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| END OF PROGRAMME EVALUATION OF THE GFATM ROUND 2 TB PROGRAMME FOR SOUTHERN SUDAN |
| **February –March 2010**  **DSC00419**  ***Ally Ahmed Ramadhan Lasu, Dr*** |

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**REVIEW TEAM**

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**List of acronyms**

**AAA Arkangelo Ali Association**

**AIDS Acquired Immune Disease Syndrome**

**ART Anti-retroviral Therapy**

**CCM Country Coordination Mechanism**

**CHD County Health Department**

**CHW Community Health Worker**

**DOTs Directly Observed Treatment**

**DQA Data Quality Assessment**

**GF Global Fund**

**GFATM Global Fund to Fight AIDS, Tuberculosis and Malaria**

**GOSS Government Of South Sudan**

**HCW Health Care Work**

**HIV Human Immuno-Deficiency Virus**

**IEC Information Education and Communication**

**LFA Local Financial Agent**

**LRA Lords Resistance Army**

**M&E Monitoring and Evaluation**

**MDR Multi Drug Resistance**

**MOH Ministry of Health**

**NGO Non-Governmental Organization**

**NTP National Tuberculosis Program**

**PGA Program Grant Agreement**

**PHC Primary Health Care**

**PHCC Primary Health Care Centre**

**PHCU Primary Health Care Unit**

**PR Principal Recipient**

**PSM Procurement and Supply Management**

**R2 Round 2 of the Global Fund Grant**

**SR Sub-recipient**

**SMoH State Ministry of Health**

**SUD Sudan**

**TB Tuberculosis**

**UN United Nation**

**UNAIDS United Nation AIDS agency**

**UNDP United Nations Development Program**

**UNICEF United Nation Children Education Fund**

**WHO World Health Organization**

**Executive Summary**

As a Principal recipient for 5 GF grants for South Sudan, the UNDP is a key player in the fight against HIV/AIDS, Tuberculosis and Malaria. Being a UN agency, the UNDP has broader developmental goals that seek to improve the lives of citizens in the host countries.

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 and Round 7, TB/HIV Round 5 and HIV/AIDS Round 4. Currently UNDP runs the Global Fund grant to totals USD 103,745,788.

End of Term evaluation review for GF R2 program was contracted by the PR and undertaken by a team of international and national consultants from 1st February to 12th March 2010 in Southern Sudan (a total of six weeks). The purposes of this End of Term Review were to assess, determine and report on Round 2 TB program inputs, processes, accomplishments and lessons learned; and to make recommendations to the PR and CCM for future program planning and implementation.

The Review found both strengths and weaknesses in Round 2 program implementation. The PR team capacities and systems fully satisfy minimum requirements to manage and oversee program implementation. Members of the GF Program team are hard working and effective in many respects. They have developed guidelines and plans for Monitoring and Evaluation (M&E), Procurement and Financial Management for SRs. The NTP is in place and coordinating the monitoring and supervision of TB program. Through the R2 program, a number of SRs were able to: 1) detect and treat 3,398 TB patients; 2) train 1,268 HCW in various TB care and other management aspects; 3) 291 laboratory assistants in TB microscopy; and 4) 2,598 CHW to support DOTs.

However some limitations were noted within CCM, NTP, PR and SRs systems.

R2 program challenges included;

* The NTP is a nascent program with mainly national outreach and hence TB prevention at PHC level is rather weak putting a lot of demand on R2 program.
* SRs were too few for the R2 TB program to achieve the expected targets. Not many actors were available for implementing TB programs in South Sudan because their main focus was on relief work.
* Conducting trainings in Southern Sudan is quite expensive and hence it becomes a challenge to train people.
* Some of the program targets were wrongly estimated making it difficult to achieve them (e.g. detecting and treating 16,750 TB cases in the R2 program lifetime assumed that there was 100% detection capability!).
* Poorly motivated staff at PHCCs especially laboratory technicians -due to lack of or irregular salaries-hindered full integration of TB services into the BPHS in some PHCCs.
* Insecurity whether in form of LRA attacks or inter ethnic/tribal clashes limited movement of SR staff in terms of case finding through outreaches and case follow up. This limited the number of new smear positive cases identified and the number of TB patients who completed treatment.
* High mobility due to social pressure such as water scarcity, poor pasture outlook and insecurity among the populace makes them not complete full course of treatment (defaulting).
* Difficult working environment with scarcity of water and most basic hygiene and sanitary services in some program areas affected service provision.
* Some reagents are delivered when already constituted, affecting the outcome of diagnostic results.
* Some Facilities lacked functional laboratories therefore adding transport burden to TB patients.

Key R2 program lessons include the following:

* R2 program used visually appealing IEC materials such as T-shirts, caps, posters and leaflets as an approach to effectively reach many people. Even the non literate in R2 program areas could understand TB as a disease.
* Proper logistics supporting regular and adequate supplies usually ensured continuity of TB service provision even when there were emergency situation in some areas.
* Engagement of TB treatment success clients to advocate for TB prevention and suspect follow up at the community is the best way to fight TB stigma and discrimination at the community level.
* SRs have found the feedback from the PR to be very useful in terms of guidance on program adjustments needed to comply with known best practice or PR guidelines and protocol. PR should therefore continue with the regular performance feedback to SRs through emails and meetings to discuss implementation progress and challenges.
* The experience with the R2 program shows that TB surveys are expensive. More effort should be directed towards effective and efficient collection of routine data.
* The strategy of intensified mobile TB awareness outreach coupled with TB diagnostic services is the best approach to bring TB services closer to the people.
* The R2 program performed well in PSM because of diligent PSM. For sustainability purpose, PSM needs to replicate its work at the state and county level to build the local capacity in PSM.

To improve future programs, the team recommends the following:

* The PR and MOH( GOSS) needs to Strengthen the capacity of NTP to manage the TB program at SMoH and County Levels as a long term strategy
* The CCM and PR should dovetail some of the R2 activities to R4 and R7
* CCM should have a technically competent committee that will review all country proposals to identify any artificially calculated indicator, offer a platform for discussion with all stakeholders and map out the strategy to inform the GF secretariat.
* Technically competent bodies such as (WHO, UNICEF, UNAIDS) should be involved at the planning and implementation phase of all GFATM programs for quality assurance and technical standards
* PR should focus on strengthening government systems so that the transition of PHC management moves form SRs to government.
* PR should strengthen its collaboration with TB stakeholders and offer more capacity building support SRs
* PR should recruit sufficiently experienced staff with medical background for disease specific positions (HIV/AIDS, TB and Malaria) within the UNDP to manage the programs effectively.
* The PR should link up with M&E department, under the Directorate for planning and research and work out the modalities of harmonizing the M&E systems of the two entities.
* CCM should select a specific number of indicators per GF program for validation and verification every quarter such that at the end of the year it can independently forecast each grant performance.
* Since TB and HIV are closely related diseases, TB/HIV initiatives should be introduced in all TB treatment sites to increase TB detection and optimize treatment outcomes.
* As a routine, the CCM should design and liase with the PR to fund grant oversight and M&E system training for CCM members to improve on the performance of their oversight role.
* The PR needs to foster and support the integration of TB component together with supply management indicators into the national M&E system and HMIS in preparation for when all TB units will be integrated into the PHC system.
* The PR and CCM needs to avail current SRs some “bridging” funds to help in the transition period to offer the basic TB services as patients are informed about the changes.
* The CCM, through the NTP should take the lead in creating awareness about alternative TB service units using the media (local radios, newspapers, TV, market announcements and posters) for the residents where TB sites that may close down.

**Conclusion**

Overall R2 program performance was satisfactory considering the magnitude of infrastructural, logistical and security constraints faced by the program. To the best of its ability, the PR executed its duty on the background of low SR capacity, high staff attrition and an emerging health system environment.

The R2 program laid the foundation for a robust TB program that is in need of serious commitment in both financial and human resource capabilities to further expand TB DOT services to the deserving people of South Sudan.

# 1.0 Introduction

The R2 TB program evaluation was planned to enable the UNDP GFATM team to assess, determine and report on the TB R2 program inputs, processes, accomplishment, lesson learned and to make recommendations to CCM, MoH, NTP and PR. It mainly focused to evaluate the outcome and impact of the TB R2 grant achieved during its implementation from 2004-2009.

The evaluation examined:

* The implementation process, the major achievements recorded, the problems and constrains faced by R2 program at different levels and the degree to which the Tuberculosis Round 2 grant fitted into the MoH strategic plan.
* The relationships among different stakeholder and the performance of the PR in terms of coordination, procurements and supply management, finance, and monitoring and evaluations as well as the role of UNDP in managing the GFATM portfolio in Southern Sudan.

The overall goal of the TB R2 program was to reduce morbidity and mortality due to TB and reduce anti TB drug resistance through;

* Improving ongoing TB activities
* Expanding DOTs services to cover 4 million people
* Strengthening of local staff capacity through recruitment, training and supervision
* Increasing of awareness of the general population on transmission, prevention and health seeking behavior

Tuberculosis control was low in South Sudan covering only 25% of the population at the inception of the R2 program in 2004. DOTs strategy was started in 2002 in South Sudan. The GF R2 TB focused on improving ongoing activities and expanding DOTS coverage by strengthening technical and management capacity of the local authority for TB program sustainability.

The results of the evaluation will be shared with the CCM, MoH, NTP and the PR and will be used to strengthen future implementation of similar GFATM and other 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.

**1.1 Background**

The R2 TB PGA (GF grant number SUD-202-G02-T-00), “ scaling up DOTS services in selected sites in South Sudan” was signed in 2004 for the implementation of the R2 TB program from 1st October 2004 to 31st September 2009 with a total budget of 14, 498,087 US dollars.

**1.1.1 Context and Description of Program Activities**

Tuberculosis is recognized by the MOH, GoSS as a major cause of mortality and morbidity. Although the exact TB situation remains unclear, the estimated incidence of new smear positive and all forms of TB is 101 per 100,000 and 228 per 100,000 respectively. With an estimated population of 13 million (NID 2007 figures), this translates to 13,300 and 29,640 TB cases occurring annually in Southern Sudan.

This situation is likely to worsen with the rising HIV epidemic which is now estimated at 3.1% in the general population.

TB control is at its early stage of development in the Southern Sudan, covering only less than half of the total population. The full adoption of the DOTS strategy took place only in early 2002. In light of the extremely serious burden of TB, the R2 program embarked on scaling up DOTS activities as quickly as possible to the program areas. Accordingly, the partners in the program identified two directions: improvement of ongoing TB activities and expansion of DOTS activities while creating demand for TB DOTs. This is being done through; facilitating partners to offer quality TB detection, diagnostic and treatment services. The program also focused on strengthening the technical and management capacities of the partners, government (NTP) and other local authorities (e.g CHD) as a priority to make the TB program sustainable. In addition, policy documents have been developed by the government to guide TB service delivery.

