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| END OF PROGRAMME EVALUATION OF THE GFATM ROUND 2 MALARIA PROGRAMME FOR SOUTHERN SUDAN 2004 -2009 |
| February - March 2010 |



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# List of Acronyms and Abbreviations

AAA Arkangelo Ali Association

ACT Artemisinin-based Combination Therapy

ANC Antenatal Care

AQ Amodiaquine

BCC Behavioural Change Communication

CBO Community Based Organization

CCM Country Coordinating Mechanism

CHD County Health Department

CO Clinical Officer

EPI Extended Programme of Immunisation

EWARN Early Warning and Response Network

FBO Faith-based Organization

GFATM Global Fund to Fight AIDS, Tuberculosis & Malaria

GOSS Government of Southern Sudan

HMIS Health Management Information System

HMM Home Based Management of Malaria

HRD Human Resource Development

IDP Internally Displaced Persons

IEC Information, Education and Communication

IMCI Integrated Management of Childhood Illness

IMR Infant Mortality Rate

IPT Intermittent Preventive Treatment

IRS Indoor Residual Spraying

ITN Insecticide Treated Net

IVM Integrated Vector Management

LLI-K Long Lasting Insecticide - Kit

LLIN Long Lasting Insecticidal Net

MCH Maternal and Child Health

MCP Malaria Control Programme

MDG Millennium Development Goal

MOH Ministry of Health

NGOs Non Governmental Organizations

PHCC Primary Health Care Centre

PHCU Primary Health Care Unit

PR Principal Recipient (GFATM)

PSI Population Services International

RBM Roll Back Malaria

RDT Rapid Diagnostic Test

SPLA Sudan People’s Liberation Army

SR Sub Recipient (GFATM)

SSR Sub Sub Recipient (GFATM)

TB Tuberculosis

SoH Secretariat of Health

SP Sulphadoxine-Pyrimethamine

SRRA/C Sudan Relief and Rehabilitation Association/Commission

TBA Traditional Birth Attendant

TWG Technical Working Group

UNDP United Nations Development Program

UNICEF United Nations Children’s Fund

WHO World Health Organization

WVI World Vision International

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**Disclaimer:** The opinions and statements made in this report are entirely those of the author and do not reflect the official UNDP, the Government of Southern Sudan or that of the Global Fund. The author takes the full responsibility for the interpretation and views expressed in this document.

# II Executive Summary

The Global Fund Malaria Round Two program was an intervention that was designed to reduce the burden of malaria as a disease in an estimated population of 1.9 million in more than 17 Counties in Southern Sudan. UNDP was the Principal Recipient for the Grant on behalf of the Ministry of Health.

The program was aimed at reducing the severity of malaria especially among children under five years of age and pregnant women who are most vulnerable to malaria attacks. Malaria accounts for between 24-36% of the health burden in South Sudan and even higher on mortality for children under five years of age. A number of key strategies were employed to reduce malaria burden and these included the use of insecticide impregnated mosquito nets for use by children under five and pregnant women, the raising of awareness of communities for the need for seeking early treatment for malaria, the provision of malaria diagnostic and treatment services at all primary health care centers and units, the provision of anti malaria drugs on continuous basis, the provision of intermittent malaria prophylaxis treatment to pregnant women in their second and third trimesters when malaria infection increases the risk of abortion, the strengthening of the health care delivery systems by training of health workers in the management of malaria and the establishment of a malaria monitoring system to enable prediction and prevention of malaria outbreaks.

The Phase 2 of the Malaria Round 2 program was implemented by four Sub Recipients that included AAA, MC, PSI and WVI in different states. In phase I the following organizations were involved and they included ADRA, IRC, Oxfam GB, , Health Net International, World Relief, Unicef, PSF-CI, World Vision International, and World Vision International Equatoria. A number of these were dropped in phase II for a variety of reasons including low performance and lack of absorptive capacities/

The purpose of the end of term evaluation was to assess, determine and report on GFATM project inputs, processes, accomplishment, lesson learned and to make recommendation to CCM and PR, mainly focusing on outcomes and impact the grant had achieved during its five year implementation.

The objectives of end of program evaluation were to evaluate the extent of progress and the relevance, effectiveness, efficiency, and impact of the program activities and formulate recommendations for the remaining period of the program life.

This end of term evaluation is intended for the Global Fund, the UNDP, the CCM, the Ministry of Health of Southern Sudan, the donors and implementing partners and program planners especially the Directorate of Malaria Control Program to use lessons learned for better future programming efforts. The results of this evaluation will help UNDP and the Global Fund to improve future efforts.

The evaluation was carried out by an external consultant with extensive experience in malaria, and due to the lack of baseline bench marks a mainly qualitative evaluation methodology was employed. Relevant documents were reviewed; interviews of key respondents in the CCM, the Ministry of Health, UNDP, Sub Recipients, CHD, PHCC and PHCUs, Community leaders and households and direct observations of homesteads in the field were carried out using guideline instruments. Information from these reviews and interviews was triangulated during the analysis and a determination of the impact of the program on the burden of malaria on the population determined.

**Findings**

The findings of the evaluation led us to believe that the burden of malaria on the population has significantly been reduced by the concerted efforts of vector control through the use of the LLITNs, the strengthening of health delivery systems to prevent and treat malaria infections and the raising of public awareness of the need to protect pregnant women and children under five from mosquito bites.

Information on program performance of individual SR involved in the implementation of the program in phase I was largely unavailable and the consolidated summary indicated a lower than expected achievements. The low performance may have been as a result of poor information gathering capacity as there were no functional monitoring and evaluation system in place as well as delays in initiating activities in the field.

The numbers of severe malaria cases have reported to have been reducing and the following summarizes the findings:

* Reduced numbers of malaria infection by use of LLITNs
* Reduced number of cases of severe malaria
* Improved capacity of health workers to diagnose and treat malaria competently
* Provided anti malaria drugs supplies
* Created a high level of community awareness by involvement of community leaders in the education process.
* Contributed to reduction of anti malarial drug wastage by treating only confirmed cases
* Established a standard HIMS for data collection from all service delivery points.
* Increased population awareness on the prevention and management of malaria through the use of insecticide impregnated mosquito nets (LLITNs), seeking of early treatment and protection of pregnant women by taking IPTs.

The implementation of the program was constrained by a number of factors that seriously impacted on the performance of the program. These constraints included the late start of program implementation, inadequate numbers of staff at the PR (UNDP) level due to high staff turn-over, weak M&E systems to monitor and guide implementation and the slow procurement processes and low absorptive capacity of sub recipients as well as poor baseline data. In addition, the indicators selected for performance appraisal were difficult to measure especially given the lack of baseline data, and that some of the indicators were too ambitious as they referred to factors beyond the changes that could be brought about by other interventions beyond the control of the program.

The program appear to have made significant achievements based on the reported indicator performance that were found to be well above the expected levels, The observed overachievements on most of the indicators are as a result of underestimation of the specific implementation targets given the lack of baseline information. It is apparent that the use of the null numbers as the baseline has tended to make the achievements look relatively high[[1]](#footnote-2). It is also clear that the indicators that have been selected are insufficient and more process oriented hence does really not provide good indices on the reduction of the impact of malaria as a burden of disease on the population within the operational areas.

Although the overall program indicators were far too high and could not have been achieved even in the best circumstances given the situation of Southern Sudan, the implementation processes employed by all SRs have made some significant changes in the prevalence and impact of malaria. The raising of population awareness on the seriousness of malaria as a health burden and the use of LLITNs, the use of IPT for pregnant women as well as seeking of early treatment for suspected malaria to reduce impact of the disease has been a major achievement of the program. The implementation of the program has also contributed to the strengthening of health care service delivery through the training of existing and new health cadres as well as establishment of new facilities in areas where there was limited access to basic health care services. However, the lack of follow-up strategy is likely to reverse the gains made as there will be no resources available for continuation of malaria treatment at the end of the program period.

Most importantly the process has provided valuable lessons learned for future programming of malaria in the country.

**Conclusions**

The evaluation findings indicate that although there has been a significant amount of shortcomings in the implementation of the program, tremendous amount of progress has been made towards finding solutions to the reduction of malaria in Southern Sudan. Lessons learned from these efforts would help shape better planning and implementation in future.

**Recommendations**

The following recommendations are made:

1. The capacity of the CCM should be developed to enable critical oversight of the implementation process, be able to vet technical staff employed by SRs to ensure that only the duly qualified personnel are employed and provide guidelines on job specifications and job employment terms and conditions to reduce multiplicity of conditions and provide a level playing field.
2. Future proposals should establish baseline benchmarks to guide the selection of appropriate and realistic performance indicators.
3. The selection of PR should include the criteria for flexibility of the goods and services procurement systems to ensure rapid responsiveness to emerging programmatic needs in the field. This will reduce the delays that were experienced in the selection of SRs, procurement of technical services and program management staff, goods and services. -Delays in the selection of sub recipients and procurement of LLITNs on timely basis are specific examples of the inflexibility of the current PR’s (UNDP) systems and operational procedures that negatively impacted on the timely implementation of activities.
4. The selection of Sub Recipients should be based on criteria of technical capacity and history of successful undertaking of similar programs in the past and an appropriately validated qualified staff complement.
5. Program resources should be optimized by using locally based organizations as SRs to avoid the high costs of external offices, staff R&Rs.
6. The capacity of the National Malaria Control Directorate should be further developed to enable the provision of technical support and supervision especially with regard to monitoring and evaluation, staff training and disease surveillance. The directorate should provide technical oversight on all implementation efforts on malaria in the country.
7. The GOSS should immediately develop a follow-up proposal for control of malaria as there will be a hiatus in the provision of general malaria control activities at the end of the program period. The GFATM Round 7 Malaria program is inadequate as it is mainly directed towards under five children and pregnant mothers.

# 1 Introduction

This is an end of term evaluation report for the Global Fund Round 2 Malaria Program overseen by the UNDP Southern Sudan over the period 2004 – 2009 implemented by four sub recipients and many more sub sub recipients. The report is intended for the Global Fund to determine the achievements made in the reduction of burden of Malaria on the population of Southern Sudan, as well as for the UNDP who was the Principal Recipient of the Grant, the sub and sub-sub Recipients who would want to know how each organization has performed as well as the Ministry of Health of the Government of Southern Sudan who would use the information for further national health planning purposes.

The primary audience of this report is the UNDP who would like to find out how it has performed as a Principal Recipient in the administration of the grant, specifically wanting to know what were the major internal and external constraints and challenges that may have impacted on the performance of the malaria program, at the same time noting the achievements and impact the program might have on malaria prevalence and impact on the population and communities targeted in Southern Sudan. The other primary audience is the Ministry of Health (GOSS) who would want to use the lessons learned from the implementation of the grant to use in subsequent and future plans and strategies for control and management of malaria as a major disease burden in Southern Sudan.

The Round 2 Global Fund Malaria Grant was intended to control and reduce the burden of malaria on the population through increased use of long lasting insecticide treated bed-nets mainly by pregnant women and children under five years of age; the improved and early diagnosis and treatment of uncomplicated malaria and early referral of complicated cases to higher level facilities; provide intermittent malaria prophylaxis treatment to pregnant women and create increased community awareness to malaria control measures. The program operational base was down to the lowest health facility (Primary Health Care Unit (PHCU and PHCC) with a significant involvement of County Health Departments. The malaria program was implemented through four major sub Recipients that included (i) the Population Services International (PSI), (ii) the World Vision international (WVI), (iii) the Malaria Consortium (MC), and (iv) the Arkangelo Ali Association (AAA) and a number of sub/sub Recipients. The program was implemented into two phases that saw a number of sub recipients and more sub/sub recipients dropping out due to either lack of adequate institutional capacity or failure to deliver on agreed targets. Those sub recipients not included in the phase II included ADRA, IRC, OXFAM, Health Net International, World Vision International Equatoria among others.

The Phase Two of the program saw reduced numbers of sub recipients and the reasons for this will be determined by the evaluation. However, it is not clear whether a midterm evaluation was carried out to shape the implementation and management processes of Phase Two even though decisions were made to exclude certain sub recipients from participating in the phase two of the program.

# 2 Description of the Evaluation

The evaluation of the Global Fund Round Two Malaria program in South Sudan is an end of term process intended to sum up the achievements, constraints, lessons learned from all levels of implementation and the determination of the effectiveness of the Principal Recipient (UNDP) in the management of the grant. The results and findings of the evaluation will assist UNDP to prepare a grant closure report, enable the accounting of resources used and determine the effectiveness of the investment made by the Global Fund towards the reduction of the impact of malaria on vulnerable population in Southern Sudan. It was also decided that an assessment of cross cutting issues such as policy and regulatory environment, socio political conditions and the impact of the evolution of government systems on the program performance be identified for future improvements of programming planning.

The objectives of the end of term evaluation are to determine the extent of progress and the relevance, effectiveness, efficiency, and impact of the program activities and formulate recommendations for current and future plans for malaria control in Southern Sudan. (See annex II for details on actual specific objectives). The evaluation is expected to provide answers to the questions on achievements made, constraints faced, challenges met; effectiveness of management and what lessons were learned (see expected results framework in Table 1).

Table 1: Expected Results Framework by Objective

|  |  |  |  |
| --- | --- | --- | --- |
| **Goal** | **Key Objective** | **Expected Results** | **Indicators** |
| **To reduce the burden of malaria in the beneficiary population in Bahr el Ghazal, Equatoria and Upper Nile Regions of Southern Sudan** | 1. To increase the use of LLITN in pregnant women and children under five | Increased percentage of pregnant women and children under five children sleeping under a LLITN | Percentage of pregnant women reporting to use LLITNs |
| 1. Expand IPT to pregnant women | Increase numbers of pregnant women given IPT at health facilities | * Numbers of pregnant women given IPT at each health facility * Numbers of IPT doses dispensed |
| 3.To improve early diagnosis and treatment of uncomplicated malaria at community health facility level | Increased access to early diagnosis and treatment of malaria | * Number of uncomplicated malaria cases diagnosed and treated * Number of anti malaria treatment drugs dispensed |
| 4.To strengthen local capacity to predict, respond and contain malaria epidemics | Enhanced capacity of local health personnel to anticipate and prepare for malaria outbreak by anticipative surveillance of climatic and environmental conditions | * Numbers of health personnel trained in EWARN system * Numbers of correctly predicted malaria outbreaks * Numbers of malaria outbreaks not predicted |
| 6.To increase the local capacity to enhance health management system in effectively containing malaria | Malaria control activities recorded and reported accurately | * Numbers of LLITN distributed * Malaria awareness increased * Pregnant women receiving IPT * Malaria cases competently diagnosed and treated |
| 7.To produce up to date information on malaria |  | * Baseline information on malaria available * Malaria surveillance reports * Malaria service delivery data available |

2.1 The Evaluation Matrix

In order to ensure that correct data was collected the following evaluation matrix was developed to guide the consultant on the type of information to be collected. The matrix also assisted in the development of instruments and guidelines used to collect information from the field.

