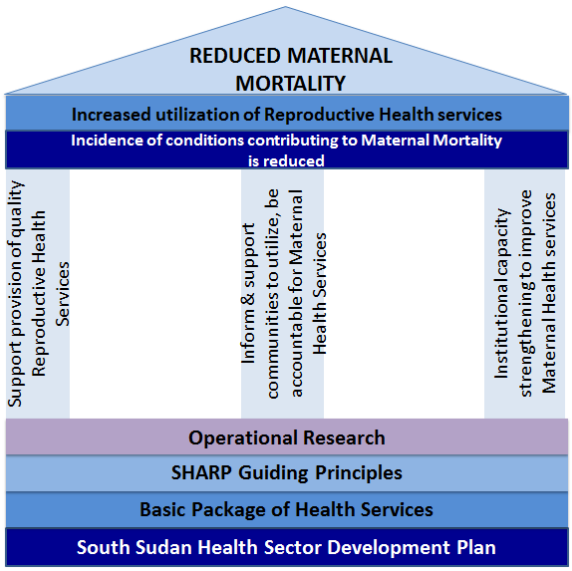
SHARP
South Sudan Health Action Research Project

KIT Project number 2100578.03



External Evaluation Report

" One maternal death is one death too many"

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Acronyms

ANC	Antenatal Care
ASRHR	Adolescents Sexual and Reproductive Health Rights
AYSRH	Adolescent and Youth Sexual and Reproductive Health
BCC	Behaviour Change Communication
BEmONC	Basic Emergency Obstetric and Neonatal Care
BHC	Boma Health Committee
BPHNS	Basic Package of Health and Nutrition Services
BSF	Basic Services Fund
BS	Birth spacing
CB	Capacity Building
CBO	Community Based Organisation
CC	Country Coordinator
CEmONC	Comprehensive Emergency Obstetric and Neonatal Care
CF	Community Facilitator
CHD	County Health Department
CHW	Community Health Worker
CMC	Country Management Committee
CMO	Community Mobilisation Officer
CMW	Community Midwife
CORDAID	Catholic Organisation for Relief and Development Aid
CPO	Community Participation Officer
CPR	Contraceptive Prevalence Rate
DAC	Development Assistance Committee
DGIS	Directorate General International Cooperation
DHIS	District Health Information System
EmONC	Emergency Obstetric and Neonatal Care
FANC	Focused Ante Natal Care
FP/BS	Family Planning / Birth Spacing
GBV	Gender Based Violence
HF	Health Facility
HHP	Home Health Promoter
HMIS	Health Management Information System
HNTPO	HealthNet TPO
HPF	Health Pooled Fund
HQ	Headquarters
HR(H)	Human Resources (Health)
HSDP	Health Sector Development Plan
HSS	Health Systems Strengthening
IDP	Internally Displaced Person
IMA	Interagency Medical Assistance
IMC	International Medical Corps
IOM	International Organisation of Migration
IP	Implementing Partner
KIT	Royal Tropical Institute
L&D	Labour and Delivery
L&M	Leadership and Management
MDG	Millennium Development Goals
MDTF	Multi Donor Trust Fund
M&E	Monitoring and Evaluation
MISP	Minimal Intervention Service Package
MMR	Maternal Mortality Rate
MoH	Ministry of Health
MPH	Master Public Health
MSF	Médecins Sans Frontières (Doctors without Borders)

MTR	Mid Term Review
NBeG	Northern Bahr el Ghazal
NGO	Non Governmental Organisation
NPE	Norms, Preferences and Expectations
OECD	Organisation for Economic Co-operation and Development
OJT	On the job training
OR	Operational Research
PHCC	Primary Health Care Centre
PHCU	Primary Health Care Unit
PMC/T	Project Management Committee/Team
PMTCT	Prevention Mother to Child Transmission
PNC	Post Natal Care
PPH	Post Partum Haemorrhage
QA	Quality Assurance
QPR	Quarterly Progress Report
RH	Reproductive Health
RMM	Resources Mobilisation & Mapping
RRHP	Rapid Results Health Project
SBA	Skilled Birth Attendant
SD	Service Delivery
SDG	Social Development Goals
SHARP	South Sudan Health Action and Research Project
SPLA	Sudanese People's Liberation Army
SS	South Sudan
SSI	Semi Structured Interview
SSIP	Sharp State implementation Plan
SMoH	State Ministry of Health
SRH	Sexual and Reproductive Health
TBA	Traditional Birth Attendant
ToR	Terms of Reference
UN	Upper Nile
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
VfM	Value for Money
VHC	Village Health Committee
WB	World Bank
WBeG	Western Bahr el Ghazal
WYPR	Women Year Protection Rate

Executive Summary

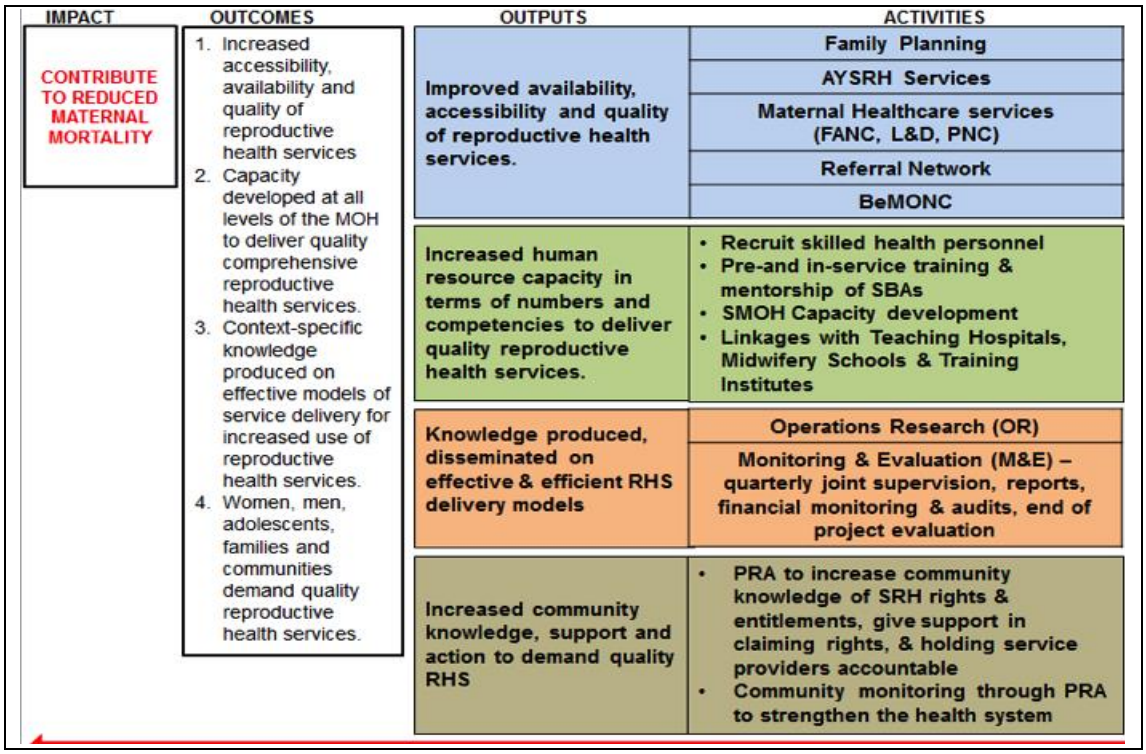
Project summary

The South Sudan Health Action Research Project (SHARP) aimed to contribute to reducing maternal mortality and increasing access to maternal health care in the states of Northern Bahr el Ghazal (NBeG), Western Bahr el Ghazal (WBeG) and Upper Nile.

The project was implemented by a Consortium consisting of the Royal Tropical Institute (KIT) in the Netherlands as lead and fund manager and three implementing partners (IPs) operational in South Sudan: HealthNet TPO (HNTPO), International Medical Corps (IMC) and Cordaid.

The project was formulated in response to a call for proposals, issued by the Sexual and Reproductive Health and Rights (SRHR) Fund of the Dutch Ministry of Foreign Trade and Development Cooperation (DGIS) in 2012. DGIS granted Euro 8.3 million for the project, which was to run from early 2013 till the end of 2015. Later, a no-cost extension of one year was granted.

The intervention logic as defined in the Inception report (2013) is presented in the figure below.



The three IPs mainly focused on the first two objectives and on community monitoring while KIT implemented the research component and governance capacity building and developed/implemented the community dialogue approach. All four consortium partners were involved in monitoring and evaluation at their respective levels.

Context

The proposal was written and approved in 2012, 7 years after the CPA (Comprehensive Peace Agreement) of 2005 and soon after South Sudan's independence in 2011. It was a period with relative stability and security that had led to an atmosphere of optimism and drive towards 'development' away from the previously predominant 'humanitarian way' of engagement. However, unexpected and unpredictable insecurity and fragility marked the country since December 2013 when a violent conflict erupted in Juba and soon spread to other parts of the country. Upper Nile was affected most and periods

of heightened insecurity seriously hampered the implementation of SHARP. Conflict also hit Wau County early 2016 and Juba in July 2016. NBeG remained relatively stable.

Objectives evaluation

SHARP formally ended by 31 December 2016. This final evaluation has the double purpose of looking back and assess achievements as well as learning lessons that might be useful for future undertakings in promoting SRHR in fragile settings.

Methodology and limitations

The evaluation entailed a desk based document review including an analysis of the monitoring and evaluation (M&E) framework combined with interviews of key stakeholders through face-to-face meetings, Skype, telephone and email. Verification of information and triangulation of findings was done as far as possible, but was limited due to the impossibility to visit South Sudan and meet with beneficiaries and key stakeholders in Juba and project locations, due to deteriorating security. Standard OECD-DAC evaluation criteria of relevance, effectiveness, efficiency, impact and sustainability guided the evaluation. Project design, management and governance, including M&E, as well as five guiding principles were reviewed.

Project design, governance and management

SHARP's intervention logic was designed from a post conflict development perspective, investing in health system strengthening and building the nation, moving away from a humanitarian mode. The four main pillars (outputs) of SHARP addressed both the supply and the demand side of reproductive health care. Governance structures were set up at the various levels engaging mainly the four consortium partners. KIT led the consortium with the ambition to be equal partner and implement several major activities in the field (community and research component as well as governance capacity building) in addition to its responsibility as fund manager and overall project manager. The project management team (PMT) was relatively small with part-time staff in Amsterdam and a country coordinator (CC) based in Juba for the first 1.5 years. This construction proved not satisfactory and KIT opted for reinforcing the Amsterdam based project management. As a result the consortium structure weakened in terms of collaboration and exchange between IPs, while the direct communication between PMT and IPs intensified. The Ministry of Health (MoH) played an advisory role on request, both at national and state level. Project governance structures proved conducive for joint planning and review, but more proximity to the field in project management would have strengthened the consortium and responsiveness to the changing context. KIT acknowledges that it underestimated the complexity of SHARP and the implications of managing a project of this size in the South Sudan context and within a limited timeframe.

Guiding principles

SHARP design and implementation were generally effectively guided by the following principles: (1) state and county level focus; (2) alignment with key policies of both donor and recipient country; (3) harmonization with the main health care funding mechanisms and SRH projects in the target states; (4) complementarity of SHARP to existing reproductive health interventions as underscored by the MoH in Juba; (5) coverage in terms of number of counties and population. Alignment, harmonization and complementarity were effectively pursued. The state level focus did not come out very clearly and was strongest in WBeG and the initial ambition to cover eight counties and at least 750,000 people was not reached.

Monitoring and evaluation

A robust M&E framework as prerequisite for effective project management was initially lacking but developed over time. It guided the monitoring of progress, results and outcomes as well as reporting. Monthly updates, quarterly narrative, financial and indicator based reports by IPs enabled the PMT in Amsterdam to remain updated about progress, constraints, deviations, challenges, lessons learned, risk management and other management issues. The PMT ensured quarterly feedback to the IPs. The quality of analysis, interpretation and utilization of quantitative data for management was affected by inconsistencies in indicator definitions, targets setting and calculation of achievements against targets. Reported service coverage rates (outcomes) tended to differ from figures in the district health information system (DHIS). This hampered the mid- term and final evaluation of outcomes. For the capacity building, research and community participation components no outcome indicators were

defined. Changes in service uptake were mostly used as proxy indicators. The consortium also used more qualitative M&E methods: supportive supervision of health facilities, joint reviews of certain activities, participants' evaluation of trainings and testimonies and on site monitoring visits by KIT staff. The community dialogues were evaluated during end-line sessions. Follow up of research outputs dissemination was minimal.

Relevance

In general the objectives, outputs and activities of SHARP were relevant in terms of the SRH policies of DGIS and South Sudan MoH; and the rights of women and girls. The limited immediate relevance of research and governance training for improved maternal health care should be weighed against their potential longer-term impact. SHARP's focus on strengthening the health system from a development perspective remains highly relevant for a sustainable contribution to the overall goal, though challenged by the changing context.

Effectiveness

Service utilization figures provided essential evidence for the effectiveness of SHARP. Most activities were expected to result in improved maternal care (supply) and higher uptake of services (demand) while community participation and operational research were expected to address some of the delays in health seeking behaviour. By the end of SHARP, reproductive health indicators in the supported states and counties should have increased and thereby contribute to the overall objective (impact level): reduction of maternal mortality and improved reproductive health. The achieved changes could however not be fully attributed to SHARP because other programmes and service utilisation figures of facilities that were not supported by SHARP influenced the reported service coverage rates. Qualitative information on effectiveness confirmed a perceived increase in RH service uptake.

Output 1. Increased availability, accessibility and quality of reproductive health services

Availability, accessibility and quality increased as a result of infrastructure improvement; recruitment of qualified staff; provision of equipment and medical supplies; investment in an improved referral system; development of basic emergency obstetric and neonatal care (BEmONC) centres and adolescent friendly SRH services. Quality of the services also improved because of training and supportive supervision by IPs and County Health Departments (CHDs).

The average reproductive health service coverage rates increased slightly during SHARP implementation and were generally slightly higher than the rates in neighbouring counties. Antenatal care 1 (ANC-1) uptake increased most and the delivery by skilled birth attendant in facility rate also increased. Family planning (FP) acceptance remained very low as everywhere else in the country. Most targets were achieved except for FP and postnatal care. The increased coverage could however not be attributed solely to SHARP because other programmes influenced service uptake as well. Moreover, county coverage rates data include the relatively high service uptake in some private not for profit facilities. Adolescent and youth sexual and reproductive health (AYSRH) received commendable attention in training, service improvement, research and community awareness activities. Effectiveness could however not be assessed, because the indicators proved inappropriate except for adolescent acceptance of contraceptives, which increased in SHARP supported facilities. Qualitative sources of information all reported a positive change in health seeking behaviour and a higher reproductive health service uptake.

Output 2. Increased human resource capacity to deliver quality reproductive health services

SHARP invested more than originally budgeted in capacity building as an essential strategy for quality of care improvement and health system strengthening. Targets for health worker training were met; those for governance capacity building and support to midwifery schools were partially achieved While recruitment and training of facility staff are expected to have an immediate effect on service delivery, the other capacity building interventions might have a longer-term effect. Its outcome in terms of a higher service uptake is not strong. This may be due the fragile context, which impacts negatively on health seeking behavior and service delivery.

Output 3. Research on effective and efficient reproductive health service delivery

The ambitions for this component were high. Several studies were planned that would inform programming and eventually led to improved reproductive health. The expected linkage between

research, policies and programming was not achieved, because of SHARP's high ambitions in a non-conducive environment and a too short time frame. However, the research results feed into a more global (research) agenda on SRH (in fragile settings) in which KIT is actively participating.

Output 4. Community participation and monitoring

Several informants considered the community dialogue the most significant pillar of SHARP. However the short timeframe hampered the potential outcome; in Upper Nile this component was not even started because of contextual constraints. KIT conducted an end-line evaluation as part of the community dialogues in NBeG; the report supports the finding of high appreciation. Sustainability of the efforts and results was perceived as the biggest challenge. Changes can have a deeper impact when a critical mass has been created that is capable to adjust harmful beliefs, norms and practices.

Other community engagement activities like home health promoter (HHP) involvement in FP and Misoprostol promotion, village health committee (VHC) training for community monitoring and traditional birth attendant (TBA) involvement in referral were not captured in the M&E framework and because the external evaluator could not meet with beneficiaries, the evaluation of this component was reduced to a minimum.

Impact

SHARP contributed to the reduction of maternal mortality and to improved accessibility of reproductive health care in the three target states. (i) The delivery by skilled birth attendant in facility rate slightly increased in all SHARP supported counties except Wau County and the proportion of facility deliveries assisted by skilled personnel increased in all four counties. SHARP increased (ii) access to BEmONC and comprehensive emergency obstetric and neonatal care (CEmONC) services and (iii) promoted Misoprostol as an effective intervention for the prevention of post-partum haemorrhage (PPH). The uptake of (iv) family planning and birth spacing commodities in SHARP supported facilities reportedly increased though the overall new contraceptive acceptance rate remained very low and its impact on the maternal mortality rate (MMR) will therefore be minimal. All four indicators relate to life saving interventions, which are emphasized in result area 2 of DGIS SRH policy.

Efficiency

The fragile context seriously affected the use of human, material and financial resources. Balance between direct versus indirect costs were affected by delays, suspension or cancellation of activities, staff turnover and increased security measures. Underspending (mainly on research and community participation) was significant but decreased over time from 64% in 2013 to 28% in 2015. These hurdles were to a large extent caused by contextual factors and made it impossible for SHARP consortium partners to implement the project according to plan with optimal resources utilisation.

The consortium covered four instead of the foreseen eight counties and directly supported 54% of functional health facilities in the three states. This resulted in a limited coverage and economies of scale.

Sustainability

The short timeframe for an ambitious project like SHARP constituted a threat to sustainability. The SHARP specific interventions (community component, operational research and governance capacity building) could not reach sufficient scope and local ownership to ensure sustainability.

The consortium did not develop a clear exit strategy although recommended by the mid-term review (MTR) and in the work plan 2016. Individual IPs however negotiated retention of staff with Health Pooled Fund (HPF), International Organisation of Migration (IOM) and own headquarters. The referral system in WBeG will be sustained at state level and the majority of results under output 1 and 2 will get attention under HPF-2. However the HPF-2 budget is relatively small and the timeframe very limited (ending Feb 2018). A next phase of World Bank (WB) support to Upper Nile was recently approved. HealthNet and Cordaid staff continues to work in W/NBeG under HPF-2.

Investments in human resources through training, Master of Public Health (MPH) sponsorships, support to midwifery schools and governance capacity building will not be lost but may enhance future development. Infrastructure, means of transport and equipment have been handed over to the CHDs. Maintenance and running costs of this hardware may be incorporated in subsequent county health plans.

Fragility

South Sudan scores high on all the five dimensions of fragility described in a recent report by Organisation for Economic Co-operation and Development (OECD) on fragility: (1) violence, (2) access to justice, (3) accountable and inclusive institutions, (4) economic inclusion and stability, and (5) capacities to prevent and adapt to social, economic and environmental shocks and disasters. Although the South Sudanese have shown incredible resilience over the years, the prospects for stability and development of the country are poor.

SHARP was designed from a post conflict perspective in a period when donors were optimistic about rebuilding the youngest nation. Nobody could have predicted that in December 2013 a violent conflict would shock the country and challenge the development perspective and health system strengthening aims of SHARP from that time onwards. The consequences of the changed context for SHARP were numerous, ranging from delays and underspending to destruction of infrastructure, high levels of staff turnover and a reduced government budget for health. Reluctance of the donor community, high levels of insecurity and displacement of people and disruption of supply chains were also among the consequences. The main response of the donor (DGIS) to the above comprised of (1) flexibility, allowing IPs to change work plans, targets, budgets and even areas of operation and (2) allowing a one year no cost extension. IPs adapted to the fragile situation through (1) resilience and coping with constraints in different ways seeking alternative solutions; (2) ongoing risks assessment and mitigation measures planning; (3) recruiting local staff from the area and keeping IP- and facility staff on payroll to maintain capacity; (4) reduction of ambitions particularly in Upper Nile and adapting work plans and budget accordingly.

The project management, IP headquarter staff and IP staff based in Juba faced a growing problem of insecurity and limited access to Juba and the counties of implementation. This hampered monitoring and support visits to the field for both South Sudan based and headquarters staff and the PMT. A more field-based management would have been more effective and efficient. Periods of relative security could have been exploited more effectively for field monitoring and support and coordination of the consortium would have been easier as well.

Main lessons learned and recommendations

General

1. SHARP faced serious challenges in terms of timespan of the project and the unexpected fragile context. A timeframe of at least five years and an adequate corresponding budget is essential for the development and effective implementation of a reproductive health program of sufficient scale and with innovative and complementary components like community participation, operational research and governance skills building. This is especially true for an unstable and fragile context like South Sudan.

2. For a consortium set-up to be effective, the added value of working as a consortium should be very clear at the onset of the project and respective distinct capacities, roles and tasks within the consortium need to be mutually agreed and documented. Modalities of mutual sharing and learning (peer approach) need to be made explicit and adhered to. Adequate funding for collaboration and coordination among consortium partners should be ensured.

Project design

3. SHARP aimed at contributing to health system development and nation building in post conflict South Sudan. In order to support a government led health system and enhance ownership of the project by the MoH at national, state and county level, the MoH should be on board from the proposal writing stage onwards.

4. The focus on both supply (output 1 and 2) and demand (output 3 and 4) is commendable and needs to be further consolidated and sustained. The innovative research and community component as well as the governance training ultimately require more time, scope and a critical mass to have a sustainable impact on reproductive health. An exit strategy or sustainability plan is therefore a prerequisite.

5. Compromising the original scale of the project by working in fewer counties without county coverage and limited statewide support affected the economies of scale and cost effectiveness of the project. It is recommended to pursue sufficient scale and coverage by e.g. (a) supporting all health facilities countywide as requested by the MoH policy and/or (b) covering more counties.