**1.1.2 Goal**

The overall goal of the program was to reduce mortality and morbidity due to TB and prevent the development of anti-TB drug resistance.

**1.1.3 Objectives**

* To expand DOTS activities to cover 4 million people
* To detect 4,000 TB cases annually by 2005, and maintain the activities in the intervening years.

**1.1.4 Target populations**

* Self-referred tuberculosis patients
* The general population

**1.1.5 Activities**

* Provision of regular supply of drugs and other consumables
* Strengthen local capacity
* Recruitment of staff
* Construction 12 and rehabilitation of 2 the peripheral TB units
* Training of health personnel
* Establishment of a quality control system for microscopy
* Establishment of TB surveillance system
* Partnership development
* Provision of food for in patients
* Community participation
* Operational research

**1.1.6 Expected outcomes**

* Expanded DOTS services to the 4 million people (50% of the total population) by 2005
* DOTS detecting around 4,000 TB cases (33% of the estimated total incidence) annually beginning 2005.
* Through the period of 2003 to 2007, a total of 16,750 TB cases would be detected and treated by the expanded DOTS services.

**1.1.7 R2 Program partners**

The eight implementing partners in the R2 program were:

* WHO
* COSV
* WVI
* CCM-Italy
* AAA
* MI
* PSF
* DOR

**1.1.8 R2 Program milestones**

|  |  |
| --- | --- |
| Milestone | Date/year of Accomplishment |
| R2 Proposal Submitted | 2003 |
| R2 Proposal Approved | 2004 |
| PR set up/staff appointed | 2006 |
| CCM established | 2006 |
| R2 First disbursement in Phase 1 | 2004 |
| R2 First disbursement in Phase 2 | 2007 |
| R2 M&E data quality assessment conducted | April 2009 |
| R2 Programme Implementation |  |
| UNDP Finance and procurement guidelines in use | Sept 2008 (latest version) |
| R2 program activities commenced | January 2005 |
| Mid-term Review of R2 TB | Not performed |
| End of term Review R2 TB | 1st 02 2010 – 12th 03 2010 |

Highlight of the R2 program to date include the recruitment of staff and establishment of a Global Fund and HIV/AIDS Unit by the PR dedicated to supporting the implementation of the GFATM grants at MoH (GOSS) compound, a functional NTP office based at WHO premises in the MoH compound and a NCE of R2 program ending 31st March, 2010.

**1.1.9 Gaps identified during evaluation process**

Currently the health care system in Southern Sudan is solely dependent on external resources brought in by international and indigenous Sudanese NGOs. The GFATM has financed TB programs in Southern Sudan in its 2nd, 5th, and 7th rounds, targeting specific thematic and geographical areas. There are also other donors that are supporting TB program in Southern Sudan. These implement the TB program through international and Sudanese NGOs. With all these funding pipelines, gaps still exist.

The major gaps identified during R2 program evaluation include; Majority of TB service units that are GF funded are not an integral part of the PHC system (vertical programs), lack of TB baseline studies and community surveys to inform the planning process for comprehensive TB services, few partners interested and involved in TB service provision, lack of a referencelaboratory for TB smear quality control, lack of involvement of community based organizations in TB prevention activities, in addition to lack of proper infrastructure, adequate and trained personnel, decentralized microscopic lab networks. There is no clear MDR suspect handling guideline and the logistical arrangement to deliver MDR samples for examination.

The capacity of the Ministry of Health to manage, coordinate and supervise health services is still weak. The National TB program (NTP), formed under the MOH is still wholly under supervision of Preventive medicine Directorate at MoH.

WHO only provides technical advice and support to the NTP such as training and developing of the TB monitoring system.

The R2 program assumed that all partners would work closely through the existing TB Coordinating Team chaired by WHO, who would take the overall coordination and quality assurance roles for the program in Southern Sudan. The coordinating bodies were formed but never carried out any major coordination activities until they were dissolved by the NTP in 2009. WHO is a member of the STOP TB partnership which is a strong TB advocacy partnership.

The population estimates used to calculate the target for TB service beneficiaries were derived from immunization campaign records reflecting potential beneficiaries in service delivery areas.

The GF R2 Program was implemented in 2 phases; Phase I started in Oct 2004 and ended in 30th Sept 2006. Phase 2 of the program began in 2006 and ended on 31st September 2009, with a NCE that will end on the 31st March 2010. The total resources spent is 14,498,087 US dollars.

**1.1.10 Synergies**

The R2 activities carried out were additional to the ongoing TB activities in Southern Sudan. The R2 program came in to scale up TB DOTS and increase case detection.

TB R2 program activities were implemented in 24 TB units (12 units existing at the start of program), operated by seven partners. Some Partners (DOR, MI and CCM-Italy) with already established TB activities benefited from extra resources from the R2 program, while the new locations proposed by the program offered TB services in areas not already covered by ongoing TB activities.

The R2 program training activities have generated a human resource pool that is highly experienced in comprehensive TB management in resource scarce environment such as South Sudan.

Use of PSF as the PSM agent (Euro health is the current agent) to supply and deliver most of the reagents, supplies and equipments needed for program service delivery at the program sites meant that timely delivery and consistency in outcomes was guaranteed and this was a boost to the SRs.

The R2 program built on the technical capacity of the NGOs already managing TB. In addition, it strengthened the local capacity to supervise, monitor and manage the TB programs in Southern Sudan, thereby improving ownership.

# 2.0 The End of Term TB R2 Evaluation process

The objectives of The End of Term TB R2 program review were to evaluate the extent of achievements and the relevance, effectiveness, challenges, constraints, and impact of the R2 program activities and formulate recommendations for future TB programs in South Sudan.

The End of Term review was conducted for 6 weeks (1st February – 12th March 2010) in South Sudan.

**2.1 Methodology**

The team conducted on site review of TB R2 program activities. This report contains information gathered through the review of program documents, guidelines, reports, plans and other reference documents; field visits, observations, interviews and discussion with PR and SR staff, CCM Chair, NTP Manager and deputy and other relevant TB partners.

**2.2 Review activities**

* Primary data collection at management level: FGD, indepth interviews, key informant interview, observation, interview with TB project beneficiaries in Juba, Yei and Yirol.
* Primary data collection at project level: FGD, in depth interviews, key informant interview, observation, interview with TB project beneficiaries in Yei and Yirol West, Morobo and Awerial counties.
* Secondary data review of R2 project proposal, guidelines, check lists, reports and other relevant documents, guidelines and articles from GFATM, PR, SR and LFA.

**2.3 Stakeholder engagement**

Activities for the End of Programme evaluation were conducted with the GFATM team, CCM Chair, NTP management, Senior Management at UNDP office, SRs (WHO, WVI, AAA, MI and Euro health), CHD coordinators and TB service beneficiaries during the evaluation process.

Attempts were made by the evaluation team to seek appointments for all the discussions, interviews and site visits and commitment to safeguard respondents’ interests observed within acceptable limits

**2.4 Major limitations to the evaluation review**

The scope of the evaluation TOR was a challenge. Much as the TORs were initially agreed upon by the PR and consultants, it became apparent once the review exercise commenced that the issues being evaluated were exceedingly complex and would not be adequately examined given the timeframe, team composition and the methodology of the evaluation.

This particularly applied to the objective a) To evaluate the grant expenditure against the grant plan and the steps followed in the procurement because there was neither time, budget nor tools for the review team to systematically conduct a systematic financial impact evaluation using standard measures and methods. As for the procurement procedure evaluation, the unavailability of the PSM agent at the time of the review limited the process.

Using a variety of methods for data collection was assumed would corroborate evaluation findings. It would happen but sometimes views expressed would be in discrepancy with findings creating conflict in evaluator’s judgment. Whenever that happened, it was hard to resolve these disparities.

**Other limitations faced by the review team;**

* Failure to get requested documents from partners as and when needed
* Challenges of access to some sites
* Delay in submission of/ sometimes no feedback to questionnaires by some SRs
* Insecurity and tension leading to abandoning some site visits planned

# 3.0 Findings and discussion

The GF Geneva approved a proposal submitted by South Sudan for TB R2. The executing body of the GFATM program was UNDP. The table below shows the R2 program phases and budget for the grant lifetime (2004-2009).

**Table 1: South Sudan GFATM program Grant Agreement R2 (SUD-202-G02-T-00)**

|  |  |  |
| --- | --- | --- |
| **Phase** | **Timeframe** | **Amount (USD)** |
| Phase I | 1st Oct 2004 – 30th Sept 2006 | 5,842, 932 |
| Phase II | 1st Oct 2006 - 30th Sept 2009 | 8,655, 155 |
| NCE | 1st Oct 2009 – 31st Mar 2010 | NIL |

The End of Term evaluation dealt primarily with R2: program structure, relationship and management issues related to PR and SR and implementation issues.

The findings summarized here cover program management, structure and program component achievements. Each sub section summarizes key findings and discusses these in relation to the purpose and objectives of the End of Term R2 evaluation. The lessons learnt and recommendations are reported separately.

**3.1 Program Management**

This section summarizes management structure and discusses M&E, PSM and finance systems as relevant for PR and SR.

**3.1.1 Principal Recipient**

The UNDP South Sudan (Juba Office) established a Global Fund and HIV/AIDS Unit in 2006 dedicated to support the implementation of the GFATM grants, in line with the corporate principles and structures established for effective institutional arrangement and management of the GFATM grants.

As an exit strategy, UNDP is working towards enhancing the capacity of the government in preparation for taking up the PR role.

The PR’s human resource base has greatly increased over time. The Global Fund Programme is now under the Poverty Reduction and MDGs Unit. The programme is headed by a Programme Coordinator and TB managed by a Project Manager. The Global Fund Programme has its own M&E Unit with two M&E Specialists and three Analysts, a Procurement Unit with an Advisor and two Specialists for health and non-health products, and as well as a Finance and Administration Units.

Key findings:

* The PR GFATM team members are generally well qualified and experienced.
* The team is small in relation to its management and reporting responsibilities and is thus overworked. There are 2 program managers responsible for 5 grants!
* The PR was able to fulfill all GF conditions precedent to disbursement of R2 funds.
* Most of the senior management positions are filled by internationals and hence the CCM’s plea to build local capacity is undermined.
* The Program Coordinator position had been vacant for sometime. The PC is responsible for the supervision and performance of PR team members who are working with SRs and building SR capacity to perform their roles.
* Program managers noted unrealistic deadlines for reporting demanded by PR senior management
* Low SR capacity affects effective management by PR

Noticeable under performance of the R2 grant was in part due to the fact that performance indicator targets (Number of New TB smear positive TB cases detected under DOTS (16,750 cases) and Number of TB units involved in DOTS (153 sites) were overestimated due to lack of proper baseline data.

**3.1.2 Monitoring and evaluation**

M&E is an important responsibility of the PR to ensure that program activities achieve their intended results. The PR has made some effort on M&E system development: M&E guidelines are available, detailing the indicators and determination of targets based on the grant proposal.