Table 2: End of Term Evaluation Matrix

|  |  |  |
| --- | --- | --- |
| **End of term Evaluation Objective** | **Expected Results** | **Indicators** |
| * To assess activities, inputs, process, output, accomplishment as implemented by UNDP as PR and put recommendation to Principal recipient and CCM under Malaria Round 2 and TB Round 2. | Performance of UNDP as PR determined in terms of support supervision, creation of an enabling environment, procurement support and monitoring and evaluation | * Completion of activities within stated time frames * Level of disbursements to SRs * Numbers of supervision missions * Midterm evaluations |
| * Assess the grant implementation steps at country level. | All planned activities implemented according to plan | * Submitted quarterly reports * Supervisory reports |
| * Assess program achievement against target throughout the implementation of the grants | * All planned targets achieved | * Levels of achievements attained |
| * To evaluate the grant expenditure against the grant plan and the steps followed in the procurements. Furthermore it will document the challenges related with the procurement | * Grant expended according to budget | Adherence to authorized expenditure  Level of disbursements according to approved expenditure |
| * To assess the activities of PR and fulfillment of terms of reference as specified in the Initial proposal and CCM document. And assess its effectiveness in each service delivery area per each grant designed to implement set targets. | PR has carried out all the activities stated in line with the Global Fund proposal and under the CCM oversight  PR has attained all objectives as indicated in the grant agreement | %age of targets reached |
| * To assess the extent to which the grant plans have been implemented and goals have been achieved by PRs and SRs. Identify significant program changes made in the course of program implementation. | All grant plans achieved | Level of achievement attained  Number if changes made in the program |
| * To assess any constraints and challenges that the grants implementation encountered and how these have been resolved by implementing partners including SRs and PRs. | Constraints and challenges identified and dealt with | Number of constraints reported  Number of organizations that reported encountering constraints |
| * To assess the activities of PR and fulfillment of terms of reference as specified in the initial proposal and CCM document. And assess its effectiveness in each service delivery area per grant designed to implement set targets | PR has fulfilled all obligations for managing the Grant | Number of obligations not met by the PR |
| * To assess PR and CCM capacity and structure for managing GFATM in relation to human resource and infrastructure. To what extent the GFATM structures have been fulfilling their roles. | Both PR and CCM has adequate capacities to manage the Grant | Number of organizational structures not filled  Numbers of activities not done or not completed due to lack of staff capacities |
| * Examine the efficacy of management of GFATM in Southern Sudan by relevant entities (PR and SRs) and assess how well they met the Global fund requirements with particular focus in the future grants**.** | All planned activities and targets met | Number of programs, activities completed  Number activities programs not completed  Numbers of SR not able to utilize allocated funds |
| * Assess whether GFATM funds in Southern Sudan are efficiently utilized | GFATM funds used effectively to attain stated targets and objectives | Number of projects not able to attain stated targets  Level of achieve results compared to level of resources utilized. |
| * Assess whether GFATM funds are making a substantial contribution in the existing program to fight Malaria and Tuberculosis, | The burden of malaria on the population significantly reduced | Drop in the number of malaria fatalities  Numbers of cases treated  % of pregnant women and children underfive sleeping under LLITNs.  %age of pregnant women and children under five sleeping under LLITNs. |
| * To assess external factors which may grossly affect implementation of GFATM grants | Program management and delivery affected by identified external factors | %age of activities not completed due to affect of external factors |
| * Document lessons learned and best practices during the implementation phase. | Experiences and lessons from the implementation management of GFATM listed and published | Best practices identified |
|  |  |  |

2.2 Scale of the Intervention

As can be surmised from the expected results map above, the Malaria program Round 2 Grant is a country wide program intended to focus on areas and vulnerable population where malaria exerts heavy burden on the community. The Malaria Round 2 grant had a total approved amount of US$25,067,660 to be spent over the projects five year life span (October 1, 2004 to September 30, 2009). A number of relevantly qualified sub-sub recipients with capacity to operate at community levels were selected.

At the time of the evaluation the program had closed and the grant had been utilized in the following manner.

2.2.1 Factors likely to Impact on the implementation

South Sudan is a geographically large area with scattered communities most of which live in isolated locations that are hard to reach. The country had been in a war situation for a period of more than twenty years and recently a peace agreement has ushered in an era of reconstruction. The health infrastructure is largely derelict and only covers an estimated 20% of the population. The health facilities and programs are variously owned by the government, faith based organizations and International NGOs thus making coordination and standardization of services difficult. The new Government of Southern Sudan has established a Ministry of Health that is currently in a state of evolving policies and procedures. Although the MOH has established some regulatory controls over service delivery through the development of national guidelines and policies, the health care system and program management and implementation processes are still fragmented and very much donor and implementing NGO dependent.

The implementation of the Malaria program under the Round 2 GFATM grant was through a number of sub recipients who in certain incidences implemented some of the activities through sub contractual agreements with specific sub sub recipients at the field operations levels. A number of internal and external factors were reported and found to have impacted on the implementation performance of these organizations and constrained program achievements and these included the following:

1. Poor socio economic conditions
   1. Absence of road network that led to logistical difficulties to transport commodities
   2. Use of air transport for movement of personnel and goods to operation sites
2. Inadequate health system capacity for service delivery due to:
   1. Absence of basic health infrastructure in many population areas;
   2. Inadequate trained health human resources
   3. Inadequate policy and regulatory mechanisms
   4. Inadequate government resource budget support to consolidate services beyond the program life Large expanses of areas to be covered
   5. Absent monitoring and evaluation capacity
3. Difficult and unfavorable climatic conditions that restricted access where distribution of nets and supervision and supply of health facilities could not be carried out due to restricted access as a result of flooding and impassable roads
4. Lack of adequate baseline information on the exact situation of malaria in the country.
5. Absence of exit strategy for sustainability after the grant support.
6. Low government involvement in program implementation leading to lack of preparation for continuation of activities and services at the end of the grant support.

2.3 Program Design Issues

The program design was influenced by the fact that the program was developed during the time of hostilities between the Government of Sudan and the SPLA. Most of the team members were representatives of organizations that were involved in health care providing activities in South Sudan, managed from their bases in Kenya. The information base from which the program proposal was based lacked the basic epidemiologic depth required to develop a responsive and comprehensive program. The lack of baseline benchmarks made the determination of targets particularly difficult and most of the targets listed were unrealistic as they were either under or overly estimated. Although the design of the Global Fund Round 2 Malaria program was designed to share resources and support services with other community based programs such as the IMCI, MCH the exact operational modalities were not adequately developed and the expected synergies were never fully realized. In addition the design of the program lacked an exit strategy that would have prepared the Ministry of Health to imbed the malaria program in the subsequent rounds of proposals.

Although there is the National Malaria Control Program, due to a number of constraints, its role and participation has been confined to establishment of base line benchmarks and has not significantly been involved in the monitoring and technical oversight of the Malaria Round 2 program.

2.4 Implementation Constraints

Implementation of the Malaria Round 2 program faced enormous constraints given the significant political changes that occurred in Southern Sudan, with the signing of the comprehensive Peace Agreement that saw a new Government being established. The change in the political scene had to be translated into the implementation modalities where the existence of a central government imposed some level of accountability of implementing agencies to evolving government policies and procedures systems. The implementing agencies including the Principal Recipient had had to relocate their operations headquarters to Juba from Nairobi or Kampala with attendant problems of finding qualified personnel willing to relocate to a situation of political uncertainty.

Implementation of Malaria programs in Phase I was articulately plagued with several start-up problems that included change over from relief to development mode of operations for many of the organizations; establishment of coordinated and collaborative approaches to health care service delivery; the establishment of policies and regulatory procedures and consolidation and refurbishment of health facilities as well as development of new ones. Other cross cutting impediments included the lack of facilitating environment due to absence of functional government guidelines which were still evolving, the lack of financial resources at government level to enable involvement of government institutions, personnel and structures to fully participate in the planning and implementation of the programs. In addition the operant environment which is still steeped in traditions and pastoralists culture limits opportunities for full community involvement and participation especially pertaining to decision making for women. The persistent pastoralist traditions of cattle rustling induced a significant degree of insecurity and severely affected the establishment of new health care facilities and functioning of those situated in conflict area. The low literacy level and lack of appropriately trained health cadres also contributed to the slow pace of implementation.

Furthermore, the political suspicions and among the signatories to the Comprehensive Peace Agreement (CPA) created an atmosphere uncertainty and therefore limited absolute commitment to the establishment of long term processes in the country. Perhaps one of the major constraint on implementing the malaria Round 2 program in Southern Sudan was the high cost of transaction involving the use of costly air transport for staff movement and distribution and supply of commodities to the largely inaccessible areas in such a vast country; the high staff costs due to employment of expatriate staff whose relatively high salaries[[2]](#footnote-3) and other terms and conditions of work that include accommodation of program personnel in costly hotel accommodations, the costs incurred on staff recuperation and recovery (R&R) travel due to the country (South Sudan) categorized as a hardship location places a significant non program expenses on the program. Other factors contributing to high operational costs are the use of international organizations to implement ground level activities which carries high overhead costs to support their base offices in Kenya and/or Uganda as well as home offices in their country of origin. The CCM and the GOSS should look at the possibility of encouraging INGOs to establish base offices in Southern Sudan through restrictions of participation of foreign country based organizations

Furthermore, the MOH currently in the stage of evolving policies and procedures and developing its human resource capacity has not been able to provide counterpart personnel in the malaria control program and many of the activities were implemented without adequate participation and involvement of the government. During the implementation of the program efforts were made to develop the capacity of the government Malaria Control Program to exercise some monitoring and supervisory controls over the program with support from the World Health Organization technical inputs. At the time of the end of term evaluation, a significant level of capacity had been created in the Malaria Control Program and a national malaria control policy and strategy had been developed. However, the capacity of the National Malaria Control Directorate to effectively monitor and provide technical guidance to implementing agencies has still not been adequately developed.

# The Scope of the End of Term Global Fund Malaria Round 2 Evaluation

The scope of the end of term evaluation of the Malaria Round 2 program is part of the global agreement for the administration of the grant by the PR. The evaluation is intended to focus on the outcomes and impact the grant has had on the beneficiaries and implementation plans over the entire five year grant period; to enable the determination of the efficacy of the PR and SR implementation, determining the effectiveness and efficiency of the use of GFATM project inputs, processes, accomplishment, lesson learned and to report these as well as make recommendation to CCM and PR.

The evaluation would comprise of total evaluation of both program design, and implementation processes carried out by the PR, SR and SSR in representative areas. The full scope of the evaluation was determined by the time and available opportunities to visit implementation sites.

3.1 Purpose of the Evaluation

To evaluate the extent of progress and the relevance, effectiveness, efficiency, and impact of the program activities and formulate recommendations for future programs

3.2 Objectives of the Evaluation

1. To assess activities, inputs, process, output, accomplishment as implemented by UNDP as PR and put recommendation to Principal recipient and CCM under Malaria Round 2 and TB Round 2.
2. Assess the grant implementation steps at country level.
3. Assess program achievement against target throughout the implementation of the grants
4. To evaluate the grant expenditure against the grant plan and the steps followed in the procurements. Furthermore it will document the challenges related with the procurement.
5. To assess the activities of PR and fulfillment of terms of reference as specified in the Initial proposal and CCM document. And assess its effectiveness in each service delivery area per each grant designed to implement set targets.
6. To assess the extent to which the grant plans have been implemented and goals have been achieved by PRs and SRs. Identify significant program changes made in the course of program implementation.
7. To assess any constraints and challenges that the grants implementation encountered and how these have been resolved by implementing partners including SRs and PRs.
8. To assess the activities of PR and fulfillment of terms of reference as specified in the initial proposal and CCM document. And assess its effectiveness in each service delivery area per grant designed to implement set targets.
9. To assess PR and CCM capacity and structure for managing GFATM in relation to human resource and infrastructure. To what extent the GFATM structures have been fulfilling their roles.
10. Examine the efficacy of management of GFATM in Southern Sudan by relevant entities (PR and SRs) and assess how well they met the Global fund requirements with particular focus in the future grants.
11. Assess whether GFATM funds in Southern Sudan are efficiently utilized
12. Assess whether GFATM funds are making a substantial contribution in the existing program to fight Malaria and Tuberculosis,
13. To assess external factors which may grossly affect implementation of GFATM grants
14. Document lessons learned and best practices during the implementation phase.

# 4 Methodology for the Evaluation

The process of data collection consisted of collection of both quantitative and qualitative information based on the set of performance indicators established and agreed with the Global Fund. Other information to be collected included assessment of the management of the program reports of the PR, the CCM and LFA as well as those of the Ministry of Health.

4.1 Evaluation Study Design

Collection of information to provide a composite and comprehensive picture of the impact and achievements of Round 2 malaria program will require a post-test cross-sectional evaluative study that will enable collection of data on activities and processes, disbursements and management used in the implementation of the program. Information sources would be selected in a purposive stratified random sampling of individual respondents, institutions, facilities and households. Multi stage sampling of areas and facilities will be based on a criteria of selecting the best performing, moderately performing and poorly performing programs in the three regions(according to old geographical divisions at the time of proposal development). Where the sample denominator is small such as number of sub recipients a total sampling approach will be employed. Multi modal collection of representative data will collection of data needed to validate and verify information from reviewed project documents and reports as well as interviews of key stakeholders involved in the implementation and oversight of the program implementation.

4.1.1 SOURCES OF DATA FOR THE EVALUATION

Multiple sources were used for the collection of data for the evaluation. Specific instruments or guidelines were developed for each source of data and a triangulation used in the analysis of the data collected.

4.1.1.1 Data from Documents Review

The first source of information will be from secondary data sources from program documents, reports and evaluation and audit reports. Other data was obtained from personal interviews of program managers, field supervisors, health workers and staff, Civic Administration at County and Payam and community levels and beneficiaries. In addition Focus Group Discussions were held at community levels as well as direct observations of facilities records and premises including visits to homesteads in the evenings.

Additional data was obtained from key individuals from the implementing Sub Recipients, beneficiaries, implementing partners, members of the CCM, the Ministry of Health Malaria Control Department and the UNDP as a Principal Recipient managing the Round Two Grant.

The selection of respondents, health facilities and Sub Recipients for inclusion in the evaluation sample was based on a purposive cluster sampling from the 17 Counties with an estimated population of 1.9 million people.

4.1.1.2 Field Visits

Visited several sites in four states where sub recipients had implemented the malaria program, these included Upper Nile State ( Panyikan), Bar el Ghazal (Aweil), Lake State (Yirol) and Central Equatoria (Yei and Lainya).

Visits were made to the County Health Departments, Hospitals, PHCC,PHCU, Payam Administration, Villages, Communities and Selected households. Interviews of key respondents and direct observations of facilities and homesteads were carried out as well as examination of record books, drug storage areas and facility reports.

(See annexes 3 &4 for detail)

# 5 Findings

The findings were based on the triangulated analysis of information collected from interviews and observations in the field and from the review of relevant reports and documents. Additional information was obtained from interviews of key informants from the PR, MOH, WHO and sub Recipients.

