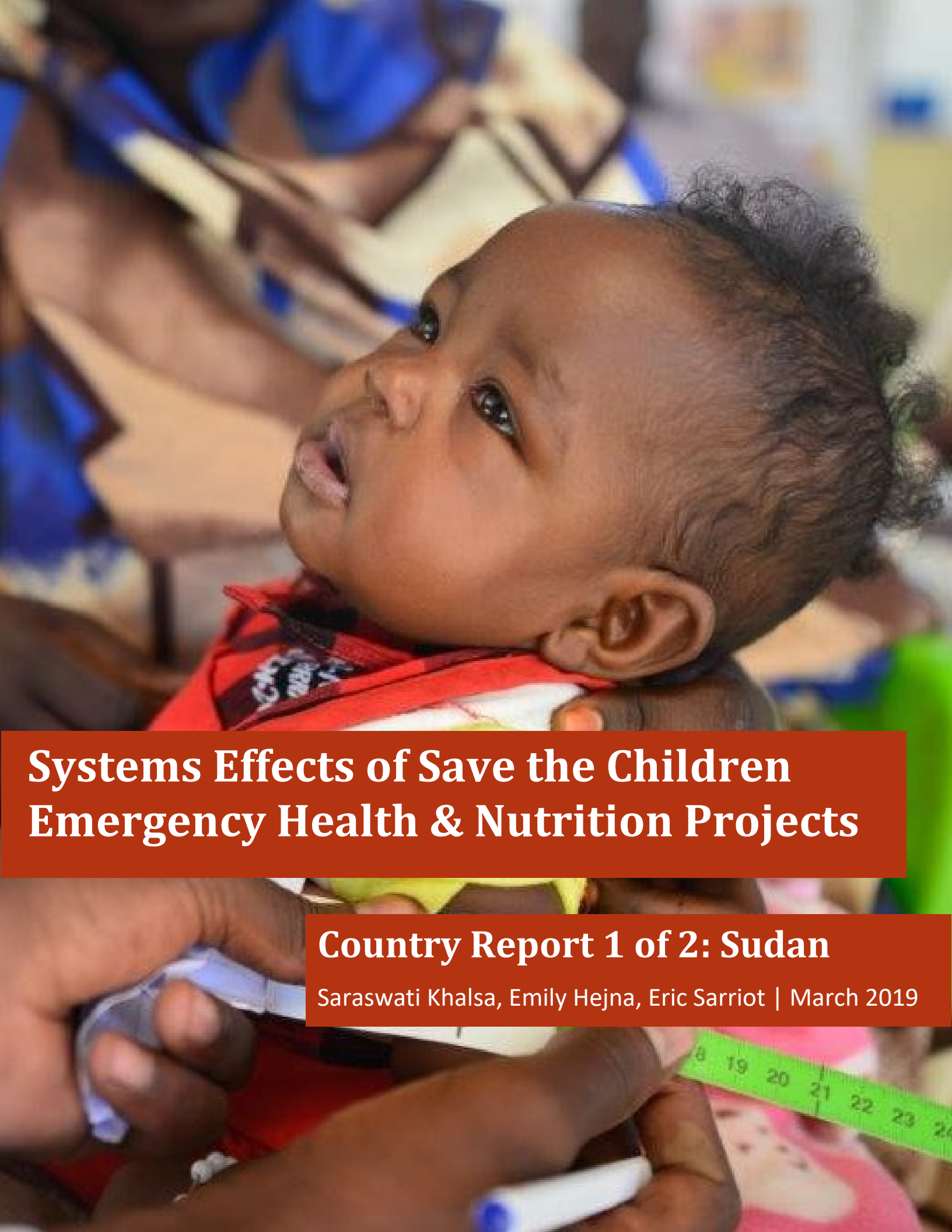

Systems Effects of Save the Children Emergency Health & Nutrition Projects

Country Report 1 of 2: Sudan

Saraswati Khalsa, Emily Hejna, Eric Sarriot | March 2019

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The CORE Group Humanitarian-Development Task Force is a consortium-led effort to increase community health and nutrition program learning and augment the evidence for community based approaches in the humanitarian and development contexts; increase global participation, coordination, and organizational collaboration to improve knowledge and build strategic capacity of stakeholders at the global and country level; and share relevant learning with USAID Missions, host governments, implementing partners and other key stakeholders.

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Abbreviations

ANC	Antenatal Care
CBO	Community Based Organization
CD	Central Darfur
CHC	Community Health Committee
CHW	Community Health Worker
CP	Child Protection
CMAM	Community Management of Acute Malnutrition
EHN	Emergency Health and Nutrition
EPI	Expanded Program on Immunization
ERMS	Economic Recovery and Market Systems
EWARNS	Early Warning System for Disease Surveillance
FCPU	Family and Child Protection Units
GKLIP	Greater Kordofan Lifesaving Interventions Package
HBB	Helping Babies Breathe
HDI	Human Development Index
HH	Household
HSS	Health Systems Strengthening
HMIS	Health Management Information System
IDP	Internally Displaced People
IMCI	Integrated Management of Childhood Illnesses
IYCF	Infant and Young Child Feeding
MAM	Moderate Acute Malnutrition
MEAL	Monitoring, Evaluation, Accountability, and Learning
M&E	Monitoring and Evaluation
MNCH	Maternal, Newborn, and Child Health
MOE	Ministry of Education
MOH	Ministry of Health
MOSA	Ministry of Social Affairs
ND	North Darfur
NGO	Non-Governmental Organization
NK	North Kordofan
N/SCCW	National and State Councils for Child Welfare
OCHA	United Nations Office for the Coordination of Humanitarian Affairs
OFDA	Office of US Foreign Disaster Assistance
PEER	Partnering for Effective Emergency Response in Greater Kordofan
PLW	Pregnant and Lactating Women
PNC	Postnatal Care
PRECAP	Partnering to Respond to the Needs of the New IDP's and Conflict Affected Populations
PRIDE	Promoting Resilience among Community in Darfur Environment
RH	Reproductive Health
SAM	Severe Acute Malnutrition
SBA	Skilled Birth Attendant
SC	Save the Children
SCUS	Save the Children United States
SK	South Kordofan
SAF	Sudanese Armed Forces
SLA	Sudan Liberation Army

SPLM-N	Sudan People's Liberation Movement-North
SWC	State Water Corporation
TBA	Traditional Birth Attendant
TWG	Technical Working Group
UN	United Nations
UNFPA	United Nations Population Fund
UNICEF	United Nations International Children's Emergency Fund
USD	US Dollars
U5	Under Five (Years of Age)
VMW's	Village Midwives
WASH	Water, Sanitation, and Hygiene
WES	Water and Environmental Sanitation Department
WK	West Kordofan
WD	West Darfur
WFP	World Food Program
WHO	World Health Organization

Contents

Abstract

We implemented an embedded case study of systems effects of successive Save the Children emergency health and nutrition projects in two countries – Sudan and Pakistan – to draw lessons and identify opportunities for strengthening health systems on the humanitarian-development nexus. This report presents the findings for Sudan.

Political conflict between the government and opposing forces in Sudan have contributed to persistent instability and crippled the health system. Save the Children received funding from OFDA to implement emergency projects from 2013-2018 in the Darfur and Kordofan regions. Our case study methodology relied on a literature review, the development of research questions and an analytical framework, systematic review of available project documentation, and key informant interviews.

Save the Children projects showed a deliberate and successful effort to integrate emergency health services into the existing health system through close coordination with the Ministry of Health (MOH), particularly at the local level. Health facilities were handed back to the MOH after upgrades and staff capacity building, triggering increased federal health financing to the state. Projects contributed health systems support and possibly strengthening by training human resources, task shifting, improving service readiness, developing and expanding the role of community-based platforms, strengthening data use for decision making at the local level, and implementing quality improvement. Documents and informant information showed intentions to maximize systems strengthening opportunities, but we found only limited documentation and formal evaluation of the potential systems effects, with unaddressed important questions regarding supply chain management, and financial sustainability.

This report is a summative statement about the achievements of successive projects, which were already evaluated based on their stated objectives. We conclude on the centrality of more ambitious evaluations to establish a systems strengthening path, as well as on the natural limit to systems strengthening expectations that can be placed on single mid-size projects. These analyses will be completed by a cross-country analysis over the two countries of the larger study.

Introduction to the Case Study

This report is one of two case studies examining health systems effects of past Save the Children emergency health and nutrition (EHN) programs in Pakistan and Sudan. This document presents the findings from two case studies in Sudan—one from Darfur and one from Kordofan. The two country reports (Sudan and Pakistan) will be consolidated in a final cross-cutting analytical publication as a next step.

Purpose

Since its origins, Save the Children has intervened in humanitarian crises, conflict areas, and provided response to disasters. This mission continues as nearly 132 million people are in need of humanitarian assistance with one of every four children in the world living in a country affected by conflict or disaster[1]. Save the Children US and Global Emergency Health and Nutrition teams work in over 40 countries providing primary health care to mothers, newborns, and children, as well as nutrition and reproductive health services.

The global community has evolved to consider a 'nexus' between humanitarian and development work. This consideration has been central to the creation of the CORE Group Humanitarian-Development Task Force, which became a partner in this study with support from the U.S. Agency for International Development, Office of U.S. Foreign Disaster Assistance (OFDA).

While important differences can be identified between humanitarian and development work, "there are important, systemic changes that can be made in international assistance efforts to meet and lessen the need for aid while also complementing local development efforts."[2] In addition, concerns for 'transition' from emergency to development are also raising more questions on how to strengthen systems (for the future) while responding to immediate emergencies, which may have overtaken the capacity of these systems.

EHN projects are heavily determined by:

- Externally driven events and crises (political, economic, natural events and disasters)
- Multiplicity of actors from donors to implementers
- National systems either weak, or lacking coherence, or both
- Often large funding, coming in discrete short frames

Projects have their own monitoring and evaluation (M&E) plans and account for delivery of outputs, and possibly outcomes. Systems effects are far less documented. Both implementation and evaluation of health systems strengthening (HSS) are challenged by the following:

- An afflux of resources and skilled labor into a weak health ecosystem in which they intervene;
- "Emergency" emerges when human suffering rises above a threshold of neglect; there is consequently and naturally a strong demand for results to lessen this suffering.

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[1] Global Humanitarian Overview: United Nations Coordinated Support to People Affected by Disaster and Conflict, United Nations Office for the Coordination of Humanitarian Affairs (OCHA), 2019; https://www.unocha.org/sites/unocha/files/GHO2019.pdf

[2] "The Humanitarian and Development Nexus" webpage, ImpactfulAid, https://impactfulaid.com/the-humanitarian-and-development-nexus/

EHN programs consequently only have 'discrete' strategic options, skewed toward results. What systems effects they can and do have requires further examination.

Save the Children launched this two-country case study (Sudan and Pakistan) to learn about both opportunities taken, and opportunities lost for strengthening systems for health through EHN funding received over the last 10 years. Evaluation and accountability to the original donor(s) are not the objective, as evaluation of the performance of projects should have been answered. The purpose of this study is to:

- Provide recommendations to Save the Children on the strategic space and opportunities for improving HSS in its EHN programs;
- Provide lessons learned and inform global development thinking on improving the strengthening of systems for health-capacity, sustainability, and resilience - while responding to the immediate health needs required in emergencies.