M&E staffing of the PR is adequate. There are now two international M&E specialists. Currently there is only one, out of the 3 national M&E analysts employed in the M&E unit. His contract will expire by end of March 2010. There is a move to embed the GF M&E unit at the recently established MoH resource centre, at MoH compound to streamline data flow from the lower levels (county and state) to the centre (GOSS), actualizing the “three ones”. Ten other International UN Volunteer M&E officers are currently under consideration for each of the ten States of the Southern Sudan.

The PR prepares and submits reports biannually to GF, unlike the quarterly arrangement in 2009.

The reporting systems to GF is highly specific and multi layered:

* SR submits report to PR
* PR scrutinizes reports and compile for internal review
* PR submits report to LFA
* LFA submits report to GFATM after clarification

This layered system is rather rigid (its an “All or nothing” principle) and sometimes compromise programming incase of any delay in the system.

The PR, CCM and other stakeholders (SRs) hold regular quarterly performance review meetings on each indicator with the view to improve both data quality and utilization. The LFA performs data verification before PR report is submitted to the GFATM Secretariat. The LFA conducted a data quality assessment in 2009 and concluded that the TB R2 programme scored B2.

A DQA was done by GF after the LFA report and found some PR M&E system failures. A costed M&E plan was developed by PR.

To address the issues raised by the DQA exercise, PR planned to: increase SR monitoring visits, carry out on site data verification, give regular feedback on reports and offer SR M&E training.

**Some issues noted:**

* PR M&E unit is still understaffed. There is difficulty in finding suitably qualified M&E candidates locally. The unit has recently recruited three M&E analysts who will be on board in April 2010.
* A national M&E training was conducted by the M&E Directorate, MOH, with the objective of equipping state and county M&E officers on the national indicators, data base and tools. This TOT training facilitated in part by UNDP staff, who were offered half a day to orient the participants about GF programs. The training entailed the broad based M&E subject content and the M&E department at MOH charted out the critical follow up strategy that is very important to such participants.
* Unlike at the national level where there is a strong collaboration between GFATM M&E and M&E department at MOH(GOSS), at the SR implementation level of GF programs, there is no clear relationship between M&E activities of the GF and that of the local authorities. That relationship needs to be well defined so as to strengthen the national M&E system.
* Beyond the human resource challenges, data base establishment, organization, verification of documents (with supportive documents) and organizing M&E training, data quality assurance for SRs is still pose a challenge. The PR developed a costed M&E plan after the DQA by GF to address some of the M&E challenges.
* The Data base at UNDP(GFATM) are established per grant, per quarter, per indicator and per SR. This makes it easier for retrieval and use on request. The major challenge is the lack of a server to specifically serve the GFATM unit at the moment. The M&E unit at MOH is being supported by the GFATM to have a centralized electronic database and all GF documents will be kept in the server at MOH.
* SRs were not obliged to submit support documents initially and hence some SRs complained when PR introduced this requirement. This, it was explained by the PR was a standard procedure when there are data quality issues (especially after the GF initiated DQA) and should be seen as normal process by the SR.
* There was no evidence of R2 program review at mid Term. It should be noted that this was not a precedent requirement by the PR for the TB R2 phase II.
* Some of the SR data records and systems do not meet the required M&E standards to improve the program through use of data.

Some SRs need to appoint a staff dedicated to M&E activities as opposed to having the program coordinator backstopping as an M&E officer. Continuous training of SR M&E and other program staff in M&E and regular field visits using standard M&E checklist can be employed as strategies to improve data quality.

**3.1.3 Finance management and systems**

The PRs’ financial management structures are sound and disbursements from the PR to sub-recipients (SRs) have been made in a timely manner overall, although some SRs noted delays. As a condition precedent to phase II disbursement, the PR was to appoint an external auditor and come up with a detailed costed 2 yr work plan. Both conditions were met satisfactorily.

**Issues noted:**

* The reporting cycle of GF doesn’t coincide with account closure dates for PR.
* GF reporting timeline is quarterly and deadline for finalization is 45 days after end of the quarter. PR does quarterly account closure and timeline for finalization is 60 days after the end of the quarter. Some program costs remain unchanged during the course of the cycle.
* The finance unit reports any kind of cost difference in the next quarter report. So the PR reports and provides evidence of the expenditure (as agreed by LFA resident representative).
* Annual SR financial audit done (March-May) subject to UNDP guidelines.
* Red tape affects quick payment for services offered promptly to PR
* PR doesn’t conduct financial visits to SR field sites because the SR financial are centralized. One can get a good idea of costs and how things work but no idea of how financial books look like. Visits not very revealing.
* SRs complaint of cumbersome financial tools needed to be filled every so often. Thus PR receives partly filled SR financial reports, sometimes inaccurately filled and making excessive disbursement requests. So no funds can be released in that case.
* Some SRs faced delays in disbursement for several reasons, i.e. the disbursement was delayed since SR still had a large cash balance as stated in the submitted PUDRs, the SR had not spent the previous fund transfer, the SR’s cash balance could cover the budget for the next reporting period.
* The high turnover of critical staff, without proper hand over undermining institutional memory of SR finance system.
* Lack of orientation and training of SR by PR in GF financial requirements and procedures.
* Infrequent visits by finance team to SRs for capacity building.

**3.1.4 Procurement and supply management**

The evaluation determined that UNDP had in place sufficient PSM structure to manage the GF programs. The system can handle most PSM duties and is able to sub contract and effectively monitor out sourced PSM contracts.

For the R2 program the PR formally contracted the Pharmaciens sans Frontieres (PSF) as the procurement agent for outsourced PSM activities such as warehousing and distribution arrangements. EuroHealth has only recently taken over the supply chain management function from PSF and has a contract with UNDP.

**Issues raised**

* Lack of PR capacity to correctly forecast the SR health and non health needs for TB facilities.
* The PR has complicated procedures when it comes to procuring services and non-medical supplies. For example, Malteser is still waiting for laptops and printers meant to be used during grant lifetime whereas the TB R2 grant has come to an end. According to the Procurement department, the funds for TB R2 for non-health items were reprogrammed to purchase anti-TB drugs instead. That is why these purchases were suspended. This was done in unison with the TB Project Manager with direction from the Portfolio Manager. This communication need to be passed to the SRs as well.
* Logistical challenges due to the size and topography of South Sudan, coupled with shortage of storage facilities at state headquarters.
* SRs are yet to be assured of the Eurohealth (the new outsourced PSM agent) performance, since no formal introduction had been made between SRs and the new agent.
* All SRs had the minimum programmatic and institutional capacity to adequately plan, implement and report on program activities.

**3.2 Sub Recipients**

The following were the key findings on SRs:

* There was staff capacity variation between SRs
* Most SRs don’t have specific personnel on ground for M&E work. Responsibility of some staff doubles as an M&E officer on top of their duties.
* Most SRs performed their activities satisfactorily meeting their set targets considering the capacity and contextual challenges.

**3.2.1 Management**

All SRs had the required minimum programmatic and institutional capacity to adequately plan, implement and report on program activities.

Some management issues related to SRs include the frequent turnover of SR staff due to better job offers or harsh working conditions. This high attrition of staff creates a recurrent demand for training and orientation by SR, which may be expensive. This has created a challenge in building the capacity of SRs.

**Issues raised:**

* Lack of a pool of competent staff with critical skills needed to effectively program
* High staff turnover
* High costs of organizing and conducting training
* Some SRs have a lot of red tape that affect activity implementation
* The local staff complain about their welfare as compared to their expatriate peers

**3.2.2 Monitoring and evaluation**

Most of the R2 program SRs had robust M&E systems that adequately meet the PR minimum requirements for GF programs. Some personnel and M&E capacity issues are constantly cropping up for the SRs.

**3.2.2.1 Data collection**

For most R2 program partners, the TB officer at the TB facility is responsible for conducting regular supervisory visits to each partner TB unit at least once in a month in order to monitor key program activities and compile the program data from the various registers in the facility (Suspect, laboratory and TB medication register).

The R2 program printed and distributed TB and lab guidelines, health education materials, program documents, recording and reporting forms. The program made sure there was sufficient supply of forms and registers available in each TB unit for the duration of the program.



**PHOTO 1:** *Some TB registers and IEC material for TB awareness*

At the bare minimum, all the program facilities visited had;

* A register for TB suspects at the screening room
* A TB lab register book for all suspects whose sputum are examined
* A basic drug management register for all patients on TB medication and their progress
* A focal person to collect reports from CHE and TB mobilizers.
* Some facilities keep a separate TB Contact register to identify whoever came into contact with the Suspect (for follow up by community supporter), and a stock card for TB patient drug record.
* All facilities had records for all forms of TB, whether Pulmonary or extra pulmonary.
* There are special forms for referral of suspects for sputum examination or TB medication.

**3.2.2.2 Reporting**

All the information is compiled into a single monthly report by TB coordinator, then passed on to the SR manager at the facility level. The report is then sent to the SR headquarters for collation and analysis before it is submitted to the UNDP in a suitable SR GF reporting template.

All SR reports are shared with CHD. There is notably no feedback from the CHD.

All SRs have a data quality assurance mechanism in place at the facility level, with at least a quarterly visit to the facility, going over the sputum positive entries on suspect registers. Some of these DQA visits were done jointly with NTP technical staff.

**3.2.2.3 Evaluation**

Most SRs were not aware whether GF R2 TB program was ever evaluated at the mid term. The SRs believe such an evaluation would be important to improve program performance of the partners involved by re-adjusting their programs.

**Key M&E issues:**

* On feedback from reports submitted to UNDP, SRs reported they always got feedback and the comments were very helpful in SR programming and improvement.
* The SRs also noted that supporting documents requested for by the PR to accompany activity reports were not part of the PCA signed between SR and UNDP.

**3.2.3 Procurement**

The SRs had no major procurement roles in this R2 program

**3.2.4 Finance**

Most of the SR have strong internal control systems and are able to comply with GF financial guidelines but some challenges are still faced.

**Issues noted:**

* Sometimes the internal systems of SRs are so rigid it hinders activity implementation.
* Some SRs found the GF financial tools cumbersome to fill and hence reporting on expenditures delayed.
* Some SRs still have some R2 funds with PR. The total SR contract amount does not necessarily represent the total fund to be transferred.  The fund transfer depends on the actual expenditure which relates to SR deliverables according to the PR finance unit. This is clearly articulated in the PCA signed by both parties.

**3.3 Program Structure**

**3.3.1 Principal Recepient**

Due to the current country context, UNDP is one of the Principal Recipients (PRs) for Global Fund grants in Southern Sudan, i.e. Round 2 Malaria, Round 2 TB, Round 4 HIV/AIDS, Round 5 TB/HIV, and Round 7 TB grants. The UNDP Country Office with support from the Regional Bureau Office and the Country Office is providing overall coordination, institutional and programmatic management, financial management, procurement and supply management systems, and monitoring, evaluation and reporting technical services for grants in Southern Sudan.

