

HEALTH POOLED FUND: SOUTH SUDAN

Mid-Term Review Report: Draft for Submission

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Executive summary

Introduction

South Sudan is one of the most underdeveloped countries in the world. Independence, in 2011, followed years of conflict that caused erosion of the physical and social infrastructure and death and displacement of millions of people. With an estimated population of 10.9 million¹, its health indicators are among the worst in the world – one of the highest maternal mortality rates (MMRs) in the world, estimated at 2,054 per 100,000 live births²; a very high Infant Mortality Rate (IMR – 102 per 1,000 live births) and Under-five Mortality Rate (U5MR of 135 per 1,000 live births); and a life expectancy of 55 years. The country's health needs are vast, partly resulting from high levels of poverty and from a long history of conflict.

The Government of the Republic of South Sudan (GRSS) has expressed its commitment to improving the health of the population through a five-year strategy, the Health Sector Development Plan 2012-2016 (HSDP), which has a vision to 'contribute to reducing maternal and infant mortality and improving the overall health status and quality of life of the South Sudanese population'.

Beginning in October 2012, five donors (Australia, Canada, the European Union, Sweden and the UK) are providing £120 million through the Health Pooled Fund (HPF) for a programme lasting three and a half years. The UK leads and manages the HPF on behalf of other contributing donors. The programme supports the delivery of the HSDP in six of the country's 10 states (Eastern Equatoria, Unity, Western Bahr el Ghazal (WBeG), Northern Bahr el Ghazal (NBeG), Lakes and Warrap), to assist the transition from a non-governmental organisation (NGO) led health service to one that is led by government. The HPF began in October 2012 with an inception period extending until June 2013, and is scheduled for completion in April 2016.

Armed conflict erupted in South Sudan in mid-December 2013, necessitating the evacuation of HPF team members and implementing partner (IP) staff from South Sudan for around six weeks. Subsequently the operating environment was extremely difficult and programme interventions were disrupted. While the acute conflict situation has eased, no peace agreement has yet been reached and there are fears that more active conflict will recur in the coming months. Due to a fluid, uncertain and politically sensitive environment during the conflict, all Department for International Development (DFID)-funded programmes were advised to limit engagement with government in the first few months of 2014. The programme responded by developing and implementing a six-month interim strategy and a separate strategy specific to Unity State (the most directly affected amongst the six HPF-supported states) to adjust the programme delivery in response to the new realities.

In October 2014, the Health and Education Resource Team (HEART) was contracted to undertake both the second annual review and a mid-term review (MTR) of the HPF. These were conducted over the period 27 October–30 November 2014, using a secondary analysis of relevant programme data, supplemented by field visits and key informant interviews. A separate annual review report has been prepared. These are the findings of the MTR.

Findings

There are, as yet, no data available to indicate whether the HPF is contributing towards the achievement of South Sudan's targets to reduce maternal and child mortality. However, there are

¹ <http://www.worldbank.org/en/country/southsudan/overview>

² <http://siteresources.worldbank.org/INTAFRICA/Resources/257994-1337357494718/Key-Indicators-SS.pdf>

data to show that outcomes in at least two project areas are improving with the project milestones for both vaccinations (children under 1 receiving three doses of the diphtheria, pertussis, tetanus (DPT) vaccine) and births attended by skilled birth attendants.

The project had an initial focus on sustaining the essential NGO-provided health services existing in the absence of adequate government resources. This was successfully done, by December 2012, through the establishment of bridging contracts for 16 NGOs to continue health services delivery in 281 facilities in the six states. Subsequently, long-term contracts, based on the county health model, replaced the bridging contracts to provide support for 562 primary health care (PHC) facilities (135 PHC centres (PHCCs), 427 PHC units (PHCUs)) and 15 hospitals by September 2014 for the 39 counties in the six target states. Eight county hospitals, seven faith-based hospitals and support to a national family planning (FP) programme are also now being supported through similar contracting models, with support to state hospitals to be introduced in the near future.

By the time of the MTR, and despite difficulties caused by the conflict in the country and the continuing problems in Unity State, the HPF had been successful in achieving its targets in the area of health services delivery (Output 1). The number of preventive and curative attendances had increased, as had the number of women attending at least four antenatal care (ANC) sessions and those using modern contraceptives. The number of emergency obstetric and neonatal care units had increased according to plan. However, as a result of the poor pre-existing health infrastructure and the very low availability of qualified health human resources in South Sudan, further gains will continue to be difficult. The HPF should continue to monitor the output of the district health management information system (DHIS) in order to be able to respond to any slowdown in the expansion in services in the areas of:

- childhood immunisation and Integrated Management of Childhood Illnesses (IMCI) statistics;
- deliveries by skilled birth attendants;
- referrals to emergency obstetric and neonatal care units;
- post-partum haemorrhage prevention; and
- use of modern contraceptives.

The HPF should continue to support improvements in the functioning and use of the DHIS as a key tool for monitoring both project and sector performance and to encourage the Ministry of Health (MOH), at all levels, to use these data to identify any changes and plan for any necessary responses to untoward changes.

Once the support to health services delivery was in place, the focus was to shift to supporting work to establish structures at the community level (Output 2), to increase the local accountability of health services, and also on health system strengthening (HSS) activities (Output 3).

Less success has been achieved in HSS, with two out of five milestones not being achieved by the end of 2014. Following a situation analysis to facilitate planning for HSS activities, no strategic plan was developed to address the identified weaknesses. However, plans to address some aspects, i.e. the development of the county model through countywide planning, monitoring and supervision, leadership and management development, payroll management and supply chain management, were developed and are being implemented.

While much further work is required, the HPF has supported the development of the county model of health care delivery in which county-level services are planned, delivered and monitored according to one plan. It is noted that there are some differences in the county model being applied in states supported by other donors. It would be appropriate to review the performance of counties supported by the different donors to try to identify the strengths and weaknesses of the different

approaches in order to inform the design of any future support programmes. Similar, successful innovations identified as being undertaken by the IPs within the HFP should be disseminated to enable cross-county learning within the HFP and beyond.

Greater emphasis needs to be placed on encouraging an improvement in the quality of services provided, with an emphasis on the most common illnesses, by supporting the MOH to finalise and implement a policy on the quality assurance of health care.

While the community engagement work stream (Output 2) has proceeded reasonably, largely meeting the project log frame targets to date, it has developed in the absence of central guidelines for its rollout. This has led to the potential for considerable divergence between the approaches in different states and counties. It is anticipated that a greater emphasis will be placed on this output for the forthcoming year with the recruitment of technical assistance (TA) to support the development of national policies and guidelines on community engagement. The existing MOH draft guidelines for community-level bodies should be finalised as part of the overall plan and then used as a common framework for all community engagement activities. This should be the basis for the HPF, through the incoming TA, to develop a community strategy and realistic operational plan for the project and its IPs.

Public finance management (PFM) strengthening is broadly interpreted in the HPF. In addition to support for the financial transfer systems and health sector financial management proper, it includes salary harmonisation, the adoption of the GRSS payroll system, the South Sudan Electronic Payroll System (SSEPS), the introduction of a human resources information system (HRIS) and the development of an attendance monitoring system (AMS). The focus of the first period has been on the development of PFM benchmarks, the introduction of SSEPS, and salary harmonisation amongst NGOs.

A major investment of PFM strengthening during 2013 was to develop a set of PFM benchmarks. The benchmarks have been agreed with the MOH; however, this review considers that they do not present a balanced set of criteria for PFM strengthening. There is a heavy focus on human resources (HR) and payroll (8 benchmarks out of 17); the budget benchmarks are focused on financing and budget releases, rather than budget execution, which is an area of high fiduciary risk; and the audit requirement presents a very low bar. It is recommended that the PFM benchmarks be revisited and the HPF engage fully with the County Transfers Monitoring Committee on a range of PFM issues.

Overall the PFM strengthening stream has made steady progress but has been limited in its achievements because of the limited resources allocated to it.

Value for money (VFM)

In April 2013, the HPF produced a strategy to monitor VFM in the programme and to fill in the gaps in measurement of performance left in the Business Case (BC) – the BC only made estimates for VFM related to Output 1 with no measures proposed for the effectiveness of community engagement nor for health systems strengthening. The VFM strategy provides nine indicators of which three are classified as economy measures, one is an efficiency measure, three measures are classified under effectiveness and seek to measure community engagement and HSS strengthening progress, and two indicators are proposed to measure equity. While all have value as indicators, not all of them are true measures of value for money. HPF was not able to collect data for the effectiveness measures, and the equity measures relate only to gender. Consequently, the MTR has proposed that the VFM Strategy should be revisited and made more practical and

measurable, more focussed on VFM per se, and particularly economy, and with a stronger ex ante component.

HPF monitoring has been hampered by the on-going conflict, but has included regular updates of logical framework indicators; annual and quarterly reports; and a year-end IP Performance Review Summary in July 2014. This monitoring process is supportive of VFM, but does not link the financial performance to any output objectives except in very broad budget and line item terms. In practice, effectiveness is not being measured. The Annual Report of 2013/14 does demonstrate that significant progress has been made in health service delivery, with many key health service indicators improving despite the difficult environment.

The consideration of VFM through the Outputs of the logical framework alone understates the value of HPF. Areas in which hard-to-measure value has been added include support to modernization of CHDs and health service delivery; training of health cadres; and there are good signs that a government-led health service is being built – a key objective. Although as yet incomplete, progress in the related SSEPS roll out, HRIS and AMS promises to support significant VFM in the health sector as a whole, ensuring that health sector funds are spent more efficiently and that health workers are more productive.

However, VFM is threatened by the shortcomings in financial management and fiduciary risk indicated elsewhere in this MTR. It is also undermined by the high levels of overhead associated with the county model, especially where direct spending is low.

It was not possible to replicate the original VFM assessment of HPF health service delivery (Output 1) based upon DALYs as the original calculations are no longer available and the lack of survey data and the movement of internally displaced people (IDPs) amongst the population also exacerbate the difficulties of making a meaningful cost per DALY averted analysis at this stage.

Governance and management

The HPF has been effective in engendering government involvement in decision making in the project through a national Steering Committee (SC) and State Oversight Committees (SOC) in each state (except Unity due to the conflict). These have provided fora for guiding project activities at state and county levels and actively involved MOH officials in decisions over request for proposal (RFP) design and in the selection of IPs for the various contracts. None of the committees have been very active in monitoring the technical or financial performance of the project, as required in their terms of reference (TOR), and so it is recommended that HPF quarterly and annual reports are used as the focus for such scrutiny by both committees in future.

Some dissatisfaction about their involvement in the project was expressed by both the contributing donor partners to the project and the members of the Strategic Advisory Board (SAB). SAB consists of representatives from each of the partner organisations that constitute the consortium, led by the Crown Agents, and contracted by DFID to manage the HPF project. A programme management update/performance improvement plan has recently been agreed between Crown Agents and DFID. It is anticipated that this will address the concerns expressed by SAB members and it is suggested that more formal meetings are arranged, around the HPF quarterly reports, to provide a forum for discussions between the donor partners.

The September 2014 management update, agreed between Crown Agents and DFID, responds to concerns first expressed in the 2013 Annual Review and then subsequent correspondence. These related to concerns around project leadership and decision making as well as communications between project partners. It is too soon to assess whether this management update will have the

desired effect in improving management performance and DFID will need to monitor the implementation of the management improvement plan.

With regard to the internal management capacity within the HPF management team in Juba, the review team concluded that its capacity seems already to be overstretched in providing adequate technical and administrative support to its IPs. The anticipated expansion of contracts and technical TA to be embedded within the MOH is likely to stretch this further, although the new TA at both national and state levels will enable existing HPF technical staff to focus on engagement with MOH at the central level while HPF support for the IPs, state MOH and CHDs will become the responsibility of the new State based HPF TA. Alongside this, a number of weaknesses in financial management were identified. So it was felt that there should be an organisational review to assess existing and anticipated workloads, in order to ensure that the team has the capacity to properly manage its workload and to enable cross-organisational learning.

The MTR identified a number of significant concerns about financial management that reinforce the findings of a recent financial systems audit undertaken by external auditors. These concerns are around the level of scrutiny of IP financial reports, the quality of the HPF's own financial reporting, the lack of external financial audits both of the IPs and of HPF itself, and the need for greater clarity in financial instructions for IPs from the HPF. These, the review felt, constituted a significant fiduciary risk such that it was felt that the HPF should develop and closely monitor an HPF financial management action plan to address these concerns.

Risk management

The HPF was considered to have a medium risk at the first annual review. This was subsequently raised to high at the second annual review. Most significantly, the risk of conflict actually came to pass during the first year of full implementation. The project responded well to the crisis, increasing security awareness and enabling a flexible approach for its IPs to respond quickly to events and resume services wherever possible. In Unity State, the state that has continued to experience considerable levels of violence, the IPs have worked with the authorities and relief providers to continue to provide services as far as possible. Although peace talks have taken place, there is no certainty that violence will not continue in Unity State or even increase again in other states.

The HPF has consistently emphasised the need for conflict sensitivity amongst its own staff and amongst the staff of its IPs and, in 2013, developed a conflict sensitivity strategy. However, there is no evidence that this strategy has been actively implemented and so it should be reviewed in light of the prevailing circumstances, modified as necessary and implemented.

This review found that fiduciary risk is undermined through many of the concerns indicated under quality of financial management: the absence of audited financial statements; the lack of scrutiny of IP documentation under the risk-based assessment (RBA) approach; several issues raised by the recent systems audit; the lateness of second-round financial management assessments (FMAs) for RFP1 IPs; the absence of a register of IP audits; and the absence of accruals-based accounting systems, which can lead to errors in reporting. It is recommended that the HPF address the mitigation of fiduciary risks within a wider financial management action plan, as suggested elsewhere in this review.

Since 2013, the HPF has been operating alongside the donor funded Emergency Medicines Fund (EMF) and consequently has benefitted from essential medicines being widely available for primary health facilities throughout the country. The EMF is scheduled to finish in mid-2015 and, while it is understood that the MOH is organising a procurement of drugs and medicines to be available when the EMF finishes, there is some uncertainty as to the quantities that will be procured, with the

possibility of shortages in the second half of 2015 and beyond. If significant shortages were to occur, health service activity, which is dependent to a great extent on the availability of adequate, good-quality drugs and medicines, could deteriorate, putting the project's achievements in jeopardy. The HPF and the donors will need to monitor the national availability of medical supplies to try to ensure adequate stocks are available and, if necessary, allowing the IPs to procure significant supplies to cover any shortfall while longer-term solutions are sought.

The HPF has supported both the introduction of a harmonised salary scale and the SSEPS for health workers employed through its IPs. MOH primary care worker salaries continue to lag behind the IP salaries, a cause of some resentment amongst MOH paid workers who work alongside their IP-paid colleagues. The MOH plans to increase the pay of its own primary care workers to a level close to the IP scales early in 2015. However, given the uncertain budget situation, with the possibility of continuing conflict and the effect this may have on both GRSS income from oil revenues and non-military expenditures, there must be some uncertainty over the GRSS ability to pay for this in addition to its commitment to procure adequate drug supplies for the country. The HPF will need to continue to support the MOH and encourage GRSS to ensure the MOH salary enhancement takes place.

The HPF supports the introduction of the county model in six states while the United States Agency for International Development (USAID) (Western and Central Equatoria States) and the World Bank (Upper Nile and Jonglei States) support similar programmes in the remaining four states. There are some differences in the approaches taken to implementing the county model by the different donor partners. It is understood that USAID is unlikely to continue support to health service delivery but may continue support to HSS.

It is understood that there are no formal mechanisms in place to share learning between HPF and the states supported by USAID and World Bank. With the results of an evaluation of the World Bank fund work anticipated in the near future, it would be appropriate for the HPF to support the MOH to undertake a comparative review of the performance of the three funding mechanisms. This would highlight any differences in both approach and outcomes, while recognising the differences in the environment, particularly related to the conflict, in each of the states. Such a review could provide valuable lessons for any subsequent redesign of the HPF.

Support beyond March 2016

The HPF has been successful in increasing access to health services in six of South Sudan's states and, while there are as yet no data to show that this is having an effect on overall mortality rates, there is evidence to show improvements in the delivery of health services such as vaccinations and attended deliveries. Shortages of skilled health workers and the limited distribution of existing health facilities are likely to limit further improvements at some stage in the future.

GRSS is committed to increasing expenditure on health (increasing health worker salaries and a substantial procurement of drugs in 2015). Uncertainty around South Sudan's national finances, resulting from the possibility of further conflict and the effect this might have on oil revenues and government expenditures, must place some doubt on the government's ability to fund these laudable objectives. Consequently, unless there is a significant improvement in the national finances, it seems unlikely GRSS will also be in a position to take responsibility for the funding of health services in the six states currently supported by the HPF when it finishes in early 2016 (and USAID support to Western and Central Equatoria States in 2017).

Without a continuation, in some form, of support for the delivery of primary care services in South Sudan, there is likely to be a significant deterioration in services, with the potential for a loss in the gains already made by the project to date. Therefore it is recommended that the funding partners actively consider the continuation of funding support for service delivery, HSS and community engagement beyond April 2016. If the project is extended, a number of factors should be considered by the design team:

- The findings of an imminent evaluation of the World Bank-supported states should be considered alongside the findings of the 2015 annual performance review of the HPF and any comparable data from the states supported by USAID to facilitate lesson learning for the design of any future support.
- In particular, the performance-based incentives used in Upper Nile and Jonglei States should be considered to see if such an approach had been successful and could be more widely employed elsewhere.
- The first phase of the HPF has seen a concentration on improving access to existing services. Any future phases should also focus on issues of service quality and improving accountability and transparency.
- There is some uncertainty over the supply of medicines to South Sudan beyond mid-2015, when the EMF finishes. It will be essential that responsibility for the future procurement of drugs is established during any subsequent HPF design mission.
- The county model seems highly appropriate as the basis for delivering support to health facilities. However, to date this has been somewhat inefficient with central IP management costs of around 39% of total spend. Any redesign should consider the possibility of introducing state-based contracts, albeit with an emphasis on maintaining the benefits of the county model, in order to reduce the number of contracted organisations and thus overhead costs.
- The current network of health facilities is extremely geographically limited, with only an estimated 44% of the population having access to a health facility. An expansion of the existing network will be essential to improve access. However, the capital requirements to fund this would be considerable and any expansion would face considerable constraints as a result of the acute shortage of skilled health workers in South Sudan such that staffing any new facilities might prove very difficult. Any new funding may need to consider supporting a rationalisation of current facilities as well as a gradual expansion of the existing health network to enable access for currently unserved populations. This would need to be carried out in parallel to programmes supporting an expansion of health worker training.
- If, as has been suggested, support from USAID to service delivery in Eastern and Central Equatoria is to finish in 2017, any future design mission will need to discuss with GRSS how services in these two states are to be supported beyond then.

The continuation of the HPF beyond its current finish date of April 2016 may require the extended process of BC development and government approval, from all participating governments, followed possibly by a new tendering process. This is a lengthy process and so it is recommended that, early in 2015, the funding partners agree a process for indicative programme renewal that complies with all their own individual bureaucratic requirements. This will enable a programme design mission to take place in the first half of 2015, which should allow adequate time for all necessary processes to be completed by April 2016.

Table of contents

Acknowledgements	i
Executive summary	ii
List of tables and figures	x
List of abbreviations	xi
1 Introduction, background and methodology	1
1.1 Introduction	1
1.2 Background	3
1.3 Methodology	3
1.4 Structure of this report	3
2 Review findings	4
2.1 Programme relevance	4
2.2 Programme implementation	6
2.3 Progress	9
2.4 Health service delivery	15
2.5 HSS	26
2.6 Community-based activities	44
2.7 VFM	46
2.8 Programme governance and programme management	50
2.9 Risk management	64
2.10 Gender and social inclusion	70
3 Conclusions and recommendations	72
Annex A Terms of reference	88
Annex B	93
B.1 Persons met	93
B.2 Documents reviewed	95
B.3 Updated risk assessment	98
B.4 The situation in Unity State	101
B.5 HSS assessment	104
B.6 PFM benchmarks	106

List of tables and figures

Table 1: Progress towards project impact and outcome indicators	10
Table 2: Health service delivery indicators, milestones and progress	12
Table 3: Community involvement indicator milestones and progress	13
Table 4: HSS delivery indicator milestones and progress.....	14
Table 5: Average performance score by performance area and by state	36
Figure 1: Organisational structure of South Sudan Health Services (Source: HSDP 2012–2016) ...	4
Figure 2: Percentage of PHCCs and PHCUs providing services (six HPF states, 2013)	17
Figure 3: Curative care consultations – quarterly data and trend lines (six states)	18
Figure 4: Safe motherhood – quarterly data and trend lines (six states)	19
Figure 5: ANC – selected services, quarterly data and trend lines (six states)	20
Figure 6: FP – quarterly data and trend lines (six states)	22
Figure 7: Immunisation – quarterly data and trend line (six states).....	23
Figure 8: Treatment of common endemic communicable diseases – quarterly data and trend lines (six states)	24
Figure 9: The key dimensions of VFM.....	46

List of abbreviations

AMS	Attendance Monitoring System
ANC	Antenatal Care
BC	Business Case
BEmONC	Basic Emergency Obstetric and Neonatal Care
BPHNS	Basic Package of Health and Nutrition Services
BSF	Basic Services Fund
CA	Crown Agents
CEmONC	Comprehensive Emergency Obstetric and Neonatal Care
CHD	County Health Department
DALY	Disability-Adjusted Life Year
DFID	Department for International Development
DHIS	District Health Information System
DPT	Diphtheria, Pertussis, Tetanus (vaccine)
EMF	Emergency Medicines Fund
EPI	Expanded Programme of Immunisation
FANC	Focussed Antenatal Care
FMA	Financial Management Assessment
FMIS	Financial Management Information System
FP	Family Planning
GRSS	Government of the Republic of South Sudan
GSE	Gender and Social Exclusion
GSI	Gender and Social Inclusion
HEART	Health and Education Resource Team
HF	Health Facilities
HFA	Health Facilities Assessment
HMIS	Health Management Information System
HPF	Health Pooled Fund
HQ	Headquarters
HR	Human Resources
HRIS	Human Resources Information System
HSDP	Health Sector Development Plan
HSS	Health System Strengthening
IDP	Internally Displaced Person
IEC	Information, Education and Communication
IECHC	Integrated Essential Child Health Care
IMA	Implementation Management Associates
IMCI	Integrated Management of Childhood Illnesses
IMR	Infant Mortality Rate
IP	Implementing Partner
IPT	Intermittent Preventive Treatment
JICA	Japanese International Cooperation Agency
LQAS	Lot Quality Assurance Sampling
LSS	Local Services Support
LSSAI	Local Services Support Aid Instrument
M&E	Monitoring and Evaluation
MMR	Maternal Mortality Rate
MOH	Ministry of Health
MOU	Memorandum of Understanding
MTR	Mid-Term Review
NBeG	Northern Bahr el Ghazal State
NGO	Non-Governmental Organisation
OPD	Outpatient Department
ORS	Oral Rehydration Solution
ORT	Oral Rehydration Therapy
PFM	Public Financial Management
PHC	Primary Health Care
PHCC	Primary Health Care Centre

PHCU	Primary Health Care Unit
PMF	Performance Management Framework
PNC	Post-Natal Care
PPH	Post-Partum Haemorrhage
PSM	Pharmaceuticals Supply Chain Management
QA	Quality Assurance
QSC	Quality Supervisory Checklist
RBA	Risk-Based Assessment
RFP	Request for Proposal
RMS	Risk Management Strategy
SAB	Strategic Advisory Board
SC	Steering Committee
SMOH	State Ministry of Health
SOC	State Oversight Committee
SP	Service Provider
SSEPS	South Sudan Electronic Payroll System
SSFFAMC	South Sudan Fiscal, Financial Allocation and Monitoring Commission
SSP	South Sudanese Pound
TA	Technical Assistance
TOR	Terms of Reference
TOT	Training of Trainers
TWG	Technical Working Group
VFM	Value for Money
U5MR	Under-five Mortality Rate
UNOCHA	United Nations Office for Humanitarian Affairs
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development
WASH	Water, Sanitation and Hygiene
WBeG	Western Bahr el Ghazal State
WHO	World Health Organization

1 Introduction, background and methodology

1.1 Introduction

South Sudan is one of the most underdeveloped countries in the world. Independence, in 2011, followed years of conflict that have eroded the physical and social infrastructure, and the death and displacement of millions of people. With an estimated population of 10.9 million³, its health indicators are among the worst in the world – one of the highest MMRs in the world, estimated at 2,054 per 100,000 live births^{4, 5}; a very high IMR (102 per 1,000 live births) and U5MR (135 per 1,000 live births); and a life expectancy of 55 years. The country's health needs are vast, partly resulting from high levels of poverty and from a long history of conflict.

South Sudan's health needs are vast and partly result from the high poverty and long history of conflict. War has left an already very basic health care system extremely weakened, with severe shortages of health workers and functional facilities. The MOH estimates that only 44% of the population live within 5 km of a health facility according to the 2011 Health Facility Mapping⁶ (HSDP). Health service user rates are low and estimated at 0.2 contacts per person per year. Other major challenges to delivering services include inadequate infrastructure, dysfunctional referral systems, and cultural and geographical barriers. In addition, returnees to South Sudan from Sudan have added to the burden placed on health facilities, particularly in 12 counties on the border between Sudan and South Sudan, some of which are in HPF-supported states.

Five donors (Australia, Canada, the European Union, Sweden and the UK), through the HPF, are providing £120 million⁷ to support the delivery of the HSDP 2012-16 of GRSS, in six of the country's ten states (Eastern Equatoria, Unity, WBeG, NBeG, Lakes and Warrap) to assist the transition from an NGO-led health service to one that is led by government. The UK leads and manages the HPF on behalf of other contributing donors. All the donors are involved in monitoring project progress etc. through periodic HPF donor coordination meetings as well as attendance at project Steering Committee meetings (see Section 2.8 for details).

Before the start of HPF, multiple NGOs supported service delivery in the six states through an individual health facility-based model, with funding from at least five major humanitarian funds/projects. This funding came to an end in December 2012 and the HPF was designed to replace this with comprehensive support for PHC delivery using a county-based model of support. (Health services in the remaining four states are funded, separately, by USAID and the World Bank, using a similar county-based model). In the county-based model, county health departments (CHDs), supported by the national and state MOHs, take on the overall leadership and management of health service delivery in each county.

The first task of the HPF was to issue standardised service delivery bridging contracts to the existing NGOs, whose contracts were about to expire, to prevent any interruption in service delivery. This was followed by long-term contracts to be awarded, through competitive tender, to NGOs to support health service delivery and system strengthening using the county-based, rather than individual facility-based, model.

³ <http://www.worldbank.org/en/country/southsudan/overview>

⁴ <http://siteresources.worldbank.org/INTAFRICA/Resources/257994-1337357494718/Key-Indicators-SS.pdf>

⁵ A more recent World Bank estimate of MMR is much lower at 730 per 100,000.

⁶ In the 2013 Health Facility Survey the MOH estimates that only 25–30% of the population has access to health care, and that the public health system covers only approximately 15% of the population, quoting GOSS-MOH: Sudan Household Health Survey 2006 as the source.

⁷ £107 million available as at November 2014

The HPF funds the delivery of a basic package of health services in the six states with support going to all levels of care up to, in the near future, state hospitals. A central fund manager, the principal implementer, subcontracts IPs at county and hospital levels in the six states. The programme also provides TA support to CHDs as well as to the central and state-level MOH to assist in capacity development of these organisations to enable them to lead and manage the health systems and service delivery effectively. Once the support to health service delivery was in place, the focus shifted to HSS activities, including strengthening PFM for the transfer of health worker salaries from NGO to government payrolls, and also supporting work to establish structures at the community level to increase the outreach and accountability of health services.

The HPF is a government-led programme overseen by a SC chaired by the MOH, co-chaired by DFID and represented by other government ministries and donors. The principal implementer of HPF is a consortium⁸ of agencies led by Crown Agents with a mandate to deliver the programme including both fund management and technical support.

The **impact** of this programme is intended to be government-led health systems that save lives. The **overall outcome** will be increased access to quality health services, in particular by children, pregnant women and other vulnerable groups. The outputs this programme will deliver to achieve the outcome are:

- strengthened delivery of health services, particularly responsive to the needs of women and children;
- increased ownership, governance and demand of communities for health service; and
- strengthened health systems at state and county level.

The programme began in October 2012 with an inception period extending until June 2013. In December 2012, bridging contracts were issued to 16 NGOs to continue health services delivery in 281 facilities in the six states. Long-term contracts based on the county health model have now replaced the bridging contracts for the 39 counties in the 6 target states. County hospitals as well as FP service providers (SPs) are now being supported through a similar model, with support to state and faith-based hospitals to be introduced in the near future.

Armed conflict erupted in South Sudan in mid-December 2013, just over one year after the project started. (See Annex B4 for a description of the effects of the violence). By May 2014, nearly one million people were reported to have been internally displaced⁹ within the country and 425,000 people had fled to neighbouring countries. Among the six HPF-supported states, Unity was the most directly affected by the conflict. The conflict necessitated the evacuation of HPF team members for around six weeks. Many IP staff were also evacuated and, when they returned, in some areas were unable to fully return to the states. Subsequently the operating environment remained extremely difficult and disrupted the programme interventions. While the acute conflict eased over the rainy season, no peace agreement has yet been reached and there are fears that more active conflict will resurface in the coming months. The programme responded by developing and implementing a six-month interim strategy and a strategy specific to Unity State to adjust the programme delivery in response to the new realities. There must be significant concern that if active conflict again occurs this could make project implementation difficult for both security reasons and the likely detrimental effect on government expenditure.

In October 2014, South Sudan continued to have a high level of relief activities responding to the needs of a reportedly now 1.4 million internally displaced persons¹⁰ (IDPs), out of an estimated total population of around 11 million. It is estimated that these 1.4 million people will face acute

⁸ The consortium, led by Crown Agents, includes Health Partners International, Montrose, SKILLS for South Sudan and Charlie Goldsmith Associates.

⁹ <http://www.unocha.org/south-sudan>

¹⁰ <http://www.unocha.org/south-sudan>

food insecurity through December 2014. There is a very active programme by the United Nations High Commissioner for Refugees and World Food Programme to support these IDPs.

1.2 Background

In October 2014, the Health and Education Resource Team (HEART) was contracted to provide a team of five consultants to undertake the second annual review, for the year ending September 2014, and an MTR of the South Sudan HPF. The aim was to provide an independent assessment of the project's progress against its objectives and to make any necessary recommendations in order to improve project performance. The annual review report is in a separate document. This is the report of the MTR. The full TOR for both the annual review and the MTR are shown in Annex A.

The review took place over the period 27 October–30 November 2014. The review commenced with the review of a number of key project documents and the substantive evaluation, including a number of field visits, took place in South Sudan over the period 3–14 November. The review team presented and discussed its draft findings at a meeting with senior staff of the HPF and the donor partners¹¹ at the end of the mission.

1.3 Methodology

The two reviews were conducted primarily through a secondary analysis of relevant programme documents, GRSS documents and other documents identified by the review team and DFID as part of the assignment. The documents reviewed are listed in Annex B2. Based on an initial reading of these documents, the team prepared interview guides for use with key stakeholders interviewed during the review.

On arrival in Juba, the team was briefed by the DFID health adviser in order to clarify points of uncertainty in the TOR and to ensure a mutual understanding of the task in hand. The agreed programme of meetings was then undertaken. The stakeholders interviewed, from within GRSS, the HPF and other partners (including the contributing donors), are listed in Annex B1. Some interviews were conducted by telephone or email for stakeholders who were not present in South Sudan during the review mission.

Field visits, to WBeG, Warrap and Eastern Equatoria States were undertaken by the consultants between 5 and 8 November. The findings of the field trips informed the subsequent stakeholder discussions in Juba.

The review team prepared a draft report for circulation, by DFID, to the project stakeholders for their comments. The resulting comments were considered by the review team and, where appropriate, the draft evaluation report has been adjusted to take account of substantive comments.

1.4 Structure of this report

Following this introductory section, this report reviews the overall performance of the HPF since its inception (Section 2.3) looking in detail at each of the three programme outputs: health service delivery (Section 2.4), HSS (Section 2.5) and community-level activities (Section 0). There follow sections on VFM (Section 2.7), management and governance (Section 2.80), a review of the risks associated with the programme (Section 2.9) and a discussion about gender and social equity (Section 2.10). A final section (Section 3) of conclusions and recommendations draws together the main findings of the report.

¹¹ No representative of Australian Aid or Sweden was able to attend the meeting.

2 Review findings

2.1 Programme relevance

The introduction (Section 1.1) briefly describes the very poor health situation in South Sudan, in relation to both health infrastructure and health outcomes. The country's health needs are vast and partly result from the high levels of poverty and a long history of conflict. War has left an already very basic health care system extremely weakened, with severe shortages of health workers and functional facilities. Other major challenges to delivering services include inadequate health infrastructure and poor physical access, dysfunctional referral systems, and cultural and financial barriers. In addition, the large number of IDPs (see Introduction and Annex B.4 for further details) have added to the burden placed on health facilities, particularly in the areas most affected by the recent conflict.

The South Sudan HSDP (2012–2016) describes a traditional tiered structure for health services delivery as shown in Figure 1 below.

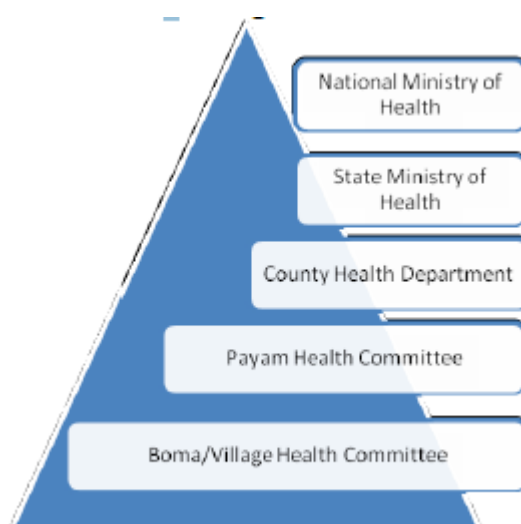


Figure 1: Organisational structure of South Sudan Health Services (Source: HSDP 2012–2016)

The HSDP recognises that CHDs have had very limited capacity to manage and support county-level health services that are provided through PHCCs, PHCUs and community health workers. Services at this level were fragmented as a result of the emergency funding provided directly, via NGOs, to individual health facilities from a variety of donors during the pre-independence struggles and up until the end of 2012.

Thus the HPF, along with the similar programmes in the four states supported by other donors, was designed to:

- Support the provision of primary health care services in the absence of adequate GRSS resources being allocated to county health care.
- Support the development of a CHD health system, comparable to a district health system in other similar countries. Such a system has the goal of all health services, whether government or non government, in a defined geographical area, operating to a single plan and being coordinated and supervised by a single supervisory body using a unified monitoring system.

- Increase ownership and involvement by the community in the management of health services.

Despite being blessed with considerable oil reserves, South Sudan has depended to a large extent on donors for the funding of front line health services. In the recent circumstances, in which GRSS revenue was projected to be significantly reduced¹² as a result of reduced oil production while government expenditure is likely to have been diverted to other uses¹³, it seems unlikely that adequate resources will be made available by GRSS for the provision of essential health services. Without the support of the HPF donors, as well as the World Bank and USAID in the remaining non-HPF states, it seems likely that South Sudan's health services would be significantly underfunded and likely to collapse.

The history of conflict in South Sudan with the resultant fragmentation of health services has not allowed the development of effective CHDs. The MOH lacks experience in the management of county health services; it lacks both the systems and the human resources with the necessary skills to manage such services. Support for the development of both systems and the training of human resources to manage these systems will take time.

There has been little coherent experience of community involvement in health services management in South Sudan, reflecting the previous patchwork approach to health services delivery by a variety of NGOs, each with a different philosophy towards community involvement. In recognition of the importance of community involvement in the management of health services, in order to increase the acceptability and thus the access to services, different NGOs have trained or empowered a variety of community health cadres to undertake a variety of roles that vary in different parts of the country. It will be important, as the health services become more organised, that a more coherent approach is taken to the further evolution of community involvement in health services.