Method

We used a systematic, embedded, multiple case study design to examine the systems effects of EHN programs in two countries, focusing on the last decade. An embedded design allowed us to assess the impact of multiple EHN projects by collecting various forms of data for each case (i.e., project or region), including annual reports, proposals, and key informant interviews. The multiple case study approach (rather than a single case study) allowed us to compare different projects within each country as well as across different country contexts. The purpose of this design was to generalize the lessons learned from the case studies through analytic generalization. The two countries were selected purposefully and opportunistically, based on expectations that documentation could be retrieved, that informants would be available, and that the experience of the projects was expected to provide lessons.

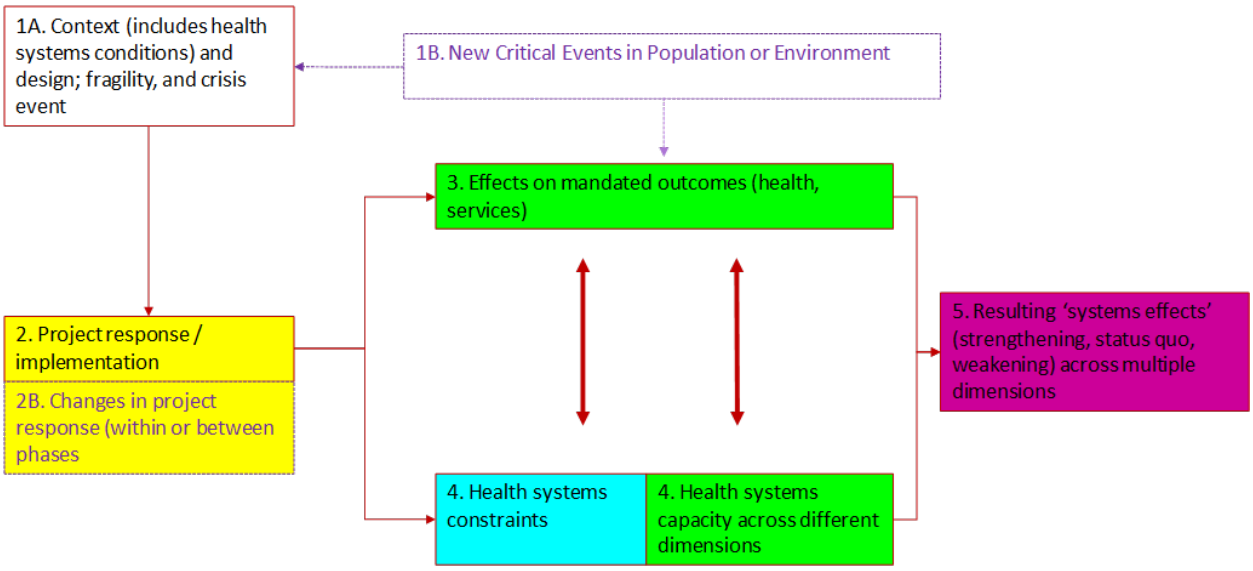
To develop our theoretical framework, we conducted an extensive literature review on the intersection between EHN programs and health systems strengthening, and summarized a total of 36 peer-reviewed articles. Based on the evidence and questions from these previous studies, we developed a conceptual model, which evolved marginally over the study period (Figure 1). In the absence of universally recognized measures for the strengthening of health systems, we also developed a set of explanatory propositions about what a strengthened health system would demonstrate in different dimensions of its operations. These dimensions bear some resemblance to the traditional HSS 'building blocks', but include additional elements. More importantly, our explanatory propositions sought to present dynamic 'dimensions' and relationships of systems strengthening.

Our case study outline focused on the following three elements for each country: country profile, population health and health services achievements, and systems effects. The country profile included the country context (i.e., the history of the protracted conflict and the national response) and a description of each project's reach and implementation (i.e., including a timeline of events and the budget, duration, reach, and demographics of the target populations). The population health and health services achievements focused on the effects of each project on project-specific outcomes. The systems effects section seeks to provide a description of the interaction between project efforts, observed changes in health systems capacity over time, and the resulting changes in the overall health system 'strength' (i.e., explanatory propositions).

We consulted closely with a team of technical 'backstops' from Save the Children US and Save the Children International, previously involved in part or in whole of the projects included in the study. We requested documentation of projects from the technical team and country offices. This included: annual reports, final reports, proposal summaries and other relevant materials from each project (see Annex 1: List of Documents Reviewed). We created a codebook to conduct our documentation review, which

consisted of eight themes, 20 sub-themes, and 19 explanatory propositions (Annex 2). For Sudan, we reviewed 13 documents from projects across two different regions: Darfur and Kordofan. Documents from each region were uploaded into the qualitative software package NVivo 11.0 and analyzed according to the codebook in Annex 2. We wrote a case report for each region using the case study outline described above. We obtained written comments to fill information gaps from the documentation review, and then conducted a series of key informant interviews (see Annex 3: interview guide). For Sudan, we conducted three key informant interviews with individuals who were closely involved with the project during its implementation (technical backstops for health and for nutrition, and a senior health advisor in country). Interviews lasted 60-75 minutes and the information gleaned from each interview was incorporated into the final country report.

A Theory of Change for systems effects of EHN interventions



Background for the Sudan Case Study

Country Profile

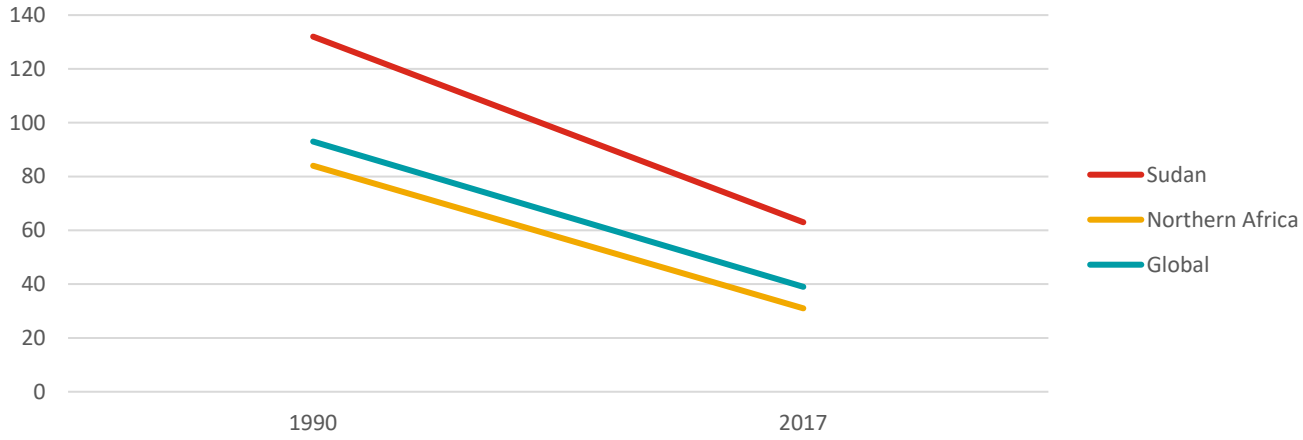
Since gaining independence from British-Egyptian rule in 1956, Sudan has been continuously engaged in a state of conflict and civil war, resulting in the loss of millions of lives and displacement of hundreds of thousands of people over the past several decades. The socio-political climate of Sudan in recent years has left the country in a constant state of crisis after the independence of South Sudan in 2011, "where the mainly Christian and Animist people had for decades been struggling against rule by the Arab Muslim north. However, various outstanding issues – especially the question of shared oil revenues and border demarcation – have continued to create tensions between the two successor states. Sudan has long been beset by conflict. Two rounds of north-south civil war cost the lives of 1.5 million people, and

a continuing conflict in the western region of Darfur has driven two million people from their homes and killed more than 200,000." [3]

The current president, Omar Hassan al-Bashir, first rose to power after a coup in 1989 and won the presidential election shortly after in 1996. Since his initial presidential term, he has been re-elected several times, most recently in 2015 when he was elected for another five-year term, despite the vehement boycotting from opposing parties. President Bashir has been issued with two international arrest warrants from the International Criminal Court in The Hague "on charges of genocide, war crimes and crimes against humanity."[4] Throughout his time in the administration, the continuous conflict between the Sudanese Armed Forces (SAF) and opposing forces, including the Sudan Liberation Army (SLA) and Sudan People's Liberation Movement-North (SPLM-N), have destroyed communities and local infrastructure, threatened the lives of millions, and caused massive migrations of internally displaced persons (IDPs) across borders. The governmental neglect for the well-being of the Sudanese and the constant state of conflict and crisis has totally crippled the health system due to insufficient manpower, funds, and supplies, along with a constantly fluctuating movement of populations across borders that stresses already weakened infrastructure and organizational capacity. As such, Sudan remains one of the world's poorest nations, exhibiting adverse outcomes in health and security for all population groups, particularly among women and children.

Figure 1 below presents under-5 (U5) mortality rates in Sudan[5] from 1990 through 2017, and illustrates that while progress has been made, Sudan's children still suffer a higher burden of mortality than its regional and global neighbors.

Figure 1: Under Five Mortality in Sudan Compared to Regional and Global Trends (1990-2017)

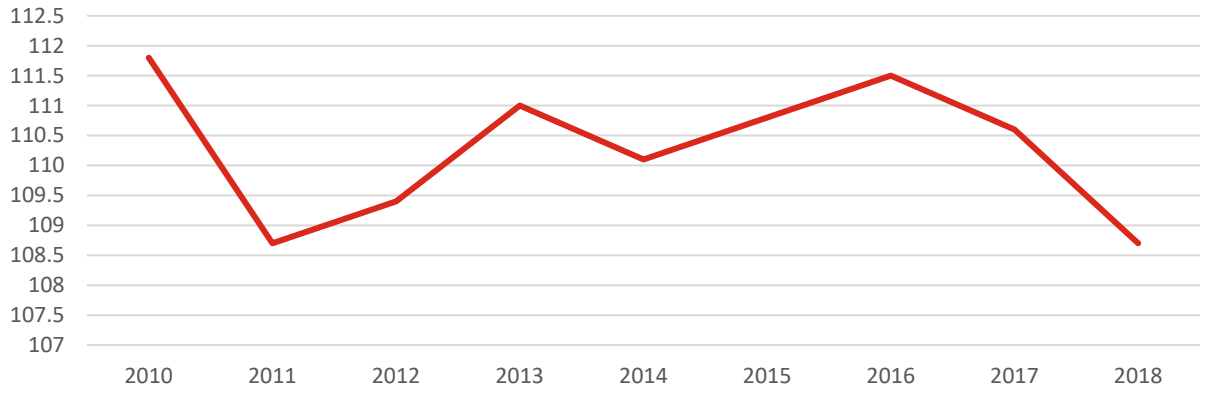


As of 2015, Sudan ranked 5th higher ranking[6] on the world fragility index, which combines four groups of measures and has remained high over the last decade (see Figure 2)[7]:

[3] BBC News. (2018). Sudan country profile. http://www.bbc.com/news/world-africa-14094995.
[4] BBC News. (2018). Sudan country profile. http://www.bbc.com/news/world-africa-14094995.
[5] Levels and Trends in Child Mortality, United Nations Inter-agency Group for Child Mortality Estimation, 2018, United Nations Children's Fund, New York. https://childmortality.org/reports
[6] Higher is more fragile
[7] Source: http://fundforpeace.org/fsi/2017/05/13/fragile-states-index-and-cast-framework-methodology/

- Cohesion indicators: security apparatus, factionalized elites, group grievance;
- Economic indicators: decline, uneven development, human flight;
- Political indicators: state legitimacy, public services, rule of law;
- Social and cross-cutting indicators: demographic pressures, refugees and IDPs, external intervention.