As the current PR, the UNDP South Sudan - Juba Office has established a Global Fund and HIV/AIDS Unit dedicated to supporting the implementation of the GFATM grants, in line with the corporate principles and structures established for effective institutional arrangement and management of the GFATM grants.

As an exit strategy, UNDP is working towards enhancing the capacity of the government in preparation for taking up the PR role. UNDP has instruments (CPAP, LPAC and IMAC) for effecting GF implementation. These detail approved workplans agreed upon by the UNDP and the relevant GOSS Ministry Directorates.

**3.3.2 Country Coordination Mechanism (CCM)**

The Country Coordination Mechanism (CCM) coordinates the submission of proposals to GFATM and monitors the implementation of activities. It is chaired by the Director, External assistance, MoH (GoSS). It coordinates a total of 125 agencies working in the health field. Currently its membership is 26, with 9 members from government line ministries and the rest from different constituencies such as academia, faith based, INGO, local NGO, PLHIV and private sector). CCM members have received capacity building training from GMS in 2009.

The CCM calls for, and conducts regular quarterly review and ad hoc meetings where the PR and SRs present updates on indicators and budgets spent to achieve them.

The CCM also keeps a donor year book to track estimated and real time budget support received by MoH.

The CCM views UNDP as a strong partner who give immense support to its programmes although sometimes tension is unavoidable.

CCM also supervises the process of SR selection.

**Issues noted**

* Stewardship of CCM is strong, agencies are being asked to be accountable. CCM is planning to track all donor funds.
* Has an executive committee (Servants’ committee) in charge of executive decisions
* CCM constituted a proposal development committee formed by the line TWG from TB, Malaria, HSS and HIV/AIDS.
* There is intention to form a resource mobilization and grant oversight committee to oversee grant performance and carry out verifications.
* The chair noted that on top of GF, the following funding mechanisms: GAVI, CHF, MDTF, BSF and SRF available to the government to improve health systems and service delivery.
* Historically, CCM had communication issues with PR but since government started coordinating all GFATM activities, leaving PR to supervise only SRs, the CCM-PR relationship has greatly improved.
* CCM notes the challenge of M&E in all the programs and hence believes the challenge needs to be addressed by supporting the nationalization of the M&E system.
* For specific disease grants, there are few SRs and so the CCM feels more SRs should be recruited so as to improve grant potential to rate better.
* CCM Chair observed that the promise to build local NGO M&E and technical capacity is not being honoured whereas that was GF target from the beginning.
* CCM Chair voiced concern about cost-benefit analysis of projects questioning what percentage of the donor money is spent where?
* CCM faces lack of office space and logistics to conduct its affairs smoothly. Currently it has only an administration consultant as a staff.
* Conflict of interest may crop up in CCM if some PRs and SRs are on the CCM executive committee

**3.3.3 LFA**

KPMG Kenya is the “ear and eye” of the GF in South Sudan. The LFA does PR oversight and report verification on behalf of the GF. The LFA team in country is composed of a team leader and 2 technical staff. The TOR scope for the LFA is only limited to the PR and does not extend to SRs. The LFA can only point out gaps identified and cannot prescribe solutions. The PR is assumed to be competent enough to rectify the problem once it is identified. On average, the LFA makes six verification visits annually. The workload is heavy and technical personnel are few.

The LFA appreciates the difficult environment that R2 grant is being implemented and the improvements achieved. The relationship between the LFA and GF in country partners has markedly improved over the last one and a half years. To that end the LFA has made some staff changes and is committed to be in Juba regularly (unlike the six times annually previously).

LFA agent limitations include limited budget to effectively carry out the oversight activities.

LFA agents noted that;

* PR should focus on building capacity of SRs so that they deliver to the PR expectation.
* CSO is minimally involved in the GF programs whereas a strong civil society can offer the necessary advocacy pressure to the PR to improve services needed.

**3.3.4 NTP**

Established in November 2006 within the Directorate of Preventive Medicine, MOH (GoSS), the NTP coordinates the monitoring and supervision of implementation of TB activities in close collaboration with the implementing partners. The program is structured in line with the governmental administrative levels, the central unit at GoSS level headed by program manager, state and county levels headed by state and county TB coordinators and facility in-charges at health facility level.

To date TB program is mainly vertically run with NGOs as the main implementing partners. The government implements TB programs in 6 counties. These implementing partners are involved in offering and supporting diagnostic and treatment services, strengthening the capacity of the NTP at all levels, training, reconstruction of infrastructure, strengthening supply management and community engagement in TB.

Global fund is the biggest donor to TB programs in South Sudan. Other donors directly fund the NGOs. Due to the external support extended to the TB program, it has been able to develop into a high quality programme with excellent treatment outcomes. It also assists in expanding access.

The dependency on this external assistance makes the resources and capacities for the TB program a potentially volatile one and pose a risk to the program continuation in the long run. Due to uncertainty of funding most of the NGO’s, expressed interest and willingness to continue their support after 2010, but can only fully commit once funding is secured.

**3.3.5 Sub Recipients**

**3.3.5.1 WHO**

WHO focus on this grant was originally to offer technical assistance in training, M&E, capacity building for the MoH and lab quality control. The PR discussion to bring WHO on board didn’t happen in 2005. WHO and UNDP concluded the discussions of WHO involvement in Round 2 in 2nd Quarter of 2009 and first and only disbursement to WHO done in June 2009.With funds received, WHO embarked on training health workers and Lab technicians.

Besides the trainings that WHO committed to undertake, WHO has also been providing technical advice to UNDP and NTP on the technical performance on the TB program in Southern Sudan .

WHO performance in TB R2 grant was very good, managing to achieve about 80% of the target number of staff to be trained.

**3.3.5.2 AAA**

AAA, the development arm of DOR was initially an SSR to DOR, but eventually replaced DOR in the TB R2 service provision. AAA runs facilities in Lakes state in: Awerial (Bunagok), Yirol west county ( Yirol ) and Yirol East (Adior) counties. Other sites include Nyamlell (Aweil West), Gordim (Aweil East), Aweil (Aweil town) and Tambura in Western Equatoria.

TB programme coordinator, ensures that all the activities are implemented as per the contract agreement and the targets met, and also the contact person with UNDP on all programme issues. The main area for the TB program includes, case finding, case holding & treatment of TB cases, Rehabilitation and equipping of TB units, extension of the TB DOTS services, capacity building and creating awareness on TB through health education and outreach services. The performance is measured by using standardized indicators of the targets set as provided by the PR.

AAA has been involved from the beginning of the R2 grant in 2004 and has fully participated throughout the period in the first two years under the Diocese of Rumbek, then as an independent organization thereafter.

The Key achievements include increasing the number of health facilities performing TB diagnosis and treatment (TB sub-units integrated in the PHCC centres), training of the different cadres of health workers involved in TB diagnosis & management, improved awareness on TB in the community and increase in case finding through the use of mobile services. The main elements that contributed to the above achievements are properly managed structure from the HQ to the health facilities, strict monitoring and supervision of the activities and intensive training & motivation of the staff.

AAA believes strengthening of the Monitoring and Evaluation component of the program was inadequate since only one M&E specialist was available. AAA believes UNDP performed very well due to the improvements made during the grant period, there has been substantial improvement, closer contact and communication and fast response to the needs of the SR

AAA promised continuation of the TB services because it has secured Round 7 Grant

Recommendations for improving TB grant performance include:

For AAA: 1) Continuous supervision of the activities and monitoring the targets on monthly basis 2) Intensive training of health workers implementing the activities on basic program management

For Government: 1) The Government should provide accurate population figures in order to have accurate targets 2) There should be focal persons at the State and County levels to ensure that there is continuous involvement and support for the program and good communication channels 3) The Government should provide salaries for the staff to ensure the programmes are sustained.

**3.3.5.3 Malteser**

Implementing agency delivering TB control services through facility and community based networks. It operates in Central and Western Equatoria and Lakes state. A strong TB, Leprosy and sleeping sickness treatment service provider for a long time in South Sudan.

An average of 80-100 in patients are fed daily with the WFP food supplies for 2 months. Cohorts of patients given dry rations (100kg) at family ratio of 1 patient: 4 dependants for the duration of 4 months for the community DOTs. Then it is terminated. Patients on DOTs are not encouraged to engage in laborious undertaking, hence the food given. The food supplies used to be given for 6 months but due to sustainability issues, that has been discontinued.

After R2 closes, Malteser has put in place to integrate its TB services into the local PHC system. In Yei and Rumbek Malteser has built TB facilities within the hospital complex and discussions are being finalized on the modalities of handing over those facilities to the government.

Malteser envisages a situation where the government through NTP is incharge of administrative roles and it concentrates on CB and technical support to build the ownership necessary to build the momentum necessary for eventual transition.

Malteser is currently attempting to demystify the “Maltesers’ business is TB, Leprosy and Sleeping sickness treatment”, which whereas well meaning, is rather misleading because Malteser fully supports government role of stewardship in health programming. The Malteser Yei TB facility is a 140 bed hospital with 95 beds reserved for TB patients. The new facility built has only a capacity of 40 beds, which is half the previous capacity!

**3.3.5.4 WVI**

World Vision International (WVI) is a Faith Based NGO delivering TB control services through facility and community based network through a Basic Treatment Unit (BTU) in Gogrial East and conducting active case identification. The TB site was left without a service provider when the previous SR left in 2008, and hence WVI came in to rescue the patients initially without GF support.

WVI is part of phase II R2 TB partners. It’s a voting member of CCM and works with TWG at MoH. It only received a single grant (167,000 USD) from R2 in July 2009. The TB service at this facility is the only one in the area. TB patients on the register as of September 2009 were 60. Patients come in big number due to WFP food. WVI has embarked on tracing the 2007 treated patient through sending messages to relatives. By the time the R2 NCE ends, some patients will be in need of TB treatment.

WVI considering handing over its facility to the SMoH and hope that Wau hospital takes over the oversight role once the R2 grant expires. Traveling from TB unit to Wau takes 2 hours by road. Another option is to hand over the TB facility to another SR or continue providing services upon securing funds for continuation. WVI is also exploring TB/HIV options.

Not all the allocated funds have been received from the PR. The PR explained that not all allocated funds are transferred to the SR. Transfer is subject to actual expenditure and deliverables as guided by the PCA signed by both parties.

**3.3.5.5 COSV**

Coordination Committee for Voluntary Services (COSV) – an INGO is an Implementing agency delivering TB control services through facility and community based networks in Unity and Jonglei state.

**3.3.5.6 PSM Agent (PSF/ Euro health)**

Pharmaciens sans Frontieres (PSF) was originally contracted as the procurement agent for outsourced PSM activities such as warehousing and distribution arrangements. EuroHealth has only recently taken over the supply chain management function from PSF and has a contract with UNDP.

**3.4 Program achievements by components**

**3.4.1 TB case detection, diagnosis and treatment**

During the five years of R2 TB program implementation (2004-2009), a total of 3,398 TB cases were detected and treated.