   Selection criteria for the selection of counties were not set beforehand. Wau County was chosen because HPF awarded that county to IMC and not because Wau County was most in need in terms of reproductive health indicators. It is recommended to select areas of operation/counties that are most in need in terms of health indicators. This enhances relevance and value for money of the project.

Project management

6. KIT underestimated the complexity and implications of managing SHARP and the consortium. The main lesson learned is that managing a fund and a project of this size in a complex context and with a consortium design requires the early set up of essential systems and structures in terms of project administration, project management and M&E. KIT did not invest sufficiently in timely development of these systems and should - retrospectively – have seconded someone full time to South Sudan when DGIS approved the funding. Projects like SHARP require a project management unit with full time project specific staff and a strong representation at country level. A field based project management team would have been conducive for effective coordination of the three IPs, a more equal partnership within the Consortium on the ground and greater visibility of SHARP. It would also have facilitated the organisation of platforms for discussion, debate, exchange, etc. Having an own office in Juba and sufficient budget would render KIT less dependent on the goodwill of HealthNet who hosted the CC and took care of logistic support to KIT. In an increasingly complex, volatile and fragile context like South Sudan proximity to the main stakeholders including the MoH as well as to the beneficiary community is highly recommended and facilitates the exploitation of windows of security for field support and field monitoring.

Monitoring and evaluation

7. A robust performance-monitoring framework at the onset of the project is a pre-requisite for effective project management. The framework can then be used to assess individual IP performance regularly, discuss this performance with the IPs, agree on priority improvements and set targets for the next year. It is recommended to ensure regular field monitoring visits including verification and validation of reported data and project outputs. If fragility does not allow access to the country, a local organisation could possibly be engaged.

8. Alignment with the DHIS should be pursued as much as possible: (i) use annually updated DHIS population figures; (ii) use the DHIS indicator definitions; (iii) use the DHIS for comparison with other counties and (iv) ensure access to and understanding of the DHIS system for all key actors. This will enhance monitoring and accountability. In addition, the M&E framework should be aligned with the performance frameworks of HPF and WB/IMA.

Support to maternal and reproductive health care

9. Alignment with the four result areas of the SRHR policy of DHIS requires a thorough understanding of programming, monitoring and evaluation of AYSRH services. Clarity on the objectives and expected outcomes of the AYSRH project component is a prerequisite for the development of project specific service delivery indicators related to adolescent reproductive health. Future strengthening of this component under HPF-2 and other fund management modalities is recommended. It requires a longer timeframe and engaging adolescents and community leaders as

change agents. Linking with organizations like Promundo, Rutgers, CARE and CORDAID [1] and organisations already active in the area of SRH in South Sudan is recommended.

Capacity Building

10. The leadership and management (L&M) training was highly valued by participants but the short timespan of the project and the lack of mentoring in between the training weeks hampered the outcome. Availability of State Ministry of Health (SMoH) staff for the training proved limited, which also affected the outcome in terms of improved governance. To increase cost-effectiveness the course material will need to be actively promoted for further use in South Sudan and/or other countries and adapted where needed.

Operational Research

11. The research component did not reach its full potential and expected outcomes. Ambitions as laid down in the Inception report proved too high and the context not conducive for full implementation of the original plans. The expectation of KIT and its partners to conduct research that would inform project programming did not materialize. For utilisation of the research results more effective modalities of dissemination of results at local level in South Sudan are needed. IP partners, NGOs and MoH as well as potentially interested parties like HPF could benefit more if results would be more accessible. The outputs of the research may provide limited benefit to the South Sudanese community at short term. More applied and needs based research is perceived as more relevant in a short time frame and fragile context.

Community Participation

12. A key lesson learned is that even in a fragile context, community-based dialogues are an appropriate tool to stimulate intergenerational communication and exchange of ideas between the different sexes on SRHR, in particular maternal health. The community dialogue approach was perceived as one of the strongest pillars of SHARP with a clear added value to facility based reproductive health services and complementary to HPF, WHO and UNFPA. Promotion of continued use of the method in and beyond South Sudan is recommended.

13. One key outcome of the end-line studies concerns the scale of the intervention. It is recommended to (i) pursue sufficient scale to develop a critical mass and (ii) ensure time for follow up at community level. This requires a longer timeframe (general recommendation) for more depth, follow up and scope.

[1] Cordaid built experience on AYSRH through the Next Generation and JeuneS3 (also funded by Ministry of Foreign Affairs; same fund as SHARP).

1 Introduction

1.1 Reproductive health in South Sudan

After two civil wars (1955-1972 and 1983-2005) the government of Sudan and the Sudan People's Liberation Movement (SPLM) reached a Comprehensive Peace Agreement (CPA) in 2005. In July 2011 South Sudan gained independency. The country is since then in the process of nation building and health system development. There is a severe shortage of health workers and supplies are irregular and generally insufficient. There are an estimated 11.4 million people in the country, but the actual number is higher due to the influx of returnees. Since the December 2013 conflict more than 1.4 million people have fled the country and almost 2 million are internally displaced. Famine is looming. The maternal mortality rate (MMR) is high with figures ranging widely from 2054 (South Sudan Household Survey – SSHS 2006) to 730 per 100,000 live births (WHO South Sudan maternal health profile). A survey on MMR was planned for 2016 but not undertaken. Early marriage and teenage pregnancies are common (SSHS 2010) with 30% of women 15-19 years having started childbearing. Most women deliver at home (80%; DHIS 2015) and the delivery by skilled birth attendant rate is around 10% (DHIS 2016). Access to Emergency Obstetric and Neonatal Care (EmONC) services has significantly increased over the past years, but faces a problem of qualified staff retention, aggravated by the current instability and fragility of the country. Youth and adolescent sexual and reproductive health and rights is a relatively neglected area but an integral part of the national RH strategy.

At the onset of the South Sudan Health Action Research Project (SHARP) in 2013, primary health care in South Sudan was supported by various funding mechanisms: the Health Pooled Fund (HPF) with DFID as lead donor supporting the implementation of the Basic Package of Health and Nutrition Services (BPHNS) in six of the ten states, USAID supporting two states through Jhpiego and the World Bank (WB) supporting the two remaining states through Interagency Medical Assistance (IMA). HPF entered its second phase (HPF-2) in November 2016 and covers also the two states previously supported by USAID, while the WB supported Rapid Results Health Project (RRHP) finally approved a second phase in early 2017. UNFPA and WHO also support reproductive health care.

1.2 Project summary

SHARP aimed to contribute to reducing maternal mortality and increasing access to maternal health care in Northern Bahr el Ghazal (NBeG), Western Bahr el Ghazal (WBeG) and Upper Nile (UN) states based on the National Reproductive Health Strategic Plan (2013). The project was implemented by a Consortium consisting of the Royal Tropical Institute (KIT) in the Netherlands, as lead and fund manager and three implementing partners: HealthNet TPO, International Medical Corps (IMC) and Cordaid. The project was formulated in response to a call for proposals, issued by the Sexual and Reproductive Health and Rights (SRHR) Fund of the Dutch Ministry of Foreign Trade and Development Cooperation in 2012, which granted Euro 8.3 million for a 2.5 years project ending December 2015. The Consortium launched SHARP officially in November 2013 after an inception period and closed the project in December 2016, after a no-cost extension of one year. IMC and HealthNet closed field operations by the 1st of July, Cordaid by 1st of October 2016. The areas of implementation were located in three different states (see fig 1).

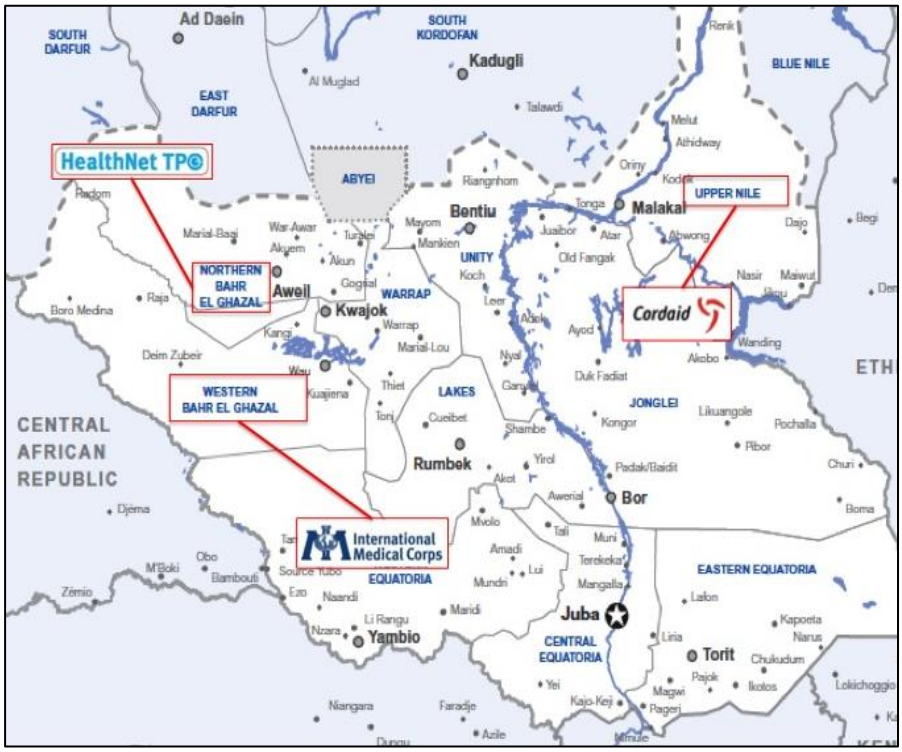
The four expected outcomes (specific objectives) of SHARP were:

1. Increased accessibility, availability and quality of reproductive health services
2. Capacity developed at all levels of the MoH to deliver quality comprehensive reproductive health services
3. Context specific knowledge produced on effective modes of service delivery for increased use of reproductive health services
4. Women, men, adolescents, families and communities demand quality RH services

Prior to official approval, KIT worked with the central and state MoH and the two main Fund Managers (HPF and WHO/IMA) to ensure that SHARP funding was complementary and synergistic to other health-related activities in the area. The project received official approval from the South Sudan MoH on 6 November 2013. Implementation started later than originally planned due to the longer-than envisaged inception period needed to obtain full MoH South-Sudan approval for the project and harmonize and adjust SHARP planning with the procurement, selection and implementation schedule for the Basic Package of Health and Nutrition Services (BPHNS) roll-out. Implementation workshops were held in all three states presenting the work plans and budgets to a wide range of governmental and non-governmental stakeholders. Almost immediately after the kick-off, activities came abruptly to a hold in December 2013. An unexpected violent conflict erupted in Juba and soon spread to other parts of the country, in particular Unity, Upper Nile and Jonglei. The fall out of these events proved relatively minor in Northern and Western Bahr el Ghazal. Unlike HPF, IMC and HealthNet hardly interrupted their programmes, in particular not at field level, but even hardly at Juba level. In the two Bahr el Ghazals, mainly the supply of essential drugs and medical supplies were affected.

The situation in Upper Nile, however, was very different. During the first couple of months of 2014, there was ongoing violence, widespread looting with different parts of the states being under control of either the government (Sudanese People's Liberation Army, SPLA) or the opposition (SPLA-IO). All activities by Cordaid in the area had to be aborted and it was difficult to even visit the area for an assessment of the situation on the ground. It was decided to suspend the SHARP activities in Upper Nile. SHARP looked into alternative areas of operations, in particular Lakes State, but this did not meet approval from DGIS, primarily because of concerns regarding the stability of this State. By July 2014 the situation in Upper Nile had stabilized, with less active fighting, and no longer rapid changes between the areas under control of one of the two parties. With the resumption of a good part of the basic health care activities of the WB funded RRHP implemented by lead agency IMA (Interchurch Medical Assistance) and a number of sub-contracted NGOs, including Cordaid, it became possible to re-assess the situation. Cordaid proposed to resume activities in the counties of Fashoda and Melut. The counties that were initially also targeted for SHARP, Renk and Panyikang, were still too unstable to resume activities, with no quick resolution expected.

Figure 1. SHARP project locations per implementing partner



Eventually Cordaid resumed SHARP implementation in late 2015 in Melut County that had been seriously hit by attacks. The Hospital and several other health facilities were destroyed.

2 Objectives, methodology and limitations of the external evaluation

SHARP formally ended by 31 December 2016. Therefore KIT commissioned a final evaluation, with the double purpose of looking back and assess achievements, but also learn lessons that might be useful for future undertaking in promoting SRHR in fragile settings.

2.1 Objectives of the external evaluation

The evaluation was expected to assess the achievements of the project as well as the way the project operated in the fragile conditions of South Sudan. Standard OECD-DAC evaluation criteria of relevance, effectiveness, efficiency, impact and sustainability were used to assess achievements. The evaluation aimed to provide recommendations to KIT, Consortium partners and the Dutch Ministry of Foreign Affairs (DGIS) regarding the formulation and implementation of reproductive health programmes in South Sudan and other fragile settings.

The full terms of reference (ToR) are found in annex 1.

This report is structured as follows:
The report starts with an executive summary that also covers the main recommendations. Chapter 1 presents an introduction to the project and context. Chapter 2 describes the objectives, methodology and limitations of the evaluation. Chapter 3 covers the project design and management and addresses the Consortium set up, governance structures, guiding principles and monitoring and evaluation (M&E) of the project. Chapter 4 - 8 cover the findings according to the OECD-DAC criteria. Chapter 9 presents the findings with regards to reproductive health programming and operations in a fragile context, while chapter 10 addresses some of the main lessons learned and recommendations for KIT, DGIS and IPs.

2.2 Methodology

The final evaluation entailed a desk based document review including an M&E framework analysis combined with interviews of key stakeholders. Contact with key informants was sought through face-to-face meetings, Skype, telephone and email. Topic guides and follow up questions emerging from the document review guided the semi-structured interviews. Verification of information and triangulation of findings was done as much as possible, but was limited due to the impossibility to visit South Sudan and meet with beneficiaries and key stakeholders in Juba and project locations.

The external evaluator worked in South Sudan (2010-2014) as field health monitor of the Basic Services Fund (BSF) and subsequently as M&E manager of HPF. In those positions she (i) monitored the performance of IMC and HealthNet at county and state level (ii) used the district health information system (DHIS) for data analysis and (iii) communicated extensively with county health departments (CHDs), state Ministries of Health (SMoH) and national MoH. This facilitated the evaluation.

2.2.1 Desk review of documents

Documents reviewed included the original proposal, inception report, Mid Term Review (MTR) report and internal evaluation of SHARP in Upper Nile by Cordaid also quarterly and annuals reports, M&E visits reports, the minutes of County Management Committee and Council meetings, some training reports, the Leadership & Management (L&M) modules and report, the Community Participation manuals and end-line report, SHARP State Implementation Plans (SSIPs) and work plans per Implementing Partner (IP) and of the Consortium. Relevant but not SHARP specific documents included: Sexual and Reproductive Health (SRH) policy document of DGIS, SRH policy documents and Health Sector Development report of the MoH in South Sudan, RRHP (WB/IMA) report, HPF-2 proposals for N/WBeG and the OECD document on States of Fragility.

2.2.2 Analysis of service utilization data

All SHARP interventions eventually aimed at an increase in utilization of quality services. This evaluation therefore paid considerable attention to the changes in service utilization indicators over time in SHARP supported facilities and counties. Some comparison with other counties in the respective states was done as well. The evaluation included an in-depth review of the M&E framework and the corresponding Excel database as well as the indicator definitions and interpretation by the Project Management Team (PMT) presented in feedback to IP reports, annual reports and in the MTR.
HPF provided a recent version of the DHIS (public domain) on request. This enabled the evaluator to compare county service data with reported figures in the quarterly reports. It also allowed some analysis of facility specific information on service uptake, which facilitated the attribution of effect.

2.2.3 Interviews with key informants

Semi Structured Interviews (SSIs) were held with resource persons in the Netherlands and in the field. A list of people who shared their inputs is attached as annex 6 and include: DGIS staff; KIT project staff: SHARP project coordinator and project management team members; KIT technical advisers involved in scoping missions, L&M training, community engagement, operational research, internal SHARP evaluation, webinars; Cordaid and HealthNet headquarter staff in the Netherlands; Juba level IP staff (health advisers) of all three IPs; former IP field staff; master of public health (MPH) students; HPF staff at state and Juba level; the former Minister of Health of Northern Bahr el Ghazal (NBeG); Chief of Party IMA and medical officer in charge of Comboni Hospital in Wau.

2.2.4 Meetings with project management team

The PMT played an important role in the provision of information on SHARP beyond the many documents. The M&E framework was jointly reviewed and contact with informants in South Sudan and elsewhere was facilitated as much as possible. The PMT also provided detailed feedback on the draft final evaluation report.

2.2.5 Debriefing of results during end of project workshop

A presentation of the initial results of the evaluation was part of the final project meeting. KIT, Cordaid, HealthNet, DGIS and HPF were present and provided valuable feedback and additional inputs for the final report.

2.3 Limitations

The evaluation of the project encountered constraints related to the unpredictable insecurity and increasing fragility in South Sudan. KIT drafted the ToR soon after a sudden violent conflict in Juba in July 2016 but the situation seemed calm soon after. Just before a planned field visit of SHARP project coordinator and the evaluator to Juba in October 2016 to (i) have a final project coordination meeting with the implementing partners on the ground; (ii) close the project officially and (iii) allow the external evaluator to meet with key stakeholders in Juba, KIT decided not to give a security clearance and re-assess the situation a few weeks later. Ongoing insecurity and volatility in the country however made KIT decide in November to cancel all fieldwork definitely to the regret of both parties.

The impossibility to meet with the primary beneficiaries of SHARP and key stakeholders in reproductive health turned this external evaluation into a desk based study with its specific limitations. Verification and triangulation of findings and reported results through visits on site could not be done. The evaluation had to rely on documents and inputs from mainly project related staff and unfortunately left the beneficiary community largely unheard by the external evaluator. However the end-line report on the community dialogues provides valuable information on perceived changes in knowledge, perceptions and health seeking behaviour at beneficiary level in mainly NBeG.

Some former field based IP staff shared their inputs, but several others were contacted by mail but did not respond. In WBeG and NBeG the project ended by the 1st of July 2016. As a result most expatriate (to a large extent regional) staff had left South Sudan and it proved hard to get in touch with them. The former Country Coordinator could not be reached either.

Some parts of the SHARP M&E framework, the database for all project information on process, outputs and outcome, were based on inconsistent indicator definitions and calculations. IPs calculated service coverage rates in different ways. This hampered the analysis and interpretation of data and graphs in the database and MTR report. The DHIS revealed some incompleteness of data particularly with regard to 2016 data and facility-based information. In general, the DHIS figures proved still useful to evaluate countywide service coverage rates, assess some trends over time and compare counties and states.

3 Project management

3.1 Consortium set up and governance structures

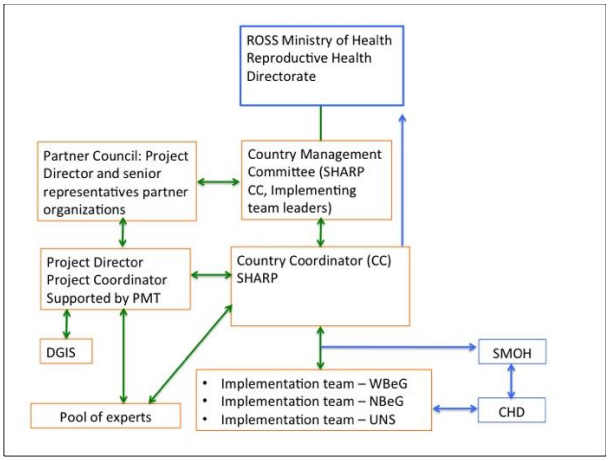
To implement SHARP, a consortium was formed, led by KIT, together with three IPs: Cordaid, HealthNet TPO, and IMC. The consortium was formed towards the end of 2012, in response to DGIS' call for proposals. The partners were selected because of their presence with field operations in the health sector in South Sudan and their potential complementary distinct capacities. In this way the areas of operation were identified: Upper Nile, WBeG and NBeG. The partners did not necessarily have a strong reproductive health profile.

KIT has been leading the consortium and was responsible for general oversight of all SHARP activities, including M&E. KIT was moreover responsible for the implementation of the governance capacity building component (design and implementation of the L&M course for senior RH staff; selection for MPH scholarships), design and technical support to the community participation component, and the operational research component. The three IPs operating in South Sudan were responsible for the service delivery component, supporting the implementation of the BPHNS in their respective counties and to a lesser extent in their respective states. This support consisted of construction and renovation of infrastructure for service delivery, supplying essential equipment and selected medical supplies, recruitment and training of health facility staff, regular supportive supervision and training & support of community based cadres such as home health promoters (HHPs), traditional birth attendants (TBAs) and village health committees (VHCs). In addition, they also focussed on the improvement of the referral system and community awareness-raising on key issues such as family planning (FP) and birth spacing, adolescent reproductive health, prevention of post-partum haemorrhage (PPH) and support to midwifery training schools.