Figure 2: Sudan Fagility Score



Timeline & Scaling of Save the Children Projects

Save the Children (SC) has been operating in Sudan for more than 30 years, and through its longstanding presence in the region, has developed strong relationships with local government, national NGOs (NNGOs), and community organizations to deliver life-saving emergency health and nutrition interventions to populations in need. Some of these early projects had their own contributions to health systems, most notably through the establishment of basic training schools for nurses and midwives that are still under operation at the time of this review.

Save the Children's operations and emergency programs were interrupted briefly in 2009 when the government abruptly expelled a number of international organizations, including Save the Children US and Save the Children UK. During this time, the health programs in Darfur and South Kordofan were handed over to the respective state Ministry of Health (MOH) officials, inclusive of three health facilities that had been rehabilitated and made functional through Save the Children's programs. These health facilities were formally added to the government's list of health facilities so that they would receive an operational budget, which meant that services continued after the handover to the MOH, but supervision was limited and there was a regular shortage of commodities, including medicines. When Save the Children resumed activities, the same facilities were supported again.

In 2013, Save the Children received funding from the USAID Office of U.S. Foreign Disaster Assistance (OFDA) to carry out a series of projects in the Darfur and Kordofan regions. The most recent project phases were still being implemented through the summer of 2018 (at the time of writing of this study). This study covers the period from 2013 to 2018.

The projects followed a generally similar format of implementation in both states, employing intensive community-based strategies to build the capacity of the health system through an integrated approach across four key sectors: Health; Nutrition; Water, Sanitation, & Hygiene (WASH); and Child Protection (CP). PRIDE II in Darfur additionally implemented project activities in the Economic Recovery and Market Systems (ERMS) sector to generate household incomes and stimulate local economies. Beyond the

provision of direct health and nutrition services, Save the Children supported the construction and rehabilitation of WASH infrastructure along with community WASH education, providing thousands of beneficiaries with improved access to clean water and sanitation facilities and improving sanitation practices in the community. The projects worked through MOH staff with support from 20-30 Save the Children project staff, and technical backstop from the US EHN team.

Across all target localities, projects, and sectors, Save the Children emphasized the inclusion of both host communities and displaced populations in the provision of EHN, WASH, and CP services in Darfur and Kordofan states. Additionally, conflicts that arose in Sudan and South Sudan over the timeline of the projects caused shifts in population movement and increased numbers of IDPs, so the different project phases were adjusted to meet the needs of fluctuating populations. For example, GKLIP III "place[d] additional emphasis on supporting 8 health clinics in crowded IDP locations to serve 136,000 IDPs and host community members" in response to displacements in the Kordofan region.

The Save the Children projects in Darfur and Kordofan included the following projects and phases of implementation (see Table 1, Table 2, and Figure 3 below):

Darfur

- Promoting Resilience among Community in Darfur Environment (PRIDE) I-III
- Partnering to Respond to the Needs of the New IDPs and Conflict Affected Populations (PRECAP) I-II

Kordofan

- Greater Kordofan Lifesaving Intervention Package (GKLIP) I-III
- Partnering for Effective Emergency Response in Greater Kordofan (PEER) I-II

Of note, Save the Children also operated other programs in Darfur and Kordofan with funding from other donors during the same time periods as the OFDA programs but are not included in this review.

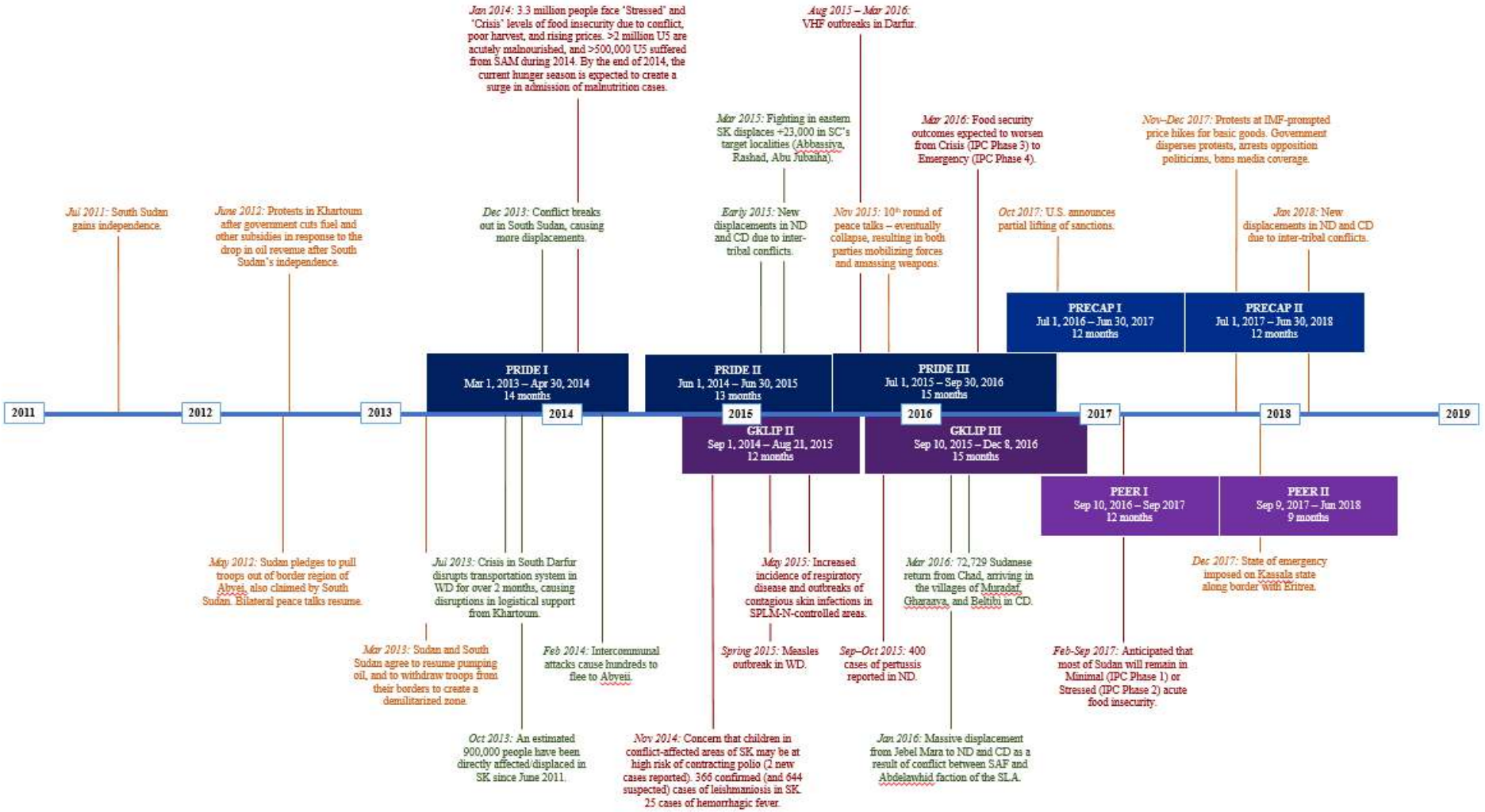
Table 1: Save the Children Project Details in Darfur (2013-2018)

Project	PRIDE I	PRIDE II	PRIDE III	PRECAP I	PRECAP II
Duration	Mar 2013 – Apr 2014	Jun 2014 – Jun 2015	Jul 2015 – Sep 2016	Jul 2016 – Jul 2017	Jul 2017 – Jul 2018
Location (State & Localities)	West Darfur (WD)				
	El Geneina Foro Baranga Habila Kereinik Murnei	El Geneina Foro Baranga Habila Kereinik	Foro Baranga Habila Kereinik		
	Central Darfur (CD)				
		Azum Bindisi Umm Dukhun Wadi Salih Zalingei	Alsalam Umjukuti	Azum Wadi Salih Zalingei	Azum Wadi Salih Zalingei
	North Darfur (ND)				
		El Malha	El Malha	El Malha Saraf Omra Tawila	El Malha Sara Omra Tawila
Total USD	--	$1,999,895	$1,800,000	$1,300,000	$900,000
Beneficiaries Targeted/Yr	--	300,390	309,729	216,550	100,000
Beneficiaries Reached/Yr	542,345	462,617	299,225	--	--
Key Sectors	Health Nutrition WASH CP	Health Nutrition WASH CP ERMS	Health Nutrition WASH CP	Health Nutrition WASH	Health Nutrition WASH

Table 2: Save the Children Project Details in Kordofan (2013-2018)

Project	GKLIP I	GKLIP II	GKLIP III	PEER I	PEER II
Duration	--	Sep 2014 – Aug 2015	Sep 2015 – Dec 2016	Sep 2016 – Sep 2017	Sep 2017 – Jun 2018
Location (State & Localities)	North Kordofan (NK)				
		El Rahad	El Rahad	El Rahad	
		Shiekan	Shiekan	Shiekan	
		Um Rawaba	Um Rawaba	Um Rawaba	
	South Kordofan (SK)				
		Abu Jubaiha	Abu Jubaiha	Abu Jubaiha	Abu Jubaiha
		Abu Kershola	Abu Kershola		Abu Kershola
		Al Qoz	Al Qoz		
			Dalami		
		Dilling	Dilling		
		El Abassiya	El Abassiya	El Abassiya	El Abassiya
		Elliri	Elliri		Elliri
			Gedir		
			Habila		Habila
			Kadugli		Kadugli
		Rashad	Rashad	Rashad	Rashad
			Reif Ashargi		
		Taddamon			
	West Kordofan (WK)				
		Al Sunut			
			Al Udaya	Al Udaya	Al Udaya
			Babanusa	Babanusa	Babanusa
		El Salam	El Salam	El Salam	
			Ghubaysh	Ghubaysh	Ghubaysh
		Lagawa			Lagawa
Total USD	--	$1,949,999	$1,900,000	$1,399,999	$849,990
Beneficiaries Targeted/Yr	--	510,773	578,300	565,938	363,822
Beneficiaries Reached/Yr	--	732,230	1,435,342	--	--
Key Sectors	--	Health	Health	Health	Health
		Nutrition	Nutrition	Nutrition	Nutrition
		WASH	WASH	WASH	WASH
		CP	CP		

Figure 3: Timeline of Save the Children Projects and Major Critical Events in Sudan (2011-2019)



Population Health and Health Services Achievements

A strengthened health system would show:	Summary findings:
• **Improved achievements (services coverage and quality, outputs, and outcomes).**	Emergency Health and Nutrition projects in Sudan were designed with a central focus on increasing accessibility of quality health care services to internally displaced populations (IDPs) and host communities, and projects were successful in delivering on these priorities. Programs were also designed to hand over health facilities and activities to the MOH or local community-based organizations; but there is limited information available on whether achievements realized under the project were sustained after Save the Children's financial and technical support were withdrawn.

