas	12 project areas under way			
				Workshop on teamwork: SHTP partners/improving service delivery			
	Year VI; 2009	**Q1**	Transition of project to MSH	GoSS assumes salaries for some of the MOH staff		4 sub-grantees implement training of health workers, awareness and counseling in health facilities	
		Q2	Nt'l Policy for Health Education & Promotion complete	Policy printed			
			Draft of Health Management Info System Implementation Manual				
			Close of JSI project	Close-out: conference and distribution of assets to USAID, MSH, MOH/GoSS, States, Wau CHD			

- Reporting in the early stages of SHTP was (mistakenly) made on percentage changes in specific activities (% increase in immunization, etc.). With significant shifting of the population after the peace agreement, the denominators, reflecting actual population numbers, were never accurate.
- Three changes to the scope of work made reporting achievements a bit of a moving target as for each SOW an adjustment in the indicators was necessary.
- The SHTP team spent a great deal of time developing and using a computer-based data gathering system for project reporting purposes. However, actual data was late and oftentimes inaccurate.

Given these constraints, the reporting below reflects what is actually known and verifiable with SHTP. Although the earlier quarterly reports seemingly show greater information, this report reflects the total accurate information for SHTP. The basis for reporting achievements can be found in Tables 2a and 2b.

Box 2. Developing National Policies and Guidelines

Through collaboration with GoSS/MoH and other partners, SHTP has strengthened the health care system with the development of National Policies, Guidelines, and Protocols:

- National Maternal and Reproductive Health Policy & Guidelines, 2006
- National Curricula for training Laboratory Technicians (Higher Diploma, Diploma and Certificate Technicians) and Nurses (Registered and Certificate Nurses), 2006
- Essential Treatment Guidelines for Primary Health Care Centers and Essential Medicines List, 2006
- Essential Drug Policy, 2006
- Malaria Policy and Guidelines, 2007
- Monitoring and Evaluation Framework, 2008
- HMIS & LMIS Guidelines, 2007
- STI Syndromic Management Guidelines, 2008
- National Policy for Health Promotion, 2009

B. Achievements by Objective

1. Improve access to high impact services

In order to improve access to the selected high impact services, infrastructure was strengthened through equipment and drug and medical distribution, an increase in number of services, and progress monitored.

A first step towards strengthening the Ministry of Health was the development of basic policy and standards. In the area of Primary Health Care documents were developed for:

1) Essential Treatment Guidelines for Primary Health Care Centers
2) Essential Medicines List
3) Essential Drugs Policy
4) Malaria Policy and Guidelines
5) Sexually Transmitted Infections Syndromic Management Guidelines
6) National Curricula for Training Laboratory Technicians and Nurses

The National Maternal and Reproductive Health and Policy Guidelines were also developed in conjunction with the GoSS. To strengthen management, education and communication activities, documents were developed on: 1) Monitoring and Evaluation Framework; 2) Health Management Information Systems; 3) Logistics Management Information Systems; and the 4) National Policy for Health Promotion. Box 2 lists the policies and guidelines developed by SHTP, with the MoH.

Four out of the five originally designated regions were reached during the life of the project with no activities carried out in Nuba Mountains State because of continued civil un-

"The development of national health policies has been a great process with participation of most of the stakeholders."

Dr. Nathan Atem, Director General, Primary Health Care



In addition to renovation of PHC facilities, SHTP renovated the MoH offices in Rumbek and turned them over to the government (buildings pictured here at left).

rest. In the states that were reached, a total of 12 pilot project areas were established with 9 counties and 3 "urban" township areas (see Figure 1).

Identification of partner INGOs were completed and coordinated in all of the 12 designated pilot areas. To encourage sustainability and strengthen local Sudanese NGO's, 16 local partners collaborated with the SHTP partners (see Box 3).

There were 145 health facilities originally planned for renovation, but actually 161 facilities were equipped and functioning at the close of the project (see Annex I.). The range of service delivery methods were increased and strengthened to include: 1) routine immunization and where appropriate campaigns; 2) malaria control through use of ITNs and prompt treatment of fevers; 3) promotion of young infant and child feeding; 4) exclusive breastfeeding; 5) growth monitoring; 6) Vitamin A supplementation twice yearly; 7) treatment of acute ARI and diarrheal diseases; 8) maternal health and nutrition; 9) skilled attendants at birth; 10) antenatal care including nutrition; 11) IPT for pregnant women for malaria; and 12) child spacing and introduction of family planning services and home life saving skills.

On-the job training was conducted on family planning for maternal health workers and Home Life Saving Skills through presentations given to all subgrantees, MoH, SMoH and CHD members at the quarterly meetings.

At selected facilities latrine and well construction was completed (see Table 2a).