The HPF design addresses all three of these key issues and thus is highly relevant for ensuring continuing primary health service delivery as well as for supporting efforts to strengthen GRSS capacity to manage these health services.

¹² The World Bank estimated that estimated that the current conflict would cost up to 15% of the potential GDP in 2014. (<http://www.worldbank.org/en/country/southsudan/overview>)

¹³ The World Bank reports that military spending is rising.

2.2 Programme implementation

The HPF commenced in October 2013 and a timetable of major project events is shown in the following table.

Period	Events	Notes
October 2012	HPF commenced.	
October 2012 – June 2013	Inception period.	Inception period extended from six months to nine months.
December 2012	Preparatory SC meeting held. Bridging contracts issued.	Role and function of committee discussed.
February 2013	1 st SC meeting held.	SC TOR agreed.
April 2013	2 nd SC meeting held.	RFP1 discussed and amended.
May 2013	3 rd SC meeting held.	NGO due diligence requirements discussed.
June 2013	4 th SC meeting held. 1 st bridging contracts expired. Draft inception report submitted.	Committee endorsed preferred bidders for RFP1 in Unity, WBeG and Eastern Equatoria States. Did not include some guidelines and strategies of programme management plan.
July 2013	Contracts issued for support to county health model.	For period July 2013–December 2015, 20 contracts for Unity, WBeG and Eastern Equatoria States
August 2013	2 nd bridging contracts extended.	Warrap, NBeG and Lakes States.
October 2013	5 th SC meeting held. First DFID annual review conducted.	Committee endorsed preferred bidders for RFP2 in Warrap, NBeG and Lakes States. Also endorsed concept for HPF support to State MOH.
November 2013	Contracts issued for support to county health model. Final inception report delivered.	For period November 2013–December 2015, 17 contracts for Warrap, NBeG and Lakes States. Draft submitted June 2013.
December 2013	6 th SC meeting held. Conflict erupted. RFP for support to comprehensive emergency obstetric and neonatal care (CEmONC) in 10 county hospitals suspended.	Committee endorsed preferred bidders for RFP2B for 2 counties in Warrap State and agreed RFP for 10 county hospitals and value of support to state MOHs (SMOHs). As result of violence.
January 2014	Contracts issued for final two counties and support to county health model. Interim strategy developed.	For period January 2013–December 2015 as a result of need to retender for 2 counties. In response to the conflict and agreed by DFID.
February 2014	Interim strategy developed for Unity State.	In response to the conflict and agreed by DFID.

	Interim work plan developed.	
May 2014	7 th SC meeting held.	Contract amendments agreed with state IPs to provide assistance to SMOHs on supportive supervision.
June 2014	RFP for FP services launched.	
July 2014	8 th SC meeting held. Contracts for support to CEmONC in 10 County and 7 faith-based hospitals. Annual performance review of support to county health services held.	Preferred bidder of FP services not acceptable to MOH. Having been delayed due to conflict.
August 2014	HPF Annual report submitted.	
September 2014	Performance review meeting of MOH, SMOHs, CHD and IP. Performance improvement plan (management update) agreed.	To present annual performance review findings and best practice dissemination. Agreed between DFID and Crown Agents.
October 2014	9 th SC meeting held. FP SP confirmed.	State hospitals RFP endorsed. Second-place bidder accepted.

The first tasks of the HPF were to establish procedures for oversight of the fund, though a joint *Steering Committee*, and to establish *bridging contracts* for the SPs that had been funded by earlier funding mechanisms. The bridging contracts were successfully issued by December 2012 for periods of six to eight months, until June or August 2013.

The SC has met 10 times over the life of the project to date, with frequent meetings early in the project as procedures were established and initial decisions made. There were no SC meetings during the period late December 2013–May 2014 as a result of the conflict. Due to a changing, uncertain and politically sensitive environment during the conflict, in addition to HPF staff being evacuated during the acute phase, all DFID-funded programmes were advised to limit engagement with government in the first few months of 2014, although contacts continued between IPs and county-level officials.

The HPF used the inception period to prepare guidelines and procedures for the implementation of the HPF as well as the TOR to be used in the issue of RFPs for the longer-term contracts anticipated between HPF and individual IPs to deliver *county model services* in the six supported states. The preferred bidders for the first RFP for services in the 20 counties in Unity, WBeG and Eastern Equatoria States were approved by the SC in June 2013 and for the 17 counties in Warrap, NBeG and Lakes States in October 2013. It was necessary to issue a further RFP for two counties (in Warrap State), with preferred bidders being endorsed by the SC in December 2013.

The MOH at both central and state levels were fully involved in the process of selecting the IPs in each state, with selection being considered on a state by state basis through the SC and SOC.

The conflict that started in December 2013 resulted in a significant reduction in HPF activities as both HPF and some IP staff were evacuated. Upon the return of HPF staff to Juba in late February 2014, the expectation was that the situation would normalise fairly quickly however this was not the case and the situation in some states continued to deteriorate. In response to this situation HPF responded actively by:

- Conducting an operational mapping exercise to identify which facilities were or were not operational, and their needs to enable them to return to full operational capacity.
- Playing a key role at national level in coordination and information sharing in both the Health Cluster and the NGO Forum.

HPF prepared, and agreed with its donors, an interim strategy, particularly for the most affected area, Unity State. This was for HPF to continue to focus on the original HPF design but with increased emphasis on coordination with the ongoing relief effort by providing a stable PHC platform to provide services for both the routine catchment population of supported health facilities as well as any IDPs relocated to the area.

Two immediate concerns were the potential for drug stock outs and the need to provide health services to IDPs. HPF acted flexibly by enabling IPs to realign their agreed budgets, if necessary, to address this and encouraged IPs to proceed with any necessary drug procurements to ensure adequate drug supplies. HPF undertook to support the additional costs of transporting essential drugs to health facilities in these difficult circumstances. HPF also enabled the IPs in affected areas to respond to the local situation by providing services within UN protected areas for IDPs as well as provide mobile services where health facilities had been damaged.

By the end of June 2014, HPF reported that regular HPF activities were being implemented smoothly in five states; however, the security situation in Unity state continued to require an emphasis on support for health services delivery in continuing difficult circumstances. This is discussed in more detail in Annex B.4.

A first annual review of the performance of county IPs, assessing performance up to the end of June 2014, was conducted involving both a quantitative assessment of performance against agreed indicators as well as a qualitative assessment involving CHDs. This resulted in 14 IPs, covering 28 counties, continuing their contracts without specific conditions while a further four IPs, supporting 12 counties, were given specific conditions and time frames to address a variety of concerns. The performance of the four IPs was reviewed after a further three months, with all but one found to have addressed the agreed performance conditions. It is understood that one IP did not make adequate improvements in two counties¹⁴ and will be recommended for contract termination, although this has yet to be ratified by the SC (see Section 2.5.6).

County hospitals: After due preparation by HPF, the December 2013 SC meeting agreed the 10 hospitals to be included in an RFP for IPs to support the provision of CEmONC. However, following a delay due to the conflict, the RFP was only launched in March 2014 and the preferred bidders endorsed by the May 2014 SC meeting. It is understood that SMOH officials were not involved in the selection process for county hospital IPs. Eight contracts have been issued and are in implementation. One hospital, in Unity, was withdrawn due to the continuing conflict in the state, while no bidder was identified for another one hospital.

Faith-based hospitals: The HPF requested proposals for support from seven faith-based hospitals in five states (excluding Unity State) and contracts were agreed, and endorsed at the July 2014 SC meeting, to provide support to these. Contracts are now under implementation.

Support to the SMOH to provide supportive supervision to CHDs: The concept of HPF to provide this support was agreed at the December 2013 SC meeting; however, implementation was delayed, due to the conflict, until May 2014. Work plans, budgets and operating modalities were

¹⁴ Rumbek Central and Rumbek East

agreed with five HPF states and contract amendments were agreed, with one of the IPs already working in each state to provide this service.

FP services: Preparations for the issuing of an RFP for an SP to support the development of FP services were endorsed at the May 2014 SC meeting and the RFP issued. The July 2014 SC meeting did not endorse the preferred provider for this and, after the preferred provider was not able to resolve its difficulties with the MOH, the second-place bidder was endorsed at the October 2014 SC meeting to provide the services.

State hospitals: An RFP for support to state hospitals to provide improved CEmONC services was agreed at the October 2014 SC and RFPs to support four state hospitals were launched in late October 2014.

Community engagement: Community engagement activities were included in the IP contracts for supporting the county health model. However, this element of the programme was not considered by any SC meetings until the May 2014 SC meeting, when the minister for health chairing the meeting requested that an emphasis on community strengthening be considered. The July 2014 SC meeting endorsed the provision of TA to facilitate community engagement activities at national (to support the development of guidelines and procedures) and state levels as part of the Strategic Health Systems Strengthening Initiative.

HSS: The June 2013 SC meeting indicated that the priority for this area of work should be the HRIS, supply chain management and M&E. The May 2014 SC meeting reported on progress on technical support for improvements in supply chain management as well as a de-junking exercise to facilitate the assessment of the contents of CHD pharmaceutical stores and disposal of expired drugs, etc. The HPF support to the development of annual plans for CHDs, incorporating HPF support to the county, was also reported.

At the July 2014 SC meeting, HPF presented a Strategic Health Systems Strengthening Initiative that proposed the provision of long-term technical assistance (LTTA) to both the MOH (six posts) and the SMOHs (eight posts in each state). This plan was endorsed by the SC.

2.3 Progress

2.3.1 Outcome and impact

The HPF established two impact indicators, with progress to be measured against childhood and maternal mortality rates. The baseline was based on estimates from the 2006 South Sudan Household Survey and the 2016 targets represent national targets rather than targets specific to the HPF project. Measurement of progress against these impact indicators will depend on GRSS undertaking a national survey to measure these indicators. Table 1 presents the impact indicators as well as the project's four outcome indicators.

Table 1: Progress towards project impact and outcome indicators

Impact indicators ^a	Baseline (2010) ¹⁵		Target (2016)
1. U5MR (per 1,000 live births)	106/1,000		95/1,000
2. MMR (per 1,000 live births)	2,054/100,000		1,643/100,000

Outcome indicators ^b	Baseline (2010)	Milestone (Dec. 2014)	Progress (Sep. 2014)
1. % of 1-year-olds vaccinated with a third dose of the DPT vaccine	18,000 ^c (11%)	75,000 (30%)	27.3% (29.3%) ^d
2. Proportion of children under 5 with fever in the last two weeks who were taken to a health facility ^e	15.3%	None set	Not measured
3. Contraceptive prevalence rate ^e	6.5%	None set	Not measured
4. % of births attended by skilled health personnel	7,311 (2.8%)	19,250 (7%)	6.4% (6.8%)

Notes:

- National surveys are required to measure impact indicators. None was carried out recently.
- Source for outcome indicators: HPF Quarterly Report July–September 2014.
- The baseline figure for this indicator is probably incorrect. It should read 27,500.
- In response to the continued insecurity in one HPF-supported state (Unity), HPF is reporting performance in all six states as well as, in brackets, performance in five states excluding Unity.
- The source of data is the LQAS survey scheduled for 2015.

The project's outcome indicators, where measured, reflect progress to September 2014, three months before the end of the year, with the likelihood that further progress will be made in the final three months of the year. The 2014 targets for both the proportion of children fully vaccinated with DPT (Indicator 1) and the proportion of births attended by a skilled health worker (Indicator 4) were close to being achieved in the first nine months of 2014, suggesting that the 2014 milestone should be achieved. The two milestone targets include the results for Unity State where implementation activities have been significantly disrupted by the armed conflict, which has also disrupted activities in the other HPF states, but to a lesser extent. If Unity State is excluded, the 2014 targets had, by September 2014, very nearly been achieved.

The remaining outcome indicators, the proportion of children under five with fever who were taken to a health facility and the CPR, are to be measured through a household survey that is next scheduled to be conducted in 2015.

Thus HPF is likely to have achieved its 2014 targets in relation to childhood vaccinations and births attended by skilled health personnel.

2.3.2 Output progress

The project defined indicators and milestone targets in three broad areas:

- increasing access to quality health services, in particular by children, pregnant women and other vulnerable groups;
- strengthened delivery of health services, particularly responsive to the needs of women and children; and
- communities' increased ownership, governance and demand for health services.

¹⁵ The World Bank (<http://databank.worldbank.org/data/views/reports/>), using statistical modelling techniques, is estimating IMR at 64/1,000 and MMR at 730/100,000, much lower than the estimates used in the log frame.

The indicators defined, and progress towards achieving them, for each of these are shown in Tables 2, 3 and 4. The tables also show the end of project (March 2016) milestones for comparison.

Health service delivery: All Output 1 milestones were achieved by the end of September 2014 or are likely to be achieved by the end of the year. One milestone was moderately, and one substantially, exceeded, even with the relatively poor performance of Unity taken into account.

In relation to the log frame milestones established for the end of the project, most remain valid. However, it would be appropriate to reassess the milestones related to indicators 1.1 and 1.5, as the 2016 targets were already achieved in 2014.

All the Output 1 indicators are quantitative in nature and given the concern expressed about the quality of care provided it would be appropriate to develop an indicator that assesses some measure of the quality of care provided through the HPF.

Community ownership: There was a mixed performance against the Output 2 indicator milestones. One milestone was substantially exceeded (2.3: female representation on health committees), one moderately did not meet expectations (2.1: functioning health committees) and one was substantially not met (2.2: joint meetings among the facility, CHD, IP and community). In 2014, Indicator 2.2 performance was assessed during a sample survey of HPF-supported facilities. In future these data will be collected through the HMIS and so it may be appropriate to review the 2016 milestone when the HMIS data start to become available.

All the Output 2 indicators are quantitative in nature and so it would be appropriate to develop an indicator that assesses some measure of the quality of community engagement enabled through the HPF.

Table 2: Health service delivery indicators, milestones and progress

Indicator(s)	Milestones (Dec. 2014)		Progress (Sep. 2014)		Milestones (Mar. 2016)		Comments
1.1 Total <5 years outpatient department (OPD) consultations & <5 yrs. OPD consultations disaggregated by gender and preventive/promotive nature	Male curative	450,000	Male curative	492,759	Male curative	500,000	March 2016 milestones likely to have been achieved in 2014. These should be reassessed and increased.
	Female curative	450,000	Female curative	503,517	Female curative	500,000	
	Preventive Male & Female	400,000	Preventive M&F	543,471	Preventive M&F	500,000	
	TOTAL	1,300,000	TOTAL	1,539,747	TOTAL	1,500,000	
			Milestone moderately exceeded				
1.2 Number (%) of children <5 years with diarrhoea who receive oral rehydration therapy (ORT)	750,000 (80%)		77.7% (78.9% excluding Unity) Milestone likely to be achieved by year-end		870,000 (90%)		2014 milestone likely to be achieved. 2016 milestone remains valid.
1.3 Percentage of women who attended at least 4 times for ANC during pregnancy	20% (57,000)		21.4% (22.4% excluding Unity) Milestone moderately exceeded		85,740 (30%)		2014 milestone exceeded. 2016 milestone remains valid.
1.4 Number of acceptors new to modern contraceptives	7,000		5,419 Milestone likely to be achieved by year-end		9,000		2014 milestone likely to be achieved. 2016 milestone remains valid.
1.5 No. of facilities with capacity to offer emergency obstetric care (disaggregated BEmONC and CEmONC)	All HPF-supported hospitals provide CEmONC ¹⁶ .		9 of the 15 HPF-supported hospitals provide CEmONC. It is anticipated that a further six county and faith-based hospitals will be providing CEmONC by the end of the year. The milestone will have been achieved.		All HPF-supported hospitals (eight MOH, seven faith-based) provide CEmONC.		2014 milestone achieved. Not clear what is to be additionally achieved by 2016. Suggest reassessing target.
	25% of all 39 counties have at least one PHCC with BEmONC		38 facilities report BEmONC capacity in 19 (49%) of HPF-supported counties. Milestone substantially exceeded.		80% of all counties have at least one PHCC with BEmONC.		2014 milestone exceeded. 2016 milestone remains valid.

¹⁶ CEmONC/BEmONC = Comprehensive/Basic Obstetric & Neonatal Care.

Table 3: Community involvement indicator milestones and progress

Indicators	Milestones (Dec. 2014)	Progress (Sep. 2014) ^a	Milestones (Mar. 2016)	Comments
2.1 No. of health facilities with a health committee in place for communities to give feedback regarding health services	80% of all HPF-supported facilities have a functioning health committee.	80% of facilities have a committee. Outputs meet expectations.	All functional health facilities have a committee in place.	2014 milestone met. 2016 milestone remains valid.
2.2 Number of documented joint meetings between the CHD/IP and the health committee and facility staff	At least two joint meetings per year held and documented in all PHCCs and in 50% of PHCUs.	Approximately 50% of the established PHC facilities had a joint four-party meeting in the first six months of 2014. Outputs significantly did not meet expectations.	At least one joint meeting held and documented per quarter in all PHCCs and in 50% of PHCUs.	2014 milestone significantly not met. However, information is based on survey data. It may be appropriate to review the 2016 milestone now that data from HMIS are to be used to monitor progress on this indicator.
2.3 Number & percentage of health committee representatives that are women	At least 20% of committee members are women.	32% of health committee members female. Outputs substantially exceeded expectations.	At least 40% of committee members are women.	2014 milestone substantially exceeded but 2016 milestone remains valid.

Note: a: HPF Survey May 2014 that assessed 82% (444 facilities) of HPF-supported facilities.

Indicator(s)	Milestones (Dec. 2014)	Progress (Sep. 2014)	Milestones (Mar. 2016)	Comments
3.1 Number of HPF SC meetings chaired by GRSS and number of SOC meetings held	(a) 10 (cumulative) HPF SC meetings chaired by GRSS. (b) At least two SOC meetings held in each state except Unity.	(a) Nine HPF SC meetings held between December 2012 and October 2014. 10th is scheduled for December 2014. Output expectations likely to be met. (b) In three states two SOC meetings were held; in two states one SOC meeting was held; in Unity no SOC meeting was held. Further meetings scheduled for final quarter of 2014. Output likely to be met.	(a) 14 (cumulative) HPF SC meetings chaired by GRSS. (b) At least three SOC meetings held in each state except Unity.	One part of the 2014 milestone was achieved while the other part was not quite met but the 2016 milestone remains valid.
3.2 Number of facilities with quarterly integrated supervision conducted by county health department using QSC tool	50% of HPF-supported health facilities	33% (36% excluding Unity) Outputs substantially did not meet expectations.	80% of HPF-supported health facilities	2014 milestone substantially not achieved. The 2016 one may then be optimistic and needs to be reviewed unless HPF places greater emphasis on IPs ensuring this activity.
3.3 No. of health facilities submitting HMIS reports through the DHIS (according to the data policy flow)	70%	78% (81% excluding Unity) Outputs moderately exceeded expectations.	80%	The 2016 milestone was achieved in 2014. The 2016 milestone should be reassessed, perhaps with the addition of some quality of reporting indicator.
3. 4 Proportion of counties with one joint plan, and one review system for all government and NGO health services	Proportion of counties with one joint plan = 50% Proportion of counties with one review system = 20% Proportion of counties with one joint plan and one review system = 20%	Proportion of counties with one joint plan = 100%. Reviews anticipated to be held in January 2015. Outputs moderately did not meet expectations.	Proportion of counties with one joint plan = 75% Proportion of counties with one review system = 60% Proportion of counties with one joint plan and one review system = 60%	No definition of the indicator component 'review system' identified. Indicator definition should be fully defined to enable understanding of what is to be measured.
3.5 Number of counties submitting SSEPS forms, disaggregated by government and IP (number of SSEPS forms completed and sent to the HPF)	75% of counties use SSEPS for salaries paid through HPF.	87% (34/39) of counties use SSEPS for IP-paid salaries. Target moderately exceeded expectations.	All HPF counties use SSEPS for all salaries, whether paid through GRSS payroll or by HPF.	2014 milestone moderately exceeded but 2016 milestone remains valid.

Table 4: HSS delivery indicator milestones and progress

HSS: Two of the Output 3 indicators were moderately exceeded (3.3: HMIS reporting and 3.5: using the SSEPS, while a further two moderately did not meet their 2014 milestone expectations (3.1: SOC meetings and 3.4: establishment of a single review system), although 3.4 may be more a problem of the indicator definition than a failure to achieve the target. Finally, the milestone for the number of facility-level quarterly supervisory visits (Indicator 3.2) was substantially not met. It may be that the 2016 milestone for this final indicator should be reassessed unless it is known that the project is going to require greater emphasis from the IPs on supporting the achievement of this target.

The HPF has performed very well in the area of health service provision, as measured by the log frame indicators. Performance in the two other output areas, community involvement and HSS, has been reasonable. **It is recommended that the September 2014 logical framework be reviewed to address a number of factors:**

1. **Outcome Indicator 1.1:** Check the logframe baseline figure and correct it if necessary.
2. **Output Indicator 1.1:** Reassess the 2016 milestone as the target will already have been exceeded by December 2014.
3. **Output Indicator 1.4:** The 2016 target does not seem particularly challenging in view of the recent contract for an IP in FP, nor does it monitor ongoing, rather than one-off use, of contraceptives. It may be appropriate to reassess the 2016 target and investigate whether the HMIS can provide information for a more informative indicator (perhaps to be used in any phase 2 of the project).
4. **Output Indicator 1.5:** It is not clear what additional achievements are to be made by 2016 and so it may be appropriate to reassess this indicator.
5. **Output Indicator 2.2:** It would be appropriate to reassess the 2016 milestone when data for this indicator start to be provided through the HMIS.
6. **Outputs 2 and 3:** HPF should consider developing indicators for these two outputs that measure the quality of services and community engagement. These are discussed in greater detail in Sections 2.4.1 and 2.4.6 below.
7. **Output Indicator 3.2:** The 2016 milestone for this indicator seems optimistic unless IPs are to place greater emphasis on this activity. Review the 2016 milestone.
8. **Output Indicator 3.3:** The 2016 milestone was achieved in 2014. Reassess the 2016 milestone including some aspect of data quality.
9. **Output Indicator 3.4:** A review system has not been defined for this indicator, which makes assessing performance difficult. Review the indicator and definition.
10. **Output 3:** There are no indicators that relate to the Strategic Health Systems Strengthening Initiative that is about to be implemented. It may be appropriate to consider developing a small number of new indicators for this area of work.

2.4 Health service delivery

Service delivery, being a key output of a health system, is addressed by the HPF with the objective 'to increase access and utilisation of quality primary health services that are particularly responsive to the needs of women and children'. The MTR assesses to what extent the programme

strengthened the health service delivery system, increased utilisation of effective health services, and achieved VFM. The latter is addressed in Section 2.7.

Among the key accomplishments of the HPF has been to forestall a break in the funding of critical health services in six states before the end of December 2012. Working closely with the MOH and DFID, the HPF worked to standardise service delivery contracts, which had previously been funded through the Basic Services Fund (BSF), European Community Humanitarian Office, the U.S. Office for Disaster Assistance and the Common Humanitarian Fund, into unified, short-term bridging contracts. The bridging contracts expired in mid-2013 and long-term contracts with SPs (IPs) were approved through three rounds of RFPs. In total, 39 county contracts are served by 19 IPs. The IP contracts define the requirement to deliver services according to the Basic Package of Health and Nutrition Services (BHNPS) and in compliance with the HSDP 2012–2016. The HSDP includes three objectives:

1. to increase utilisation and quality of health services;
2. to increase health promotion and protection; and
3. to strengthen institutional functioning, including governance and health system effectiveness, efficiency and equity.

In terms of service delivery, HPF adopted the objective ‘to improve access, use, and quality of PHC services and Emergency Obstetric and Newborn Care services’¹⁷ or ‘to increase the utilisation and quality of health services, with an emphasis on maternal and child health’.

The three main dimensions of access to services are the **availability, acceptability or quality and affordability of services**¹⁸. The MTR addresses only the availability and quality, along with the utilisation of services. While it is understood that MOH policy is for services to be delivered with no charges, the affordability, to users, of access to health services is not considered in this report. The BC refers to it by stating, ‘Part of the challenge in ensuring access is the lack of sufficient, predictable domestic and global financing and inefficient global funding mechanisms’.¹⁹ It is understood that national health accounts will be established shortly and out-of-pocket expenditures will then be measured.

The following sections provide an evaluation of health facility coverage and the availability of key health services. Utilisation in the specific programme areas of safe motherhood and reproductive health, child health, communicable diseases and public health risks and non-communicable diseases are considered.

2.4.1 Health facility coverage

The HPF has been successful in increasing the availability of health services in all six supported states, including Unity. However, as support is limited to existing health facilities, many families still have no easy access to health care provision.

The increased availability of basic health care services, in particular for women and children, is likely to be due to increased numbers of health facilities that are now operational. These doubled from support to 281 primary care facilities and three hospitals through the original bridging contracts to support for 562 PHC facilities (135 PHCCs, 427 PHCUs) and 15 hospitals by September 2014.

¹⁷ Inception report

¹⁸ *Bulletin of the World Health Organization* 2013;91:546-546A: <http://dx.doi.org/10.2471/BLT.13.125450> [PDF]

¹⁹ World Health Report 2010 - Health systems financing: the path to universal coverage.

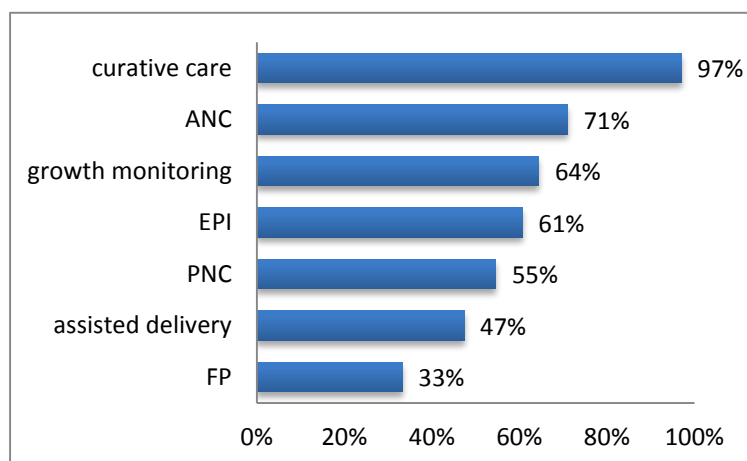
The HPF enabled additional health staff, medical equipment, drug supplies, and rehabilitation of facilities and stores to improve the functioning of facilities. (See Section 2.5, HSS.)

It was not possible for all facilities to be made fully functional. The concentration of facilities in certain areas triggers competition and utilisation of HPF-supported facilities could be low due to facilities run by humanitarian agencies and private pharmacies/clinics within close proximity. The government should strive for a well-balanced mix of public and private facilities to make the health system more efficient. **Although not in its direct mandate, the HPF programme should strongly support the government in this endeavour. Performance-based management and financing solutions could be part of that.**

2.4.2 Key health service at PHCCs and PHCUs

A national HFA was recently completed by the MOH (2013). The availability of key services included in the BPHNS was reported as poor. Only 23% of PHCCs offered all three minimum services for child health (consultations for sick children, immunisation, and growth monitoring and promotion) five days per week, with the weakest service area being growth monitoring (35%). 56% offered immunisation five days per week, and 60% offered ANC five days per week. The 2013 HFA did not report on the availability of Family Planning Services.

Figure 2: Percentage of PHCCs and PHCUs providing services (six HPF states, 2013)



The programme's priority during the first year of implementation was to ensure the availability of key health services in the health facilities according to BPHNS.²⁰ As part of the 2014 annual assessment of implementing agencies, service availability was measured²¹ (Figure 2). Whereas curative care is provided in almost all facilities, other BPHNS services often are not. While the proportions of facilities providing ANC and immunisation are slightly higher

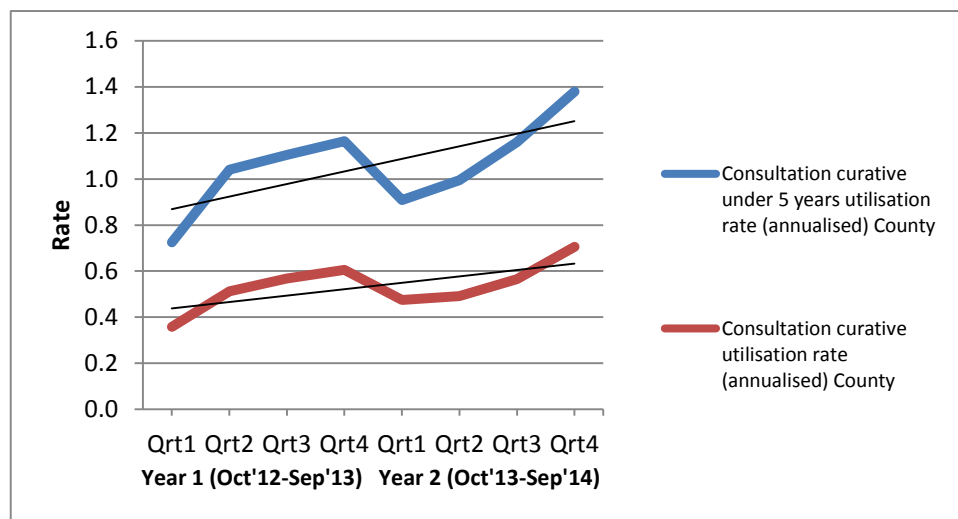
than the national average (HFS 2013), growth monitoring is recorded in twice as many HPF-supported facilities (64%) as the national average.

In contrast, FP services, assisted deliveries and post-natal care (PNC) are provided in only half to a third of the facilities (see Figure 2). These figures are for all the six states combined, which means that, for example, there are some counties that do not provide FP (or 'child spacing') services at all.

It is recommended that HPF standardise the analytical method used to assess services provided and regularly analyse the data in order to observe any changes in the future of the availability of the services at facility level.

²⁰ See Annual Report Implementation Year 1.

²¹ Source: derived from Database HPF IP Assessment, July 2014 (3 counties omitted because of inconsistent data).

Figure 3: Curative care consultations – quarterly data and trend lines (six states)^{22, 23}

Consultative curative services have increased over the duration of the programme (see Figure 3). For all ages and for under-five children these services have doubled – from 0.35 to 0.70 curative consultations per person per year, and from 0.73 to 1.38 curative consultations per under-five child

per year. The dip for the period October–December 2013 is likely to have been a result of the conflict. Despite this, a steady increase was consolidated afterwards and the programme milestone (1.5 million by March 2016) for under-five curative consultations has already been reached. With the inclusion of hospitals in the HPF programme (see below), it is likely that the recording of their OPD services will further increase coverage of curative consultative care.

Given progress to date, it is recommended that HPF reassess the 2016 milestone of Output Indicator 1.1, as the target will already have been exceeded by December 2014.

The current network of health facilities is limited but the proportion of population having access to health facilities is unclear. In 2010 it was estimated that only 44% of the population lived within 5 km of a health facility but the 2013 HPF (which did not measure access) quotes MOH estimates of 25-30% of the population having access to health care. This apparently falling trend for access seems to be in contradiction to the increase in functioning health facilities as a result of HPF support as well as a likely similar increases in functioning facilities in the four states supported by the similar USAID and Worlds Bank funded projects. Whatever the current situation, an expansion of the existing network will be essential to improve access. However, the capital requirements to fund this would be considerable and any expansion would face considerable constraints resulting from the acute shortage of skilled health workers in South Sudan such that staffing any new facilities might prove very difficult. **Any new funding, beyond April 2016, may need to consider supporting a gradual expansion of the existing health network to enable access for currently unserved populations, in accordance with MOH policy objectives that address access and quality of services.** This would need to be carried out in parallel to programmes supporting an expansion of health worker training.

2.4.3 Safe motherhood and reproductive health

South Sudan has the highest MMR in the world, with an estimated 2,054 women dying for every 100,000 births.²⁴ The government has set itself a Millennium Development Goal 5 target to reduce maternal mortality by 20% in three years. HPF has adopted 'strategies that will increase the numbers of women that deliver with the assistance of skilled birth attendants. These should include

²² Source: DHIS data provided by HPF

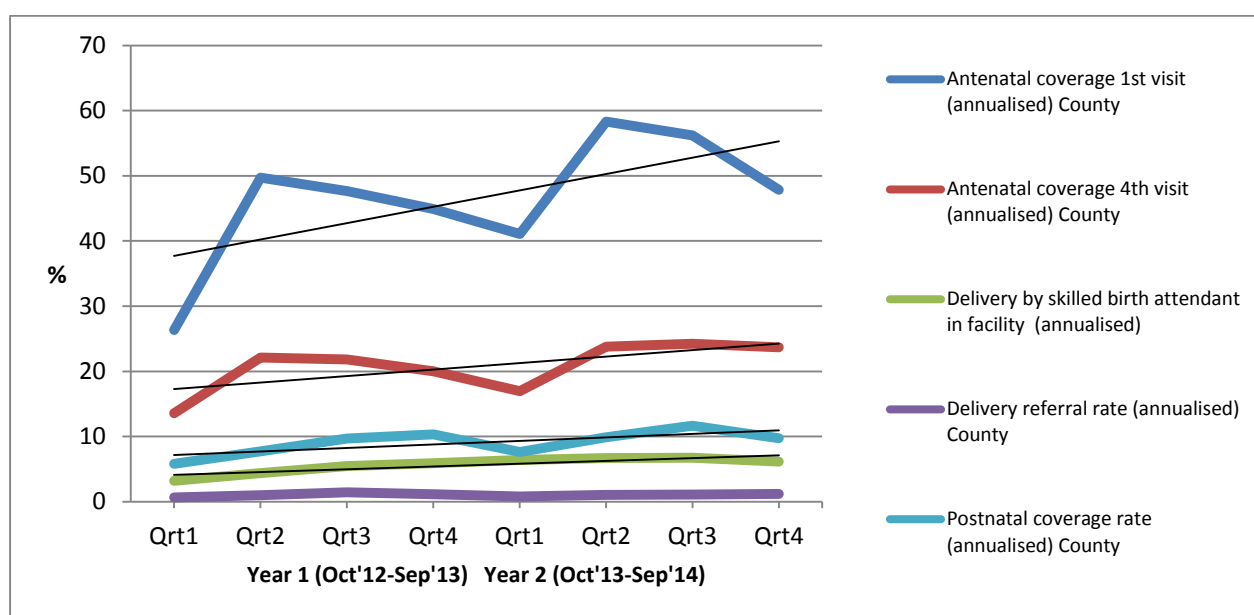
²³ The figure for the fourth quarter of year 2 represents the average of only 2 months, unlike the three months of the previous quarters. The data for Sept 2014 have been left out to reduce bias from incomplete data due to late reporting.

²⁴ South Sudan Household Survey 2010

improving the availability of ANC, and PNC as close to the community as possible, and increasing the uptake of FP²⁵.

While observing the data on access and utilisation of safe motherhood and child health services, it is important to note that other programmes may be running in parallel and supplement or complement the HPF outputs and outcome. Achievements by HPF, as presented here, can therefore also include the results of combined efforts. It would be difficult to disaggregate the results according to the different donors and partners.

Figure 4: Safe motherhood – quarterly data and trend lines (six states)²⁶



Source: DHIS data provided by HPF.

The effect of the conflict in December 2013 is visible (Figure 4) with a fall in the coverage for all states at the end of 2013. Only Unity did not recover from the dip in coverage (not shown). Coverage of ANC has increased since the inception of HPF. Both 1st and 4th ANC visits grew in all states except for Unity State, although first visits appear to have fallen in the quarter up to September 2014. This may be as a result of delays in reporting.