**3.4.1.1 Case detection**

To date the R2 programs’ expanded DOTS services has detected around 3,389 TB cases, who were either “Self-referred” TB patients or detected during TB outreaches. The patients admitted for treatment were given essential information on nature of TB, treatment, necessity of DOTS, and way of transmission. The aim was to improve patients’ adherence to chemotherapy and increase the cure rate. After discharge TB patients were encouraged to be active in their communities in providing TB information and education about transmission, prevention, and adequate health care seeking behaviors.

**3.4.1.2 Case detection challenges**

* Insecurity in some areas eg Yirol, Lasu, Tore and Rumbek. This made outreaches impossible and defaulter follow up complex.
* Difficulty in transportation due to poor roads and long distances between TB facility and outlying localities. During the rainy season (April- November), most areas are inaccessible.
* Community attitude of denial: Some communities believe TB is a curse and is for other people.
* Suspects will never disclose their true complain, the TB nurse has to be tactical to probe effectively.
* Late presentation of TB cases compromises treatment outcome. Most client end up dying (some are miraculously saved!).



**PHOTO 2:** *This boy presented to the TB facility very sick, and was put on TB medication after smear positive diagnosis(courtesy of AAA)*

* There is thus high stigma and discrimination against the TB patients and their carers.
* Logistical: Breakdown of cars and high maintenance costs
* Few community mobilizers relative to the large areas they need to cover.

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**PHOTO 3***: Poor roads: Time to “push” during a TB outreach in Bunagok, Lakes state.*

**3.4.2 Diagnosis and quality assurance**

The R2 programs’ expanded DOTS services detected 3, 389 TB cases. The list of standard permanent equipment for performing TB microscopy at peripheral laboratory recommended by WHO (TB Handbook, WHO, 1998) was adopted by the program and the procurement of the laboratory equipment was centralized and the responsibility of PSF.

* + - 1. **Laboratory personnel and training**

The program recruited and trained local laboratory technicians/ assistant on TB

microscopy techniques such as specimen collection, smear slide preparation, slide reading, recording and reporting of results. The training methodology used was mostly skill- rather than knowledge-based.

The adapted versions of WHO TB training modules (“Managing TB at District Level”) were used. The lab staff were visited regularly in their work places in order to reinforce the impacts of the training courses and monitor their performance.

* + - 1. **Facilities, equipment and supplies**

The Program helped the SRs to establish TB diagnostic services by procuring and supplying light microscopes, laboratory reagents and supplies. Laboratory technicians and assistants were trained under this program.

Some TB satelite facilities were also equipped to carry out TB diagnostic services. Most facilities without diagnostic facilities just refer patient to the nearest TB diagnostic unit.

All needed reagents and supplies were available for quality TB microscopy. The laboratories followed the “3 sputum sample” rule (Spot sample, early morning and spot sample again) for all TB suspect cases.



**PHOTO 4***: A lab assistant in a well equipped TB microscopy lab in Yirol TB unit, Lakes state.*

* + - 1. **Smear quality assurance**

For some SRs Internal quality assurance is done by a competent lab technologist, who re- examines all slides from each site. A mechanism for inter-TB site slide exchange for TB sites under the same SR is in place for one SR (AAA). This provides a feedback to lab peers about the quality and effectiveness of their smears.

All SRs seemed to have their external smear quality assurance done by AMREF in Nairobi, Kenya. The AMREF checked and reported on; slide labeling, quality of smear preparation and staining, packing and reporting. The feedback got from the AMREF TB smear QA laboratory noted above 90% accuracy for all R2 SR submitted slides on all aspects.

**3.4.2.4 TB Diagnosis challenges**

* Poor network of TB diagnostic labs
* Few and poorly motivated lab staff in PHCCs
* Applicator sticks not supplied with the other diagnostic kit contents. PSF notified of the anomaly. No action since then.
* Some reagents are supplied when already re-constituted. The Lab personnel would prefer to receive these reagents separately in powder form and then re-constitute them in ratios that optimize the diagnostic outcome.
* Xylene, a TB lab reagent was received with expiry date nearly 2 months away in some facilities.

**3.4.3 Treatment**

The drugs used for TB treatment within the R2 TB program were: Isoniazid (H), Rifampicin (R), Pyrazinamide (Z), Streptomycin (S) and Ethambutol (E).

The WHO recommended treatment protocols were used, as outlined in the “Guidelines for TB Control in the Southern Sudan”. The regimens include an intensive phase of 2-3 months and a continuation phase of 4-6 months according to the different treatment categories.

The program provided standardized short-course chemotherapy under direct observation (DOTS strategy). The patients were made to swallow the drugs in front of TB nurse who always made sure that the right drugs, in the right doses, at the right interval was taken.



**PHOTO 5:** *Some Anti TB drugs with clear expiry dates labeled*

Strategies for case retention (provision of food, in patient health education, free accomodation) and for defaulting /retrieval (involvement of TB treatment success cases, community participation in sensitization) were implemented to optimize the treatment outcome.

The response to TB treatment was closely monitored at regular intervals by sputum microscopy. Most TB patients seen in R2 program treatment facilities smear converted at 2 months.

Clinical examination was used to monitor smear negative patients.

**3.4.3.1 Treatment outcome issues**

* Death from early TB presentation cases rare according to most TB program staff interviewed.
* After 2 weeks of the intensive treatment phase, most patients show marked improvement and can walk round facility unaided and looking healthy Most sputum conversion is at 2 months and above 75% for most facilities visited.



**PHOTO 6:** *Same boy in* ***photo 2*** *above after 2 months of TB medication. He is now strong and goes to school (courtesy of AAA).*

* Defaulting is a challenge. Some patients have to be held in the facility to finish their medication, such as the cattle camp residents. Their out of facility treatment adherence is poor. There is need to strengthen community DOTs in this areas.
* Sometimes relatives run away from patients if they stay too long in the hospital. The program in Bunagok is designed such that a relative provides support to the patient. This can spell a challenge to the patient in terms of feeding and hygiene issues.
* Soldiers also default a lot due to the nature of their lifestyle and work. Need to have a link with senior commanders on how to move forward on this.
* Generally, there were very few treatment failure cases initially in 2005, now even fewer cases are noted. This could be due to improvement in awareness and early presentation for treatment.
* A single case of re-treatment of a failure case who did not improve after 5 months and became an MDR suspect seen in Yei: wrong MDR specimen bottle was used to collect sample, which was rejected by the Laboratory in Nairobi. Patient ultimately died.
* Logistical challenge and unclear MDR suspect reporting channel is a challenge to SRs.

**3.4.4 Human resource development**

The R2 program recruited and trained both expatriate and local staff at PR, SR and TB facilities to plan, implement, monitor and report on the R2 program activities. The program envisaged that the local staff involved in the TB service implementation would be able to gradually take over the management of the TB program.

The R2 TB program identified and developed a crop of competent TB managers (Doctors, Clinical officers or Senior TB nurses) capable of running the basic TB treatment Unit and conducting active TB case identification and prevention within the community.

These managers were mostly expatriates.

Some of the other staff cadres found at the facilities visited included; Clinical officers, TB officers, Lab assistants, Laboratory technicians and technologists, Program support officers, Support workers and some Community health educators and mobilizers.

Some SRs felt there is need to have sufficiently experienced staff with medical background for disease specific positions within the UNDP to manage the programs effectively.

The TB Basic Treatment Units (BTU) had other staff like pharmacy assistants, cleaners, cooks and logisticians who offered the necessary support for the program.

**3.4.5 Infrastructure and equipments**

The program expanded DOTS activities to 12 new TB units which were constructed (in addition to 12 other pre-existing centres). Through resources secured from the R2 program, rehabilitation of more TB units took place. The program also supported the renovation and where necessary construction of accommodations for TB patients and their care givers, laboratories to perform smear examinations, drug stores, kitchen, pit latrines and showers. The grant also had provision for rehabilitation and maintenance of these infrastructures during subsequent years.



**PHOTO 7:** *A TB unit constructed with R2 funds and integrated into Lasu PHCC. Note the outreach van availed through R2 program.*

AAA, through R2 funds embarked on the **r**ehabilitation of existing PHCUs and incorporating TB services (e.g. Abuyung, Mingkaman and Awerial in Awerial county)

The Program helped the SRs to establish TB diagnostic services by procuring and supplying light microscopes and other laboratory equipment necessary for quality TB microscopy.

**3.4.6 Logistics: Method for prediction, Storage, distribution and monitoring of drugs and laboratory materials**

Regular and uninterrupted supply of drugs and laboratory materials was crucial for the success of the R2 TB control program in keeping with best practice to avoid MDR TB. PSF was the SR responsible for sourcing and recommending TB drug suppliers to the PR, choosing the best products at competitive price. The PR then handled the procurement whereas PSF offered central storage and distribution of these supplies to the facilities.

Each program partner requested drugs and consumables in quarterly manner on the basis of number and category of cases treated and number of microscopy examinations performed.

Most program partners visited reported constant availability of most TB drugs in sufficient quantity. No major stock outages reported. The shelf life of most of the drugs was mostly beyond 2011 and most SRs are managing their drug stock to optimize shelf life. SRs reported that “lead time” for drugs was not very long. Loose tablets are used within the facilities and blister packs used in the community DOTs.

Challenge with streptomycin-run out of stock from PSF central warehouse but only for 2 weeks in some TB units (Yei). Streptomycin is unavailable in the open market, so patients can sometimes suffer, even when they have the ability to buy the drug.

**3.4.7 Training: case management, microscopy, program management**

All cadres of staff responsible for R2 TB units participated in TB training courses organized by different R2 program partners such as the PR, SRs, WHO and NTP. After training, some trainees embarked on training of their colleagues in their respective TB units. Laboratory technicians and the staff in charge of pharmaceutical activities were trained on TB microscopy and on pharmaceutical supply management, respectively.

The Program gave a high priority to strengthening local technical and management capacities through recruitment and training of local personnel for the sustainability of the TB program



**PHOTO 8:** *Uniformed forces staff after a community leaders TB awareness training*

Most SRs training are planned for based on training needs identified and reflected in the AWP. TB training were conducted by TB officer or consultant, using any one of the following curriculums developed in collaboration with the NTP and other SRs.

* + TB/HIV training manual for CHW
  + TB/HIV training manual guide for community leaders
  + TB/HIV community-linked radio programme
  + TB/HIV testing guide for general health workers and
  + TB/HIV training manual for village health volunteers
  + Fact sheet on TB/HIV for community leaders

Technical training content is in line with MoH protocols and guidelines and WHO best practice. Most training is done on site. Trainings are mostly quarterly with the duration depending on the cadre of CHW being trained. For some cadres such as nurses or laboratory staff, training may be longer and out of site.

Some technical personnel, e.g. Lab technicians are trained for much longer period (18 months). Malteser health training institute in Rumbek trains some lab technicians to diploma level.