Increased availability and improved management of supplies at health facilities through the development of drugs, cold chain and vaccine procurement and distribution management was im-

Box 3. Local Partners—Key to Short- and Long-Term Results

- Sudan Inland Development Foundation (SIDF) – Save the Children's local partner
- Mundri Relief and Development Agency (MRDA) – AAH's local partner
- COMPASS – AMREF's local partner
- Catholic Diocese of Wau (Sallesian Sisters) – JSI's local partner in Wau
- MAYA Active Youth Group – AAH's local partner in Mundri
- Yubu Youth Group – IMC's local partner in Tambura
- IHAA's local partners:
    - SPLA HIV/AIDS Secretariat – Prevention (awareness and condoms)
    - Munuki Youth League – Prevention and peer education
    - CEDA Foundation – Prevention, peer education, home visits, psychosocial support
    - Barakat initiative – Prevention and peer education
    - Lwoki Youth Association – Prevention and peer education
    - South Sudan Old People's organization (SSOPO) - Prevention, peer education for street kids, orphans and vulnerable children (OVC)
    - Sudan Council of Churches (SCC) – Prevention and peer education
    - People Living with HIV/AIDS in South Sudan (PLASS) – Prevention, peer education, counseling and palliative care
    - South Sudan Women Effort to Fight HIV/AIDs (SWEFA)
    - Mubadiroon South Sudan Network of PLHIV – Prevention, peer education, counseling, coordination and advocacy

plemented. A logistics management training workshop was conducted for the MoH CHD and INGO staff using a newly developed LMIS training manual developed for the MoH. A reporting form for stock outs and drug management was developed and implemented. Stock out reports decreased from 78 facilities in 2006 to 31 in 2007.

A monitoring information system was begun with the development of forms which were collected and analyzed for feedback, with data used in the quarterly meetings.

2. Increase southern Sudanese capacity, particularly women's, to deliver and manage health services

National policies and health standards were disseminated to the INGOs and standard supervisory guidelines were established and implemented with regular visits conducted using a team approach with Sudanese staff. Between April and July 2008, 113 PHCC/U's were visited with on-the-job training conducted.

Five training facilities were rehabilitated with training materials developed for most service delivery methods. A system of mentor training was developed to strengthen Sudanese staff.

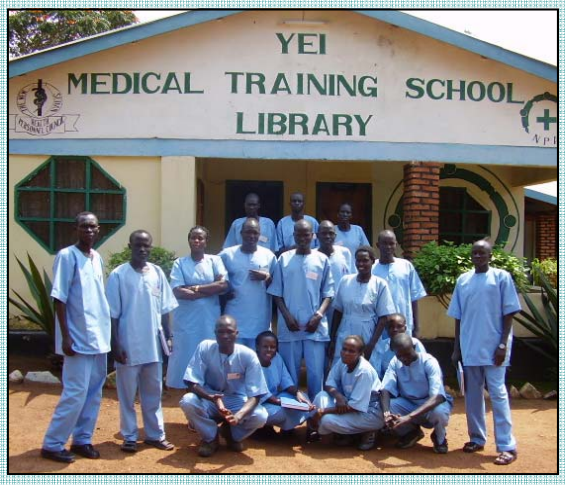
SHTP trained staff taught 1454 CHWs with 187 students graduated from the strengthened Regional Training Centers.

3. Increase demand for primary health services and practices

In SHTP, the focus for increasing demand for services was on communication for prevention, behavior change, and basic health education. The approach to increasing demand for services by SHTP began by review-



Graduation ceremony in Ganyiel Regional Training Center. The guest of honour congratulates one of the four female students who completed the Community Health Worker course.



A newly renovated Regional Training Center (RTC) in Yei. The five RTCs renovated and assisted through SHTP add approximately 200 health workers and laboratory technical assistants a year to South Sudan's human resource pool.

ing materials developed, and methods used by the variety of health stakeholders in Southern Sudan. SHTP sought the support of the MoH in creating a national policy and guideline for health promotion while also working to coordinate NGO actors, as well as integrating behavior change communications (BCC) programming into activities with sub-grantees.

Phase I consisted of two main components and was carried out by Counterpart International in the first years of project implementation. Activities included:

- Collection and assessment of existing materials and creation of new materials. All existing materials being used by NGOs, both by SHTP sub-grantees and other NGOs and international organizations working in Southern Sudan, were collected, assessed for quality and compiled for sharing. All materials were put on CDs and housed at the Health Promotion sub-Directorate at the MoH as well as disseminated to all NGOs.
- Additionally, as the country transitioned out of an emergency state, targeted radio campaigns were developed and disseminated in partnership with the MoH to create awareness about certain health issues ranging from topics such as cholera to HIV/AIDS to immunization.
- In this first phase, extensive NGO coordination around health promotion was undertaken. A monthly BCC task force was formed, creating a forum for sharing materials in development, strategic objectives of health promotion programming, and opportunities for collaboration and avoiding duplication of work at community level. This task force was chaired by the Director of Health Promotion from the MoH, and was extensively supported by the BCC team from SHTP.

Once the country stabilized and the overall health system began to rake root, SHTP launched

Phase 2 of the BCC/health promotion activities. Managed by the Manoff Group, Phase 2 consisted of the development of the national policy for health promotion as well as a set of strategic planning matrices designed to guide policy use.

The policy itself follows the outline in Box 4, clearly defining health promotion as used by the MoH, the promoted model of behavior change, the process organizations should follow in implementing programs, and the process for behavior monitoring. The strategic planning matrices apply the process outlined in the policy to each of the seven high impact areas so as to facilitate work planning and actual use of the policy in program development.

The policy was created through a very participative process. First, an extensive list of stakeholders was consulted, including representatives from the MoH and all implementing partners in Juba. Once a draft was developed, groups of stakeholders participated in workshops to dissect the policy and planning matrices, carefully ensuring their appropriateness for Southern Sudan culturally and their acceptance technically by the implementing community. These vetting sessions were led in Juba as well as across the country at the state level, where local representative of the MoH and implementing agencies were given a chance to have their perspectives included in the policy. These meetings were successful in generating enthusiasm and resulted in buy-in for the policy top-to-bottom.