5.1 Overview of Findings

Information on the performance of the program in Phase I was scanty and limited to summary consolidated reports (SUDM –Budget Reports) that indicated that moderate to low achievements were made (see annex 6 – 2SUDM\_5\_272\_Budget request), The results used in this report was partially based on the cumulative assessment found in the last Quarter (Q20) evaluation of the Malaria Round 2 indicating an overall achievement of 68% (B1 according to the Global Fund rating).BI rate refers to satisfactory achievement and does not refer to either long or short term effect of the grant The project has, however, impacted on the short term reduction of malaria among those communities that participated in the program evidenced by the increasing numbers of people treated for malaria, perceived reduction in mortality from malaria as perceived by respondents interviewed in beneficiary communities. Although the program was implemented by several different sub recipients the overall general achievements were relatively similar in each locale where the program was implemented. The only differences were the extent to which the County Health departments were involved as well as the internalization of the program by the community that was determined by how closely they had been involved in the planning and execution of the program.

The achievements can be attributed to a number of factors that include following:

1. The beneficiary communities were well sensitized to the objectives and intentions of the project and through health education they were fully informed and aware of the services that the program was offering,
2. LLITNs distribution targets were in some areas even exceeded despite of delays in the initial procurement through the UNDP procurement systems.
3. Early detection and treatment of malaria was being carried out in the PHCCs and PHCUs that are involved in the program.
4. Staff in these facilities had undergone training in the diagnosis and treatment of malaria
5. Malaria prophylaxis for pregnant women (IPTs) were being administered at every ANC clinic on referral by TBAs
6. LLITNs were found in every home that was randomly visited and members of the household demonstrated the knowledge on the use of the nets.
7. It was reported that most cases of malaria that came to the facilities did so in early stages of infection and there were very few cases of complicated malaria treated or referred to a higher facility for treatment,

A doctor running a mission hospital reported a significant reduction in the number s of cases of heamolytic anaemia as a result of severe malaria parasitic infection as a result of early treatment,

1. A significant change in the behavior change of communities where children under five were fed early and sent to bed under a mosquito nets before 7pm
2. Health facilities including government supported ones had available anti malarial drugs except in a few occasions when supplies were delivered late. The situation of stock out of drugs at the health facilities was reduced during the program support but is now likely to happen with the closure of the program as government resources are not adequate to provide for the raised high demand for malaria.

Summary Table 5.1.1 Achievements by Indicators for PR[[3]](#footnote-4)

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Indicator Description** | **Baseline** | | **Intended Yearly Targets** | **Actual Yearly Results** | **Comments** |
| Value | Year |
| 1. % of Children under five years sleeping under LLITN |  |  | 60% | 55% | Difficult to ascertain |
| 1. % of pregnant women sleeping under ITNs(LLITN) |  |  | 60 | 61 | There are no registers for all pregnant women and difficult to confirm whether they do sleep under mosquito nets |
| 1. Incidence of clinical malaria cases- number of clinical (symptomatic) cases of malaria illness per 1,000 person years |  |  | 66 | TBD | Unrealistic as not all cases of clinical malaria are likely to attend clinics |
| 1. All cases of under five child mortality in highly endemic areas |  |  | 245 | TBD | Unrealistic indicator as there are no deaths registers |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Objective No.** | **Service Delivery Area** | **Indicator Description** | **Baseline** | | **Intended Targets** | **Actual Results** | **Comments** |
| Value | Year |
| 1 | Prevention:  ITNs | #of service deliverers trained in distribution and implementation of ITNs | 1343 | Sept 06 | 5496 | 4411 | This is 80 % achievement. |
| 1 | Prevention: ITNs | # of LLITNs distributed | 168647 | -do- | 2,181,912 | 711,783 | The **67 %** shortfall was due to delays in the PR’s procurement of LLITNs. These had to be procured through PSI systems and were later distributed through a mass distribution campaign after September 2009. |
| 1 | Prevention: malaria prevention during pregnancy | # of health care service deliverers trained in providing IPT | 1228 | -do- | 2854 | 2639 | There was a slight 8% shortfall which could be explained by the high attrition rate of health workers due to poor conditions of service |
| Proportion of facilities providing IPT to pregnant women | 143 | -do- | 98% | 57% | The **41%** was as a result of logistical problems especially in areas that are inaccessible as result of floods and poor roads |
| 2 | Prevention: Malaria prevention during pregnancy | # pregnant women receiving IPT | 30,620 | -do- | 183,835 | 82,588 | Poor performance in this areas is as a result of setting up ambitious and unrealistic targets given the poor health infrastructure and the lead time needed to create adequate awareness among the communities and pregnant women in particular |
| 2 | Treatment: Prompt effective anti malarial treatment | # health workers trained on BCC to promote early care seeking from appropriate provider | 205 | -do- | 8705 | 4047 | The targets were not achieved given the unrealistic targets set in an environment where most community health workers are no on salary and the attendant high staff turnover as a result of poor conditions of service. |
| 3 | Treatment: Prompt effective anti malarial treatment | # of patients with uncomplicated malaria treated | 177,895 |  | 959,511 | 616,852 | The targets set here were based on guess work as there was no baseline survey to realistically estimate the incident of uncomplicated malaria. |
| # patients with severe malaria given treatment according to WHO guidelines | 8,825 |  | 33,344 | 29,512 | Similarly the determination\ of severe malaria is subjective and some of the referrals may have been to other ailments |
| # (Proportion) of facilities with no stock outs of anti malaria drugs | 149(95%) |  | 98% | 71% | This was not achieved given the weak drugs supplies and management systems and poor transport systems at the field levels. In addition there was a weak drugs supplies management system especially for government facilities. |
| 4 | Treatment : Prompt effective anti malaria treatment | # health workers trained in emergency preparedness (predicting and containment of epidemics) | 532 | Sept 06 | 2212 | 1622 | WHO did not fully implement the program due to high staff turnover. In some areas State level TOT training was carried out but there was no follow-on to facilitate county and Payam level training. |
| 4 | Prediction and Containment of Epidemics | # health facilities following the WH’s EWARN for Southern Sudan | 101 | -do- | 406 | 381 | There is some doubt whether the high level of achievements are real given that EWARN training was not carried out in a majority of operation areas |
| 4 | Health Systems Strengthening | #health service deliverers trained in health information system | 536 | -do- | 1585 | 1968 | There was an over performance in this area as a result of the establishment of the M&E Unit at the PR level |
|  |  | # of health facilities implementing revised HIS | 121 | -do- | 510 | 168 | Most facilities are owned and managed by NGOs and would require policy to standardization the use of HIS |

The indicator performance shows a mix result that indicate the need for the review of the target levels given the magnitude of the constraints encountered in the implementation of the program. The impact of the poor socio economic and environmental impediments on the program implementation has been significant and would require parallel health infrastructural development for the next malaria control program to succeed.

5.1.1 Summary Grant Disbursements and Expenditure

Disbursements done for both phases are presented below showing the levels of grants given to each SR. However, it was not possible to triangulate disbursements to each SR against achievements made in this report. Disbursements for phase I were abstracted from consolidated budget request 2005 reports and for phase II from the 2008 Global Fund Annual Report. The disbursement request have been used as indications of expenditure at each SR level

Table 5.1.3 :Summary Malaria Round 2, Phase I Disbursement and Expenditure [[4]](#footnote-5)

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Grant  Number** | **Phase and Year of Implementation** | **Total Budget in 2005 (US$)** | **Total Disbursements from GFATM in 2005 (US$)** | **Opening Balance at 01-Jan-08** | **Total Available Funds in 2008** | **Total Expenditure in 2005** | **Closing Balance at 31-Dec-05** | **% Disbursement vs. Budget in 2005** | **% Expenditure vs. Budget in 2005** |
| **SUD-5-272-G01-M** | Phase 1, Year 2\* | 5,228,,408.38 | 2,795,780.95 | 4,903,414.00 | 4,903,414.00 | 2,795,780.96 | 2,107,633.04 | 57% | 57% |

Being a start up period %age disbursements versus budget and expenditure versus budget were similar. However the level of 57% spending indicates some significant lack of absorptive capacity to spend funds. This could have been due to a number of factors that could include slow disbursement process from PR, lag time in establishing program structures and operational systems..

Table 5..1.4: Summary Malaria Round 2 Phase II Disbursement and Expenditure Trends[[5]](#footnote-6)

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Grant  Number** | **Phase and Year of Implementation** | **Total Budget in 2008 (US$)** | **Total Disbursements from GFATM in 2008 (US$)** | **Opening Balance at 01-Jan-08** | **Total Available Funds in 2008** | **Total Expenditure in 2008** | **Closing Balance at 31-Dec-08** | **% Disbursement vs. Budget in 2008** | **% Expenditure vs. Budget in 2008** |
| **SUD-202-G01-M** | Phase 2, Year 4\* | 12,250,388.00 | 2,484,931.00 | 1,894,521.00 | 4,379,452.00 | 4,004,195.00 | 511,057.00 | 20% | 33% |

The table above clearly indicates that significant degree of inadequate absorptive capacity of the SR to utilize the funds disbursed to them. There could be a number of reasons for the SRs inability to spend the funds that may be related to the management of the disbursement processes by the PR, the lack of capacity at the SR level.

5.2 Specific Performance by PR and SRs

Performance of the PR and SRs were examined and the following findings were noted.

5.2.1 PR Performance

The PR was expected to diligently manage the grants to ensure that all the key deliverables are reached by the SRs and to create an enabling environment for the implementation of activities indicated in the proposal.

UNDP has to a great extent been able to manage the processes notwithstanding the numerous systems and capacity constraints experienced. However, it took some time for UNDP to get the processes going and a significant part of phase 1 was lost in setting up systems and assembling the team. Due to lack of adequate personnel the M&E part of the project was developed late and training was only started in 2008 and 2009 for the SR field personnel. Other major problems were the delays experienced in procurement of commodities such as drugs and the LLITNs which impacted on the momentum of implementation of activities at the field level. It was reported that at one time the PR had to request assistance for procurement of nets from PSI to avoid further delays in net distribution. These delays were such that some nets were delivered to distribution sites in September 2009 when the project was scheduled to close. The delays in procurement is exemplified by the need to motivate a no cost extension for the program as some of the commodities such as the last batch of LLITNs were delivered to Sub Recipients in November two months after the program closure date in September 2009. Although the UNDP grant disbursements were frugal its overall performance was significantly constrained by its bureaucratic controls that often delayed implementation of activities as shown by disbursement delays in Table …..:

Table 5.2.1 Indicative Financial Statement by End of March 2010[[6]](#footnote-7)

|  |  |  |
| --- | --- | --- |
| **PR** | **Amount (USD)** | **Comments** |
| Closing balance as of 30 Sep 2009 | 39 099 | per PUDR |
| GFATM disbursement on 7 October 2009 | 2 027 776 |  |
| Final disbursement expected in next month | 405 342 | This disbursement was requested from GFTAM and is expected to be disbursed as soon as possible |
| Revenue generated by PR using grant funds -in line with interest earned in 2008 | 40 000 | This is assumed to be in line with the interest earned in 2008, although the figure will only be known in Dec 2009 |
| **Total funds available for period to 31 March 2010** | **2 512 217** |  |
| (Less PR Disbursements to Sub-Recipients) | 1 486 877 | This is 90% of the balance of amounts due to SR's under the SR agreements as the final payment will only be paid once the SR's have submitted their final reports |
| Less PR payments for commitments already contracted for as at 30 Sept 2009 | 459 138 | See details on commitments worksheet included in this workbook |
| (Less PR Expenditure to March 2010) | 400 000 | See PR details worksheet included in this workbook |
| **Estimated PR Cash Statement as at 31 March 2010** | **166 202** | This will be used to pay the 10% retention on the SR agreements |
| **SR** | **Amount (USD)** | **Date** |
| Total Commitment to disburse to SRs by PR | 7 309 223 |  |
| (Less: Actual disbursed to end Sept 2009 by PR to the SR) | 5 657 137 | Disbursed as at 30 Sept 2009 |
| **SRs Cash Balance to be paid by PR** | **1 652 086** | See SR worksheet for detailed breakdown by SR. This consists of the $1,486,877 to be disbursed immediately and $165,209 which will be disbursed on submission of SR final reports |

The overall assessment of UNDP performance could be rated at average and the organization needs to change a lot of processes and procedures to make it responsive to program requirements.

5.2.2 Discussions

UNDP was assessed to have managed the financial disbursements relatively well but seriously fell short in its slow procurement efforts. The use of UNDP procurement systems involves a number of several processes intended to eliminate improper practices but in the end contributed to delays in the procurement of goods and services for the program. Although in theory, UNDP was carrying out the PR role on behalf of the Ministry of Health the latter was not fully involved in the management and oversight of activities that were being carried out by the SRs.

One of the major weaknesses of the grant management has been the failure to develop adequate capacities of local institutions such as the National Malaria Control Program to oversee the implementation of the program activities, the state and County Health Department and other relevant national institutions. As a result of this there is evidence from the field indicating that once the SRs have completed their activities at the end of the program, the situation of malaria in the country is likely to worsen as there will be no anti malaria drugs when the current stocks run out. The current Round 7 malaria program is a program restricted to women and children under five and does not provide for management of malaria for the general public. There will be an urgent need for the GOSS to solicit for emergency support to procure anti malaria drugs as soon as possible to avoid the hiatus created by the absence of continuity strategy of the Malaria Round 2 program.

5.3 Specific SR Performance

There were four main sub recipients in the Phase Two of the Round Two Malaria Program. Information the SRs for Phase One is scanty and records could not be accessed. It is understood that the de facto implementation of the Program seriously began in late 2006 with the appointment of the four sub recipients comprising of AAA, MC, PSI and WVI. The appointed SRs implemented the program in different states and different locations in an attempt to cover the whole targeted areas of Southern Sudan. Some of the SRs operated in more than one State.

5.3.1 Arkangelo Ali Association (AAA)

AAA is a faith-based indigenous Sudanese NGO and a founder member of Bakhita Consortium that comprises of 7 other Italian, Kenyan and Sudanese NGOs. Association involved in developmental assistance to Sudan. AAA is involved in health care delivery programs in five states of the Southern Sudan. The organization focuses on providing care and treatment to some of the world’s oldest diseases such as Leprosy, TB, HIV Malaria and general medical and surgical treatment through primary health care units established by the Catholic Church in the areas of operations. AAA was implementing the malaria program in (Mapourdit) Yirol West County covering a population of more than 130,000.