Governance structures were set up at all levels (figure 3) and included:

- SHARP implementation teams in the three states supported by their respective IP country headquarters in Juba. The implementation teams, based at county level, collaborated closely with the CHD and with IP staff recruited under HPF/RRHP.
- A country coordinator (CC) based in Juba, recruited in May 2013. She resigned in January 2015 and was not replaced.
- A Country Management Committee (CMC) consisting of senior IP staff based in Juba, led by the CC. The CMC initially met on a monthly basis. Upon departure of the CC the country management committee meetings were held irregularly and mostly when KIT staff visited Juba.
- The Partner Council: project coordinator and senior representatives of the partner organisations, meeting in Amsterdam on an annual basis with its final meeting in December 2016. Staff turnover within IMC affected the mutual consultation process within this governance structure
- A Project coordinator supported by a project management team (PMT), answerable to DGIS and submitting annual reports to DGIS.
- A foreseen Project Advisory Committee (PAC) proved not feasible. Instead, as suggested by DGIS, SHARP became active member of the Reproductive Health Forum, led by the MoH and supported by UNFPA, in which all stakeholders in the domain of RH in South Sudan regularly convene, for coordination, elaboration of national strategies, and information exchange.
- The Director General of the Directorate for RH in the MoH formed the natural link of SHARP with the MoH and SHARP reported on a quarterly basis to the Directorate. At state level Ministers of Health in WBeG and NBeG played an advisory role. Engaging the SMoH in Upper Nile proved not possible. On an almost daily basis, IP and CHD staff collaborated within the CHD. Co-location in the CHD office was a guiding principle of HPF and RRHP, and also of SHARP.

Figure 3: Governance structures SHARP project



Challenges in project management

KIT was lead and fund manager but also responsible for the implementation of more than 50% of the project components: operational research, community participation and governance capacity building of CHD and SMoH staff. It proved a challenge for the KIT to be responsible for the overall project management from its basis in Amsterdam and at the same time lead the consortium with the ambition to be equal partners and also implement several major activities. The PMT was relatively small with eventually three part-time staff. Other KIT staff supported the fund management.

The lead function of KIT with many different technical staff (pool of experts) involved part-time and for very brief periods has been perceived as not very conducive by IP staff as well as by several KIT staff. Most KIT staff had several other tasks within KIT. The project coordinator was the most continuous person according to IP staff in the field and headquarters

The CC was recruited in May 2013 as representative of KIT who was the Consortium lead and project manager. The CC chaired the CMC. In 2013/2014 this country management structure functioned rather well with regular meetings at country level and consolidated reporting to the PMT. The CC played a crucial role in acquiring approval from the MoH and enhancing the visibility of SHARP at Juba level among government authorities, Fund Managers, at the NGO Health Forum and in the national Reproductive Health Forum. She contributed significantly to the situational analysis including a policy and risk analysis and she set up the initial M&E framework. KIT revised and improved this framework in 2015. The CC also drafted a conflict sensitivity analysis (2015) for SHARP. When she resigned in January 2015 KIT decided not to replace the CC and to manage the project and the consortium from a distance with frequent field visits. CMC meetings were then subsequently held on a more irregular basis, mainly when KIT project management staff visited Juba. Whenever it proved difficult to get all three partners attend at the same time for CMC and Partner Council meetings, KIT held bilateral meetings instead. Bilateral contact through Email, phone and Skype between IPs and KIT were frequent. In terms of governance structures, the CC position and the CMC were no longer functional and the project coordinator and his PMT developed a direct relationship with the IPs and with the MoH in Juba. According to KIT and IPs the distant management mode strengthened the direct relationship of KIT with the IPs in the field. However, both field and headquarter staff of the partners and KIT agree that a project management team based in Juba with full time staff would have been a better management set up.

Involvement of the MoH in project governance was limited to bilateral meetings of KIT with the MoH, submission of reports and some consultations with the Directors General of reproductive health. The MoH was not participating in CMC meetings.

Implementing partners and other stakeholders interviewed underline that the Consortium set up and functioning has been less effective than expected. This key finding was also reported in the MTR and internal SHARP evaluation of Cordaid in Upper Nile and was discussed during the final workshop in

December 2016. During CMC meetings in 2013 concerted action and mutual consultation constituted the basis for the inception report including work plans. During subsequent years of implementation programmatic collaboration was rather limited according to IP informants. Cordaid felt often left out because activities could not take off in the same way due to the insecurity in UN. HNTPO and IMC conducted joint evaluations linked to community participation and L&M training.

According to consortium members, exchange opportunities have not been fully exploited. Monthly and quarterly reports by IPs were not shared between the IPs. Limited use was apparently made of individual distinct capacities of IPs. A peer review approach whereby partners review each other's project implementation performance *on site* could have addressed the constraint of international travel and insecurity. Since the harmonisation workshop in the beginning of the project (2013) another joined review of the project by IMA, HPF and SHARP has not taken place although planned during the first workshop. IPs admit that they could have lobbied more actively themselves for stronger collaboration and exploitation of specific partner expertise and capacities such as community involvement, research, training and others. They could have created opportunities for joint learning, sharing resources and capacities, discuss coping and resilience in the fragile context etc. The also could have taken a more active role in representing the Consortium at national level and continue meeting as a Consortium without or with KIT.

The NGO Health Forum is no longer operational in South Sudan for over a year. As a result there is significantly less platform for various NGOs at national level to share experiences, results and best practices and seek advice from others. Implementing partners perceive this as a loss and hampering coordination and exchange.

Collaboration between IPs operational within the same state (WBeG) was not optimal either. Partners worked mainly on their own, preoccupied with implementation in their own county. The tendency to work independently is also reflected in the limited proactive collaboration with organisations supporting the BPHNS in neighbouring counties, though NGOs met frequently at state and national level Health Forums, Cluster meetings and RH meetings. HealthNet and Cordaid will pursue stronger collaboration and coordination under HPF-2. In 2016, the two organisations submitted two proposals as consortium with AFOD and were granted the contract.

Continuity within the Consortium was affected by turnover of staff, particularly at South Sudan IP level and at IMC headquarters level. People who were involved in the initial stage of SHARP are no longer there, except for Cordaid. This affected the institutional memory of the organisations.

It proved a major lesson learned that a Consortium set up requires (i) clarity from the beginning on the expected added value of the consortium set up and on monitoring of the consortium performance, (ii) frequent meetings based on shared concerns and interests, which are well documented and (iii) a strong peer support and peer review approach. The value of the consortium should be more than the sum of the individual parts. The PMT emphasized the importance of availability of an adequate budget for consortium meetings, peer review activities and exchange visits

3.2 Guiding principles

SHARP design and implementation was to be guided by several principles, which the external evaluation reviewed. A summary of the main findings is presented in the following paragraphs.

3.2.1 State and county level perspective

According to the inception report "*the activities to be implemented in the three states should be formulated with a 'state perspective' in mind, to result in a mix of activities that are specific for and operational in one or more counties and activities that run at state level are of benefit to a range of, if not all, counties in that state*". Partners were expected to use a health systems lens in line with the development perspective of SHARP. SHARP state implementation plans (SSIPs) were to include both state level activities and county specific activities.

In July 2013, all three IPs submitted draft SSIPs that constituted the basis for the later final SSIP/work plans and budgets of individual IPs. The final SSIPs (November 2013) have a state focus on:

- Referral system development (all three states)
- Support to RH coordination role of SMoH (all three states)
- Coherence and harmonization of interventions by other HPF partners, IRC and CONCERN (NBeG)
- Development of a state model for youth and adolescent sexual and reproductive health (WBeG)
- Training of hospital staff on specific sexual and reproductive health (SRH) topics (WBeG)

The state focus proved tangible in NBeG and WBeG in (i) promotion of a state referral system; (ii) support to state level midwifery schools and (iii) capacity building of state and county level government health authorities on leadership and management (all 3 states) and (iv) support to the coordination role of the SMoH (NBeG and WBeG) . Coordination with IRC and CONCERN (NBeG) and development of a state model for AYSRH (WBeG) did not materialize.
The original SSIP for Upper Nile covered many state level activities but almost immediately upon the implementation workshop in November 2013, Cordaid had to withdraw from Upper Nile while the SMoH in Malakal ceased to exist. Coverage ambitions had to be scaled down due to insecurity.

In WBeG and NBeG key stakeholders including the SMoH also developed State SRH Plans in November 2014, one year after the SHARP inception report and SSIPs. The state SRH plan for NBeG 2015-2016 foresaw a role for SHARP/HPF in governance and leadership and activities under this component included a knowledge, attitude and practice (KAP) survey, sexuality education in secondary schools, countywide supervision on BEmONC services and community sensitization on SRH. Most of these plans did not materialize. The SRH plan for WBeG (Nov. 2014) did not include a specific role for SHARP at all. The evaluator does not know the reason. However in reality IMC did support a number of initiatives beyond Wau County. IMC trained health workers in all three counties on certain topics and research was conducted in two of the three counties. The referral plan for WBeG materialized into an operational referral system with means of communication, a hot line, referral forms, functional means of transport and access to CEmONC in two hospitals in Wau County and one hospital in Raja County (in 2016 looted and no longer fully operational). The state referral system in NBeG proved less operational. However, at county level, Aweil North has a functional referral system linking the primary health care centers (PHCC) to the state hospital in Aweil (in Aweil West county). As mentioned above, for Cordaid a state perspective proved not feasible because the SMoH ceased to exist after the December 2013 conflict and the state was divided between SPLA and SPLA-IO counties.

At county level, SHARP's support to the BPHNS has been the most important intervention and activities were integrated into the annual county health plans. SHARP supported selected health facilities directly in terms of (i) construction and rehabilitation of health facilities, latrines and staff houses; (ii) health worker recruitment and retention measures, (iii) provision of equipment and essential medical supplies, (iv) monthly or quarterly (IMC) supportive supervision with the CHD and (v) training of health workers. On a daily basis, IP implementation teams collaborated with CHD staff and supported the CHD in their daily operations e.g. planning, supervision, training and M&E. In addition, SHARP played a key role in strengthening the relationship with the community through community dialogues, community monitoring and support to community-based structures like HHPs, VHCs, Boma Health Committees (BHCs) and schools. With regard to some specific issues, SHARP supported all facilities in the county e.g. provision of FP commodities and training of staff on prevention of PPH by Misoprostol. SHARP IP staff participated in the annual review of the county annual health plan.

3.2.2 Alignment

The project proved well aligned with the key national SRH related policies and operationalized in close collaboration with the national, state and county level ministry of health; an important principle for the transition from a humanitarian to a development perspective. Though the socio-political climate changed in Dec 2013 and subsequent conflict and fragility tended to push the country back in the humanitarian mode, SHARP rightfully maintained the development approach in close collaboration with HPF. In Upper Nile however, the situation proved extremely fragile due to high level of political instability and insecurity, very short funding periods of six months or less and a non-functional SMoH and according

to IMA an emergency approach was almost unavoidable. Cordaid agreed that a full-fledged development approach proved not feasible. Cordaid initially planned to implement all four pillars of SHARP, but had to withdraw from Upper Nile in 2013 before even starting. Subsequently Cordaid reduced the work plan for Fashoda and Melut and eventually came up with a very reduced package for Melut from Q4-2015 onwards. Cordaid did not drop its development ambitions, but in reality had to limit its strategies to service delivery support including construction and means of transport for referral, training of health workers and some community awareness. The research and community participation components as well as AYSRH could not be implemented. CHD capacity proved very limited for effective collaboration while the SMoH was not operational at all.

3.2.3 Harmonization and complementarity

SHARP considered harmonization of strategies and activities as one of the cornerstones for development. Harmonization was operationalized during a harmonization workshop mid 2013 with the following key stakeholders in reproductive health:

- Other primary health care funding mechanisms (HPF and RRHP) to ensure that SHARP funding is synergistic and complementary
- WHO in terms of support to CEmONC in state hospitals (Wau and Aweil state hospitals)
- Initiatives of UNFPA (e.g. FP commodities), UNICEF, MSI and PSI

Tangible evidence for harmonization at county level is found in the integrated county health plans with one plan for all actors and one budget. SHARP's role in terms of activities and funding was incorporated in these plans but not always clearly distinguished from HPF's role, which affected the attribution of effect.

SHARP activities intended not to duplicate other initiatives, but rather form a complementary and relevant package to boost the full range of reproductive health services to improve maternal health, including the full continuum of care as well as family planning. The complementary role to the HPF is most tangible in terms of increasing the scope of activities by community- and facility based attention for FP, YASRH and EmONC. SHARP was also complementary in filling a funding gap and thus boosting maternal health services. SHARP components that were not directly supporting the BPHNS such as the operational research, L&M training and the community participation programme and community monitoring had a clear added value.

3.2.4 Coverage

All three IPs decided to focus on selected facilities for direct support. This complicated the analysis of quarterly reports in terms of service coverage and assessment of outcomes. Table 1 presents the proportion of PHCC/Us supported by SHARP in terms of staffing, supervision, construction, rehabilitation and equipment. For other activities SHARP often covered all facilities e.g. for training in FP, YASRH friendly services and BEmONC as well as for support to referral system.

The initial ambition of SHARP as per the original proposal was to cover at least eight counties and an average of at least 250,000 people per state. The achieved coverage is lower (see also chapter on efficiency). This reduction of coverage in terms of number of counties was not a strategic choice but the outcome of the HPF-1 awarding process whereby the SHARP partners were selected for less counties than expected. The number of directly supported facilities was a strategic choice.

Table 1: Coverage in terms of directly supported health facilities per county

County	Wau	Aweil North	Melut	Fashoda	Total
County population	151,636	173,039	63,350	48,692	**436,717**
Total number of functional PHCC/U	39	25	9	11	84
Number of SHARP supported PHCC/U	13	18	4	9	44
Additional IDP* clinics	2 (2016)	0	2	3	7
Hospitals	2	0	1 (destroyed)	1 not functional	2
% PHCC/U supported by SHARP	**33%**	**72%**	**44%**	**82%**	**52%**

IDP = internally displaced person

3.3 Monitoring and evaluation

3.3.1. Intervention logic

The intervention logic of the SHARP project has undergone repeated revisions since the initial proposal, particularly at the level of indicators and targets but some foreseen activities were dropped or replaced, mainly with regard to research and community participation. This is partly due to the fact that KIT developed the initial proposal under time pressure and based on a superficial situational analysis. The logic related jargon on outputs, results and outcomes was not consistent across the different documents. In the original proposal (Dec. 2012) the intervention logic was based on an overall objective and four specific objectives (Table P8.1 of the proposal). The proposal described six outcomes with 17 progress indicators and sources of verification. A second table in the proposal presented the activities, outputs, indicators, targets and sources of verification. Activities were grouped according to the specific objectives (pillars) and not according to the six outcomes.

In the inception phase (Jan – Sept. 2013) the PMT, with inputs from the IPs, revised the logical framework. The logic in the inception report is based on

- Impact: to contribute to reduction of maternal mortality
- Outputs (corresponding to specific objectives) 1 – 4 with a number of (sub) outputs under each of the four main outputs.

Indicators for impact and each individual output were included as well as annual targets.
Both versions of the logical framework do not include a set of assumptions and risks, which would have been appropriate in the fragile and volatile context of South Sudan.

3.3.2. Monitoring and reporting

As described in the inception report, SHARP used two different approaches in monitoring: programme monitoring based on the logical framework and community 'monitoring' to engage the beneficiary community in feedback to and accountability of service providers. This paragraph describes the findings for programme monitoring. Community monitoring is covered under output 4.

IPs monitored the project progress and results closely on a regular basis according to their detailed work plans and indicators laid down in a standardized reporting format based on the M&E framework.

On a monthly basis: A brief monthly update was drafted by the CC (till January 2015) and sent to the SHARP project coordinator/PMT.
On a quarterly basis the IPs reviewed progress according to work plans and filled the quarterly reporting formats and then submitted the three different reports to the PMC at KIT:

1. Narrative quarterly report on the key achievements; major deviations from the work plans; operational challenges; sharing of SRH learning; financial update and a risk analysis. Separate reports on training, workshops and other major activities were attached as separate files.
2. Report in Excel on progress against objectives based on the indicators and targets in the M&E framework. A standard reporting format was used for the quantitative information and covered a total of 30 indicators: 19 for output 1 (service delivery); 6 for output 2 (recruitment and training) and 5 for output 4 (community participation). IPs did not report on output 3 (research). Quantified information needed for the 30 indicators was collected from different sources: (a) the HMIS monthly reports at facility level (b) SHARP specific data collection registers in the SHARP supported facilities; (c) project reports and (d) supportive supervision visits to the facilities.
3. Quarterly financial report on expenditure versus budget.

On an annual basis the IPs submitted a narrative report summarized in a standardized table format and covering information according to the four major outputs of SHARP in terms of activity, result, short narrative, justification of any deviation/change. Further analysis was done at the level of the project management team at KIT. An overview of reporting is provided in table 2.

Table 2: Overview of reporting system

Implementing partners	Country coordinator	KIT; SHARP management team
Monthly update on activities	Collated the monthly reports	Feedback on consolidated monthly report
	Reports discussed in CMC	
Quarterly narrative report + reporting against indicators	Collated IP reports into a single quarterly report; from 2015 none	Feedback on the quarterly report sent to IPs
Quarterly financial report		Feedback
Annual narrative reports		Feedback to IP Annual report submitted to DGIS
Annual financial reports		Feedback
Mid Term Review: internal MTR: one for the Bahr el Ghazal states and one for Upper Nile		
End of Project Evaluation by external consultant		

Programme monitoring and reporting also involved monthly[2] supportive supervision by the IP jointly with the CHD and quarterly review of progress as part of the HPF M&E approach.

The M&E framework of the inception report initially guided the work plans and target setting of the IPs and KIT as well as the quarterly report. In 2015 the PMT revised the M&E framework in order to be used as database for the MTR. Though the framework has some shortcomings it proved a useful tool to review progress in terms of the status of implementation, progress against targets (where targets were appropriate) and trends over time. The external evaluation encountered some problems in the use of the framework due to some inconsistent and/or incorrect definitions and calculations of rates. The reported quarterly figures on uptake of services were not all corresponding to the DHIS figures while the DHIS is based on the monthly HMIS reports submitted by the CHD with support of IPs. In addition, some indicators did not seem relevant the way they were defined, particularly indicators on YASRH. As a result, the evaluator could not use all aggregated data in the database.

Baseline values and targets for the HMIS related indicators have undergone revisions in the course of the project based on improved understanding of the DHIS and actual progress and attainability. It remained however a challenge for the evaluator to fully grasp some targets and to understand the reported numbers and rates. Cordaid reported utilization figures for the SHARP supported facilities only, IMC reported figures for all PHCC/Us and left out hospital figures and HNTPO reported figures for all facilities. County target population figures were used as denominators by all three IPs. There was moreover no uniform understanding amongst the IPs and KIT on target setting.

SHARP expected to use data and other information for informed decision-making and improved management. Annual reports and the MTR provide evidence that efforts were made to analyse and interpret data. Charts based on data showed the trends over time in service utilisation against targets. Cordaid included an analysis of achievements against targets in some quarterly reports including charts of trends over time; a commendable effort.

[2] IMC conducted quarterly supportive supervision visits instead of monthly. The other two IPs conducted monthly supportive supervision visits.

4 Relevance

In general the activities and outputs of SHARP are in line with the overall and specific objectives of the project and with the objectives of the SRHR Fund and main result areas of the Dutch Ministry of Foreign Affairs. They are equally well aligned with the South Sudanese SRH policy documents. The focus on access to reproductive health and reduction of maternal mortality addresses essential needs of South Sudanese women and girls from a rights based perspective.

The project proposal that was awarded a grant from the SRHR Fund was not based on an in-depth analysis of the situation and needs of the people. Inputs from IPs who worked in South Sudan and relevant documents constituted the basis for the proposal. In the following year a more in-depth analysis of the situation and needs in the selected states was conducted, including scoping missions, a health facility assessment in Aweil North and a RH assessment in Melut (in 2016).

In terms of proven relevance of the implemented activities, one should distinguish between the immediate relevance within the project period and the longer-term relevance. Service delivery support and training of facility health workers as well as community engagement have a clear immediate relevance for the beneficiaries. The leadership and management training as well as the research component may contribute to reproductive health improvement at longer term. Operational research was selected as one of the main strategies to develop insight in local norms and practices with the aim to adapt reproductive health interventions accordingly. IMC and KIT emphasized that the research was very relevant for a better understanding of the target communities and health seeking related factors in Wau county. Its relevance for RH programming could not be fully exploited because of the short timeframe.

4.1 DGIS SRHR Fund and policies

In 2012, the Dutch Government drafted a policy on Sexual and Reproductive Health and Rights including HIV/AIDS for development cooperation. The four result areas for SRHR were formulated as follows:

1. More knowledge and freedom of choice for young people with regards to their sexuality
2. Improved access to family planning and essential drugs
3. Improved care for women during pregnancy and delivery including a safe abortion
4. More respect for the sexual and reproductive rights of populations who are denied these rights

By the end of SHARP, SHARP's added value was to be found primarily in result area 2 and 3. The focused attention for FP and Misoprostol fits in result area 2, while SHARP's support to service delivery (antenatal care (ANC), labour and delivery, postnatal care and referral) fits in result area 3. Safe abortion however has been given little attention while the needs may have increased because of fragility and gender based violence. Youth and adolescents' sexual and reproductive health has been given due attention in training, awareness raising and youth friendly service provision.

4.2 South Sudan Reproductive Health policies and strategies

In the course of the past five years the newly independent South Sudan developed a series of policy and strategic documents in the domain of SRHR:

1. Health Sector Development Plan 2012-2016; subtitle "*One maternal death is one too many*"
2. Reproductive Health Policy
3. Reproductive Health Strategy (February 2013) for 2013-2016
4. South Sudan Basic Package Health Nutrition Services (BPHNS) 2009, revised in 2012
5. South Sudan BPHNS for Secondary level (2011)
6. Emergency Obstetric Neonatal Care (EmONC) Investment Plan
7. South Sudan Family Planning Policy (February 2013)
8. South Sudan Reproductive Health (RH) Commodities Security Situation analysis (July 2014)
9. Roll out of Misoprostol for the prevention of post-partum haemorrhage (MoH/HPF)

All above mentioned policies stress the urgent need for (i) effective interventions that will reduce maternal mortality in SS; (ii) having more skilled personnel, who are more equally distributed in the country; (iii) capacity building and continuous education of key staff in PHC units and health centres.