The policy and strategic planning matrices were approved by the MoH and printed in the early summer 2009. Subsequently, they will be disseminated throughout the country. Further, the SHTP project met numerous times with the follow-on project to transfer knowledge, lessons learned and all the resources gathered throughout the project, including materials as well as research findings on behavioral determinants. Specific activities achieved included:

Design of health education programs and messages:

- Increase community knowledge of what services are offered and where to go
- Health education materials developed

Box 4: National Policy for Health Promotion Table of Contents

Ch. 1: Introduction
- Background
- Current health promotion activities in South Sudan
- Purpose/expectations
- Intended audience
- Policy development process

Ch. 2: Health promotion leadership: role of the Health Education and Promotion sub-Directorate of the Ministry of Health
- Mission statement
- Strategic objectives of the sub-Directorate of Health Education and Promotion

Ch. 3: Guiding principles for health promotion in South Sudan
- Definition
- Health promotion/behavior change model
- Ideal vs. feasible behaviors

Ch. 4: Process for development of health promotion programs
- Strategizing/problem analysis
- Behavioral analysis
- Activities planning and communications development
- Implementation
- Monitoring

Ch. 5: Mechanism for health promotion
- Relationships and flow of health promotion activities and planning
- Roles and responsibilities
- Coordination mechanism
- International best practices

Ch. 6: Concluding notes
- Ethics and standards

Dissemination of messages:

- Radio; critical messages developed
- Primary schools (or other creative channels)
- School education manual

Women's groups trained:

- Providing health education activities

Village health committees:

- Individual messages developed
- Health management committees trained

4. Improve access to safe water and sanitation

Beneficiaries were identified for the construction of 105 boreholes (see Table 2a). This represents 67% (out of a total of 156 renovated facilities) having a protected water source.

Greater than 90 health management committees and 75 water management committees have been established in the SHTP counties. This includes refresher training in water technology management, and communities trained in maintaining the water points. There was an increase in the availability of latrines with 123/156 (79%) of facilities having functional latrines.

5. Increase access to HIV and AIDS services

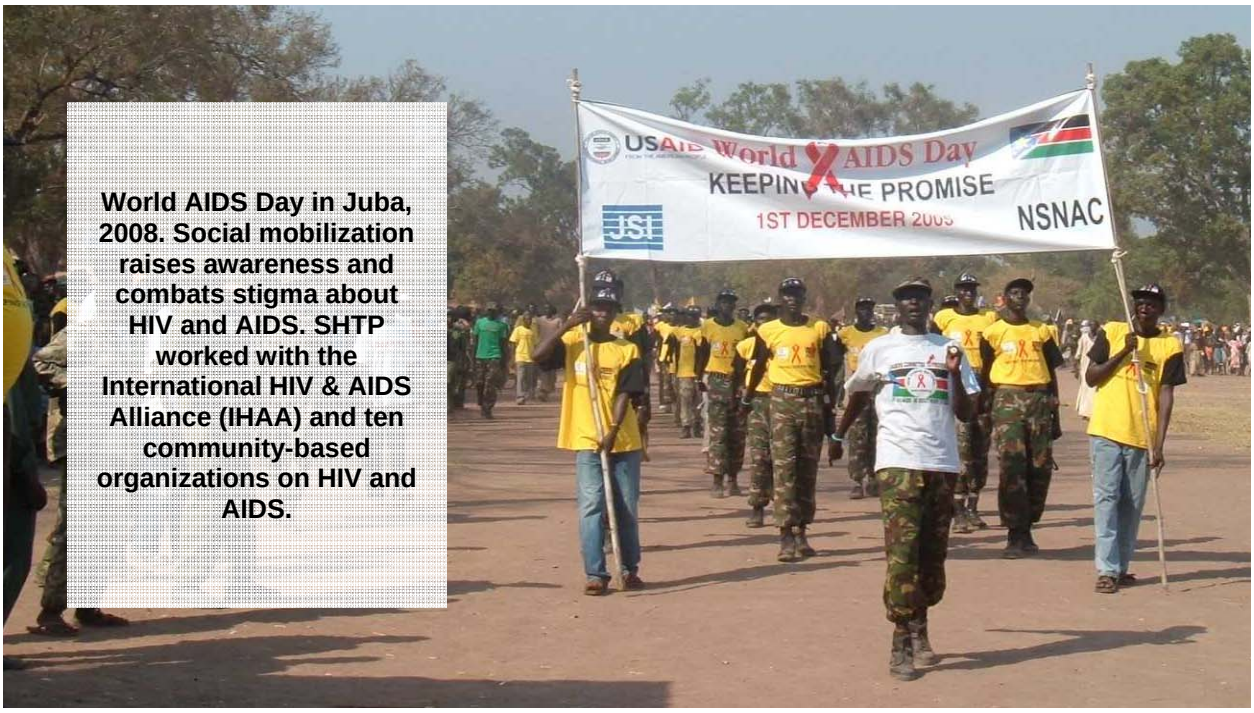
Prevention activities were initiated with 53,044 people reached with HIV prevention and safer sex messages. Grassroots organizations were organized to deliver targeted behavior change communications to at risk populations. Condoms became available through the distribution of 66,026 condoms distributed through International Africa Action Help NGO. These were mainly distributed through the 28 rehabilitated PHCC's that offer STI services.

Guidelines were developed for HIV/AIDS voluntary counseling and testing (VCT) sites and a total of 6 VCT sites were established, exceeding the original goal of opening at least 3 sites (see Table 2b).



SHTP has provided more than 100 safe water sources (boreholes) in the 12 counties in which we work.