The Malaria program was implemented as part of the health care services centered around Mapourdit Hospital and a circuit of community and church managed PHCU outlets that were already in existence and 12 new ones that were established by the program to increase access to treatment for communities that were far from the existing health facilities. The services offered by these facilities included early diagnosis and treatment, community awareness education, provision of IPTs through the MCHs and referrals of complicated cases of malaria to higher level facilities and training of community health workers as well as the distribution of nets and community education on the use and care of LLITNs

The Malaria Program activities had several components to comprising of the following:

1. Creation of the general awareness of the program within the community through community education campaign to inform, educate and sensitize the public to the use of long lasting insecticide impregnated nets for children under five years of age and pregnant women; to the establishment of malaria diagnosis and treatment capacities at all PHCUs in the County and to the use of Intermittent Prophylaxis Treatment for malaria for all second and third trimester pregnant women.
2. The training of all the health workers in the County health facilities in the diagnosis and treatment of malaria of uncomplicated malaria and referral of complicated cases to PHCCs or hospitals; in record keeping and reporting and management of drugs supplies.
3. Training of health workers especially TBAs in referral of pregnant women to PHCCs for antenatal services and IPTs
4. Training of health workers in recognizing outbreaks of malaria (EWARN) and planning how to manage the outbreaks.
5. Registration of households that qualified for nets based on the number of children under five and pregnant women in each household.
6. Training and education of communities on the use and care of the LLITNs including precautions that needed to be undertaken when washing and disposal of the waste water from the wash.

5.3.1.1 Results Found

The malaria program activities were directed towards the achievement of the six objectives shown in the table 5 on the following page. The review of the financial disbursement (assuming that the information is based on actual utilization revealed that AAA was able to utilize most of the funds received. As this was not an audit access to financial management of the funds at the SR level was not deemed necessary. It is assumed that the funds received were used appropriately as there were no major queries from previous audit reports

Table 5: Grant Allocation for AAA

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **SR** | **Contract Value (US$)** | **Cash Received from PR**  **(US$) at Sept 2009** | **Amount due to SR(USD $) at Sept 2009** | **Final 10% to be paid on receipt of final reports(USD $) May-10** |
| AAA | 427 736 | 325 901 | 101 835 | **10 184** |

A.2 Comments on the Results

The results found at the AAA program sight indicate a fairly mixed result in that there were over achievements in some areas and gross under achievements in some. This may have been as a result of a number of operational, environmental and organizational constraints.

AAA’s performance in the distribution of nets was compromised by the late deliveries of nets from UNDP. The other major shortfall in the achievements has been that of training of health workers where only a moderate 26 % for complicated malaria and 39% for uncomplicated malaria treatment were achieved. The shortcomings can be explained by the fact that the program gad created an additional 15 new PHCUs where none existed before and these required additional staff that had to be trained. In their reporting AAA may have failed to notice that creation of additional PHCUs had increased their sample base and therefore affected the performance levels downwards.

An important element to note from the results is that facilities within the AA program managed areas had not recorded any short falls in drugs supplies as the Mission always filled in the shortfalls even in government owned facilities. Another important element to note is that community confidence and the value accorded to the program is very high as demonstrated by the following remarks from a community elder when asked about his impressions on the program “AAA malaria program has helped us a lot as our children are no longer dying of malaria, because AAA has taught us how to prevent malaria by sleeping under a mosquito nets. Their nits (AAA) are much more potent than those brought by…… and that why you will never see AAA nets thrown about because they are valuable”.

#### Table 5.3.1.1: AAA Indicator Performance Assessment

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Objective No.** | **Service Delivery Area** | **Indicator Description** | **Baseline** | | **Intended Targets** | **Actual Results** | **Comments** |
| Value | Year |
| 1 | Prevention:  ITNs | #of service deliverers trained in distribution and implementation of ITNs |  | Sept 06 | 323 | 306  (95%) | Target achievement was due to late establishment of some PHCUs their target could not be achieved in the quarter |
| 1 | Prevention: ITNs | # of LLITNs distributed |  | -do- | 271975 | 70257  (26%) | Only low achievement was due to non availability of nets. A consignment was delivered in late November and have yet to be distributed |
| 1 | Prevention: malaria prevention during pregnancy | # of health care service deliverers trained in providing IPT |  | -do- | 165 | 223  (135%) | The high achievement was due to the fact that new service providers were engaged to man the additional PHCUs that were established after the proposal was written |
| Proportion of facilities providing IPT to pregnant women |  | -do- | 100% | 100% | All the CBHIC were trained in IPT provision |
| 2 | Prevention: Malaria prevention during pregnancy | # pregnant women receiving IPT |  | -do- | 21886 | 9647  (44%) | The low achievement was due to the fact the target was arbitrarily set without baseline information on fertility trends. |
| 2 | Treatment: Prompt effective anti malarial treatment | # health workers trained on BCC to promote early care seeking from appropriate provider |  | -do- | 664 | 494  (65%) | The achievement was commendable given the volatile security situation in the area. |
| 3 | Treatment: Prompt effective anti malarial treatment | # of patients with uncomplicated malaria treated |  |  | 70804 | 28139  (39%) | The low achievement level could be due to the high target setting as there were no baselines information on the incidence and prevalence of malaria in the area |
| # patients with severe malaria given treatment according to WHO guidelines |  |  | 2124 | 558  (26%) | Low but this is due to the fact that targets were set too high without considering the incidence of severe malaria in the community |
| # (Proportion) of facilities with no stock outs of anti malaria drugs |  |  | 100% | 100% | There were no facilities reporting anti malarial drug stock outs due to the fact that the Diocese health services supplemented the drugs supplies when Global fund supplies ran out |
| 4 | Treatment : Prompt effective anti malaria treatment | # health workers trained in emergency preparedness (predicting and containment of epidemics) |  | Sept 06 | 141 | 129  (91%) | The training was conducted without the technical support of WHO, although the WHO guidelines were used there was no quality guarantee as the Supervisor was not trained in a formal EWARN system |
| 4 | Prediction and Containment of Epidemics | # health facilities following the WHO’s EWARN for Southern Sudan |  | -do- | 18 | 12  (67%) | PHCC and PHCU reporting using EWARN, more efforts need to be done to increase EWARN coverage |
| 4 | Health Systems Strengthening | #health service deliverers trained in health information system |  | -do- | 63 | 92  (146%) | Over achievement was due to lower target setting that did not consider the additional staff that were later engaged to manage the newly established to increase program coverage |
|  |  | # of health facilities implementing revised HIS |  | -do- | 18 | 12  (67%) | More time was needed to train the additional staff in the use of HIS especially those managing the newly established facilities |

a.3 Discussion of the Results

AAA has within the time limits and constraints that they faced been able to effectively create a high level of awareness on the management of malaria through the use of LLITNs, early treatment seeking and provision o f IPT to pregnant women. These appear to have been achieved through a carefully crafted community education and sensitization program where community leaders were involved. However, the program has failed to effectively get the community to buy in the program and own it and essentially remains an AAA program and will have limited sustainability outside the church support and tutorage.

AAA has relatively done better with regard to drug supplies as a result of their ability to get stocks from the Diocese’s resources to buy anti malaria drugs from the open market. However, these stocks are limited and are also part of the cost sharing system and are therefore not given freely to patients except on special arrangements.

AAA’s implementation of the malaria program was helped by the integration of the malaria program activities into the network of health facilities managed by a sister organization, where direct control on staffing, supplies of drugs and other commodities, and quality and nature of service was possible. The close cooperation between AAA and the Comboni Mission provided for opportunities to draw on resources (staff and drugs) from each other for a sustainable program. The AAA program may be the only one to continue to provide services through the Comboni Mission health care service delivery system.

5.3.2 The Malaria Consortium

The Malaria Consortium is an international organization dedicated to control of malaria and supporting malaria programs in many parts of the world. It was one of the Sub Recipients of the Round Two Global Fund Grant for Malaria operating in a number of areas in Southern Sudan. The evaluation of their component was carried out in Aweil County in the Bhar el Ghazal State.

The program covers Aweil North, Central and West and implemented through 36 health facilities and one referral hospital comprising of 30 PHCUs, 5 PHCCs and 1 hospital. The activities that were carried out by Malaria consortium were slightly different from those employed by AAA due to the fact that MC do not have health care facilities that they own and were implementing through the existing health care facilities run by government and other agencies such a CORDAID. This needed a different approach where there had to be memorandum of understanding (MOU) signed with the County Health Department and the other Service providers in the area on how the program was to be implemented. Thereafter, the program activities had similar approaches comprising of the following:

1. Creation of the general awareness of the program within the community through community education campaign to inform, educate and sensitize the public to the use of long lasting insecticide impregnated nets for children under five years of age and pregnant women; to the establishment of malaria diagnosis and treatment capacities at all PHCUs in the County and to the use of Intermittent Prophylaxis Treatment for malaria for all second and third trimester pregnant women.
2. The training of all the health workers in the County health facilities in the diagnosis and treatment of malaria of uncomplicated malaria and referral of complicated cases to PHCCs or hospitals; in record keeping and reporting and management of drugs supplies.
3. Training of health workers especially TBAs in referral of pregnant women to PHCCs for antenatal services and IPTs
4. Training of health workers in recognizing outbreaks of malaria (EWARN) and planning how to manage the outbreaks.
5. Registration of households that qualified for nets based on the number of children under five and pregnant women in each household.
6. Training and education of communities on the use and care of the LLITNs including precautions that needed to be undertaken when washing and disposal of the waste water from the wash.

The results are presented in the Table 5.3.2 on the next page.

Table 5.3.2.2 Summary Performance Indicator Assessment for Malaria Consortium

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Objective No.** | **Service Delivery Area** | **Indicator Description** | **Baseline** | | **Intended Targets** | **Actual Results** | **Comments** |
| Value | Year |
| 1 | Prevention:  ITNs | #of service deliverers trained in distribution and implementation of ITNs |  | Sept 06 | ND | 273 | These consisted of volunteers and health workers |
| 1 | Prevention: ITNs | # of LLITNs distributed |  | -do- | 200,000 | 212,880  (106%) | Additional numbers were due to the fact that there were a significant number of returnees that were included in the distribution. |
| 1 | Prevention: malaria prevention during pregnancy | # of health care service deliverers trained in providing IPT |  | -do- | ND | 100 | The numbers of available health workers are difficult to determine due to high staff turnover. The program adopted a pragmatic approach of training all health workers that were available in the 36 supported health facilities. |
| Proportion of facilities providing IPT to pregnant women |  | -do- | 36 | 36 | All supported health facilities provided IPTs |
| 2 | Prevention: Malaria prevention during pregnancy | # pregnant women receiving IPT |  | -do- | ND | 3183 | Targeting was problematic as there was no baseline data on pregnancy rates to determine the denominator for setting targets for of pregnant women qualifying to receive IPT. |
| 2 | Treatment: Prompt effective anti malarial treatment | # health workers trained on BCC to promote early care seeking from appropriate provider |  | -do- | ND | 115 | Most health workers in the supported health care facilities were trained |
| 3 | Treatment: Prompt effective anti malarial treatment | # of patients with uncomplicated malaria treated |  |  | ND | 79559 | The targets under this indicator would have been arbitrarily determined as it is difficult to determine the total number of malaria cases in the community. |
| # patients with severe malaria given treatment according to WHO guidelines |  |  | ND | 11150 | This indicates a high level of diagnostic acumen and may point to the adequacy of training given as well as the alertness of health workers to the management of malaria |
| # (Proportion) of facilities with no stock outs of anti malaria drugs |  |  | 0 | ND | A significant level of stock outs was reported by a number of health facilities visited but it appears there is no effective mechanisms for reporting and dealing with stock outs. Since MC was implementing the program through GoSS and Other NGO manage health facilities, reports on drug supplies and supplies management was not their direct forte. |
| 4 | Treatment : Prompt effective anti malaria treatment | # health workers trained in emergency preparedness (predicting and containment of epidemics) |  | Sept 06 | 30 | 17 | Health workers at the facility levels were trained in WHO EWARN system as only a single Training of trainers workshop attended by County health officials was conducted and there was no follow-on support to train facility based health workers. |
| 4 | Prediction and Containment of Epidemics | # health facilities following the WHO’s EWARN for Southern Sudan |  | -do- | 12 | 0 | None of the health facilities were capacitated to report on EWARN system |
| 4 | Health Systems Strengthening | #health service deliverers trained in health information system |  | -do- | 60 | 142  (236%) | More health workers that originally determined were trained in HIS – this may be due t the fact that staff from non included health facilities may have been included in the training at the County level. |
|  |  | # of health facilities implementing revised HIS |  | -do- | 36 | 36 | All the supported health facilities were implementing the revised HIS (quality of data not verified in this evaluation) |

Table 5.3.2.3: Grant Allocation for MC

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **SR** | **Contract Value (US$)** | **Cash Received from PR**  **(US$) at Sept 2009** | **Amount due to SR(USD $) at Sept 2009** | **Final 10% to be paid on receipt of final reports(USD $) May-10** |
| MC | 1 447 735 | 1 036 171 | 411 564 | **41 156** |

Based on the funds disbursements from the PR it could be assumed that MC was able to absorb the funds given according to planned activities as disbursements are based on authorized budgets. The prudent use of funds received could not, however, be validated as no audits were undertaken in this exercise.

B1 **Pertinent Observations**

The program implementation under the MC area of operations was smoothly implemented and generally met most of the expectations despite severe constraints with regard to drug supplies. The distribution of nets to all the registered families was carried out with an additional nets distributed to the returnees that came after the registration process.

The use of nets was confirmed by visits to household and discussions with community members who ascertained that the nets were correctly being utilized for the purposes they were intended for. Based on interviews of household it was clear that there has been a significant change in behavior at household level where children under five were fed and put to bed as early as 6.30 pm to protect them from mosquito bites that were reported to be common between 7 to 9pm.

Women interviewed indicated that they were aware that they were supposed to receive IPTs at the ANC as well as receive treatment for malaria from the PHCCs and PHCUs.

All health workers interviewed acknowledged being trained in the diagnosis and management of malaria cases including management of complicated cases through referral at the lower end facilities to actual treatment at the PHCCs and hospitals.

Training for emergency preparedness for malaria epidemics was done only at the State level where a TOT in EWARN system was carried out but there was follow-up to provide resources for the trainers to train health workers at the County level.

**B2 Discussions**

The MC implementation process has generally been satisfactory and had met all the expected targets except in the ensuring a continuous supply of ACTs at the PHCC and PHCU levels. They were significant delays in the supply of LLITNs that impacted on the distribution of the nets to the communities.

The implementation of IPTs seem to have been impacted by the policy that stopped TBAs to provide ANC services to pregnant women, but this was however dealt with by training them to refer ANC clients to PHCUs for IPT. The program estimates that more than 90 % of pregnant women do take IPT1 but less than that number take IPT2. No specific reasons can be given to the reduced uptake of IPT2.

The program reported a marked reduction in the number of severe malaria cases that were being attended to by the facilities in the program and credited this to the impact o the use of mosquito nets in the homes. However, the M&E Officer cautioned that this may be due to the dry season and the situation might change during the onset of the rainy season.

Interviews of the health workers in selected facilities did indicate that they had not received any training in EWARN system to manage and forecast malaria epidemics.

County Health Department personnel noted that training in monitoring and evaluation had been carried out recently and there was a workshop where the indicators were discussed and a framework for reporting on the indicators developed. The new developments in M&E were regarded as positive developments leading to strengthening of reporting systems in the program.