Some CHD staff have benefited from Human resource management, Fundraising and resource mobilization training. Supervisors’ training has also been extended to CHDs to help with DTLS (District Supervision of TB and Leprosy Services).

**3.4.8 Provision of commodities: food and other needs**

In Southern Sudan, TB cases, often coming from far places, require lengthy period of admission. It is therefore necessary to provide food for all the patients and for those accompanying them. Food shortage is often a main cause of treatment defaulting.

R2 program partners signed an agreement with WFP and other similar organizations (e.g. sign of Hope (Germany) for the provision of food to each of their location on the

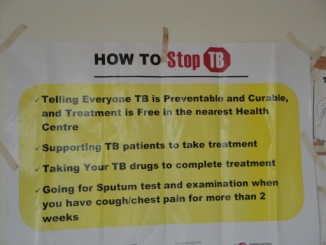
basis of the number of cases expected. Partners however procured contingency food when there were delays or shortcomings.



**PHOTO 9***:R2 program beneficiaries in the female TB ward at Bunagok TB Unit, Lakes state.*

Other forms of motivation for TB patients included the following;

* Free TB medication
* Free place to sleep
* Free education about TB and its problems
* Free transport where possible for patients



**PHOTO 10:** *A poster in the local language in Lasu PHCC, Central Equatoria*

**3.4.9 Program coordination**

The NTP was established as the TB coordination body under MoH in 2006 to ensure uniformity of TB implementation modalities among the different organizations and to chair the forum where partners would exchange their experiences.

Quarterly Coordinating Meetings are called by the CCM in collaboration with NTP and PR for the various TB partners to review the status of implementation of their programs, revise indicators and targets, identify constraints and possible solutions.

PSF coordinated pharmaceutical trainings, supply storage, transport and distribution.

Generally coordination of the R2 program was rated as good by the partners. PR staff at least visited facilities for supportive supervision. This was greatly appreciated by the SRs visited. The PR being a UN body, was expected to have unlimited capacity to coordinate the program better than it did.

Given the fact that the GFATM Coordinator position for the PR was vacant for a prolonged period of time, the PM TB for GF R2 was acting GFATM Coordinator as well as responsible for TB R2. That was seen as challenge by the SRs. All TB program related issues could not be dealt with quickly. The PM TB was always available for clarification and support before his workload increased. Currently the PM TB position is vacant.

That the grant has performed fairly well is testament to the fact that UNDP sought for SRs to take more activities and this is how WHO got involved in the implementation of this grant. On balance, the PR is doing the best under difficult conditions and context.

**3.4.10 Supervision: frequency and content, microscopy quality control**

Program partners each had a TB Coordinator who was responsible for conducting regular supervisory visits to each partners’ TB unit at least once in a quarter in order to monitor key program activities. At the bare minimum the supervisors reviewed all TB Treatment Cards, observed health workers doing their work, talked with health workers and TB patients, and inspected supplies and their storage.

The supervisors also checked the appropriateness of: diagnosis, classification and treatment of TB cases, management of supplies and TB recording system. At the end of the visit, the TB Coordinator would as a practice summarize their observations, and discuss with the TB unit staff the problems found and the appropriate actions to be taken.

Regular supervisory activities were conducted by NTP and CHD staff. Local TB unit staff were extensively involved in supervisory visits to strengthen the local capacity.



**PHOTO 11:** *A lab technician being trained in TB microscopy by NTPs Mr Habib.*

**For R2 SR TB treatment sites;**

* The program performance for most SR sites are internally measured using a quarterly implementation review organized by the SR for their management staff.
* Most SRs offered adequate supervisory support visits to their TB facilities, at least 3 times in a quarter offering both TB technical and M&E support.
* The SRs reported that they also got supervisory visit from PSF and the SRs learnt a lot from those visit in terms of drug stock management and storage.
* The SRs knew about the change over from PSF to Euro health as the supply agent, but had neither been formally informed nor visited by the Euro health team.
* The Yei County TB coordinator and surveillance officer also regularly visited the SR in Yei.
* The NTP also regularly offered technical support in a quarter to the facilities. Mostly the NTP manager and the trainer in charge of the laboratory standards made frequent visits
* The CHDs officials do carry out supervision and coordination roles (on behalf of NTP) at their respective counties. Most CHD staffs are unaware of the source of TB program funds, but have good working relationships with the SRs providing TB services within the counties. They are involved in planning outreaches and TB site supervision. Generally the CHD staff felt the SRs were doing a good job, trying their best under very difficult circumstances.

**3.4.11 Community engagement and Partnership development**



**PHOTO 12:** *TB awareness session at church in Yirol, Lakes state.*

The R2 program gave priority to community participation and explored all possible measures in this regard. Some measures employed included; health education and using a local CHE nominated by the community for the support in defaulter retrieval and for assessment of close contacts of smear positive cases. The program also organized and held massive TB community awareness /outreaches and offered mobile diagnostic services.

As for the TB awareness for the Community using a CHE;

* Most TB sputum positive clients are asked to choose a “TB treatment supporter”, who is educated on TB and its treatment. S/he offers support to the clients after discharge from the facility.
* Most facilities engage in 2 months intensive TB medication within the facility and then 4 months of community DOTs (continuation phase).
* Through the CHD, focal person is nominated by the community to act as the TB CHE
* These CHE are supported by community mobilizers to create awareness about forthcoming TB outreaches.
* They meet community leaders, and call meetings and educate the community on TB as a disease, its prevention, treatment and other relevant health care seeking behaviour.
* They then refer suspects for TB screening at diagnostic facilities.
* They deliver TB medication to patients who are due for medication but don’t show up. They follow up patients and trace defaulters, in collaboration with auxiliary nurse and other facility staff.
* They distribute IEC materials in local languages to communities.
* There are regular meetings between the CHE and the facility staff which act as evaluation meetings to share experiences.

**3.4.12 Collaboration**

The program developed collaboration with, but not limited to, the following partners during its lifetime;

* CCM (Italy) in Bunagok where TB referrals are received from the CCM run PHCC.
* Government run PHCUs in Minkamang.
* WFP for in-patient feeding program in most facilities.
* Sign of hope for in-patient feeding program in Yirol.
* Norwegian Red Cross who integrated TB services in Nyang PHCC
* Yirol County Hospital, whose staff were trained in TB case finding and referral
* Many churches used for TB awareness and referral of patients
* The R2 Malaria Program PHCCs used to find new TB cases

**3.4.13 Some of the Positive elements that enhanced R2 program success / achievements**

* On balance, SRs believe there was good cooperation with PR.
* Availability of regular and adequate TB drugs and supplies, including lab kits and registers from PR, MoH and PSF
* Expanded NTP and WHO teams helped implementation of some activities within a short time. Support from NTP to open up new TB units like Lui Hospital, Mundri Town PHCC reduced journey time for some TB patients.
* After the signing of the LOA, UNDP transferred the money promptly to the some SRs and the funds were available to implement the activities immediately.
* Well motivated and competent SR staff in the field and at Juba level made program implementation possible.
* Relatively stable security conditions in majority of the counties of SR operation made most of the activities to be implemented safely.
* Fairly sufficient financial resources from GF for implementation of TB control activities
* Good experience of the SR staff in local area and knowledge of communities came in handy to navigate local challenges faced.
* Good relation with different relevant stakeholders like community leaders, local governmental staff enhanced uptake and community ownership of the program

**3.4.13 Major R2 program SR constraints**

1. **Institutional and Programatic challenges**

* SRs were too few for the R2 TB program to achieve the expected targets. Not many actors were/are interested in implementing TB programs in South Sudan.
* Conducting trainings in Southern Sudan is quite expensive and hence not all the targeted staff could be trained.
* Lack of critical staff or if available, they are poorly motivated since most local personnel at the PHCCs are not TB program staff and so salary challenges.
* When some SRs e.g. WHO, WVI agreed to take some activities, there was very little time left before the end of the grant and so they committed to undertake limited activities
* Delay in disbursements from PR for some SRs: e.g. Malteser reported receiving first installment, then no installment for 1 year, then again six months delay. According to the PR, the PCA prescribes that fund disbursement depends on the SR deliverables, i.e. if SR does not spend the allocated fund, the next fund transfer will be delayed too.
* On some SR claim that PR gives short notice on deadlines for reporting, important visits and data quality assessments, the PR clarified that it only requests SR reporting as per PCA and the deadline is clearly stated in the PCA.
* Sometimes UNDP requests are in conflict with grant agreements signed between PR and SR for instance deadlines of reporting, supporting documents etc
* Poorly motivated staff at PHCCs especially laboratory technicians -due to lack of or irregular salaries- still hinders full integration of TB services into the BPHS
* Delay in delivery of requested program equipment such as laptops and printers for some SRs.

1. **Contextual factors (Socio-economic, political and geographical)**

* Participants from some areas could not be trained as they were not able to travel due to Security reasons.
* Insecurity in Mvolo, Ibba, Yei, (LRA attacks) Akot, Cueibet (tribal clashes) limited movement of SR staff in terms of case finding through outreaches and case follow up. This limited the number of new smear positive cases identified and the number of TB patients who completed treatment.
* Lack of food for the TB patients admitted during intensive phase in Lui hospital. Many of these patients came from far places like Mvolo, Yeri, Lakamadi. Such patients would consequently default treatment.
* High mobility due to social pressure such as water scarcity, poor pasture outlook and insecurity among the populace makes them not complete full course of treatment.
* Challenges with defaulters, particularly mobile populations affecting treatment outcome. Mostly affect cattle camp residents and soldiers who are the major TB sufferers in some regions.



**PHOTO 13:** *The TB program officer (lady in black)standing with young men after a TB outreach at a cattle camp.*

* Difficult working environment with scarcity of water and most basic hygiene and sanitary services.
* Weak TB control strategies at the community (PHCC) level burdens the facilities.
* Poor road network which are unusable during rainy seasons.
* Floods are a challenge during rainy season. Risk of malaria infection is high.
* Tribal clashes and inter-ethnic tension hamper service uptake. Some local staffs become potential targets/victims because of their ethnic leanings.
* Some TB patients are traditionally scarred by traditional healers as a form of treatment for some extra pulmonary cases which manifest as swelling. Their intervention is neither effective nor efficacious. This is a challenge since eventually this clients present late to the TB facility, thus compromising treatment outcome.



**PHOTO 14:** *The lower back “scarying” typical on a TB patient!*

1. **Procurement and logistical**

* Logistical challenges of few program cars and frequent breakdown.
* Shortage of supply of some anti TB drugs (especially Streptomycin) and diagnostic supplies from the NTP. This briefly affected case finding and treatment activities.
* Delay in procurement of some supplies. Some supplies e.g. laptops and printers have never been delivered till now yet the grant is about to close. This was however because the budget went to drugs.
* Some reagents are delivered when already constituted, affecting the outcome of results.
* Some Facilities lacked functional labs

**3.4.15 Suggested ways to improve TB services as identified by SRs;**

* Engagement of TB treatment success clients to advocate for TB prevention and suspect follow up at the community.
* More training for the TB program staff.
* Recruitment and training of more laboratory personnel.
* Transport facilitation for TB suspects
* More TB service integration into PHC.
* CHD should be supported to supervise TB and other vertically run programs effectively. They need to clearly understand their role in the sustainability of these programs.
* Strengthen government structures and systems such as NTP, laboratory networks, CHD support framework, payroll access etc.
* Train more CHE
* Government needs to absorb some of the critical TB program staff onto the government payroll.
* Supply the reagents in powder form so that the end user constitute in ratios they deem appropriate.