World AIDS Day in Juba, 2008. Social mobilization raises awareness and combats stigma about HIV and AIDS. SHTP worked with the International HIV & AIDS Alliance (IHAA) and ten community-based organizations on HIV and AIDS.

C. Expected Specific Results

The following specific results were prescribed in the original SHTP cooperative agreement, and its various modifications over the life of the project. A table that summarizes the data, and is the basis for this sub-section, can be found in Annex I.

1. Project beneficiaries will include at least 1.5 million people.

Result: An estimated 2,336,671 people are included in the areas directly covered by SHTP, and they benefitted from access to high impact services, and improved water and sanitation facilities. This represents strengthened services offered in 8 County Health Departments, 25 Primary Health Care Centers, and 120 Primary Health Care Units.

2. Expand PHC coverage from less than 30% to 60% coverage in USAID focus areas.

Result: Most facilities were assessed to be non operational at the start of the project. SHTP rehabilitated and increased services in a total of 120 facilities.

3. Rehabilitate and develop up to 5 CHW training institutes.

Result: Five regional training centers were selected, renovated and equipped. 130 health workers are graduating; expected 40 nurses, 40 clinical officers, 30 community midwives, and 20 laboratory technicians.

4. Train up to 2000 CHW's (with 40% women using scholarships and incentives such as childcare to increase participation of women).

Result: 1454 CHWs were trained with an additional 187 students graduated from the strengthened Regional Training Centers totaling 1641 (representing 82% of goal).

5. Basic public health systems in 20 County Health Departments to be established.

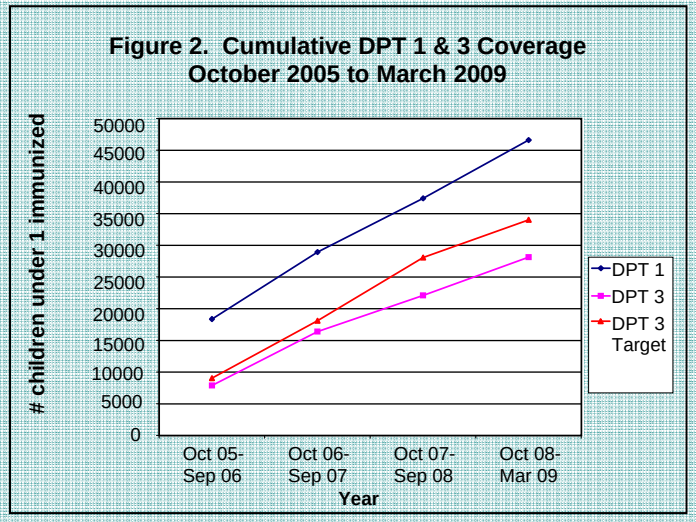
Result: Nine County Health Departments were rehabilitated and established along with 3 urban township areas totaling 12 major focus areas. (see: Modification # 6 dated September 2006 to decrease to 6 counties from original 20, followed by Modification # 10 dated September 2007 to increase from 6 to 12 counties)

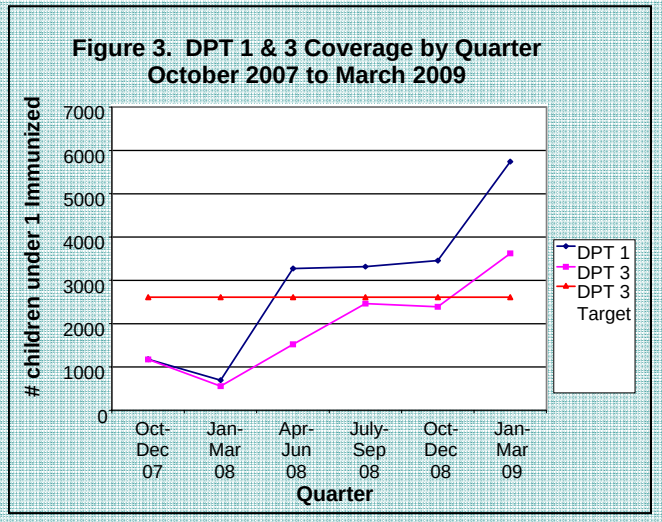
6. Increase immunization coverage from less than 10% to 40% DPT3.

Result: DPT3 coverage for surviving infants increased from less than 10,000 in September 2006 to over 25,000 in March 2009 (see Figures 2 and 3).

7. Provide 300,000 insecticide treated nets (ITNs) targeted for pregnant women and children under 5 years of age.

Result: SHTP distributed 281,469 bednets to pregnant women and children.





Measuring SHTP achievements in DPT 1& 3 coverage, it is evident from the two graphs that significant progress has been made. The graphs above illustrate a significant increase in number of children reached with both DPT 1 and DPT 3 immunizations.

8. Provide 2 million free or subsidized condom distributions through PHC facilities, the military or other outlets.

Result: 66,026 condoms distributed through International Africa Action Help NGO. These were distributed through 22% of the PHCC's that offer STI services.

9. At least one Sudanese NGO from each USAID-assisted county, mentored over the life of the project, with capability to administer USAID funds appropriately by the end of the project.

Result: Identifying local NGOs to be involved via the INGOs in SHTP was problematic. In many counties there simply were no existing agencies, or when they did exist, they were not capable or interested in providing services to SHTP. A list of organizations that did participate is shown in Box 3.

D. Achievements by County and Urban Township

Aweil South is the largest estimated population served by SHTP out of the 12 total areas. Partnered with the Tearfund with less than a year for full operation of activities, Aweil South reported the largest number of women having had at least one antenatal care visit during 2008.