Save the Children projects in Sudan improved the quality and accessibility of acutely needed services and interventions to both host populations and IDPs, with an intentional approach to limiting the systems of effects of a "refugees-only" approach. This included technical and operational support to health facilities in target locations through partnership with local organizations and by working in tandem with the MOH. Project inputs for service delivery included infrastructure, human resources, management support, technical support, supplies, and commodities for health facilities, nutrition centers, and mobile outreach services. As a result, host and IDP populations were able to utilize services in reproductive health, nutrition, vaccinations, disease prevention, and basic primary healthcare.

The Save the Children projects improved a number of service output and outcome indicators to both displaced and local populations (see Tables 3 and 4 below). The health and nutrition achievements may have also been influenced by integrated implementation of projects in other sectors (WASH, child protection, and economic recovery and market systems). Some specific activities under these sectors were linked to health activities, such as health facility improvements under a cash-for-work program. These initiatives mutually reinforced and contributed to the success of health activities, particularly at the community level, where health promotion and education initiatives were complemented with the utilization of community networks for WASH and child protection.

Table 3: MAM and SAM Outcome Rates in Darfur (PRIDE I-III) and Kordofan (GKLIP II-III) Projects

Project / Indicator Rate		PRIDE I (March 2013 – April 2014)	PRIDE II (June 2014 – June 2015)	PRIDE III (July 2015 – Sept 2016)	GKLIP II (Sept 2014 – Aug 2015)	GKLIP III (Sept 2015 – Dec 2016)	PRECAP I-II July 2016-July 2018
MAM	Cure	89.4%	85.9%	94.9%	68.2%	89.6%	95.1%
	Default	5.9%	7.1%	4.7%	30.6%	10%	2.5%

	Death	0.1%	0%	0%	0%	0.4%	0%
	Non-response	4.6%	--	0.4%	--	--	2.4%
	Non-recover	--	7%	--	--	--	--
SAM	Cure	90.3%	90.2%	89.1%	75%	89.2%	94%
	Default	6.2%	5.2%	9.1%	21%	1.6%	3%
	Death	0.1%	0%	0%	0.9%	1.6%	1%
	Non-response	3.4%	--	--	--	0.4%	--
	Non-recover	--	4.6%	1.8%	--	--	2%

Select indicators illustrate achievements (Table 4) from the initial project phases in both Darfur and Kordofan, with combined data from final reports for Darfur (PRIDE I-III and PRECAP 1-II) and Kordofan (GKLIP II-III). Final reports were not yet available for PEER I-II projects in Kordofan at the time this report was completed. Projects did not capture the scale of contributions to changes in service quality and availability over time. Instead achievements are framed here through measures of service utilization (as in Table 4), and some quality measures, such as the MAM and SAM outcomes presented in Table 3.

Table 4: Select Achievements under Darfur (PRIDE I-III, PRECAP I-II) and Kordofan (GKLIP II-III) Projects for Health, Nutrition, and WASH

	Service Outputs	Population Outcomes
Health	• 119,461 cases diagnosed and treated per standardized case management protocols such as IMCI	• 67,653 pregnant women attended at least 2 comprehensive ANC clinics • 30,019 women delivered with an SBA • 25,699 women & newborns received PNC within 3 days of delivery
Nutrition	• 6018 people treated for SAM • 150,617 children screened for malnutrition in the community by trained community volunteers • 14,272 infant/mother pairs attending Mother to Mother Support Groups (no data from PRECAP I-II)	• 5,682 infants (0-6 months) who are exclusively breastfed (no data from PRECAP I-II) • 10,995 children (6-24 months) who receive foods daily from 4 or more food groups (no data from PRECAP I-II)
WASH	• 19 water points are clean and protected from contamination (no data from PRECAP I-II) • 2,146 HH latrines completed and clean/in use • 900 handwashing facilities in use (no data from PRECAP I-II) • 18 water points developed, repaired, or rehabilitated (no data from PRECAP I-II)	• 7267 HHs with no evidence of feces in living areas • 13,800 HHs collecting all water for drinking, cooking, and hygiene from improved sources (no data from PRECAP I-II) • 7,389 respondents know 3 of 5 critical times to wash hands (no data from PRECAP I-II) • 5013 HHs store drinking water in clean containers • 4770 HHs properly dispose of solid waste • 447 HHs have clean and protected water containers (no data from PRECAP I-II)

Systems Effects

Service and health achievements, discussed above, did have 'systems effects,' if only by demonstration of what is possible. In this section we focus on effects of the interventions on major domains, which should be considered nodes in a network of interdependent systems.

National Coordination & Policy Setting

A strengthened health system would show:	Summary findings:
• **Evolution toward humanitarian and health polices in support of essential interventions at the national or regional level** • **Signs of ownership and commitment to the policy, manifested through different levels of the health system.**	If government is seen realistically as a collection of actors with varying influences on behavior (as opposed to a single, rationally operating entity), then Save the Children's emergency health projects played a role in strengthening national coordination and policy. In spite of restrictive national level policies on NGO movement and program monitoring, the government's coordination with humanitarian partners ultimately enabled and supported the implementation of health interventions by the MOH, Save the Children, and other partners. In turn, MOH ownership was fostered through strong relationships and close coordination of activities, all signs of commitment to national policies to deliver an essential package of health services. National guidelines for health interventions were also updated as a product of project activities.

As mentioned in the background section, the government's resources for services were extremely constrained; in some cases, humanitarian aid was the primary resource available. The government had to coordinate with international and local partners (such as the United Nations [UN], Save the Children, and local implementing NGO's) to maximize the availability of health services offered to IDP and host communities. The government of Sudan has a 25-year Health Sector Strategic Plan (developed in 2003) that served as a policy framework for health. Save the Children projects were, in principle, aligned with and support the plan, which is based on fair financing and the rebuilding of the country's crumbling health system, and "aims to reduce the burden of diseases; to promote healthy lifestyles; to develop and retain human resources; and to introduce advanced technology all while assuring equity, quality and accessibility of health services." In addition to tacit support and alignment with the national framework, one informant commented that Save the Children projects influenced and contributed to updated health policies that guide and support the essential package of interventions provided through project supported facilities and activities.

Emergency health program implementation illuminated how commitments and action to realize goals under the Health Sector Plan were manifested in varying and even disparate ways between different government actors. At the national level, a number of government restrictions limited Save the Children's ability to deliver services and assess program implementation – including restrictions on NGO staff movement and on the ability to conduct health and program assessments. There were also cumbersome administrative processes such as negotiating national and state level MOU's, contracts and technical agreements between NGO's and the Humanitarian Aid Commission, and restrictions on the ability to conduct program and health assessments. These restrictions and limitations were identified by program staff to detract from opportunities offered by Save the Children projects to build the capacity of the MOH to sustainably serve the local community, particularly with respect to understanding health

needs and program impact through assessments and evaluations of community health status. To prompt a progressive evolution from this environment, Save the Children staff advocated with government counterparts at national and state level for the ability to assess health impact and collect better data for health, nutrition, and WASH. There is no evidence that restrictions on health assessments were eased. This would have placed limits on how projects were able to capture some dimensions of change.

Paradoxically, there was also intensive coordination and buy-in from different actors within the government at national, state, and local levels that enabled and allowed Save the Children's activities – for example with the Ministry of Health, the Water and Environmental Sanitation (WES) Department, and the Ministry of Social Affairs (MOSA). Save the Children also worked with Family and Child Protection Units (FCPU), National and State Councils for Child Welfare N/SCCW, the State Ministry of Education (MOE), and the State Water Corporation (SWC). Projects operated within the national system using national policies to deliver on interventions and provide health services. Save the Children developed relationships with key government partners over the course of the different projects. Projects intentions and efforts were oriented toward close coordination, with the hope of a foundation for planned hand-overs of project facilities and activities to the government. As one key informant put it, "[w]e work closely with the Minister of Health, who have no objections – they give us the green light at any time." Another informant indicated that strong relationships with the government were however also subject to personality and affinity issues. Close coordination was also mentioned, not only in relation to the government, but also with NGOs and stakeholders of the UN cluster systems.

When looked at it in isolation, the restrictive policies of the government on NGO movement and activities would make it seem that there was limited evolution toward humanitarian and health polices in support of essential health interventions. On the other hand, close collaboration between Save the Children's project activities and government stakeholders to implement activities at district and local levels indicates an intention and actions to respect principles of alignment and coordination. In other words, while some government actions have detracted from progressive humanitarian action to support health interventions, other actors within the government have evolved toward policies that both support and enable essential interventions. Save the Children had to navigate those two spaces of policy and coordination.

Decentralization & Management Capacity

A strengthened health system would show:	Summary findings:
• **Decentralized MOH system uses processes for program learning and management course correction based on information** • **Decentralized MOH system limits or corrects displacement of other essential routine services by emergency response**	Save the Children's emergency health and nutrition programs were designed as an expansion to essential primary care services in geographical areas where they did not previously exist or were extremely weak. Changes in the MOH's use of processes for program learning at decentralized levels, and program management course correction were not formal objectives of the projects and were not formally documented. However, several indicators—such as successful service delivery outcomes, documented transition strategies, and eventual handover of activities and facilities to the MOH—suggest the possibility of gains in capacity by the MOH through implementation. Service

	delivery sites were eventually handed over to the MOH as Save the Children progressively transitioned out of these areas. This approach expanded the role of the MOH in providing routine services and avoided the risk of displacement of national capacity.

Program Learning and Management Course Correction – The Save the Children-supported health services were implemented and managed by local NGO's with technical and logistical support from Save the Children, which was also provided at central and district levels in an effort to build management capacity and decentralize health, nutrition, and WASH activities. Save the Children also worked to monitor, evaluate, and supervise its health and nutrition activities to guide decision-making processes and adjust program implementation and to better inform the MOH of community needs and issues. MOH service delivery and facility management staff regularly participated in Save the Children and partner NGO efforts to monitor programs and course correct as needed, with capacity building of MOH staff for these management processes as a likely outcome. Additionally, program design documents indicate that project phases progressively assessed organizational capacity throughout implementation processes, with Save the Children gradually withdrawing permanent presence and instead providing administrative support for the continuation of projects. For example, the construction of "emergency response hubs" in Kordofan through the GKLIP projects established static structures for the organization of local response among local agencies, with Save the Children limiting its direct involvement and instead providing logistical support and mobile outreach activities. Exit and transition strategies outlined Save the Children's progressively minimal involvement and handover to respective government line ministries, although Save the Children continued to conduct monitoring visits and provide support. There was no assessment and limited documentation of management capacity, readiness for handovers, and actual handover processes. Therefore, contributions towards management capacity building are only suggested from the eventual handover of activities and facilities to the MOH.