The RH Policy and Strategy as well as the FP policy and RH Commodities Security Situational Analysis emphasize the importance of community participation; increased demand; equity with focus on youth and the poor; continuum of care; need for infrastructure and human resources development (pre-service training); promotion of research as a tool for innovative and creative response; role of the media; roll out of Misoprostol to prevent PPH; behavioural change communication (BCC) campaigns focusing on men and women to increase acceptance of contraceptives. All these elements are covered in the SHARP project design and interventions.
The objectives and strategies of SHARP are therefore considered fully in line with current policies on how to strengthen RH services: support service delivery, promote and integrate FP in the services; enhance referral from community to facility level and on to hospital level if needed. The same holds for SHARP's active involvement of community based resource persons and structures such as TBAs, HHPs and VHCs in the promotion of health seeking behaviour.

However, the RH policies of SS also stress the (gradual) phasing out Community Midwives (CMW) and TBAs, which is not justified according to project staff given the context of South Sudan and its increasing fragility. These cadres play an important role in providing delivery services as long as there are not sufficient qualified midwives. With adequate support and mentoring the CMW and TBAs can improve their knowledge and skills. SHARP has rightfully incorporated CMWs and TBAs in capacity building and health promotion like FP and Misoprostol.

4.3 Situational analysis and needs assessment

Under the pressure of the bidding deadline for proposal submission, the original project proposal was written in the Netherlands with inputs from the three IPs that the KIT had selected. The authors of the proposal had never been in South Sudan and knew little about the country. The decision to target South Sudan was taken by the area leader Health in KIT. The proposal was eventually based on information from different policy documents, the experience of the three IPs in South Sudan and on KIT's long experience in health system strengthening, research and fragile countries. The IPs had been operational already for several years in the target states and stressed the need for improved RH services and capacity building of health workers. The choice of the other three main pillars (besides service delivery) corresponded with KIT's specific expertise and long-term experience in the area of capacity building, community participation and operational research.

The national MoH in South Sudan was not actively involved in drafting the original proposal and perceived this as an omission. The Director General (DG) for Primary Health Care put emphasis on the involvement of the SMoH as well in the further elaboration of the project and work plans to enhance ownership. A development perspective as pursued by SHARP requires involvement of the national MoH in the earliest phase possible; this has been a key lesson learned.

During the inception phase (2013), scoping missions were undertaken in all three states and health authorities at county and state level were consulted. Findings contributed to a better understanding of the context, key stakeholders, governance and major gaps. County level assessments were undertaken by IPs to ensure relevance of programme activities.

Findings of the scoping missions were translated into potential interventions in the following areas:
- Not all health facilities provide essential RH services
- Human resources for health: insufficient qualified staff
- Governance, actors and financing: impact austerity measures on health budget; informal fees
- Communication (m-health), referral and equipment
- Research, innovation and capacity building in HMIS
- Community empowerment

IMC conducted a health facility assessment in 2013 in close collaboration with Wau CHD and Cordaid conducted an assessment of RH services and needs in Melut County in September 2015. Both assessments formed the basis for the Work Plans. HealthNet TPO did not conduct a specific assessment for SHARP but proved well informed about the needs at health facility level, based on their long-term presence in the area under BSF and HPF. The initial plan to repeat the assessments at the end of the project did not materialize, mainly due to inaccessibility of facilities both in Wau and Upper Nile.

5 Effectiveness according to the 4 specific objectives (outputs)

In this chapter the four main outputs (pillars) of SHARP based on the specific objectives of SHARP are reviewed in detail along using the indicators set out in the M&E framework. Achievements against targets are presented in a table for each of the 4 outputs. More qualitative information on the effectiveness of the different activities is included. It was beyond the ToR of the external evaluation to pay attention to each activity in detail. The project logic (fig. 2) is guiding this chapter.

The 4 main outputs of SHARP as formulated in the Inception Report (fig.2) were:

1. Increased accessibility, availability and quality of reproductive health services
2. Capacity developed at all levels of the MoH to deliver quality comprehensive RH services
3. Context specific knowledge produced on effective modes on effective modes of service delivery for increased use of reproductive health services
4. Women, men, adolescents, families and communities demand quality RH services

5.1. Output 1: Improved availability, accessibility and quality of reproductive health services.

Table 3: Achievements against targets – output 1

Output 1	Indicator	Base Line	Target 2014	Target 2015	Source of verification
Output 1.1 Construction/ rehabilitation of health infrastructure[1]	Number of constructed or rehabilitated health infrastructure NBEG+WBEG Number of constructed or rehabilitated health infrastructure Upper Nile	N/A	19 CC/CU 11 Staff-house 7 CC/CU 3 Staff-houses	19 CC/CU 11 Staff-houses 8 CC/CU 4 Staff houses	Project reports
By the end of the project 23 infrastructures such as ANC wings, delivery rooms, staff houses and latrines were either rehabilitated or newly constructed. Target (42) was not achieved					
Output 1.2 Family Planning	Number of new acceptors of modern contraceptives		3000	4000	South Sudan HMIS
By the end of project the IPs reported a total of 6540 new acceptors of modern contraceptives since the start of SHARP. Target (7000) was not achieved. However, actual use is considered higher as some acceptors and health workers are reluctant to be registered.					
Output 1.3 AYSRH services	1. ANC use at age less than 20 years (of all ANC-1) 2. Adolescent birth rate at health facilities (of all facility deliveries) 3. New contraceptive acceptance rate among adolescents (15-19 years)	30% 4% <1%	40% 7% 3%	50% 10% 5%	Registry sampling
1. On average 14% of ANC users were 15-19 years old. Indicator and target not very meaningful **2. On average 7% of facility deliveries were girls 15-19 years. Indicator and target not very meaningful** 3. **On average 5% of girls 15-19 years accepted contraceptives in 2016 in NBeG and WBeG. Target achieved**					
Output 1.4 Maternal Health Care	1. ANC rate (ANC1) 2. Percent of women who delivered in health facility with skilled health personnel 3. Percentage of new mothers who attend PNC1	32% 4% 14%	60% 6% 15%	70% 8% 20%	HMIS
1. Average ANC-1 coverage rate reached 77% in the 4 counties together; Target (70%) achieved **2. Delivery by skilled birth attendant in facility rate reached approximately 10% in Melut and Aweil North and over 40% in Wau County. No data for Fashoda. The target (8%) was achieved. LQAS reports even higher rates** **3. PNC: Target (20%) not achieved except in Melut county (**verification not possible**)**					
Output 1.5 Referral Network	1. %Women delivered in BEmONC/CEmONC facilities 2. Nb of deliveries referred	9.5%	12% 2%	15% 5%	HMIS
1.Indicator was not monitored by SHARP. This indicator as defined here is not part of the HMIS/ DHIS. However the DHIS does provide data on the number of deliveries per BEmONC facility. Facility based data for Wau reveal that few deliveries took place in SHARP supported facilities whether BEmONC or not (see annex 4) and whether referred or not. Target not achieved. **2. According to IP reports and DHIS 1%-2% was referred. Target not achieved**					
Output 1.6 EmONC	Number of facilities with capacity to offer BEmONC NBEG+WBEG Upper Nile	0	 4 2	 9 2	Certification of facility; photos; observation; Project reports
Wau: 6 PHCC with BEmONC capacity/ potential; however midwives were hard to retain and in 2016 only 2 SHARP supported BEmONC facilities remained operational due to insecurity. Aweil North: 4 BEmONC					

[1] Delivery room, ANC room, PHCC/U, staff houses, MWH (maternal waiting home)

For output 1 SHARP achieved 3/8 targets (38%) while 5/8 targets were not achieved (62%).

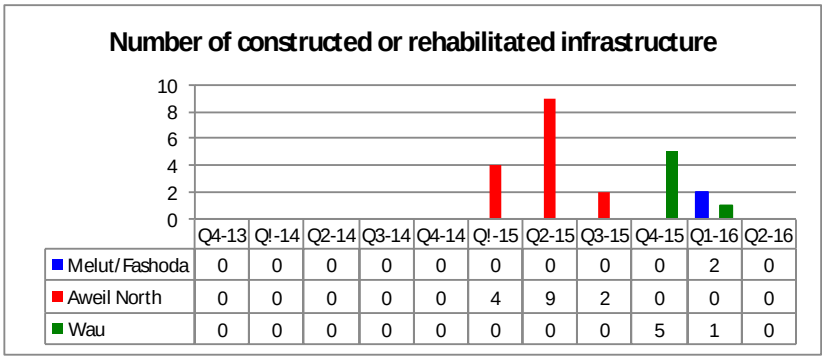
5.1.1 Construction, renovation and rehabilitation of infrastructure

In general the construction of latrines, staff houses, ANC wings and renovation of existing buildings resulted in improved infrastructure, increased access to services that were not provided before SHARP because of lack of space, in (some) staff retention and increased quality of care. Moreover, health workers perceived themselves as more respected once they could work in adequate spaces and well-equipped infrastructure. This project component is seen by the IPs and the MOH as a successful and tangible achievement of SHARP.

The targeted number of construction activities (42) was not fully achieved. Total number of constructions was 23 (see figure 4 below). Construction and renovation started relatively late. Delays were due to the insecurity, prices of construction materials and inaccessibility of the area in rainy season. While HealthNet TPO and IMC completed the planned construction activities, Cordaid had to cancel part of the construction plans particularly in Fashoda, due to insecurity and withdrawal from that county in 2015. However, Cordaid will finalize the construction in Fashoda with own funds. The construction of a BEmONC centre in Melut was finalized. Completed infrastructures were handed over to the respective CHDs.

IMC and Cordaid conducted a health facility assessment at baseline. None of the three IPs repeated the health facility assessment as endline. Progress was reported in the quarterly and annual IP reports. Validation of reported results could not take place during the external evaluation.

Figure 4: Number of constructed or rehabilitated infrastructure – IP reports



	Q4-13	Q!-14	Q2-14	Q3-14	Q4-14	Q!-15	Q2-15	Q3-15	Q4-15	Q1-16	Q2-16
Melut/Fashoda	0	0	0	0	0	0	0	0	0	2	0
Aweil North	0	0	0	0	0	4	9	2	0	0	0
Wau	0	0	0	0	0	0	0	0	5	1	0

5.1.2 Promotion and provision of family planning and birth spacing

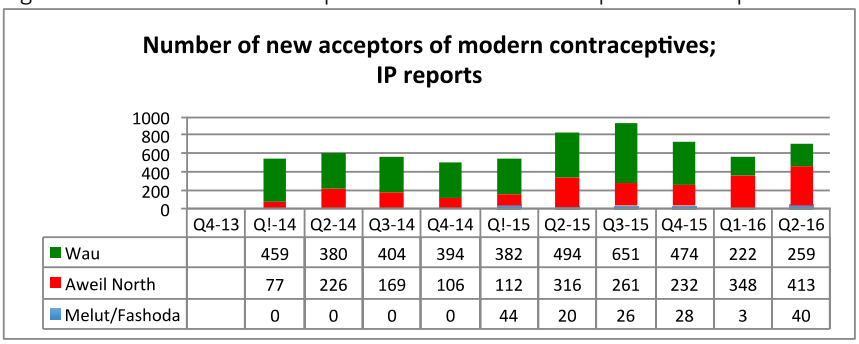
SHARP addressed FP and birth spacing both at supply and demand level aiming at an increased acceptance of modern contraceptives and birth spacing as a proven strategy to reduce maternal mortality and allow families to better care for their children. IPs, in cooperation with the CHD implemented the following activities:

Supply level:
- Training of health workers in class and on the job (mentoring) on short and long term FP methods
- Procurement and distribution of short term and long term FP commodities through UNFPA or other channels like Mary Stopes International (in Wau County)
- FP services: static and outreach services

Demand level:
- Operational research on Norms, Preferences and Expectations (NPE) in Wau and Jur River County
- Community participation programme / community dialogue in both Bahr el Ghazals
- FP and Birth spacing (BS) awareness creation at community level through HHPs, TBAs, VHCs, youth/peer groups and other community groups

Acceptance of modern contraceptives increased slightly in 2015 compared to 2014 in the SHARP supported facilities in Wau and Aweil North (figure 5). Increase was biggest in Aweil North. Wau County had the highest number of FP acceptors but increase was less tangible and in 2016 affected by insecurity, inaccessibility of some facilities and the departure of Marie Stopes mid-2015. A closer look at the DHIS revealed that FP in Wau county increased during SHARP compared to 2013 while in Aweil North, Melut and Fashoda the acceptance was lower in 2014 than in 2013 according to the DHIS.

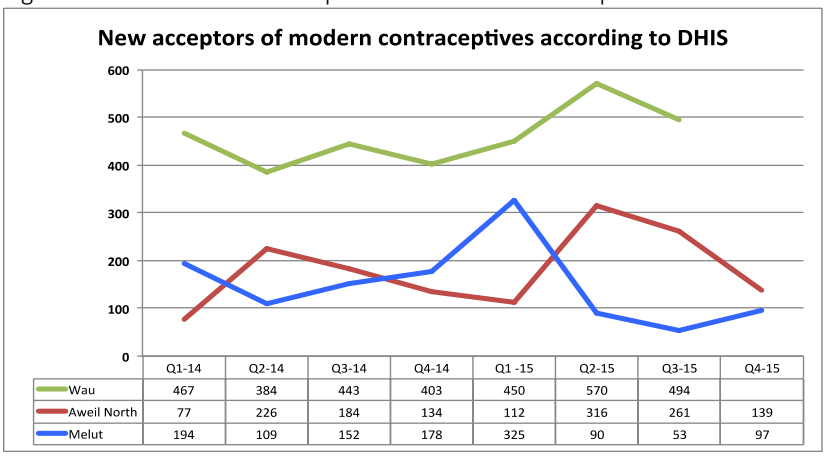
Figure 5: Number of new acceptors of modern contraceptives – IP reports



	Q4-13	Q!-14	Q2-14	Q3-14	Q4-14	Q!-15	Q2-15	Q3-15	Q4-15	Q1-16	Q2-16
Wau		459	380	404	394	382	494	651	474	222	259
Aweil North		77	226	169	106	112	316	261	232	348	413
Melut/Fashoda		0	0	0	0	44	20	26	28	3	40

The target of 7000 (cumulative) new acceptors by the end of 2015 was not achieved. IP staff, community dialogue reviews and the NPE policy briefs stress the fact that reported figures on contraceptive uptake may be lower than the actual uptake, because clients and even health workers may be reluctant to report contraceptive use.
Figure 6 presents the totals for all facilities in the SHARP supported counties according to the DHIS. The figures differ slightly, because IMC did not report to KIT on hospital based FP uptake and Cordaid reports uptake in SHARP supported facilities only. The overall trend is the same: on average there is a very slight increase in acceptance in 2015 countywide.

Figure 6: Number of new acceptors of modern contraceptives in all facilities - DHIS



	Q1-14	Q2-14	Q3-14	Q4-14	Q1 -15	Q2-15	Q3-15	Q4-15
Wau	467	384	443	403	450	570	494	
Aweil North	77	226	184	134	112	316	261	139
Melut	194	109	152	178	325	90	53	97

The MoH decided to replace the indicator on new acceptors in 2016 by WYPR (Women Years Protection Rate) and add detailed data on the different commodities (Pills, IUCD, Implant and Depo Provera). Condom distribution is a separate reporting line in the DHIS. This change in DHIS indicators affected the alignment of SHARP reporting with the government led HMIS/DHIS. The new contraceptive acceptance rate, postnatal care and referral rate from facility were all three removed from the HMIS monthly reporting format.

5.1.3 Adolescent and Youth Sexual and Reproductive Health Services

In line with the DGIS SRHR policy and the South Sudanese RH policy and strategic plan SHARP promoted and provided AYSRH services in Wau and Aweil North counties. Cordaid did not have enough time to include this component in its reduced intervention package and in the one year left for implementation. The AYSRH component covered the following:

- Awareness raising among community leaders and community in general
- Training health facility staff in supported facilities on youth friendly services
- Creating a youth friendly working environment in supported facilities
- Monitoring and reporting of AYSRH specific activities, not captured in HMIS

The specific attention for adolescent SRHR constitutes an important added value of SHARP because there is limited attention for AYSRH in the main health support programs of HPF, RRHP and UNFPA. It is a commendable complementary intervention that should be further strengthened in future to reach tangible results according to the people interviewed. It would also need an adequate M&E framework and sufficient time for implementation at the different levels of the health system and the community. The outcome of community sensitization, health workers capacity training and provision of youth friendly services could not be evaluated because the evaluation had no access to beneficiaries. IP staff indicated that awareness among health workers and community groups increased and that service uptake by young people increased as a result of demand creation and increased access to youth friendly services.

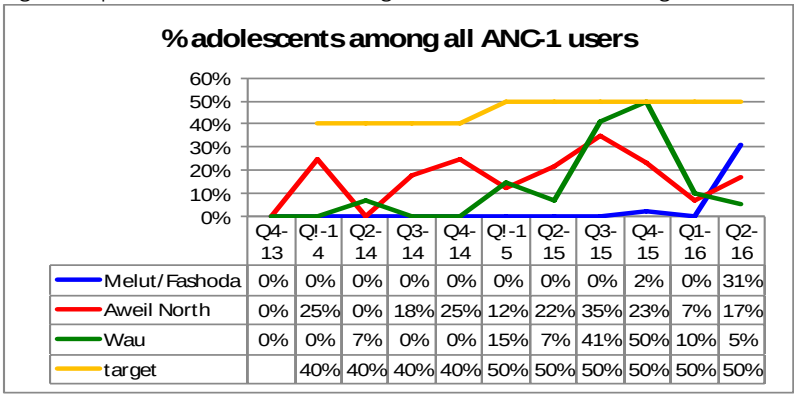
SHARP staff monitored and reported on three AYSRH specific indicators that are not in the DHIS

1. % Adolescents (15-19) among new acceptors of modern contraceptives
2. % Adolescent pregnant women (teenage pregnancies) among ANC-1 users
3. % Adolescents among all women giving birth in a facility

The indicators did unfortunately not provide very relevant information because the numbers of adolescent service users were initially calculated against the total service users and not against the target population of adolescents aged 15-19 years. It would have been more relevant to monitor the % adolescents in the county or catchment area of the facility that (i) attend ANC; (ii) give birth in a facility and (iii) accept modern contraceptives and then assess trends over time during (2013 – 2016). SHARP project management team decided to change the denominator for the indicator on adolescent use of contraceptives: Instead of the total number of users (in 2014) IPs calculated number of new acceptors against the total population of women 15-19 years from 2015 onwards. Rates dropped to more realistic figures except for Q1 and Q2 in 2016 with a steep rise in Aweil North that cannot easily be explained (see figure 7).

Any target for indicator 2 and 3 will be ambiguous: the more teenage pregnancies, the higher the proportion attending ANC or delivering in a facility. If SHARP pursues less early pregnancies then the target (proportion) should decrease over time. Data submitted by IPs prove that monitoring was not done in a regular well-understood way. The figure below presents the proportion of adolescent (15 – 19 years) ANC-1 users (teenage pregnancies) in the SHARP supported facilities. The three AYSRH indicators were SHARP specific and monitored by SHARP staff. Specific reporting tools were developed for this. The rates in fig 6 fluctuate a lot per quarter. It is not clear whether this is reflecting variable service uptake or quality of monitoring and reporting. The reported peak of 41% and 50% in Q3 and Q4 in 2015 by IMC may be an error rather than fact. Comboni hospital reported an adolescent proportion (teenage pregnancies) of 16.1% of all ANC users (7648) in 2016.

Fig. 6 Proportion adolescents among all ANC-1 users according to M&E framework/ IP reports



	Q4-13	Q!-14	Q2-14	Q3-14	Q4-14	Q!-15	Q2-15	Q3-15	Q4-15	Q1-16	Q2-16
Melut/Fashoda	0%	0%	0%	0%	0%	0%	0%	0%	2%	0%	31%
Aweil North	0%	25%	0%	18%	25%	12%	22%	35%	23%	7%	17%
Wau	0%	0%	7%	0%	0%	15%	7%	41%	50%	10%	5%
target		40%	40%	40%	40%	50%	50%	50%	50%	50%	50%

The targets of 40% and 50% are inappropriate according to the evaluator and interpretation of the reported data difficult. According to targets IP expected an increasing proportion of teenage ANC users while FP promotion aims for less teenage pregnancies

The % of adolescents (15-19) using modern contraceptives in Aweil North increased from 1.5% in Q1 2015 to 30% in Q2 2016 according to the quarterly reports submitted to KIT. This would mean that almost 1 in 3 young women in Aweil North uses modern contraceptives. It needs data verification and/or further analysis whether this figure is related to the uptake of condoms (and not necessarily the actual use). KIT staff reported a higher acceptance of contraceptives in Wau County because of its large semi urban population (end-line evaluation community dialogue report). It was beyond the scope of this evaluation to validate these reported (contradictory) trends.

The figures on adolescent birth rate as proportion of all facility deliveries in the respective counties vary a lot and are difficult to interpret. Targets cannot be set when comparing adolescent births with all births in the facility.

There is a strong emphasis on FP and AYSRH in the HPF-2 proposals (2016). This will enhance the sustainability and continuity of results achieved under SHARP. Cordaid and HealthNet will benefit from the experience gained during SHARP. Communities in Melut and Fashoda counties are more at risk of not accessing FP and ASRH services unless Cordaid and/or World Bank will cover these aspects.