Observing the trend lines in Figure 4, the increase in the proportion of 4th visits (about 3% per year) lags behind the increase in the proportion of 1st visits ANC (about 8% per year). At the time of the review, only about half of pregnant women who had an ANC first visit completed at least four visits (see also Figure 5). In general, it has been reported that pregnant women start late with their 1st visits, encouraged by the incentive of free mosquito nets. Women may be less motivated to attend subsequent visits due to perceived lack of quality services and drugs, the absence of incentives, long waiting times, etc. There are examples of small incentives that may help to change this behaviour (e.g. in Nimule Hospital in Eastern Equatoria State, women receive 20 South Sudanese pounds (SSP) (approximately US\$ 4) for delivery in the facility). **Apart from improvements in the quality of services, small incentives may have large effects on health behaviour and so it is recommended that the HPF review such lessons learned by some IPs and trial successful incentive schemes more widely.**

²⁵ See IP RFP.

²⁶ The figure for the fourth quarter of year 2 represents the average of only 2 months, unlike the three months of the previous quarters. The data for Sept 2014 have been left out to reduce bias from incomplete data due to late reporting.

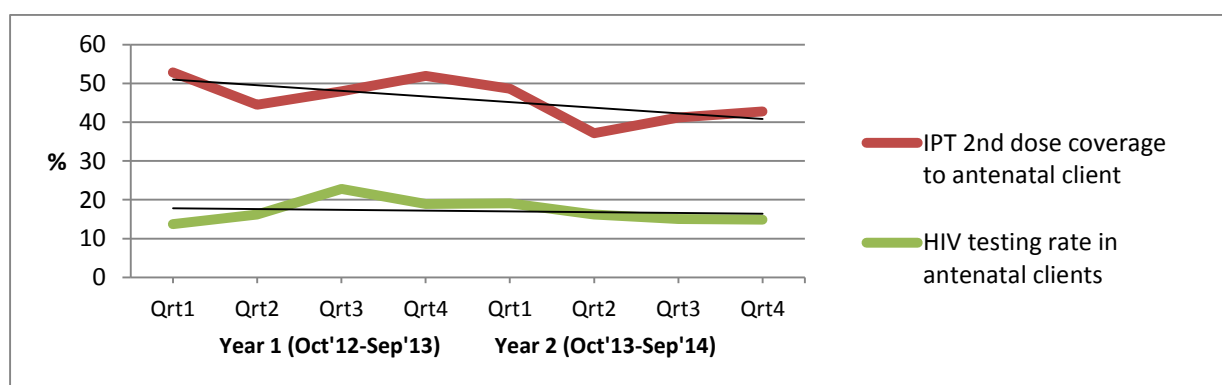
Despite increased ANC coverage in HPF-supported facilities, a downward trend can be seen in intermittent preventive therapy (IPT), which aims to treat and prevent malaria episodes in pregnant women, and in HIV testing among pregnant women during ANC visits (Figure 5). **It is recommended that the HPF and its IPs closely monitor trends in IPT and HIV testing and take action in order to ensure that at least the 2016 milestone target of 30% of pregnant women attending four ANC sessions received at least two doses of intermittent presumptive treatment of malaria as part of their ANC.**

To respond optimally to the needs of pregnant women, ANC must address multiple conditions directly or indirectly related to pregnancy, including malaria, nutrition deficiencies, STIs, HIV, and TB. This so called focussed ANC (FANC) should also provide necessary information and advice on pregnancy, childbirth, and the postnatal period, including newborn care. The most effective way to do this is through integration of programmes and availability of health care providers with a wide range of skills. Although there are signs of integration, integration is easier to say than to do and adding more interventions has implications for the HPF programme, often already overloaded and challenged by general health system weaknesses and social, economic and cultural barriers. **Nonetheless, during its preparation, the next cycle of HPF could include increased guidance on FANC by means of directing stakeholders on the road to integration and continuum of care.**

Figure 4 shows that overall coverage of PNC²⁷ increased slightly, to 10% of pregnant women under the HPF programme, but decreased in two states, WBeG and Unity. Coverage remains very low, and only slightly more than half (55%) of the health facilities provide PNC. The validity of this DHIS indicator on PNC could be questioned as the indicator 'postpartum visits' does not capture the frequency, purpose or quality of visits. Even more important, PNC has not been addressed by a clear strategy and a standardised evidence-based protocol in South Sudan.

It is recommended that any further phase of HPF is guided by a PNC strategy and protocol. Steps would need to be taken in the remainder of the current project to advocate for and support MOH in formulating the PNC strategy and clear protocols, and consider options for improving coverage.

Figure 5: ANC – selected services, quarterly data and trend lines (six states)²⁸



Source: DHIS data provided by HPF.

Deliveries by a skilled birth attendant at facilities increased from 3.5% in the first quarter of year 1 to 6.6% at the time of the review (Figure 4). Although a levelling off in the rising trend is observed towards the end of the year, it seems likely that the milestone for December 2014 (7%) will be

²⁷ The level of PNC is reported to be greater than the number of pregnant women delivering in facilities. This would be unusual and warrants investigation and confirmation.

²⁸ The figure for the fourth quarter of year 2 represents the average of only 2 months, unlike the three months of the previous quarters. The data for Sept 2014 have been left out to reduce bias from incomplete data due to late reporting.

reached. **The potential levelling off in the number of supervised deliveries could signal a certain threshold being reached (in community involvement/mobilisation, home health promotion work, etc.). The HPF and IPs should monitor this indicator carefully and if the figures remain steady, rather than rise, renewed focus should be placed on this important service provided by the facility, looking at referral mechanisms and demand creation in the community. It is suggested that small scale operational research could guide any improvements in the short run.**

The HPF started with an assessment of, and bridge funding, for three hospitals (Yirol, Raga and Nimule hospitals). RFPs for hospital contracts were subsequently issued. Currently, the HPF is finalising the process of contracting all 15 hospitals (eight county and seven faith-based) in the six states by the end of the year. By the end of September 2014, 10 hospitals were providing CEmONC. The contracts include the procurement of high-value medical equipment.

In the meantime, facilities that will provide BEmONC have been identified, and the minimum services that will be available at facilities in the county defined. Already about half (19) of HPF-supported counties have at least one PHCC with BEmONC capacity. With this progress the mid-term milestone has substantially been exceeded and there is good prospect that a further 12 counties will be added in the coming year, thus achieving the end of project milestone (80%).

IPs have been requested to demonstrate how they will support the CHD to increase referral linkages to the next level of care – that is, county hospitals that provide CEmONC. Referral systems have been strengthened with the procurement of ambulances and support for their maintenance. However, although the need is apparent, there is no national or state policy that guides the development of a robust referral structure.

The October 2013 emergency obstetric and neonatal care assessment²⁹, carried out by the MOH, resulted in the introduction of a post-partum haemorrhage (PPH) prevention programme supported by the HPF. Advocacy activities were conducted at the national level and in five states, drawing this issue to the attention of IPs, SMOHs, CHDs, midwifery training schools, UN agencies and others. The CHD/IP work plans included PPH rollout activities with the introduction of Misoprostol – provided by the United Nations Population Fund (UNFPA), Marie Stopes International and the World Health Organization (WHO). Training was provided by WHO, UNFPA and Jhpiego by their (state) technical staff. A consultant PPH trainer supported three training of trainers (TOT) workshops held in July 2014 in NBeG, WBeG and Warrap States to enable cascaded trainings at county level. **It is recommended that HPF maintain its emphasis on PPH prevention in order to ensure its integration and mainstreaming into reproductive health programmes and community activities.**

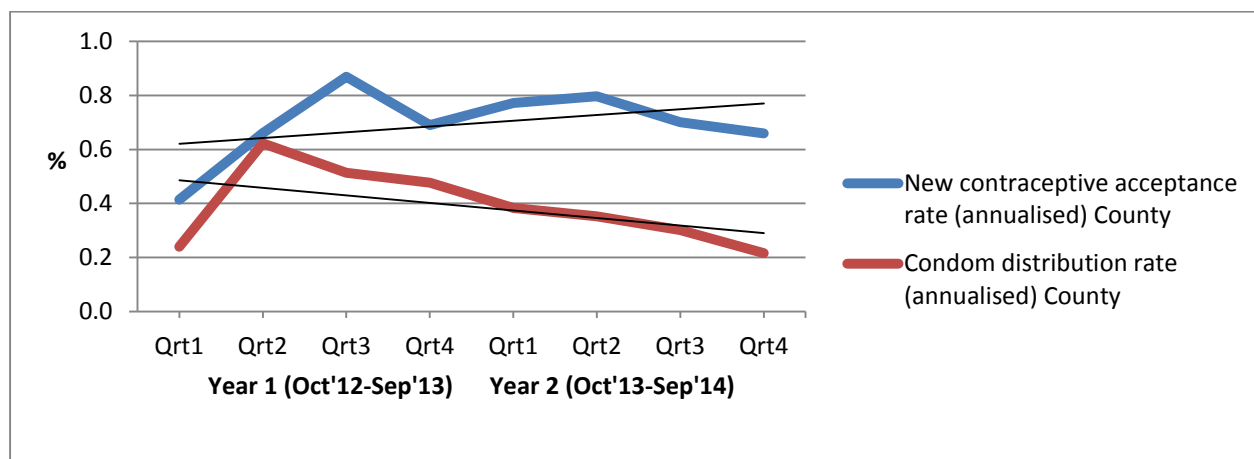
2.4.4 FP

Although the milestone of 7,000 acceptors of modern contraceptives is likely to be achieved by year-end, the need for a boost in FP has been signaled by the HPF. To respond to the low availability of FP services – on average, only one-third of facilities offer FP services – FP will receive focused attention, following the RFP for FP of June 2014, which resulted in the contract being awarded to the Reproductive Health Association of South Sudan. The aim of this contract is to scale up support for FP by increasing access, utilisation and quality of comprehensive FP services by increasing community awareness and demand for FP services, and strengthening the stewardship role of the government at county level.

²⁹ Supported by the Canadian Department of Foreign Affairs, Trade and Development.

HPF data (Figure 6) show that there has been a fall in the distribution of condoms through health facilities since year 1. This could suggest that there has been a reduction in their availability at facilities. **It is recommended that the HPF ensures that modern contraceptives are widely available, and that likely socio-cultural and gender barriers in relation to FP service utilisation receive full attention in order to create innovative and locally adapted interventions to increase uptake.**

Figure 6: FP – quarterly data and trend lines (six states)³⁰



Source: DHIS data provided by HPF.

The indicator used by HPF (Number of acceptors new to modern contraception) is not particularly useful as it does not monitor their continuing use which an indicator such as Couple Years of Protection might provide. The existing indicator information is derived from HMIS data and it may be that this is the most sophisticated family planning information that can be obtained from the HMIS in its current format. **It is recommended that an indicator that monitors continuing use of modern contraceptives is included in any further phase of the HPF.**

2.4.5 Child health

The utilisation of health services offered to children has increased over time (see OPD utilisation in Table 2 and immunisation data in Figure 7). However, the coverage of under-five curative consultations for endemic communicable diseases (Figure 8) as well as for nutrition indicators did not change significantly over the period.

The data shown are from all six states and demonstrate only moderately improving trends, partly because data from Unity State are included. Unity State IPs report difficulties with several facilities not functioning and the Expanded Programme of Immunisation (EPI) and other programmes are functioning only with difficulty as a result of the insecurity, as well as problems with the timely submission of health facility data.

During the field visit, the review team encountered several examples of weaknesses in the cold chain – non-functioning solar and kerosene refrigerators in health facilities making vaccination programmes dependent on the transfer of ice packs from a higher level facility to maintain vaccine viability. Weaknesses in the systems for this resulted in the potential of delivery of non-viable

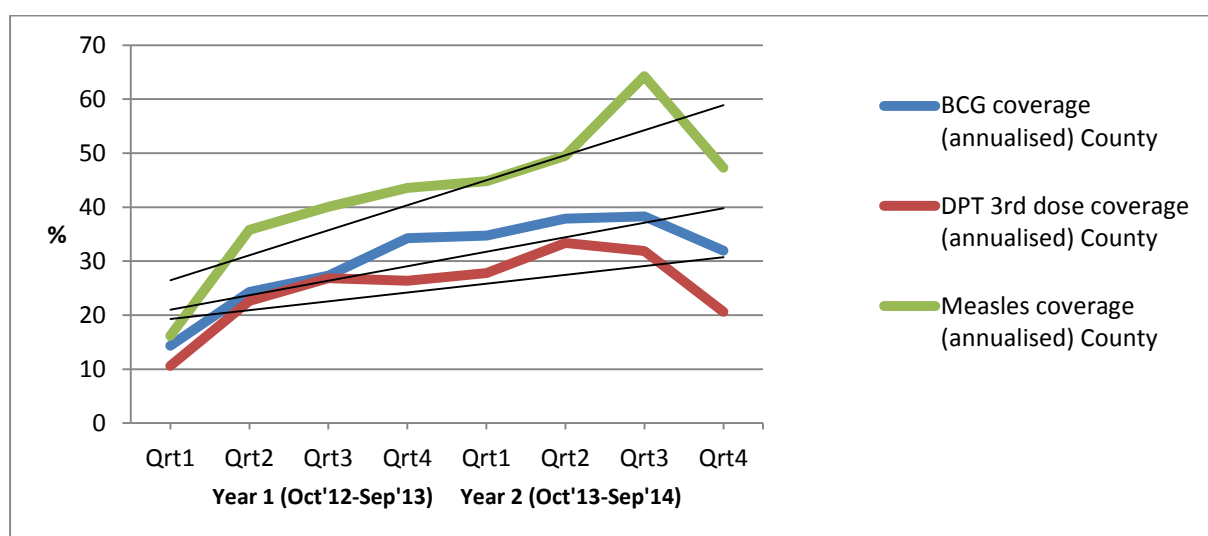
³⁰ The figure for the fourth quarter of year 2 represents the average of only 2 months, unlike the three months of the previous quarters. The data for Sept 2014 have been left out to reduce bias from incomplete data due to late reporting.

vaccines. IPs were attempting to address this problem by liaison with the mOH and UNICEF and the procurement of cold chain equipment.

A steady growth in immunisation coverage can be observed since HPF inception (see Figure 7)³¹. The milestone of 30% of one-year-old children vaccinated with a third dose of DPT by the end of 2014 is likely to be achieved.

The trend line for the administration of the DPT 3rd dose and BCG coverage suggests some further growth, although not enough to suggest that half the children under one will be covered by the end of the programme. In fact, the actual increase shows a levelling off in the last two quarters, and while this may be ascribed to incompleteness of data coverage in the last quarter, other factors such as limited outreach and community mobilisation, poor maintenance, and knowledge of use of the cold chain, as well as conflict-related issues, could be involved. **It is strongly recommended that the HPF carefully monitors immunisation statistics and where needed adjusts the interventions that IPs/CHDs implement, to ensure that the milestone of 50% DPT 3rd dose coverage is achieved by March 2016.**

Figure 7: Immunisation – quarterly data and trend line (six states)³²



Source: DHIS data provided by HPF.

The RFP for IPs state that IPs are to ensure that integrated management of childhood illness (IMCI) protocols are adhered to in the facilities, including joint monitoring and quality assurance of services in the facilities. In fact, the MOH IMCI guidelines have been updated as integrated essential child health care (IECHC) after the MOH initiated a revision of the guidelines with support from UNICEF in 2013. The HPF has supported the printing of the updated IECHC guidelines.

The HFA (2013) reports that WHO and NGOs have begun training health workers in IMCI, 'but training has reached only about half of all facilities, and follow-up training and supervision have been weak'. Moreover, only '6 % of the health facilities in South Sudan had all the essential equipment needed to perform IMCI consultations'.

³¹ The peak in measles vaccination coverage in the 3rd quarter of year 2 is likely to have been due to a measles outbreak in Lakes State.

³² The figure for the fourth quarter of year 2 represents the average of only 2 months, unlike the three months of the previous quarters. The data for Sept 2014 have been left out to reduce bias from incomplete data due to late reporting.

63% of the HPF-supported health facilities (IP assessment 2014) conduct growth monitoring, around twice the national average. IPs are expected to adopt integrated approaches to nutrition counselling, growth monitoring and referral.

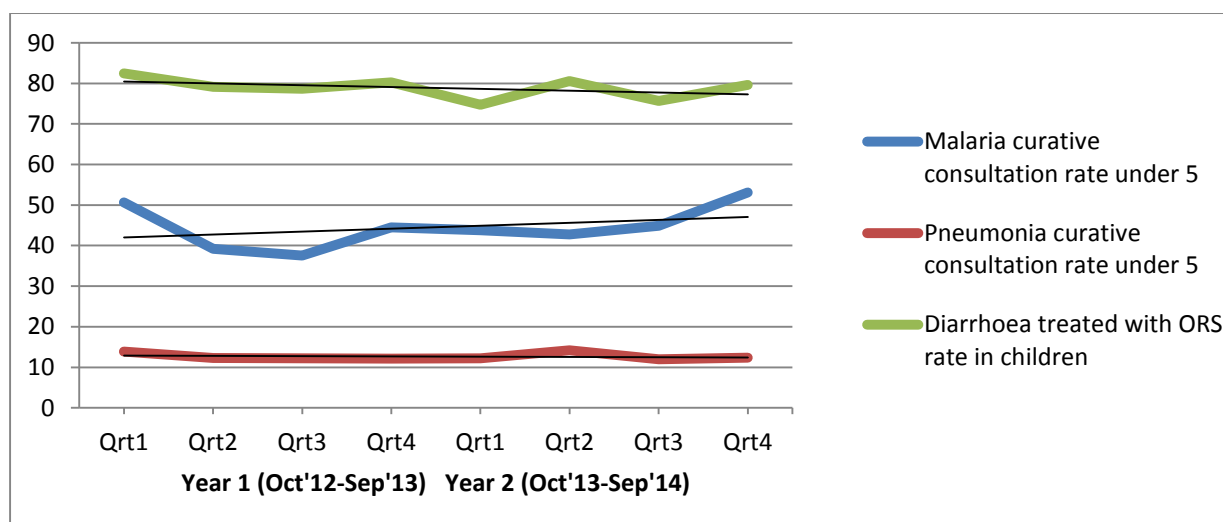
The HPF has not been supporting procurement of nutritional supplements and commodities. However, it is understood that the HPF may be modifying its mandate to support a joint plan, with UNICEF and other partners, to provide nutritional supplements and commodities and also TA for the development of a nutrition plan. **Given the low performance on nutrition indicators³³, and the known effectiveness of nutrition interventions, it is recommended that increased efforts are made to further improve growth monitoring coverage and support prevention and treatment of malnutrition.**

2.4.6 Communicable diseases and public health risks

Common endemic communicable diseases and public health risks (malaria, tuberculosis, sexually transmitted infections, HIV/AIDS, diarrhoea, enteric infections, acute respiratory infection, and neglected and tropical diseases) exert a significant toll on the population. They contribute to a high disease burden in South Sudan and are considered a public health threat.

The number of children who attend a clinic with diarrhoea and are treated with ORT has not changed significantly in the past two years, remaining at around 80%³⁴ (Figure 8). While this is the milestone figure for 2014 and so the milestone is likely to be achieved, the lack of any significant growth would suggest that the 2016 milestone of 90% is unlikely to be reached without some changes.

Figure 8: Treatment of common endemic communicable diseases – quarterly data and trend lines (six states)³⁵



Source: DHIS data provided by HPF.

Similarly, TB suspect and referral rates (data not shown) and rates for the successful treatment of acute respiratory infection (ARI) (Figure 8) have not increased. However, malaria curative

³³ <http://databank.worldbank.org/data/views/reports/>

³⁴ The 2013 Health Facility Study identified a shortage of oral rehydration solution (ORS) present in health facilities. There would seem to be a discrepancy between the reported shortage of ORS in health facilities and the high level of appropriate treatment of diarrhoea with ORS.

³⁵ The figure for the fourth quarter of year 2 represents the average of only 2 months, unlike the three months of the previous quarters. The data for Sept 2014 have been left out to reduce bias from incomplete data due to late reporting.

treatment for under-five children shows some progress, particularly in the last half-year of implementation (Figure 8).

Overall, there has been little progress demonstrated in the treatment rates for key childhood illnesses. Consequently, **it is recommended that the HPF and the IPs review its promotion, prevention and treatment strategies for the common childhood infections in order to try to increase the level of treatment through increasing community awareness and knowledge (thus increasing treatment seeking), expanding case detection and diagnosis, and encouraging standardisation of treatment to follow the national guidelines.**

2.4.7 Non-communicable, high priority diseases and conditions

The MOH acknowledges that the current health sector focus should be on the prevention and the treatment of communicable diseases and on maternal and child health in the short and possibly medium term. Attention to common chronic non-communicable diseases such as diabetes and hypertension is not yet a high priority. Nonetheless, IPs have been requested to start supporting CHDs to be aware of such non-communicable diseases (case detection and quantification) in order to help with future planning. In addition, it should be ensured that simple eye diseases can be prevented and treated at the lowest PHC level.

2.4.8 Quality of care

In the project BC the need for 'quality health services' was stated; however, the BC only refers to the assurance of quality of care within a framework of providing oversight and TA. No reference was made to the need to develop a quality assurance (QA) policy or mechanisms to ensure that health services were of an acceptable quality. This limited attention to QA in the BC is reflected in the HPF work plans and HSS activities (see Section 2.5).

The HPF has addressed quality of services through the engagement of significant numbers of qualified health workers, and focus on the distribution of drugs and medical supplies and treatment guidelines, as well as joint supervisory visits. Despite these efforts the quality of care is low and remains a significant cause for concern, with shortages of qualified health workers, inadequate facilities, poor drug management, limited guidelines and protocols, and inadequate supervision (particularly clinical) of peripheral health workers. (More details are presented in Section 2.5.4 **Error! Reference source not found.**)

Countrywide health facility assessments (HFAs) were conducted in 2011 and 2013 in order to assess the quality of services in GRSS health facilities³⁶. The HPF, as well as other partners and agencies, uses the HFA results to monitor the quality of service at health facility level.

The 2013 HFA demonstrated some significant weaknesses:

- only 9% of surveyed facilities had the minimum required infrastructure (which included a working ambulance at PHCC level);
- only 6% had all essential equipment needed to perform IMCI consultations, although 67% had a working vaccine refrigerator;
- infection control was particularly worrisome, with only 8% of PHCCs passing for this indicator; and
- fewer than 30% of facilities had some means to properly sterilise instruments, and only 64% had soap for hand washing.

³⁶ Carried out by the Liverpool Associates in Tropical Health on behalf of the MOH

In order to improve the quality of care provided through HPF, **it is recommended that HPF and its partners:**

- **concentrate on the three most common diseases – malaria, pneumonia and diarrhoeal – to provide focused, on-the-job-training in the most effective interventions to ensure a good quality of care, in addition to the continuing major focus of HPF on safe motherhood;**
- **in addition HPF should support the MOH to develop simple, durable, easily readable and visually attractive information, education and communication (IEC) materials (based on the existing treatment guidelines) for health facilities, which focus on diagnosis and treatment of the most common diseases;**
- **consider undertaking an assessment to inform the development of an overarching strategy, guidelines and processes on QA;**
- **develop and implement a roadmap for priority policies on quality of care and QA; and**
- **consider alternatives such as results-based financing approaches for improving quality of care.**

2.5 HSS

The HPF BC made the assumption that the oil-related crisis (that was affecting South Sudan's fiscal position) would take some time to resolve and so service delivery would be the key focus of the fund, with capacity building to support the transition to government-led service delivery to be considered later. The BC assumed that the programme would be split into three phases:

- **Phase 1** would focus primarily on sustaining essential health services in the absence of adequate government resources and might include some provision of support to CHD to build their capacity to assess, plan and monitor.
- **Phase 2** would be a transition phase focusing on HSS activities, with a substantially enhanced government capacity building and transfer of responsibility for health staff from NGOs to government.
- **Phase 3** would focus on strengthening PFM for the transfer of health worker salaries from NGO to government payrolls.

The BC did not anticipate that the proposed phases would necessarily be successive but if conditions become conducive to support components of Phases 2 and 3 (depending on government revenues and absorptive capacity to take on intensive TA), they could start in order to facilitate the move towards 'government-led, effective health systems that save lives'.

The HPF theory of change combines all three phases. One of its premises is that strengthening health systems improves access to, and quality of, health services, which leads to improved health outcomes and saves lives. All of the six building blocks for health systems strengthening 'need to be present and prioritised simultaneously and continuously across the entire health network'. The following *assumptions* are presented in the BC and are to be addressed by HPF Output 3:

1. **Health services** that deliver effective, safe, quality personal and non-personal health interventions to those who need them, when and where needed, with minimum waste of resources.
2. **Leadership and governance:** ensuring strategic policy frameworks exist and are combined with effective oversight, coalition building, regulation, attention to system design and accountability. In addition there needs to be political will to prioritise prevention, the health of the poorest and most vulnerable, and responses to their needs.
3. **Health workforce** ensuring there are sufficient staff, fairly distributed, who are competent, responsive, motivated, remunerated and productive.

4. **HIMSS** are essential for district health systems and necessary for budgeting, planning and decision making. It should provide reliable information on the health determinants, health system performance and health status.
5. **Medical products**, vaccines and technologies of assured quality, safety, efficacy and cost effectiveness that are affordable and appropriate.
6. A **health financing system** that raises adequate funds for health, in ways that ensure people can use needed services, and are protected from financial catastrophe or impoverishment associated with having to pay for them. It provides incentives for providers and users to be efficient.

Only 7.5% of project funds are explicitly earmarked for HSS (Table 6, below). Although other areas of expenditure, including those to IPs to support CHDs, do include elements of HSS expenditure, the overall proportion of HPF allocations for this is low relative to the high cost of health service delivery.

The MTR addresses the three phases and each of these assumptions in this section on HSS and takes into account the findings of the HSS assessment conducted by the MOH and HPF in 2013 (see Annex B5).

A series of plans derived from the 2013 HSS situation analysis has been prepared to carry forward the HSS component. No overarching HSS strategy was prepared. Work was carried out over the year to support the development of the county model through support to planning, HR management, drug supply management and public sector financial management, at both state and county levels. Given that the aim of HPF is to support the development of a government-led health system, and while taking into account the difficult operational context, the implementation of the important leadership and governance component of HSS has lagged behind.

2.5.1 Health service governance and leadership

A draft implementation plan (Nov 2013) for leadership and management development guided HPF input in the area of governance and leadership. Five core activities were proposed at the county level:

1. Developing and implementing a **strategic leadership programme** targeted at all 39 counties, with particular emphasis on supporting counties that are experiencing significant challenges.
2. Building the capacity of state teams in the six states to provide ongoing **mentoring, coaching and on-the-job capacity building of CHDs**.
3. Building on the successful quarterly review meetings in Eastern Equatoria State, by hosting similar **quarterly review meetings** in each of the six states.
4. Strengthening county leadership to provide support and **guidance to the annual planning and budgeting process at county level**.
5. Strengthening the capability of managers to adequately **supervise facilities and institutions under their management**.

The plan was only partly implemented due to the December 2013 conflict and also due to difficulties in the release of funds for short-term TA.

2.5.2 County model

In alignment with the HSDP 2012–2016, the HPF adopted the county model in all its six partner states. This model is a shift away from the previously predominant humanitarian model, to a collaborative approach to the planning, implementation and monitoring of countywide PHC. The

premise is to have one county lead IP which will be accountable to the CHD (and the MOH), thus placing the CHD central to planning, leadership and accountability.

The HPF's vision of the county model is to enable long-term sustainability of the health system and to catalyse the transition of responsibility for PHC service delivery to the CHD and MOH. The county model does not expect IPs to deliver services in all of a county's facilities but to work with the CHD to define priorities through criteria of access, cost and resources available. The lead IP will support and facilitate the CHD to manage PHC service delivery throughout the county.

Part of the county model is increasing the emphasis of IPs on strengthening the health system under the stewardship of the MOH. Activities outlined in the RFP for IPs include:

- resilience planning: planning for seasonal weather changes, floods, seasonal increases in disease burden, and ways to mitigate against these;
- joint planning, based on evidence through the utilisation of HMIS data, and coordination to share resources;
- development of an effective referral system linking the different levels of service delivery (community, health facilities and hospital);
- development of job descriptions for health workers and county health department staff;
- establishment of training needs at county level;
- joint quarterly supervision of health facilities, while building the capacity of the relevant CHD staff to effectively use the QSC tool and provide continuous QA; and
- strengthening of stakeholder coordination from all vertical programmes and other funding streams in order to harmonise activities.

County governance and leadership capacity: IPs and CHDs are co-located in nearly all counties and the CHD human resource capacity has increased, but is still weak in some counties. CHDs have been provided with (new) office space, infrastructure improvements and computer capacity, including access to internet. The co-location arrangement is perceived as a pre-condition for increased collaboration and capacity building in both technical and managerial aspects of health care and governance.

The oversight and coordination roles of the CHDs have improved with support of the IPs. In many counties there are now monthly coordination meetings with other actors in health, and CHDs play a key role in the quarterly HPF review meeting. CHDs show increasing assertiveness demanding stewardship and transparency of the IP. However, there is still a long way to go for CHDs to be playing a central role in planning, monitoring, supporting and supervising the work of NGOs, and overseeing health service delivery.

Job descriptions of CHD staff and facility staff have been developed in several counties, but they are not based on a national template/guidelines for this. Internal supervision mechanisms within the health facility and within the CHD were not found to exist. However, in hospitals managed by NGOs, internal supervisory coordination mechanisms existed.

The MTR team makes the following recommendations:

- **The roles and responsibilities at each government level, including job descriptions, of CHDs need to be further articulated by the central MOH, supported by national policies/guidelines for CHD operations.**
- **Internal supervision, within each health facility and within each CHD, should be an established part of the management tasks within these bodies and should be reflected in the job descriptions.**

County health planning: HPF reports³⁷ that the county health work plans were developed for implementation year 2 (July 2014–June 2015) in all six states by CHDs and IPs with TA from the HPF and MOH. This process included the involvement of other health care providers and health actors in each county. However, the recent study on supportive supervision in Warrap State³⁸ mentioned that only 'some of the CHDs organised joint planning meetings, with the participation of the IPs'.

Key challenges identified during the county health planning workshops³⁹ included:

- establishing what could or could not be funded by the HPF, and the changing nature of this;
- problems with which dataset to use for calculating indicators and the lack of national targets for several indicators;
- the wide variation between counties' performance and the capacity of county teams to identify and analyse their own successes and challenges, caused by the uneven performance/capacity of the IPs and possible tensions between the IPs and the CHDs;
- limited engagement with some other NGOs and faith-based organisations implementing services in the county;
- the limited resources of some IPs to plan countywide services and support capacity building in CHDs; and
- the lack of financial transparency for all funding sources.

Another key challenge in county planning is the alignment of plans of parallel and vertical programmes and humanitarian assistance. This particularly relates to humanitarian aid programmes, warranted due to the influx of IDPs, but which still run without integration into the county health plan. In some counties, large health development programmes⁴⁰ run simultaneously to the HPF programme, also contributing to the outcome and impact of BPHNS activities. **It is recommended that the state and national MOHs provide clear policy guidance to support county planners in insisting on the inclusion of all county programmes in their annual plans.**

HPF should also use the important role of the leadership and governance component of HSS to guide – at state and county levels – government, HPF and other programme responses to the humanitarian crisis in directly affected conflict and adjacent areas through supporting joint planning, steering and review mechanisms.

County and IP review system: Although one might expect the M&E function to be inextricably linked to planning, this was not the case with the county-level planning exercise in June 2014. A standard set of output/outcome indicators was not used during the county health planning workshops. The resulting county plans and their process indicators were then used, by the HPF, as the IP contractual work plan for year two, with the targets being that indicators are strengthened and annual targets for each activity are completed.

In parallel, building on the implementation of the year 1 IP performance review process, by October 2014, the HPF had developed an expanded list of performance and informative indicators, the IP Performance Management Framework (PMF). This includes general notes and a detailed description of 48 indicators (both output/outcome and 'informative' indicators), together with a sample of how the framework would look for one county. The HPF decided that developing a

³⁷ HPF document 'County Health Planning' June 2014

³⁸ Strengthening Supportive Supervision, Gap Analysis Study. October 2014

³⁹ HPF document 'County Health Planning' June 2014

⁴⁰ E.g. the US\$ 8 million SHARP programme or programmes supported by the Canadian Red Cross

comprehensive planning and performance management system at county level would be an incremental process.

This appears to be an example where there were inadequate linkages between the health service delivery and the HSS work streams within the HPF, leading to a lack of coordination. **It is recommended that the HPF ensures greater coordination between the HSS and service delivery work streams to ensure that the programme benefits from the obvious synergies between the two.**

County budgets and transparency: At county level the transparency of budgets and expenditures has improved, and there are signs of trust being built between partners, thus increasing synergy. However, the HPF document 'County Health Planning'⁴¹ states that, 'although all budget information on direct transfers to the counties is claimed to be available by MOH and processes are transparent, in practice expenditure information is not always transparent.' Similarly, 'although the agreed HPF budgets (through to end 2015) and expenditure to the end of April 2014 were presented (except in NBeG), the government allocations were unfortunately not available (except in WBeG), neither were contributions from other development partners and international NGOs.' It is reported that not all IPs always provide information on all their expenses either.

GRSS resources should be transferred to CHDs through a direct transfer, via the SMOH; however, this direct transfer does not always arrive directly in the account of the CHD. Instead, the CHD may need to submit a plan in order to access the resources either from the SMOH or from the county commissioner. With the support of PFM work activities, these operational budgets for the CHD are being monitored, which means that most CHDs can make sure they do get access to (at least part of) these funds for the service delivery.

While there has been progress in increasing transparency and accountability, with some regional variations, **it is recommended that the process of sharing fully information on budgets, expenses, plans and performance should continue to be fostered, with sharing of lessons learned on approaches and results to be encouraged by the HPF.**

The role of IPs in CHD capacity building: Although in the county model, it is the role of the county IP to support capacity building within the CHD, the closeness of their role, and the fact that the IP is the budget holder, could influence such a role. Also, in some cases, IPs, whose traditional role has been limited to managing a small number of facilities, have only limited capacity to support CHDs in planning and leading the provision of health services to meet a whole county population⁴². Thus IPs and CHDs have been found to require greater support than anticipated to move towards a model of county partnership. This suggests a need for greater support to be provided to both CHDs and their IPs to enable partnership and capacity strengthening of county governance. Therefore **it is recommended that the HPF commence the full implementation of the leadership and governance strengthening plan.**

The IPs to share innovative approaches and assist each other: Many counties are developing innovative approaches to deal with challenges and these need to be shared and made available to all. This is a key knowledge management practice. Best practices can be identified through the state and national HPF offices, through the IPs, through the SMOH and CHDs and through the quarterly and annual review processes. Although the HPF has established this through the monthly and quarterly reports, **it is recommended that the HPF identify and implement mechanisms to share best practices between different counties, within states and between states. In addition, opportunities for IPs to assist each other should be explored.** For example, a

⁴¹ HPF, June 2014.

⁴² HPF document 'County Health Planning' June 2014

‘buddy⁴³’ system has been developed in procurement and supply chain management of medicines and is well appreciated by the IPs. This concept might be further developed.

County model effectiveness: The performance and effectiveness of the county model has not yet been separately assessed. The review team’s impression is positive, with support articulated by stakeholders including from all levels of the MOH, the IPs, the HPF team and the development partners. **It is suggested that the county model may increase its functionality by applying the one plan–budget–review concept also at SMOH and national MOH levels.**

In some counties there is a lack of clarity about the detailed roles and relationships required between the IP and CHD. **It is recommended that formal memoranda of understanding (MOUs) between the state MOH, CHD, hospitals and the relevant IPs be introduced, based on an HPF-approved template.**

It would be appropriate to undertake a formal assessment of the county model with reference to effectiveness, functionality, sustainability, transparency and accountability in time to inform planning for any subsequent phase of the HPF.

2.5.3 Supportive supervision to improve quality of care

The MOH recognised the importance of supportive supervision in the HSDP 2012–2016 and in the design of the QSC in 2011⁴⁴.

TA has been provided by HPF on supportive supervision and consists of activities in two phases:

- 1) an assessment of current practices; and
- 2) the development of mechanisms for strengthening the supervision systems.