In one specific example of program learning and subsequent MOH adoption, GKLIP II carried out a Community Management of Acute Malnutrition (CMAM) coverage assessment in four health facilities (HFs) in NK and SK states. The assessment was a scaled down version of initial program plans to conduct a comprehensive CMAM coverage survey to help in mapping out the CMAM services, identify boosters and barriers and recommend actions to inform the CMAM scale up plans and update the CMAM related guidelines and strategies. "While this [was] indeed progress for data collection on key areas like nutrition, the limitations on surveys in our program areas remain in place and our ability to survey the needs of the communities we serve are impacted greatly."[8] The survey restrictions enacted by the Sudanese government (mentioned previously under *National Coordination and Policy Setting*) impeded the abilities of Save the Children and the MOH to comprehensively assess community needs outside the confines of health facilities. Nonetheless, Save the Children helped the MOH to establish a systems-level nutrition database for CMAM, and began to understand some of the local barriers that limit access and utilization of nutrition services such as long distances to health facilities and nutrition centers and the mobility of the IDP population. Subsequent project phases continued to utilize and strengthen the nutrition database through regular submissions of CMAM data and training for nutrition staff in monthly

[8] Bourns.(2015). Greater Kordofan Lifesaving Intervention Package (GKLIP II). *(Final/Annual Report).*

reporting protocols, and sustained CMAM surveillance and site mapping to strengthen capacity for CMAM scale up.

Limited Displacement of Routine Services – Save the Children's emergency programming in Sudan focused on the provision of primary health and nutrition services and the strengthening of WASH infrastructure to meet basic needs for both displaced populations and host communities. These projects were implemented through the MOH system and did not displace routine services in order to provide emergency response relief, but rather expanded the services available to IDP's and host communities in specific geographic areas. Activities were highly integrated at different levels of the healthcare system to offer IDPs and host communities a comprehensive platform for health and nutrition, WASH, and child protection services. For example, nutrition activities—including human resources trainings, health behaviour education, and prevention and treatment of malnutrition—were implemented through target health facilities alongside primary healthcare services "to ensure provision of comprehensive, effective and continuous care through a service that is decentralized and integrated."[9] Additionally, Save the Children worked to decentralize expanded program on immunization (EPI) and outbreak response initiatives through mobile campaigns and community outreach, allowing health facilities to focus their static activities on the provision of basic primary healthcare and nutrition services. In short, decentralized emergency response activities did not displace essential routine services, but rather strengthened existing structures and established new ones to provide more comprehensive and higher quality services to host communities and IDP populations fleeing conflict.

Engagement with Community Organizations & Societal Partnerships

A strengthened health system would show:	Summary findings:
• **MOH engages in effective societal partnerships and with community organizations to improve efficiency and resilience of community systems and facility-based services** • **Health systems stakeholders (MOH, non-health sectors, civil society, private sector) develop stronger accountability mechanisms** • **The health system has mechanisms in place to mobilize community volunteers during emergencies (in addition to paid CHWs)** • **There are signs of increased trust and social capital between community leaders/organizations and the health system**	Program partnerships with and strengthening of community assets—including community health workers (CHW's), volunteers, volunteer networks, and community health committees (CHC's)—were successful in enhancing community mechanisms and resources while also strengthening linkages and accountability mechanisms between the MOH, health facilities, the community, and health system stakeholders. Gains in service delivery and community utilization of services, regular engagement between the community and the formal health system through CHC meetings, community level monitoring, surveillance, and referrals by volunteers and CHWs indicate achievements in strengthening the role of the community as a partner and asset to the MOH. These elements could be expected to contribute to increased trust between the community and the health system. Engagement with and strengthening of community structures was considered by stakeholders and program staff to be a successful component of Save the Children's emergency health programming in

[9] Bourns. (2015). Promoting Resilience Among Communities in Darfur Environment (PRIDE) III. *(Proposal Summary),* 18.

	Sudan and was a strategy that strengthened on-the-ground relationships between the community and the MOH. This was possible even as national politics detracted from the ability of the humanitarian community to support the MOH in providing services.

Community engagement initiatives were perhaps the most successful aspect of Save the Children projects in Darfur and Kordofan, and sector activities were designed to increase community capacity and – correspondingly - social capital while strengthening ties between the local community and formal health system. Save the Children projects, in coordination with the MOH, provided trainings and capacity-building spaces for community health workers, local volunteers, and other community leaders. Community volunteers received extensive trainings in social behaviour change communications and delivered health promotion and education messages to individuals and community groups. These volunteers were instrumental in bridging the divide between community and health system-level objectives, and integrated sector activities through behavior change interventions and awareness-raising campaigns. Save the Children programs also utilized the CMAM framework to address emergency nutrition needs, which relies heavily on community mobilization. In the course of CMAM implementation, Save the Children trained outreach volunteers to screen and refer children for malnutrition and worked with community health workers to follow up with at-risk children during weekly check-ups.

Community structures established through program activities in the sectors of WASH and child protection played a role in strengthening community health and ownership at the community level. This included the community-based hygiene promotion volunteers (CBHPVs), who worked alongside the government of Sudan to stimulate ownership of WASH infrastructure and health at the community level through the monitoring and rehabilitation of WASH infrastructure and the delivery of hygiene promotion messages in the community. CBHPV's also worked closely with local schools to improve institutional water and sanitation facilities and promote good hygiene through primary and secondary education. Additionally, Save the Children supported the functioning of community-based child protection networks (CBCPNs) that utilized social networking structures of the community, schools, and government social workers to identify and address issues related to child protection, abuse, and exploitation.

Along with these sector-focused community networks, Save the Children projects also guided the establishment and development of community health committees (CHCs) to oversee local initiatives and identify community needs and priorities in sector activities. The CHCs became a voice of accountability within the local health system. CHCs attended regular meetings at health facilities with healthcare providers, CHWs, and local officials to discuss developing issues, share in presentations of data and information, and participate in conversations regarding solutions and changing community needs. Many CHC members and other community volunteers also received training from Save the Children projects across key sectors, including health and nutrition, WASH, and child protection, and their grassroots presence in the community allowed these volunteers to then contribute significantly towards behaviour change communication as well as the monitoring, surveillance, and referral of malnutrition, child abuse,

and other health and emergency cases. Under PRIDE II in Darfur, CHC's assumed responsibility for projects that aimed to improve the purchasing power of vulnerable households—cash payments were given in exchange for manual labor for the construction, rehabilitation, and maintenance of health facilities and WASH infrastructure. CHC's also provided oversight for a solar panel pilot project implemented in target health facilities under PEER II in Kordofan (more detail under *Costing & Financing section* below). This oversight of economic recovery for households, local health facilities, and the community as a whole gave CHCs some ownership of local issues and contributed to local health financing.

While this is not evaluated in projects' documents, these initiatives put in place by Save the Children projects likely contributed to building community capacity and relationships with the health system. The projects in Darfur and Kordofan effectively mobilized individuals and social networks to assume responsibility for their own health and well-being while providing the logistical tools to proactively address these issues at the grassroots level and build connections with the formal health system.

Finally, community-based NGO's served as critical partners for program activities and health service delivery. In some cases, technical and operational support for Save the Children -supported facilities was provided by local partners, and some local NGO's took over service delivery in select facilities as part of Save the Children's exit strategy. The intention behind this strategy for implementation was to strengthen local NGO's to serve as capacity building partners to the MOH when international partners withdrew from their respective program areas.

Costing & Financing

A strengthened health system would show:	Summary findings:
• **Progressively increased domestic funding for services with reduced financial hardship on users, without displacement of resources from other essential public goods.**	Save the Children programs were not designed to address large scale sustainable financing for health services in program areas. Nonetheless, Save the Children's emergency program activities may have induced some degree of local financing for health staff and clinics that it initially operated and then handed over to the MOH. By increasing the number of functional facilities registered and managed by the MOH, projects contributed to the federal government's allocation for states' health budgets. Save the Children's activities also stimulated community-owned local-level financing initiatives.

Save the Children emergency health activities in Sudan were not designed to address financing issues. The projects nonetheless sought to avoid doing harm, and to find opportunities for positive contributions to local financing. For example, the MOH covered the salaries of health staff in the Save the Children operated clinics that were eventually handed over to the MOH when Save the Children withdrew at program close. Operational and facility level costs (except health staff salaries) were provided by Save the Children through OFDA funds; when clinics were handed over at project end, project reports indicated that "the MOH, community-based structures, and NNGOs [would] continue

financing and engaging in all management steps to [sustain] desired outcomes". Although there was little detail in program documentation on exactly how and from where domestic financing would continue, one key informant noted that Save the Children re-instated several MOH facilities that were non-functional; these facilities were added back to the federal governments' list of functional facilities, with the secondary positive effect of increasing domestic financing for health in the program areas, since the number of functional facilities informs the federal government's allocation of state health budgets.

Some local level health financing was incorporated into Save the Children's intensive community-based work. The PEER II pilot Health Committee Sustainability Initiative, first implemented in Kordofan in 2017, is one such example. The program's installation of solar panels at two pilot HFs to generate electricity allowed the facilities to expand their operational hours into the evening and improve accessibility and coverage in the community, but also provided an opportunity for the facilities to generate profits. The electricity was sold to community members for mobile phone charging, and funds raised directly supported the daily operational costs of the health facility. The solar panels and sale of electricity were wholly managed and operated by the local CHC, thereby creating a self-sustaining source of funds for the health facility that covered minor expenses without the involvement of central systems. The solar panel pilot was a notable community innovation to financially sustain EHN and WASH facilities. Throughout project phases, community organizations and social networks were engaged to mobilize local resources and funds in support of EHN projects, which provided gap financing and fostered deeper community ownership in health service delivery operations.

Human Resources

A strengthened health system would show:	Summary findings:
• **The health system is expanding its human resources for health through domestic resources, including through incorporation of CHWs** • **The health system appropriately uses task shifting to ensure a more efficient use of staff time and skills**	There are proxy measures which indicate that Save the Children's emergency activities expanded human resources for health and contributed to task shifting in program locations. For example, the service delivery rates achieved in supported clinics is a reflection of the MOH's ability to expand the presence of healthcare providers and the strong performance of the providers themselves. Another indicator is the strengthened linkages between MOH staff and community resources such as CHW's, traditional birth attendants, village midwives, and community networks, and the use of these community assets for health promotion, monitoring, surveillance and referrals in program areas. In the absence of direct measures, these indicators are a useful gauge of human resource contributions in program areas. However, more centralized, national level contributions towards strengthening human

	resources and task shifting beyond program areas were not documented.

In program areas, Save the Children worked with the MOH to expand health services and corresponding MOH human resources for health across all cadres in areas where they were not previously available, thus expanding the formal health workforce in these locations. However, in a context of uncertainty, with constantly fluctuating movement of IDPs across border lines, health facilities still consistently reported shortages of healthcare staff, physicians, and laboratory staff, which affected the ability to maintain accessible, comprehensive services to local populations.