> *" The uptake and access to quality Adolescent Sexual and Reproductive Health and Family Planning/ Birth spacing services will be increased by making available family planning/birth spacing services and adolescent friendly counselling on sexual and reproductive health services in all the PHCCs. However, given the cultural environment and the relative low acceptance of FP/SRHR services, most of the efforts need to be concentrated at the village level. For this reason, the SP (IP) and the CHDs will provide support to the HHPs to reach out to the communities (especially adolescents, girls of child bearing age and women) and disseminate FP and sexual and reproductive messages in the places where adolescents usually gather and spend their leisure time (markets, bars, churches etc.) by organising focus group discussions, organizing monthly health education sessions, organizing community meetings etc. The IPs/CHD will conduct community dialogue meetings on SRH/FP to address myths and misconceptions"* [quote from HPF-2 proposal by Cordaid and HealthNet]

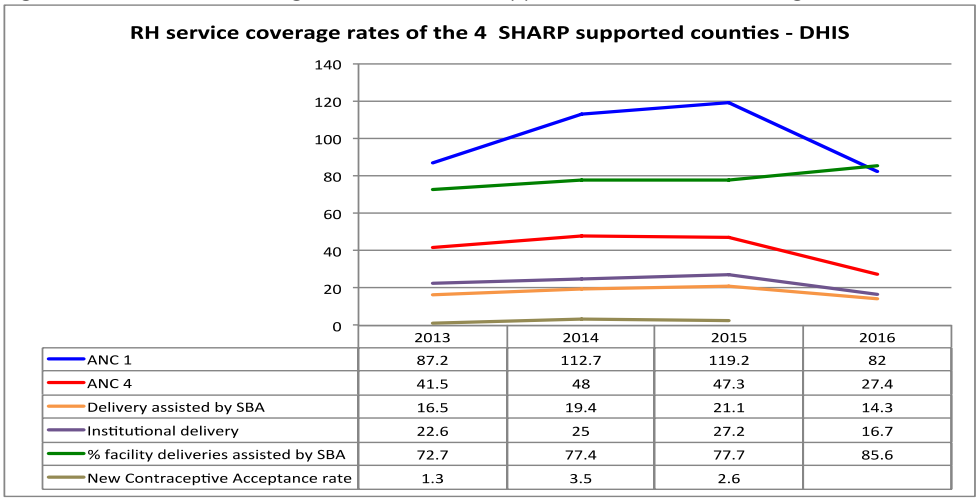
5.1.4 Maternal care improvement

SHARP aimed for improvement of maternal care through a comprehensive package of interventions / activities at community as well as health facility level:

- Infrastructure improvement of maternity wards, delivery rooms and ANC wings
- Recruitment of RH staff for the SHARP teams as well as for the supported health facilities
- Training of health workers
- Provision of RH equipment (for BEmONC and other RH services) and materials, supplementary drugs and solar power according to priority needs.
- Monitoring and supervision at facility level in close collaboration with CHD
- Awareness raising at community level
- Promotion of ANC/PNC, Birth Preparedness/Complication Readiness and normal labour and delivery (L&D) services through HHPs, community groups and other community structures
- Strengthening the referral system to increase access to BEmONC and CEmONC services
- Roll out of PPH prevention program (Misoprostol) in close collaboration with HPF and UNFPA
- Operational research to identify underlying causes of delays in maternal health care seeking

To assess the effectiveness of SHARP's investments in maternal care the evaluation looked at the service coverage rates in the SHARP supported facilities, counties and states. The IPs reported on three indicators for maternal health: ANC-1 coverage, institutional delivery rate and postnatal care (PNC) coverage. The evaluation also looked into ANC-4 or more, delivery by a skilled birth attendant in the facility and the proportion of facility deliveries attended by skilled personnel. The chart below shows the reproductive health service coverage rates over time for the 4 counties together. One expects a gradual increase in service coverage rates as a result of community awareness, construction, recruitment, training and supervision as well as research and community participation activities.

Figure 9: RH service coverage rates in SHARP supported counties according to DHIS



	2013	2014	2015	2016
ANC 1	87.2	112.7	119.2	82
ANC 4	41.5	48	47.3	27.4
Delivery assisted by SBA	16.5	19.4	21.1	14.3
Institutional delivery	22.6	25	27.2	16.7
% facility deliveries assisted by SBA	72.7	77.4	77.7	85.6
New Contraceptive Acceptance rate	1.3	3.5	2.6	

N.B. coverage rates above 100% are related to underestimation of populations by the DHIS. Returnees have not been counted because the DHIS is based on the Census of 2008

According to the DHIS antenatal and delivery care services slightly increased in the course of SHARP and particularly ANC 1st visit. The drop of all rates in 2016 is most likely related to (i) the incompleteness of the DHIS database for 2016. Past experience with the DHIS showed that it takes time before all monthly reports from all counties are processed into the national DHIS system and data cleaned by the MoH. (ii) In Wau many facilities were closed and no data were submitted to the CHD-DHIS system.

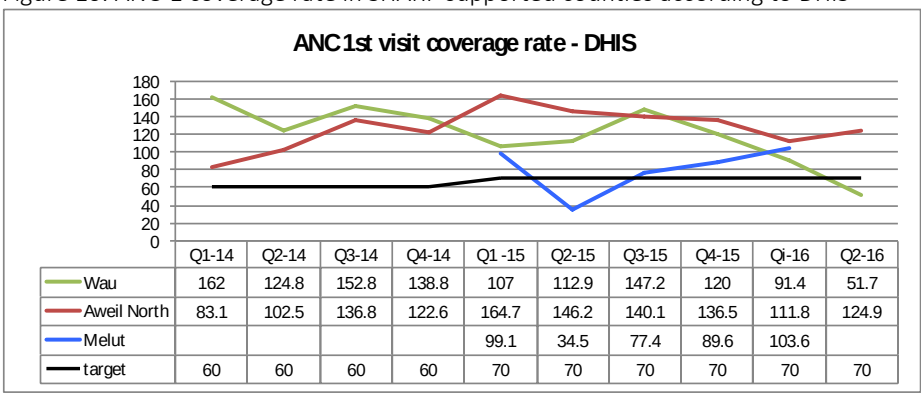
The DHIS county coverage rates in the chart above are based on data from all health facilities in the respective counties and include uptake in facilities that are not supported by SHARP such as 2 hospitals in WBeG, IDP camp services in UN and MSF supported PHCC in Aweil North and public PHCC/U.

The increase in service coverage is small but the targets for ANC-1 (52%) and delivery attended by a SBA (8%) were achieved in all SHARP supported counties in spite of the fact that the context in which services were delivered was often not conducive at all, particularly in Upper Nile and recently (2016) in Wau as well.
Comparing data for SHARP supported counties with data of counties that were not supported by SHARP shows that in many not SHARP supported counties service coverage rates for ANC and delivery were lower. Annex 6 provides detailed information on service coverage rates in some neighbouring counties.

Attribution of the increase in service coverage to SHARP may not be justified. The attention of SHARP for the continuum of care and the comprehensiveness of the intervention package has probably contributed to the increasing service coverage rates. Other parties however like HPF, UNFPA, WHO, WB also supported maternal care. The annual county health plans cover the roles of the different stakeholders in the county; the role of SHARP is not always distinct and/or measurable. SHARP had a more exclusive role in fostering community participation and operational research than in service delivery support.

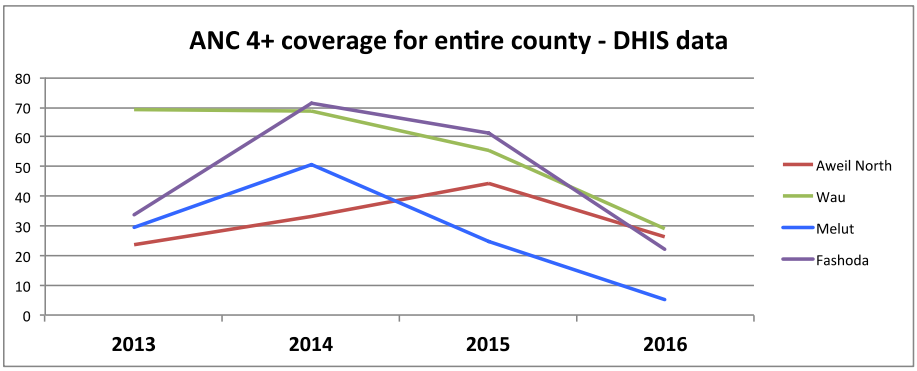
ANC-1 coverage rates (see charts below) increased over time in all four counties. Aweil North and Wau report rates that exceed 100%, which de facto is not possible. If target populations are underestimated coverage rates turn out higher than they actually are. In the past HPF staff discussed this issue of underestimation with the MoH and HISP who provide technical assistance to the MoH but the figures were not revised. All counties performed well in terms of reaching the target of 70% ANC-1 according to DHIS county figures.

Figure 10: ANC-1 coverage rate in SHARP supported counties according to DHIS



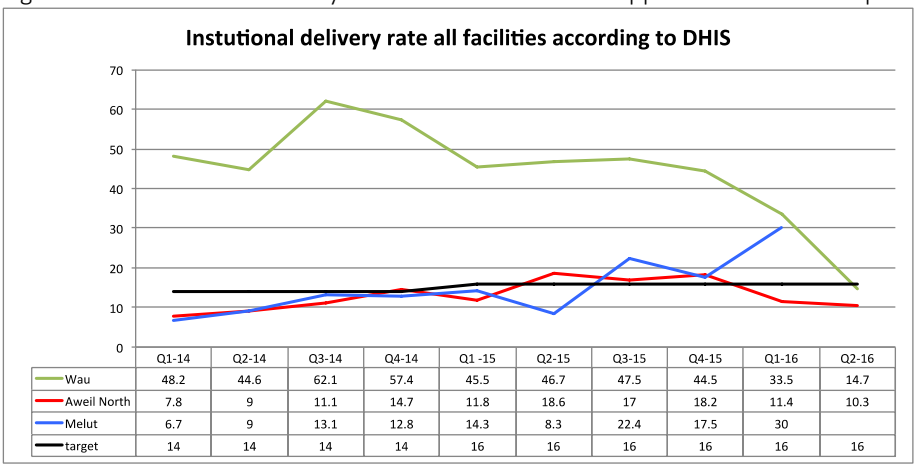
	Q1-14	Q2-14	Q3-14	Q4-14	Q1 -15	Q2-15	Q3-15	Q4-15	Qi-16	Q2-16
Wau	162	124.8	152.8	138.8	107	112.9	147.2	120	91.4	51.7
Aweil North	83.1	102.5	136.8	122.6	164.7	146.2	140.1	136.5	111.8	124.9
Melut					99.1	34.5	77.4	89.6	103.6	
target	60	60	60	60	70	70	70	70	70	70

Figure 11. ANC-4+ coverage rate over time in SHARP supported counties according to DHIS



Except for Aweil North the ANC 4th coverage rate went down in 2015. When pregnant women do not attend ANC regularly and from an early stage in pregnancy onwards, they run more risk that complications and risk factors are not identified in time. On average less than 50% of pregnant women attend 4 times or more.

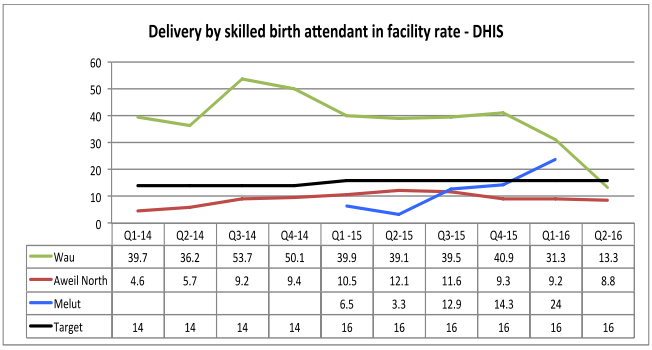
Figure 12. Institutional delivery rate in the three SHARP supported counties compared with target



	Q1-14	Q2-14	Q3-14	Q4-14	Q1 -15	Q2-15	Q3-15	Q4-15	Q1-16	Q2-16
Wau	48.2	44.6	62.1	57.4	45.5	46.7	47.5	44.5	33.5	14.7
Aweil North	7.8	9	11.1	14.7	11.8	18.6	17	18.2	11.4	10.3
Melut	6.7	9	13.1	12.8	14.3	8.3	22.4	17.5	30	
target	14	14	14	14	16	16	16	16	16	16

Because the IP did not use the same formula when calculating coverage rates, this report uses the DHIS county coverage rates based on reported uptake of services. According to the DHIS figures approximately 50% of women in Wau county delivered in a facility in 2014-2015; in Melut and Aweil North approximately 20% with a trend towards 30% in Melut in 2016. The target of 16% institutional delivery rate was achieved in 2015

Fig. 13: Delivery by skilled birth attendant in facility rate in SHARP supported counties (DHIS)



	Q1-14	Q2-14	Q3-14	Q4-14	Q1 -15	Q2-15	Q3-15	Q4-15	Q1-16	Q2-16
Wau	39.7	36.2	53.7	50.1	39.9	39.1	39.5	40.9	31.3	13.3
Aweil North	4.6	5.7	9.2	9.4	10.5	12.1	11.6	9.3	9.2	8.8
Melut					6.5	3.3	12.9	14.3	24	
Target	14	14	14	14	16	16	16	16	16	16

SHARP set a target for the delivery by a skilled birth attendant rate (16% by end of project) but this indicator was not included in the M&E framework while it is a proxy indicator for maternal mortality reduction. In Wau County more than 40% deliver in a facility assisted by skilled staff, particularly the pregnant women in urban areas. Women who live far from town and depend on rural health facilities have less access to skilled staff or use the facility services less. SHARP recruited midwives for the rural PHCCs but the utilisation of ANC and delivery services remained very low (see annex 5).
While in Wau 40%-50% of all pregnant women delivered with the assistance of a skilled birth attendant and almost 90% of all facility deliveries were attended by skilled staff, the target of 14% skilled birth attended delivery rate was not achieved in Aweil North in spite of all the efforts of HealthNet/CHD to improve access to quality care by recruitment of midwives, construction, training, equipment etc. The rate increased over time but more than 85% of pregnant women delivered without skilled assistance. Cordaid managed to raise the rate a lot in short time to 24%. If the WB will not fund RRHP-2 Cordaid will continue supporting maternal care with alternative funds. This is a commendable initiative to sustain SHARP achievements.

Fig. 14: Proportion of facility deliveries assisted by a skilled birth attendant (DHIS)

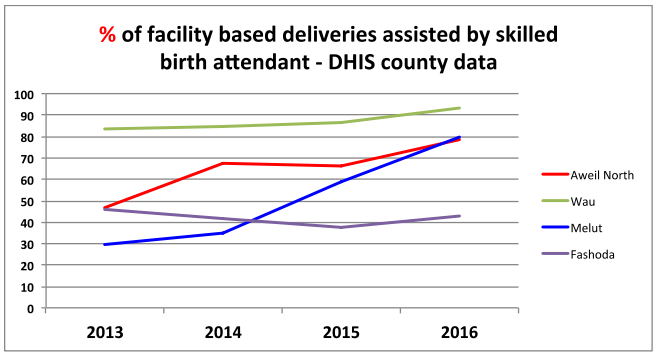
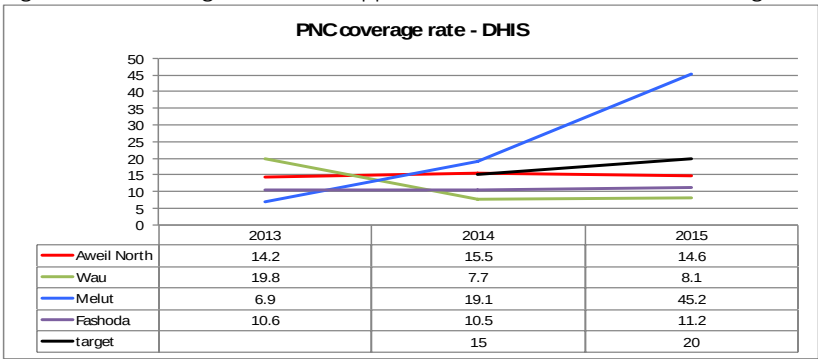


Figure 14 shows that the proportion of facility deliveries attended by skilled staff increased in 3/4 counties. Once a pregnant woman seeks delivery care in a facility, skilled staff will likely attend to her. This is a major step forward in terms of quality care.

Fig.15: PNC coverage in SHARP supported counties over time according to IP reports versus DHIS



	2013	2014	2015
Aweil North	14.2	15.5	14.6
Wau	19.8	7.7	8.1
Melut	6.9	19.1	45.2
Fashoda	10.6	10.5	11.2
target		15	20

Postnatal care did not develop well except in Melut (if data are reliable). Generally less than 15% of women attended postnatal care services after delivery in 2014-2015. The indicator has been removed from the DHIS in 2016 due to difficulties with indicator definition and inconsistent reporting.

The prevention of post partum haemorrhage (PPH) program, initiated by JHPIEGO in Western Equatoria in 2012, taken forward by HPF in 2014 to all 6 HPF states, gradually covers facility level and has started to reach out to community level with support of SHARP and HPF. SHARP has contributed by training HHP and TBAs and raising community awareness on the PPH program. It needs continuation of efforts in 2017 and beyond to become fully integrated in the BPHNS as well as in the Boma Health Initiative. There are no reliable data available to measure the outputs for PPH prevention activities.

SHARP did not prioritise abortion related morbidity and mortality and Gender Based Violence, which are key elements in SRHR and emphasized in MISP (Minimum Initial Service Package) for Reproductive Health in Crisis Situation. MISP-training was provided for some health workers but interventions addressing abortion, post-abortion and GBV have not been covered in reports.

5.1.5 Improvement of the referral system in the state and the county

The main activities undertaken by SHARP partners in close collaboration with the CHD were:
- SMoH (WBeG) referral system: Policy, guidelines and procedures (June 2015)
- Setting up a state level referral taskforce in NBeG
- Development of referral tools
- Procurement of communication tools (VHF radios)
- Procurement of means of transport (ambulances, quad bikes)
- Follow up and monitoring of the actual referral system effectiveness

A target of 5% referral of deliveries from a facility to a higher level was set by SHARP for 2015 and a second target of 15% deliveries in a BEmONC /CEmONC facility. Both targets were not achieved. The delivery from facility indicator has been removed from the DHIS in 2016.

In the course of 2014-2015 a State Referral Guide was developed for WBeG and an official SMoH document on referral has been formalized. It describes policy, guidelines and procedures to be adhered to by all stakeholders. IMC has been leading this process with funding from HPF and with involvement of all key stakeholders. It is a major step forward to address obstetric complications and other emergencies effectively and will contribute to the reduction of maternal mortality if the system will be sustained. HPF will continue funding the system after SHARP.

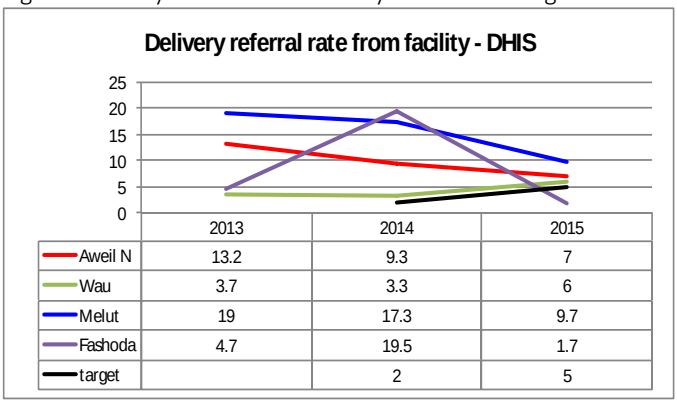
The State referral system development in NBeG encountered problems in getting off the ground. According to SHARP staff there was resistance / poor commitment of the SMoH. In 2014 SHARP conducted a very relevant statewide assessment of the distribution of modes of transportation and communication and based on this assessment a draft plan and budget was drafted. However, in spite of many efforts the statewide plan did not materialize as it did in WBeG. The ownership and engagement

of the SMoH level in WBeG appears stronger and therefore the referral system may prove more sustainable.

Given the investments in means of communication and transport in the four counties, the 24 hours CEmONC services in Wau Teaching Hospital, Comboni Hospital and Aweil State hospital and the call centre for emergencies in Wau county, the referral system has effectively improved and more obstetric emergencies effectively dealt with. It was not possible to validate this assumption and assess whether the improved referral system has resulted in more referrals and timelier lifesaving interventions. The DHIS has taken out the two indicators for referral since 2016 and has introduced a new indicator on EmONC related referral for which there is no data yet. The DHIS nowadays includes specific data for hospitals but it is beyond the scope of this evaluation to analyse the hospital-based data. HPF-2 will probably report to the donor on hospital-based achievements.

IPs reported on referred deliveries from facilities. The DHIS included 2 indicators for referral (from community to facility and from facility to higher level) till 2016. The charts prove hard to interpret because a decrease in referral could reflect improved care in the PHCC; but the contrary could be true as well. When looking at county rates the target (2%-5%) is reached in each county. Validation of the data is impossible.

Fig 16: Delivery referral from facility rates according to DHIS



	2013	2014	2015
Aweil N	13.2	9.3	7
Wau	3.7	3.3	6
Melut	19	17.3	9.7
Fashoda	4.7	19.5	1.7
target		2	5

5.1.6 Improvement of access to EmONC services

- Infrastructure improvement for BEmONC services preparedness
- Construction of staff houses (NBeG) to ensure 24 hours accessibility to staff
- Recruitment and retention of skilled birth attendants / midwives
- Training of facility staff on EmONC
- Procurement of equipment and supplies
- Support to Raja Civil hospital (WBeG)
- Support to the development of a State referral plan in NBeG / WBeG.
- Training of TBAs and HHP on early identification of danger signs and facilitation of referral

All IPs managed to develop BEmONC services according to their targets: 5 BEmONC centres in Wau County, 4 in Aweil North, 1 in Melut and 1 in Fashoda. However, the BEmONC centres could not sustain 24 hours access to skilled personnel and this was a huge problem in Wau county where most SHARP supported midwives resigned in the course of 2015 and where the conflict in 2016 urged facilities to close their doors. By mid 2016 only 2/6 SHARP supported PHCC were operational. Staff from closed PHCC was contracted for work in the IDP camp in Wau with support from IOM; midwives in functional facilities were taken over by HPF. Availability of oxygen cylinders has apparently been a problem so offering all 7 BEmONC services continues to depend on certain supplies, often beyond NGO capacity.