**3.4.16 Conclusion**

TB R2 grant was poorly formulated, due to poor assumptions/data used for baseline calculation and immense conflict of interest issues by INGO during proposal writing in 2003. The PR was minimally involved in the R2 proposal writing.

On balance, the R2 performed satisfactorily considering that the environment in which the grant was implemented was a conflict/post conflict one with immense infrastructural, logistical and human resource challenges. Five indicators performed above 75% whereas 3 performed below 35% due to poor target setting among other reasons. The PR, SR and all stakeholders did their best under very difficult circumstances.

There is skepticism about the proposed TB program transition from SRs to MoH. Most SRs noted that there were mild signs of the MoH taking over R2 activities, let alone managing the whole TB program. The worst case scenarios envisaged is for the facility to be abandoned by TB staff after the SR has handed it over to the government, due to lack of funds. In that case, TB patients will be left unattended to.

Therefore CCM and PR should work out a way to dovetail some R7 with R2 activities.

At its close out in March, 2010, the R2 will leave in place a robust TB program that is hopefully NTP led, still in need of serious commitment in both financial and human resource capabilities to further expand TB services to the deserving people of South Sudan.

# 4.0 Lessons learnt

The R2 program offered many opportunities to learn about TB and other program planning, implementation and monitoring and the following are a few;

* Effective Program performance requires strong SR institutional and organizational capacity, responding to timely data compilation, collation and computation. Delays by PR in ensuring timely training, procurement and supply of key inputs like laptops and printers to the SRs in turn leads to delay in meeting program deadlines and targets.
* SRs work in very difficult socio-economic, geographical and political environments. Proper logistics supporting regular and adequate supplies usually ensure continuity of service provision even when there is an emergency situation.
* Reports submitted to the PR by the SRs capture all the programmatic and financial updates of the agency. SRs have found the feedback from the PR to be very useful in terms of guidance on program adjustments needed to comply with known best practice or PR guidelines and protocol. PR should therefore continue with the regular performance feedback to SRs through emails and meetings to discuss implementation progress and challenges.
* The human resource needs of South Sudan is immense and there is a high staff turn over for SRs. PR should continue regular training/retraining in M&E, Finance and grant management for the SRs and based on needs as identified from the performance of the SRs to consolidate the capacity to adequately deliver services.
* In the early days of the program, stigma and discrimination against TB patients was high within communities. Effective TB medication and support heralded an era where fewer people died from TB, as most patients walked home looking healthy. Engagement of TB treatment success clients to advocate for TB prevention and suspect follow up at the community is the best way to fight TB stigma and discrimination at the community level.
* One of the most effective ways of creating TB awareness is by use of visually appealing IEC materials such as T-shirts, caps, posters and leaflets which even the uneducated can appreciate. R2 used this approach effectively and reached many people with TB message.
* Surveys and studies are essential for guiding programs to respond to identified factors influencing particular aspects of a program. The experience with the R2 program shows that surveys are expensive and sometimes not a priority for a nascent program like the TB one. More effort should be directed towards effective and efficient collection of routine data.
* Having an M&E expert based at the PR GFATM Unit at all times makes the team to be responsive to M&E demands of partners as evidenced by one staffs’ comment: “It was difficult to find say a report of Malaria Q8 a year ago. It is now easy because the system has been put in place!”
* Sitting at facilities and waiting for self referred TB patients may not work in some circumstances. The strategy of intensified mobile TB awareness outreach coupled with TB diagnostic services is the best approach to bring TB services closer to the people.
* Community outreaches are planned and carried out by CHE. The CHEs need to be trained and established as focal points for training at community level to train community HCW consistently to ensure sustainability.
* Proper PSM is core to the success of any TB management program because of the forecast and supply challenges. The R2 program performed well in PSM because of diligent PSM. For sustainability purpose, PSM needs to replicate its work at the state and county level to build the local capacity in PSM.

# 5.0 Recommendations

The review team strongly recommends the following;

* The PR and MOH, GOSS needs to Strengthen the capacity of NTP to manage the program at SMoH and County Level as a long term strategy
* The CCM and PR should dovetail some of the R2 activities to R4 and R7
* CCM should have a technically competent committee that will review all country proposals to identify any artificially calculated indicator, offer a platform for discussion with all stakeholders and map out the strategy to inform the GF secretariat.
* Technically competent bodies such as (WHO, UNICEF, UNAIDS) should be involved at the planning and implementation phase of all GFATM programs for quality assurance and technical standards
* PR should focus on strengthening government systems so that the transition of PHC management moves form SRs to government.
* PR should have prompt planning for and implementation of GF program activities.
* PR should strengthen its collaboration with TB stakeholders and offer capacity building support SRs
* PR should recruit sufficiently experienced staff with medical background for disease specific positions (HIV/AIDS, TB and Malaria) within the UNDP to manage the programs effectively.
* PR and the SR should adhere to the signed PCAs and always refer to it to avoid misunderstanding during program implementation.
* The PR should link up with M&E department, under the Directorate for planning and research and work out the modalities of harmonizing the M&E systems of the two entities.

# Annexes

## ToR for the evaluation

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| undplogo2  TERMS OF REFERENCE  End of program GFATM-UNDP  TB Round 2 and Malaria Round 2   |  | | --- | | **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.   |  | | --- | | **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.   .   |  | | --- | | **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.  |  | | --- | | **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.   |  | | --- | | **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;   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.     |  | | --- | | **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** | |  |  |  |  |  |  |  | |  |  |  |  |  |  |  |  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  .   |  | | --- | | **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.  |  | | --- | | **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.   |  | | --- | | **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.   |  | | --- | | **10. Time Frame** |   The evaluation consultancy is tentatively scheduled to take place from **February 8-March 19, 2010**   |  |  | | --- | --- | | **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** |  |  | | --- | | **11. Reporting** |   The consultant(s) will be reporting directly to UNDP Global fund coordinator and CCM chairperson.   |  | | --- | | **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  |  |  | | --- | --- | | **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 |  |  |  | | --- | --- | | 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. |

# Data collection instruments

**B.1: Sub Recepient Evaluation**

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| **End of term evaluation of GFATM-UNDP**  **TB Round 2**  **February- March, 2010**  **South Sudan**  **Sub Recipient EVALUATION TOOL**  **Name of Respondent………….Title :…………….Organization:……………………………**   1. What is the main Focus area for your organization within the TB Program? 2. How long has your organization been involved with the GFATM Round 2 TB Program? 3. What has been your specific responsibility in the Round 2 TB R2 programme within your organization? 4. What do you understand to be the role of your organization, as a Sub recipient, in the implementation of the TB R2 grant? How do you measure your performance? 5. To what extent was your organization involved in the proposal development, Planning, designing and implementation of the TB R2 program? 6. What are the key achievements registered by your organization during the GF R2 grant life time? 7. What positive elements contributed to the above achievements? 8. What were the main constraints that limited your achievements in the TB R2 program? 9. Are you aware whether the GF TB R2 program was ever evaluated at the mid term?   If yes were the results of the evaluation ever used by your organization to improve the implementation of subsequent phase?   1. Did UNDP GFATM Unit effectively facilitate your implementation of the R2 TB program? In which key areas was the UNDP facilitation useful? 2. Which areas did the UNDP not effectively facilitate implementation of the R2 TB program? 3. What were the reasons for the poor facilitation? 4. How do you rate the overall UNDP supervision and oversight of the TB R2 program? (Poor, fair, good, excellent). Explain your rating. 5. Are there any specific issue/s you strongly feel impacted your performance during the implementation of the TB R2 program? 6. Were there, if any, specific areas where the UNDP performed exceptionally well? 7. What are your general comments, if any, on the competence and performance of the UNDP as a PR? 8. Do you have any specific concerns about capacities and competences of UNDP? 9. Any plans for continuation of the R2 TB services, with this grant closing in March,10? 10. What are your recommendations for improving TB grant performance for your organization, the UNDP and the government next time round?   **NB:** Please provide an indicator matrix showing **all the indicators** your SR agreed to report on showing **annual targets, actual achievements and cumulative figures** for the whole lifetime of the grant. |

**B2: Facility Evaluation**

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| **End of term evaluation of GFATM-UNDP**  **TB Round 2**  **February- March, 2010**  **South Sudan**  **FACILITY EVALUATION TOOL**  **TB Facility:………Boma:………Payam:…………County:………………………… State:……………………Sub Recipient Name:…………………………………………**   1. What TB services are offered at this facility? 2. State the number and cadres of TB staff at the facility   Doctors…… Clinical officers………. nurses……….  Laboratory technician/s……………..  Community mobilizers…Others……………………..   1. What types of in service training related to TB program was undertaken by each of the above cadres? What curriculum was used? 2. Are TB diagnostic laboratory services available at the facility? What quality assurance measures are in place at this facility? 3. Are TB drugs available at the facility? Any TB drugs stock outs reported at this facility? If yes, how many times? 4. Please respond briefly to the following in facility TB program matrix;  |  |  |  | | --- | --- | --- | | **Activity** | **Challenges** | **Solutions** | | a. Case detection |  |  | | b. Sputum conversion |  |  | | c. Treatment outcome |  |  |  1. How do you keep TB records? Can the records tell: “Numbers of clients diagnosed and treated successfully in the last one year?” 2. Do you receive support supervision visits from your main office or UNDP? If yes, how many times for each? 3. How does the facility engage the community in the TB service delivery? 4. Any major challenges faced at the facility in terms of health service delivery? 5. How best can TB service delivery be improved? |

**B3: Beneficiary Evaluation**

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| **End of term evaluation of GFATM-UNDP**  **TB Round 2**  **February- March, 2010**  **South Sudan**  **BENEFICIARY EVALUATION TOOL**  **Number of respondents for FGD:……………………………………………… Venue:………………………..**  **Boma:……………………. Payam: ……………………………………………..**  **County:……………………………………… State:…………………………………**   1. What is your view about the TB burden in this community before the start of the TB program at this facility? 2. Has there been any change in the TB burden within the community since the TB program was started to date? 3. What could have contributed to the change in the burden of TB within the community? 4. Are TB diagnostic and treatment services always available at the facilities near you? 5. What benefits have you enjoyed from having the TB facility within your community? 6. What challenges do you face in accessing TB services within the community? 7. How can the TB service delivery be improved to serve the community better? Any suggestions? 8. Are there any regular awareness and education activities on TB prevention and treatment organized within the community? How frequent and by whom? 9. Any other comment?............................................................................................................ |