Save the Children projects were also successful in expanding human resources for health available to the MOH in Darfur and Kordofan beyond the formal health workforce, through strengthening the capacity of the health system to mobilize community volunteers and traditional healthcare providers to collaborate in emergency health, nutrition, and WASH initiatives. Save the Children's programs worked to build social networks for WASH and CP monitoring and utilized the talents of CHWs and other community leaders to increase local capacity to address emergency health and nutrition needs. The inclusion of traditional birth attendants (TBAs) and village midwives (VMWs) in project trainings is an important example of the expansion of domestic human resources for health through an understanding of sociocultural structures, practices, and beliefs. Overall, Save the Children's programming laid a foundation for the MOH to tap into a comprehensive and integrated network of human resources for health, incorporating the skills and knowledge of both formal healthcare providers and community level resources.

The projects' extensive training of government staff, healthcare providers, and community volunteers across all cadres of the health sector, and emphasis on community engagement played a role in shifting the burden of service provision off of strained HFs and overworked healthcare providers and into the hands of community health workers. In a time of chronic emergency, rallying community members and strengthening social structures to monitor health and nutrition and WASH issues did, at a minimum, help to shift responsibility for the health of the community beyond just the health facility and MOH staff.

Supply Chain Management

A strengthened health system would show:	Summary findings:
• Increased capacity and autonomy of the health system to manage procurement and supply of commodities	In order to deliver on emergency health program objectives, Save the Children operated its own supply chain management in coordination with partners and donors, as the MOH did not have a supply chain management system in place that was capable of responding to service delivery needs. As part of program vaccination efforts, Save the Children supported MOH facilities in program areas with appropriate cold storage infrastructure. Aside from this contribution, there is no indication that the health system's ability to manage procurement and supply of commodities was strengthened through these emergency health programs.

In order to deliver on emergency health program objectives, Save the Children operated its own supply chain management in coordination with partners and donors, as the MOH did not have a supply chain management system in place that was capable of responding to service delivery needs. The country was, and still is, strongly reliant on international aid, and Save the Children projects did not build capacity for supply chain management. Save the Children ran a parallel supply chain management system and directly oversaw the procurement and distribution of drugs, equipment, and food supplies and coordinated with international donors, including the WHO, WFP, UNICEF, and UNFPA, to contract the supply of essential commodities to supported facilities and develop appropriate cold storage infrastructure for vaccines. Despite project oversight, drug stockouts and supply shortages remained a persistent challenge for all Save the Children programming. These issues were attributed to limited donor funding, pipeline breaks, increased demand for services, transit issues resulting from conflict and poor-quality roadways and transportation networks. The remote location of Save the Children project sites posed challenges in the physical delivery of supplies to rural areas, as well as high operational costs and increasing prices and inflation rates in Sudan. Save the Children coordinated with donor agencies to secure funds for supplies and commodities to continue providing lifesaving interventions to IDP and host populations.

Data – Health Information Systems, Monitoring & Evaluation (M&E)

A strengthened health system would show:	Summary findings:
• **Appropriate human resources are allocated to HMIS in the health system to inform decision makers** • **Data systems and information have been strengthened within the health system**	Save the Children projects contributed to a CMAM database and the WHO Early Warning System (EWARNS) for disease surveillance. There may have also been some local level capacity building by virtue of implementation itself in the process of data collection and management in facilities as a result of program efforts. Some evidence showed that regular management processes, led with country partners, advanced the practice of data use for decision-making. Beyond these contributions, there is no documentation of a comprehensive program effort or effect on strengthening health management information systems, nor is there documentation of increased allocation of human resources to that end.

Some specific instances in strengthening the health systems' ability to capture data were documented. For example, Save the Children initiated the development of a CMAM database under GKLIP II; subsequent project documentation indicates that this database continued to be used to capture essential nutrition information, and training continued for health facility staff to use it for monthly reporting. Additionally, Save the Children worked diligently to strengthen the WHO Early Warning System (EWARNS) for disease surveillance (see section below). A key informant also noted that processes which the project and national stakeholders undertook to use data for decision-making became relatively institutionalized practices, albeit not summarized in project reports.

Additionally, Save the Children's monitoring, evaluation, accountability, and learning (MEAL) approach to monitor program implementation and document results was designed primarily to respond to donor reporting requirements. The program partnered with the MOH to use facility data for reporting and to facilitate decision making with corresponding efforts to strengthen data completeness and quality, which likely did have the effect of strengthening overall MOH data collection and quality at the facility

level in program areas. However, there is no clear documentation, assessment, or quantification of these contributions.

While the program did make some contributions to improving facility level data and information systems, the emergency programs were not designed to effect a comprehensive impact on health information systems at the system or even health facility level, and program documentation did not have information on program activities to strengthen national data collection, information systems, or data use.

Quality of Service Delivery & Referral

A strengthened health system would show:	Summary findings:
• **Services that include host population (not just displaced population) in improved services** • **Services are responsive to community needs and adapted to context.** • **Health system innovations for coverage of health services and preparedness for EHN needs** • **Health system has the capacity to contribute to large EPI campaigns and outbreak responses**	Program activities to strengthen quality of service delivery included improved facility preparedness, joint monitoring visits to facilities with program technical staff and MOH service delivery staff, and technical training to health workers. While these activities contributed to quality improvement, corresponding measures were not captured in program monitoring and reporting. Save the Children's emergency health programs were targeted towards and were effective in incorporating both IDP and host populations into service delivery, with both stationary and mobile services to adapt to population fluctuations. Additionally, programs were responsive to the community needs with focused efforts on vulnerable populations. Programs also responded to cultural context through adaptive and innovative programming to ensure the greatest reach for services in the community. In one example, Save the Children adapted a sub-optimal strategy to reach women who could not be convinced to deliver in the facility, and programs trained village midwives in key interventions at birth and strengthened referral linkages to increase coverage and quality of care even where there were cultural barriers for facility delivery. These programs were also effective in strengthening surveillance capacity, outbreak response, and MOH capacity to contribute to large EPI campaigns. At the same time, the procurement of vaccinations and commodities were facilitated by the emergency programs and sustainable supply and financing within the MOH were not addressed; this continued health system weakness will limit the ability of the MOH to deliver vaccination services after Save the Children's withdrawal.

Save the Children conducted joint monitoring visits with facility staff, during which tools were used to monitor quality of services, and documentation indicates that these visits were an important source of information for making program adjustments as needed. Additionally, training was provided to some facilities on how to maintain cleanliness standards in the facility as noted by one key informant. However, program reporting does not include information on quality of care indicators or changes in

quality of care over time. One key informant noted the concern about sustaining the same quality of services once programs withdraw, as MOH does not have the same type of resources available to ensure quality services for all aspects of service delivery. Finally, a lot of focus and effort was placed on technical training for service delivery staff and community health workers, which likely had a positive impact on service delivery outcomes.

As mentioned in the program background, Save the Children emphasized the inclusion of both host communities and displaced populations in the provision of EHN, WASH, and CP services in Darfur and Kordofan states. Save the Children projects and sector activities were heavily geared towards the provision of services to vulnerable populations, including children, pregnant and lactating women (PLW), IDPs, and female-headed households. Interventions were tailored to address community and cultural needs, particularly in nutrition sector activities which considered the time commitments of mothers to devote to nutrition programs, issue of sociocultural norms for sensitive issues such as breastfeeding, and the essential role of grandmothers and other community leaders in infant and young child feeding (IYCF) practices. In another example, after observing low rates of obstetric care utilization under PRIDE I, Save the Children re-examined strategies to better respond to the cultural and historic preference to deliver at home with village midwives (VMWs) or traditional birth attendants (TBAs). Advocacy for facility-based delivery continued to be a program priority, but subsequent phases also responded to the reality that many women would still choose to deliver at home. The programs therefore included a sub-optimal strategy in order to make progress with safe delivery even when it was not possible to convince women to deliver in the facility. This included capacity building activities for VMW's, including training on Helping Babies Breathe (HBB) for newborn resuscitation, equipping VMW's with safe delivery kits provided by UNFPA, and encouraging VMW's to refer their clients to health facilities for antenatal care (ANC), postnatal care (PNC), and emergency obstetric care. By bridging the gap between VMW's and formal healthcare providers, Save the Children facilitated the strengthening of relationships between the community and the health system, which increased coverage of services, built social capital in the community, and opened the space for further improvements for initiatives on safe delivery.

Save the Children was heavily involved in large-scale EPI campaigns and worked cooperatively with the MOH and partners to secure drugs and commodities and accelerate immunization. In spite of fluctuating populations and poor awareness among newcomers, the success of vaccination activities for host communities was notable: by the end of PRIDE I, Save the Children had vaccinated more than 17,000 children as the only provider of vaccines in the Murnei, Kereinik, and Habila localities of West Darfur, and through continuous scale up across the project phases, vaccination coverage averaged around 90% or above in Save the Children's coverage areas in Darfur, with a similar progression of scale up of EPI coverage in program areas of Kordofan. EPI services were delivered by government staff through facilities that were equipped with functioning storage units and solar refrigerators that were eventually handed over to the government; it is a reasonable conclusion that over the course of implementation the capacity of these facilities to run EPI campaigns was strengthened, as was the cold storage infrastructure. However, all procurement of vaccinations and supplies was facilitated by Save the Children and international aid partners, and there is no indication that the MOH supply chain was significantly strengthened in this process. Without a reliable supply chain, the system's ability to deliver vaccination services is severely compromised, and for this reason it cannot be concluded that Save the Children's successful vaccination efforts were parlayed into sustainable capacity of the MOH to deliver these same services.

During implementation, Save the Children programs sought to strengthen MOH capacity to respond to disease outbreaks and orchestrate surveillance activities. For outbreak response, Save the Children provided trainings for MOH healthcare providers in case management and integrated management of

childhood illnesses (IMCI) protocols, incentives for vaccinators, and logistical costs for mobile outreach teams, as well as technical support to the MOH as a member of the state-level epidemic disease committee. Save the Children also designated health facilities as sentinel disease surveillance sites and oversaw the weekly submission of morbidity reports to the State MOH and WHO EWARNS for disease surveillance; under PRIDE III the strengthened capacity of health facilities in Save the Children's four sites in West and Central Darfur through the submission of these reports was documented.

Discussion

Methodological caveat and limitations

The caveat of this country report (and the overall case study design) is a restatement of its premise: this is not a project evaluation, but an exploratory and analytical examination of health systems effects of successive projects, which already carried out their donor-mandated objectives. This distinction is a perilous exercise: pointing to unsatisfactory or negative system evolutions can lead the reader to reflexive responses such as, "the project should have… the project failed to…" This is not the object of the study. The study remains a natural baseline of sorts on how system effects manifest themselves, and as it turns out both influence and are influenced by projects. The tension between "doing" and "strengthening" is a constant tension in development and emergency assistance. There is an ongoing questioning of HSS approaches vis-à-vis the achievements of results at population level. We reversed the question—what are systems effects of projects designed to achieve results—in order to discover possible adjustments to a results-first strategy from a country systems and sustainability perspective. We will expand on this in our cross-country analysis but acknowledge the inherent challenge of the method.