Implementation of activities through facilities management by other agencies did seem to provide a certain level of difficulty for MC. The dependency on cooperative agreements with the CHD and others limited the organizations ability to influence quality of service delivery, as well as the involvement of communities in the management of the services. Institutions like MC should perhaps in future be used to developing technical capacities of service delivery organizations at County levels and not be directly involved in service delivery as they would have limited influence on the actual delivery of services. .

5.3.3 Population Services International (PSI)

PSI is an international organization involved in provision of services including malaria in Southern Sudan. PSI was one of the Sub Recipients of the malaria Round Two grant and operated in the following Counties,: Juba, Yei, Lainya, Tambura, and Mundri Counties as well as through following partners*:* AAH in Yei, the County Health Department in Lainya, IMC in Tambura, and the County Health Department in Mundri.

The program provides health systems support to approximately 94 health facilities consisting of 19 PHCCs and 80 PHCUs. The support comprises of logistical support to county health departments, administrative assistance for IDSR reporting and salary assistance to 14 health workers and1 facilitator in Lainya County.

For the purpose of this evaluation only Yei and Lainya Counties were included in the evaluation under the assumption that they will reflect the overall performance of PSI in the program.

PSI implementation of the malaria program involved the development of the necessary capacities in the government and faith based organization facilities to carry out anti malaria activities in their areas of operations. The activities were carried out had several components to comprising of the following:

1. Creation of the general awareness of the program within the community through community education campaign to inform, educate and sensitize the public to the use of long lasting insecticide impregnated nets for children under five years of age and pregnant women; to the establishment of malaria diagnosis and treatment capacities at all PHCUs in the County and to the use of Intermittent Prophylaxis Treatment for malaria for all second and third trimester pregnant women.
2. The training of all the health workers in the County health facilities in the diagnosis and treatment of malaria of uncomplicated malaria and referral of complicated cases to PHCCs or hospitals; in record keeping and reporting and management of drugs supplies.
3. Training of health workers especially TBAs in referral of pregnant women to PHCCs for antenatal services and IPTs
4. Training of health workers in recognizing outbreaks of malaria (EWARN) and planning how to manage the outbreaks.
5. Registration of households that qualified for nets based on the number of children under five and pregnant women in each household.
6. Training and education of communities on the use and care of the LLITNs including precautions that needed to be undertaken when washing and disposal of the waste water from the wash.

**Table 5.3.3.1: Performance Indicator Assessment for PSI**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Objective No.** | **Service Delivery Area** | **Indicator Description** | **Baseline** | | **Intended Targets** | **Actual Results** | **Comments** |
| Value | Year |
| 1 | Prevention:  ITNs | #of service deliverers trained in distribution and implementation of ITNs |  | Sept 06 | 276 | 232[[7]](#footnote-8) | The figures presented here are intended to show the progressive changes as access to latest results were not available |
| 1 | Prevention: ITNs | # of LLITNs distributed |  | -do- | 20000 | 362,000  (181%) | The overachievement was made through mass distribution. |
| 1 | Prevention: malaria prevention during pregnancy | # of health care service deliverers trained in providing IPT |  | -do- | 119 | 214 | As PSI had a resident training officer in the program, training of all health deliverers was possible |
| Proportion of facilities providing IPT to pregnant women |  | -do- |  |  | All supported facilities provided IPT to all legible pregnant women |
| 2 | Prevention: Malaria prevention during pregnancy | # pregnant women receiving IPT |  | -do- | 60% | 100% | All pregnant women in Second or later trimester were given IPT |
| 2 | Treatment: Prompt effective anti malarial treatment | # health workers trained on BCC to promote early care seeking from appropriate provider |  | -do- | 36 | 89 | Workers were trained in BCC and led to the creation of high level of malaria awareness in the community. |
| 3 | Treatment: Prompt effective anti malarial treatment | # of patients with uncomplicated malaria treated |  |  | 63,929 | 91,375 | Patients were reported to report early for treatment and there were fewer complications than before. |
| # patients with severe malaria given treatment according to WHO guidelines |  |  | 5,161 | 3107 | A significant number of cases were referred to higher level facilities as part of the agreed management of malaria |
| # (Proportion) of facilities with no stock outs of anti malaria drugs |  |  | Less 40% | <10% | The level of anti malarial stick outs were minimized by provision of transport at the facility level used for supply procurement. |
| 4 | Treatment : Prompt effective anti malaria treatment | # health workers trained in emergency preparedness (predicting and containment of epidemics) |  | Sept 06 | 63 | 214 | A significant number of health workers were trained in EWARN by the clinical training officer attending the WHO EWARN training workshop |
| 4 | Prediction and Containment of Epidemics | # health facilities following the WHO’s EWARN for Southern Sudan |  | -do- | 7 | 15 | A small proportion of health facilities were able to report using EWARN system |
| 4 | Health Systems Strengthening | # health service deliverers trained in health information system |  | -do- | 65 | 209 | A significant number of health workers were trained in HIS and were able to use it for reporting on service delivery activities in their areas. |
|  |  | # of health facilities implementing revised HIS |  | -do- | 18 | 55 | All the health facilities supported by the program had implemented the revised HIS. |

Table 5.3.3.2: Grant Allocation for PSI

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **SR** | **Contract Value (US$)** | **Cash Received from PR**  **(US$) at Sept 2009** | **Amount due to SR(USD $) at Sept 2009** | **Final 10% to be paid on receipt of final reports(USD $) May-10** |
| PSI | 1 431 965 | 745 749 | 686 216 | 68 622 |

Similar to the other SR discussed above, this was not an audit access to financial management of the funds at the SR level was not deemed necessary. It is assumed that the funds received were used appropriately as there were no major queries from previous audit reports

**C 1 Pertinent Observations**

The PSI implemented malaria program in Western Equatorial was properly thought out comprising of key staff able to provide the necessary technological expertise to the implementation efforts. The program provided a clinical trainer to oversee the preparation and training of health workers on the management of malaria. The presence of a full time clinical trainer on the team helped to facilitate the training of several cadres in the diagnosis and treatment if malaria at health facilities in the State.

The PSI team complained of the low educational capacities of most of the health workers, most of whom only have had basic education but the training helped to develop the capacities needed to manage the program.

Notwithstanding the constraints experienced the PSI managed malaria program was reported to have developed the primary healthcare system in the State to a functional levels reducing individual NGO reporting system to a unified one thus making it easy to collate information from all facilities. In addition the team reports to have achieved the following:

* Improved the capacity of health workers to diagnose and treat malaria competently
* Improved their capacity to write program reports using standard formats
* Established functional working relationship with the County health Department personnel that have facilitated the coordination of activities in each County.
* The establishment of the CHD as the repository for County service data
* Created a high level of community awareness by involvement of community leaders in the education process.
* Contributed to reduction of anti malarial drug wastage by treating only confirmed cases
* Established a standard HIMS for data collection from all service delivery points.

Although the level of education of most of the health workers who came for training was low, the presence of an in-house trainer within the PSI team made it easy to adjust the training to fit the pace and speed to suit the participants.

During the site visits the evaluator did not see any signs of misuse of LLITNs and confirmed the proper use in interviews with household members.

**C2 Discussions**

The implementation of the program was competently done and a number of constraints that could have seriously impacted on the performance of the program were solved by having a team in the field that had the experience in the different aspects of malaria programming. The observed overachievements on most indicators are as a result of underestimation of the specific implementation targets given the lack of baseline information. It is apparent that the use of the null numbers as the baseline has tended to make the achievements look relatively high.

Although the overall program indicators were far too high and could not have been achieved even in the best circumstances given the situation of Southern Sudan, the implementation processes employed by PSI have made some significant changes in the prevalence and impact of malaria have been made. Most importantly the process has provided valuable lessons learned for future programming of malaria in the country.

It is also clear that the indicators that have been selected are insufficient and more process oriented hence does really not provide good indices on the reduction of the impact of malaria as a burden of disease on the population within the operational areas.

The findings on the PSI Malaria Round Two program lead us to believe that the burden of malaria on the population can be reduced by concerted efforts of vector control and strengthening if health delivery systems to manage the malaria burden. However, even at this stage it is clear that involvement of community leadership in the education of community members is important as it guarantees community responsibility for caring of the nets, community awareness to get people to seek early treatment as well as responsible use of malaria drugs and services.

Similar to AAA, PSI’s program interventions have no exit strategies as service delivery is based on cooperation and collaboration of other institutions such as CHD, Faith Based health facilities. Sustainability of program service delivery activities are entirely dependent on management and operational capacities and the ability of these institutions, and it stands to test whether after the cessation of PSI support they will be able to continue with the anti malaria services; given the fact that appropriate management development capacities have not been developed in these institutions.

5.3.4 The World Vision International (WVI)

The World Vision International is an international faith based organization that provides humanitarian, development and relief services to populations in need. In Southern Sudan WVI is one of the four main Sub recipients of the Global Fund Malaria Round Two Grant. The Round Two malaria program that WVI was implementing was based in Upper Nile State in Panyikan County.

WVI implementation of the malaria program is based on approaches similar to those employed by MC and PSI as it has no health facilities of its own. The process involved the development of the necessary capacities in the government and faith based organization facilities to carry out anti malaria activities in their areas of operations.

The Malaria Program activities that were carried out had several components to comprising of the following:

1. Creation of the general awareness of the program within the community through community education campaign to inform, educate and sensitize the public to the use of long lasting insecticide impregnated nets for children under five years of age and pregnant women; to the establishment of malaria diagnosis and treatment capacities at all PHCUs in the County and to the use of Intermittent Prophylaxis Treatment for malaria for all second and third trimester pregnant women.
2. The training of all the health workers in the County health facilities in the diagnosis and treatment of malaria of uncomplicated malaria and referral of complicated cases to PHCCs or hospitals; in record keeping and reporting and management of drugs supplies.
3. Training of health workers especially TBAs in referral of pregnant women to PHCCs for antenatal services and IPTs
4. Training of health workers in recognizing outbreaks of malaria (EWARN) and planning how to manage the outbreaks.
5. Registration of households that qualified for nets based on the number of children under five and pregnant women in each household.
6. Training and education of communities on the use and care of the LLITNs including precautions that needed to be undertaken when washing and disposal of the waste water from the wash.

The results are shown in Table 9 overleaf.

**Table 5.3.4.1: Summary Indicator Achievements for WVI**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Objective No.** | **Service Delivery Area** | **Indicator Description** | **Baseline** | | **Intended Targets** | **Actual Results** | **Comments** |
| Value | Year |
| 1 | Prevention:  ITNs | #of service deliverers trained in distribution and implementation of ITNs |  | Sept 06 | 276 | 232 | A significant number of health workers and volunteers were trained |
| 1 | Prevention: ITNs | # of LLITNs distributed |  | -do- | 290,000 | 285,000 | The numbers of nets distributed appear to have been a lot more compared to other SRs; it may be possible that these numbers include those distributed in Phase I on the program. |
| 1 | Prevention: malaria prevention during pregnancy | # of health care service deliverers trained in providing IPT |  | -do- | 479 | 224 | The slow process of health worker training may have been due to the high staff turnover among the voluntary health work force where a number of them are not on salary and tend to move to other areas looking for work. |
| Proportion of facilities providing IPT to pregnant women |  | -do- | 78 | 40 | Many of the facilities do not have adequately trained staff and this could explain the under achievement. Many of the facilities are isolated during the rainy season and access to training venues may also have contributed to the problem |
| 2 | Prevention: Malaria prevention during pregnancy | # pregnant women receiving IPT |  | -do- | 41,444 | 36,115 | Despite the limited numbers of facilities able to provide IPTs a large number of pregnant women have accessed the IPT program. This may be an indication that the communities are adequately educated on the prevention and of malaria during pregnancy. |
| 2 | Treatment: Prompt effective anti malarial treatment | # health workers trained on BCC to promote early care seeking from appropriate provider |  | -do- | 750 | 510 | A significant numbers of workers have been trained and this may explain the high level of malaria awareness on observed among the beneficiary communities |
| 3 | Treatment: Prompt effective anti malarial treatment | # of patients with uncomplicated malaria treated |  |  | 12,375 | 9,307 | This is significant; it indicates that the program has been internalized among the community psyche. It was reported that many mother now take their children first to the health facility for fever instead of the traditional healer as was the case before. |
| # patients with severe malaria given treatment according to WHO guidelines |  |  | 510 | 510 | The relative high number of referrals might be an indication of improved diagnostic capacity of lower levels and their adherence to the malaria management guidelines. |
| # (Proportion) of facilities with no stock outs of anti malaria drugs |  |  | 78 | 39 | Stock outs were a common occurrence due to inadequate supplies management systems and difficult logistics. The stock out were also occasioned by the use of a push supply system where the centre pushes drugs to the facilities rather than the facilities initiating orders at the buffer stock levels. |
| 4 | Treatment : Prompt effective anti malaria treatment | # health workers trained in emergency preparedness (predicting and containment of epidemics) |  | Sept 06 | 440 | 364 | The training was carried-out with assistance from WHO but due to lack of follow-up support a number of staff from some facilities did not receive the training. |
| 4 | Prediction and Containment of Epidemics | # health facilities following the WHO’s EWARN for Southern Sudan |  | -do- | 78 | 40 | Only those facilities with trained staff were able to report on EWARN |
| 4 | Health Systems Strengthening | # health service deliverers trained in health information system |  | -do- | 440 | 345  (78.4) | Only 78.4 % of staff were trained in the use of the revised HIS |
|  |  | # of health facilities implementing revised HIS |  | -do- | 78 | 39 | But only 50% of health facilities had or were implementing the revised HIS. |

**Table 5.3.4.2 Grant Allocation for PSI**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **SR** | **Contract Value (US$)** | **Cash Received from PR**  **(US$) at Sept 2009** | **Amount due to SR(USD $) at Sept 2009** | **Final 10% to be paid on receipt of final reports(USD $) May-10** |
| PSI | 1 431 965 | 745 749 | 686 216 | 68 622 |

Similar to the other SR discussed above, this was not an audit access to financial management of the funds at the SR level was not deemed necessary. It is assumed that the funds received were used appropriately as there were no major queries from previous audit reports

**D1 Pertinent Observations**

Although WVI helped to establish a number of health facilities in the State it had to work through the County Health Departments to implement the programs, using almost similar approaches as the other Sub recipients. WVI aimed at distributing LLITN to all households with children under five years of age and pregnant women. The problem similar to other sites was that there were no baseline information on the estimated numbers of children under-five and pregnant women. Although a registration of legible families was carried out in preparation for net distribution this was only an estimate. The lack of baseline data did not seem to have a significant impact on the organization’s ability to implement the project. However the following pertinent observations were made:

* The CHD were mainly reactive and did not seem to have been active in the plan and design stages of the program. Their involvement seems to have been limited to their attending the meetings and training courses organized by the program. The lackluster involvement may have been due to lack of resources and incentives to be involved in a program that some-else was responsible for.
* The CHD and state administration voiced their concerns about the long term effectiveness of the program given that it did not comprehensively augment the vector control with residual spraying that was proven to be effective during the colonial days
* There was shortage of trained human resources thus limiting the projects ability to strengthen health service delivery systems and increase access to malaria treatment outlets
* A drugs supply has been a problem throughout the program period.
* Although the nets were supplied to most households – during the time of evaluation most families were sleeping outside using the dumoria nets that were not impregnated with insecticide for privacy thus missing the opportunity for mosquito kills. Children were however made to sleep under the LLITNs.
* Suppositories were hardly used for children and the preference was to grind the tablets and add water and administered as a suspension. There was a call for use of syrup medications for children. The community seems to think that suppositories are not effective given the method of administration.
* As most of the staff working on the program were government employees, the frequent late payment of salaries led to a high staff turnover and the program had to constantly get new staff for training to replace those that had left. Some facilities that were involved in the management of facilities had to close due to lack of trained personnel to manage the services.
* The limited numbers of health facilities in the target areas contributed to the reduction of access to malaria diagnosis and treatment facilities for a significant proportion of population.
* The area is a low laying flood plain and has therefore limited road network and many areas are not accessible during the rainy season except by boat. Transportation of medical supplies including drugs was therefore limited.
* The last consignment of nets for distribution was received after most of the distribution staff were laid off and have not been distributed yet!
* Estimation of the population legible for to receive LLITNs left out a large detachment of soldiers and their families that were moved in the areas recently, as well as the growing numbers of returnees who had fled to the north during the time of conflict. The returnees many of them had lived in the low malaria environment for a long time and therefore require the nets even for adults due to lower immunity against malaria.
* The malaria team and select health workers from the CHDs were trained in M&E in 2009.