As part of the first phase, the MOH and HPF conducted a joint one-week study in Warrap State that analysed the gaps in supportive supervision⁴⁵. The HPF intends to support similar studies in the other states (except Unity), following which a supportive supervision manual will be developed for approval by the MOH. The following sections draw on the Warrap State study.

The study demonstrated considerable differences between CHDs and facilities on the coordination, process and effectiveness of supervision. Whereas CHDs tended to consider that they had a reasonably clear understanding of the purpose, mechanism and approach to supervision, facilities tended to find all of these unclear, found the implementation of supervision to be weak, and particularly complained about the lack of follow-up.

The study found that the mechanisms for coordination of supportive supervision activities were not robust. Some CHDs did not have evidence of minutes of meetings, some weekly visit schedules missed facility names, and not all relevant staff were involved in planning the visits. Furthermore the study found no evidence for a systematic process of training of staff in the mechanisms of supportive supervision, the only exception being the M&E officer receiving training in the DHIS.

Facility staff do not feel they benefit from supervisory visits. Only one in five of the facility respondents viewed supervision as promoting any change. Staff mentioned the need for planning, feedback and training in supportive supervision in order for it to become relevant and effective.

⁴³ A system in which a county that has good skills in some aspect of supply chain management is paired with a county that needs to develop the skills, so that one can learn from the other.

⁴⁴ The recently issued reproductive health policy however does not refer to supportive supervision.

⁴⁵ Strengthening Supportive Supervision, Gap Analysis Study. October 2014.

Overall, as reported by HPF staff, the QSC is increasingly used by the CHD/IP during supervision⁴⁶. Results are processed through the DHIS system and submitted to the state and national MOHs (with the HPF usually receiving a copy). By October 2014, the DHIS reported that 33% (36% without Unity) of the expected QSC results had been uploaded onto the system. This reflects a significant improvement on the 7% QSC reporting rate in 2013, but QSC use is not likely to meet the 50% milestone by the end of 2014.

The HPF is collaborating with the MOH and Liverpool Associates for Tropical Health (LATH) in the revision of the QSC.

The supportive supervision role of state MOHs towards CHDs and county hospitals has been limited by a lack of any tool (checklist) that they can use to supervise. However, the problem of limited financial means available to enable SMOH supervision has been addressed by the establishment of a supportive supervisory fund that should allow the SMOH to conduct more regular supervisory visits. At present, in most states they are conducted on an ad-hoc basis. In Eastern Equatoria the state MOH developed a plan for quarterly supervisory visits to all counties.

At present, the HPF state coordinator participates in field visits conducted by the state MOH. The deployment of more HPF TA at the state MOH in the future will likely help to delineate their roles and responsibilities, establish coordination mechanisms and encourage robust implementation of supportive supervision.

The HPF uses two MOH quality of care tools: (1) health workers observation tools and (2) the exit interview tool to assess patient satisfaction in the health facilities. Exit interviews are carried out at some health facilities and results reported in the quarterly technical reports.

There is no finalised MOH QA policy or strategy and no management guidelines at state MOH and CHD levels; nor are there practical tools at facility level. Hence, **it is recommended that the HPF support MOH in the development of a QA policy and procedures for the CHD through:**

- **facilitating MOH approval of existing draft QA materials;**
- **supporting development of a QA policy, strategy and standard operational procedures using results-based management protocols/standard operational procedures** (alternatives, such as the findings in the two World Bank-funded states, should be studied and if suitable applied on a pilot basis within the HPF programme); and
- **preparing clinical information materials for health facilities that focus on diagnosis and treatment of a selection of the most common diseases.**

2.5.4 HR for health

The Health Facility Study 2013 for South Sudan assessed the HR situation at PHC level. Only 3% of the surveyed PHCCs employed all the minimum number of technical staff according to MOH standards, and only 13% had at least one of the required cadres. It would appear that the BPHNS-specified staffing norms may not be realistic given the shortage of qualified staff in the country. In addition to the absolute shortage of trained health staff, HR management issues, i.e. salary levels, payroll and information systems, analytical tools, and HR development issues, have been reported as significant concerns.

Within this overall context, the IPs were contracted by the HPF to support the CHDs to:

⁴⁶ The actual use of QSC was observed in Eastern Equatoria State during supervision visits by HPF staff.

- ensure that health facility staffing plans were kept current and included strategies for rationalising the distribution of health workers;
- update job descriptions for all the health workers and make them available at facility and CHD level;
- make consistent use of the HRIS and develop and enforce staff attendance registers;
- record the receipt of health worker salaries at the facility level; and
- identify the training needs of staff and provide in-service training and other capacity development activities, in accordance with MOH guidelines.

The HPF has supported the IPs and SMOH to recruit health workers for both health facilities and the CHD offices. However, recruitment of staff has been a challenge at state level but also, more significantly, for health facilities in the counties. A shortage of qualified staff has been identified by the IPs as the limiting factor to have BEmONC services available in the PHCCs. Even when the budget is available to recruit staff, positions remain vacant because of the unavailability of qualified staff. There is a shortage of qualified nurses, midwives, clinical officers and doctors. In order to address this shortage, the HPF has been supporting efforts at task shifting to facilitate the expansion of skills for existing staff. **It is recommended that the HPF continues to support the process of task shifting as it is regarded as central to addressing HR capacity needs.**

At county level the HR capacity improved since programme inception. In many CHD offices the number and quality of staff has improved and state MOHs have tended to try to appoint qualified staff in key county-level positions. For example, in WBeG the SMOH has appointed medical doctors as county medical officers in the CHD.

In collaboration with the MOH and other government bodies, the HPF has contributed significantly to the development of the HRIS. The system has been designed with HPF support and has so far been piloted in two counties. Wider rollout is expected in early 2015. The HRIS enables HR management by the MOH and HPF and is seen as having critical financial as well as managerial benefits. It is strongly supported by central government, and is an example of the government-led nature of HPF. The HRIS is expected to identify discrepancies on the payroll, but already its introduction has enabled the SMOHs to have a better insight into who is working where.

The current recruitment of staff by the IP/CHD is primarily based on the BPHNS staffing norms for health facilities rather than on the workload and specific local requirements. HPF tracks facility staffing levels on a quarterly basis. The HRIS rollout will further increase knowledge of facility staffing and the transparency of payroll issues. With the improvement in information about staffing levels and information about service activity, the HPF will be in the position to promote efforts at more rational health staffing distribution. The present emphasis of the MOH, HPF and others is on ensuring compatibility of the payroll systems of the NGOs and the government. **The HPF should continue to support work on introducing the HRIS as a precondition to enabling rational staffing workload analysis in order that, ultimately, realistic and affordable staffing norms can be established.**

After the HRIS has been rolled out early in 2015 the next step is to introduce an AMS that will enable CHDs and state MOHs to gauge the level of absenteeism and, if necessary, respond appropriately.

The HPF has facilitated, through its IP contracts, the harmonisation of NGO health worker salaries. The harmonisation and the use of the SSEPS are two stepping stones in the process that should ultimately enable all PHC staff salaries to be included on the MOH payroll. With 34 out of 39 counties submitting SSEPS forms for IP-paid salaries, the milestone for the end of 2014 has already been exceeded.

A further stepping stone is the MOH plan to increase workers' salaries in government primary health facilities, through the payment of an infection allowance⁴⁷, from 2015 onwards. This will bridge the gap between salary levels of government and IPs' health workers. Provision to pay for this has apparently been included in the government budget from January 2015.

It is understood that the introduction of the harmonised NGO salaries has resulted in some loss of staff to both the private sector and humanitarian agencies working in conflict- and IDP-affected areas (who are not party to the salary harmonisation agreement). In addition it has been reported that difficulties are experienced in recruiting qualified staff for remote areas. In the long run, it is anticipated that the harmonisation of salaries will result in a 'balancing act' with, on the one side, the advantage of reduced competition and more equity – between IPs and between states, for health workers, and on the other side the disadvantage of reduced flexibility to encourage the deployment of skilled health staff to work in remote areas.

At the request of the Minister of Health, the HPF supported an assessment of health training institutes. However, the possibility of the HPF supporting a plan to increase the number of skilled birth attendants was not taken forward, at least until the current debate about the future status of traditional births attendants within the MOH is resolved.

In-service training for health workers and CHD staff is mainly provided by IPs and occurs regularly on different aspects of quality of care. As mentioned in Section 2.4.8 on QA, **it is recommended that the HPF take steps to support the government in developing and implementing QA policies, regulations and guidelines. These would need to include regulations on the accreditation of training programmes and minimal standards of training.**

2.5.5 Printing and distribution of treatment guidelines and IEC materials

One of the findings of the HSS assessment in 2013 was that 'SMOHs and CHDs are unable to provide facilities with key MOH guidelines such as the BPHNS or treatment guidelines'. With support from the HPF, BPHNS and treatment guidelines for PHCCs and PHCUs have been reprinted and distributed through SMOHs and CHDs to facilities⁴⁸. Not all facilities have received them yet; indeed, the review team's field missions encountered very few reference materials (treatment guidelines, IMCI guidelines, training manuals, wall charts or other IEC materials) in the facilities.

HMIS registers have recently been printed by the United Nations Development Programme and are being distributed to the state level by HPF or by the IPs directly. MOH HMIS tools were printed with HPF support and distributed through the SMOH with support of the HPF state coordinators.

The distribution of materials appears to differ by state and county. IPs are reporting on the availability of guidelines in the county and in the facilities, but the information is not processed as such, but reviewed as part of the quarterly programme review by technical managers in the HPF team.

It is recommended that the HPF encourage the IPs and CHDs to ensure the full distribution of all available guidelines, manuals, etc.

⁴⁷ Qualified government PHC workers are to have an infection allowance, a device to increase take home pay that will not, it is hoped, impact on salary demands for GRSS employees in other sectors.

⁴⁸ In Unity State they were sent directly to facilities.

2.5.6 M&E

The log frame indicators, including baselines and milestones, designed in the HPF BC were to be reviewed and defined during the inception period. However, this was not completed until after the 2013 annual review. The conflict, of late 2013 into 2014, resulted in the development of an interim M&E strategy and a review of the log frame. The outcome of this review was the reduction in a small number of indicator targets and the revision of some indicators. It was agreed that the HPF would report separately on some indicators to show the effect of the reduced implementation in Unity State on overall performance. Subsequent to this, in September 2014, a further revision of the log frame was agreed with DFID and this provides the basis for this current review (see Tables 1–4 above).

Measurement of the impact and outcome indicators depend on South Sudan undertaking some nationally representative surveys to determine impact targets such as maternal mortality and infant mortality rates. Other indicators are assessed using reports provided by IPs but most are linked to data provided from the MOH DHIS. (See Section 2.3.1 for a discussion of the project indicators.)

Prior to the inception of the HPF, there had been little uniformity of reporting by the various NGOs that had been supporting service delivery and so data reconciliation in county, state or national reports was difficult. An HPF analysis of the pre-existing DHIS showed that between 20 and 70% of service provider information was missing across the counties and only 50% of SPs were using the DHIS, with the majority only capturing the data as paper records. CHD HMIS units had been established and staff trained on the use of HMIS and DHIS software (which had been introduced previously with the support of the Japanese International Cooperation Agency). However, adherence to the national HMIS data flow policy was low and mechanisms for assessing the quality of data were not in place. The data that were captured were not analysed for use for management and service outputs were not monitored or reviewed.

An M&E strategy was developed as part of the HPF inception report, which concluded that, in order to strengthen government systems, the HPF would use the MOH DHIS as the basis for collecting information on project achievements. Subsequently, as a result of the December 2013 conflict, HPF produced an amended interim M&E strategy for the period of March–August 2014, still based on the use of the DHIS.

Thus, IPs were to support the use of the DHIS for submission of facility-level reporting to both their CHD for entry into the DHIS and, in parallel, to the HPF. The HPF has created a data file that mirrors the MOH system, with harmonised facility names and data. In order to support this, the HPF has organised training courses for the SMOH, CHDs and IPs to provide the basic skills required for using the DHIS and also to retrospectively capture all available historic information available, in order to provide baseline information.

The IPs/CHDs routinely reported to the HPF in Juba through:

- 1) a monthly DHIS export file reported by the 15th of each month;
- 2) quarterly narrative reports, with quantifiable output of the programmes;
- 3) monthly invoices with statements certifying the accuracy of the invoiced costs;
- 4) quarterly financial reports of expenditure – spending by programme component for the quarter, cumulative spending, available funding for the remainder of the activity and any variances from planned expenditures;
- 5) annual reports of progress and achievements related to agreed activities; and
- 6) an annual independent audit report.

Despite considerable improvements, there continue to be weaknesses, both in the timeliness and in the quality of data reported by some counties. There is a lack of standardisation in the sources

used to determine population statistics in each county and state, a factor that led to uncertainty over the validity of DHIS statistics. It is understood that some reconciliation of DHIS data inconsistencies takes place at national level. It would be better that this took place at county level, where there would be access to the primary source of data to assist such reconciliation.

It is recommended that the HPF continues to provide support for training of health workers at facility and county levels to ensure continued improvements in the quality of data reported.

The HPF efforts to build CHD capacity to analyse and utilise the HMIS data should be continued. The national and state MOH and CHDs should be supported to undertake the systematic analysis of quarterly reports at county and state level.

The HPF should also support the introduction of QA measures at the CHDs and Health Facilities (HF) levels to enhance the reliability of the HMIS data that are collected, reviewed and finalised. The DHIS data should not be corrected at the national level, where the original data capture forms are not present, but at county level, close to the source of the information.

The HPF should advocate and support the MOH to determine what population data to use for the DHIS (and HPF) indicators and to set national targets for all PHC indicators.

The IPs report on a monthly basis to the HPF M&E team, providing a copy of their DHIS reports and highlighting progress and challenges. All reports are reviewed by the M&E team and written feedback is sent to the IPs. The M&E team provides a help desk function for IPs and provide support and assistance to IPs, CHDs, etc. as required.

The collation of IP reports by the HPF could be made more timely and efficient and **it is recommended that the HPF consider ways to further automate the reporting of information regularly collected from IPs, and others, through suitable IT solutions.**

In mid-2014, the HPF conducted a review of IP performance using a set of 25 indicators, both qualitative and quantitative, covering (i) service delivery, (ii) community empowerment, (iii) HSS, (iv) fund and contract management, and (v) VFM. Quantitative data were used from the HMIS and qualitative input from both CHDs and HPF contract managers were used to score the performance of IPs and primary care services in this review. of this assessment.

Table 5 shows the results, by state and performance area, of this assessment.

Table 5: Average performance score by performance area and by state

County and IP	Service Delivery	Community Empowerment	Health Systems Strengthening	PROGRAMME OUTPUTS	Funds and Contract Management	Value for Money	PROGRAMME MANAGEMENT	OVERALL
EES	6.00	6.67	4.26	5.72	6.58	2.13	5.69	5.70
Lakes	6.91	4.05	4.89	6.22	5.16	4.25	4.98	5.60
NBeG	8.06	6.89	7.76	7.88	8.14	1.40	6.79	7.34
Unity	5.07	6.79	4.46	5.12	5.73	1.44	4.87	5.00
Warrap	6.77	7.51	5.35	6.56	6.32	2.83	5.83	6.19
WBeG	8.09	4.91	5.75	7.31	7.33	0.00	5.86	6.58

Source: End of Year One Implementing Partners Performance Review Summary. HPF July 2014.

Note: The arrows indicate trends in performance, with green indicating performing smoothly, amber some concerns to monitor carefully, and red requiring immediate action. The maximum score in each category is 10.

When looking at county performance, only one, Magwi County in Eastern Equatorial State, recorded a very good performance with an overall score of 8.22 (out of 10). Also, only one county,

Rumbek East in Lakes State, recorded a very poor performance with a score of 2.58. Eleven counties (28%) recorded a score lower than 5.00.

This review was used to identify areas of weaknesses (and strengths) in individual IP performance and this information was used to inform discussions between individual IPs and the HPF in agreeing their work programmes and performance targets for year 2. It was agreed that contracts of 14 IPs, supporting 28 counties, would be continued without any specific conditions but with defined milestones to be achieved by the end of year 2. A further four IPs, supporting 12 counties, were given a set of specific conditions that were to be met within an agreed time frame of three months. It is understood that, for two counties (Rumbek Centre and Rumbek East), the IPs have failed to meet the specific conditions within the agreed timetable and active consideration is being given to terminating the contracts.

For the good of the services being provided in the two Rumbek counties, it is important that the situation is resolved there as soon as possible to enable an improved level of services to be available there.

The annual review process was clearly a very useful process in highlighting the strengths and weaknesses of performance in the 39 counties. It should be continued and used to encourage the continuous improvement of health services delivery in the six states.

2.5.7 PFM system strengthening

PFM strengthening is broadly interpreted in HPF. In addition to support for the financial transfer systems and health sector financial management proper, it includes salary harmonisation, the adoption of the GRSS payroll system (the SSEPS), the introduction of an HRIS and the development of an AMS. The focus of the inception phase and first year, on which this evaluation focuses, was on the development of PFM benchmarks and a PFM baseline, the introduction of SSEPs and salary harmonisation amongst NGOs.

Work Plan 2013–2014: In the initial 12-month work plan covering the period from July 2013 to June 2014, the HPF work plan specified a number of PFM activities including:

- facilitating the development of state annual operating plans and budgets in all six states;
- supporting the state MOH to further develop transparent, efficient and effective budgeting systems;
- supporting the introduction of an AMS for health workers; and
- supporting the roll out of HRIS.

Work Plan 2014–2015: It is only in the second work plan for the year from July 2014 to June 2015 that PFM strengthening appears as a component in its own right, even though one of the consortium partners was responsible for this area. In the 2nd year work plan, Section 5 is dedicated to PFM system strengthening rollout, with the following categories and sub-categories:

HR information systems

- Start up the pilot of the HRIS at the county/facility level;
- Improve the HRIS programme using lessons learnt from the pilot;
- Develop a core MOH training and implementation team for the HRIS;
- Establish TOT for state rollout;
- Facilitate HRIS training sessions at the national level for IPs;
- Provide support to IPs and the MOH (state and county) to roll out the HRIS;
- Monitor the IP implementation of the HRIS; and
- Update the HRIS website.

SSEPS

- Support all IPs to complete payroll using SSEPS;
- Support IPs to provide training to CHDs on the SSEPS tool; and
- Support splitting of state/county payrolls through the decentralisation of SSEPS to the county level.

AMS

- Start up the tried and tested AMS <http://sssams.org/>;
- Analyse present practice with IPs and counties;
- Provide training to the MOH and IPs on the AMS;
- Support the IPs to roll out the AMS;
- Monitor IP implementation of the AMS; and
- Develop a web portal for the AMS.

Government PFM coordination and oversight

- Deploy a PFM expert at the MOH (supported through the Strategic Support Initiative);
- Deploy a PFM Officer at six SMOHs (supported through Strategic Support Initiative);
- Support the MOH and State Transfer Monitoring Committee;
- Support the SMOH and establishment of County Transfers Monitoring Committees;
- Support the PFM information flow from county–state–national level; and
- Support local PFM policy implementation.

PFM monitoring

- Continue monitoring the PFM benchmarks on a quarterly or bi-annual basis; and
- Finalise the PFM baseline study and circulate to all development partners.

This section of the 2014–2015 Work Plan demonstrates a strong focus on HR and HR-related aspects of PFM. It sets out clearly the current priorities of this work stream, and progress in each area is discussed below:

HRIS: In late 2013 the HPF was requested to improve the HRIS. Design began at that time and was refined in the first half of 2014. Documentation is limited but there is a rollout plan and a brief report on the pilot that took place in June 2014. It is a bespoke system and the ministry is closely involved in its preparation. In particular it is hoped that the HRIS will eliminate payments to ‘ghost workers’⁴⁹. In this way, the HRIS can provide real savings in the health sector.

Training is now underway on how to use the system, and the MOH hopes it can be implemented in all counties by early 2015 through training county-level staff in its use. In tandem with the HPF input, a consultant is developing a local government HR manual.

Functionality and reliability of the HRIS is critical. It is recommended that after installation of the HRIS an external independent review should be commissioned to comment on its integrity and functionality and to recommend any enhancements.

SSEPS is an Excel-based tool that is used across GRSS for payroll. It is effectively a protected Excel spreadsheet. The HPF-supported SSEPS activity is well advanced. It has now been introduced in 34 of 39 counties, and this will in due course aid the smooth transfer of NGO staff to government. The first SSEPS workshop was in August 2013, following preparatory work from April to July 2013.

⁴⁹ Including, amongst others, health workers who have left the service and not been removed from payrolls, whether intentionally or through oversight.

During that period, there was intensive discussion of harmonisation and SSEPS/PFM benchmarks. A PowerPoint presentation was developed in August 2013, and also a manual. Both are available, as are online SSEPS training sessions.

NGO salary harmonisation refers to the harmonisation of salaries amongst staff recruited by IPs (NGOs) supporting the health sector in all programmes (HPF as well as World Bank and USAID programmes). There is no mention of this in the PFM strengthening plan but the PFM team has been actively involved supporting the process.

The objective has been to avoid excessive staff switching from one IP to another for a better salary, and to enable easier assimilation, in due course, of NGO staff by government. GRSS is fully supportive and issued a directive on the subject on 18 July 2013, which is now being implemented. The HPF has been actively involved, providing technical support in respect of the six states in which it is active, and harmonisation is now complete in these states, although with some limited exceptions that relate to different benefits, or different levels of salary increase.

There is a related programme to harmonise salaries of IP-recruited staff with salaries of GRSS health staff, from early 2015. This will require a large increase in GRSS health worker remuneration and has the potential to create tension with workers in other sectors. As a result, the increase will be implemented as an 'infection allowance' and is a supplement to salaries for PHC workers only. County hospital staff will not be part of the harmonisation exercise and are not scheduled to receive the allowance. There is continued support from government for this activity.

AMS: Although the introduction of an AMS was in the first year project work plan, progress is still reported to be minimal. It is expected to be intensified in the current phase. At present attendance monitoring is not systematised, although there are initiatives in individual counties. Delays in achievement have been caused by delays in the HRIS and the limited number of staff allocated to the PFM component that is responsible for this.

PFM benchmarks: A major investment of the PFM strengthening team during 2013 was to develop a set of PFM benchmarks. The benchmarks were agreed with the MOH and a September 2013 presentation stated their purpose as being twofold:

- to monitor, and drive, improved performance of PFM systems as they apply to the health sector; and
- to measure progress against which donors might shift to putting funds through government systems during the life of HPF.

The benchmarks can be categorised in three groups as: budget (five benchmarks); HR, personnel and payroll (eight benchmarks); and broader PFM issues related to implementation of the local government accounting manual (four benchmarks). The detailed benchmarks are provided in Annex B6 to this review.

There are difficulties with the benchmarks as they do not present a balanced set of criteria for PFM strengthening. They have a heavy focus on HR and payroll (8 benchmarks out of 17); the budget benchmarks are focused on financing and budget releases, rather than budget execution, which is an area of high fiduciary risk (it is critical to PFM strengthening, but requires intensive support); they contain nothing on procurement or cash management; and the audit requirement, in which a qualified audit report is acceptable, presents a very low bar. Finally, the PFM baseline being developed in relation to these benchmarks since mid-2013 remains incomplete, and needs a renewed focus.

The PFM benchmarks are individually desirable in themselves. However, it is understood that DFID is no longer likely to use GRSS financial systems for HPF funds within the current HPF

phase, as a result of concerns about the readiness of GRSS PFM systems. This seems eminently wise. As a result the second reason for the benchmarks falls away. Nonetheless, strong support continues from donor partners to strengthen health sector PFM, and the PFM benchmarks will continue to have a role.

The PFM benchmarks were originally established to be triggers for direct funding of GRSS by DFID. This is no longer expected within the current HPF phase. In view of this, and in recognition that PFM reforms notoriously take an extended period of time (and the HPF end date in March 2016 is close), they should be revisited to assess what can practically be addressed with HPF resources. If they are intended to improve health sector PFM overall, which donor partners continue to support, they should (1) be broadened to include routinised and robust audits, internal controls, cash management, procurement, bank reconciliation, accounting systems, budget monitoring and control, and financial reporting, and (2) be the subject of a comprehensive phased and realistic plan for PFM strengthening, particularly in non-salary areas. Regular monitoring should be established. Relevant log frame indicators should be introduced. At present the log frame includes only indicators for SSEPS.

The HPF should use its strong connections to the MOH and the experience of the recently recruited PFM strengthening specialist and the State-based PFM staff, to engage fully with County Transfers Monitoring Committees and the Local Service Support (LSS) agenda more broadly, following the lead of the Ministry of Finance. The engagement should cover the range of PFM issues indicated in the recommendation above in addition to monitoring and assuring the smooth transfer of funds to the health sector. A detailed plan of engagement should be produced and closely monitored.

In carrying out these recommendations the HPF must be continually aware that the establishment of financial management policy is the preserve of the Ministry of Finance, and HPF support for PFM will be to ensure good practice and compliance with Ministry of Finance guidelines and the implementation of sub-national financial procedures as laid out in government accounting manuals.

The HPF PFM strengthening focus in practice has included the establishment of PFM benchmarks and work on the partially completed PFM baseline. But the interventions themselves have been focused heavily on the HR and payroll indicators, particularly the introduction of SSEPS, NGO salary harmonisation, and latterly the introduction of the HRIS.

Management of PFM strengthening activity: The PFM strengthening stream has made progress steadily. It has been limited in its achievements because funds have only allowed for 0.75 full-time equivalent staff allocated to the function. HPF has now recognised the need for much greater inputs and 12 PFM staff are being recruited (six to work in HR) to work at state level to ensure better financial flows (from GRSS) and better financial management. Six of these new staff members have already been recruited. They will need to be intensively supervised.

Under the newly inscribed Strategic Health Systems Support Initiative the PFM component is expected to receive an additional £2 million of funding – which is not yet planned and budgeted. The PFM strengthening stream has been able to strengthen its rapport with the MOH further by arranging for the HPF to finance an already embedded and trusted PFM expert based in the MOH. This will deepen the HPF/MOH relationship, and support the joint action in this area.

It is recommended that the PFM component of the Strategic Health Systems Support Initiative, along with all components of the plan, be the subject of a costed and monitorable work plan, focused on non-salary PFM. It should be subjected to robust challenge to ensure

VFM, and to ensure that absorptive capacity exists in the health sector to take advantage of all planned PFM interventions.

2.5.8 Procurement and supply chain management (PSM)

For a long time, PSM in South Sudan has been a 'reactive' system that was characterised by pushing medical supplies and drugs down the distribution chain from central level to the health facilities. The Health Facility Study 2013⁵⁰ included an assessment of the availability of medicines at facility level. This demonstrated that only about 40% of facilities had all necessary drugs for IMCI (amoxicillin, ORS, ACTs and ciprofloxacin), 50% had all required vaccines in stock and 60% had all drugs for ANC (SP/Fansidar, iron and folic acid).

After a period of low drug availability, the EMF⁵¹ became operational in October 2013 and is understood to have been effective in providing essential drugs to health facilities in South Sudan. Although there seems to be sufficient supply of essential drugs to the primary level, there is insufficient information available at national level on average monthly consumption or stock levels at facilities and counties to inform future national-level quantifications and forecasting of essential drugs⁵². Also, it should be noted that distribution of medicines and supplies to counties in the conflict-affected states is currently a serious challenge. The HPF has been closely monitoring access to EMF drugs in Unity State. The EMF funding finishes in mid-2015.

It is recommended that the HPF support the MOH to monitor national drug availability and liaise with IPs to enable them to procure supplies if it seems likely that gaps will emerge, particularly when the EMF finishes in mid-2015.

The IP contracts with the HPF require the IPs to address challenges in the PSM and ensure equitable access to quality pharmaceuticals and medical products. The RFPs state that IPs are expected to support the CHDs in strengthening the supply and utilisation of quality pharmaceuticals and medical products in each county through activities that would assist them to move from a push to a pull system according to the needs of the facilities. While still using the MOH Essential Drugs list, IPs support the CHD in applying coherent strategies that oversee quantification, requisitioning, storage and distribution of drugs and supplies. This includes training of county officials on basic supply chain management, ensuring the consistent use of stock cards at facilities and warehouses, and providing support to the county warehousing and storage options. In addition, IPs work with the CHDs to ensure a continuous and consistent supply of the most essential medicines, which can include procuring top-up drugs and supplies as required by the county.

In general, at the facility level, IPs encourage health workers to use drugs rationally and use best practice drug prescription. At community level, IPs work with the CHDs to improve drug usage among the community.

The HPF has supported the MOH in capacity building and quality improvement in PSM, facilitating the removal of expired drugs and reorganising drug storage space through the so called 'de-junking' exercises in which CHDs and health facilities were assisted in disposing of expired drugs and reorganising medicines and medical supplies. The exercise has almost been completed in all 39 counties. It was considered very successful and very motivational for medical staff.

⁵⁰ Conducted November 2013–March 2014, so just as the EMF was coming into operation.

⁵¹ Supported by Norway, the UK and USAID.

⁵² 'Procurement and supply chain management', HPF report April 2014

The HPF introduced the features of a pull system in drug supply management for a more rational distribution of drugs. The pull system should minimise expired drugs and optimise drug use according to needs. Information management is key to this and so where quantification of drugs has been a problem due to insufficient population data, stock levels are now reported upward from the facility to CHD, enabling the distribution of drugs to facilities based on needs. CHDs have undertaken a more prominent role in the distribution of medicines, receiving and managing EMF drug supplies on behalf of the whole county.

Four states have so far been introduced to the pull system, with NBeG and Warrap States scheduled to be included before the end of 2014. In these states, HPF has established an effective PSM mechanism that has allowed EMF supplies to be better managed, supplemented by HPF-procured supplies where needed. The amount of drugs procured through the HPF has been lower than anticipated.

Drug storage capacity at county level is regarded as essential for the establishment of a pull system. With the support of the HPF, storage facilities were re-established and stock cards introduced for monitoring. In general, IPs have been proactive in the process.

In practice, the pull system encountered some limitations. Not all parties are convinced yet of the need for re-distributing the drugs (EMF allocates drugs to specific health facilities and so these supplies are seen as owned by the individual facility even though not all facilities receive EMF supplies). In addition, the current large quantity of medicines distributed 'could potentially encourage irrational use, wastage and leakage, and be further challenged by the often insufficient and inadequate storage space at country and facility level.'⁵³

It is recommended that the HPF and its IPs liaise with the EMF manager to try to ensure that all health facilities in all counties are eligible and receive EMF drugs.

The 2014 PSM report⁵⁴ states that 'the procurement capacity of IPs has been assessed by HPF's lead consortium member, although the criteria or policies used by the IPs to ensure medicines are purchased from quality assured (QA) sources were not specifically verified.' It is reported that most IPs procure through QA suppliers; however, three IPs have or were about to procure medicines from local vendors (one Kenyan and two Juba-based suppliers) from non-quality assured sources. The purchasing of drugs from non-QA suppliers by IPs cannot be sanctioned on legal grounds. The issue was addressed by the HPF PSM expert and the three IPs were linked to other IPs that do have stringent quality procurement criteria in place in order to facilitate access to reliable quality approved suppliers.

The PSM report also notes that, while a centralised procurement mechanism for all IPs was assessed and most likely is not an option, opportunities for pooling of procurement and/or distribution between some of the IPs is something that could be further explored, and could result in increased efficiencies. In order to make small steps towards strengthening the medicine supply chain system in South Sudan, **it is recommended that the HPF focuses on selected issues. These include managing waste, training and building capacity, upgrading storage facilities, facilitating pharmaceutical consumption information flow, sharing best practices and successes, and further exploring the role of the community in drug management.**

An HPF PSM expert⁵⁵ is providing intermittent technical support to procurement and supply chain management. Capacity building through TOT in PSM and rollout has been taking place in cooperation with the MOH in four of the six states. PSM tools have been printed. To further

⁵³ 'Procurement and supply chain management', HPF report April 2014

⁵⁴ 'Procurement and supply chain management', HPF report April 2014

⁵⁵ Through periodic short-term TA

strengthen the capacity at state level, PSM coordinators/experts are being recruited by the HPF for each of the six states. **It is recommended that the HPF take measures to ensure that the state PSM coordinators, currently under recruitment, are properly managed to make sure that their TA translates into sustainable solutions.**

2.6 Community-based activities

The HPF was tasked with scaling up health promotion and protection interventions so as to empower communities to take charge of their own health. This was to be achieved both through working at the central level to support the MOH to formulate policies that define the role and functions of community mechanisms and through direct activities in each county where the relevant objective of IP contracts was to increase community participation, utilisation and demand for health services.

Considerable progress has been recorded by the IPs in community-based activities. Facility health committees are in place in most facilities with reasonable female representation (see Table 3: Community involvement indicator milestones and). Information is not routinely available to assess HPF performance against a third indicator (documented meetings held involving the community, the health facility, the CHD and the IP); however, it is understood that this will be collected in future. The community involvement work stream indicators are all process orientated (number of committees, female members, meetings held).

The IPs contracted by the HPF are reported to be supporting community mobilisation in many ways, such as:

1. supporting facility outreach activities such as immunisations;
2. validating local staff being recruited;
3. monitoring attendance of health workers at health facilities;
4. resolving community disputes;
5. conducting community needs assessments;
6. supervising facilities;
7. carrying out health education and promotion;
8. performing disease surveillance; and
9. reporting the status of health facilities.

A variety of community groups, such as Village Health Committees and Community Health Committees, are reported to have been in existence, formed or reactivated, as well as a number of community level cadres, e.g. community-based distributors, home health promoters and social mobilisers. During the field visit, communities reported they had been engaged in health facility-related decision making. For example, two IPs, the International Medical Corps and World Vision International, had conducted village focus group discussions at health facility level to assist in prioritisation of their activities. The IPs recruited women qualified for opportunities in the programme, seeking to address embedded gender issues and promote gender equity.

The IPs have actively engaged with their communities. However, this was carried out with no direction from a national plan, resulting in the potential for widely diverging approaches being taken in different counties and by different IPs.

Work to support the development of MOH guidelines for the role of community bodies has lagged behind within HPF. The October 2013 annual review was concerned that HPF work on community engagement lacked a central focus and recommended that the project initiate central technical support to the counties (CHDs and county partners) to strengthen community engagement and governance in local health service delivery by December 2013. A community strategy and operational plan was prepared for the project only in July 2014, and this has not yet been finalised or shared with the MOH and DFID. This identified that the MOH guidelines on community health workers (home health promoters, vaccinators, social mobilisers, community health committees, health facility committees) have not been finalised and the home health promoter curriculum is still

in draft form as the community mobilisation approach document. There is however an MOH policy on health education and promotion (2009) for use in communities.

The July 2014 community strategy and operational plan was not taken forward, although its preparation did prompt the reconstitution of an MOH Technical Working Group on community-based health care. However, there has been a lack of capacity within both the MOH and HPF to carry on this work at central level. This is about to change as the SC has agreed plans for the recruitment of TA to support work on community engagement. Capacity at national MOH level is to be enhanced through the recruitment of a TA staff member to be embedded within the MOH to assist in the development of MOH policy while each state MOH is also to have TA focused on promoting community involvement in the state.

While the community engagement work stream has proceeded, largely meeting the project log frame targets to date, it has developed in the absence of central guidelines for its rollout, leading to the potential for considerable divergence between the approaches in different IPs, states and counties. **The recruitment of TA to support the development of national policies and guidelines on community engagement is to be welcomed. The existing draft guidelines for community-level bodies should be finalised as part of the overall plan and then used as a common framework for all community engagement activities.** The development and introduction of guidelines, training curricula and manuals for village health committees, community health committees, home health promoters, social mobilisers and traditional birth attendants to form a common framework of actions among the IPs should be a first priority for this TA.

A community strategy and realistic operational plan should be prepared by the incoming TA staff in this area, and, subject to approval by the SC or Technical Working Group (TWG), implemented.