Access to BEmONC services in SHARP supported PHCCs increased but the actual utilization varied per county. In Wau County only 2% of all skilled attended deliveries took place in SHARP supported facilities

and 89% in Comboni, WTH and Lokoloko where 75% of all facility deliveries in Wau County in 2014 and 2015 took place. During the crisis Comboni Hospital and Lokoloko PHCC remained functional while WTH services were affected. The referral system in Wau County suffered because ambulances could not move freely outside town. Raja Hospital was totally looted in 2016 and had to stop EmONC services.
IPs reported from 2015 onwards on number of deliveries in EmONC facilities but data proved incomplete and not useful for any conclusion. Facility based data for the three counties were collected by the evaluator and analysed. In the SHARP supported facilities in Wau County the uptake of ANC and delivery services remained very low during SHARP implementation. In Aweil North and Melut the ANC uptake was rather high but delivery services uptake low. See annex 5 on facility-based information.

5.2. Output 2: Increased Human Resources Capacity for quality RH services

Table 4: Achievements against targets – Output 2

Output 2	Indicator	Base Line	Target 2014	Target 2015	Source of verification
Output 2.1 Recruitment of HF staff	Number of COs, Nurse, MWs, MCHWs recruited and retained NBEG+WBEG Upper Nile		5 COs 5 Nurses 10 MWs 25 MCHWs 2 CO 2 Nurses 13 MW 1 MCHW	5 COs 5 Nurses 10 MWs 25 MCHWs 2 CO 2 Nurses 13 MW 1 MCHW	Project reports
158 health workers were recruited, which is far beyond the target. High staff turnover necessitated continuous recruitment of new staff. Target (126) achieved					
Output 2.2 Training of HF staff and community health workers	Number of trained HF staff on family planning (50 staff), youth friendly services (50), maternal health (90) and EmOC (50 staff). (NBEG+WBEG) UN: Nr trained HF staff on FP (18) and EmOC (12)		240 30		Project reports
713 health workers attended trainings; not all different individuals because many attended more than one trainings. Target (270) achieved.					
Output 2.3 Health governance capacity building	1. SRH management training (L&M) and mentoring programme for 25 staff of the SMOH and CHDs 2. Scholarships for a Masters in Public Health	N/A	25 6		KIT training monitoring report
Of all participants, often changing per block, 9 CHD staff received a certificate for having attended at least the full first four blocks. One from Upper Nile, the others all from N/WBeG. Target not achieved **Three SS medical doctors got a scholarship and attended the MPH course in KIT. Target (6) not achieved**					
Output 2.4 Support and capacity building for medical and public health education	1. Operational support provided to midwifery school in Aweil ensuring continued training of 19 students for 2nd and 3rd year. 2. Wau Midwifery school supported for practical placements 3. Collaboration established with University of Wau to build institutional capacity	N/A	Students trained 2nd yr: 19 Capacity staff incr.	Students complete training: 19 Curriculum developed	NBEG project report WBEG project report KIT training report
1. Support provided according to plan. Target achieved and school operational today **2. Wau School received one off support but no facilitation of placements. Target not achieved** 3. **Staff of the University participated in the Research; some institutional capacity building. Achieved**					

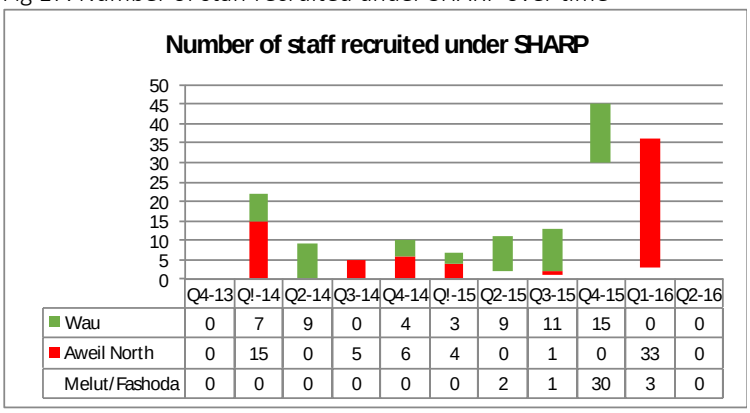
5.2.1. Recruitment and retention of health workers

Recruitment has been a continuous ongoing activity because it proved very hard to find qualified staff and retain staff in remote and/or unstable areas with a limited conducive working environment.
Qualified staff was recruited but several soon resigned to seek greener pastures. IPs sought solution to this problem and initiated staff retention measures such as:

- Building staff houses near the health facilities to create a more conducive environment
- Supportive Supervision and mentoring of health workers.
- Support to midwifery schools in the state to increase access to qualified staff (from the area)
- Harmonisation with HPF in terms of salaries (harmonized salary scales set by the MoH)

In total 158 health professionals were recruited. This was beyond the targets of WBeG and NBeG (126). Staff turnover presumably affected the quality of the services though hard evidence is lacking. The evaluation could not meet with health workers to review the problem of retention.

Fig 17: Number of staff recruited under SHARP over time



	Q4-13	Q!-14	Q2-14	Q3-14	Q4-14	Q!-15	Q2-15	Q3-15	Q4-15	Q1-16	Q2-16
Wau	0	7	9	0	4	3	9	11	15	0	0
Aweil North	0	15	0	5	6	4	0	1	0	33	0
Melut/Fashoda	0	0	0	0	0	0	2	1	30	3	0

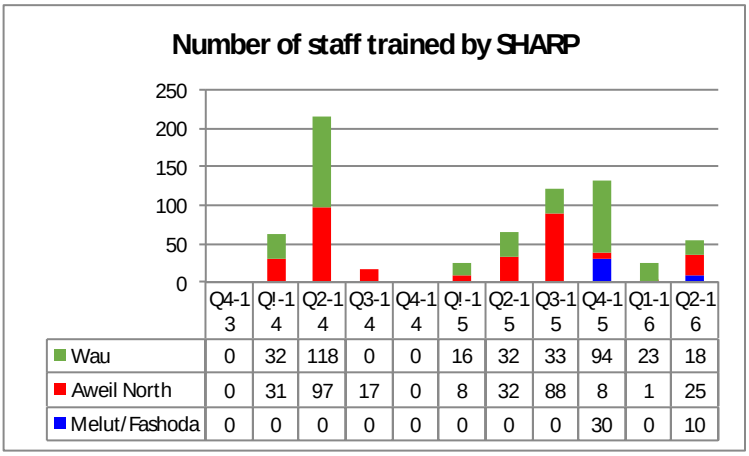
5.2.2. Training of health workers

Health workers were trained on a range of topics:

- Family Planning
- Youth Friendly SRH Services
- Maternal care
- BEmONC signal functions
- PPH prevention (Misoprostol)
- MISP

A total of 713 health workers attended the trainings, well beyond the target of 270, a commendable achievement. Many health workers attended several trainings so the number of 713 represents participants, not all different individuals. Follow up of training by IPs/CHD was done during supportive supervision visits.

Fig 18: Number of health facility staff trained by SHARP



	Q4-13	Q!-14	Q2-14	Q3-14	Q4-14	Q!-15	Q2-15	Q3-15	Q4-15	Q1-16	Q2-16
Wau	0	32	118	0	0	16	32	33	94	23	18
Aweil North	0	31	97	17	0	8	32	88	8	1	25
Melut/Fashoda	0	0	0	0	0	0	0	0	30	0	10

A distinct strength of SHARP has been the focus on AYSRH, which was given limited attention under HPF-1 & RRHP. The training on FP in combination with the Operational research on family planning, awareness raising by HHP and the community dialogue sessions that also covered FP and child spacing constitutes a commendable added value of SHARP and might be sustained under HPF-2. Overall the acceptance rate of modern contraceptives remains very low, not only in SHARP supported counties but in the entire country.

IP reports indicate that CHD and health facility staff reported back-to-back trainings of CHD and a perceived overkill of trainings of health workers, hampering other activities. Health workers risk being more in class than in the facility. This is not primarily due to SHARP, but to the amount of trainings provided by the sum of stakeholders: HPF, UNFPA, UNICEF, MoH and SHARP. Under SHARP 713 people were trained, far beyond the target of 270. To what extent this number has affected staff availability at work is not known but the feedback from training participants reveals a serious risk. The comprehensive county health plan and review and donors/fund managers/IPs should continue to critically look at the needs base for training and added value of trainings. On the job mentoring and peer review may sometimes be good alternatives.

IMC trained many health workers, not only in Wau county but also in other counties in the state and adheres thereby to one of the guiding principles of SHARP: state- and county focus.

Without field visits and meetings with beneficiaries of trainings and observation of quality of services the assessment of the training outcome by the evaluator remains superficial.

5.2.3. Capacity building of County and State level health authorities

The governance capacity building of government health authorities included (i) an elaborate Leadership and Management training for CHD and SMOH staff from the three states as well as (ii) a post graduate Public Health Master course in KIT of three South Sudanese medical doctors.

The L&M course consisted of 6 modules of each one-week aiming at stepwise building the capacity of county and state level health authorities. KIT staff developed the course material in close consultation with representatives of L&M course target groups and a representative of the national MoH.
The intended outcomes were:

- Improved capacity to lead and manage the provision of integrated SRH services, incl. human resource management
- Improved strategic and operational planning of integrated SRH activities.
- Improved supportive supervision, monitoring and evaluation of integrated SRH service delivery.
- Improved coordination of actors working on SRH at the Primary and Secondary Health Care level.

To get feedback from beneficiaries of the component the evaluator contacted the two HPF state coordinators for NBeG and WBeG who participated in the L&M training and the three MPH students.

In interviews it came out clearly that the training was highly appreciated. Well prepared, well structured, interactive and corresponding with a felt need of staff of CHD and SMOH. The training built capacity in the areas of: SRH management and planning; Monitoring, supervision and performance management; SRH leadership and accountability; advocacy; presentation and writing skills; community participation and research basics.

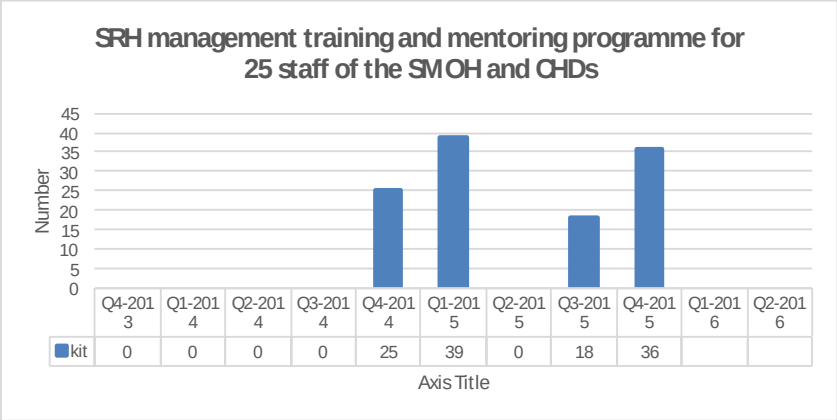
KIT paid adequate attention to monitoring and evaluation of the course through (i) daily evaluation of the course during the 6 blocks; (ii) testing knowledge in some pre- and post-tests; (iii) assessment of satisfaction of participants and their recommendations for subsequent blocks; and (IV) monitoring/mentoring of writing skills by London based editor.

Feedback by participants after the various blocks concerned among others:

- Assignments and reading before and in-between workshops, with feedback/remote tutoring; interactive group work and practical exercises were perceived as most effective learning modalities. Appreciation of skills development through practical tasks came out very clearly.
- Language barrier affected the effectiveness of the course for some participants. Many health workers were trained in Sudan (North) and do not master English language
- Health authorities tended to delegate lower level staff; this should be avoided
- Recommendation to link the course content to SHARP project components where relevant e.g. community participation

Having the same group of approximately 25 participants attend all blocks appeared not feasible. Eventually 9 CHD staff received a certificate of attendance (attended at least the four first blocks). So the target was not achieved. Upper Nile health authorities were under-represented due to insecurity, distance and availability of CHD staff. The course could not be held in Upper Nile so selected MoH staff needed to travel to Wau.

Fig.19: Number of CHD/SMOH staff attending Leadership and Management training



The planned mentoring in between the six training modules has not taken place. It is perceived as a shortcoming by KIT staff and participants' evaluation reports confirm this. It would have enhanced the outcome of the training in terms of applied knowledge and skills.
A foreseen role of IMC and HealthNet in follow up on training implementation in daily interactions, liaise with mentor and KIT on what works well in practice and what does not did not materialize as it was part of the mentoring trajectory.

KIT consulted HPF on the complementarity of L&M training to the Supportive Supervision and County level integrated health planning support provided by HPF (HSS section). HPF state coordinators participated in the training. While the HPF training modules were developed together with the MoH, KIT developed the modules as KIT/SHARP with inputs from modules previously used by Abt Associates in WES and CES. For future use in South Sudan KIT may need to actively lobby. Involvement of the MoH will

contribute to sustainability. During the final Council meeting in December 2016 in KIT the training was presented with a representative of HPF/MoH present.

The Modules are open source so other interested parties can access the modules. HPF-2 proposals do not explicitly mention the L&M training modules to be used but the need for continued capacity building is clearly indicated: "*Although some governance and leadership programme have been set up during HPF-1 in Raja, Aweil North and Aweil West counties, it can be argued that the CHD stewardship function still needs to be properly developed and that the lack of key skills and knowledge prevent the CHD team from taking a real proactive role as coordinator of all partners (NGOs, UN agencies) active at the county level. The SP/IP will continue to work with the CHDs to build its planning and supervisory skills by assisting the team in the development of quarterly activity plans and by jointly conducting quarterly supervisory visits to the health facilities".*

It was impossible to assess the outcome of the training in terms of improved leadership and management capacity and its impact on maternal health. But the knowledge and skills are essential for effective leadership and the health care system will presumably benefit in the coming years. With continuation of health system strengthening under HPF-2 knowledge and skills will continue to increase.

5.2.4. Upgrading MoH RH staff: MPH in the KIT

After a period of negotiations with the MoH on the relevance of sending South Sudanese for an MPH study to Amsterdam versus investing in local midlevel training and pursue institutional collaboration in-country, both parties agreed that a post graduate public health training in KIT would eventually be a good investment. It proved hard to find suitable candidates and get all preconditions met. Three medical doctors, not necessarily hailing from SHARP supported states, attended and graduated in 2016. The target was 6 sponsorships; so 50% achieved. At short term this intervention may not contribute to achieving the specific objectives of SHARP but it is considered a long-term investment in human resources development. All three participants expressed that they are very satisfied with the course content and confident that they will contribute to health development in South Sudan. It is however not ensured that they will work within the domain of Reproductive Health. One personally felt the need to keep up his medical knowledge and skills, which he acquired during his training as medical doctor and work as a doctor but with a public health perspective.

5.2.5. Support to South Sudanese Training Institutions

According to the *Inception Report* SHARP would provide technical support for the establishment of a midwifery-training institute in Upper Nile; contribute to the midwifery curriculum development process at national level; contribute to coaching for medical staff involved in practical training at the Wau Teaching hospital. SHARP would explore the possibility of strengthening existing public health education capacity in the country through support for curriculum development, training of teachers, and institutional capacity building, particularly of the University of Bahr el Ghazal Institute for Public Health and Environmental Health.

These ambitions have not fully materialized as realities on the ground proved different. SHARP contributed to the training of tutors in Wau Midwifery School and provided as a one-off intervention material and operational support that enabled the schools to function. The main support consisted of:

- Support to Aweil Midwifery Training School in NBeG. One off support to the running of the school: office supplies; student stationaries; training manuals and modules; furniture; computers and printers; projector; generator. This support was in line with the request of the SMOH in NBeG and the former Minister expressed his high appreciation for SHARP's role in revitalizing the school. The school is fully functional by the end of 2016 with 45 students enrolled in training.
- Support to Wau Midwifery School: Tutors were trained as Master trainers on a variety of topics by RH experts of IMC; training models /phantoms were procured and donated to the school for training purposes. The expected role in coaching medical staff and support curriculum development did not happen.

- One staff member of the University of WBeG participated in the Research conducted by the KIT on Norms, Preferences and Expectations (NPE).There has been limited technical assistance to the institutes in terms of curriculum development, coaching of students and institutional capacity building. The planned support to a training institute in Upper Nile proved not feasible.

5.3. Output 3: Knowledge produced and disseminated on effective and efficient reproductive health service delivery models

Output 3	Indicator	Base Line	Target 2014	Target 2015	Source of verification
Output 3.1 Operational research / Operational innovation	Number of OR activities initiated and completed	N/A	3	6	KIT OR progress report
3 Studies on NPE were undertaken in 2 different counties and one among young people; all in WBeG 2 Policy briefs were produced and disseminated; 2 Research articles published in late 2016; training of some journalists accomplished; 4 webinars initiated. Several other planned outputs (additional studies, policy briefs, research articles) did not materialize. Target (9) was not achieved					
Output 3.2 Monitoring and evaluation	1. 5 M&E field visits 2. 1 Midterm review 3. Final external evaluation **4.** Quarterly reports received and reviewed	N/A	2 field visits 1 MTR 4 Quarterly reports	3 field visits Fin. Evaluation 4 Quarterly reports	KIT reports MTR report Quarterly reports
5 M&E visits realized but not covering all counties every time. Upper Nile actually not visited in 2015/ 2016 1 desk based Midterm evaluation undertaken by KIT for SHARP in NBeG & WBeG. 1 internal evaluation by Cordaid in Melut/ Upper Nile (desk based); 1 final evaluation by the end of 2016 (desk based). Targets achieved All expected quarterly reports were submitted: 27/ 30. Three reports not submitted because Cordaid was not operational for some period. Target achieved					

The location of M&E under the Operational Research component of SHARP in the logical framework is considered inappropriate. M&E is part of project management and cutting across all pillars of SHARP. In the SHARP budget Operational Research and M&E have also been separated. This evaluation report reviews the M&E of SHARP therefore in a separate section under management of SHARP.

5.3.1. Operational Research

According to the Inception report the operational research component would consist of close monitoring, evaluation and documentation of a number of innovative aspects of the SHARP programme, as well as a number of distinct research projects, which would inform the programme. A research agenda was developed through a situation analysis (desk review and scoping missions), consultations with key stakeholders and a prioritization exercise with implementing partners.
From a list of potential research topics only the study on Norms, Preferences and Expectations about family planning, pregnancy, childbirth, and about related services was actually conducted towards the end of 2014. The aim was to inform the design and redesign of SRH program activities. The study consisted of 3 parts: one study on NPE among the general population in Wau County, a second one in Jur River County and a third NPE study in Wau County with a specific focus on youth.

To facilitate research-policy-programming linkages, SHARP originally planned to:
- Engage stakeholders throughout the research process and disseminate findings to all these audiences with appropriate tools.
- Knowledge exchange meetings across a wide variety of audiences (policy makers, service managers, NGOs, communities) towards achieving a variety of ends (influencing policy, improving service delivery, and strengthening community ownership and accountability).
- Hold workshops with researchers and partners to document lessons learned and develop knowledge products.
- Disseminate findings and lessons learned through international, national and local meetings on reproductive health, and conferences, as well as various web-based media

The expected linkage between research, policies and programming has not been fully achieved. Some policy briefs were developed and disseminated but the expected link with programming could not be developed primarily because of the too short time frame and a non-conducive environment.

IP staff involved in the research in WBeG expressed great appreciation of the study in terms of newly gained insights as well as research skills. The findings opened their eyes. SHARP staff in other states did not gain much from the research in WBeG. HealthNet expected applied research based on operational questions would enable IPs to do a better job. The intended studies for 2016 were more in line with these expectations particularly the VHC and staff retention studies. However the studies did not effectuate.

Based on the NPE research findings the following outputs were achieved
- 2 Policy Briefs written up by KIT and disseminated through the MoH
- Some journalists working with Internews were trained on appropriate health messaging.
- 3 Research articles were published in the course of the second half of 2016
- 4 Webinars, spin off Dec 2015 conference in KIT on RH in fragile context were launched
- 2 Videos on SHARP were made for promotion
- Presentations of IMC and KIT staff at international conferences

These outputs may not have immediate effect on the reproductive health status and programming in South Sudan but are potentially valuable in future programming.

Several planned activities for 2016 were eventually not accomplished by the end of 2016
- Retention study
- Village Health Committee study
- Production and dissemination of a policy brief on sexuality education
- Policy analysis study and publish 1 paper

Part of the delay in implementation was caused by the South Sudanese context related constraints but limited implementation capacity within KIT as result of workload also contributed.
Applied research / case studies on operational innovations, on piloting referral reporting forms, on village health committees and retention of health workers did not materialize. For some studies ethical approval was eventually received but then feasibility was low in Wau County due to increasing insecurity and limited time left. HealthNet had not been involved in then research because of limited capacity in 2014.

It proved difficult for the evaluator to get a full picture of the dissemination of the findings. Only few interviewees were aware of the Policy Briefs and IPs could not indicate well how the research changed their interventions or activities. Interviewees involved in the research in WBeG however appreciated the insights gained during the research a lot and shared the findings on international platforms and conferences

The HPF-2 proposal of HealthNet, Cordaid and AFOD (Consortium) mentions under Lesson learnt and information dissemination**: "** *HealthNet is a research driven organisation with vast experience in creating and disseminating knowledge. During the implementation of activities special attention will be given to the identification of best practices. These will continuously be documented, shared with all stakeholders and suitably implemented. Research findings, success stories, lessons learnt and key challenges will be documented, shared and built upon during the entire project period*." This could be an opportunity for sustaining and applying the NPE study results.