**D3 Discussions**

The program was appropriately implemented and managed to impact significantly on the level of malaria infections among children under five in the operations area. There were observed overachievements on most indicators are as a result of underestimation of the specific implementation targets given the lack of baseline information. It is apparent that the use of the null numbers as the baseline has tended to make the achievements look relatively high. This could be explained by the fact that although the overall program indicators were far too high and could not have been achieved even in the best circumstances given the situation of Southern Sudan, the implementation processes employed by WVI have made some significant changes in the prevalence and impact of malaria have been made. Most importantly the process has provided valuable lessons learned for future programming of malaria in the country. It is also clear that the indicators that have been selected are insufficient and more process oriented hence does really not provide good indices on the reduction of the impact of malaria as a burden of disease on the population within the operational areas.

The implementation of the program in such difficult environment will provide valuable lessons to all program developers in future, especially with regards to building if capacities of government institutions that are likely to inherit such program in the near future when the public health systems are finally evolved. The involvement of CHDs should have been directed at providing more technical support to management development capacity building especially in community awareness creation among the beneficiary communities.

The absence of a clear exit strategy as to what would happen to the health facilities that have been established has given the program an air of non sustainability. Although the communities have been mobilized to participate in malaria care delivery services their involvement is limited to attending health committee meetings and does not involve significant level of management of services.

Sustainability of the program is compromised by the lack of counterpart capacity on the government side to provide resources to support activities at the end of the program period.

# 6 global Assessment of the Management of the Malaria Program (Round 2)

The grant proposal was prepared by consortia of organization that have been working in South Sudan in the conflict days on behalf of the CCM. Due to the fact that the Ministry of Health responsible for malaria control through the Directorate of Malaria did not have the capacity to administer the Grant, UNDP was asked to be the Principal Recipient of the grant including that of TB (Round 2) and HIV and AIDS (Round 4).

The CCM a representative mechanism to oversee the implementation and management of the grants is structured to represent both the beneficiaries and implementing agencies in such a way that it guarantees good governance of the grant management. In order to carry out this responsibility the CCM needs to have a certain level of technical capacity and supportive environment to be able to oversee the implementation of the programs.

6.1 The CCM

The CCM has provided some guidance and oversight on the implementation of the program but this has not been enough as there were several technical issues that were not solved or addressed during the implementation of the program. However, the role of the CCM has not been adequate in the monitoring of implementation efforts and assessment of performance of both the PR and the SRs. The CCM could have dealt with a number of issues that delayed implementation of activities but since it had not developed a strategic management check list a number of these potential problems were not anticipated. In addition the CCM has been mainly reactive only responding to issues when they have occurred.

The CCM seem not to have applied specific measures to effectively monitor and evaluate implementation activities, nor able to provide effective oversight of the implementation process.

6.1.2 Program Design

The design of the program was faulty and by submitting the proposal the way it was structured there was an indication that the CCM may not have applied a stringent level vetting of the proposal as should have been the case. The very over ambitious targets that were set without the benefit of base line survey indicated a lack of technical expertise in the field. It was evident that a number of costly mistakes that were made in the field especially at the beginning of the grant could have been avoided had there been.

6.1.3 Implementation Management

Implementation management of the program was weak as indicated by the shortcuts that were allowed to take place and led to poor operationalization of activities; for example by ordering mass distribution of nets in some areas the CCM failed to realize that this effort would not prepare the communities well to internalize and value the nets, which resulted in the nets that were mass distributed to be considered as less useful and have been used abusively for fencing cattle posts, protecting plants from livestock and it some village in Mapourdit used as football; goal posts nets. Several hundred nets were found discarded at one cattle post with some dumped in the cattle watering site.

6.1.4 Discussion

The CCM role in the management of the program implementation was found to be weak and did not exercise the controls required on both the PR and SRs. The absence of stringent guidelines and policies to govern the implementation of the program activities may have contributed to the relative poor performance of the program.

The role of the CCM in ensuring technical excellence in the implementation of activities is critical and should have involved the vetting of both PR and SRs’ operations plans, provision of policies and guidelines and demand for engagement of only duly qualified personnel to ensure optimum investment of malaria program resources. The evaluation exercise found that a significant number of personnel employed in the program at the SR level did not have the appropriate qualifications to manage a technical program. Most of the personnel did not have specific training in malaria. It was, therefore, not surprising that the field workers did not contribute to technical observations on the following key malariometric indices such as the prevalence of spleenomegally among children, the vector types and behavior necessary for community education on the use of LLITNs and the level of self[[8]](#footnote-9) medication among the beneficiary communities.

The evaluation findings indicate that the CCM should have its capacity strengthened to enable it to carry out effective oversight functions over GFATM programs including malaria.

6.2 The Ministry of Health

The Ministry of Health was not the Principal Recipient for this round but had an important role and responsibility in ensuring that the program is implemented within the frame work of its strategic plans. Given that the program involved the implementation through CHDs and other health facilities under the overall regulatory ambit of the Ministry, its role in the directing and monitoring of activities was crucial. However, due to the lack of in-house capacity in the Ministry this role and responsibility was not exercised and resulted in the program not fully integrated in the MOH operations and budgeting plans, but as a useful but separate program.

The Ministry of Health through the Directorate of Malaria Control is a major partner to implementing agencies but has not exercised adequate controls and guidance over the implementation process, and has not been able to provide a facilitating environment for effective management of Malaria in South Sudan, by providing an enforceable regulatory framework. Although the Directorate of Malaria Control has played a vital role in the development of guidelines for diagnosis and treatment of Malaria, it has not fully executed its direct supervisory role in the implementation of the program. The role of the Ministry is particularly critical in the provision of a facilitating work environment by establishing the following:

1. Regulatory framework and policies for importation of approved anti malarial drugs into the country to safeguard the safety of the population.
2. Establishment of regulatory policies on prescription and use of reserved second and third line anti malarials. This would safeguard against misuse that could lead to development of drug resistance.
3. Establish national malaria surveillance mechanisms to guide planning and management of malaria control measures based on evidence from the field.
4. Develop a long term human resource development plan and establish malaria technical cadres, set up minimum qualifications and clear terms and conditions of service to ensure long term competent management of malaria in the country.

The MOH should be work towards becoming the PR for future GFATM malaria program,

6.3 The United National Development Program (UNDP): Global Fund Principal Recipient

The UNDP was appointed as a principal recipient for the Round 2 Global Fund Grants for Malaria and Tuberculosis for 2004 to 2009 period.

Although UNDP have the systems of governance and accountability in place, its appointment as a principal recipient posed a number of challenges to the effective an efficient management of the program. To start with the UNDP had to establish a dedicated unit to manage the program and with its lengthy procurement procedures it took a long time to get suitable staff on board to manage the grant, the lengthy and slow tendering processes meant that supplies could not be obtained on time as was indicated by the constant delays in procurement of nets and anti malarial drugs.

In addition UNDP had such a high staff turnover that it lost institutional memory and of the records for Phase One of Round two are not available. The matters were not helped much by the lack of capacity in the CCM for implementation oversight. It was only recently in 2007 and 2008 that some stability in the Global Fund team was established when M&E Officers were recruited to help in the establishment of single M&E framework for the country. In addition other program officers for malaria Tb and HIV were also recruited which lessened the burden on the M&E Officer.

The UNDP’s role as the Grant manager was carried out diligently under very difficult external and internal conditions. The constraints under which the grant was administered included working in an environment where government support was inadequate, the political environment uncertain and very poor socio economic infrastructure. Internal constraints included the highly bureaucratic systems impeded speedy responses to developing and emerging needs in the field, thus led to delays in procurements of key items for program implementation such as the long lasting insecticide impregnated bed-nets, and anti malarial drugs.

Despite these difficulties the program was implemented. There was little progress made n the phase I part of the program as most time was spent on establishing systems and procedures as well as adjusting to the new political dispensations.

# 7 General Discussion

The overall performance of the Global Fund Round Two Malaria program has been significant in terms of establishing a greater level of population awareness of malaria as a major disease burden and adoption of LLITNs as an effective preventive measure. The greater awareness has led to significant change in the behavior of communities with regard to the protection of young children and pregnant women against malaria. Although the program achievements in terms of the global reduction of malaria in the country has been minimal in terms of the actual reduction of malaria as a major burden on the population of Southern Sudan, the program has initiated a process that will in the long term lead to substantive control over the disease. However, the lack of continuity strategy in the current program will quickly turn the situation back to the beginning when the program activities cease to exist in a few months time.

1 Key Critical Achievements:

1. Greater community awareness of malaria as a major cause of morbidity and mortality among children and pregnant women
2. Effectiveness of LLITNs use in reduction of malaria illness as well as reduction of mosquito bites
3. Some level of community participation and involvement in health preventive actions
4. Increased utilization of health care facilities and less use of traditional healers for malaria treatment
5. Increment of population access to basic health care through the strengthening of existing facilities and creation of new ones where there were none.
6. Provide a learning platform for the health sector development.

2. Key Critical Program Impediments

There were however a number of key program design weaknesses that directly or indirectly impacted on the performance of the program and these included the following:

1. The program was developed without the benefit of baseline data thus it had limited objectivity.
2. There was no exit of follow-on strategy developed that would have ensured the consolidation of the gains made in health systems strengthening and personnel development.

The lack of an exit strategy for the Program has created a major public relations problem, where the population that was getting used to have malaria diagnosed and treated at their local PHCU would now have to buy their own drugs from unlicensed drugs stores where quality is not assured. This will bring down the controls that had been established by the Program to reduce development of drug resistance

1. The lack of concurrent management development capacity building process for both regulatory and policy systems, did not provide a supportive environment for the implementation efforts.
2. The absence of capacity building of health infrastructures and personnel did not provide for long term sustainable malaria reduction intervention. Reliance on expatriate expertise without making arrangement for training of local counterparts contributed to this also.
3. Use of externally based organizations increase operational costs which could have been avoided by insisting on using locally based organizations.
4. Lack of Regulatory Framework impacted on the application of some controls needed to manage the program effectively.

The Ministry of health has missed the opportunity that was presented to it for introducing legislation to control drugs importation, prescription and use in order to safeguard efficacy of second line drugs for treatment of malaria. During the evaluation the consultant found that one could obtain second line treatment drugs including antibiotics from unlicensed drug stores. This is a situation that should not be allowed and should be dealt with immediately with regulatory legislation.

# 8 Conclusions and Recommendations

The evaluation has provided the country with valuable information that should immediately be used to strengthen planning for the next malaria program proposal. It is our wish that the country consider to put together a professional team to assist in drafting a proposal for holistic Malaria Control in the next Global Fund Proposal.

8.1 Recommemdations

The following recommendation are made based on the findings and discussions

The following recommendations are made:

1. GOSS should solicit for resources to undertake a population based household survey to provide baseline benchmarks for program and planning proposes. Limited population studies could be undertaken and data used for development of future project proposal that would then be based realistic assessment.
2. MOH should immediately constitute a panel of experts to develop a malaria follow-on program to ensure continuation of the services in the country. There is an opportunity to develop such a program for the Round 10 GFATM proposal.
3. The CCM should be strengthened to enable it to diligently select PR based on a set of criteria that would not only be based on financial frugality of the organization but also on flexibility of their systems to respond changing and emerging needs from the field during implementation. Although UNDP systems have worked well for the grant management, the inflexibility of its procurement of technical services and goods were slow and not adequately responsive to changing needs in the field.
4. The MOH capacity should be developed to assume the role of PR for all health programs
5. The CCM should critically vet technical staff employed by SRs to ensure that only the duly qualified personnel are engaged in the implementation of the program. Guidelines on job specifications should be provided for the vetting exercises to avoid engagement of personnel not duly qualified in the field as is the case as was the case in the program.

The selection criteria for Sub Recipients should be based on both on the specificity of the organization’s missions, technical capacities and competence to ensure that only the duly qualified sub recipients are given the responsibility to implement – as a significant number of current sub recipients implementing the programs did not have appropriately qualified personnel to deal with technical issues of malaria at the implementation level. There was no single trained malariologist in the whole program

1. Program resources could be optimized by using locally based organizations as SRs to avoid the high costs of external offices, staff R&Rs.
2. The National Malaria Control Directorate should take charge of all the technical and M&E aspects of the next program. The directorate should provide technical oversight on all implementation efforts on malaria in the country. The Directorate should develop a research agenda to include development of capacity for operations research to determine the long term impact of the LLITN on the development of mosquito resistance to insecticides. This will be a rational enquiry given the expected development of natural selection of insecticide resistance mosquitoes.
3. In the next Country proposal consideration should be made to include environmental management including indoor spraying for mosquito control as part of a long term plan.
4. In order to safeguard the efficiency of drugs for malaria and prevent development of resistance to current and second line drugs against malaria, the country should immediately consider development of legislation regulating importation, distribution, sale, prescription and use of anti malarial drugs

# 9 Appendixes

1. TOR
2. Inception Report
3. Data Collecting Instruments
4. References
5. List of Persons interviewed



TERMS OF REFERENCE

End of program GFATM-UNDP

TB Round 2 and Malaria Round 2

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| **1. Background and context** |

The Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) was set up as an international financing institution to increase resources to fight the three diseases namely HIV/AIDS, Tuberculosis and Malaria. Global fund has supported large scale prevention, treatment and care program against the three diseases. The purpose of GFATM is to attract, manage and disburse resources in public –private partnership that will make sustainable and significant contribution to the reduction of mortality and morbidity caused by the three major diseases and contributing for achievement of millennium development goals. To date, over 2 million peoples are on ARVs, 7.4 million peoples under DOTS and 70 million bed nets have been distributed.