Twic East, Tambura, and Mundri counties, representing a population size of approximately 262,358 benefited from the construction of 73 new latrines or wells, and 55 boreholes (Table 3). This represents some of the highest accessibility to improved water and sanitation for this region.

The greatest training activities occurred in Panyijar and Tambura where training sessions were held for an estimated 429 health workers.

Six counties; Twic East, Panyijar, Tambura, Mvolo, Mundri, and Tonj South received the bulk of the 239,000 bednets to help prevent malaria (Box 5).

Twic East, having been active since March 2005, reported the highest estimated DPT3 coverage of all SHTP-supported counties. Along with this

Table 3. Water and Sanitation Matrix

	# of operational boreholes	# of operational latrines
Twic East	15 **	26
Tonj South	15	5
Tambura	17	26
Mundri	23	23
Mvolo	6	5
Panyijar	11	12
Aweil South	6	2 ***
Terekeka	11	12
Malakal	1*	7*
Kapoeta North	0	2*
Wau Urban	0	3
Total	105	123

* Not funded by SHTP
** 8 early boreholes were drilled through SHTP; later boreholes through CARE Water & Sanitation Project
*** Three clinic latrines collapsed due to flooding



Water and sanitation projects were an extremely important component of SHTP, particularly in the early years, when funding was provided to dig boreholes in all SHTP-supported sites. Water and sanitation continued to be extremely important components of the IPs' portfolio including the drilling of new boreholes near PHC facilities as well as the rehabilitation and maintenance of existing boreholes. IPs reported that these activities helped to decrease the magnitude of water-borne diseases presenting at PHCUs and PHCCs.

Box 5. A Drive to Protect All from Malaria

SHTP started a campaign to protect communities in the state of Western Equatoria from malaria through the distribution of long lasting insecticide treated nets (LLITN) in Mvolo, Wulu, Tambura Mundri East and West counties. This is the first campaign in these counties and in Western Equatoria in general to include a mass distribution of bed nets. The distribution was done at the peak of the rainy season, when the already poor road infrastructure was at its worst. In addition, as is a concern throughout South Sudan, none of the counties had accurate population data, and some areas were remote and difficult to reach. Despite all of these challenges, a team composed of County Health Departments, Local Administration (Payam and Boma Administrators), SHTP partners i.e., AAH, MRDA, SAVE, SIDF, IMC and Yubu Youth were able to distribute 100,000 bed nets in less than one month during August and September 2008.

The communities were happy with the campaign. The Commissioner for Tambura stated, "*this is the best gift I have received for the Tambura people especially now that the whole place is infested with mosquitoes,*" and a health worker in Tambura PHCC said, "*I will participate in the bednet distribution because I understand the burden of malaria. If the community has bednets it will reduce the number of patients and I will have time to give attention to fewer patients and hence improve the quality of service"*

A major challenge experienced by the team is the poor state of the country's roads.



Treating malaria cases also was a significant part of the SHTP program in all counties. SHTP provided intermittent treatment of malaria for pregnant women and treated malaria in its PHC clinics.

"I lost a child due to malaria because I did not have bednets, but now all my three remaining children will be protected."
A mother in Mvolo

high vaccination coverage was an estimated 13% of children under 5 years of age having received at least one dose of Vitamin A by March 2009.

Voluntary counseling and testing services were offered in 6 facilities by March 2009 in the counties of Tambura, Myolo, and Mundri. This represents access to an estimated population of 441,540.

Overall, within the project 9 counties and 3 urban areas, 8 CHDs, 28 PHCCs and 120 PHCUs were refurbished and rehabilitated, and staffed with newly trained health workers given periodic supervision.

IV. LESSONS LEARNED

The experience of implementing SHTP was unique for all stakeholders. Emerging from a long civil conflict, the GoSS MoH had just been formed, and only employed a few officials at the national, state, and county levels; few of whom had any experience working in a formal government. Nor did they have any experience working with the development donor community. Expectations were high, while experience was limited.

USAID, a well-established donor organization, had limited experience in the health sector transitioning from relief to development programs. USAID's established process for implementing typical development projects was not always appropriate for directing work such as that of SHTP.

JSI, the grantee, also held unrealistic expectations on how to proceed based on its established and successful methods for implementing public health projects in a typical development environment. Its approach, which has been heavy on decentralized management, was not appropriate for the South Sudan experience, and JSI had to significantly adjust its project support model half way through SHTP. Equally important was the challenge of staffing a project that eventually was based in Juba, which made it very difficult to attract qualified and experienced staff.

Finally, the INGOs, which had been operating in Southern Sudan for several decades, were not used to being part of a larger project, such as SHTP. After years of working with a great deal of autonomy in a relief and conflict environment, they, too, were not prepared. Rules and regulations under a cooperative agreement demanded greater accountability to SHTP.

While a great deal was achieved during SHTP, in spite of the many challenges, one of the most significant outcomes was a series of lessons learned that could be applied to future projects found in the difficult situation of moving from the relief to development. Certainly, there were many lessons learned from SHTP. Because of the uniqueness of the project working in a post-conflict setting, we are emphasizing only those lessons that apply to this environment, and not those lessons which are relevant for more typical development projects. These lessons learned are as follows:

Lesson 1: Develop expectations of project results in close collaboration with all stakeholders.