We discovered that gathering all documentation about projects implemented by Save the Children was itself a minor but real challenge. Project documentation has its own flavor and possible biases—informant interviews were essential to providing nuances or correction about the sequence of events on a number of elements. Unfortunately, finding informants with a clear memory of these projects' history proved to be difficult, given high project staff turnover, and the remote implementation of the study. More investigation in country and more informants, notably from national institutions, would likely have been helpful with additional resources. We feel however that the study achieved its ambition to maximize learning from available data in a retrospective exercise.

A general limitation is that, in spite of a lot of documentation, we explored a substantial number of lessons that could be inferred from the narratives, but many could not be conclusive for lack of focused evaluation efforts on these domains. This can be attributed to the projects' scope of work – for example, project reports were focused on immediate outputs and outcome indicators related to the reach of emergency health services. Another reason for the limited information available on program contributions was the weakness in evaluation capabilities given the political context and limitations on NGO mobility in Sudan.

Finally, the programs selected for review in this country report used a reporting format guided by the donor, which was heavily focused on the outcomes and outputs of service delivery, as compared with some other donor formats that include more detail on systems strengthening processes of implementation. And even though systems strengthening activities took place in the course of implementation, programs were not designed from a systems strengthening standpoint so systems measures were not incorporated into program monitoring measures and reporting. As such, elements of process that may have strengthened the health system such as the execution of exit strategies and

handovers were not detailed in these reports and corresponding measures of success were not available.

Finally, the field of health systems strengthening is itself struggling to advance a clear evaluation model.[10] We used explanatory propositions, expanding on evaluation questions from previous authors[11], but as useful as these propositions are, to construct a multidimensional narrative, they do not have the simplicity and power of reliable quantified measures of change.

Conclusion: Lessons learned from the Sudan Case Study

Few of our explanatory propositions could be proved or disproved conclusively by review of project evaluations and reports. Appreciation of systems effects required teasing out narratives in project reports and informant interviews.[12]

We identified a number of areas where the projects contributed, certainly as health systems support and possibly as systems strengthening. The OFDA-funded emergency health programs that were implemented by Save the Children in Darfur and Kordofan were designed to deliver critical emergency health services to displaced and conflict affected populations, using an integrative approach with the existing health system and utilizing community-based assets for health. Save the Children actively coordinated with the MOH and through the cluster mechanism, and facilities were eventually handed over to the MOH. The close coordination and relations with different government stakeholders likely contributed to the institutional support received by the projects, even in a challenging humanitarian and institutional context. Improvements in systems capacity included facility readiness, infrastructure for regular service delivery, the expansion of services itself, revisions and updates to national technical guidelines, training of both facility staff and traditional community health providers. Service availability was expanded for both IDPs and host populations, a contribution to systems strengthening according to our explanatory propositions. Other contributions included mobilizing community assets and connecting them to the health infrastructure through shifting tasks to CHWs, engaging health committees, and community networks for WASH and child protection. Projects expanded efforts in working with MOH partners in quality improvement processes, data use for decision-making, and management.

These contributions demonstrated a clear intentionality in working with and in support of the national system, where opportunities could be found, as illustrated by the one small scale sustainable financing pilot through a solar panel project. Ultimately, by increasing the number of functional facilities registered and handed back to the MOH, the project possibly influenced an increase in local financing for health staff and clinics, through federal government's allocation for states' health budgets, even if this was not stated as a strategic objective at the onset (the handover was).

Overall, however, while many program elements may possibly have had positive effects on the local health system's capacity, there is little program documentation and formal evaluation of these potential effects. The degree to which they may have influenced positive changes, and general systems effects are often only suggested or assumed from our findings. In the absence of reliable measures to gauge impact of systems strengthening activities, it is difficult to ascertain to what degree these

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[10] Adam T, Hsu J, de Savigny D, Lavis JN, Røttingen JA, Bennett S. Evaluating health systems strengthening interventions in low-income and middle-income countries: are we asking the right questions? Health Policy Plan. 2012 Oct;27 Suppl 4:iv9-19

[11] Chee G, Pielemeier N, Lion A, Connor C. Why differentiating between health system support and health system strengthening is needed. Int J Health Plann Manage. 2013 Jan-Mar;28(1):85-94

[12] This observation is also valid for the companion Pakistan report.

activities left a sustainable impact on the health system in Sudan. Illustratively, project emphasis on a regular data use practice at facility level with facility staff and managers could reasonably be considered learning-by-doing, and to have advanced professional norms, but this is not demonstrated. The projects handed over responsibility for health facility operation and service delivery to the government, but there was little documentation of these handovers, how they were managed, and what the potential was for services to be sustained after Save the Children's support ended.

We also documented a number of weaknesses or sub-optimal directions from the perspective of long-term systems effects and sustainability. (Again, we cannot fully judge whether the projects really could have taken a different direction at the time.) Laudable adaptation efforts to accommodate cultural preferences led to work with traditional birth attendants, a definitely sub-optimal strategy in terms of long-term maternal and newborn health outcomes. Interventions to improve quality of services again can provide a learning-by-doing opportunity but cannot be considered on a par with the development of quality assurance mechanisms. Similar questions can be raised about the sustainability of the HIS improvements.

We observed limits to the potential of single projects for systems strengthening. The projects worked hard to ensure a supply chain of drugs and commodities. This contributed to successful service delivery indicators and high vaccination coverage in program areas. Program efforts to ensure drug supply were however completely parallel to the health system (which lacked a functional system of its own). On the financing side, we noted the positive effect on federal budget allocation, but there was no indication that the federal allocation is sufficient to cover the true cost of service delivery in each facility, including infrastructure and maintenance needs, human resource requirements, and necessary medical commodities. These two elements – procurement and supply chain and financing – of course rely on national level coordination (certainly for procurement and financing), political commitment, and investments most likely beyond the scale of the projects in our study. This illustrates a natural limit to systems strengthening expectations from the achievements of a single project, even with the best systems strengthening efforts—'strengthening' does not equate 'strengthened.'

This raises challenging questions, which we will revisit through our cross-country analysis. We hope that raising these questions will ultimately help improve how we collectively address health systems strengthening on the 'humanitarian-development nexus'.

Annexes

Annex 1. List of Documents Reviewed

Darfur

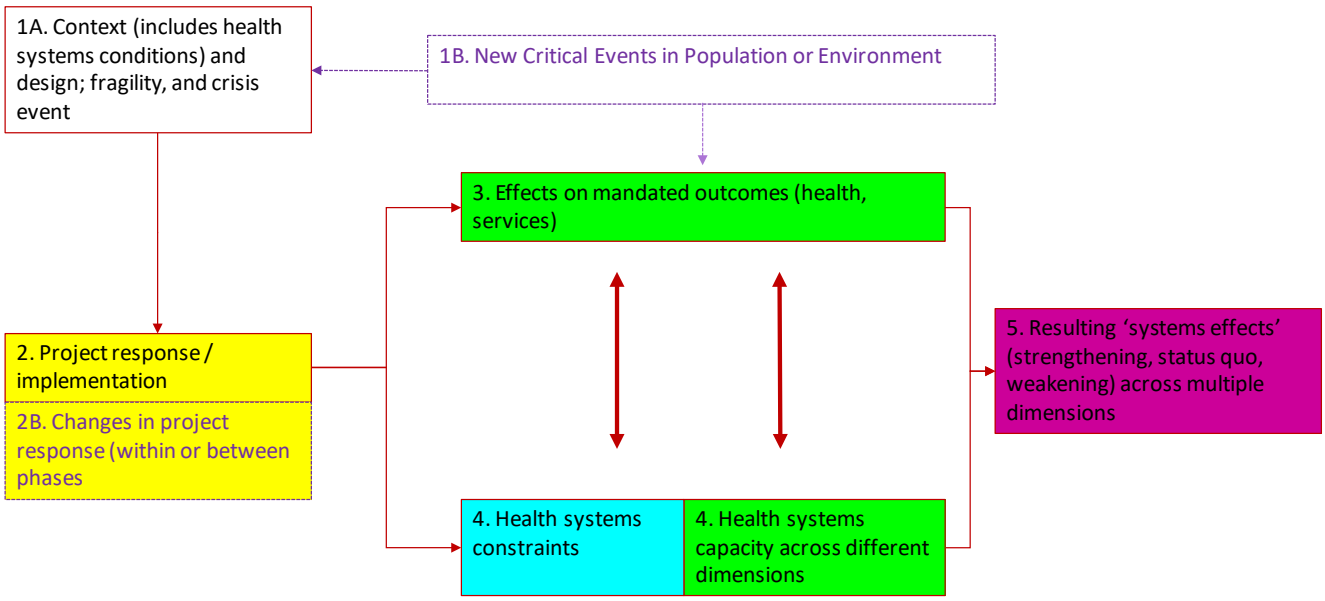
1. Bourns, D. (2015). Promoting Resilience among Communities in Darfur Environment (PRIDE) III. (*Proposal Summary*). Save the Children.
2. Bourns, D. (2015). Promoting Resilience among Communities in Darfur Environment (PRIDE) II. (*Final/Annual Report*). Save the Children.
3. Bourns, D. (2016). Promoting Resilience among Communities in Darfur Environment (PRIDE) III. (*Final/Annual Report*). Save the Children.
4. Bourns, D. (2016). Partnering to Respond to the Critical Needs of the New IDPs and Conflict Affected Populations (PRECAP) I (*Proposal Summary*). Save the Children.
5. Bourns, D. (2017). Partnering to Respond to the Critical Needs of the New IDPs and Conflict Affected Populations (PRECAP) II (*Proposal Summary*). Save the Children.
6. Khush, S. (2014). Promoting Resilience among Communities in Darfur Environment (PRIDE) I (*Final/Annual Report*). Save the Children.
7. Khush, S. (2014). Promoting Resilience among Communities in Darfur Environment (PRIDE) II (*Proposal Summary*). Save the Children.

Kordofan

8. Bourns, D. (2014). Greater Kordofan Lifesaving Intervention Package 3 (GKLIP III) (*Proposal Summary*). Save the Children.
9. Bourns, D. (2015). Greater Kordofan Lifesaving Intervention Package (GKLIP II) (*Final/Annual Report*). Save the Children.
10. Bourns, D. (2016). Greater Kordofan Lifesaving Intervention Package (GKLIP III) (*Final/Annual Report*). Save the Children.
11. Bourns, D. (2016). Partnering for Effective Emergency Response in Greater Kordofan (PEER I) (*Proposal Summary*). Save the Children.
12. Cardinal, L. (2017). Partnering for Effective Emergency Response in Greater Kordofan (PEER II) (*Proposal Summary*). Save the Children.
13. Khush, S. (2014). Greater Kordofan Lifesaving Intervention Package 2 (GKLIP II) (*Proposal Summary*). Save the Children.