In conclusion, the research component as defined in Inception report proved very ambitious given the South Sudanese context and the short timeframe and could not fully develop into a tool for improved RH programming. The local capacity was lower than expected and getting ethical approval very time consuming. The changing context from post conflict recovery to conflict also caused delays and cancellation of certain activities. Several outputs were not completed by Dec 2016. From a longer-term perspective the NPE research and the products that are and will be produced may have an impact on RH programming. The involvement of men in FP is high on the agenda of Rutgers, Promundo, CARE and others. With active promotion of KIT the research outputs may be highly appreciated at a more global level of SRHR research. This lobby is already taking place.

As response to poor maternal health indicators the research component could have been set up differently according to IPs: a stronger applied research approach with more involvement of the IPs.

5.4. Output 4: Increased community support and action to demand quality reproductive services

The main activities under this pillar were:

1. Fostering participatory reflection and action at community level for SRH rights and maternal health using Community Dialogue approach
2. Set up and facilitation of a Community Monitoring system through community based structures e.g. VHC, HHP and TBAs
3. Increase community awareness and demand for SRH services through other community based activities e.g. supporting HHPs, peer education, community awareness sessions etc.

On a quarterly basis IPs reported on 7 indicators:

1) Number of maternal health BCC materials procured / adapted & distributed (flipcharts, posters, job aids and others)
2) Number of FP/BS promotion sessions led by HHP in the community
3) Number and % of HHP (TBAs) trained on SRH rights
4) Number and % of HHP monthly reports received from HHP supervisor
5) Number of HHP-mothers pairs formed per PHCC/U
6) Number and % of health facilities organizing joint planning meetings with community groups (community monitoring outcome)
7) Number and % of action plans implemented by the community (community dialogue outcome)

Only indicators 6 and 7 were incorporated into the consolidated M&E framework and were used for the assessment of outcome of 4.2 and 4.3.

Output 4	Indicator	Base Line	Target 2014	Target 2015	Source of verification
Output 4.1 Participatory Reflection and Action activities	1. Number of facilitators trained to conduct participatory community activities (e.g. community dialogues)	0	20	20	Quarterly reports
	2. Number of communities that are engaged in participatory activities.	0	15	30	
	3. Number and percentage of action plans implemented by the community	0	15 - 80%	30 - 80%	
1. 112 facilitators trained; Target (40) achieved. 2. 40 communities reached by the Community Dialogue; target (45) not achieved. 3. No reported action plans though some local initiatives were apparently taken. Target not achieved					
Output 4.2: Community monitoring	Number of joint planning meetings between facility and community groups			>50% of facilities covered	Project reports
Very variable frequency of meetings. Target of 50% of all facilities was not achieved mainly due to Insecurity and inaccessibility of many areas					

5.4.1. Participatory reflection and action at community level with a focus on Community Dialogue

Initially KIT planned to involve a local organization to develop and implement this component on community participation. KIT staff explored the local capacity among NGOs involved in community participation. When a suitable local or regional partner could not be found KIT decided to develop the training material itself. KIT developed 2 elaborate manuals for Community Facilitators based on KIT's experience in Sierra Leone and existing manuals developed by other organisations like GIZ. External consultants from Malawi and IMC/HNTPO staff in South Sudan further supported the development of the manuals. KIT then conducted the initial trainings while IMC and HNTPO continued through their Community Participation Officers (CPO).

The main objective of the Community Dialogues was to improve health-seeking behaviour and increase service uptake. Whether this happened is difficult to assess because direct attribution of increased utilization rates to the community dialogue is not justified. There may be many more causes of changes in health seeking behaviour. SHARP provided a range of interventions to increase service utilization: equipment, staff recruitment, training, referral support, health education and collaboration with HHP etc. However, at a more qualitative level, the opinions of the community are important sources of information and evidence. During community dialogue reviews and end-line consultations community members reported that service utilization increased as a result of the community dialogues (see below) because of changes in knowledge and attitudes. Endline consultation sessions report many positive responses on the community dialogue sessions and communities requested to continue and expand the sessions to other communities.

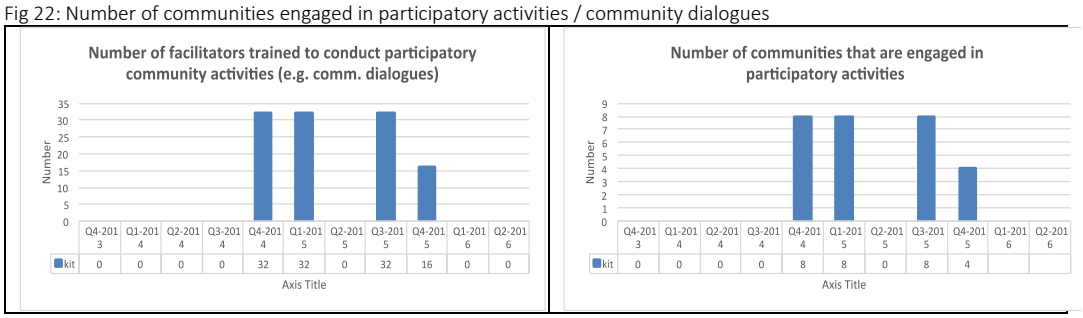
Several informants consider community participation and involvement and the Community Dialogue approach the most significant and distinct pillar of SHARP.

- IMC has introduced it in other counties in other states
- HNTPO will continue investing in community involvement and empowerment
- Cordaid could not implement the CP component but will apply it in HPF-2 in WBeG and NBeG

There was also agreement on the need to further consolidate the approach, engage more communities and go back to communities already covered to build on what was achieved.

KIT with support of the Community Participation Officers trained 112 community facilitators who led the community dialogue sessions; they covered 40 communities in N/WBeG

Fig 21: Number of community facilitators trained in Wau County in the course of SHARP
Fig 22: Number of communities engaged in participatory activities / community dialogues



KIT conducted endline consultations with key informants. This evaluation of the community dialogue approach is part of the Community Dialogue process and can be done internally or externally. A report based on transcripts of FGD presented the following outcomes:

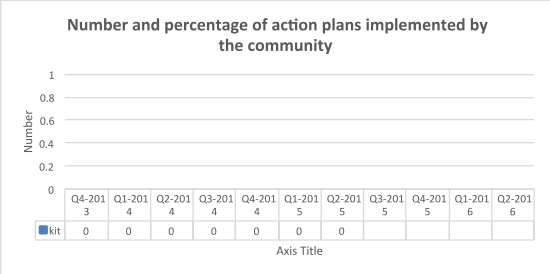
- Changes in knowledge, attitudes and practices (KAP)
  - Increased awareness of the impact of culture on health
  - Increased awareness of the negative consequences of early marriage and teenage pregnancies; willingness to adjust harmful practices
  - Increased awareness of gender relationships
  - More open attitude towards other generation
  - Increases uptake of SRH services (*though weak evidence according to the HMIS*)
- The more controversial issues, (e.g. family planning and youth ASRH services) have been addressed in the pledges, but in the end line FGDs only birth spacing was emphasized. Family planning registers were not filled in correctly because women did not want to be registered or health workers themselves were afraid to register clients.
- From the end line evaluation it was not clear how collaboration between community and health workers has improved.
- The possibility that respondents gave socially desirable answers exists. The self-reported changes in health seeking behaviour and perceptions need therefore to be weighted carefully.
- The report proposes some recommendations for future Community Dialogue interventions:

- Engage community health workers during public meetings for them to support the actions that need to be taken to improve SRHR, but also to engage them during sessions
- Engage the village health committees (VHCs) during community dialogues
- Stimulate attitude change of health facility staff by training them

- Sustainability of the efforts and results was perceived as the biggest challenge. Changes can have a deeper impact when a critical mass has been created who is capable to adjust the harmful beliefs, norms and practices. This would assist in initiating an ongoing process of social transformation.

These recommendations could be taken along if Cordaid and HealthNet indeed manage to incorporate the Community Dialogue approach into HPF-2 work plans.

Fig 23: Number and % of action plans implemented by community



IPs monitored the number of action plans that community groups developed as a result of the community dialogue sessions. This proved a bridge too far. Though communities apparently undertook some actions, no action plans were reported as implemented by the community.

Sustainability and continuation of the community component was already on the agenda of the Partner Council in 2015. KIT/SHARP could have consulted HPF to discuss the relevance of the modules for HPF-2. In the two proposals by HealthNet/Cordaid that were awarded a contract, the community dialogue is not presented as an effective and innovative community engagement approach. However, both IPs decided in December 2016 during the last Partner Council to review the possibility to still incorporate the Community Dialogue approach.

One may question whether the scale of the community dialogue under SHARP was large enough to have a significant impact on health seeking behaviour. In each community 40 people were reached and those may spread the message and influence others. Whether they effectively did so or will is not known.

5.4.2. Community Monitoring through community based structures

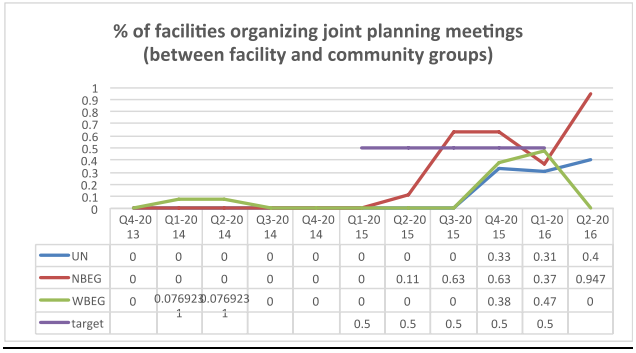
- Training and support of community structures particularly Village Health Committees
- Capacitating community resource persons like HHP and TBAs to provide feedback to the health system/facilities

SHARP has strengthened the different community structures through training and engaging them in different community based activities such as community sensitization, referral of patients, promotion of RH services etc. SHARP expected to build the capacity of the community structures to provide feedback about community concerns and perception of the quality of services to health workers in the nearby facilities, to build stronger links between services and service users, between the demand and the supply sides. Particularly HealthNet has prioritized community action (see below under demand creation). The objective of community monitoring goes beyond community participation. It aims to build the capacity of the village health committee to be able to hold health workers accountable for the service quality and to improve the relationship between health facilities and beneficiary communities.

It is unclear how effective this activity has been. Without access to the field it is difficult to assess. Suggestion boxes were placed, meetings held but the overall impact on service quality could not be assessed. In the M&E framework the number of joint planning meetings between community and health facility is reported as indicator. Achievements at that level indicate that HNTPO achieved the best results. IMC and Cordaid report variable results per quarter. HNTPO has generally been the most active SHARP partner in terms of activities beyond the health facilities, strengthening community-based structures and engaging them in health development in the county. Cordaid faced a time constraint with hardly a year to implement SHARP in Melut County. IMC as organization has a stronger clinical track record with more experience in service delivery and HRH development than community engagement. However IMC has

been very much engaged in the Community Dialogue and in the Operational Research, both strongly linked to the communities, as partner of KIT.

Fig. 24: Percentage of health facilities having met with community groups against target



	Q4-2013	Q1-2014	Q2-2014	Q3-2014	Q4-2014	Q1-2015	Q2-2015	Q3-2015	Q4-2015	Q1-2016	Q2-2016
UN	0	0	0	0	0	0	0	0	0.33	0.31	0.4
NBEG	0	0	0	0	0	0	0.11	0.63	0.63	0.37	0.947
WBEG	0	0.0769231	0.0769231	0	0	0	0	0	0.38	0.47	0
target						0.5	0.5	0.5	0.5	0.5	

In the last year of implementation of SHARP NBeG managed to reach the target of 50% of facilities having organized joint planning meetings; in Wau and Melut counties joint planning meetings only started in the last quarter of 2015 and reached approximately 40%. This information is hard to validate and the content of the meeting is unknown.

According to the Inception report the focus in 2015 would be more strongly on accountability mechanisms, through a 'Community Monitoring' approach. A detailed guidance on 'how to' do community monitoring would be developed towards the end of 2014, informed by the outcomes of the community dialogue. This detailed guidance has not been developed by SHARP; use has apparently been made of existing other guidelines for training Village Health Committees. It is unclear to what extent the link of community monitoring with community dialogue outcomes has been made in practice. Community monitoring did not mature within the timeframe of SHARP. Under HPF Village Health Committees have also been trained and/or supported. How this related to the Community monitoring of SHARP remains unanswered.
IPs expressed concern about the remuneration of community-based volunteers (HHP, VHC, TBA) and all agree that these cadres need support and follow up by the health sector for sustainability.

5.4.3. Community awareness raising and demand creation

In addition to the Community Dialogue and Community Monitoring particularly HealthNet in Aweil North undertook other activities as well under SHARP:

- Youth Peer education sessions in a school health promotion initiative
- Youth panel discussions on early marriage and FP
- Stakeholders sensitization meetings with Payam chiefs and elders
- Boma Health Committee meeting
- Support to HHP and TBAs to raise awareness at community level on timely referral of pregnant women with risk factors and on PPH prevention by Misoprostol
  HealthNet seems to have established very strong links with the beneficiary communities of the SHARP supported health facilities and the Community Participation Officers and Community Facilitators enhance these links between the health system and the community. Increase in service uptake may at least partly be attributed to this.

> *"To promote youth peer education sessions a school health promotion activity was conducted in Manyiel primary school with the theme; "Know Your Sexual Reproductive Health Rights". The sessions were attended by 30 pupils 18 girls, 12 boys), 2 teachers, 1 chief and the in charge of Manyiel PHCU and the CHD representative. The topics covered during the discussions included brainstorming on causes of school dropouts, early marriages and their dangers and prevention of sexually transmitted infections. The pupils took part in putting up many posters written with markers indicating the rights of an individual regarding sexuality. Some of the message proposed by the pupils included stay in school, avoid surprise gift from unknown opposite sex, say no to sex, abstain from sex, delay marriages etc. These discussions helped the pupils to realize the major causes of school dropouts, causes of early marriages, and how to build their self-esteem and career. The pupils received health booklets and flip charts while the teachers we provided with incentives in form of T-shirts so that they can continue with these sensitization activity"* [Quarterly report HealthNet – NBeG]

6 Impact

The overall objectives (expected impact) of SHARP were:
1. Reduction of maternal mortality in South Sudan
2. Improved accessibility of reproductive health care, as set by the South Sudan Reproductive Health Strategic Plan (SSRHSP, 2011-2015) in Upper Nile, NBeG and WBeG

SHARP expected to contribute to the reduction of maternal mortality and to improved accessibility of RH care. SHARP cannot be held accountable for the impact. Measuring impact is also beyond SHARP's responsibility and capacity. SHARP's contribution is discussed below.

The maternal mortality in South Sudan is high. However figures on the maternal mortality rate (MMR) differ according to the source of information. The SHARP project proposal refers to the South Sudan Household Survey (SSHHS) in 2006, which reports a MMR of 2056 per 100,000 live births. WHO[3] reports an MMR of 789. Whatever the precise value of the MMR, one expects a decrease over time as a result of increased access to Emergency Obstetric and Neonatal Care (EmONC). Multi donor funds (MDTF, BSF, HPF) and funding by USAID, World Bank, UNICEF, WHO, CIDA and UNDP as well as bilateral aid provided a substantial boost to primary and secondary health care over the past years including specific attention for reproductive and maternal health.

The first target of the fifth United Nations Millennium Development Goal (MDG-5) was to reduce the maternal mortality ratio (MMR) worldwide by 75% between 1990 and 2015, with the proportion of all deliveries attended by skilled health personnel being used as a proxy indicator of progress. The second target for MDG-5 was to achieve universal access to reproductive health care, as judged using indicators such as the contraceptive prevalence rate and the unmet need for family planning.

In addition to skilled attended birth and acceptance of modern contraceptives as contributing to the reduction of maternal mortality, there are other interventions that may as well have a significant impact on maternal mortality: increased access to emergency obstetric care and the prevention of Post-Partum Haemorrhage (PPH) by Misoprostol. HPF initiated this programme in the six HPF supported states based on JHPIEGO initiative in West Equatoria and started the PPH prevention rollout through its partners like IMC and HealthNet TPO. With financial and technical support of SHARP the PPH prevention rollout at facility level was successful in Wau and Aweil North counties. Melut and Fashoda were not covered. In NBeG the roll out to community level through the HHP started as well and might continue under HPF-2.

6.1 Delivery attended by skilled birth attendant in facility rate

Contrary to what one would expect SHARP did not monitor or report on skilled attended births in the facility. Instead the IPs reported on facility-based deliveries (institutional deliveries) whether attended by a skilled or an unskilled person. IPS recruited midwives for almost all supported facilities and monitoring the facility-based trend of skilled attended births would have provided essential feedback on whether a midwife has an impact on health seeking behaviour or not.

The table below presents the reported delivery by skilled birth attendant in facility rates for the entire counties and not for SHARP supported facilities only.

Table 3: Delivery by skilled birth attendant in facility rate (DHIS)

County	2012	2013	2014	2015	2016
Wau	24.2	39.5	44.9	39.8	21
Aweil North	1.1	4.3.	7.2	10.9	9.0
Melut	7.6	3.2	3.6	9.3	8.0
Fashoda	2.3	3.3	4.8	5.0	3.1

[3] Maternal and perinatal health profile South Sudan, WHO. http://www.who.int/gho/maternal_health/countries/ssd.pdf

Increase in skilled attended deliveries in Aweil North County is steady over time (see table 3) and could be partly attributed to SHARP support because 18/25 facilities are SHARP supported. There is no hospital in Aweil North. However, there is one MSF supported PHCC in the County with a very high uptake of RH services, outnumbering the sum of ANC and deliveries in all SHARP supported facilities together (annex 5). This illustrates the need for careful interpretation of data and attribution of effect.
The rates in the SHARP supported counties in Upper Nile also increased gradually. In the very fragile context of Upper Nile and the insecure funding by World Bank this increase is an achievement. The national delivery by a skilled birth attendant in facility rate for 2015 is 8.2 and below the rate in Melut (9.3). Dropping service coverage rates in 2016 have probably multiple underlying causes e.g. (i) insecurity in Fashoda and Wau; (ii) funding insecurity in Upper Nile with health worker' salaries and performance at stake; (iii) reporting problems at different levels.

Wau County reached significantly higher skilled attended birth rates than Aweil North and the 2 counties in Upper Nile. In Wau County this rate was already high in 2013, before the start of SHARP. Further analysis of details on deliveries in Wau County revealed that over 85% of all skilled attended deliveries in Wau County takes place in St. Daniel Comboni Hospital, Wau Teaching Hospital and Lokoloko Health Centre (See table 4) and less than 3% in SHARP supported facilities. In 2016 IMC included Lokoloko PHCC for SHARP support to the development of a YASRH clinic but the plan could not be implemented due to the sudden conflict in the county.
An important expected role of SHARP has been the promotion of institutional deliveries, preferably by a skilled midwife, in facilities far from the hospitals in Wau town and support to an effective referral system. The figures per facility, shared by IMC with the evaluator, show that in the SHARP supported PHCCs with skilled staff - recruited and funded by SHARP – the monthly number of deliveries attended by skilled or other ("unskilled") RH workers (CMW, MCHA, TBA) did not increase much in the course of SHARP and monthly average number of deliveries and ANC attendance figures proved low (annex 4). Moreover in 4/5 BEmONC centres in Wau County the midwife resigned in the course of 2015. In 2016 the conflict disrupted almost all services and pregnant women were facing big problems in accessing quality RH services.

Table 4. Deliveries in Wau County 2014 -2016 according to DHIS

Data in deliveries in Wau County according to DHIS	2014	% of all	2015	% of all	2016 jan-sept	% of all
Total number of deliveries in the sum of facilities (39)	4553		4237		1553	
Deliveries attended by skilled birth attendant (SBA)	3804	83.5%	3657	86.0%	1444	93.0%
Deliveries attended by unskilled birth attendant (USBA)	749	16.0%	580	14.0%	109	7.0%
		100%		100.0%		100.0%
Deliveries by SBA in Comboni, WTH, Lokoloko	3381		3159		1262	
Deliveries by USBA in Comboni, WTH, Lokoloko	93		99		41	
Total number of deliveries in Comboni, WTH, Lokoloko	3474	76%	3258	76.9%	1303	83.9%
Deliveries by SBA in SHARP supported facilities	93		99		41	
Deliveries by USBA in SHARP supported facilities	161		219		27	
Total number of deliveries in SHARP supported facilities	254	5.6%	318	7.5%	68	4%
DHIS institutional delivery rate	53.1		46.1		22.5	

The delivery rate by skilled health worker in facility (proportion of health facility deliveries attended by SBA), which is not the same as the delivery by skilled birth attendant in facility rate, increased in the course of SHARP times except in Fashoda (see table below). This rate informs about the availability and use of skilled birth attendants in facilities and reflects SHARP investments in staff recruitment and retention. Access to a skilled birth attendant in Wau and Aweil North counties proved high. In Wau primarily because of the well staffed hospitals and Lokoloko PHCC where all deliveries are assisted by skilled staff. However in the PHCCs retention of skilled birth attendants and BEmONC services turned out to be a huge problem. Several midwives resigned in 2015 from SHARP supported PHCC. Fortunately some women had an alternative and the statewide referral system with 24hrs services and ambulance services mitigated the impact to some extent.

Table 5: Delivery rate by SBA in facility: SHARP counties compared to non-SHARP counties

	2013	2014	2015	2016
Wau (WBeG)	83.6	84.6	86.5	93.1
Jur River (WBeG)	16.7	16.8	21.8	19.7
Aweil North (NBeG)	46.8	67.8	66.4	78.6
Aweil East (NBeG)	67.9	70.8	60.1	67.1
Aweil West (NBeG)	73.1	30.6	78.8	90.5
Melut (UN)	29.6	34.7	59.1	80.0
Fashoda (UN)	46.0	41.5	37.6	42.9
Panyikang (UN)	55.7	No data	No data	No data
Ulang (UN)	2.4	0	4.6	2.1

NB: Delivery rate by SBA in facility refers to the proportion of facility deliveries attended by SBA out of all deliveries in the facility. The figure informs whether a SBA attended the delivery in a facility or not. It does not relate to the % of women who deliver in a facility with a SBA out of all pregnant women

6.2 New Contraceptive Acceptance rate

According to a report of the Economic and Social Affairs department of the UN in 2015 (*Trends in contraceptive use worldwide, 2015*) the CPR anno 2015 in South Sudan varies between 1.2 and 4.6 with a median value of 2.6. South Sudan has one of the lowest CPR for modern methods of the world.