Project TA is also planned for attachment at state level. Their first role should be to fully document the situation in the different counties in their states to provide a full picture of community activities in the six states. This process should be directed by the national TA and the findings feed into the policies and guidelines to be developed at the centre. Once agreed, the state TA will then coordinate the rollout of activities, by individual IPs, in each county.

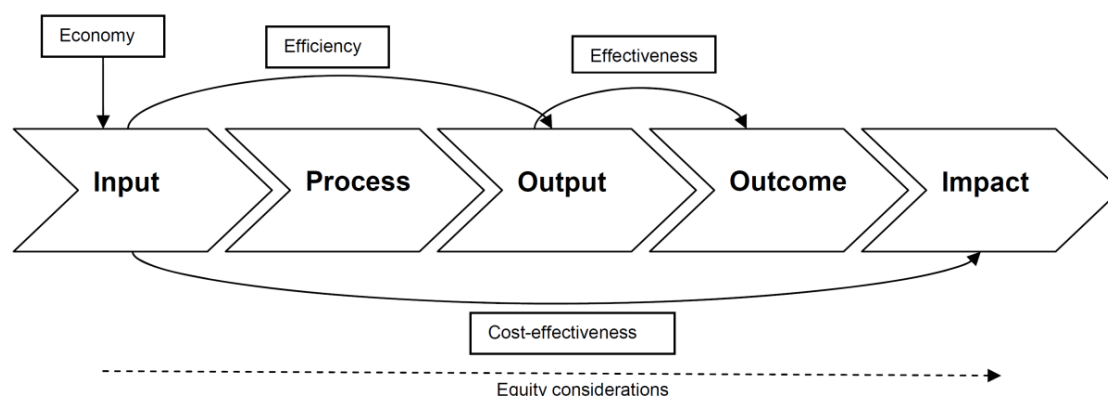
While recognising the difficulty of defining and measuring the quality of community engagement, **the HPF should seek to define such indicators that can be used in future. These could relate to a chosen focus of community activities such as the number of successful community referrals of pregnant women for ANC or delivery in a health facility or the number of children successfully referred for immunisation services or immunisation defaulters traced.**

2.7 VFM

2.7.1 The dimensions of VFM

The DFID results chain is a comprehensive overview of the different dimensions of VFM. These dimensions are illustrated in Figure 9:

Figure 9: The key dimensions of VFM



Source: DFID, *DFID's Approach to Value for Money*, 2011

Assessment of VFM requires linkage of costs and performance measures. The HPF BC and subsequent logical framework identified key performance measures from this results chain, i.e. impact, outcome and output indicators that the HPF M&E team has monitored over the last 18 months where data are available.

2.7.2 VFM performance compared to the VFM proposition in the BC

The BC sets out projections for DALYS to be averted under Output 1, health service delivery. They were based on specific health delivery outputs which envisaged seven sets of high-impact interventions under the HPF including child health, nutrition, malaria, hygiene and sanitation, maternal health, FP and prevention of HIV/AIDs activities. This cost US\$ 1.42 million per annum per county, resulting in a projected average of 6,959 DALYs averted per county per annum at a cost of US\$ 204 per DALY averted.

In practice the HPF covers a range of health service delivery activities including many of the above but excludes some of the broader community preventative interventions such as malaria control or water, sanitation and hygiene (WASH) activities beyond those specific to health centre activity. For example, malaria treatment is included, but not the widespread use of insecticide nets; good WASH standards for the health centre are included, but not community WASH programmes. As a consequence of these variations, and a slower than anticipated startup, the actual planned 2013/14 budget for HPF activities was lower than originally envisaged in the BC at US\$ 0.825 million per county across 39 counties and actual spend was only US\$ 0.567 million per county, compared with the BC projection of US\$ 1.42 million across 40 counties. Unfortunately from a VFM perspective some of the omitted activities such as use of insecticide-treated bed nets are known to be highly effective in saving lives at relatively low cost⁵⁶.

The original calculations underlying the projected DALYs averted are no longer available and it is therefore difficult to assess the VFM achievement of the HPF health service delivery (Output 1)

⁵⁶ http://www.cdc.gov/malaria/malaria_worldwide/reduction/itn.html

over the first 18 months against the original BC. Also, the HPF service activities are not measured against the groups of services listed in the WHO CHOICE data and the DHIS patient data analysis does not give a breakdown of the types of interventions offered within the preventative or curative consultations or ANC visits. The lack of survey data and the movement of IDPs amongst the population also exacerbate the difficulties of making a meaningful cost per DALY averted analysis at this stage.

The BC VFM analysis focused on Output 1, health service delivery. No measures were proposed for the effectiveness of community engagement (admittedly a very difficult area to measure). For HSS it recorded⁵⁷ that measuring this 'will be challenging and more work will be done ... to consider how these benefits can be measured and evaluated'. The VFM strategy was intended to fill these gaps.

2.7.3 VFM monitoring and the VFM strategy

A VFM strategy was produced in April 2013 to monitor VFM in the programme, and to fill in the gaps in measurement of performance left in the BC. The strategy states in the assumptions and principles that indicators should be directly linked to the logical framework and theory of change from the BC, and proposes a set of nine indicators:

- Three are classified as economy measures: first, percentage spend against IP budget; direct costs per head of population; and indirect costs per head of population.
- One efficiency measure of cost per consultation visit.
- Three measures are classified under effectiveness and seek to measure community engagement and HSS progress: first, using 'opportunity cost' measures to value community contribution compared with external contributions; second, the strategy proposes to correlate improvements in health seeking behaviour with specific health education/promotion inputs; and third, to record the number of effective CHD-initiated supervision visits. Unfortunately, these measures are fraught with practical measurement difficulties and assumptions such as defining effectiveness of supervisions, or community contribution and the cause/effect attribution to specific HPF activities. In practice these measures have suffered from lack of data.
- Two indicators are proposed to measure equity: both are gender based, measuring first the proportion of women's consultation visits; and second the proportion of women attending training events. These indicators respect the HPF focus on gender inclusion, and on maternal and child health. However, equity is broader than gender, and it should be considered in broader perspective such as income disparity or geography dispersion/remoteness. On the other hand, data availability may preclude such measures, especially given the population movement and IDP developments over the last 12 months. It should however be possible to record trends in disbursements per capita by county, from the HPF and government together, using available population data.

It is recommended that VFM economy measures be enhanced through the conduct of regular external procurement audits covering all IPs. These reviews could be scored by procurement area such as tender process, record keeping, etc. and used as an effective measure of economy.

⁵⁷ Page 30.

2.7.4 HPF monitoring of VFM

HPF monitoring of VFM takes place against a background of major service disruption and data communication problems caused by the ongoing conflict. Specific evidence of HPF monitoring of VFM includes the following:

- HPF logical framework indicators are regularly updated and the project appears on track to achieve many of its 2014 milestones.
- The HPF annual report, backed up by the quarterly reports, contains a significant financial performance section that focuses on percentage of spend (burn rate) by line items analysed over each IP in all six states.
- The year-end IP Performance Review Summary of July 2014 assessed individual IP performance against 25 performance indicators divided across two performance areas: programme outputs and programme management. This report contains two explicit VFM measures for IPs relating to actual indirect cost as a percentage of budget spend and the average cost per consultation.

The IP Performance Summary shows VFM as the worst-performing area of all (Table 5: Average performance score by performance area, by state), with a score of 2.01 out of a possible 10 and trending downwards in all states. However, this is misleading for two reasons. The first is that it is based upon only one indicator – the indirect cost rate⁵⁸. This is a very limited base and one which is seriously distorted by underspending in the period, which is discussed and partially explained in Section 2.8.7 below. Secondly, it is misleading because VFM is a programme-wide assessment that derives from comparing overall inputs with overall performance, and cannot be expressed well in a single indicator that excludes output information.

The HPF M&E process thus captures information on overall spend, direct/indirect spend and expenditure in relation to population or per consultation. This approach enables some financial management conclusions to be drawn. However, it does not link the financial performance to any output objectives, except in very broad budget and line item terms. In practice, effectiveness is not being measured.

Moreover, this analysis of performance at the micro level is informative, but partial. VFM becomes another separate dimension of performance rather than the comprehensive assessment of costs and benefits of all the project dimensions as envisaged in the original BC (which measured the overall cost effectiveness of the HPF in terms of cost per DALY averted). This is a consequence of reporting financial aspects of the project against line item spending, separate from project activities within each programme area. To measure the VFM of service delivery, community empowerment and HSS will require allocating and monitoring spending in each of these areas, which would increase the burden of financial systems' overhead to the project (but could be secured with a stronger financial management information system as described elsewhere in this report).

It is recommended that the VFM strategy be revised. In particular, the strategy needs to acknowledge more clearly the limitations of HMISs in South Sudan and the difficulties in measuring VFM for all three outputs, but especially 2 and 3. The strategy can move to a simpler approach, which could include a greater focus on management and supervision of programme activities and qualitative monitoring processes for community activities and HSS; an analysis of interventions undertaken, to ensure that they prioritise those known to be most effective in terms of DALYs averted; stronger ex ante measures through the use of

⁵⁸ The report comments that 'value for money appears pretty poor (using the IP indirect cost rate as proxy indicator in this area)' ... p5. There are in fact two indicators selected in the report for VFM but the second is the average cost per consultation, but it is measured as a deviation from the average. Consequently, it can only give a reading for each IP and not for the programme as a whole.

procurement and management guidelines as well as ex post reviews of procurement and spending to provide assurance of economy; and considerations of resource equity amongst counties and within counties through the tracking of resources.

2.7.5 VFM achieved

The HPF annual report demonstrates that significant progress has been made in health service delivery despite the many difficulties encountered, particularly in Unity State. The indicators for these services in South Sudan were initially very poor and the HPF baseline for coverage therefore very low. For example, maternal indicators such as ANC 4 visits was 12.9% and tetanus toxoid 2 for ANC was 5.2%. Similarly, for children's services only ORS treatment coverage was reasonable at 72.8%⁵⁹, but immunisation rates such as BCG (13.4%), DPT3 (11.5%) and measles (21.5%) were all very low.

Significant progress has been made through HPF health facilities over the last 18 months, with coverage more than doubling for many of these services, e.g. ANC 4 up to 23.2%, tetanus toxoid 17.1%, BCG and DPT now over 30% and measles over 50%, together with the development of other services. Whilst these examples are not yet a comprehensive package and other services such as safe delivery in HPF facilities are still at an early stage, the trend for these services is also positive. For example, supervised deliveries are up from 3.5% to 6.4%; HF deliveries are up from 7% to 12.6%; and post-natal coverage is up from 6.1% to 10.2%.

The original BC envisaged 30% coverage for a children's service package, which has already been reached for some services, and a less ambitious 20% coverage for maternal health services, starting from a lower base.

Other matters: As described above, it is clear from indicator movements in Output 1 that the HPF, together with other initiatives, has added significant value. It is more difficult to demonstrate value in the areas of Outputs 2 and 3 – community mobilisation and HSS. However, the consideration of VFM in the BC alone understates the value of this project. Areas in which hard-to-measure value has been added include the following:

- HPF IPs have provided support to CHDs in the implementation of modern health delivery methods, but which may not impact indicators immediately.
- HPF IPs have contributed to the training of health cadres.
- There is a significant increase in service utilisation; the size of the increase suggests that health outcomes are likely to have improved, although there are, as yet, no data to support this.
- There are good signs that in addition to saving lives, a government-led health service is being built – a key objective. Evidence includes the following: (1) the MOH indicates that the HPF is responsive to government needs, (2) the HPF has close links to the MOH, (3) some particular initiatives (harmonisation and HRIS) have been carried out in close concert with MOH, and (4) the SC is active, attended by high-level MOH staff, and there is evidence that it introduces new initiatives and takes an active role in key decisions, occasionally exercising a right of veto.
- Although as yet incomplete, progress in the related SSEPS rollout, HRIS and AMS promises to support significant VFM in the health sector as a whole, ensuring that health sector funds are spent more efficiently and that health workers are more productive.
- HPF has, together with sister projects in USAID and World Bank, pioneered the county model.

⁵⁹ Although concerns on the reliability of this data exist elsewhere in the document

However, VFM is threatened by the shortcomings in financial management and fiduciary risk indicated elsewhere in this MTR. It is also undermined by the high levels of overhead associated with the county model, especially where direct spending is low.

The points made in the BC still hold: in the absence of HPF, 6 of the 10 states in South Sudan, with a population of approximately 5 million, would have significantly reduced health services.

2.8 Programme governance and programme management

This section considers both the governance and the management of the HPF. HPF governance bodies exist at various levels in the project, with overall project direction being guided by a national SC. SOC in each state⁶⁰ provide a forum for guiding project activities at state and county levels. In addition, the contributing donors have a role in both monitoring and agreeing significant changes to the project while the managing consortium, led by Crown Agents, meets periodically as a SAB, to provide strategic direction to the various technical aspects of the project.

Management functions have been considered in relation to both management relations between the HPF office in South Sudan and the head office function provided by Crown Agents in the United Kingdom and within the HPF office in Juba, while issues of financial management are also considered in Section 2.8.7.

2.8.1 HPF SC

The role of the HPF SC^{61,62} is to:

- oversee the HPF mechanism;
- ensure that the HPF is aligned with the GRSS and MOH strategies;
- approve changes to the HPF with a high impact on timelines and budget;
- assess the HPF's progress on agreed milestones;
- provide advice and guidance on high-level strategic issues;
- review and approve final HPF deliverables; and
- disseminate information to health partners and other sectors.

The SC is chaired by the under secretary for health, or his or her designate, and co-chaired by the DFID health adviser. Membership is made up of an MOH representative as well as representatives from the Ministry of Finance and Economic Planning and the Ministry of Labour and Public Services and a representative of the HPF donor group (Canada, Australia, Sweden and the EU). A number of non-voting observers are permitted and these include the donor co-chair of the Health Sector Working Group, the NGO Health Forum coordinator, USAID, the World Bank and an observer from a SOC.

SC meetings were initially held frequently, with seven meetings held between December 2012 and December 2013 while procedures were being established and decisions made on the initial contracts. There was a five-month break as a result of the conflict, with SC meetings resuming in May 2014. Since then meetings have been held approximately quarterly.

⁶⁰ Except Unity.

⁶¹ Steering Committee TOR, 26 March 2013.

⁶² The SC TOR include the provision that its TOR should be reviewed annually. This has not been done and thus the SC TOR are overdue for review

The SC has met nine⁶³ times since the project began; the under secretary for health has chaired the meeting on five occasions and the minister for health once. On the remaining three occasions a senior MOH official chaired the meeting in the absence of the chair. As co-chair, DFID representatives have attended all the meetings while Canadian representatives have attended seven meetings. The NGO coordinator has also attended regularly as an observer while two other donor representatives, Sweden and the EU, have attended occasionally. A Ministry of Labour and Public Services representative has only attended one SC meeting while the Ministry of Finance and Economic Planning representative attended the first four meetings but has only attended one of the more recent meetings.

While provision is made for a member of the SOC to attend the SC meetings as an observer, with a rotating membership between the six HPF states, no SOC member is recorded as having attended any meeting.

Based on the minutes of the 10 SC meetings, the SC has been actively involved in decision making for the project:

- Reviewing TOR for the various RFPs for county health services, county and faith-based hospitals, and FP services. 'Sub-committees', including representatives from the beneficiary states, have been actively involved in preferred provider selection for all the RFPs. In one instance the SC vetoed the selection of one preferred provider (for FP services) due to them having outstanding issues with the MOH.
- Reviewing other HFP activities such as survey findings and confirming priority areas for activities in the HSS output areas.
- Initiating consideration of expansion of HPF activities such as FP, state hospitals and health training institutes, which had not been included in the original HPF concept.

There is no reference in the SC minutes to any review of the HPF inception report or any subsequent quarterly or the first HPF annual report, either technical or financial. Individual HPF technical reports such as those related to gender and social inclusion or community involvement do not appear to have been tabled at any SC meeting.

The SC was given an update on the first annual performance review held in September 2014 to examine the performance of IPs. However, there are no minutes to suggest that the SC endorsed the findings of the review or, ultimately, the HPF recommendation to terminate the services of one of the IPs following its failure to improve its performance after the review.

The SC has been an effective forum for engaging GRSS in the management of the project with the SC being active in reviewing and endorsing the many activities involved in establishing contracts for county, hospital and FP services, etc., demonstrating the active engagement at senior levels within the ministry. The committee has been less active in monitoring either the technical or financial performance of the project, as required in its TOR. **It is recommended that the SC meetings are scheduled to coincide with the production of HPF quarterly and annual reports such that the SC formally reviews the HPF quarterly financial and technical reports in order to provide better oversight of project performance.**

2.8.2 HPF SOC

An SOC has been constituted in five of the six HPF project states (all except Unity) with the TOR⁶⁴ being to review proposals relevant to each state, considering any risks associated with the

⁶³ A preparatory meeting, before the formal constitution of the SC was held in December 2012 before a first formal meeting of the SC in February 2013.

⁶⁴ TOR dated 11 March 2013

proposals, and to provide oversight for state HPF activities through the review of quarterly reports that summarise allocations, expenditure, outputs and outcomes, as well as results against agreed performance indicators.

Each SOC is chaired by the director general of each SMOH with two further members from the SMOH and a member from each of three state ministries (Local Governance, Finance and Economic Planning, Labour and Public Services), with DFID, as co-chair of the SC, and other HPF donor partners also allowed to attend. The state NGO health coordinator serves as an observer of the SOC.

It was anticipated that each state, except Unity, would hold two SOC meetings during 2014 and this is likely to be achieved. The target for 2015 is three SOC meetings in the year.

The SOCs were actively involved in the consideration of proposals submitted by NGOs to support the county-level services. The development and use of formal criteria for adjudicating competing proposals involving SOC members would have contributed to strengthening GRSS procedures and given each state ownership of the decisions made. It is understood that SOCs were not involved in the adjudication of bids to support some hospital services, a factor that may have reduced SMOH acceptance of such decisions.

SOC members were also involved in the annual review of IP performance in mid-2014.

Based on the minutes of a number of SOC meetings reviewed, it would appear that the membership of SOC varies from state to state with fluctuating membership, in some instances, making it difficult to act as well as had been hoped. However, there was evidence of individual SOCs reviewing the performance of the IPs in their state as well as providing a useful forum for discussions about problems of health service delivery in each state. There did not seem to be a consistent format for technical or financial reporting by IPs. No evidence of SOCs considering the financial aspects of IP performance was seen. **It is recommended that the monitoring role of this committee be encouraged through the sharing of standard format quarterly financial and technical reports with them.**

2.8.3 HPF donors' coordination

Relationships among the contributing donor partners (Australia, Canada, Sweden, the European Union and UK) to the project are governed by bilateral agreements between each donor and the UK. These agreements⁶⁵ stipulate that the donor partners will meet annually at an annual donor meeting, that a representative of the donors is a member of the SC, and that regular meetings and correspondence will take place between the donors to ensure that discussions with GRSS on the HPF reflect common positions agreed between the donors.

It is understood that the donors resident⁶⁶ in South Sudan try to meet prior to any SC meeting. As indicated above, there have been frequent SC meetings. However, there was a five-month period during 2014 when, as a result of the conflict, the engagement of donors, particularly DFID, with the government remained limited. No HPF donor meetings were held during this period. In addition, some SC meetings are held at short notice, making a preparatory donor meeting in advance of the SC difficult to arrange.

⁶⁵ Only the agreement between the Canadian International Development Agency and DFID was viewed. It is assumed that the agreements between UK and the other donor partners are similar.

⁶⁶ The Kenya-based Australian Aid office is responsible for the Australian South Sudan programme.

No minutes of any annual donor meeting or other donor meetings were seen for the review. However, in discussions with some of the donor partners, a number of points were raised:

- Donors expressed gratitude for the lead role played by DFID in the management of the HPF.
- There was some concern that the HPF was straying into new areas without proper consultation with the partners. The preliminary SC discussions about HPF involvement in health training institutions were cited as an example of this.
- There was concern that the HPF needed to address issues of service quality, social and gender inclusion, conflict sensitivity, etc. within existing contracts before expanding its remit to new areas.
- Some donors indicated that they were not aware of some of the documented outputs of the project and they would welcome input into draft reports. For example, the first annual report of HPF was finalised prior to circulation to the donor partners.
- There was some concern about the lack of technical capacity in the area of sexual and reproductive health within the HPF.

The MTR review team was made aware of a number of other issues that are likely to affect the overall HPF:

- It is understood that Australia will not be making their final contribution to the HPF.
- Canada is seeking to have greater visibility of its contribution to the HPF.
- Sweden would like to see the inclusion of nutrition in the HPF.

There is some limited dissatisfaction amongst donor partners about their involvement in developing the strategic direction of the HPF. While, as a result of the conflict, there was a long period when donor discussions were limited, periodic meetings have been held and, it is understood, key documents circulated, DFID may need to make greater efforts to ensure common ground is maintained amongst the donor partners over the direction of the HPF.

If, as recommended above, SC meetings are held quarterly around the production of quarterly and annual financial and technical reports, the donors should meet formally in advance of the SC meetings to review progress and agree common positions prior to the SC meeting.

2.8.4 HPF SAB

The SAB is made up of representatives of each of the partner organisations that constitute the consortium, led by the Crown Agents, which has been contracted by DFID to manage the HPF project. Each of the partner organisations is responsible for providing a strategic overview of the project and providing technical inputs, where agreed, in these respective areas. The consortium partners are:

Partner	Area of technical oversight
Crown Agents	Lead partner contracted to DFID for HPF
Charlie Goldsmith Associates	PFM
Health Partners International	HSS
Montrose	M&E
SKILLS for South Sudan	Community engagement and local employee contracting

The TOR of the SAB are to:

- support the formulation of strategic programme objectives for each year of the project;
- provide support to the annual work planning process;

- undertake periodic reviews of project objectives and targets; and
- ensure consistent external representation of HPF by all consortium partners.

In practice the consortium partners have provided technical inputs to the project in a variety of ways:

- A number of the HPF senior management team are formally contracted by consortium partners to work on the project (e.g. Montrose employs the M&E manager, Health Partners International employs the HSS manager), while these employees are directly answerable for their activities to line managers within the HPF.
- Paid for by the project, some partners provide regular back stopping for their in-country staff (e.g. the M&E manager receives distant support and periodic support visits from an experienced external M&E professional).
- Partner companies have also provided support to undertake studies such as the HSS assessment that was supported by senior consultants from Health Partners International in September 2013.
- Partner companies are using their extensive networks to assist in the recruitment of consultants for the Strategic Health Systems Strengthening Initiative, providing a wider pool of potential consultants than could be expected from any single company.

The recent management update (see 2.8.5) agreed between Crown Agents and DFID indicates that the advisory board will have monthly telephone conference call updates led by the Crown Agents project director and quarterly meetings (ideally in Juba) to involve HPF staff in country.

No minutes of any SAB meetings were seen, for either the telephone or the face-to-face meetings. A number of points were raised in discussions with the consortium partner representatives concerning the functioning of the board:

- There was concern that the board had not functioned as intended, with decisions made in meetings not carried forward and inadequate information being shared by the consortium lead with its partners.
- Board members had provided support for the development of plans in the annual work planning process but the plans had not been, or only partially, implemented. The link between plans prepared and fund availability seemed to be weak. This was particularly the case for the first year of project activities. As an example of this, the responsible consortium partner, SKILLS for South Sudan, had, with the HPF, prepared plans for community engagement activities for the first year of activities but no elements of this had been included in the year's work programme.
- The plans for year two of the project seem to have taken note of the advisory board's concerns to move forward more actively in the areas of HSS and community engagement. However, significant implementation has yet to start, well into the project year. Considering that these plans include the provision of significant numbers of TA to be embedded at national- and state-level MOH, the time remaining for the project is likely to limit the impact that such TA can make.
- Consortium partners did not seem to be aware that Crown Agents had been requested to prepare a performance improvement plan/management update (see next section).

The management update defines a formal schedule of meetings and consultations for consortium partners that, if adhered to, should improve communications between the partners. **The consortium partners should, at their next face-to-face meeting review the implementation of these arrangements and, if necessary, agree further adjustments to their respective roles in HPF strategic oversight.**

The consortium arrangement used in the HPF has the potential to provide senior strategic advice to the programme design for the benefit of the project. The four consortium partners all appear to have strong track records⁶⁷ in the areas of responsibility allocated to them, with experience either in South Sudan or in other countries with challenging environments. It also has the potential to source a wide range of suitable consultants for long- and short-term roles in the project. This has worked well in some areas, notably M&E, but for the reasons highlighted above the full potential of the consortium has not been realised. **It is suggested that greater transparency and clarity be brought to the functioning of the SAB in order to maximise the potential for partner inputs.**

2.8.5 Programme management: HPF in South Sudan and Crown Agents

The first annual review of the HPF, in October 2013, indicated that the principal implementer, Crown Agents, needed to consider rationalising programme management roles to improve efficiency and ensure effective government leadership in programme delivery. The review recommended that major HPF programme management decision making be shifted more from the UK headquarters to the in-country HPF leadership. It is clear that problems in this area continued as, in June 2014, concerns were formally raised by DFID about the quality of Crown Agents' UK programme management and the impact that this was having on the operations in-country. This letter was followed by a series of meetings in both UK and South Sudan between Crown Agents and DFID. In September 2014, Crown Agents prepared a management improvement update or performance improvement plan, and that was agreed with DFID.

The agreed plan details a number of changes that, it was anticipated, would address DFID's concerns. These were:

Project director with Crown Agents, UK: A senior manager (Jonathan Borsley) was to assume day to day management responsibility, as project director, for the HPF.

Communications: Enhanced communications were found to be one of the key elements for improving HPF management and the plan defined a series of regular, mainly telephonic, communications that would be instituted between the project director and the in-country team leader or his deputy but also between the project and DFID and with Crown Agent's consortium partners.

Roles and responsibilities: The respective roles and responsibilities of Crown Agents headquarters (HQ) and HPF senior management had been first defined in 2013. These were reviewed and updated, reaffirming the role of the team leader. In addition the plan:

- reinforced the in-country team management hierarchy to ensure that team members know that their reporting lines are to their in-country superior;
- confirmed that the development of the annual work plan will be led by the team leader (or his or her designate); and that,
- approval of TOR for new roles, including short-term TA, will be given by the team leader (or his or her designate).

Other measures agreed included increasing the number of signatories within Crown Agents HQ able to sign off on contracts, and thus avoid delays caused by the unavailability of key signatories; increasing the capacity of the finance function within Crown Agents to prevent future delays in this

⁶⁷ Based on information on their organisational web sites and discussions with their representatives on the SAB.

area; and agreeing a number of key performance indicators⁶⁸ by which future performance might be addressed.

Crown Agents internal rules require that the issuance of contracts remain an HQ function, preventing the delegation of this role to HPF Juba, another request from DFID. However, it was anticipated that the proposal to increase the number of signatories able to sign off on contracts would, in future, help to reduce delays in contracting caused by this.

While it is too soon to assess whether this management update will have the desired effect in improving management performance, the various elements contained in the plan should result in such an improvement. **DFID will need to monitor the implementation of the management improvement plan.**

2.8.6 Programme management within HPF, South Sudan

The review team was not able to conduct a detailed review of the management arrangements within the HPF team in Juba but made a number of observations in connection with other aspects of the review.

Contract management capacity: The primary task of the HPF is to manage the contracts of its IPs with both technical and financial oversight of those contracts. The HPF BC anticipated contracts with IPs to support service delivery at county level in 39 counties and in 15 county hospitals. In addition TA support was anticipated for CHDs. Contracts are now in place for all these. New areas of activity are (or will shortly be), in addition, been undertaken by HPF, with contracts for an FP SP having been created, while contracts for support to state-level hospitals are being prepared.

The HPF is working in a very difficult environment, with significant support and supervision required for the many IPs. The resources required to monitor these contracts, both technically and financially, are limited and there is evidence (see 2.8.7) that the HPF is already not providing enough support to the IPs in some matters. The further expansion of contract numbers as well as the recruitment of significant new TA staff to be embedded in the national and state MOHs will stretch these supervisory resources more thinly.

Coordination between work streams: Through the supervision of service delivery contracts, the HPF has gained a detailed insight into the problems and issues of service delivery at county level. In parallel to this, the HSS work stream is working with the central MOH to support the development of guidelines, etc. for national health service delivery. It is not clear that lessons by the health service delivery stream within the HPF are always being transferred across to the HSS work stream. Examples of this are county planning workshops and the current HSS work on the development of supervisory visit guidelines, which both might benefit from the lessons learned through health service delivery.

It is understood that it has been the intention to hold internal HPF meetings to discuss such technical, rather than managerial, aspects of the HPF to enable lessons to be transferred across, but such meetings are infrequently held.

Community engagement work: The first annual project review noted a lack of progress in this area of work at a central level. The IPs have engaged with communities in their counties; however, there has been no central direction for this, resulting in the potential for widely divergent approaches in different states and counties. There is nobody within the HPF who is directly responsible for progressing this aspect of HPF activities and while one of the consortium partners, SKILLS for

⁶⁸ Not seen by review team

South Sudan, has an oversight role in this area of work, this has not been successful in ensuring this work stream advances.

Programme cycle management: There is evidence of the various elements of programme cycle management (situation analysis – strategic plan – funded action plan) being implemented but in a number of areas there appear to have been gaps in this process:

- The HPF has undertaken situation analyses in gender and social exclusion and conflict sensitivity and further developed strategies to manage these issues but there is no evidence that these have been further developed into implementable action plans, despite the importance of these issues.
- A detailed situation analysis was undertaken for HSS in September 2013. This highlighted numerous areas where HPF support could assist the MOH. However, no document has been seen that sets out the strategic direction for HSS work by the HPF, although the project has prepared and implemented plans to support work in a number of these areas.
- A detailed situation analysis was undertaken for community engagement in July 2014, with strategic and operational plans prepared. However, the status of this document is not clear and it has not been shared with donors or the MOH or been considered by the SC. It is understood however that work by the project on central- and state-level support for community engagement is about to begin, but no strategic or action plan to guide these inputs was seen.

Additional TA: It is understood that a considerable increase in TA is anticipated in the near future, with new staff to be embedded in both the central and state MOH. The review team was unclear about the anticipated arrangements for managing, both administratively and technically, this TA. This particularly applies at state level, where the state HPF teams are anticipated to be expanded from one state coordinator to a team that includes TA in monitoring and evaluation, supply chain management, community empowerment, post partum haemorrhage and PFM (HRIS/SSEPS)⁶⁹.

The capacity of the HPF team in Juba seems already to be stretched to provide adequate technical and administrative support to its existing contracts. The anticipated expansion of contracts and technical TA to be embedded within the MOH is likely to stretch this further. **It is recommended that the HPF urgently conduct an organisational review to assess existing and anticipated workloads to ensure that it has the capacity to properly manage its workload and enable cross-organisational learning. Further strengthening may be required to address the weaknesses observed by this review.**

The MTR is particularly concerned about the apparent lack definition for the management of the considerable amount of TA that is under recruitment to implement the Strategic Health Systems Strengthening Initiative. Other than the job descriptions, no description was seen of how these new staff, at both central and state MOH levels, will fit into the existing HPF organisational structure, what their targets will be, and how they will be managed and their activities funded. **It is recommended that detailed management plans be quickly prepared and considered by the SC to demonstrate how these staff will operate and what their objectives will be.**

2.8.7 Fund management and PFM

Quality of financial management: There are three layers of financial management in the programme, excluding financial oversight from DFID, GRSS and external auditors. These are:

⁶⁹ Presentation to HPF Steering Committee No. 8 of 31 July 2014.

- Crown Agents in the UK, which approves financial management policies, has overall budgetary authority and is responsible for the management of the main account at Crown Agents Bank;
- the Finance Director in Juba. who is responsible for the review and verification of all IP submissions, as well as implementation of approved programme accounting policies at Juba HQ and amongst IPs; and
- the IPs themselves, which manage finances at county level, usually with oversight from their HQs in Juba. The comments here are for the most part restricted to systems operating in South Sudan.

Analysis of budgets and spending in the HPF: Budgets and spending in the HPF as reported in the financial statements to 30 June 2014 are as follows:

Table 6: HPF budget and spending (in £'000)

	committed budget	% of committed budget	funds disbursed to 30/6	% of funds disbursed	% spent to 30/6	balance unspent
Bridging contracts	11,750.4	11.0	9,521.1	40.8	81.0	2,229.3
County Contracts RFP 1	31,032.5	28.9	5,673.5	24.4	18.3	25,359.0
County Contracts RFP 2	25,976.9	24.3	3,231.5	13.9	12.4	22,745.4
Sub-total active contracts	68,759.8	64.2	18,426.1	79.1	26.8	50,333.7
CEMonc Hospitals	10,296.6	9.6	-	-	-	10,296.6
Faith based hospitals	2,844.8	2.7	-	-	-	2,844.8
External data verification	1,500.0	1.4	-	-	-	1,500.0
Support - Strategic Health Syst	8,000.0	7.5	-	-	-	8,000.0
Support - State Supervision	1,280.0	1.2	-	-	-	1,280.0
Support - Family Planning	2,000.0	1.9	-	-	-	2,000.0
Sub-total direct costs	94,681.2	88.5	18,426.1	79.1	19.5	76,255.1
Inception fees & expenses	1,903.7	1.8	1,690.0	7.3	88.8	213.7
Implementation expenses	10,363.5	9.7	3,156.5	13.6	30.5	7,207.0
TOTAL	106,948.4	100.0	23,272.6	100.0	21.8	83,675.8

Source: unaudited financial statements to 30 June 2014

The three active budget lines under direct costs (bridging contracts, along with county contracts under RFP1 and 2) make up 79% of funds disbursed and a total of £18.4 million. In an evaluation such as this they warrant further examination, and further detail is given in Table 7 below, which reproduces another table from the financial statements for the year ended 30 June 2014.

The two tables are not easily reconciled. In Table 6 contracts committed total £68.8 million but in Table 7 only £57 million. Spending in the first table against active contracts is £18.4 million but in the second only £13.8 million. The financial statements do not explain the reasons for these differences. It may be that the second table excludes bridging contracts or the inception phase but it is not clear, and before these statements are audited the two sets of figures will need to be fully reconciled. It is understood that certain figures are prepared in Juba from Excel spreadsheets and others in UK from payment data. Whatever the reason, at present the financial statements do not inspire confidence, and an audit is urgently required. This matter is discussed further below.

Table 7 shows contract values in the first column, and the year 1 budgets derived from these contracts in the second column. The third column shows year 1 budget figures as a percentage of the total, such that direct costs can be seen to be 67.7% of the budget. The fourth column shows year 1 spending, and the column immediately following shows the composition of spending in

percentage terms. The 'burn rate' is the rate of execution of the budget expressed as a percentage.