Each stakeholder came into SHTP with significantly different experiences and expectations for success. It would have been better had these been discussed, and consensus reached, by all at the beginning of the project. When firmly established by all stakeholders, it would have then been easier to agree upon and make project adjustments throughout the life of SHTP, especially as it transitioned from post-conflict/relief to development work. The actual process of advancing is as crucial to the success of a project moving along the relief to development continuum as achieving its actual results; and in the early stages coming to consensus is even more important than specific results.

Lesson 2: Be flexible in designing, and then administering, projects.

It is very difficult to anticipate, i.e., plan, what will happen in a rapidly changing, and unproven environment. As governments are formed, staff hired, and policies made, it will be necessary to adapt to this uncertain environment. Rather than strictly adhering to proven development methods or pre-formed plans, all stakeholders have to be prepared to react to actual situations on the ground. For example, faced with an absence of qualified INGO or SNGO partners available for primary health care improvement work in Wau County, JSI made a strategic decision to implement this work directly rather than strictly adhere to the subgranting model employed in all other SHTP-supported counties.

Lesson 3 : Build on existing successes before trying to overhaul the entire system.

The INGOs were typically the only organizations providing health services during the civil war period. Further to providing well functioning services, it was evident that many INGOs had considerable prior experience in various regions of the country, and also had concurrent funding from other donors or other USAID projects. These often complemented the SHTP-funded efforts. For example, Tearfund noted in their June 2008 Quarterly Report that "high attendance at antenatal clinics has been a result of having feeding sessions targeting pregnant and lactating women. Providing assistance to mothers who are malnourished has encouraged more women to attend ANC sessions." Past experiences and successes from the INGOs were not given enough weight throughout SHTP.

Lesson 4: In a post conflict setting, systems strengthening and capacity building take second place to actual service delivery.

There is no question that health systems need to be strengthened when they are weak. However, when systems are extremely weak, the immediate focus should be on service delivery so that health services are provided (and thus the health system gains some credibility) for the population. In order to accomplish this in Southern Sudan, service delivery needed to be improved while keeping in mind the best use of scarce resources (including human capacity). Visible well functioning health services have greater value in the early stages in a post-conflict setting (not to mention the urgent need to provide health services), and are viewed as the government serving the population. Once solid services begin to be provided, a shift in emphasis to systems strengthening then makes sense, with the focus on quality and increased access to services by the population.

Lesson 5: As PHC services are being established, it is essential to implement a dual strategy that advocates for the use of services and educates communities as to the importance of health services.

In a post-conflict setting such as Southern Sudan, which has been devoid of PHC services for decades, it is important to prepare the community as to the benefits and appropriate use of health services. In the immediate post-conflict period, health coverage for rural or isolated communities will require both fixed site and mobile services in order to reach beneficiaries. At the same time, resources should be dedicated towards community-oriented advocacy and health education/health promotion, so that demand for newly established services is increased.

Lesson 6: Collection of useful baseline data is not realistic in a relief and post-conflict environment.

At the beginning of SHTP (and to a certain extent throughout the life of the project), data did not exist or was of poor/unknown quality, and dynamic population movements throughout Southern Sudan greatly reduced the accuracy of population denominators. These facts hampered SHTP's ability to collect useful and reliable baseline information. Clearly at the beginning of any development project some level of baseline data ought to be sought, but because of data quality and availability issues, adjusting the baseline will be necessary over time and thus tracking quantitative progress of activities will be challenging.

Lesson 7: Reporting on progress is challenging when targets (denominator) are constantly moving.

While not a norm for development projects, in settings such as Southern Sudan, it makes greater sense to report on raw (absolute numbers) data than on relative data (percentages, proportions and/or indicators; see Lesson 6 regarding difficulties with unstable population denominators). For example, rather than trying to report on percentage of women and children receiving vitamin A supplements, it is more realistic to report progress in terms of volume of increased activity or absolute numbers of women and children receiving doses of vitamin A, or even total doses administered.

Lesson 8: Be prepared to acknowledge unanticipated outcomes.

Work is extremely difficult in a post-conflict environment, and accomplishments are few. The GoSS MoH learned a great deal during the implementation of SHTP. At various times they credited SHTP for giving them the opportunity to learn how to work with donors, as well as how to improve their own capacity to better manage the MoH. Acknowledging unanticipated outcomes allows people to take credit for, and feel good about, indirect or intermediate achievements.

Lesson 9: Anticipate (and plan for) delays.

The work environment in Southern Sudan was obviously challenging and accomplishing any given task took significant amounts of time. Expectations about timing of activities (such as recruitment, subgrant development, and procurement) should be realistic and delays should be anticipated from the outset. Early identification of deadlines, active planning and forecasting,

and early initiation of tasks is needed in order to complete activities on time. While also a problem in development environments, issues of delays are even more acute in post-conflict settings.

Lesson 10: Staffing issues must be addressed head-on throughout the project's lifecycle.

It is difficult to attract qualified staff for post-conflict settings. Post-conflict environments are challenging places in which to live and work, and require a skill set that few in the development world have. Initially it may be necessary to provide substantial backstopping for field-based staff. As time moves along the relief to development continuum, it may be possible to attract more appropriate staff.

Lesson 11: Clear roles and responsibilities of each stakeholder are critical for advancing from relief to development.

Relief operations are characterized by their reactive nature to events and conditions, and focus on service delivery for public health programs. Development work, on the other hand, is more systematic about balancing supply of services with building capacity so that this work can continue in a sustainable way by those ultimately responsible (communities and government). An adjustment period is necessary through the transition from relief to development, and requires that roles and responsibilities of key stakeholders are frequently revisited and adjusted to this changing reality.