Annex 2. Codebook for Document Review

Theory of Change



Legend

PROCESS

PDP (Project Design & Process): the project implemented by Save the Children and partners was trying to advance such things

OUTCOMES (POPULATION AND SERVICES)

CIS (Changes & Improvements in System): observed changes in the way the stakeholders of the health systems (MOH or partners) behave and perform

HEALTH SYSTEM CONSTRAINTS

HSC (Health System Constraints): health system factors that act as barriers to project implementation or factors that the project must overcome in order to achieve its intended effect

EXPLANATORY PROPOSITIONS

COUNTRY LEVEL (background data)

1) Project Information
   - Budget (total USD)
   - # of Years
   - Geographic reach (province and districts)
   - Beneficiaries reached (# of women and children)
   - Stakeholders and partners involved in the emergency
2) Health Outcomes

3) Cluster mechanisms and operations
4) New critical events in population or environment – events calendar
    - Natural or manmade disasters
    - Population migration

PROJECT LEVEL

1. **Overall Achievements**
    - Health service use
        - Skilled Birth Attendance
        - Antenatal care
        - Postnatal care
        - Family Planning (contraception use)
        - Unmet need for family planning
        - Immunization indicators
    - Outbreak and response indicators or information
        - Number of disease outbreaks that Save the Children was involved in responding to
        - Functional disease surveillance system
    - ERMS
    - Child Protection
    - Health
    - WASH
    - Nutrition

2. **Quality of Health Services**
    - **Improving quality of services to clients of EHN**

      Efforts made to improve service quality to EHN target beneficiaries.

      Changes in service quality.
    - **Improved capacity for service delivery among the MOH and other national stakeholders (service readiness), and quality improvement processes**

      Efforts made to develop the capacity of the MOH and other national stakeholders to provide quality services and assess improvement

      Changes in the capacity of the MOH and other national stakeholder to deliver high quality services

    - **Health system includes host population** (not just displaced) in improved services
    - Services delivered by the health system are **responsive to community needs** and adapted to context
    - **Health system innovations** for coverage of health services and preparedness for EHN needs
    - Health system has the **capacity to contribute to large EPI campaigns and outbreak responses**.

3. **Coordination and Policy Setting**
    - **Program operated with the MOH or as a parallel system**

      EHN project/program operated in partnership with the MOH or as a parallel system
    - **Program was able to follow existing humanitarian policies**

      Documentation of humanitarian policies that were guided the implementation of the project

Documentation of humanitarian policies that hindered the implementation of the project

- **Evolution toward humanitarian and health policies** in support of essential interventions at the national or regional level
- **Signs of ownership and commitment** to the policy, manifested through different levels of the health system

4. **Decentralization and Management Capacity**
   - **Project support to MOH district coordination, and capacity building for planning and management.**

     Capacity building efforts to support district coordination for planning a management.

     Changes in capacity for planning and management at the district level.
   - **The project supports the management of human resources for EHN (supervision, performance management, non-financial motivation)**

     Capacity building efforts to increase supportive supervision and performance management in the health system.

     Improvements in the health system in terms of roles and responsibilities in supervision, performance management, and incentives/motivation for health workers (i.e., government health staff conducting supervision visits)

     Obstacles to providing adequate supervision and management.
   - Decentralized MOH system uses processes for **program learning and management course correction** based on information
   - Decentralized MOH system **limits or corrects displacement** of other essential routine services by emergency response

5. **Engagement with Community Organizations & Societal Partnerships**
   - **Development of local partners – identification, engagement, incremental responsibilities and handover**

     Efforts made by project to establish partnerships with civil society organizations, local non-profits, and other community-based organizations.

     Partnerships for EHN established.
   - **The project supports strategic SBC communication efforts**

     Efforts made to implement SBC activities
   - **The project seeks to build SBC communication capacity with local actors**

     Efforts made to build capacity for SBCC

     Changes in capacity for SBCC implementation
   - **The project seeks to increase the internal organization and capacity of communities to promote their own health, including in engaging with the health care system**

     Efforts made to develop community capacity.

     Changes in community capacity.
   - MOH engages in **effective societal partnerships and with community organizations** to improve efficiency, and resilience of community systems and facility-based services
   - Health systems stakeholders (MOH, non-health sectors, civil society, private sector) develop **stronger accountability mechanisms**
   - The health system has mechanisms in place to **mobilize community volunteers** during emergencies (in addition to paid CHWs).

- There are signs of **increased trust and social capital** between community leaders/ organizations and the health system

6. **Costing and Financing**
   - **Health system financing goes directly to EHN services, rather than through MOH or MOH accredited routine services**

     Internal or external funding applied directly to the implementation of EHN programs and services.
   - **Project investments spill over to support other (non-emergency, routine) interventions**

     Internal or external funding intended for EHN services, but is applied to other non-emergency services.
   - **Managing financial resources**

     Describes the entities responsible for managing health financing (i.e., Ministry of Finance), and the systemic factors pertaining to the distribution of financial resources for health.

     Project activities are directed at developing and strengthening the infrastructure to manage financial resources for EHN.

     Changes in management strategies for financial resources.

     Weak financial systems at the national or regional level or evidence of lack of engagement with finance.
   - The national health system progressively **increases domestic funding for services**, seeks to reduce financial hardship on users, without displacement of resources from other essential public goods.

7. **Human Resources**
   - **EHN interventions are expanding human resources for EHN (hiring, training) at facility level**

     The project builds the health workforce, including recruitment and trainings, and the growth and development of human resources at the health facility level.
   - **EHN interventions are expanding human resources for EHN (hiring, training) at community level (CHWs)**

     The project builds the health workforce (e.g., CHWs), including recruitment and trainings, and the growth and development of human resources at the community level.
   - **Financial compensations (salary or other) are provided to human resources for EHN interventions**

     The project invests in health worker compensation (salary, stipend, volunteers)

     Tensions between paid and unpaid health workers (or level of compensation among health workers) and any accompanying challenges.
   - The health system is **expanding its human resources for health** through domestic resources, including through incorporation of CHWs
   - The health system appropriately uses **task shifting** to ensure a more efficient use of staff time and skills

8. **Supply Chain Management**
   - **EHN project implementing commodity supply management (distribution, stock monitoring, etc.)**

     Project addresses gaps in the procurement of commodities to ensure that incoming commodities can adequately supply the entire catchment area

Health system is obtaining essential commodities at the appropriate level (i.e., district health offices) to provide the health workforce with the proper tools for carrying out EHN activities; includes diagnostic equipment, drugs, etc.

Distribution of commodities at the national level (i.e., prioritization, equity, etc.), and availability of resources (or lack thereof).

- **Project is building skills and capacity for managing procurement and supply management**

  Project helps system for supply chain management move from dependency to long-term ownership by MOH and other key stakeholders.

  Improved skills and capacity to manage the distribution of supplies

  Bottlenecks in the health system and extrinsic factors that affect supply chain management activities

- There is **increased capacity and autonomy** of the health system to manage procurement and supply of commodities.

9. **Monitoring and Evaluation**
   - **Collection of EHN related data is carried out through MOH or appropriate national stakeholders**

     Project builds the capacity of the MOH to collect EHN data.

     HMIS is too crowded with indicators and the MOH will not add additional EHN indictors.
   - **Aggregation, processing, and analysis of EHN related data is carried out through MOH or appropriate national stakeholders**

     Project builds the capacity of the MOH (or other national stakeholder) to aggregate, process, and analyze EHN data.
   - Appropriate **human resources are allocated to HMIS** in the health system to inform decision makers
   - **Data systems and information have been strengthened** within the health system

Annex 3: Key Informant Interview Guide

Introduction [checklist of points to cover]

- Thank you for accepting to be interviewed as part of our case study.
- [As appropriate] Thank you for having provided comments on the draft report. The purpose of this interview is to explore some questions that have emerged from the country studies, about options and choices faced by Save the Children and/or donors.
- We intend to finalize the country report after all interviews have been completed, and integrate lessons from these interviews in the report
- Do you have any reservation being cited in the report?

  __ Yes

  _X_ No [in this case, we will acknowledge you as an informant but not cite you by name]
- This interview may be recorded, to allow me to double check my notes, although the recording will not be kept, and we do not intend to produce a transcript.

[text in brackets is for the interviewer]

Question #1

Background: Coordination at the national and district levels can be difficult in protracted crisis situations. Governments can, at times, act as barriers to information and access to communities. Therefore, there is a need to work around the health system by working directly with communities and community organizations or working with other humanitarian response organizations to meet the immediate needs of vulnerable populations.

Question: **How did you work with the government? What contributed to your success in working with the government? What made it difficult to work with the government? What decision points did you encounter that caused you to seek alternative approaches to working directly with the DOH/MOH or other government agencies? What were the results?**

[Be ready to probe for relevant details.]

Question #2

Background: Evaluation limitations—Emergency responses must account for rapid delivery of life-saving interventions, in contexts where health systems are often underperforming. This comes with increased emphasis on output reporting, and limited time for more complex systems strengthening assessments. But we are talking more and more about 'transition', so...

Question: **How can EHN projects develop better systems for evaluating health outcomes and health systems strengthening interventions?**

Probe: Beyond projects, what role should there be for coordination or donor structures to build better evaluation platforms?

[Be ready to probe for relevant details.]

Question #3

Background: Parallel health systems are often built when responding to a humanitarian emergency to meet the immediate needs of vulnerable populations. For example, creating a system to ensure supply chain management to meet emergent health needs without building the capacity of the national health system to sustain the supply chain management system.

Question: **[In the case of Pakistan, would you call what SCI set up for supplies/commodities, and information systems a parallel systems?] If so, what do you think could be alternative strategies to parallel systems? Even in a protracted emergency, what could allow us to avoid parallel systems?**

[Be ready to probe for relevant details.]

Question #4

Background: Human resources are difficult to maintain during crisis situations, which can compromise the quality of care that is delivered. For example, if you invest time in building human resource capacity of government personnel or local health professionals, you risk losing this newly developed capacity due to staff turnover. On the other hand, if you build the internal capacity of SC to maintain high quality care, then you would compromise the sustainability of your response.

Question: **What did you decide to do when it came to the decision between building SCI internal capacity or focus on building the capacity of the government and local health professionals? What were the main factors that drove your decisions? What would you have done differently?**

[Be ready to probe for relevant details.]

Question #5

Background: In the midst of an emergency, most funding comes from external donors and it is difficult to ask a stretched national health system to support an emergency response in addition to meeting the existing needs.

Question: **How can you move toward financial sustainability when it comes to your emergency response? In what way did you try (and succeed) to share the burden of the costs of the response with national stakeholders, or at least prepare for financial 'transition'?**

[Be ready to probe for relevant details: like signals that it's possible to transition…]

Question #6

Background: The report seeks to describe major events and changes in the context of the country.

Question: **Where there other significant challenges/unintended consequences faced in the projects that were not mentioned in the reports? On the other hand, were there positive events or surprises that were not reported? How did the Save the Children handle those events, positive or negative, in your opinion?**

[Be ready to probe for relevant details.]

Question #7

Background: Post-project periods are a time of adaptation by local and national stakeholders. This can be negative (loss of support), but this can also lead to a positive reaction.

Question: **What evidence have you seen after the end of the projects for local/national system actions (positive or negative), based on responding to the gap created by project closures?**

Conclusion

Thank you for your time.

Let me ask you again, now that we have discussed: Do you have any reservation being cited in the report?

Please do not hesitate to contact me (william-story@uiowa.edu) if you have any follow on comments or thoughts.

You can also contact Eric Sarriot at esarriot@savechildren.org.