As described in chapter 5 figures reveal that the FP acceptance rates have not increased significantly during SHARP and remain low with probably a negligible impact on maternal mortality (See annex 3).

However, reported numbers may be lower than actual use of contraceptives because clients may feel insecure when their use of FP is registered, even anonymously. Quarterly IP reports on service uptake show that the numbers of acceptors increased in 2015 compared to 2014 in all counties. This means that the focused attention for FP in community dialogues, health workers training and provision of commodities has a positive effect on service uptake.

6.3 Use of Misoprostol at facility and household level

Figures about the use of Misoprostol by all women who deliver in the facility or at home as laid down in the PPH strategy of the MoH could serve as additional indicator for reduced maternal mortality because one of the main causes of maternal death is post-partum haemorrhage. Available data reveal that Misoprostol is not given systematically yet to all women immediately after birth. The figures can therefore not be used for further analysis.

7 Efficiency

7.1 General

The changing context of South Sudan in the course of the project has significantly affected the use of resources. Without referring to details on budget versus expenditure it is clear that the balance between direct versus indirect costs was affected by the multiple delays, cancellations, staff turnover, suspension of activities and increased security measures. These hurdles that were to a large extent caused by contextual factors made it impossible for SHARP to implement the project according to plan with optimal resources utilisation.

7.2 Project design and management

The SHARP project aimed to boost the reproductive health component of the BPHNS in close collaboration with other implementing partners, and work synergistically with their programming and funding streams such as the HPF, World Bank and CIDA. This would contribute to the efficient and effective use of resources.

The Consortium set up with three different IPs in three different states and in only four counties without county coverage but with partial support coverage of facilities resulted in a limited economy of scale. Initially SHARP assumed project activities to be implemented in 8 selected counties but HPF awarded only 2/4 bids in the Bahr el Ghazals and Cordaid eventually implemented SHARP in 2/4 planned counties. The option to also include the two HealthNet supported counties in WBeG in SHARP was initially considered as an opportunity to achieve more coverage but the option was not further pursued by KIT.

SHARP supported 54% of the functional PHCCs and PHCUs in the four counties with a total population of 438,717 (in 2015), which is below the targeted minimal coverage of 250,000 per county / state [4] (see coverage criteria in Inception report). The SHARP budget constituted a substantial additional budget to the HPF budget in the selected states and SHARP could have pursued a higher population and/or facility coverage. Whether the original proposal was too ambitious and the actual coverage more realistic is difficult to assess. With a larger target population and/or more facilities the work plans would change. It is beyond the capacity of this evaluation to have a judgement on what would have been the outcome.

The huge scaling down of activities in Upper Nile due to conflict, insecurity and inaccessibility while some fixed costs remained relatively high has significantly affected efficiency. This is a direct consequence of the changed context and not due to poor management.

SHARP pursued alignment and complementarity with HPF and RRHP in order to have added value and avoid duplication, both conducive to efficiency. This has been achieved to a large extent, reflected in the integrated county health plans in the Bahr el Ghazals. IMC staff pointed at some duplication of activities in WBeG and some overstaffing of SHARP team, both affecting efficiency negatively.

Application of a state focus in training of health workers (WBeG), capacity building of CHD/SMOH during L&M training and referral (WBeG/NBeG) raised the coverage and hence efficiency.

7.3 Budget versus expenditure

The complicated financial reporting system of SHARP with individual IPs reporting in different formats and DGIS requiring its own format made analysis of budget versus expenditure difficult. It proved difficult

[4] " County-level activities should be implemented in one or more counties per State and cover a minimum of 250,000 people in total for that State"; SHARP Inception report 2013

to draw conclusions on the Value for Money of the four different pillars of SHARP. At the time of writing this report end of project financial data were not yet available.

The financial reports for 2013, 2014 and 2015 show:

- Overall annual increase in expenditure rate from 36% in 2013 to 61% in 2014 and 72% in 2015. The evaluator had no access yet to consolidated information for 2016. Available data reflect an increasing capacity to spend according to budget and to implement according to plan.
- Underspending (less than 40% spend) on component 4 (community empowerment) in both years 2014/2015 as well as underspending on research during 2014/2015. The community component got a boost in 2016 while no field-based research could be undertaken in 2016 but several desk based research outputs were produced.

7.4. Value for Money

The outcome of SHARP in terms of improved reproductive health indicators is tangible though modest. Antenatal care uptake, deliveries by skilled birth attendants and contraceptives acceptance have all slightly increased in the course of SHARP and uptake figures are generally slightly better than in most neighbouring counties (see annex 6)

The investments in training and community awareness on specific RH interventions such as Family Planning and Adolescents Reproductive Health (AYSRH) services resulted in a modest increase in service uptake but the acquired knowledge and skills of communities, IPs and facility staff in these domains will hopefully continue to be used in the coming years
The same holds for staff turnover among recruited and trained staff. This affected VfM of training but is hard to influence. Staff retention is a widely observed problem in South Sudan. The investment will not be lost. Health workers will use their knowledge and skills elsewhere in SS.

SHARP budget for Wau and Aweil North were almost equal. HNTPO supported however significantly more facilities and with a larger catchment population. RH indicators changed more in Aweil North (and probably Melut but data are too limited) than in Wau County. This may be understood as more VfM in Aweil County than Wau County. IMC invested more than HealthNet in statewide trainings. It is difficult to assess the impact of these trainings but the service coverage rates in Jur River County and Raja County did not increase. This may have multiple causes.

The implementing partners differ with regards to office and IP staffing costs. IMC spends significantly more on international human resources and office costs than HealthNet or Cordaid while IMC supports fewer facilities than HealthNet. More analysis is needed for a firm conclusion on value for money but there are signs of comparative underperformance of IMC against the budget and other partners' performance. This would result in less value for money. Higher overhead costs for IMC SHARP project does not translate in better performance.

8 Sustainability

8.1. General

The project started late; the actual implementation did not take off before the end of 2013 and was suspended for several weeks after the December conflict. Both IMC and HNTPO closed project activities by mid 2016. The total implementation period was therefore approximately 30 months for HealthNet and IMC and hardly a year for Cordaid. These very short time frames for an ambitious project like SHARP constitute a real threat to sustainability.

For sustainability stability is needed. The December 2013 conflict that deeply affected Upper Nile and the sudden change in context in Wau with BEmONC centres vandalized, other facilities closed, staff resigning and pregnant women afraid to seek health care because of the insecure environment represents an example of how fast a situation can change and jeopardize results.

8.2. Strategies

SHARP did not formulate an exit strategy as such although the need for one was underlined in the recommendations of the MTR and in the workplan for 2016. However, the individual implementing partners have undertaken steps to ensure retention of staff and smooth continuation of the referral system. Moreover they (rightfully) expect HPF-2 to ensure sustainability of some of the interventions implemented under SHARP because they will implement HPF-2 themselves (in Consortium with AFOD). In interviews IP staff proved well informed about prospects regarding sustaining referral services, staff salaries and FP services. Individual IPs discussed handing over of assets and continuation of some services at their CHD level.

There has been no joint meeting between HPF and SHARP on how to best sustain results and incorporate best practices into HPF-2. The absence of a country based project coordinator and liaison between the three IPs may have played a role in this. Individual IPs negotiated with HPF on the handover of salary payments to health workers in the facilities. A HPF representative attended the December 2016 meeting and contributed to discussions about the future of SRH care in South Sudan and the priorities for the national MOH in South Sudan.

Opportunities for continuation of some of SHARP's distinct results such as community participation programme, L&M training and research related policy briefs through timely consultation with HPF / RRHP have not been exploited very well, though other options to further work on community participation programme have been explored by KIT (applied with another NGO for USAID funding). Reduced access to South Sudan in 2016 for KIT staff contributed to this. With a PMT on the ground (recommendation) it would have been easier.

Consultative meetings with the MoH at national level to discuss an exit strategy or sustainability plan for 2017 have not taken place. It is not known whether at SMOH level the end of SHARP was on the agenda of the SRH Forum in WBeG and NBeG.
The efforts to ensure alignment with government policies and harmonization with HPF and IMA contributed to the sustainability of project results particularly with regards to the BPHNS but adequate funding will be needed to maintain the infrastructure, keep the ambulances running, pay health workers salaries and ensure supply of drugs, vaccines, Misoprostol and other supplies. Support to the implementation of the BPHNS will continue unless funding becomes problematic like in Upper Nile and Jonglei. Cordaid is exploring funding for continued support to service delivery in Melut, Fashoda and Panyikang.

HPF-2 has secured DFID led pooled funding till February 2018. Sustainability will be high on the HPF and donor agenda and a possible HPF-3 is already being discussed. The funds available for HPF-2 however

are significantly lower than in the past years: 70 million GBP for 16 months, 8 states[5] and all counties (> 60) in the 8 states. And HPF's bridge funding during 2016 has also been considerably lower than in 2015. IPs had to reduce staff to cope with the smaller budgets.

Suspension of WB support to Upper Nile (and Jonglei) is a huge threat to the RH services and basic package of health services in general. The end of SHARP adds to this threat. Cordaid therefore decided to look for funding to sustain primary health care services in Melut, Fashoda and Panyikang for some time while waiting for the decision of World Bank to fund RRHP-2. In June 2016 the WB announced available funding of 40 million USD for the RRHP-2 but then suspended the actual contracting and payment till today.

The handover of staff and assets to IMA / RRHP is problematic because the funding of the RRHP-2 by the World Bank is not guaranteed yet.

HealthNet and Cordaid in Consortium with AFOD have paid attention to health system strengthening and community participation approaches in their joint HPF-2 proposals as required by the tender documents. The use of the specific SHARP training packages on community participation and Leadership and Management is not included explicitly but HealthNet and Cordaid agreed during the project closure workshop in December 2016 to review their HPF-2 work plans and include the SHARP community participation and dialogues programme if possible.

Handing over to the government of service delivery (salaries, capacity building, referral, medical supplies, support to community based structures e.g. HHP, VHC, TBAs) is apparently not a realistic option. The MoH depends to a large extent on external donors. There is some operational support to the CHD from the Ministry of Finance. The HPF partner organisations (HealthNet and Cordaid) will continue to support the CHD as part of a government led health system development. Buildings constructed and/or rehabilitated under SHARP were successfully handed over to the CHD upon finalization of construction.

The capacity building approach was intended to leave behind a 'capacity legacy'. The 6 blocks of Leadership and Management training are an investment in people who may continue to hold key governance positions. With additional training, supervision and mentoring by the HSS unit of the HPF knowledge and skills may be sustained and even strengthened.

Collaboration with potential partners was foreseen and discussed during the November 2013 State level implementation workshops in the domains of (i) referral and (ii) training. Collaboration with other stakeholders in WBeG for the development of a referral system was successful and for training as well. In NBeG and Melut collaboration remained minimal.

[5] In October 2015, South Sudan's President Salva Kiir issued a decree establishing 28 states in place of the 10 previously established states. The decree established the new states largely along ethnic lines. A number of opposition parties challenged the constitutionality of this decree and the decree was referred to parliament for approval as a constitutional amendment. In November 2015 the South Sudanese parliament approved the creation of the new states.

9 RH programming and operations in fragile context

The impact of the unexpected very fragile context has been underlined in different previous chapters of this report and is further elaborated in the following paragraphs.

9.1. Main features of fragility in South Sudan

The main features related to fragility were

- Unpredictable eruptions of violence, increasingly along ethnic lines. As a result insecurity increased, accessibility to implementation areas decreased in several parts of SHARP supported states. As a result SHARP could not implement its work plans fully according to plan.
- Socio-economic crisis and extreme poverty levels
  - Reduced government health budget; stock outs of essential drugs and medical supplies
  - Low salaries of health workers and no ensured monthly payment
- Wide spread insecurity in many parts of the country and spreading into the Equatoria states since 2015. In 2016 WBeG severely affected. Occupation, looting and closing down of health facilities in Wau County. Increasing inaccessibility of areas in WBeG with massive displacement of populations seeking protection in POC sites in Wau. IMC now providing RH services in the POCs
- Major changes in the governance structures of South Sudan with a presidential decree on the number of States in South Sudan that was approved in November 2015. Transition from 10 to 28 states largely along ethnic lines with huge administrative consequences and changes of health authorities at SMOH level some of who were deeply involved in SHARP.
- Impunity with no access to justice

A recent report by OECD on fragility ("*States of Fragility 2015; Meeting Post 2015 Ambitions*") lobbies for a new understanding of fragility beyond fragile states. The OECD report takes three indicators related to targets of SDG 16 and two from the wider SDG framework: (1) violence, (2) access to justice, (3) accountable and inclusive institutions, (4) economic inclusion and stability, and (5) capacities to prevent and adapt to social, economic and environmental shocks and disasters. South Sudan scores high on all the five dimensions. The impact on the achievement of both the Sustainable Development Goals (SDG) and the Millennium development Goals (MDGs) should not be underestimated.

9.2. Fragility and the project design

The project was designed in a period (2012/2013) when the situation in South Sudan was relatively calm. People in South Sudan and the donor community were optimistic about possibilities to start rebuilding the country, the youngest nation in the world. The design was therefore based on a development perspective and aligned with relevant SS policies and complementary to HPF/RRHP. There was a strong belief that a design that focuses on the supply as well as demand side and on the continuum of care would increase access and utilization of RH care services,

The project was designed in Amsterdam by KIT staff with very limited experience in South Sudan and limited time to get well informed. The Inception phase however allowed KIT and the selected three partner organisations to gradually develop a much more coherent project that was better embedded in the realities on the ground, oriented towards health system development and harmonized with other health support programmes. The Inception report included a risk analysis.
However, nobody could have predicted that even before the project implementation actually started the December 2013 conflict would shock the country and challenge the development perspective of partners and donors.

9.3. Major consequences of the changing context for SHARP

- Impossibility to implement the project according to plan resulting in significant underspending and repeated changes in the Work plans of the IPs. Underspending decreased by year but a no-cost extension could not be avoided

- Community activities were put on hold when insecurity increased (Wau, Panyikang, Fashoda)
- It was difficult to conduct regular M&E of the project, support IP teams in the states and verify reported achievements on site. Planned visits had to be cancelled quite often.
- High staff turnover at all levels: from health facility level to CHD and IP level
- Health workers' salaries not ensured particularly in Upper Nile (RRHP/WB) in 2016
- Irregular access to areas of implementation and to the beneficiaries by IP staff
- Disruption of supply chain (essential drugs, medical supplies, vaccines, Misoprostol, FP commodities)
- Destruction of achievements such as infrastructure (e.g. Melut hospital); looting of health facilities (e.g. Raja Hospital) and occupation of some facilities (Wau County).
- Closing down of health facilities, particularly in Wau County
- Repeated delay, which made the time frame even tighter and caused the late implementation of certain project components particularly in Upper Nile.
- Reduced government budget for health. One of the results has been stock outs of essential drugs and medical supplies and irregular payment of health workers' salaries.
- Displacement of people. Fashoda, Melut and Wau counties all have large IDPs communities and Wau County now as well since 2016.
- Reluctant donor community to continue funding support to primary health care e.g. World Bank

- Poverty is increasing and salary payments increasingly insecure. Health workers face moral dilemma of wanting to serve their people but having to survive themselves as well. One of the consequences is low motivation of health workers and high levels of staff turnover. Alignment with the Harmonized Salary Scales made it impossible to offer higher salaries for retention.
- NBeG least fragile and therefore the least interruption of project activities. The SMoH and the CHD with support of HPF and SHARP have been able to work towards a better functioning health system

9.4. Adaptation to the changing environment

During implementation SHARP was confronted repeatedly with high levels of insecurity, inaccessibility of areas, displacement of populations, etc. See above. SHARP has to a large extent adjusted adequately to the changing security situation but not without effect on the level of achievements. If the context had not changed so significantly SHARP would likely have achieved more, more timely and with better outcomes.

Key features of adaptation of SHARP to the changing environment have been the following:

- International re-locatable staff of all three IPs was evacuated in Dec 2013. HealthNet and IMC field staff resumed work within a few weeks. CHD and SMoH operating at minimal level.
- Flexibility of the donor and the lead (KIT) allowing changes in work plans and budgets according to context and feasibility. Flexibility and resilience also on the side of the partners in the field and the local staff e.g. with no access to the community for community dialogue sessions, IMC changed its approach and organized 11 radio emissions on health topics; midwives were redeployed to more secure areas; research was taken out of the work plan for 2016.
- Ongoing risk assessment and mitigation measures planning as integral part of quarterly reports; security meetings with CHD and SMoH and national level; Emergency evacuation plans
- Accepting delay and sustaining efforts to implement later instead of cancelling. However cancellation of some planned activities could not be avoided, especially in Upper Nile. By mid 2016 SHARP partners had completed 77% of the planned activities; cancelled 21% and still in progress (Upper Nile) 1.3%. DGIS agreed with a budget neutral extension of six months in 2016 for IMC and HealthNet and another three additional months for Cordaid to address gross underspending.
- Reduction of ambitions particularly in Upper Nile: less counties, other counties, less interventions, narrowing SHARP down to most essential and feasible activities. Withdrawal from initial counties in Upper Nile in 2014 with later return to Fashoda; project put on halt in Fashoda mid 2015 and start in Melut in September 2015
- SHARP partners kept own IP and facility staff on the payroll during all periods of crisis, delay and project halts to avoid the loss of staff. This affected indirect and running costs of SHARP but maintained the human resources capital and capacity.

- IPs tried to recruit national staff and where possible hailing from the area where SHARP was implemented in order to reduce staff turnover, increase staff retention and contribute to sustainability. Language proved a huge hurdle in staff retention, reporting and supervision.
- Implementation in UN was put on hold and eventually resumed in the second half of 2015. The Cordaid team has shown good coping capacity in dealing with major changes in area of operation, package and scope of interventions and decreasing support from IMA/WB

9.5. Operational responses to the fragile conditions

- Withdrawal from Upper Nile in 2014 and re-entry in Upper Nile in 2015 when insecurity declined Particularly in Upper Nile the ambitions of the project were reduced to render implementation possible. Selection of most feasible interventions: investment in hardware (construction, ambulances, equipment) and maintaining the basic PHC services running
- Cancellation of certain activities in Wau County in 2015 and 2016 because of increasing insecurity
- Close consultation with the Fund Managers (IMA and HPF) to discuss funding problem.
- All IPs submitted quarterly updates on Risks Analysis and Mitigation & response measures e.g. pre-positioning essential medicines and supplies in local warehouse; emergency preparedness on the job training to staff (HNTPO); evacuation plan with other partners in the area; security forum in Melut County and security and safety training by Cordaid.
- High staff turnover: (i) support to CHD to implement the revised /new harmonized salary scale starting March 2016; (ii) Supportive supervision; (iii) staff house construction; (iv) on the job training; (v) re-submission of application for PHCC grants from the MoH; (vi) upgrading living conditions.

9.6. Project management in the changing fragile environment

In this often changing and unpredictable context a more field-based management would have been more effective and efficient. Access for project management staff to the counties would have been more feasible in windows/periods of security.

From mid 2013 a Country Coordinator coordinated the Inception process and negotiations with the MoH. She drafted consolidated risk assessment reports and updated the KIT and DGIS on the socio-political developments and security matters. When she left her position the in-country coordination between IPs and with the MoH in Juba decreased and hampered the concerted response to the changing context. The country coordinator could have been replaced to ensure proximity of the project management team to the IPs, to the MoH and to the field based teams and beneficiaries. Or – as suggested once during a meeting with IPs – the IPs could have taken the role of country coordinator on rotating basis.

The Partner Council structure in the Netherlands did not reach its full potential to address the challenges related to the increasing fragility in South Sudan. It proved difficult to engage IMC to the same extent as HealthNet and Cordaid in the Council meetings. High staff turnover within IMC at HQ level was one of the key causes.

9.7. Conflict sensitive project implementation

It is not clear whether partners and KIT have actively discussed ways (a) to minimize negative impacts and do no harm and (b) maximize positive impacts on conflict in the way SHARP was designed and implemented. However, all three IPs have been operating in SHARP supported counties for several years before SHARP started and all three organisations have been engaged in health cluster meetings and other state and national level forums to remain optimally informed about risks, conflict sensitivity and do no harm approaches. The Country Coordinator drafted a Conflict Sensitivity Analysis for SHARP in June 2014. Nobody referred to this document during interviews. It is unclear what the status of the document is and how it has been utilized in SHARP.

In Upper Nile the SPLA and SPLA-IO have segregated the state in government and opposition held areas. Cordaid has been carefully manoeuvring in this state and with low profile continued to support primary health care services in Fashoda where the government is not supporting the services because it is opposition held area.

Whether SHARP has helped build peace and do no harm is difficult to assess. The focus on Family Planning and Birth Spacing and the promotion of life saving Misoprostol to prevent Post-Partum Haemorrhage are sensitive activities that potentially could have met resistance. However both interventions are aligned with government policies.

Given these challenges and complexities, South Sudan is a difficult environment in which to operate and programming remains very much affected by the lack of capable, accountable and responsive systems and institutions, the precarious security situation, and the absence of a reliable and wide-reaching road and transport network. While infrastructure coverage is generally poor, the rainy season exacerbates conditions, and many areas become unreachable by road. Given the scale of the humanitarian crisis, the fragile economic and fiscal environment, and weak labour market, the outlook for South Sudan for 2017 and beyond is deeply concerning.