Lesson 12: Direct supervision as 'on-the-job training', requiring frequent trips in the field, is the most effective way to monitor progress and to make program adjustments.

Regular meetings to report out are less useful due to the nature of the work that includes a constantly changing environment, and the fact that those who best know the specifics of the work oftentimes are not able to attend regular meetings (they are too busy implementing activities in the field). Thus direct monitoring and supervision of field activities on the part of project staff provides a critical vehicle for timely feedback, problem-solving, on-the-job training, and team-building. While certainly a relevant lesson for development projects, the need for site visits in a post-conflict environment is even more compelling.

Lesson 13: Clear, frequent and honest communications is crucial among all stakeholders.

A system for project communications is essential given the rapidly changing environment, range of stakeholders, and difficulty of logistics in a post conflict setting. This also includes frequent travel to project sites by all stakeholders. Too much valuable information is lost without a clear plan for communications, and subsequent use of this information.

Lesson 14: Take a team approach to grants management.

To ensure continuity of health services where INGOs had been operating under OFDA grants, the bulk of SHTP's activities came in the form of subgranting to INGO/SNGO partners. Because of the pressure to not have the grants lapse as USAID took over from OFDA through SHTP, the SHTP team approached granting as an administrative and finance task from the beginning of the project. Early configurations of SHTP's staffing design did not include public health technical staff, despite the focus of subgrants being inherently technical in nature. The SHTP team became more effective once technical staff were brought on board and grants management became more than a finance/admin matter. Taking a team approach to managing subgrants (and subgrantees) is more likely to yield high quality results, as the technical, financial, and administrative aspects of the grant are monitored and managed holistically rather than in a piece-meal fashion.

Lesson 15: Use subgranting as a mechanism to build INGO/SNGO organizational and technical capacity; not just pass along funds.

INGOs/SNGOs working in conflict areas have varying levels of experience and skills implementing development activities, and managing project resources. It is therefore important to assess their capacity at the outset, and to build capacity to implement and manage in areas where abilities are weak. For example, resources should be dedicated towards planning and provision of technical assistance required to equip partners to transition from relief to development activities, and applying lessons from successful NGOs to less experienced NGOs.

Lesson 16: An emerging country needs to see its government serving its people, and the government getting credit for that.

For several decades during the civil war all health services in Southern Sudan were provided by the INGOs. One of the larger goals of SHTP was to contribute to the peace dividend, which was to build the credibility of the new GoSS, and its MoH. From the beginning, SHTP and its partner INGOs should have focused on ensuring that all progress in improving and providing health services in the SHTP counties were perceived as coming from the MoH rather than from individual INGOs, SHTP, or USAID. This apparent non-health achievement could have greatly enhanced the perceived role of government in Southern Sudan as the country looks toward the 2011 Referendum.

Box 6. In Their Own Words: Ways to Improve Programs

- "NGOs can help change thinking and attitudes of the community on representation of women in Village Health Committees." Terekeka County, Central Equatoria State, AMREF
- "Incentives such as bars of soap to participants in hand washing education programs coupled by follow-up of health staff can ensure that participants adopt hand washing practices." Wau County, Western Bahr el-Ghazal State, JSI
- "Provision of uniforms to health workers has indeed motivated staff." Tonj South County, Warrap State
- "It has been realized that some facilities have the capacity to improve if they are given frequent and individually-tailored mentoring." Tambura County, Western Equatoria State, IMC
- "It is important for higher-level staff to be aware of and trained in different facets of implementation of health activities, such as procurement procedures (for motorcycles)." Malaria Consortium participant
- "Low demand for PHC can be explained by examining current issues faced by the communities, such as violence, insecurity or difficulty traveling during the rains." Kapoeta North County, Eastern Equatoria State, Save the Children
- "Training for maintenance, operation, and repairs of water pumps should be done at the time of development of boreholes and include VHWs." Ephantus Wahome, SHTP Environmental Health Advisor
- "Outbreaks can severely disrupt routine PHC activities. There is need for a separate plan for preparedness and response to disease outbreak." Tonj South County, Warrap State, World Vision
- "It is important to ensure that health facilities have emergency preparedness plans." Malakal County, Upper Nile State
- "HIV/AIDS activities can be more effective if there is enough space and privacy in health facilities." Kapoeta North County, Eastern Equatoria State, Save the Children
- "Creating plans to pre-deliver supplies to PHCs which are at risk of isolation during the rains can help avoid suspension of health activities during the rainy season." Kapoeta North County, Eastern Equatoria State, Save the Children
- "There are a few attendees at quarterly meetings whose primary language is Arabic; arrangements for a translator at quarterly meetings (into Arabic) would be helpful for some attendees to ensure they take the information to their counties." Dr. Ali Yusif, Director of Onchocerciasis and Trachoma, GoSS/MoH



Dr. Ali Yusif, Director of Onchocerciasis and Trachoma, MoH (right) provides translation during a SHTP training.