1. **Summary activities for the End of Term TB 2 Review**

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| **Time Frame** |
| The evaluation consultancy took place from 1st Feb – 12th March 2010   |  |  | | --- | --- | | **Activities and time frame** | | | **Evaluation Team** |  | | Orientation with CCM and PR, finalized and agreed on ToR , revision of Plan of action, avail documents, evaluation of methodologies, desk review of relevant of documents, interview with CCM members and PR | 2nd – 5th February 2010 | | Desk review | 8th-12th February 2010 | | Discussion with SRs and PRs | 15th-19th February 2010 | | Field visits to selected SRs implementation sites and health facilities to see program implementations | 20th- 2nd March 2010 | | Preparing draft report, using power point presentation | 10th March 2010 | | Incorporation of comments and submission of final report with clear set of recommendations | 12th March 2010 | | **Total days for consultancy are 6 weeks.** | | |

1. **List of individuals interviewed**

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| **No** | **Name** | **Title** | **Organization/Location** |
| 1. | Dr Baba Samson | Chair, CCM | MoH, GOSS |
| 2. | Gerrard Van Mourik | GFATM coordinator | UNDP |
| 3. | Dr Tedla Mezemir | TB program manager | UNDP |
| 4. | Dr Richard Laku | Director, M&E | MOH |
| 5. | George Cornway | D/Head of Office (Prog) | UNDP |
| 6. | Yonas Bekele | M&E Specialist | UNDP |
| 7. | Amanda | LFA focal point | KPMG, Kenya |
| 8. | Willy Otieno |  | COSV |
| 9. | Dr Severin Kabakama | Health Coordianator | WVI |
| 10. | Dr Mubeezi Micah | Medical coordinator | Malteser |
| 11. | Asja Hanano | Country Coordinator | Malteser |
| 12. | Dr Lasu Hickson | Program Manager | NTP |
| 13. | Dr Lou Peter | D/Program Manager | NTP |
| 14. | Dr Philip Ejikon | TB focal Person | WHO |
| 15. | Albino Chweya | Payam Administrator | Bunagok Payam |
| 16. | Henry Ambrose | CHD Coordinator | Yirol West County |
| 17 | David Okello | Admin. Consultant | CCM |
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1. **Groups interviewed and Sites visited**

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| **Locations of FGD interviews** | **Names of respondents/Titles** |
| 1. Bunagok TB Unit   Aguarkuoth Boma, Bunagok Payam, Lakes State.  SR: AAA | * Doris Muthiani, Program Officer * Mangar Peter Puol, Lab. Assist. * Abraham Akuot, Nurse Assist. * Kejo Geng, Lab Assist. |
| 1. Bunagok TB Unit Beneficiaries who had successfully completed their TB treatment. | * Gabriel Atem (from Gogrial) * Rachel Achol (Awerial) * Rebeca Nyajok (Awerial) |
| 3. Bunagok TB Unit, In patients still undergoing the intensive phase of treatment | * Sarah Akur (Alel payam) * Mary Kona (Abuyung ) * Jacob Majak (Magok) * Martha Nyie (a care taker) |
| 4. Yirol West PHCC | * Lucia Mwema, TB nurse * Benjamin Bol, TB officer * Samuel Machar, Nurse * Gladys Pimer, Nurse * Joseph Mabuor, Nurse * James Pial, Lab Assist. |
| 5. Yirol PHCC TB unit beneficiaries, successfully treated for TB and discharged | * Ayen Pecheal (from Wunthow) * Majuk Dak (Husband to Ayen) * Rebeca Lou (Yirol) |
| 6. Yirol PHCC In patient beneficiaries | * Abdallah Wel (from Mapuordit) * Kuot Marial (from Pagarao) * Arop Chok (from Pagarao) |
| 7. Malteser Yei Hospital (Specialized Unit)  Yei Town Boma, Yei Town Payam, Yei River County, Central Equatoria State | * Drani Joackin, Program Coordinator, Yei Office * Flora Bukania, Health Project Manager * Birungi Charles, Liason and Capacity Building coordinator |
| 8. Malteser Yei Hospital in patient beneficiaries | * Justin Lukeji, from Kupera * Martha John from Bor * Benjamin Lubari, Nurse from Lasu * Alex Lumoro Sebbit, Lasu * Christopher Estans from Wau * John T. Dawa Stephen, from Mundri |
| 9. Lasu PHCC | * Modi Chaplin, Auxillary Nurse * Daniel Abugor Elisa, CHE * Odison Mabe Martin, CHE * Peter Lagu Paul, CHE |

1. **List of supporting documents reviewed**

* TB R2 proposal for South Sudan
* SUD-202- 602-T-00 Grant agreements
* Disbursement requests
* Grant performance
* Grant score cards
* PME hand book
* TB managers hand over report
* Vouchers for reimbursement F10
* PUDR SUD-202-G02-T-00
* Model SR Agreement
* Final AWP TB R2

1. **Beneficiaries stories**

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| **The beneficiaries’ responses to evaluation questions as recorded by the Evaluation team**  **On TB burden within the community before the start of the TB program**  Most respondents reported that long ago there much suffering related to an unknown disease that made people cough. Some people would say they were cursed and would consult magicians. They would not be healed.  For those who coughed out blood, it would be said they have been “poisoned!” creating fear and mystery around the “disease that made people to cough”.  The problem was that many people were not aware what was killing them. Coupled with that was the fact that nobody knew where to get the proper drugs to cure the disease.  Those who had cattle would sell them and use the money to seek treatment in far place (such as Bor in Jonglei states and Arua in Uganda). The poor had no way out but to resort to local medication which was rather ineffective and put the patient at risk of bleeding since part of the treatment involved cutting some body parts.  One former TB patient reports that she was abandoned by her husband when she fell sick for a long time. She was isolated from the community. Thanks to the free TB medication she received from the program, she recovered and is re-united with her husband and is a strong TB community mobilizer.  **Any change in the TB burden within the community since the TB program was started**   * Most people within communities surrounding TB units are aware about TB disease, its prevention and treatment. There is still need to go beyond the current communities covered by DOTs. * This TB program has helped many people. Mostly in areas where the TB services are found. As for the other areas without TB services, the TB problem may be great but nobody knows. There may be need to go there and find out the magnitude of the challenge. * After 2 weeks, even for the bed ridden, there is marked improvement of the patient, the in patient beneficiaries reported. One patient reported coming to hospital, being wheeled on a bicycle, but after a week of medication he could walk unaided to the market and back to the facility. * Gabriel Atem, a beneficiary who was interviewed was the first TB patient admitted to Bunagok TB facility and successfully treated in 2005. Was discharged after 6 months but was re-admitted after one and half years. The second treatment was better and he has been okay ever since. * Some wasted patients come to the program TB units for the initial 2 months medication and go back home having put on some weight and looking healthy. Community members notice the difference made by the care given to these patients. Such patients serves as “model” patients, using their newly acquired TB knowledge to create TB awareness within their communities. * There is less news of so and so died of the “disease causing people to cough” in most communities where there are TB services. * Free TB drugs, accommodation and food given at the TB facilities have improved TB self referral cases for the program.   **Factors that contributed to the change in the burden of TB within the community**   * Those community members who heard and responded to the TB awareness message early managed to save themselves and survived. Those who did not died. * And some people who were successfully treated would be seen by the community members looking healthy and this would motivate more patients to come to the TB unit. * The TB mobilizers educated people on what TB was, how it can be prevented and where to go when one coughs for a longer than 2 weeks, and has not healed. There, they would be examined and then given TB medication once found with TB.   **TB diagnostic and treatment services availability**   * Most beneficiaries reported that apart from the facilities visited, there were generally no TB services within their communities. And that TB services were far apart, necessitating moving for long distances to get the service.   **Motivation for TB treatment included the following according to respondents;**   * Free TB medication * Free place to sleep * Free food * Free education about TB and its problems   **Challenges faced in accessing TB services within facility/ community?**   * TB is still highly stigmatized within the community * Some communities that are far off don’t have TB services. * Poor attitude where people just ignore illness till it gets serious and kills them. * Some in patients are dissatisfied with the diet offered to them at facility. * Some communities still live in crowded spaces making TB control difficult * Food given in some facility is semi processed and thus puts more burden on the patient, especially if s/he is unaccompanied by a relative. * Lack of lighting at the facility at night is a challenge, seeing that some washrooms and toilet are far from wards. It can be scary. * Challenge of fresh, clean water in some areas. * There is a challenge of very warm temperatures in the wards, causing difficulty to sleep for patients. * Challenge of insecurity within some areas can hamper TB outreach activities.   **Suggestions for TB service delivery improvement to serve the community better**   * Mobilization needs to be massively carried out to reach more people within the community * More TB treatment success cases should be used to fight TB stigma within the communities where they come from. One former TB patient reported that now she dispels stigma in the community by saying: “No more slaughtering of chicken and cows (a common practice in her culture where TB is seen as a taboo that needs to be warded off by blood)…there are TB drugs available now!” * Food for patients should be available in sufficient quantity and quality. * Patients should get their drugs from nearest PHCCs to their location to minimize moving long distances. * Food given to patients should be in a form suitable for consumption and not semi processed, putting more burden on the patient or caretaker. * Training of more former TB patients as CHE * Patients face transport challenge to and from TB units to honor appointments and pick food and drugs. * Regular supervision of TB services within the community to gather the views of the community on TB program performance   **Other comments**   * “ We appreciate all the services provided by this facility and since the road has been opened, more patients will come. This good service should never stop!”   Mary Kona, Bunagok, Commenting about the TB services at Bunagok TB Unit.  “Most private clinics are money minded and don’t offer proper care, so we need to need to support Malteser to continue its good work by opening more such facilities in communities so as to stop TB in South Sudan” Christpher, Yei |

**I: Indicator matrix showing R2 program Achievements as of Sept, 2009.**

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| **Indicator** | **Target** | **Achievement to date** |
| Number of new smear positive TB cases detected under DOTS (baseline included) | 10,075 | 3,389 |
| Number and percentage of new smear positive TB cases registered under DOTS who are successfully treated | 771 (85% ) | 314/420 (74%) |
| Number and Percentage of new smear positive TB cases registered under DOTS who smear convert at 2 month of treatment out of  all new smear positive cases registered under DOTS | 923 (90%) | 363/435 (84%) |
| Number of TB units involved in DOTS with sufficient drugs and laboratory supplies and adequately staffed out of all TB units  supported by GF | 153 | 31 |
| Number of TB health workers trained / retrained in diagnostic, treatment, case holding and information system | 1,572 | 1,268 |
| Number of Laboratory Assistants trained/retrained in TB microscopy | 312 | 291 |
| Number of community health workers trained to support DOTS | 2,608 | 2,598 |
| Number and percentage of TB units submitting accurate, complete and timely reports | 153 | 21 |
| Number of villages/communities with a trained community health worker to support DOTS | 1,668 | 1,199 |