UNDP is a key partner to the Global Fund and is the UN Agency assuming the role of Principal Recipient of GFTAM grants in Southern Sudan. As Principal Recipient for GFATM, assisting the country to meet its main goals in reducing mortality and morbidity from HIV, TB and Malaria, UNDP Southern Sudan Office is responsible for the financial and programmatic management of the GFTAM grant as well as for the procurement of health and non health products. In all areas of implementation, it provides capacity development services to relevant national institutions, sub recipients and implementing partners. Currently, UNDP, as Principal Recipient bears full responsibility for the operational and financial management of 5 grants: Malaria Round 2, Tuberculosis Round 2, Round 5 and Round 7, HIV/AIDS Round 4 .Currently UNDP run the Global Fund grant to totals USD 31,252,807.56.

United Nations Development Programme (UNDP) Southern Sudan is therefore planning to conduct End-of-program evaluation for the implementation of GFATM program. The end-of-program evaluation will be done for Tuberculosis Round 2 and Malaria Round 2 grants.

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| **2. Evaluation Purpose** |

It is planned to enable the team to assess, determine and report on GFATM project inputs, processes, accomplishment, lesson learned and to make recommendation to CCM and PR. It mainly focuses to evaluate the outcome and impact the grant achieved during its five year implementation.

The evaluation should

1. Evaluate the implementation process of Malaria Round 2 and Tuberculosis Round 2 grants
2. Assess major achievements during the grants implementation – mainly focusing on outcome and impact level
3. Examine the performance of the PR in terms of coordination, procurements and supply management, finance, and monitoring and evaluations as well as evaluate the role of UNDP in managing the GFATM portfolio in Southern Sudan.
4. Assess the major problems and constrains faced by the GFATM project at different levels including national, state, county, health facilities and SRs.
5. Assess the degree to which the GFATM project fits into the MoH health strategic program.
6. Assess the relationship among different stakeholders involved in the implementation of GFATM project including CCM, PR and SRs, and the relationship with GFATM.
7. Assess the extent of UNDP commitment to the human development approach and how effectively equality and gender mainstreaming have been incorporated in the design and execution of the programme.

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| **3. Objectives of End of Program Evaluation** |

The objectives of end of program evaluation are to evaluate the extent of progress and the relevance, effectiveness, efficiency, and impact of the program activities and formulate recommendations for the remaining period of the program life. Specific objectives include the following:

* To assess activities, inputs, process, output, accomplishment as implemented by UNDP as PR and put recommendation to Principal recipient and CCM under Malaria Round 2 and TB Round 2.
* Assess the grant implementation steps at country level.
* Assess program achievement against target throughout the implementation of the grants
* To evaluate the grant expenditure against the grant plan and the steps followed in the procurements. Furthermore it will document the challenges related with the procurement.
* To assess the activities of PR and fulfillment of terms of reference as specified in the Initial proposal and CCM document. And assess its effectiveness in each service delivery area per each grant designed to implement set targets.
* To assess the extent to which the grant plans have been implemented and goals have been achieved by PRs and SRs. Identify significant program changes made in the course of program implementation.
* To assess any constraints and challenges that the grants implementation encountered and how these have been resolved by implementing partners including SRs and PRs.
* To assess the activities of PR and fulfillment of terms of reference as specified in the initial proposal and CCM document. And assess its effectiveness in each service delivery area per grant designed to implement set targets.
* To assess PR and CCM capacity and structure for managing GFATM in relation to human resource and infrastructure. To what extent the GFATM structures have been fulfilling their roles.
* Examine the efficacy of management of GFATM in Southern Sudan by relevant entities (PR and SRs) and assess how well they met the Global fund requirements with particular focus in the future grants.
* Assess whether GFATM funds in Southern Sudan are efficiently utilized
* Assess whether GFATM funds are making a substantial contribution in the existing program to fight Malaria and Tuberculosis,
* To assess external factors which may grossly affect implementation of GFATM grants
* Document lessons learned and best practices during the implementation phase.

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| **4. Scope of the Evaluation** |

The evaluation will review UNDP-GFATM Southern Sudan country programme TB (Round 2) and Malaria (round 2). It will refer to the UNDP activities under PR by

providing an examination of the effectiveness and sustainability of the UNDP programs by i) highlighting main achievements at programme since the implementation of GFATM project, at the national level in the last five years and UNDP’s contribution in terms of key outputs, ii) ascertaining current progress made in achieving different outcomes and impact in the given thematic areas and UNDP’s support to this. Qualify UNDP’s contribution to the programme with a fair degree of plausibility.

The results of the evaluation will be used to strengthen future implementation of similar GFATM programs. The findings will help in planning the project document for future rounds of Global Fund. It will also highlight areas where more funding should be allocated. The End of program review will try to identify the Global fund structure at country level and review its effectiveness.

Malaria Round 2 has been implemented in all 10 states. The states to be visited as part of end of program will be selected in consultation with CCM.

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| **5. Methodology** |

The Evaluations will utilize both qualitative and quantitative methodology. The consultant will make the best use of the existing documents and conduct individual interviews/group meetings with relevant stakeholders. Thus both primary and secondary data will be utilized. The following data collection methods should be included as minimum.

* Desk review of relevant documents
* Discussions with the GFATM unit, CCM, HIV directorate, GoSS, Senior Management at UNDP office;
* Briefing and debriefing sessions with UNDP-GFATM, MDG and the Government, as well as with other SRs
* Interviews with partners and stakeholders (including gathering the information on what the partners have achieved with regard to the outcome and what strategies they have used); other donors
* Field visits to selected project sites and discussions with project teams, project beneficiaries;

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Outcome evaluation questions might include:

* To what extent the grant implementation have achieved the targets?
* To what extent the grant brought difference to the country TB and Malaria program
* What are the key challenges and lesson learned from the grant implementation
* What factors have contributed to achieving or not achieving intended outcomes?
* To what extent the grant implementation have been monitored?
* To what level the grant cover

Evaluation questions will be agreed upon among users and other stakeholders and accepted or refined in consultation with the evaluation.

The evaluation will led by one national and one international consultant. The lead consultant, International after brief orientation, s/he will develop plan of action stating the methodologies and required resources for the end of program evaluation. In the plan of action, areas of evaluation, indicators and data collection should be clearly spelled out. The consultants need to attach interview questionnaires and focus group guide.

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| **6. Key deliverables (Evaluation products)** |

The consultant(s) will produce a comprehensive structured End-of –program evaluation report that provide evidence on the results and impact of the grants as well as lessons learnt and give a rating of performance.

1. Evaluation inception report—an inception report should be prepared by the evaluators before going into the full fledged evaluation exercise. It should detail the evaluators’ understanding of what is being evaluated and why, showing how each evaluation question will be answered by way of: proposed methods; proposed sources of data; and data collection procedures. The inception report should include a proposed schedule of tasks, activities and deliverables, designating a team member with the lead responsibility for each task or product. The inception report provides the programme unit and the evaluators with an opportunity to verify that they share the same understanding about the evaluation and clarify any misunderstanding at the outset.

**Evaluation matrix** should be included in the inception report. The evaluation matrix is a tool that evaluators create as map and reference in planning and conducting an evaluation. It also serves as a useful tool for summarizing and visually presenting the evaluation design and methodology for discussions with stakeholders. It details evaluation questions that the evaluation will answer, data sources, data collection, analysis tools or methods appropriate for each data source, and the standard or measure by which each question will be evaluated. (See the Table below)

Sample evaluation matrix

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Relevant evaluation criteria** | **Key Questions** | **Specific Sub-Questions** | **Data Sources** | **Data collection Methods / Tools** | **Indicators/ Success Standard** | **Methods for Data Analysis** |
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1. A report (i.e. Hard copy, a soft copy in MS Word and Acrobat reader, Times New Roman, Size 12, Single Spacing) containing:
   1. Executive summary of conclusions and recommendations
   2. Introduction, rational, objectives, evaluation methodologies,
   3. Results (this need to include key finding per thematic areas of assessment)
   4. Key lessons learnt, highlighting key factors that might have strengthen or hampered the impact of GFATM in mortality and morbidity, and the health system of the country
   5. Limitation of evaluation assumptions made during the evaluation, and
   6. Conclusions and recommendations
   7. Annexes: ToRs, field visits, people interviewed, documents reviewed, questionnaires etc
2. Provide a draft report before leaving Sudan, and submit a final report within two weeks

3) Debrief UNDP, CCM members, SRs and health facilities

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| **7. UNDP’s obligations- Implementation arrangements** |

**UNDP will**:

1. Provide the consultant with all the necessary support (not under the consultant’s control) to ensure that the consultant(s) undertake the study with reasonable efficiency.
2. Appoint a focal point in the programme section to support the consultant(s) during the evaluation process.
3. Collect background documentation and inform partners and selected project counterparts.
4. Meet all travel related costs to project sites as part of the programme evaluation cost.
5. Support to identify key stakeholders to be interviewed as part of the evaluation.
6. The programme staff members will be responsible for liaising with partners, logistical backstopping and providing relevant documentation and feedback to the evaluation team
7. Cover any costs related to stakeholder workshops during dissemination of results
8. Organize inception meeting between the consultants, partners and stakeholders, including Government prior to the scheduled start of the evaluation assignment.

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| **8.Supervision and Management of the Assignment** |

The consultants shall work under the supervision of CCM and Global fund coordinator with technical guidance from the GFATM M&E unit. MoH, Preventive Medicine Directorate shall provide further guidance in the review of TB and Malaria grant activities.

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| **9. Evaluation Ethics** |

The evaluation will be conducted in accordance with the principles outlined in the UNEG ‘Ethical Guidelines for Evaluation’ and should describe critical issues evaluators must address in the design and implementation of the evaluation, including evaluation ethics and procedures to safeguard the rights and confidentiality of information providers.

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| **10. Time Frame** |

The evaluation consultancy is tentatively scheduled to take place from **February 8-March 19, 2010**

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| **Tentative timetable (Sudan)** | |
| **Evaluation Team** |  |
| Orientation with CCM and PR, finalize and agree on ToR , revision of Plan of action ;avail documents, evaluation of methodologies, Desk review of relevant of documents ,interview with CCM members and PR. | February 1- 5, 2010 |
| Discussion with PR and SRs. | February 8-12,2010 |
| Field visits to selected SRs implementation sites and health facilities to see program implementations | February 15-19,2010 |
| Continue field visit and discussion with SRs | February 22-26,2010 |
| Discussion with MoH director general and Synthesis of finding, clarification of issues, formulation of preliminary finding and recommendation, Report writing | March 1-5 ,2010 |
| Prepare draft report, De-briefings through power point to UNDP,CCM and other stakeholders, submitting final report, | March 8-10,2010 |
| Incorporation of comments and submission of final report with clear set of recommendations | March 11-12, 2010 |
| **Total Work Days** | **30 working days** |

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| **11. Reporting** |

The consultant(s) will be reporting directly to UNDP Global fund coordinator and CCM chairperson.

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| **12. Evaluation team composition and required competencies** |

The evaluation team shall consist of 2-4 consultants: an International consultant (team leader and member 2) and national consultants (2) with extensive knowledge of the country situation. The Team Leader (International) will have the responsibility for the overall co-ordination of the evaluation and for the overall quality and timely submission of the evaluation report to the UNDP Country Office

.The teams need to consist experiences and skills in the following area of fields

* Primary health care system, functionality of health system
* knowledge on HIV/AIDS, Tuberculosis and Malaria
* Program designing and strategic planning
* Grant manager familiarity with financial function .knowledge on global fund financial system will be an asset
* Procurements ,supply system managements at international level, monitoring and evaluation of the implementations system, designing of work flow
* General monitoring and evaluation system, basic monitoring frame work and result based management
* Experience in GFATM process and programmes will be an asset

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| **International Consultant** | |
| Education: | Degree in public health with master in public health, Medical doctor will be advantage**.** |
| Experience: | * Proven experience of a minimum of 15 years at the international level, preferably with UN experience. Knowledge and familiarity of the United Nations system, its reform process and UNDP programme policies, procedures. * Familiarity with the GFATM project, UNDP Multi-Year Funding Framework and other results based M&E frameworks. * Previous experience in conducting country programme evaluations is an asset.   Knowledge of the political, cultural and economic situation in south Sudan or ability to quickly acquire such knowledge is desirable  Excellent writing and analytical skills   * Ability to meet tight deadlines |
| Language Requirements: | Fluency in English |

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| National Consultants | |
| Education | Degree in Public health or sociology. Medical Doctor is an advantage |
| Experience: | * Knowledge on health care system of southern Sudan * Basic knowledge and training on HIV/TB/Malaria program * Experience in monitoring and evaluation of health related projects * Basic knowledge in primary health care system * Proven excellent analytical and written skills |
| Language Requirements: | Fluency in English |

**13. Remuneration and Terms of Payment**

National consultants will be paid in accordance with UNDP standard contract rates as applicable for national consultants. The international consultants will be recruited and paid in accordance with UN conditions and procedures.

**14. Conditions of Work**

Consultants will be expected to use their own laptop computers. UNDP will support and facilitate the consultants travel, provide administrative, logistics and facilitate security related issues of the consultancy. Consultant wills expected to arrange offices and accommodation during consultancy period.

15. Reference materials

The consultants should study the following documents among others:

1. UNDP Handbook on Monitoring and Evaluating for Results
2. Ethical Code of Conduct for UNDP Evaluations;
3. Guideline for Reviewing the Evaluation Report;
4. UNDP Results-Based Management: Technical Project Documents and relevant reports
5. Documents and materials related to the GFATM (proposal, agreement…)
6. GFATM M&E guidelines.

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| INCEPTION REPORT ON THE END OF TERM EVALUATION OF THE GLOBAL FUND MALARIA PROGRAM IN SOUTH SUDAN |
|  |
|  |
| **Dr. Amusaa Inambao** |
| **2/10/2010** |

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| A short report on the proposed implementation methodology outlining the rationale behind the selection of the implementation methodology and implementation time frame. |

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# Overview of the Evaluation Assignment

The Global Fight Against AIDS, Tuberculosis and Malaria had provided financial grants under the Round Two cycle. The United Nations Development Programme was appointed by the Global Fund to take the responsibility as the Principal Recipient for the million dollar grant due to the absence of local institutions that would meet the qualification criteria required by the Global Fund. The Grant for Malaria was administered through the four main Sub Recipients, the PSI, World Vision International, the AAA and the Malaria Consortium who in turn had implementing partners at the health facility levels and county levels. The Round two Malaria programme had come to an end and a new programme for Round 7 has been approved for implementation. There is a requirement for end of term evaluation of the Round 2 Malaria Programme for accountability purposes as well as to document the impact of the activities that were implemented and lessons learned for input into the next interventions.