Table 7: IP budgets and spending in the HPF (£'000)

	Contract value	%	Year 1 budget	% of Year 1 budget	Year 1 spending	% of spending	Burn rate	Year 1 budget balance
CHD Support -personnel	20,695.1	36.3	6,888.7	34.2	5,370.4	38.8	78.0	1,518.3
CHD Support - Others	6,580.6	11.5	2,433.9	12.1	1,579.2	11.4	64.9	854.7
Service delivery - drugs	2,658.8	4.7	901.9	4.5	452.1	3.3	50.1	449.8
Service delivery - others	959.1	1.7	348.0	1.7	197.3	1.4	56.7	150.7
HSS - Rehabilitation	1,834.3	3.2	707.2	3.5	132.5	1.0	18.7	574.7
HSS - Training	2,192.9	3.8	655.6	3.3	280.9	2.0	42.8	374.7
HSS - Other	1,623.3	2.8	674.5	3.4	197.2	1.4	29.2	477.3
Community participation	1,881.9	3.3	630.4	3.1	185.7	1.3	29.5	444.7
M & E	901.4	1.6	329.4	1.6	118.0	0.9	35.8	211.4
NGO Health Coordinators	56.4	0.1	57.4	0.3	44.0	0.3	76.7	13.4
<i>Sub-total Direct Costs</i>	<i>39,383.8</i>	<i>69.1</i>	<i>13,627.0</i>	<i>67.7</i>	<i>8,557.3</i>	<i>61.8</i>	<i>62.8</i>	<i>5,069.7</i>
SP Support	13,902.2	24.4	5,187.7	25.8	4,381.1	31.7	84.5	806.6
Overhead 7%	3,704.0	6.5	1,303.9	6.5	893.5	6.5	68.5	410.4
Total	56,990.0	100.0	20,118.6	100.0	13,831.9	100.0	68.8	6,286.7

Source: unaudited financial statements to 30 June 2014

Disregarding for the time being the inconsistencies between this table and the previous one, and working with what we have, several things invite comment. First, the analysis of IP spending indicates that, in accordance with the expectations of the original BC, the largest spending category has been salaries of health workers – 38.8% of the total. Other support to the CHDs represented 11.4% of the total. 'SP Support'⁷⁰ was budgeted to be 25.8% of the total but has turned out to be 31.7%. This necessary line item covers support to the IPs themselves for expenses usually incurred at their Juba HQs. It includes variously a proportion of certain IP HQ salaries deemed to relate to the programme; travel costs in overseeing the programme; and such other costs as are agreed with HPF in contract negotiation. Taken together with an automatic 7% of costs to cover other overheads, these IP overhead categories make up 38.2% of all spending. These three major spending areas of CHD salaries, other CHD support and IP support/overhead, represent 88.4% (38.8+11.4+38.2) of the total spending of IPs and 70% of total HPF spending. Contrary to BC expectations, pharmaceuticals are not a major cost driver, at only 3% of the total IP spend.

The CHD Support-personnel (salary) figure is as expected. If IPs had been able to find more qualified staff, more quickly, it might have been higher. There remains a question concerning the effectiveness of salary spending, and the commentary on HR elsewhere addresses this (Section 2.5.4).

'CHD Support – Other' comprises a number of inputs ranging from vehicles and clinical equipment to training and fuel. No analysis of this figure is currently available at the HPF. Non-salary CHD support is an important area of programme expenditure, representing 12% of spending in year 1. **It is recommended that a full analysis of the type of support provided be produced, updated monthly, and reviewed by management. The capital cost element should be reconciled to asset registers.**

⁷⁰ Service Provider (abbreviated to SP) and Implementing Partner (abbreviated to IP) are used interchangeably in HPF to refer to the NGOs that support the programme in different capacities.

The overhead items warrant further discussion. SP support costs represented a higher percentage of spending than expected because direct costs were underspent, whereas the SP support costs are relatively fixed – such as 10% of a particular IP salary. It can therefore be expected that if spending catches up, the cumulative percentage for SP support will return to the percentage anticipated in the budget. It should be monitored carefully. Although no benchmarks are available, existing levels of 38% (including the automatic percentage addition) seem excessive, even in the difficult circumstances prevailing in South Sudan. Moreover, they generate no incentive to the IP. They represent a large amount of money (they can be up to £500,000 for each IP over the period of a contract), which is paid without regard to performance or results. The percentage addition for overheads is limited to a maximum of 7% and is determined by the budget attached to the contract. It is calculated as a percentage of the direct costs **plus** SP support.

Almost all contracts have now been finalised for the current phase of the HPF. **It is recommended that any future phases of the project rethink the way in which SP overheads are reimbursed.** This might be more of a percentage on direct costs, and might also include performance elements directly, even if these are initially focused on compliance.

Forecasting in the programme: A key concern for the evaluation is whether the programme will be able to achieve its goals within the budgetary envelope provided. The flexibility of the fund, as well as the unpredictable environment in which HPF operates, require that forecasting is carried out on a regular basis.

In Juba HQ, HPF forecasts are only prepared for the coming three months, and are derived by consolidating forecasts from each IP. The latest estimate of future costs for the project as a whole was carried out by DFID in June 2014 and indicates a full spend of the currently committed £107.2 million. However, as indicated at Table 6 above, to 30 June 2014 only £23.3 million had been spent from a budget of £106.9 million, representing only 21.8% after 21 months (the programme's halfway point)⁷¹. Slow spending on county contracts (RFP1 spend is only £5.7 million from £31 million; RFP2 is £2.6 million from £26 million) and county hospital contracts only now starting suggest that further reallocations may be necessary as a result of this underspending. IPs frequently report on the difficulties they have in recruiting staff, and this contributes to the underspend from both the salaries unspent and the activities foregone as result of vacant positions or delayed appointments.

Underspending, particularly by smaller or indigenous IPs, may be aggravated by the requirement for IPs to pre-finance all costs. However, this was not widely reported to be an issue. Most IPs reported the conflict that erupted in December 2013 was a factor in underspending – this was just five months after the contracting of RFP1 IPs and only one month after the contracting of RFP2 IPs.

On the other hand, a closer examination of spending under RFPs 1 and 2 provides some comfort. Table 8 below includes recent data that show that spending is indeed occurring at an increasing rate.

⁷¹ The financial statements for the quarter to 30 September 2014 have been made available to the team, and show that a further £6.7 million was spent, raising the total to £30 million for the 24-month period or 28% of budget. However, the figures presented in the text are for the period to 30 June 2014, which is the mid-point and the financial year-end. There is also more analysis than in the quarterly financial statements.

Table 8: Spending by quarter for RFP1 and RFP2 IPs (£'000)

	Q/E 9/13	Q/E 12/13	Q/E 3/14	Q/E 6/14	Total to 30 Jun. 2014	Q/E 9/14	Total to 30 Sep. 2014
RFP1	166.8	1,536.2	1,679.3	2,291.2	5,673.5	2,638.9	8,312.4
RFP2			616.1	2,615.4	3,231.5	2,790.3	6,021.8
	166.8	1,536.2	2,295.4	4,906.6	8,905.0	5,429.2	14,334.2

Source: unaudited financial statements to 30 June 2014, supplemented by the quarterly financial report to 30 September 2014

Table 8 shows that, for RFP1 and RFP2 taken together, there has been a fairly rapid escalation of spending. With the coming on stream of hospital and FP contracts, this escalation should continue, and perhaps accelerate. The quarterly financial report to 30 September 2014 shows total programme spending (excluding management expenses) of £6.1 million and projected programme spending (excluding management expenses) of £10.5 million in the quarter to 31 December.

The understandably strong focus on burn rates must not come at the expense of quality. The danger will be that in escalating expenditure to ensure completion of activities within programme time limits, value, quality and economy might all be sacrificed. To ensure continuing value, quality and economy as spending rates intensify, **it is recommended that the HPF team intensify their scrutiny of expenditures to ensure that all are productive and economical, with clear links to performance.**

Financial reporting from IPs to Juba HQ is done in Excel, based upon Excel submissions (invoices) from IPs. These submissions classify expenditures according to the categories indicated above, and provide lists of the individual transactions making up each category total. These submissions are reviewed for reasonableness and verified where prior approval for spending has been obtained. No dedicated accounting software is used. Although the finance staff seemed to be accomplished Excel users and the spreadsheets examined are professionally created, Excel remains a problematic accounting tool with inadequate internal controls. In particular:

- there is no control or oversight of entries (an entry in a dedicated accounting system will normally be held in a cache until approved and then 'posted' irreversibly to the system);
- Excel has no facility to allow a hierarchy of users with different authorities;
- there is no audit trail and it is possible to delete items without a record of deletion (cf. a reversal of an accounting entry in accounting systems); and
- Excel has none of the checks and balances of a double entry system that links back to the **verifiable** stock variables of accounting (assets and liabilities).

In addition Excel does not have the analytical and report generating power of a dedicated accounting system. An accounting system would still require Excel inputs from IPs, and data would need to be imported into the accounting system in Juba or elsewhere from a predesigned template. However, it would enable the HPF to attach several analysis fields (county, employee, vehicle, facility, IP) to selected codes, allowing detailed analysis of payroll and training by employee, cadre and facility; of fuel and other vehicle expenditures by vehicle; of SP support by type; and of many expenses by facility. Furthermore it could keep track of spending on capital assets to link to an asset register, as well as total expenditure types across counties and contracts, and facilitate full accrual accounting. In short, an accounting system would require a data entry finance officer, but would provide much stronger internal control and greater capacity for the development of analytical

reports. It is likely that it would save much of the time spent in manipulation of Excel data to generate the current set of reports.

Excel summaries are forwarded to Crown Agents in the UK where payments are made. The UK accounting system has not been examined by the review team.

This programme in excess of £100 million is too large and complex to be managed under Excel alone and it requires a greater investment in accounting systems and controls. Although **it is late in the programme to introduce an accounting system, it is recommended that the possibility of doing so be explored urgently**. The present arrangement represents a significant fiduciary risk.

Financial statements to 30 June 2014 have been prepared. They provide an overview and are accompanied by a narrative, but there are several difficulties. First, these are the first formal financial statements produced since October 2012, covering a 21-month period, and that is much too late. It would have been appropriate to produce comprehensive financial statements (and had them audited) at 30 June 2013, at a minimum. Second, there are unreconciled differences in the financial statements that have been referred to above. Third, the financial statements are not accrual based and do not include a balance sheet recording the assets and liabilities of the programme. Fourth, they have not been audited and there are no plans for an audit. And fifth, they include no statement of the accounting policies adopted.

It is recommended that the programme produce accurate and internally consistent, accrual-based financial statements on a quarterly basis and disclose accounting policies in use. These statements should include analysis and comment on key spending areas.

HPF quarterly financial reports are very limited. They include only spending against budget in summary with no analysis. They would be much improved if they included tables showing expenditure by type, such as the table from the annual financial statements that is summarised in Table 7 above, sub-analysis of spending in key areas such as CHD support and capital spending, and analysis of trends, as well as if they processed information on which county invoices were outstanding with an estimate of the likely liability. The information should also be summarised in one or two paragraphs in the main quarterly report. **It is recommended that the HPF strengthen its quarterly financial reports.**

Audit and verification activity: The due diligence process described under fiduciary risk is a critical underpinning of the eventual audit process. The requirement for IPs to undergo an assessment of their financial management and procurement policies provides a valuable assurance.

As well as assessing the IPs themselves, HPF staff report that the programme carries out further ex ante procedures on key expenditures in requiring no objection for expenditures over SSP 3,500, vehicles and major equipment, although this was not directly verified. The recent KPMG audit found no system weaknesses in procurement.

The HPF procedures outline a process of RBA under which the documentation from IPs is to be retained and reviewed during periodic (quarterly) monitoring visits. This is effectively an internal audit process. This documentation is mostly held at IP HQs, mostly in Juba. However, the critical quarterly review of documentation required under the RBA is not being carried out, leaving open a significant area of fiduciary risk. This was confirmed to the team by the Finance Director and is consistent with the findings of the KPMG audit (KPMG, 2014, South Sudan: Audit of Health Pooled Fund (HPF) Fund Manager pp12-13).

It is recommended that the RBA documentary verification urgently be commenced, with sampling back to contract commencement; an RBA plan be developed through to programme completion; and this activity be incorporated into the relevant job descriptions. It is understood that staff capacity is the cause of this omission. The programme should consider the establishment of an internal audit function.

Individual IPs are required to submit their audited financial statement to the HPF, but as yet this has been partial, with only six annual audit reports having been received to date under RFPs 1 and 2. The IPs have only been requested to submit a report for the HPF spending. However, this is not sufficient. They should submit audited financial statements *for their organisation as a whole*, which clearly indicate amounts received and spent on their HPF activities for each contract. These audited financial statements should be carefully reviewed and compared with the HPF's own records, and discrepancies followed up.

IP audits should be obtained for all IPs as a matter of some urgency; they should be for the organisation as a whole, with HPF income and expenditure clearly identified. This supports the FMA process and also prevents IPs from reporting the same expenditures in two different projects. The programme should carry out an annual procurement audit of all IP procurement within South Sudan.

There has been no external audit of financial statements since project inception in October 2012 despite this being a requirement of the HPF TOR. The absence of audited financial statements, coupled with the absence of IP audits and the lack of RBAs, creates a serious fiduciary risk. It is understood that DFID will now arrange this directly.

It is recommended that HPF financial statements be drawn up for the years ended 30 June 2013 and 2014 and they should be audited without delay.

The evaluation was unable to examine procurement in detail, and a recent systems audit gave procurement within HPF itself a clean bill of health. However, the asset register provided to the team indicated that prices paid for motor vehicle and other acquisitions varied widely from one IP to another. **This should be investigated, and possibilities for procurement efficiencies explored.**

A systems audit was carried out in October 2014 and has identified 8 areas of high risk and 12 areas of medium risk. The areas of high risk identified are:

1. There is an inadequate budget setting process, with budget lines seriously over and underspent; budget lines that could have been foreseen introduced mid-programme; no evidence of regular budgetary review; and absence of a costed work plan.
2. Programme financial reports are prepared on a cash (not accruals) basis, and there is no way to know what expenses are accrued; financial reports lack sufficient analysis; and financial information is reported not sufficiently challenged.
3. The current organisational structure is not clearly articulated: review is required to ensure effective oversight.
4. The process of review of monthly IP reporting is informal and not evidenced, leaving Crown Agents (CA) vulnerable (and managers cannot verify that the process was thoroughly carried out). The review process should be formalised.
5. CA responds late to IPs. Additional resources are to be introduced if required to ensure prompt response.
6. Financial assessments of IPs are not being carried out in accordance with procedures.
7. External audits of IPs are not being submitted.
8. The system for assessing staff needs is weak and requires review.

Many of the points raised reinforce the issues raised in this MTR. **The recommendations of the auditors require immediate attention.** However, this review raises additional risk areas including the absence of audited financial statements and the unclear policy on asset management.

Asset monitoring and control: There is no section on asset management in the HPF procedures manual and it was not addressed by the recent systems audit. Contracts contain some provisions but a clear policy statement is needed.

Asset registers for both Juba HPF HQ and assets purchased by IPs are maintained by the HPF. The latter was not complete, but was being updated during the review. Each quarter NGOs are required to provide a list of assets acquired, but no guidance on this has been seen.

It is understood that procurement of vehicles requires preauthorisation, and all vehicles are required to have an NGO number plate. It is not clear what happens to assets purchased for the county level. Contracts state that assets are the property of the project until the project ends. Some IPs report vehicles are registered in their names, or in the name of the CHD, in the absence of guidelines.

There is no information on whether IPs have insured the assets and policy is silent on the issue.

An HPF branding policy is in force and is evident at Juba HQ. IPs have been told to do the same at county level and have been provided with the necessary budgets to do this.

It is recommended that HPF produce a comprehensive policy on asset management for IPs, to be incorporated into wider financial management guidelines for IPs.

Financial management guidelines for IPs: The HPF procedures are written for the HPF in Juba, but do not contain guidance for IPs. There is some guidance for IPs in contracts, but many of the issues raised here should be included in financial management guidelines for IPs. These guidelines should include, amongst other issues, clear and explicit guidance on asset management, financial reporting, procurement and 'no objection' procedures, retention of documentation, and the requirement to carry out and submit audits. **It is recommended that the HPF produce financial management guidelines for IPs.**

Financial management action plan: In view of the many risks and weaknesses identified in financial management of the HPF, both in this MTR and in the recent systems audit, **it is recommended that the HPF develop and closely monitor an HPF financial management action plan.**

2.9 Risk management

Annex B3 presents the programme risks identified in the BC, with a current assessment carried out during this review. A number of the identified risks are discussed further in this section.

2.9.1 Security risk management

The BC identified 'increasing insecurity resulting from conflict in South Sudan prevents access to programme areas' as having a high probability of occurring. In the event of it happening, the BC estimated a medium impact on project performance. As to be expected, the HPF considered seriously the issue of security and the inception report indicated that security protocols had been drafted for each of the six project states and Juba and that security training would be conducted for

all personnel. The logistics officer was to be responsible for coordinating security updates. A risk assessment review was to be undertaken every six months.

The conflict that started in December 2013 resulted in the evacuation of HPF staff and the curtailment of project activities. The situation had eased enough by mid-February to enable HPF staff to return to South Sudan. However, the situation was by no means normal, resulting in the project preparing interim strategies for operating in Juba and the five states that had returned to relative normality and, separately, for Unity State, where fighting continued.

Acceptance of the interim strategy, prepared with the assistance of security consultants, permitted the HPF to resume operations in Juba and the five states, subject to the implementation of appropriate security measures, which were defined. The project's IPs, who had had to include details of their security procedures as part of the contracting process, were supported to review these procedures and greater flexibility was given to them to both strengthen their security and to respond to the humanitarian consequences of the conflict. The conflict had resulted in large numbers of IDPs, who required humanitarian assistance, moving from the areas of greater conflict to the lesser affected counties and states and into the catchment areas of some HPF-supported health facilities.

The HPF priority during this period was to support the various IPs working in the affected counties to re-establish, or continue providing, services wherever possible, commensurate with ensuring the safety of staff. The priorities were ensuring medical supplies for the affected counties; ensuring salaries for health workers; providing support for county hospitals to provide, particularly, maternal and child health care services; and supplying health service support in coordination with the humanitarian effort provided by other agencies.

Following the return of project staff to Juba, a security plan was written and HPF technical staff participated in security training, all vehicles were equipped with very high frequency (VHF) radios and security procedures were established (for example, protocols for regular contact with the HPF office by staff travelling outside Juba). The HPF ensures regular contact with the IPs, seeking updated security information and providing support where necessary.

The HPF response to the December 2013 armed conflict seems to have been relevant, adequate and effective. Following the necessary evacuation of staff, a temporary office was established in Kampala, Uganda and contact maintained with IPs who had decided to remain in South Sudan. Upon being permitted to return to Juba, the HPF moved quickly to assist IPs to reinstate services where they had temporarily ceased and to provide alternative approaches to service provision in counties where provision continued to be disrupted. Despite the reduced services over the emergency period (which has continued in Unity State), there was no overall reduction in health service utilisation over the year, with indicators for utilisation in Output 1 likely to exceed the 2014 milestones.

The HPF will need to maintain its current level of security vigilance while the current level of conflict is continuing. The HPF will also need to continue to provide flexible support to the IPs, enabling them wherever possible to continue supporting service delivery and, in the worst-affected counties, supporting relief agencies in those areas.

Any deterioration in the security situation, with an upsurge of violence, either locally or more widely throughout the country, will require the HPF to review its operations. Its response will be dependent on the actual and anticipated levels of violence.

Any lessening of the conflict in South Sudan will of course be welcomed and the HPF will need to respond flexibly to any change in the situation, with conflict-sensitive support

provided to reinforce any peace agreements. Even in circumstances where overall conflict is lessened in South Sudan, it is likely that the HPF will need to continue to maintain a high level of security awareness to ensure the safety of its own staff and those employed by IPs.

2.9.2 Conflict sensitivity

The BC identified 'programme is insensitive to conflict' as having a high probability of occurring. In the event of it happening, the BC assessed a medium impact on project performance.

The project developed a conflict sensitivity strategy paper in April 2013. This included implementation plans for conflict sensitivity training and consultations with communities by IPs and CHDs. The paper indicated that work plan elements to enhance conflict sensitivity were included in the HPF work plan.

Conflict sensitivity was addressed in the inception report, which recognised the need to mainstream conflict-sensitive approaches to development in South Sudan. As such, planning for the conflict sensitivity of the HPF programme, particularly through SPs, was of significant and cross-cutting importance during the inception phase. Conflict sensitivity was to be viewed by the HPF as one intertwined with issues of gender, social inclusion, and ultimately the responsiveness of health provision at the sub-national level, with conflict sensitivity training anticipated for both IP and HPF field staff. The effect of this training was to be measured by pre- and post-intervention assessments.

Following the December 2013 violence, the HPF Interim Strategic / Operational Plan of January 2014 emphasised that all activities should be undertaken in a conflict-sensitive way. The HPF interim M&E strategy of March 2014 indicated that the project would place a greater emphasis on conflict sensitivity and that a 'conflict-sensitive strategy' would guide the work of HPF.

An outline conflict sensitivity strategy was presented and discussed at the annual project review meeting in September 2014 and the 2014–2015 work plan includes updating and redesigning of the conflict-sensitive strategy in October / November 2014. Although this has been delayed, it is anticipated to take place in the near future.

No reference to any conflict sensitivity training or the outcome of conflict sensitivity assessments at community level was found in any of the HPF reports, inception, quarterly or annual. Thus it seems that there has been little or no implementation of the formal conflict sensitivity strategy and plan developed in April 2013. It is recognised that the HPF IPs all have long experience of working in South Sudan and should already be operating in a conflict-sensitive way.

The anticipated review and updating of the 2013 HPF conflict sensitivity strategy, scheduled to take place in the near future, provides the opportunity to reinvigorate this important aspect of the programme. **The HPF should ensure that the planned review takes place in the near future, with the final document providing an implementable plan for enhancing conflict sensitivity within the HPF and its IPs. Any agreed plan for implementing an updated HPF conflict sensitivity strategy should be implemented as a matter of urgency.**

2.9.3 Fiduciary risk management

Fiduciary risk is the risk that money is spent for purposes for which it was not intended, is not correctly reported, or fails to achieve VFM. The programme has developed a risk management strategy (RMS) in accordance with the TOR and it incorporates a substantive section on fiduciary risk. The RMS was updated in July 2014.

In particular the fiduciary risk strategy outlines:

- a due diligence approach in selecting IPs (described below);
- an ongoing risk management and contract monitoring process including scrutiny of submissions from IPs; and
- procedures for managing fiduciary risk when working through GRSS systems.

The strategy depends primarily on the first of these, a thorough due diligence process on IPs, which incorporates:

- an initial assessment reviewing technical capacity, financial standing and ethical policies;
- a procurement assessment; and
- an FMA that reviews the financial arrangements of the applicant for management of HPF funds.

The RMS does not incorporate a Fiduciary Risk Management Action Plan (as envisaged in the TOR) that could be monitorable under the Annual Statement of Progress, and one could usefully be developed. Suggestions for inclusion are proposed at the end of this section.

The RMS considers at length the fiduciary risks associated with use of government systems. However, this is now not expected to be a feature of this phase of the programme.

The RMS makes the valid point that payment of IPs in arrears reduces fiduciary risk in the programme.

In spite of its strengths in considering fiduciary risk of IPs and GRSS, the RMS does not consider fully the ongoing risks of the programme itself where routine tasks are not carried out in a timely manner within the HPF, including at HQs in Juba or Sutton; where errors occur at county level, perhaps as a result of insufficient guidance, and go undiscovered; or where CHDs or IPs may pursue parallel agendas in which misspending, poor recording or failure to achieve VFM goes undetected.

This means that fiduciary risk is undermined through many of the concerns indicated under quality of financial management above, including: the absence of audited financial statements; the lack of scrutiny of IP documentation under the RBA approach; several issues raised by the recent systems audit; the lateness of second-round FMAs for RFP1 IPs; the absence of a register of IP audits; and the absence of accruals-based accounting systems, which can lead to errors in reporting.

It is recommended that the HPF address the mitigation of fiduciary risks within a wider financial management action plan, as suggested elsewhere in this review (Section 2.8.7).

2.9.4 Procurement of drugs and medical supplies

The BC identified 'Low financial, procurement and distribution capacity contributes to unreliable and interrupted supplies of commodities such as drugs that are essential for service delivery' as having a high probability of occurring, with the potential for a medium impact on the project in the event of this happening.

Subsequent to the 2013 annual review, South Sudan has benefitted from the implementation of the EMF, a multi-donor initiative including DFID. This has used a kit system to push drugs and medical supplies to peripheral health units, significantly improving their availability in primary health facilities. Not all health facilities have been included in this distribution and so, at least in a number of counties, the kits are held in county medical stores and used to supply all facilities in the county using a pull system that requires facilities to order supplies from the county store based on actual

utilisation. Thus while there have been some shortages, the availability of drugs has been much better than a year ago. The HPF does not envisage a procurement of significant quantities of medical supplies but contracts with the IPs do allow their purchase to supplement those of the EMF where local shortages occur.

The EMF support is due to finish in mid-2015 and, it is understood, the MOH has commenced a procurement process for medical supplies, to be purchased using GRSS funds, to be available from mid-2015. No information was available as to the contents of this procurement and a number of concerns were expressed to the review team about this:

- The procurement was to be priced in South Sudanese pounds, which was likely to be considered risky by potential suppliers and thus result in higher prices, particularly with the high level of inflation currently affecting the country.
- A flare up of the internal conflict in the country may have the result of reducing oil exports and increasing government expenditure on the war effort, putting the MOH budget to procure supplies at risk.
- The procurement was for an estimated one quarter's requirements, hopefully confirming supplies until late 2015. However, no funds have been earmarked to provide supplies beyond this.

Medical supplies for service delivery seem to be assured until mid-2015. However, there is some uncertainty about supplies in the second half of 2015. If the MOH procurement is successful, supplies should be assured for at least a further three months, but beyond that, in late 2015 and into 2016, there is the potential for drug shortages.

It is recommended that the HPF monitor the national medicine procurement process that is underway and advise the IPs of the likely national drug supply situation so that, if necessary, the IPs can procure drugs and medical supplies in the event of an anticipated shortfall.

The HPF donor partners should also monitor the national drug procurement process and promote discussion as to how the country should obtain supplies beyond those hopefully being procured by the MOH for late 2015.

2.9.5 Health worker salaries

The BC identified 'Interruption of services due to unrest when salaries are changed from NGO rates to government pay scales' as having a medium probability of occurring, with the potential for a medium impact on the project in the event of this happening.

HPF contracts with the IPs have resulted in a uniform salary scale⁷² for PHC workers paid by the IP. This has resulted in the salaries offered by IPs no longer being a factor in the competition between the IPs for scarce health workers. However:

- NGOs providing relief services, funded from other sources, are not obliged to follow the uniform health worker salary scale and thus may offer higher salaries to encourage workers to join them.
- A uniform salary scale does not allow salary incentives to be paid to encourage health workers to be posted to locations that are more than usually difficult, such as the more remote health facilities. In South Sudan, where there is an absolute shortage of skilled

⁷² Anecdotal evidence points to a small number of exceptions to this.

health workers, alternative incentives⁷³ may be required to encourage health workers to be posted to the more difficult facilities.

- The reasonable HPF salary scale has had the benefit of attracting some skilled health workers from neighbouring countries to work in South Sudan. The recent high inflation rates is reducing the value of salaries for these workers, making work in South Sudan less attractive.
- The uniform salary scale only applies for primary care workers. With the recent expansion of HPF support to county, faith-based and state hospitals, the issue of salary scales for secondary care level workers comes to the fore. During the field visit, the review team became aware of discussions over salaries at a county hospital in which workers had been paid from a wide variety of sources (MOH, NGOs, international agencies) and on a variety of scales. It is understood that, following discussions in the hospital and with the HPF IP contracted to support the hospital, the state minister of health was to decide on a hospital salary scale for the state.

The uniform salary scale used by HPF has resulted in many facilities in which IP employees work alongside MOH employees who currently receive a much lower salary. This was cited as a cause of considerable friction during the visits to health facilities. GRSS intends to address this significant pay differential by increasing the pay of qualified MOH primary care employees to close to the IP scales using an 'infection allowance'. This is planned to take place early in 2015. If this takes place, the first two steps (a uniform NGO salary scale and comparable MOH salary scales) in the process of GRSS taking responsibility for all health worker salaries will have been achieved.

Given the uncertain budget situation, with the possibility of continuing conflict and the effect this may have on both GRSS income from oil revenues and non-military expenditures, there must be some uncertainty over the GRSS ability to pay for this (as well as procure adequate drug supplies for the country – see Section 2.9.4). **The HPF should continue to support the MOH in its work on HRIS as a precursor to the MOH salary revision and encourage GRSS to ensure the MOH salary enhancement takes place.**

The review team was not able to ascertain what the MOH policy is on the pay scales of secondary health care workers, but based on the limited information obtained during the team's field visits there is the possibility that a variety of different state-sponsored salary scales will emerge for these workers. **If not already supporting the analysis of this issue, HPF should encourage the development of a pay policy for secondary care workers and provide guidelines on this to the IPs that are supporting county, faith-based and state hospitals.**

2.9.6 Fragmentation of services

The BC identified 'Fragmentation in service delivery across the country due to the three different funding mechanisms using different modes of service delivery' as having a low probability of occurring, with the potential for a medium impact on the project in the event of this happening.

The HPF supports the introduction of the county model in six states while USAID (Western and Central Equatoria States) and the World Bank (Upper Nile and Jonglei States) support similar programmes in the remaining four states.

Unlike with the HPF, where a single organisation provides support to most aspects of county-level care, the USAID model has separate contractors supporting health services delivery (Jhpiego) and health systems strengthening (Abt Associates), but, as with HPF, contracts one partner per county

⁷³ The example of one IP was cited during the field visit where the employer ensured that support was provided to health workers in a remote facility to ensure they had regular access to shops and food markets.

to provide support. USAID support is scheduled to continue until 2017, but the funding was front loaded, diminishing resources for funding support each year. It is understood that USAID is unlikely to continue support to health service delivery but may continue support to HSS.

As is normal with World Bank funds, the MOH implements the project through a project implementation unit within the MOH that contracts Implementation Management Associates (IMA) to manage activities. For a variety of reasons⁷⁴, funding for IMA has been through short-term contracts of three months. There appear to be some differences in implementation for the World Bank-supported states where performance-based incentives are used to encourage health service delivery. This is considered to be a pilot project and a full evaluation is anticipated to be completed in the next six months.

It is understood that there are no formal mechanisms in place to share learning between the HPF and the states supported by USAID and World Bank. With the results of an evaluation of the World Bank fund work anticipated in the near future, **it would be appropriate for the HPF to support the MOH to undertake a comparative review of the performance of the three funding mechanisms. This would highlight any differences in approach and any differences in outcome, while recognising the differences in the environment, particularly related to the conflict, in each of the states.**

2.10 Gender and social inclusion

Through its TOR, the HPF is required to encourage the inclusion of feasible health interventions, through the IPs, that will impact on youth, people living with disabilities, and gender-based inequalities, discrimination and violence, especially for women and girls. This is in recognition of the connections between various social determinants and health.

HPF developed a gender and social inclusion (GSI) strategy and work plan in April 2013 and the inception report of November 2013 indicated that, to support GSI mainstreaming in all activities of the project, a GSI training would be developed. This was to be linked to work on improving conflict sensitivity for staff and partners (see above).

The GSI strategy proposes that there should be:

- GSI training for Juba staff and IPs in states (April–June 2013);
- consultative meetings with state and county stakeholders (April–September 2013);
- drafting of state GSI strategies and plans (October 2013–September 2014).

This review found no reports, in either the annual or any of the quarterly reports, that these proposed activities had been implemented, nor any evidence of the proposed GSI strategy activities had been included in any HPF work plans.

While the first-year HPF annual report highlighted the need for gender and social exclusion mapping as a priority, the year 2 work plan makes no mention of such an activity.

⁷⁴ Prior to independence, assistance to South Sudan was channelled through World Bank trust funds. This country support project was originally prepared during the transition to independence, and so was originally funded, in 2013, through a trust fund. Since 2014, the project has been funded through International Development Association resources (credit and grant) and this change in funding modality required it to both be approved by the Bank's board, and, following GRSS requirements, by the South Sudan Parliament. The long process of approval of projects by GRSS has delayed the renewal of the contracts and so, in order to avoid a break in health services the Bank approved short-term contracts using financial advances to avoid potential gaps.

A small number of the project indicators are gender disaggregated (1.1: childhood curative consultations; 1.3: women attending for ANC; 2.3: female members of health committees) but such disaggregation is not relevant for a further eight indicators. Two others (1.2: children treated with ORT and 1.4, FP acceptors), are not disaggregated by gender because the HMIS, upon which project reporting is based, does not provide this information.

Gender and Social Exclusion (GSE) often translates into poorer levels of health due to distinct and specific barriers to equal and unimpeded access to health services for disadvantaged members of society. In the context of South Sudan's present health service and infrastructure where a large proportion of the population are already excluded from accessing services, GSE may lead to a total lack of access to even the minimum health care for vulnerable groups in society. The challenge remains to highlight issues of discrimination and relative exclusion in a setting where services elude so many, and socio-economic disparities are not so evident. As the sector continues to be supported and developed, disparities may become more apparent unless this is recognised and addressed at the outset and may undermine state-building processes as marginalised groups emerge. It is therefore important that the HPF and its partners mainstream a strong GSI perspective before health inequities become entrenched into the system that they are helping to re-build.

The HPF GSI strategy provided a description of the limited available evidence on gender and social exclusion in South Sudan, argued for the inclusion of a GSI approach in planning the elements of the HPF and proposed a work plan to implement this. It is not clear why this was not implemented and, as most elements of the HPF are now in place, with contracts with IPs for support to service delivery at primary and secondary care levels largely agreed, **it would be appropriate to revisit the HPF approach to GSI to consider what could practically be done by the HPF in the remaining period of the contract to promote a GSI approach. This would best be undertaken alongside consideration of the HPF's approach to conflict sensitivity** (see Section 2.9.2).

3 Conclusions and recommendations

Since its inception in 2012, the HPF has performed well in very difficult circumstances, achieving an overall 'A' score (outputs met expectations) in both the 2013 and 2014 annual DFID project reviews. The mid-term review was asked to look more deeply at the implementation of the project and, as is to be expected for a major project working in the difficult circumstances of South Sudan (particularly with the continuing hostilities that significantly affected activities during the first quarter of 2014 and that still continue in Unity State), has identified, in the preceding narrative, a large number of issues where it might be possible to improve project implementation. It is recognised that, in the difficult circumstances in which the HPF operates and in the limited time until the end of the project, it is unlikely that all the suggestions made in the preceding report can be acted upon. Therefore this section discusses the findings and the priority recommendations that the review team feel HPF, and other stakeholders should try to address in the remaining time until April 2016.

This section also discusses and makes recommendations for the preparations of a future phase of the project where the less urgent recommendations discussed above might be considered.

3.1.1 Impact and outcome

While there are, as yet, no data available to indicate whether the HPF is contributing towards the achievement of South Sudan's targets to reduce maternal and child mortality, there are data to show that outcomes in at least two project priority areas are improving, with the project milestones for both vaccinations (children under 1 year receiving three doses of DPT) and births attended by skilled birth attendants improving. If maintained, these improvements will contribute to achieving South Sudan's mortality targets.

3.1.2 Output 1: health service delivery

One of HPF's first objectives was successfully achieved with the establishment of bridging contracts with NGOs to maintain existing services in facilities previously funded by a variety of donors. Thus an existing level of service delivery was successfully maintained and a significant reduction in health service availability prevented. Once this was achieved, HPF, along with its partners in GRSS; the MOH at national, state and counties levels, developed the TOR and undertook a tender process to select implementing partners to support the introduction of a CHD model of health services delivery, thus supporting GRSS to implement one of its key policies, as elaborated in the HSDP.

The tender process was successfully implemented in three rounds with, ultimately, eighteen IPs selected to support the CHD and health facilities services in all the 39 counties of the six target States. Most of the IP contracts were signed by November 2013 with the final two becoming operational in January 2014.

The conflict that broke out in January 2014 delayed the planned process to further contract IPs to support 10 county and 7 faith based hospitals as well as for an IP to support nationwide FP services. The hospital contracts were signed in July 2014 while the FP contract was not finalised until October 2014.

The process used by HPF was very successful if involving the MOH, at the various levels, in considering the many issues involved in contacting IPs, from developing the TOR, which were to help define a CHD model and how the IPs were to support its development, to the selection of bidders for individual contracts. Where State MOHs were involved in the selection of their IPs, there is evident buy in and acceptance of the chosen contractors. Where there was less state MOH

involvement, as in the selection of hospital IPs, there may have been less acceptance of the winners. Thus, from the point of view of obtaining MOH involvement, the process used by HPF to select IPs to support the CHD model was very successful.

Through this process, HPF has enabled the number of supported health facilities to be doubled from the 281 primary care facilities and three hospitals supported by the original bridging contracts to support for 562 PHC facilities (135 PHCCs, 427 PHCUs) and 15 hospitals by September 2014, resulting in an increased availability of basic health care services. Also by the end of September 2014, 10 hospitals were providing CEmONC and about half (19) of HPF-supported counties had at least one PHCC with BEmONC capacity.