V. FINANCIAL SUMMARY

Table 4. Summary of SHTP Quarterly Expenditures from April - June 2009

Project Line Items	Expenditures April 2009 FY 09	Expenditures May 2009 FY 09	Expenditures June 2009 FY 09	Expenditures Final FY 09	Expenditures 1 April - 30 June 2009
Salaries	$207,330.85	$80,785.67	$64,019.07	$19,680.00	$371,815.59
Indirect Cost/Overhead	$22,960.56	$27,134.15	$40,865.38	$0.00	$90,960.09
Consultants	$5,270.00	$63,588.00	$1,830.00	$3,809.20	$74,497.20
Travel, Transportation, Per Diem	$44,796.65	$25,127.61	$18,445.81	$11,760.96	$100,131.03
Allowances	$0.00	$32,418.95	$0.00	$33,336.77	$65,755.72
Equipment, Material, and Supplies	$15,026.86	$9,899.00	$2,535.00	$7,781.09	$35,241.95
Other Direct Costs	$30,388.45	$15,183.61	$8,267.45	$22,278.91	$76,118.42
Program Costs	161,550.00	$88,696.82	$58,170.50	$98,153.00	$406,570.32
Sub-grants	$115,346.99	$10,013.93	$336,835.92	-$272,283.78	$189,913.06
Total Cost	$602,670.36	$352,847.74	$530,969.13	-$75,483.85	$1,411,003.38

Table 5. Summary of SHTP Total Financial Expenses to date

Project Line Items	Total Expenditures to Date	Total Approved Budget	Total Variance to Date
Salaries	$4,332,366.28	$4,319,447.00	-$12,919.28
Indirect Cost/Overhead	$1,542,238.68	$1,595,988.00	$53,749.32
Consultants	$611,678.59	$606,000.00	-$5,678.59
Travel, Transportation, Per Diem	$2,141,566.04	$2,410,703.00	$269,136.96
Allowances	$737,643.69	$867,574.00	$129,930.31
Equipment, Material, and Supplies	$1,569,975.33	$1,659,459.00	$89,483.67
Other Direct Costs	$2,492,306.77	$2,491,725.00	-$581.77
Program Costs	$4,413,178.79	$4,384,820.00	-$28,358.79
Sub-grants	$19,338,965.46	$19,176,194.00	-$162,771.46
Total Cost	$37,179,919.63	$37,511,910.00	$331,990.37

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ANNEX I

Table 6. SHTP Achievements by State, County, and Urban Area

State	SHTP-Assisted Country	Subcontract completed; Start up Date	Partner INGO	Estimated Population	Estimated % of Pregnant Women	Number of Functional SHTP Health Facilities	Number of Boreholes Installed	Latrine or Well Construction	HIV/VCT or PITC *(start up Sept 2007)*	Bednets Distributed	Antenatal Care Visits (≥1 Visit)	DPT3 Coverage (%; Jan-March 2009)	Vitamin A Coverage (%; Oct 2008-March 2009)	# of Health Workers Trained in 2008
							Interventions							
Jonglei	**Twic East**	Mar-05	Care International	136,000	58	CHD = 0 PHCC = 2 PHCU = 13	15	26	0	6000	800	80	12.6	75
Unity	**Panyijar**	Mar-05	IRC	114,729	12.9	CHD = 1 PHCC = 1 PHCU = 8	11	12	0	8000	362	15.4	4	286
Western Equatoria	**Tambura**	Mar-05	IMC	100,866	14.9	CHD = 1 PHCC = 5 PHCU = 21	17	26	1 VCT + PITC	41,000	883	13	0.6	143
Western Equatoria	**Mvolo**	Mar-05	Save the Children	215,162	29.1	CHD = 1 PHCC = 3 PHCU = 15	6	5	1 VCT	66,000	268	33.9	3.1	34
Western Equatoria	**Mundri**	Mar-05	AAH	125,492	15.3	CHD = 1 PHCC = 4 PHCU = 32	23	23	4 VCT	101,000	369	32.2	6.1	22
Warrap	**Tonj South**	Mar-05	World Vision	300,000	1.6	CHD = 1 PHCC = 2 PHCU = 7	15	5	0	17000	559	0.5	4.1	42
Upper Nile	**Malakal***	Nov-08	IMC	105,000*	NR	CHD = 1 PHCC = 4 PHCU = 8	1	7	0	0	552	24.4	9.8	41
Northern Bahr el-Ghazal	**Aweil South**	Apr-08	Tearfund	336,000	29.3	CHD = 1 PHCC = 2 PHCU = 4	6	2	0	0	952	2.8	0	125
Central Equatoria	**Terekeka**	Apr-08	AMREF	250,000	10.2	CHD = 1 PHCC = 2 PHCU = 12	11	12	0	0	152	5.5	0	121
Central Equatoria	**Juba***	Nov-08	IMC	110,134*	NR	CHD = 1 PHCC = 1 (SHTP) PHCU = 3 (SHTP)	ND	ND		0	ND	NR	ND	NR
Western Bahr el-Ghazal	**Wau***	Nov-08	--	248,288*	NR	CHD = 1 PHCC = 4 (SHTP) PHCU = 3 (SHTP)	0	3	0 *(other NGOs are providing services)*	0	ND	24.7	ND	NR
Eastern Equatoria	**Kapoeta**	Apr-08	Save the Children	295,000	NR	CHD = 0 PHCC = 1 (SHTP) PHCU = 5 (SHTP)	0	2	0	0	ND	NR	ND	NR
Total	**3 urban areas***			**463,422***	**18.8**	**CHD = 8**	**105**	**123**	**1 PITC**	**239,000**	**NA**	**35.5%**	**NA**	**States=889**
	9 counties			**1,873,249**		**PHCC = 31**			**6 VCT**					**In RTCs=200**
	Total			**2,336,671**		**PHCU = 122**								**Total= 1089**

Notes:
Estimated Population data: these figures are predicted to increase as much as 30% per year as a result of post-war returnees.
ND = No data available.
NR = programming either not begun or still in start up phase.
* = SHTP-supported urban area

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