The TOR for the evaluation of the end of programme indicates a requirement to evaluate the extent of the progress and the relevance, effectiveness, efficiency, and impact of the programme activities and formulate recommendations for the remaining period of the program life.

The evaluation of the Malaria Programme Round 2 will be expected to assess activities, inputs, processes, outputs, accomplishments as implemented by UNDP as PR and make recommendations to the Principal Recipients and CCM.

Analysis of the TOR indicates the requirement to assess the programme achievements against the targets throughout the implementation of the grants, evaluate grants expenditure against the grant plan and steps followed in the procurement, assess the activities of the PR and fulfillment of the terms of reference as specified in the Initial proposal and CCM document, assess the extent to which the grant plans have been implemented among the key objectives. Some of the evaluation requirements may not be achieved given the paucity of baseline data and the lack of benchmarks upon which progress made can be measured. Whereas it will be possible to determine the performance of the PR and the capacities of the CCM and sub recipients, the determination of the performance against the unrealistic target set in the project proposal. Given these findings the evaluation of the Malaria Round 2 program will require the use of different methods to collect information that will give a comprehensive picture of the achievements made in the project, how it was managed and how the PR had performed in the management of the Program.

# Proposed Methodology for the Evaluation

The process of data collection will consist of collection of both quantitative and qualitative information based on the set of performance indicators established and agreed with the Global Fund. Other information to be collected will include assessment of the management of the programme reports of the PR, the CCM and LFA as well as those of the Ministry of Health.

2.1 Evaluation Study Design

Collection of information to provide a composite and comprehensive picture of the impact and achievements of Round 2 malaria program will require a post-test cross-sectional evaluative study that will enable collection of data on activities and processes, disbursements and management used in the implementation of the program. Information sources would be selected in a purposive stratified random sampling of individual respondents, institutions, facilities and households. Multi stage sampling of areas and facilities will be based on a criteria of selecting the best performing, moderately performing and poorly performing programs in the three regions(according to old geographical divisions at the time of proposal development). Where the sample denominator is small such as number of sub recipients a total sampling approach will be employed. Multi modal collection of representative data will collection of data needed to validate and verify information from reviewed project documents and reports as well as interviews of key stakeholders involved in the implementation and oversight of the programme implementation.

2.2 Sources of Data for the Evaluation

2.2.1 Data from Documents Review

The first source of information will be from secondary data sources from program documents, reports and evaluation and audit reports. This information will come from the review of the following documents:

1. The Malaria proposal document
2. The National health strategic plan (if its available)
3. SR implementation reports
4. Evaluation reports
5. Annual PR reports including Disbursement reports
6. LFA reports
7. Associated malaria surveys and studies
8. Associated health strengthening documents
9. General formal and informal health Policy Documents.

2.2.2 Confirmatory DATA SOURCES

There will be a need to find the prevailing situation on the state and impact of the program on the ground by collection of both qualitative and quantitative information through primary information collection processes. These will include interviews of key implementing individuals from the implementing Sub Recipients, beneficiaries, implementing partners, members of the CCM, the Ministry of Health officials and health facility staff. UNDP program managers, Global Fund Unit Head, the LFA and other donors.

Due to the nature of information to be collected a multi modal type of information collection will be used. Observational assessments of facilities and sample homes will be undertaken to confirm the use of the LLITNs, the proper storage of drugs, the state of laboratories in health facilities and global assessment of the performance of the health service delivery system in the project arrears. Personal interviews, Focus Group Discussions, direct observation tools will be developed and used to collect the required information.

Selection of Respondents, Health Facilities and Sub Recipients for inclusion in the Evaluation Sample

A sampling approach will be used to select respondent institutions, individuals and areas to be included in the data collection. This is necessary as the program had been implemented in more than 17 Counties covering an estimated population of 1.9 million, and in order to minimize costs and complete the evaluation in the given time of five weeks sampling the decision to use a sampling method to determine the respondent sample frame

2.3 Evaluation Framework

An evaluation framework will be developed to guide the development of the questionnaires for data collection. The purpose of this frame work is to provide a guide for the type of data to be collected and to ensure that the data collection methodology is comprehensive.

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| Goal | Objective | Source of Data | Key Indicator |
| To reduce the burden of malaria in the beneficiary population in Bahr el Ghazal, Equatoria and Upper Nile regions in Southern Sector of Sudan | To increase the use of LLITN in pregnant women and children under five | SR reports on distribution of LLITN | # LLITNs distributed |
|  | Health facility reports | Numbers of pregnant women attended clinic and given LLITN |
|  | Beneficiary H/households | # of hou**seholds where pregnant** women and children under five sleep under LLITN |
|  | Evaluation and audit reports | # of LLITN procured and distributed to SRs |
| Expand the IPT to pregnant women | Health facility (ANC) reports | # PW seen and given IPT for malaria  # pregnant women treated for clinical malaria |
|  |  | Interviews or pregnant women | %age of pregnant women who have ever received IPT |
|  |  | Drugs consumption reports | IPT drugs dispensed for IPT |
|  | Improve early Diagnosis and treatment of malaria at community health facility level | Community health facility level service reports | # of malaria cases diagnosed and treated  %age malaria cases fatality  #uncomplicated malaria seen |
|  | Strengthen local capacity to predict, respond and contain malaria epidemics | National malaria surveillance programme | %age increase in malaria incidence  Increase in incidence of malaria |
|  |  | Facility reports (EWARN) | Increase in numbers of malaria diagnosed and treated  Increase in consumption of malaria drugs  Episodes of anti malaria drugs at health facilities |
| Other Indicators to be assessed | |  |  |
|  | Increased levels of awareness of program activities and intentions | Awareness surveys (where available) | %age of awareness increase among the population |
|  | Establishment of baseline indices | Baseline surveys (where conducted) | %age of change in the indices from the baseline |
|  | Development of malaria data bank | Implementation reports  Systems strengthening reports | Data on malaria being collected, processed, used and stored in a formal data bank |
|  | Activities of the malaria program being monitored and evaluated | M$E reports  Audit reports | # monitoring and supervision reports available  M&E framework for malaria developed |
|  | Capacity of CHD and stakeholders enhanced | Program implementation reports | #training of CHD officials trained  #training of local community health committees held  Improvement in the support management of malaria program from CHD |
|  | Burden of Malaria reduced | Service delivery reports  Malaria surveillance reports | %age reduction of malaria cases  Change in the number of malaria cases diagnosed and treated |
|  |  |  | Reduction on diagnosed uncomplicated malaria cases at health centers by 3% |
|  |  |  | %age of women and children under five sleeping under LLITN increased to 80% |
| PR Performance | | | |
| Financial Management | Funds disbursed | Disbursement reports | Amount disbursed against planned for the period |
|  | Capacity building | Capacity Building reports  Interviews of capacity building personnel | # of personnel from MOH and local partners trained |
|  |  | Inspection of facilities | # facilities refurbished |
| Management | Organizational strengthening | Capacity building training reports  Interviews of mgt personnel | #organization development activities |
| General performance of PR | Effectiveness and efficiency of operations | Audit reports  LFA reports | Performance grade given by GFATM  Supervisory reports |

2.4 Proposed Implementation Schedule

The proposed implementation schedule comprises of the planned interviews of personnel from the four Sub recipients, the MOH (part of which has been done), UNDP Global Fund Program team, WHO, County Health Department Officials, health care providers at PHCC and PHCUs, select community leaders and members as well as observational assessment of select facilities and households for the purpose of validating what is in the official reports, and to document the actual situation as it is.

**Proposed Implementation Schedule Table (Tentative)**

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | **Proposed Activity** | **Place** | **SR** | **Time In Weeks** | | | | | |  |
| 1 | Review of Documents and development and presentation of Inception plan/ report | Juba |  |  |  |  |  |  |  |  |
| 2 | Interviews of PR/SR and other Stakeholders  Development of instruments for field data collection | Juba |  |  |  |  |  |  |  |  |
| 3 | Travel to the field |  |  |  |  |  |  |  |  |  |
|  | Equatorial region (former) | Juba | PSI |  |  |  |  |  |  |  |
|  |  | Yei |  |  |  |  |  |  |  |  |
|  |  | Lainya |  |  |  |  |  |  |  |  |
|  | Bahr el Ghazal | Awil | Malaria Consortium |  |  |  |  |  |  |  |
|  | Upper Nile | Panyikan | WVI |  |  |  |  |  |  |  |
| 4 | Analysis of data |  |  |  |  |  |  |  |  |  |
| 5. | Draft report submitted for review and comments | Juba |  |  |  |  |  |  |  |  |
| 6 | Submission of final Report | Juba |  |  |  |  |  |  |  |  |

2.5 Implementation Requirements

1. Transport to the field
2. Air travel
3. Ground transport at the point of evaluation
4. Satellite telephone for teams in the field
5. Instruments for data collection
6. Arrangements of appointments with facilities and organizations in the field through SR and MOH County Health Authorities
7. Authority to travel to the selected areas.

# Annexes

1. Document review checklist
2. Personal Interview (program oversight, management, supervision, service provider, beneficiary
3. Focus Group Discussions (service managers and providers, community beneficiaries)
4. Facility and Household Assessment observations

## Instrument 1. Document Review table matrix

|  |  |  |  |
| --- | --- | --- | --- |
|  | Title of Document | Program Focus Area | Summary of Main Findings |
| 1 |  |  |  |
| 2 |  |  |  |
| 3 |  |  |  |
| 4 |  |  |  |
| 5 |  |  |  |
| 6 |  |  |  |
| 7 |  |  |  |

## Instrument TWO (2): Personal interview Guide

*(For all levels of personnel involved in the program)*

1. Name of Respondent
2. Title/Position in Organization
3. Organization
4. Type of Recipient
5. Main Program Focus
6. How long have you been involved with the GFATM Round 2 malaria Program
7. What has been your responsibility in the Round 2 malaria programme
8. To what extent have you been involved in the design and plan implementation of the program
9. What are, according to your perceptions, the most key achievements made by the program on malaria and why
10. What were the key elements that contributed to the achievements you have reported
11. What were the main constraints that limited higher achievements in the role you have or are playing in the program
12. Were there any major internal factors facilitating or constraining program performance (plse explain)
13. Are you aware whether the Global Fund Malaria program ever evaluated at the midterm?

If yes did the results of the midterm ever used to improve implementation of the subsequent phase?

1. Did UNDP GFATM Unit effectively facilitate implementation management of the program

In which key areas was the UNDP facilitation useful?

1. Which areas did the UNDP not effectively facilitate implementation of the Malaria program facilitation was poor or inadequate or problematic
2. What were the reasons for the poor facilitation
3. How do you rate the overall supervision and oversight of the program by UNDP
4. Are there any specific issue/s you strongly feel had impacted on the performance of the PR in the implementation of the program?
5. Were there any specific areas where the PR had performed exceptionally well?
6. What are your impressions on the competence and performance of the SRs
7. Do you have any specific concerns about capacities and competences of SRs – any particular SR for example
8. What would you have changed to improve the implementation performance of the PR and SRs?

## Instrument Three (3). Focus Group Discussion Guideline

*(For service providers, beneficiaries and CHD officials)*

1. Has there been any change in the burden of malaria since the program has been implemented
2. What do you think could have contributed to the change in the burden of malaria in the community
3. Did most of the households receive LLITN
4. Who usually sleeps under these mosquito nets
5. What time do the children and pregnant women go to bed
6. What do children do , sit, stay before going to bed
7. Do pregnant women receive malaria prophylaxis on regular basis from the PHCC/U
8. Are malaria treatment drugs always available at the clinics
9. Have the communities been educated on the malaria prevention and treatment
10. Has the malaria program been effective in reducing the burden of malaria on the community?

## Instrument Four (4). Direct Observation facility and Homestead Assessment

*(For the assessment of health facilities capacity to manage malaria according to the program and homesteads to verify the use of LLITNs)*

1. Health Facility/ Household Name
2. Payam
3. County
4. State
5. SR Name
6. Number of staff deployed
7. Types of staff cadres available in the program
8. Types of training undertaken by cadres
9. Availability of basic laboratory services
10. Availability of LLITN
11. Numbers of LLITN distributed
12. Average Number of LLITN in a Household
13. Frequency of malaria drugs stock outs reported at the centre
14. Frequency of anti malaria drug stock out reported by clients
15. Frequency of reported support supervision visits from SR

## Fianal Data Collection instruments (revised)

**Focus Group Discussion Guide on the impact of the GFATM Round Two Malaria Program**

**Introduction**

My name is \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ and that of my colleague here is\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_. We are both researchers working at Impact Research International. Thank you very much for coming to this group discussion meeting.

We are conducting an evaluation of the Global Fund Round Two Malaria Program We are interested in everyone’s views and experiences – therefore it is very important that, during the discussion, you all feel free to express yourselves. In fact, there are no right or wrong answers to the questions we will be asking – it is OK for people to have different views on the issues we will be discussing.

The discussion is scheduled to last for about one hour but, it may take slightly longer.

**Inform on the need to Tape Record the Discussions**

**Question 1: (**OPENER). Are you aware of the activities undertaken under the Global Fund Round Two Malaria Program? ***From what you have heard, what are people in this community saying when they talk the program***?

{Let everyone talk and probe individuals if necessary to say something to break the ice}

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**Question 2**: ***What do you think have been the greatest change that the program brought to your community?***

(Probe different areas of possible change)

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**Question 3**: ***Has the program made any significant changes to the level of malaria in your community? From what you know, do you think that mosquito nets have been useful in reducing malaria among pregnant women and children under five?***

(If yes probe further :)

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**Question 4**: ***From what you have noticed in this community, did most of the households receive LLITN?***

(Use appropriate probes)

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**Question 5**: ***From what you k now of your community has you noticed any misuse of the LLITNs***

(Use appropriate probes)

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**Question 6**: ***What do you think are some of the main reasons some community members are misusing the nets provided?***

(Probe further :)

**Question 7**: ***What do you think are some of the main challenges the community is likely to face with the phasing out of the Malaria Round Two Program?***

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**Question 8**: ***In your opinion, what should be done to control malaria?***

(Probe further :)

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1. As reported in the annual Global Fund Annual Report 2009 [↑](#footnote-ref-2)
2. Compared to regional countries such as Eritrea. Ethiopia. Kenya and Uganda [↑](#footnote-ref-3)
3. Abstracted from PUDR 202-G01-M-00 progress update period 1 April to 30th September 2009, disbursement period 1 October 2009 – 31st March 2010. [↑](#footnote-ref-4)
4. Abstracted from 2SUD\_5\_272\_budget request report on Southern Sudan [↑](#footnote-ref-5)
5. Extracted from the 2008 Global Fund Annual report for Southern Sudan [↑](#footnote-ref-6)
6. Malaria Grant Closure Statement of UNDP-Estimated Cash Statement as of 31 March 2009 [↑](#footnote-ref-7)
7. From the March 2009 PowerPoint presentation to CCM as current numbers were not available [↑](#footnote-ref-8)
8. Quite often self medication leads to incomplete dosing and may contribute to development of drug resistance. [↑](#footnote-ref-9)