Despite this increase in the number of facilities supported, the 2013 national HFA reported that the availability of key services, included in the BPHNS, was poor. Nationally, only 23% of PHCCs offered all three minimum services for child health five days per week, with the weakest service area being growth monitoring (35%). 56% offered immunisation five days per week, while 60% offered ANC five days per week. Only 3% of the surveyed PHCCs employed all the minimum number of technical staff according to MOH standards, and only 13% had at least one of the required cadres. While this national data may not apply fully to the HPF supported states it helps to explain the difficulties that IPs have faced in implementing their support contracts as a result of adequate numbers of trained staff not being available.

The principal difficulty faced by IPs is the absolute shortage of qualified health staff (nurses, midwives, doctors and other cadres of health workers) available in the country to provide essential services and so it would appear that the BPHNS-specified staffing norms may not be realistic. The project, through supporting the development of the harmonized salary scale (see HSS below) , has reduced the competition between agencies for health workers but the shortage of available staff has inevitably affected the services that can be offered and the quality of care delivered in the health facilities supported by HPF's IPs.

Success has been registered in IP support to CHDs with the two partner institutions now co-located in nearly all counties. CHDs have been provided with office space, infrastructure improvements and computer capacity, including access to the internet. HR capacity has increased, but, also suffering from the general shortage of trained HR, is still weak in some counties. The oversight and coordination roles of the CHDs have improved with support of the IPs.

The HPF support to the MOH, at national, state and CHD levels has included a strong emphasis on the introduction and strengthening of an HMIS. While improvements to this system are still possible (see HSS below), considerable amounts of useful health services performance information is becoming available to county, state and national health departments, as well as to HPF. The ongoing challenge for HPF is to assist health departments at all levels, which all, to a greater or lesser extent, lack capacity in data analysis and, when a response to evidence from the HMIS is required, the tools, staff or funds to address challenges that are identified.

The HMIS data shows a number of achievements while its analysis can start to highlight areas of interest or concern:

- Coverage of ANC has increased since the inception of the HPF. Both the 1st and 4th ANC visits grew in all states except for Unity. Fourth visits lag considerably behind first visit numbers.
- Despite increased ANC coverage in HPF-supported facilities, a downward trend can be seen in IPT for malaria and in HIV testing among pregnant women during ANC visits.
- Deliveries by a skilled birth attendant at facilities almost doubled, from 3.5% to 6.6% during year 1, but is still a very low proportion of all births.

- The project milestone of 7,000 acceptors of modern contraceptives is likely to be achieved by the end of 2014, but this is a very small proportion of possible acceptors.
- A steady growth in immunisation coverage can be observed since programme inception. 30% of one-year-old children are likely to have been vaccinated with a third dose of DPT by the end of 2014.
- However, while the trend line for DPT 3rd dose and BCG coverage suggests some further growth, this may not be strong enough to achieve the target of half of under one children being covered by the end of the programme.
- 63% of the HPF-supported health facilities conduct growth monitoring, around twice the national proportion.
- The numbers of children attending health facilities with diarrhoea and treated with ORT has not changed significantly in the past two years, remaining at around 80%.

Thus, through the improved output of the HMIS, basic health services management information is starting to become available for health managers to use and respond to. **While HPF should continue to support improvements in the HMIS, it should also continue to support the MOH at the various levels (e.g. through the IPs at CHD level, through the HPF State Coordinators at State level) to use and respond to the new information.** As examples in areas of particular concern to the project, the review team noted the following:

- Despite increased ANC coverage in HPF-supported facilities, a downward trend can be seen in IPT for malaria and in HIV testing during ANC visits.
- A possible levelling off in the rising trend in deliveries by a skilled birth attendant was observed towards the end of 2014.
- While the project milestone of 7,000 acceptors of modern contraceptives was likely to be achieved by year-end but even this low target is unlikely to be an indicator of continuing use of contraceptives. Other data would suggest that there was a diminishing availability of condoms towards the end of 2014.

With regard to a number of specific services - family planning, a service for which an IP has only just be contracted for; PPH, an innovative service only recently introduced into South Sudan; and nutrition, a service that has recently been added to the South Sudan basic package of health services (to give the BPHNS) additional consideration is given below.

The HPF targets for FP are low, reflecting the previous low emphasis on FP services in South Sudan. The MOH has supported an increased emphasis on FP by supporting the contracting of an IP (the Reproductive Health Association of South Sudan) with specific responsibility for improving FP uptake in the country. In the context of active conflict and strongly male dominant culture, it is unlikely that rapid gains will be made in FP usage but the benefits of FP in reducing maternal mortality (as well as the many other benefits) justify the increased focus on FP. The review team learned that there was a shortage of modern contraceptives in health facilities and so as a basic requirement **it is recommended that the HPF facilitate consideration of the procurement of modern contraceptives by the MOH and / or donors. If necessary, HPF might authorise its IPs to undertake procurements that ensure that modern contraceptives are available in HPF states. The Reproductive Health Association of South Sudan is encouraged to address the likely socio-cultural and gender barriers in relation to FP service utilisation in order to create innovative and locally adapted interventions.**

The October 2013 EmONC assessment, carried out by the MOH, resulted in the introduction of a PPH prevention programme that has been supported by HPF. This addresses a significant cause of maternal and pre-term child mortality and has been shown, in other countries to be effective in reducing this mortality. **It is recommended that the HPF maintain its emphasis on PPH**

prevention in order to ensure its integration and mainstreaming into the reproductive health programme and associated community activities.

Nutrition services were not initially considered to be included as a specific activity to be supported by the HPF, however widespread food shortages are occurring, and projected to increase, as a consequence of the conflict in South Sudan which has disrupted agriculture in several parts of the country. Currently, 63% of the HPF-supported health facilities conduct growth monitoring, around twice the national figure. However, there is currently no regular system for health facilities to obtain the necessary food supplements to treat any children identified as malnourished. **Given the low performance on nutrition indicators, it is recommended that increased efforts are made to further improve growth monitoring coverage and support prevention and treatment of malnutrition.**

The quality of care provided by health facilities is not routinely monitored and assessed by HPF, however the 2013 HFA showed that a majority of health facilities were not able to offer the full BPHNS, primarily due to the unavailability of qualified staff. The data from HPF supported states shows that there has been little progress demonstrated in the treatment rates for key childhood illnesses. One reason for this may be that the quality of care offered by many facilities is poor resulting in a lack of confidence in services. While, without doubt, the BPHNS requires a focus on a limited number of key health services, it may be that in the present context, without adequate trained staff or some alternative delivery mechanism, it may be appropriate for HPF to encourage a concentration on an even more limited (than in the BPHNS) set of services and ensure that all supported health facilities have the necessary support and capacity to:

- **concentrate on the three most essential diseases – malaria, pneumonia and diarrhoeal as well as ANC and safe delivery– to provide focused, on-the-job training in quality of care; and,**
- **with MOH, and based on the existing treatment guidelines, support the development of, simple, durable, easily readable and visually attractive IEC materials for health facilities, which focus on diagnosis and treatment of these five diseases or activities.**

As indicated above, the process to contract IPs to support project implementation at county level was successful. Following the first year of IP implementation, HPF led, with MOH involvement, a process of IP performance assessment. This used a set of standard criteria to assess a number of key technical and managerial performance indicators for each contract and the findings were presented to IPs at a workshop. The first year performance of individual IPs in their different counties formed the basis for performance targets for the second year of the contract. This was quite clearly a useful process that allowed the performance of different IPs and counties to be monitored and highlighted areas of both success and where increased efforts need to be made. It is understood that this process is to be repeated, which the review team strongly supports.

The assessment resulted in the contracts for fourteen IPs, supporting 28 counties, being continued without any specific conditions but with defined milestones to be achieved by the end of year 2. A further four IPs, supporting 12 Counties, were given a set of specific conditions that were to be met within an agreed time frame of three months. Of these it is understood that for two counties (Rumbek Centre and Rumbek East), the IPs have failed to meet the specific conditions that were agreed to within the agreed timetable and HPF has recommended that their contracts should be terminated. It is not clear why there has been a delay in implementing this, but **for the good of the services being provided in the two Rumbek counties, it is important that the situation is resolved there as soon as possible to provide certainty for the county health authorities, health facilities staff and clients.**

The annual review process was clearly a very useful process in highlighting the strengths and weaknesses of performance in the 39 counties. **It should be continued, with examples of innovative, best practice or particularly successful performance highlighted and shared to encourage the continuous improvement of health services delivery in the six states. It may be appropriate to develop mechanisms that enable IPs to directly assist each other to pass on best practices.**

3.1.3 Output 2: community-based activities

The indicators used by the project to measure progress in this area of work would indicate that it has been successful in achieving its targets (improving from a 'B' in the first annual DFID review to an 'A' in the second). This has been the result of the work by the IPs which have built on pre-existing efforts in this area. However this work has taken place without any central direction, resulting in the potential for widely varying approaches in different parts of the country. The first annual DFID review recommended that the project should 'Initiate central technical support to the counties (CHDs and county partners) to strengthen community engagement and governance in local health service delivery by December 2013'. This did not take place, however the project did support the development of a community strategy and operational plan in July 2014. This document has not yet been finalised or shared with the MOH and the donors either through the SC or separately. The process of preparing this report did however prompt a first meeting of an MOH Community Healthcare Technical Working Group through which the MOH concept of a Boma Health Programme was articulated.

The HPF second year work plan would indicate that, despite the absence of an agreed comprehensive plan for its community based activities, the project will increase the emphasis on this output during the year. The Strategic Support Initiative, endorsed during the 8th SC meeting, includes the recruitment of TA to support the development of national policies and guidelines on community engagement, and this is to be welcomed as it will provide HPF with a focal point for community engagement activities and, hopefully, support the reinvigoration of the MOH Community Healthcare Technical Working Group. **It is recommended that a first task for this Working Group should be the finalisation of the existing draft guidelines for community-level bodies, including the Boma Health Programme.** This will provide a framework for all community engagement activities with HPF supported counties. Following this, **it would be appropriate for HPF to support the IPs, and their state and county counterparts, to develop locally appropriate plans to implement this new central strategy.**

The HPF work plan also foresees the recruitment of community engagement TA staff to be recruited for attachment at state level. **Their first role should be to fully document the situation in the different counties in their states to provide a full picture of community activities in the six states.** This process should be directed by the new national TA and the findings fed into the policies and guidelines to be developed at the centre.

3.1.4 Output 3: HSS

An HSS situation analysis was conducted in 2013 and while no overarching HSS strategy has been prepared by the project, a series of plans were developed out of the original analysis to provide the basis for the HSS component. Implementation of these plans has not been as anticipated with the component achieving a 'B' (moderately did not meet expectation) in both the first and second annual DFID reviews. One explanation of this, for 2014, was that, in response to the conflict, an interim HPF strategy was developed that emphasised the need to prioritise health services delivery, while reducing the project's emphasis on HSS activities. These were to be deferred until such a time that the situation was more normal, enabling development work to carry

on. Despite this delay, considerable progress has been made in several parts of the HSS programme area.

Strengthening the county model of health services delivery, in alignment with the HSDP, was a primary focus of HSS. In support of this objective, a draft implementation plan for leadership and management development proposed five core activities for the county level: (i) the development of a strategic leadership programme; (ii) mentoring, coaching and on-the-job capacity building of CHDs; (iii) quarterly review meetings; (iv) support to the annual planning and budgeting process; and (v) strengthening of capacity to undertake supportive supervision. Of these, only activities (iv) and (v) have started to be implemented. Therefore **it is recommended that HPF should commence the full implementation of the leadership and governance strengthening plan.**

County health work plans were developed for the period July 2014 to June 2015 in all six states by CHDs and IPs with TA from HPF and MOH. The objective of preparing single county plans, encompassing all county level health activities, was not fully successful, but there was progress in increasing transparency and accountability. A number of challenges to this were identified during the county health planning workshops. While the CHDs' role in planning, monitoring, supporting and supervising the work of NGOs and overseeing health service delivery has grown, there is still a way to go. **The following recommendations are made:**

- **The roles and responsibilities at each government level, including job descriptions for CHD officials, need to be further articulated by the MOH, supported by national policies/guidelines for CHD operations.**
- **Internal supervision, within each health facility and within each CHD, should be an established part of the management tasks within these bodies and should be reflected in job descriptions.**
- **The national MOH, supported at State level, should provide clear policy guidance to support county planners in insisting on the inclusion of all county level programmes in their annual plans.**
- **HPF should continue to foster the process of fully sharing information on budgets, expenses, plans and performance.**

In some counties there is a lack of clarity about the detailed roles and relationships required between the IP and CHD. MOUs that set out the respective roles and responsibilities of the two parties have been developed in some counties and **it is recommended that similar agreements are developed between the HPF-contracted IP and the body they are working with - SMOH, CHD or hospital. After consultations, HPF should develop a template for such agreements to be used by IPs.**

The HSS support to encourage the improvement of supportive supervision of health facilities by CHDs has necessitated a focus on the HMIS, to provide a tool for monitoring performance. Prior to the inception of HPF, adherence to the national HMIS data flow policy was low and mechanisms for assessing the quality of data were not in place. The data that were captured were not analysed for use for management and service outputs were not monitored or reviewed. Consequently, the HPF appropriately concluded that, in order to strengthen government systems, HPF would use the MOH DHIS as the basis for project M&E. In support of this, HPF has organised training courses for SMOH, CHDs and IPs to provide the basic skills required for using the DHIS and also to retrospectively capture all available historic information available to provide baseline information.

Despite considerable improvements, there continue to be weaknesses in the HMIS. **It is recommended that the HPF continue to provide support for training of health workers at facility and community levels to ensure continued improvements in the quality of data**

reported. The HPF efforts to build CHD capacity to analyse and utilise the HMIS data should be continued.

A significant basic problem for the HMIS is the lack of standard population figures that can be used at county level as accepted denominators for HMIS indicators. **The HPF should advocate for, and support the MOH, to determine what population data to use for the DHIS (and HPF) indicators and to set national targets for all PHC indicators.**

The 2013 HFA demonstrated some significant weaknesses in the quality of care available at primary health facilities, an issue that has, by necessity been secondary, for HPF, to the need to get services up and running. Improvements in the quality of care will be hampered by the shortage of qualified health staff, but will be assisted by an effective system of supporting supervision.

HPF is actively supporting the MOH in developing its priority to enhance supportive supervision for health service delivery. It has supported the MOH to conduct an assessment of current practices and to develop mechanisms for strengthening the supervision. However, there are no confirmed QA policy, strategy and management guidelines at SMOH and CHD levels. Therefore, **it is recommended that the HPF support the MOH in the development of a QA policy and procedures for the CHD through:**

- **Facilitating MOH approval of existing draft QA materials.**
- **Supporting development of a QA policy, strategy and standard operational procedures using results-based management protocols/standard operational procedures.**

HPF support to the important issue of qualified HR availability have focussed mainly on a number of PFM elements, discussed below. However, in addition, and while the IP contracts have provided the funds to enable an increase in the number of qualified staff employed in health facilities, the limited availability of such staff (discussed above) has hampered this. The BPHNS-specified staffing norms may not be realistic. In order to address this shortage, the HPF has been supporting efforts at task shifting to facilitate the expansion of skills for existing staff. **It is recommended that the HPF continue to support the process of task shifting as it is regarded central to addressing the HR capacity shortage.**

HPF support to PFM has resulted in a number of significant achievements:

- HPF contracts with the IPs have resulted in a uniform salary scale for PHC workers paid by the IP. This has resulted in the salaries offered by IPs no longer being a factor in the competition between the IPs for scarce health workers and is clearly a major achievement and a first step towards a national health worker salary scale that will eventually include GRSS health workers.
- The HPF-supported SSEPS activity is well advanced and has been introduced in 34 of the 39 HPF counties, and this will, in due course, aid the smooth transfer of NGO staff to government.
- The HPF has contributed significantly to the introduction of the HRIS, which has the purpose of identifying and eliminating payments to 'ghost workers'.
- The development and agreement, with MOH, of a set of PFM benchmarks required before HPF funds could be paid directly to GRSS. However the PFM baseline being developed in relation to these benchmarks remains incomplete, and needs a renewed focus.
- Support for the introduction of an AMS is expected to be intensified in the 2014/15 work plan.

While considerable success has been demonstrated the Review Team has some concerns.

While the PFM benchmarks were originally established to be triggers for direct funding of GRSS by donors, and in recognition that the time required for PFM reforms can be lengthy, this is no longer expected. Despite this, such reforms are valuable in themselves. However the Review Team considers that the agreed benchmarks do not present a balanced set of criteria for PFM strengthening. There is a heavy focus on HR and payroll (8 benchmarks out of 17); the budget benchmarks are focused on financing and budget releases, rather than budget execution, which is an area of high fiduciary risk; and the audit requirement, in which a qualified audit report is acceptable, presents a very low bar. Consequently, **it is recommended that HPF and the MOH revisit the benchmarks to assess what can practically be addressed with HPF resources in the time available.** If they are intended to improve health sector PFM overall, which donor partners continue to support, they should (1) be broadened to include routine and robust audits, internal controls, cash management, procurement, bank reconciliation, accounting systems, budget monitoring and control, and financial reporting, and (2) be the subject of a comprehensive phased and realistic HPF plan for PFM strengthening.

The functionality and reliability of the HRIS is of critical importance and HPF should continue to support its development as a precondition to enabling rational staffing workload analysis in order that, ultimately, realistic and affordable staffing norms can be established. **It is recommended that, after installation of the HRIS, HPF should commission an external independent review to comment on its integrity and functionality and to recommend any enhancements.**

The PFM strengthening stream has made steady progress but has been limited in its achievements because of the limited resources allocated to it. The newly agreed Strategic Health Systems Support Initiative recognises that, indicating a greater emphasis by HPF in the coming year with additional PFM staff to be employed for central and state level support which will enable work to proceed more rapidly. **Their engagement should cover the range of PFM issues already included in the programme in addition to engaging fully with the County Transfers Monitoring Committees to monitor and assure the smooth transfer of allocated MOH funds to the county health sector. A detailed plan for the activities of these new staff should be produced and closely monitored with attention paid to ensure that the absorptive capacity exists in the health sector to take advantage of all planned PFM interventions**

In carrying out these recommendations the HPF must be continually aware that the establishment of financial management policy is the preserve of the Ministry of Finance, and HPF support for PFM will be to ensure good practice and compliance with Ministry of Finance guidelines and the implementation of sub-national financial procedures as laid out in government accounting manuals.

Drugs and medical supplies: A significant area of support provided by HPF has been in PSM where successful capacity building and quality improvement activities have included:

- Facilitating the removal of expired drugs and reorganising drug storage space through the so called 'de-junking' exercises, which has almost been completed in all 39 counties.
- Supporting the introduction of a pull system of drug supply management in four of the States, through assisting CHDs to take a more prominent role in the distribution of medicines, receiving and managing EMF drug supplies on behalf of the whole county.
- Drug storage capacity at county level has been enhanced where necessary along with drug information management systems.

While pharmaceutical procurement by the IPs has been less than had been anticipated a HPF report on PSM highlighted opportunities for IPs to pool procurement and/or distribution. In order to make small steps towards strengthening the medicine supply chain system in South Sudan, **it is recommended that the HPF focuses on selected issues. These include managing waste, training and building capacity, upgrading storage facilities, facilitating pharmaceutical**

consumption information flow, sharing best practices and successes, and further exploring the role of the community in drug management.

Thanks to the implementation of the EMF, the need for procurement of pharmaceuticals by the HPF has been less than had been anticipated in the BC. Medical supplies for service delivery, through the EMF, seem to be assured until mid-2015. However, there is some uncertainty about supplies in the second half of 2015. If the MOH procurement is successful, supplies should be assured for at least a further three months, but beyond that, in late 2015, there is the potential for drug shortages.

It is recommended that the HPF monitor the national medicine procurement process that is underway and advise the IPs of the likely national drug supply situation so that, if necessary, the IPs can procure drugs and medical supplies in the event of an anticipated shortfall.

The HPF donor partners should also monitor the national drug procurement process and promote discussion as to how the country should obtain supplies beyond those hopefully being procured by the MOH for late 2015.

3.1.5 VFM

HPF supplemented the limited VFM analysis of the HPF business case by the development of a VFM strategy. This VFM strategy provides nine indicators of which three are classified as economy measures, one is an efficiency measure, three measures are classified under effectiveness and seek to measure community engagement and HSS strengthening progress, and two indicators are proposed to measure equity. While all have value as indicators, HPF has not been able to collect data on a number of them and the review team considers that not all of them are true measures of VFM. Consequently, **it is recommended that the VFM strategy be revised. In particular, the strategy needs to acknowledge more clearly the limitations of the HMIS in South Sudan and the difficulties in measuring VFM for all three outputs, but especially 2 and 3. The strategy could move to a simpler approach, with a greater focus on management and supervision of programme activities and qualitative monitoring processes for community activities and HSS.**

HPF monitoring has included regular updates of logical framework indicators; the preparation of annual and quarterly reports; and a year-end IP Performance Review. These activities are supportive of VFM, but there is no link between financial performance and any output objectives, except in very broad budget terms. In practice, effectiveness is not being measured. However, project reports do demonstrate that significant progress has been made in health service delivery, with many key health service indicators improving despite the difficult environment.

It is clear from indicator movements in Output 1 that the HPF, together with other initiatives, has added significant value. It is more difficult to demonstrate value in the areas of HSS and community mobilisation. However, the consideration of VFM in the BC alone understates the value of this project. Areas in which the review team consider that hard-to-measure value has been added include the following:

- HPF IPs have provided support to CHDs in the implementation of modern health delivery methods, but which may not impact indicators immediately.
- HPF IPs have contributed to the training of health cadres.
- There is a significant increase in service utilisation; the size of the increase suggests that health outcomes are likely to have improved.

- There are good signs that in addition to saving lives, a government-led health service is being built – a key objective.
- Although as yet incomplete, progress in the related SSEPS rollout, HRIS and AMS promises to support significant VFM in the health sector as a whole, ensuring that health sector funds are spent more efficiently and that health workers are more productive.

However, the review team considers that VFM is threatened by the shortcomings in financial management and fiduciary risk (discussed below). **It is recommended that VFM economy measures be enhanced through the conduct of regular external procurement audits covering all IPs. These reviews could be scored by procurement area such as tender process, record keeping, etc. and used as an effective measure of economy.**

VFM is also undermined by the high levels of overhead associated with the county model, especially where direct spending is low. This is likely to improve as project expenditure picks up.

The points made in the BC still hold: in the absence of HPF, 6 of the 10 states in South Sudan, with a population of approximately 5 million, would have significantly reduced health services.

It was not possible to replicate the original VFM assessment of HPF health service delivery (Output 1) based upon DALYs as the original calculations are no longer available and the lack of survey data and the movement of internally displaced people (IDPs) amongst the population exacerbate the difficulties of making a meaningful cost per DALY averted analysis at this stage.

3.1.6 Programme governance and management

HPF governance bodies exist at various levels in the project, with overall project direction being guided by a national SC. SOC in each state provide a forum for guiding project activities at state and county levels. In addition, the contributing donors have a role in both monitoring and agreeing significant changes to the project while the managing consortium, led by Crown Agents, meets periodically as the SAB, to provide strategic direction to the various technical aspects of the project.

The HPF SC has been an effective forum for engaging the senior management team of the MOH in the management of the project, with the SC being active in reviewing and endorsing the project activities. The committee has been less active in monitoring either the technical or financial performance of the project, as required in its TOR. **It is recommended that the SC meetings are scheduled to coincide with the production of HPF quarterly and annual reports such that the SC formally reviews the HPF quarterly financial and technical reports in order to provide better oversight of project performance.**

Similarly SOC in have been constituted in five of the six HPF project states (all except Unity), with each SOC scheduled to have met at least twice during 2014. As with the SC, although with some variation between States, the SOC in have been successful in engaging State MOH officials with the project. SOC members were actively involved in the annual review of IP performance in mid-2014 and there was evidence of individual SOC in reviewing the performance of the IP in their state. In some states, the SOC provided a useful forum for discussions about problems of health service delivery in each state. There did not seem to be a consistent format for technical or financial reporting to the SOC by IP in. No evidence of SOC in considering the financial aspects of IP performance was seen. **It is recommended that the monitoring role of this committee be encouraged through the State IP in sharing standard format quarterly financial and technical reports with them. HPF could assist by facilitating the development of an agreed report format.**

While coordination meetings between the contributing donor partners have taken place, some limited dissatisfaction from partners about their involvement in the project was indicated by the non-lead partners, indicating the need for more regular and formal engagement between the donor partners. **If, as recommended above, SC meetings are held quarterly around the production of quarterly and annual financial and technical reports, the donors should meet formally in advance of the SC meetings to review progress and agree common positions prior to the SC meeting.**

Some dissatisfaction with the way the SAB has operated was expressed to the review team and the September 2014 management update agreed between Crown Agents and DFID responds, in part, to these concerns. The reforms agreed in the management update, if adhered to, should improve communications between the partners. **The consortium partners should, at their next face-to-face meeting, review the implementation of these arrangements and, if necessary, agree further adjustments to their respective roles in HPF strategic oversight. It is suggested that greater transparency and clarity be brought to the functioning of the SAB in order to maximise the potential for partner inputs.**

The first annual review of the HPF recommended that major HPF programme management decision making be shifted more from the UK headquarters to the in-country HPF leadership. However, it is clear that problems in this area continued as, in June 2014, concerns were formally raised by DFID about the quality of Crown Agents' UK programme management and the impact that this was having on the operations in-country. Following discussions, Crown Agents and DFID agreed, in September 2014, a management improvement update or performance improvement plan that, it was anticipated, would address DFID's concerns. The concerns centred on project leadership within Crown Agents, as well as the need to improve communications and to define roles and responsibilities within the project to reaffirm the role of the in-country team leader. While it is too soon to assess whether this management update will have the desired effect in improving management performance, the various elements contained in the plan should result in such an improvement. **DFID will need to actively monitor the implementation of the management improvement plan.**

The review team made a number of observations in connection with the management requirements of this large programme and the limited physical capacity available within the Juba office to manage this:

- HPF Juba is already managing the financial and technical aspects of a large number of contracts with an increase in the number of contracts foreseen in the near future.
- There is some evidence of weaknesses in coordination of activities across the HPF work streams.
- Weaknesses have been demonstrated in some aspects of project financial management (see below).
- There is evidence of the various elements of programme cycle management (situation analysis – strategic plan – funded action plan) being implemented but in a number of areas there appear to have been gaps in this process.
- The implementation of the Health System Strengthening Initiative will result in a significant increase in the TA contracted to work at National and State levels. This will include a greater emphasis on community engagement, a new activity for central HPF.
- Computer systems and software for accounting and for technical reporting are not commensurate with a programme of the magnitude of HPF.

The capacity of the HPF team in Juba seems already to be stretched to provide adequate technical and administrative support to its IPs. The anticipated expansion of contracts and technical TA to be embedded within the MOH is likely to stretch this further. **It is recommended that the HPF**

urgently conduct an organisational review to assess existing and anticipated workloads to ensure that it has the capacity to properly manage its workload and enable cross-organisational learning. Further strengthening may be required to address any weaknesses observed by the proposed review.

The MTR is particularly concerned about the apparent lack definition for the management of the considerable amount of TA that is under recruitment to implement the Strategic Health Systems Strengthening Initiative. Other than the job descriptions, there is no description of how these new staff, at both central and state MOH levels, will fit into the existing HPF organisational structure, what their targets will be, and how they will be managed and their activities funded. **It is recommended that detailed management operational plans be quickly prepared, for consideration by the SC, to demonstrate how these staff will operate and what their objectives will be.**

The MTR identified a number of significant concerns about financial management that reinforce the findings of a recent financial system audit undertaken by external auditors. These concerns are around the level of scrutiny of IP financial reports, the quality of the HPF's own financial reporting, the lack of external financial audits both of the IPs and of HPF itself, and the need for greater clarity in financial instructions for IPs from the HPF. **The weaknesses as detailed in the recent audit report will need to be addressed**, including:

- **The documentary verification for RBAs should urgently be commenced, with sampling back to contract commencement;**
- **HPF quarterly financial reports are very limited, with limited analysis of, for example, non-salary CHD support. It is recommended that the programme produce accurate, internally consistent, accrual-based financial statements on a quarterly basis. These statements should include analysis and comment on key spending areas.**
- **IP audits should be obtained for all IPs as a matter of some urgency; they should be for each organisation as a whole, with HPF income and expenditure clearly identified. This supports the FMA process and also prevents IPs from reporting the same expenditures in two different projects.**
- **It is recommended that HPF financial statements be drawn up for the years ended 30 June 2013 and 2014 and they should be audited without delay.**
- **The HPF asset register showed considerable variations between the costs reported by individual IPs for, for instance, for motor vehicle. This should be investigated, and possibilities for procurement efficiencies explored. In addition, the programme should carry out an annual procurement audit of all IP procurement within South Sudan.**
- **It is recommended that the HPF produce a comprehensive policy on asset management for IPs, to be incorporated into wider financial management guidelines for IPs that should be prepared by the HPF.**
- **In view of the many risks and weaknesses identified in financial management of the HPF, both in this MTR and in the recent system audit, it is recommended that the HPF develop and closely monitor an HPF financial management action plan.**
- **This programme, in excess of £100 million, is too large and complex to be managed using Excel spreadsheets alone and it requires a greater investment in accounting systems and controls. However, while it is late in the programme to introduce an accounting system, it is recommended that the possibility of doing so be explored urgently. The present arrangement represents a significant fiduciary risk.**

3.1.7 Cross-cutting issues

HPF was significantly disrupted by the violence that started in mid-December 2013 but responded well with a staff evacuation and the speedy establishment of temporary offices in Kampala. When circumstances permitted, after the initial emergency had calmed, IP support to counties was quickly reinstated. Despite the reduced services over the emergency period (which has continued in Unity State), there was no overall reduction in health service utilisation over the year. HPF responded well developing interim plans for operation in the worst affected areas that enabled IPs to operate flexibly, maintaining services where possible, introducing mobile services or new services for IDPs in coordination with relief agencies.

There has been no overall reconciliation between the warring parties and so **HPF will need to maintain its current level of security vigilance while the current level of conflict is continuing. The HPF will also need to continue to provide flexible support to the IPs, enabling them wherever possible to continue supporting service delivery and, in the worst-affected counties, providing support to relief agencies in those areas.**

Any deterioration in the security situation, with an upsurge of violence, either locally or more widely throughout the country, will require the HPF to review its operations, with a response dependent on the actual and anticipated levels of violence.

Any lessening of the conflict in South Sudan will of course be welcomed and **the HPF will need to respond flexibly to any change in the situation, with the provision of conflict-sensitive support to reinforce any peace agreements.** Even in circumstances where overall conflict is lessened in South Sudan, it is likely that the HPF will need to continue to maintain a high level of security awareness to ensure the safety of its own staff and those employed by IPs.

The HPF has always been aware of the need for a conflict-sensitive approach to its work and, in April 2013, developed a strategy paper and outlined plans for its implementation. These plans, for conflict sensitivity training and outcome conflict sensitivity assessments were not implemented although it is recognised that the HPF IPs all have long experience of working in South Sudan and should already be operating in a conflict-sensitive way. A review and updating of the 2013 HPF Conflict Sensitivity Strategy, scheduled to take place in the near future, provides the opportunity to reinvigorate this important aspect of the programme. **The HPF should ensure that the planned review takes place in the near future, with the final document providing an implementable plan for enhancing conflict sensitivity within the HPF and its IPs. Any agreed plan for implementing an updated HPF Conflict Sensitivity Strategy should be implemented as a matter of urgency.**

GSI was also an important consideration for HPF at inception and a GSI strategy and work plan was developed. This strategy provided a description of the limited available evidence on gender and social exclusion in South Sudan and argued for the inclusion of a GSI approach in planning the elements of the HPF. This mid-term review found no evidence that the proposed GSI strategy activities had been included in any HPF work plans. As most elements of the HPF are now in place, with contracts with IPs for support to service delivery at primary and secondary care levels largely agreed, **it would be appropriate to revisit the HPF approach to GSI to consider what could practically be done by the HPF in the remaining period of the contract to promote a GSI approach. This would best be undertaken alongside consideration of the HPF's approach to conflict sensitivity (see above).**

A number of suggestions for amendments to the log frame were made throughout the report. These are collected here.

Outcome Indicator 1: The 2012 baseline should be checked and corrected if necessary..

Outputs.

Indicator 1.1: Total <5 years outpatient department (OPD) consultations & <5 yrs. OPD consultations disaggregated by gender and preventive/promotive nature.

The 2016 target will already have been exceeded by December 2014 and so it is recommended that HPF reassess the 2016 target.

Indicator 1.4: Number of acceptors new to modern contraceptives.

The 2014 milestone was achieved. The 2016 target does not seem particularly challenging in view of the recent contract for an IP in FP, nor does it monitor ongoing, rather than one-off use, of contraceptives. It may be appropriate to reassess the 2016 target and investigate whether the HMIS can provide information for a more informative indicator (perhaps to be used in any phase 2 of the project).

Indicator 1.5: No. of facilities with capacity to offer emergency obstetric care (disaggregated BEmONC and CEmONC).

It is not clear what additional achievements are to be made by 2016 and so it may be appropriate to reassess this indicator.

All the Output 1 indicators are quantitative in nature and given the concern expressed about the quality of care provided it would be appropriate to develop an indicator that assesses some measure of the quality of care provided through the HPF.

Indicator 2.2: Number of documented joint meetings between the CHD/IP and the health committee and facility staff.

The 2014 milestone was significantly not met. However, the information used for the 2014 reports was based on survey data. In future, this information is due to be obtained from the HMIS and so it may be appropriate to review the 2016 milestone when more accurate information starts to become available.

While recognising the difficulty of defining and measuring the quality of community engagement, the HPF should seek to define such an indicator that can be used in future. This could relate to a chosen focus of community activities such as the number of successful community referrals of pregnant women for ANC or delivery in a health facility or the number of children successfully referred for immunisation services.

Indicator 3.2: Number of facilities with quarterly integrated supervision conducted by county health department using QSC tool.

The 2014 milestone substantially not achieved. The 2016 milestone may then be optimistic and needs to be reviewed unless HPF places greater emphasis on IPs ensuring this activity.

Indicator 3.3: No. of health facilities submitting HMIS reports through the DHIS (according to the data policy flow).

The 2016 milestone was achieved in 2014. The 2016 milestone should be reassessed, perhaps with the addition of some quality of reporting indicator.

Indicator 3.4: Proportion of counties with one joint plan, and one review system for all government and NGO health services

There is no clear definition what constitutes a review system in this multiple level indicator. The indicator should be fully defined to enable understanding of what is to be measured.

There are no indicators that relate to the Strategic Health Systems Strengthening Initiative that is about to be implemented. It may be appropriate to consider developing a small number of new indicators for this area of work.

3.1.8 Support beyond March 2016

The HPF has been successful in increasing access to health services in South Sudan and while there are as yet no data to show that this is having an effect on overall mortality rates, there is evidence to show improvements in the delivery of health services such as vaccinations and attended deliveries. Shortages of skilled health workers and the limited distribution of existing health facilities are likely to limit further improvements at some stage in the future.

GRSS is committed to improving health worker salaries to a level close to the uniform salary scale developed through the HPF and also to a substantial procurement of drugs for when the EMF comes to an end in 2015. Uncertainty around South Sudan's national finances, resulting from the possibility of further conflict and the effect this might have on oil revenues and government expenditures, must place some doubt on the government's ability to fund these laudable objectives. Consequently, unless there is a significant improvement in the national finances, it seems unlikely GRSS will also be in a position to take responsibility for the funding of health services in the six states currently supported by the HPF when it finishes in early 2016 (and USAID support to Western and Central Equatoria States in 2017. The situation in the two states currently supported by World Bank funds is less clear with an anticipated closing date of 31 October 2015, although the current funding is through a series of short term advances while formal approval of the project is being considered by GRSS, a process that has taken some considerable time).

Without a continuation, in some form, of support for the delivery of primary care services in South Sudan, there is likely to be a significant deterioration in services, with the potential for a loss in the gains already made by the project to date. **Therefore it is recommended that the funding partners actively consider the continuation of funding support for service delivery, HSS and community engagement beyond April 2016.**

In order to do this, it is understood that the existing BC will need to be reviewed and possibly re-written. In which case the following factors should be considered by the review team:

- A formal evaluation of the World Bank-supported states (Upper Nile and Jonglei) should shortly be available. The findings of this evaluation should be considered alongside the findings of the 2015 annual performance review of the HPF and any comparable data from Eastern and Central Equatoria (supported by USAID) to facilitate lesson learning for the design of any future support.
- In particular, the performance-based incentives used in Upper Nile and Jonglei States should be considered to see if such an approach was successful and could be more widely employed elsewhere.
- The first phase of the HPF has seen a concentration on improving access to existing services. Any future phases should also focus on issues of service quality and improving accountability and transparency.

- The HPF has benefitted from the parallel implementation of the EMF, which has supplied reasonable quantities of medical supplies to primary health facilities. There is some uncertainty over the supply of medicines beyond mid-2015, when the EMF finishes. It will be essential that responsibility for the future provision of drugs is established during any phase 2 HPF design mission.
- The county model seems highly appropriate as the basis for delivering support to health facilities. However, to date this has been somewhat inefficient, with central IP management costs of around 39% of total spend. Any redesign should consider the possibility of introducing state-based contracts⁷⁵, albeit with an emphasis on maintaining the benefits of the county model, in order to reduce the number of contracted organisations and thus overhead costs.
- The current network of health facilities is extremely limited, with an estimated 56% of the population not living within 5 km of a health facility. An expansion of the existing network will be essential to improve access. However, the capital requirements to fund this would be considerable and any expansion would face considerable constraints resulting from the acute shortage of skilled health workers in South Sudan such that staffing any new facilities might prove very difficult. Any new funding may need to consider supporting a gradual expansion of the existing health network to enable access for currently unserved populations. This would need to be carried out in parallel to programmes supporting an expansion of health worker training.
- If, as has been suggested, support from USAID to service delivery in Eastern and Central Equatoria is to finish in 2017, any future design mission will need to discuss with GRSS how services in these two states are to be supported beyond then.
- Similarly, the situation in the two States (Upper Nile and Jonglei States) supported by the World Bank will need to be considered. The expected closing date for this support is 31 October 2015⁷⁶, although an extension may be possible. Any future HPF design mission will need to discuss with GRSS and World Bank how services in these two states are to be supported beyond then.

The continuation of HPF beyond its current finish date of April 2016 may require the extended process of BC development and approval followed by a new tendering process. This is a lengthy process and so **it is recommended that, early in 2015, the funding partners agree a process for indicative programme renewal that complies with all of their own individual bureaucratic requirements and will enable a programme design mission to take place in the first half of 2015.** This should allow adequate time for all necessary processes to be completed by April 2016.

⁷⁵ The original BC considered the option of state-level contracts but rejected the idea.

⁷⁶ http://www-wds.worldbank.org/external/default/WDSPContentServer/WDSP/IB/2014/03/07/000442464_20140307101333/Rendered/PDF/841760PJPR0P14010Box382156B00OUO090.pdf

Annex A Terms of reference

ANNUAL and MID TERM REVIEWS

HEALTH POOLED FUND (HPF) SOUTH SUDAN (ARIES NO. 203109)

Introduction

DFID carries out Annual Reviews of all of its programmes to assess progress against the objectives contained in the logframe, and to check if the programme is on track, and if any adjustments need to be made. This ToR is for the second annual review of the HPF programme, which started in October 2012. The first annual review was done in November 2013. The HPF is a 3 ½ years (October 2012 - April 2016) programme. In October 2014 it will complete two years of implementation. Hence a mid-term review, building on the second annual review, will also be carried out simultaneously. This ToR also covers the mid-term review.

The UK is providing £56 million over 3 ½ years to the HPF to improve health outcomes in South Sudan. Four other donors (Australia, Canada, Sweden and the European Union) are contributing £51 million to the programme (as committed through Delegated Cooperation Agreement with DFID). HPF is a government-led programme overseen by a steering committee chaired by MoH, co-chaired by DFID and represented by other government ministries and donors. The HPF is managed and implemented by a consortium of agencies led by Crown Agents with a mandate to deliver the programme in its entirety, which includes fund management and technical support.

The **impact** of this programme will be Government led health systems that save lives. The **overall outcome** will be an increased access to quality health services, in particular by children, pregnant women and other vulnerable groups. Three outputs this programme will deliver to achieve the outcome are:

1. Strengthened delivery of health services, particularly responsive to the needs of women and children
2. Increased ownership, governance and demand of communities for health service
3. Strengthened health systems at State and County level with detailed focusing on
 - Policy
 - Human resources for Health
 - Health Financing including strengthening of payroll and Local Services Support Framework
 - Health Information
 - Leadership and governance

The results attributable to DFID are:

1. 254,959 under five year olds are seen for a curative consultation
2. 21,853 women have at least four antenatal visits
3. 21,853 pregnant women receive at least two doses of intermittent presumptive treatment of malaria as part of their antenatal care
4. 10,926 additional people start a family planning method

Background

South Sudan is one of the poorest countries in the world. Years of conflict causing erosion of physical and social infrastructure and death and displacement of millions of people have made South Sudan one of the most underdeveloped regions in the world. The onset of violent conflict in December 2013

has severely impacted on the development, which was at its nascent stages, of this world's youngest country.

South Sudan's health needs are vast and partly result from the high poverty and long history of conflict. Its health indicators are among the worst in the world. The recent war has weakened further an already very basic health care system, with severe shortages of health workers, medical commodities and functional facilities, poor access, dysfunctional referral systems and cultural and financial barriers.

The Government of the Republic of South Sudan (GRSS) have expressed their commitment to improving the health of its population through a five year strategy, Health Sector Development Plan 2012- 2016 (the 'HSDP'), which has a vision to 'contribute to reducing maternal and infant mortality and improving the overall health status and quality of life of the South Sudanese population'. However this is much harder to achieve without adequate state finance, which has been grossly inadequate owing to, among others, oil crises and conflict. The international community have continued to finance the delivery of many health services, and helped prevent a breakdown in the health systems and protect the most vulnerable. This has been vital to preventing excess morbidity and a further deterioration in the already poor humanitarian situation.

With four other donors the UK, through the Health Pooled Fund (HPF), is supporting the delivery of the GRSS's five year health strategy (HSDP) and helping government start transition from an NGO led health service to a 'government led health service that saves lives'. The HPF funds the delivery of a basic package of health services comprehensively, including referral level up to county hospitals (and some missionary hospitals), in six (Eastern Equatoria, Unity, Western Bahr el Ghazal, Northern Bahr el Ghazal, Lakes and Warrap) out of South Sudan's ten states. This is done through contracting a central fund manager to sub contract service delivery agents at county levels in the six states. The programme also provides technical assistance (TA) and capacity building support to County Health Departments and the central and state level Ministries of Health to lead and manage the health systems and service delivery, and engage communities effectively. The contract for Fund Manager and TA provider was awarded to Crown Agents following competitive tender under EU Procurement regulations. Delivery of primary health care in remaining states is funded by USAID and World Bank, each covering two states.

The onset of armed conflict in mid-December 2013 has made the operating environment extremely difficult and disrupted the programme interventions in many ways. The implementers had to suspend the operations temporarily while many expatriate staffs were evacuated in December, however the core HPF team and other implementing partners were back in action fairly soon in January 2014. The programme responded by developing and implementing a six-month interim strategy and a strategy specific to Unity (the most and directly affected amongst the six HPF supported states) to adjust the programme delivery in response to the new context and realities.

Objectives

1. To conduct an Annual Review of South Sudan Health Pooled Fund

- Assess progress achieved since the first annual review of the programme in November 2013, including an assessment of the quality of progress;
- Reflect on the impact of the armed conflict that began in mid-December 2013 on the programme, particularly focusing on the results and priorities, and the programme's response to the new situation. Assess whether conflict sensitivity strategy and adaptation of the programme made through an Interim Strategy and Plan (Mar-Aug 2014) were relevant, adequate and effective;
- Make feasible recommendations and identify doable action points regarding any major issues and problems affecting progress, particularly noting any further changes to be made in light of the continuing conflict;

- Assess and score the project's progress during the last year against the Outputs in the revised logframe, including a consideration of Assumptions and Risks, and determine whether and what changes are required;
- Provide judgement on whether future progress will achieve the logframe Outputs and Outcome by the end of the project based on progress to date;
- Review the governance arrangements for the programme at different levels; reflect on the roles and the effectiveness of engagement of key stakeholders and partners of the programme (Ministry of Health at different levels, HPF donors, Crown Agents and other consortium members of HPF, HPF Programme Team, Implementing NGOs) in the delivery of the programme; and make recommendations on how these could be enhanced or improved;
- Assess the relationships between Programme Implementers (HPF Programme Team and Implementing NGOs) and Ministry of Health at different levels and how the relationships have influenced achievement of project milestones and particularly the move towards a government led health services;
- Assess the partnership arrangements and the role divisions within the HPF consortium partners (Crown Agents, Health Partner International, Montrose International LLP, Charlie Goldsmith Associates, the Health Information Systems Programme and SKILLS for South Sudan and how it is managed – e.g. how appropriate inputs from the consortium members are ensured based on their individual strengths;
- Assess whether inputs and support provided by the consortium/ HPF in-country core team to the implementing NGOs in delivering the programme in the frontline are relevant, adequate and effective;
- Assess the progress of the recently undertaken programme management update (Performance Improvement Plan and Contract Performance Review) submitted by Crown Agents and provide recommendations on the next steps.
- Assess the risk management policies, plans and interventions of the programme and confirm whether checks and balances in place are sufficient to manage risks and minimise opportunities for fraud and corruption; and
- Assess whether the project is on track to deliver Value for Money (in line with DFID Approach to VfM 2011).

2. To conduct a Mid Term Review of South Sudan Health Pooled Fund

In addition to the specific objectives covered under the annual review, the mid-term review will focus on the following (taking into consideration the whole programme period, Oct 2012 to Oct 2014):

- Assess the overall progress towards the long term objective of a Government led health systems that delivers and saves life, and appraise whether this is relevant in the current context;
- Assess to what extent the programme strengthened the health service delivery system, increased utilization of effective health services, and achieved value for money;
- Reflect on the programme's role and success in transitional development – strengthening health sector governance through government's involvement in implementation and through accountability mechanisms at community level;
- Review to what extent the programme was flexible and responsive to evolving local needs and contextual changes in the operating environment and whether adjustments, modifications and reprioritization made to the implementation modalities were relevant and effective (or are likely to be effective);

- Make recommendations on the changes and reprioritisation required to operational aspects of the programme in order to achieve its objectives in remaining project period (until March 2016); and
- Reflect on the relevance of continuing/extending the programme beyond March 2016 and, taking into account the more recent global, regional and local evidence, suggest whether continuation/ extension should re-consider:
 - strategic objective and approaches;
 - programme and system interventions; and
 - operational modalities.

Scope of the Work

The reviewers will carry out an annual review of the programme in line with DFID's 'How To Note on Reviewing and Scoring Projects' and prepare a report in the Annual Review Template given in the document. The review will cover all key areas/questions in the Template and respond well to the annual review specific objectives outlined in this ToR.

The programme is at a middle stage now, so the reviewers will also cover a mid-term review of the programme, assessing the overall progress since the start of the programme and analysing the relevance, achievements, challenges and future outlook, responding to the mid-term review specific objectives given in this ToR. The output will be a mid-term review report.

Methodology

The tasks will include:

- A desk review of available documentation, including, but not limited to, the Business Case, previous annual review report, revised logframe, periodic progress (programmatic and financial) reports, HPF policies, strategies, plans and updates, meeting minutes, technical reports, relevant national policies and plans, relevant national monitoring and survey data, and other programme related documents
- Preparation of a plan for annual and mid-term reviews, outlining the review methodology, team members, their roles and responsibility, activities and timelines, after initial desk review of key documents
- Visits to Juba and to at least two programme sites (covering County Health Department, primary care facility, county and/or faith based hospital, outreach clinic and communities) for a first-hand observation of programme implementation (spending at least seven calendar days in the country). The sites will be identified jointly with DFID and the HPF team
- Individual or group meetings/ interviews/ focussed discussions (as appropriate) with key stakeholders (including by phone or email with some who are not present in South Sudan):
 - MoH of different levels up to service delivery points
 - Community members /local health management committees
 - HPF Team (Juba, States)
 - Crown Agents and other consortium members
 - Implementing partners (NGOs, Faith Based Organisations)
 - Key health sector donors and UN agencies
- A debrief to the DFID team in Juba at the end of the visit (MoH and other HPF Donors will be invited to this debrief session)
- Preparation of completed reports (Annual Review in the DFID template. Mid Term Review separately in a format agreed with DFID team in Juba)

Reporting and Deliverables

The lead consultant will report to DFID South Sudan Health Adviser.

The lead consultant will deliver the following:

- A plan for the annual and mid-term reviews, outlining the review methodology, team members, their roles and responsibility, activities and timelines
- A draft report on the DFID annual review template
- Final annual review report (incorporating comments received from DFID and other key stakeholders)
- A draft mid-term review report (in a format agreed with DFID)
- Final mid-term review (incorporating comments received from DFID and other key stakeholders)
- PowerPoint slides on the key findings and recommendations of the mid-term review

Timeframe

The reviews will take place in October/November 2014, with the in-country visit expected around mid-October.

Deadlines for deliverables:

- Plan for the reviews - within three working days of signing the contract
- Draft annual review report – 07 November
- Final annual review report – within 3 working days after receiving comments/feedback from DFID
- Draft mid-term review report – 30 November
- Final mid-term review report / PowerPoint slides – within 7 working days after receiving comments/feedback from DFID

Team Composition

The review will be carried out by at least a team of three consultants (with at least one national or regional expert) with experience in evaluation of large development programmes in conflict affected and fragile states. The team will among them have a mix of expertise/ experience covering majority of the following areas:

- Public health – health management, service delivery, maternal, child and new born health, Quality of care
- Health governance – health policy and planning, public financial management, community accountability, human resource management, health commodities management, health information systems
- Health economics, Value-for-Money

It is expected that one of the consultants will function as a Team Leader for this assignment, taking overall responsibility for the fulfilment of the Terms of Reference. The other consultants will be accountable to the Team Leader who will ultimately be accountable to DFID South Sudan for delivery of the review. The Team Leader will be responsible to prepare and execute a plan for the reviews as well as to compile and finalise the reports. The TL may stay a bit longer (than the other consultants) in-country in order to have additional consultations and data collection for the mid-term review purpose.

Annex B

B.1 Persons met

Donor Representatives	
Dr Amit Bhandari	Health Adviser, DFID South Sudan
Sandra McGuire (T)	Programme Officer, DFID, East Kilbride, UK
Elisabeth Harleman	First Secretary, Embassy of Sweden
Jamie Schnurr	Head of Cooperation, Embassy of Canada
Sue Wiebe	First Secretary (Development), Embassy of Canada
Lisa Woods	Health Adviser, Embassy of Canada
Laura Campbell	Office Director, USAID
Basilica Modi	Health Specialist, USAID
Anja Bauer	European Union
Anne Bakilana (T)	World Bank
HPF, Juba	
Dr Damianos Odeh (T)	Deputy Team Leader
Dr Naseer Nizamani	Deputy Team Leader
Shoko Tyanai	Finance & Operations Director
Grace Cahill	KMC Specialist
Gertrude Kortman	M&E Manager
Campbell Katito	HSS Manager
Sonja Nieuwenhuis	HSD Manager
Imke van der Honing	PFM Manager
Dr Cerino AChar (T)	Maternal & Child Health Expert
MOH	
Dr Makur Kariom	Under Secretary for Health
Dr Richard Lako	Director General, Policy Planning and Monitoring
Dr Baba Samson	Director General, Primary Health Care
Holly Brown	NGO Health Coordinator
WBeG State	
Hon. Dr I Cleto Hassan	Minister of Health, SMOH
Dr James Ukello Morgan,	Director General, SMOH
Henry Gabriel Sasa	Director of PHC
Malish John Peter	HPF WBG State Representative
Dr Mohammed Bakhtiar	IMC Program Coordinator, Wau CHD
Arthur Aseka	IMC Field Coordinator, Wau CHD
Dr Joyce Acok	IMC Clinical Advisor, Wau CHD
Catherine Peter	CHD Acting Medical Officer, Wau CHD
Joseph Nasir	CHD Finance/Admin Officer, Wau CHD
Dr George Lutwama	HNTPO Project Manager, Jur River County
John Lagu Bosco	HNTPO Community Development Officer, Jur River County
Hakim Victor	CHD Finance/Admin Officer, Jur River County
Joseph Philip	CHD Acting Medical Officer, Jur River County
Warrap State	
Hon. Mrs Nyanawut Kuol Deng	State Minister of Health, SMOH Gogrial West
Michael Nyang	Director of PHC, Gogrial West SMOH
John Akot	Director of Adm. and Finance, Gogrial West SMOH

John Akol	M&E SHD, Gogrial West SMOH
Joseph Deng	County Health Officer, Gogrial West County
Alfred Ngong	HPF IP/WVI Coordinator, Gogrial West County
Jenipher Onyango	WVI Zonal Program Manager, Gogrial West County
Benson Otieno	WVI Program Officer, Gogrial West County
	WVI Community Dev. Officer, Gogrial West County
Eric Nimungu	WVI/HPF M&E officer, Gogrial West County
Emmanuel Moju Andrea	Warrap HPF State Representative
Eastern Equatoria State	
Dr Sylvester Omin	Commissioner, SMOH Eastern Equatoria
Dr Elijo Omoro	Director, Pharmaceutical Services, SMOH Eastern Equatoria
Mrs Ersilia Lakulu Oneh	Director, PHC Services, SMOH Eastern Equatoria
Maric Anthony	M&E Officer, SMOH Eastern Equatoria
	Director, CHD Torit County
Dr William Marcello	Cavitas, Torit
Dr John Lagu	NPIT, Budi County
Kasio Luka	NCA, Torit
Dr Joachim Drani	CORDAID, Chukudum Civil Hospital
Dagostino Francesco	AUSI Area Team Leader, Ikoto County
Simon Bwire	Save the Children
Ginny Fox	Save the Children
Meckamo Kassa	Save the Children
Beatrice Nyalwal	ARC, Magwi County
Staff	Nyong PHCC, Torit County
Staff and health committee members at the following health facilities	Imuruk, PHCU, Torit County
	Khormus PHCU, Torit County
	Paluonyanyi PHCU, Magwi County
	Magwi PHCC
	Nimule Hospital
	Pageri PHCC
	Moli PHCU
Excutive Director	Magwi CHD
NGOs/IPs	
Catharine McKaig	Chief of Party, Jhpiego
Pat McGloughlin	Incoming Chief of Party, Jhpiego
Dr Edward Luka	Deputy Chief of Party, Jhpiego
Dr William Clemmer	Country Director, IMA
Dr M C Lado Lugga	Chief of Party, IMA
April McCoy	Senior Programme Officer, IMA
Dominic Aurelio	Programme Manager, SKILLS for South Sudan
Implementing Consortium Partners	
Jonathan Borsely	Project Director, Crown Agents
Charlie Goldsmith	Charlie Goldsmith Associates
Emmanuel Sokpo (T)	Health Partners International
Bridget Brown (T)	Montrose
Fred Mukholi	Director, SKILLS for South Sudan

Note: T indicates discussions held using telephone/Skype

B.2 Documents reviewed

1. Project documents

- Business Case and Intervention Summary: South Sudan Health Pooled Fund. DFID, undated.
- Logical Framework for the Health Pooled Fund. DFID Original, undated.
- Report of the First Annual Review of the Health Pooled Fund. DFID, October 2013.
- Fund Manager Terms of Reference for Health Pool Fund. DFID, revised June 2013.
- Briefing Note on HPF. DFID, July 2014.
- Logical Framework for the Health Pooled Fund. DFID / HPF September 2014.
- Fund Manager Terms of Reference for Health Pool Fund. DFID, (draft) revised October 2014.
- HPF Programme Management Update (part only). Crown Agents, September 2014.
- Terms of Reference: HPF Audit October 2014.

2. HPF periodic reports

- HPF Inception Report, November 2013.
- HPF Quarterly Report, July–September 2013.
- HPF Quarterly Report, October–December 2013.
- HPF Quarterly Report, January–March 2014.
- HPF Quarterly Report, April–June 2014.
- HPF Annual Report, August 2014.
- HPF Quarterly Report, July–September 2014 with annexes:
 - Annual Work Plan
 - Contract Risk Register
 - HPF Risk Matrix
- HPF Monthly Report, October 2014 with annex:
 - Updated Annual Work Plan
- HPF Quarterly Financial Report, July–September 2013.
- HPF Quarterly Financial Report, October–December 2013.
- HPF Quarterly Financial Report, January–March 2014.
- HPF Quarterly Financial Report, April–June 2014.
- HPF Annual Financial Report, August 2014.
- HPF Quarterly Financial Report, July–September 2014 with annexes:
- HPF Financial Status Analysis, June 2014.

3. HPF strategies and plans

- HPF Conflict Sensitivity Strategy, April 2013.
- HPF Monitoring and Evaluation Strategy, April 2013.
- HPF Strategy to Measure Value for Money, April 2013.
- HPF Gender and Social Inclusion Strategy, April 2013.
- Implementation Plan: Leadership and Governance, December 2013.
- HPF Interim Strategic and Operational Plan, January 2014.
- HPF Interim Monitoring and Evaluation Strategy, March 2014.
- HPF Interim Strategy, Unity State, April 2014.
- HPF Knowledge Management and Communications Strategy (updated), July 2014.

- HPF Strengthening Supportive Supervision: Gap Analysis, October 2014.
- Implementation Plan: Leadership and Governance. Updated, (September 2014?).

4. Other HPF documents

- HPF Organogram (undated).
- HPF form of contract – bridging phase.
- HPF form of contract – RFP2
- HPF Bidding Documents – support to county hospitals.
- Terms of Reference; HPF Steering Committee.
- Minutes of the HPF Steering Committee Meetings:
 - December 2012
 - February 2013
 - April 2013
 - May 2013
 - June 2013
 - October 2013
 - December 2013
 - May 2014
 - July 2014
 - October 2014
- Terms of Reference: State Oversight Committees.
- State Oversight Committee Minutes.

Eastern Equatoria	Lakes	NBG	WBG	Warrap
July 2013	Sept. 2013	Nov. 2013	Sept. 2013	March 2014
May 2014	Nov. 2014	March 2014	Oct. 2013	Aug 2014
		Aug 2014	Aug. 2014	
			Oct. 2014	

- HPF job descriptions:
 - Deputy Team Leader
 - Finance and Operations Director
 - Contracts Manager
 - Health Systems Strengthening Manager
 - Knowledge Management and Communications Officer
 - Supply Chain Management and Logistics Officer
 - Enhancing SMOH Capacity for Supportive Supervision
 - Health Services Delivery Manager
 - M&E Manager

5. GRSS documents

- Prevention and Treatment Guidelines for Primary Health Care Centres and Hospitals. MOH, 2006.
- Prevention and Treatment Guidelines for Primary Health Care Units. MOH (undated).
- Immunization Policy. MOH, 2009.
- Quantified Supervisory Checklist Guidelines. MOH, 2011.
- Quantified Supervisory Checklist.
- Health Sector Development Plan 2012–2016. MOH, January 2012.
- National Reproductive Health Strategic Plan 2013–2016. MOH, February 2013.

- Clinical Guidelines for the Prevention and Management of Postpartum Haemorrhage in South Sudan. MOH, May 2013.
- Integrated Management of Neonatal and Childhood Illnesses. MOH, December 2013.
- National Assessment for Emergency Obstetric and New born Care. (Draft) September 2013.
- 2013 Rapid Health Facility Survey. GRSS (undated).
- Strategic Plan for Implementation of Integrated Community Case Management of Childhood Illness in South Sudan, 2015–2021 (Draft). MOH.

6. DFID documents

- Operational Plan 2011–2015. DFID South Sudan, updated June 2013.

7. Other documents

- When Kleptocracy becomes Insolvent: Brute Causes of the Civil War in South Sudan. Alex de Waal (2014) *African Affairs* 113/452. Pgs. 347–369.

B.3 Updated risk assessment

The following table lists the risks identified in the project BC and provides a brief comment on the current status of each. The review team identified a further risk, not identified in the BC. This has been added to the section headed fiduciary risk (*in italics*).

Risks	Prob'ty (3 high, 1 low)	Impact (3 high, 1 low)	Comments
Budget: Decrease in projected government health budget over the next three years due to decreasing revenue, continued diversion of resources into defence and security, making it difficult for GRSS to support procurement of drugs, expansion of HRH, and payment of salaries.	3	2	The MOH is planning for an increase in salaries for PHC workers as well as earmarked grants to CHDs, and thus seems optimistic about at least maintaining funds for the health sector. In the event of a significant decrease, the HPF will enable a continuation of primary services in the six states. However, the HSS and community streams of work may be adversely affected any significant decrease in government health spending.
Donor commitments and government expectations from donors result in decreased GRSS investment in health.	2	2	Donor funding for essential drugs is coming to an end mid-2015. MOH has committed to procure a further supply.
Security and conflict: Increasing insecurity resulting from conflict in South Sudan prevents access to programme areas. The programme is insensitive to conflict.	3	2	The conflict that started in December 2013 has not been resolved and still has the potential to flare up significantly again. Localised conflict, separate from the main conflict, continues sporadically. In all states other than Unity, HPF activities have resumed as before with a greater emphasis on security. HPF has enhanced its security procedures and checked those of IPs, enabling budget flexibility to enable them to enhance their security where lacking.
Political risk: Lack of cooperation / opposition from government. This may primarily be because we are unable to allow GRSS to hold the contracts for the fund manager for governance and fiduciary reasons.	1	2	A demand by GRSS for the departure of all foreigners in 2014 was quickly rescinded. The HPF is collaborating well with the MOH, where the modalities of the fund seem to be well recognised and accepted.
Political risk: Government may not support the HPF and make it difficult for external partners to operate in South Sudan.	1	3	The HPF is collaborating well with the MOH, where the modalities of the fund seem to be well recognised and accepted.
Partner risk: Donors may not be keen for funds to be put through the Local Services Support Aid Instrument (LSSAI) system despite benchmarking. This would place more risk on to DFID.	2	1	There is no immediate prospect for funds to be put through the LSSAI system.
Social risk: Health services are not provided in remoter, more rural and poorer areas of South Sudan, leading to exclusion from the benefits of development and deteriorating state–citizen relations.	3	2	HPF is supporting most primary care facilities in the six states, following the existing pattern of health care provision. Large sections of the population live too far from the supported facilities to enable access. HPF targets are set such that they are realistic without accessing these unserved communities. Without a capital programme and increased availability of qualified staff it

			is unrealistic to expect an expansion into these areas.
Fiduciary risk of supporting salaries through conditional transfer system (i.e. government system) – funds do not reach the SMOH or are not used appropriately by the SMOH.	2	2	There is no immediate prospect for funds to be put through the LSSAI system.
Fiduciary risk inherent in the programme at both programme management and IP level and the additional fiduciary risk that may arise from non-compliance with good practice and/or guidelines issued.	1	2	<i>Annual financial audits of both the HPF and the IPs.</i>
Breakdown in services: Interruption to service delivery during the transition from the BSF to HPF.	1	1	Transition from BSF to HPF happened without disruption to services.
Insufficient interest from NGOs to expand coverage to county level.	1	1	NGOs showed interest in the HPF to enable competition to provide county services to take place.
Adverse impact on operations due to inflation/currency management issues and its impact on NGO operating costs, fuel, etc.	2	2	There has been inflation, particularly affecting the price of fuel in the conflict-affected states as well as a depreciation of the currency, which has reduced the attractiveness of South Sudan for Ugandan health workers.
Fragmentation in service delivery across the country due to the three different funding mechanisms using different modes of service delivery.	1	2	All three funding mechanisms take broadly the same approach, albeit with some variation. There is evidence of collaboration among the three fund-managing organisations and the HPF is supporting the development of GRSS guidelines, etc. for use nationwide.
Interruption of services due to unrest when salaries are changed from NGO rates to government pay scales.	2	2	The MOH anticipates increasing the salaries of its qualified primary care staff through a new infection allowance. This will bring such workers' salaries close to those of the NGO harmonised salary scales and, if implemented, minimise the possibility of unrest.
Insufficient HR for health: Insufficient number of suitable qualified staff to deliver services and manage implementation of HSDP/HPF.	2	2	The IPs are experiencing a shortage of qualified health workers, particularly in the more remote locations where the harmonised salary scale does not allow for incentives to attract such workers.
Low financial, procurement and distribution capacity contributes to unreliable and interrupted supplies of commodities such as drugs that are essential for service delivery.	3	2	The Emergency Drug Fund will provide core primary care drugs until mid-2015. GRSS has indicated that it will procure drugs from this fund, although the quantity anticipated from GRSS is not clear. If inadequate there is the potential for drug shortages in late 2015. The HPF supports the procurement of drugs to cover temporary shortages.
Business continuity: NGOs are unable to hand over operational responsibility for clinics to the MOH at the end of the fund.	2	3	The HPF is working to strengthen CHDs and various health systems including the payroll as and when conditions permit. Progress will need to be assessed towards the end of the project.
Inability to tailor funding to the needs in each state due to political rejection of the Census result.	1	1	There has been no evidence of significant disagreement with the funding envelopes provided for each county/state.

Inter-sectoral synergies (with WASH and education) are lost as the new fund is not cross-sectoral (unlike BSF).	2	1	There is no evidence available concerning continuing inter-sectoral linkages.
Disaster risk reduction: Flooding or other environmental hazards disrupt service delivery.	2	2	Floods are a normal feature of many states. The selected IPs are experienced in the conditions pertaining to their counties and plan for them.
Weak M&E and use of information for evidence-based decision making at lower levels of the health system.	2	1	The HMIS is being used to report on county-level activities and while there are still weaknesses in the use of the HMIS, HPF/IP support is resulting in improvements. The HPF/IP is also encouraging the use of such data through annual performance reviews.
Aid Impact and effectiveness: Donors fail to align and harmonise activities across the country.	2	1	In the South Sudan context, with so many donors, misalignment is almost inevitable. Strengthening the MOH to undertake a coordinating role will improve this.

B.4 The situation in Unity State

As of September 2014, the UN Office for Humanitarian Affairs (UNOCHA) estimated⁷⁷ that some 5.8 million people suffered from some degree of food insecurity in South Sudan. This number was projected to increase to 6.4 million during the first quarter of 2015. The same source estimates that 1.95 million internally displaced people and a projected 293,000 refugees will need support in 2015. In addition, in 2014 and 2015, a total of around 270,000 people will likely have sought refuge in neighbouring countries by the end of 2015.

While political negotiations continue, and are needed to end the suffering, they are unlikely to yield rapid improvements on the ground. Various agreements between the warring parties in January, May, October and November 2014 have yet to stop fighting. Even when fighting does stop, the humanitarian impact of what has already happened will continue to be felt throughout 2015.

The conflict resulted in violence being reported in multiple locations, especially in Unity, Upper Nile and Jonglei States. Continued violence against civilians, displacement, market destruction, food shortages, unusual livestock migrations, destroyed health facilities, and disrupted farming aggravated the humanitarian crisis. The ongoing conflict made the aid operation more difficult, restricting movement of supplies and aid workers to areas of need.

Following the outbreak of violence mid-December 2013, most of those staff of both the HPF and the IPs' who could be were evacuated from South Sudan. Some of these staff started to return from the first week of January onwards but others only came back in February 2014. Upon their return, the resultant insecurity made access to some counties, most notably in Unity, impossible. Health facilities were destroyed and vehicles looted. This did affect service delivery in the most affected counties. Generally, however, health facilities continued to function but with less staff and less supervision from the CHD and IPs.

During the first quarter of 2014, access to the counties improved and, with the exception of Unity State, by the end of April, IPs had access to their counties, but with increased costs and requiring additional humanitarian HPF assistance.

In response to this situation HPF responded actively by:

- Conducting an operational mapping exercise to identify which facilities were or were not operational, and their needs to return to full operational capacity.
- Playing a key role at national level in coordination and information sharing in both the Health Cluster and the NGO Forum.

HPF prepared, and agreed with DFID an interim strategy, particularly for the most affected state, Unity. This was for HPF to continue to focus on the original HPF design but with increased emphasis on coordination with the relief effort by providing a stable PHC platform to provide services for both the routine catchment population of supported health facilities as well any IDPs relocated to the area.

Two immediate concerns were the potential for drug stock outs and the need to provide health services to IDPs. HPF acted flexibly by enabling IPs to realign their agreed budgets, if necessary, to address this and encouraged IPs to proceed with any necessary drug procurements to ensure adequate drug supplies. HPF undertook to support the additional costs of transporting essential drugs to health facilities. HPF also enabled the IPs in affected areas to respond to the local

⁷⁷ UNOCHA Humanitarian Response Plan 2015. (Dec 2014)

situation by providing services with UN protected areas for IDPs as well as provide mobile services where health facilities had been damaged.

By the end of June 2014, HPF reported that regular HPF activities were being implemented smoothly in five states; however, the security situation in Unity state continued to require an emphasis on support for health services delivery in continuingly difficult circumstances.

In Unity, HPF remained committed to providing health services in all areas, whichever of the warring parties held control in particular areas. The findings of the needs assessment exercise were used to guide resource allocation for procurement of drugs and medical supplies and addressing the damage to the health infrastructure, buildings and equipment caused during the conflict.

HPF, as a member of the Health Cluster, has played an active role in coordinating the response between its' IPs, other humanitarian participants in the State and the GRSS.

Examples of activities⁷⁸ in individual counties in Unity State include:

- Payinjiar County: this county saw a large influx of IDPs. Health facilities continued to function and mobile services were instituted by the IP to provide services to the IDPs.
- Koch County: The IP was unable to access the county until June 2014. A majority of health facilities were looted. The existing CHD and health facilities staff continued to provide services outside the looted facilities to the remaining populations.
- Mayendit County: many health facilities were looted and all the county's fridges were destroyed and the IP's vehicle was stolen. Communications were very difficult. The county's health staff have provided services through mobile clinics and the staff of the CHD are travelling by foot to support services. Community support is being provided to transport drugs from the airfield to health facilities as no transport is available.
- Leer County: The majority of health facilities, including Leer hospital, a referral centre for four counties, were looted. The IP only regained access to the county in June.
- Pariang and Abiemon Counties: the site of a large UNMISS Protection of Civilians (POC) site for IDPs. The IP has supported the provision of health services for this site.
- Rubkona County: the location of another site for IDPs where most of the county population are staying. Health facilities in the county are not functioning and the IP has supported the provision of health services for this site.

In addition HPF supported the training, implemented by PSI, of Community Health Workers in five counties in Unity State. The objective of this was to enable participants to diagnose, treat and provide drugs for a limited number of important diseases in locations where static health facilities were not available.

In October 2014, other areas were also affected by violence stirred up by inter-clan disputes. In Lakes State Rumbek North county was badly affected and violence was also reported close the state capitals of Malakal and Bentiu in Upper Nile and Unity state respectively. A total of 1.9 million people have been displaced by violence since December 2013, with half a million of those fleeing to neighbouring countries as refugees.

To make matters worse the final few weeks of the rainy season continue to impede the delivery of vital services in the country. HPF partners, in Lakes and Unity state in particular, have reported

⁷⁸ HPF Annual Report (2014)

difficulties in the transport of drugs and other essential medical supplies due to flooded roads and airstrips. Heavy flooding was also reported in Mingkaman (Lakes) and Bentiu (Unity) IDP camps where HPF is supporting partners CCM and CARE respectively.

B.5 HSS assessment

In the inception period two principal HSS activities took place: joint HSS needs assessment by the HPF with the MOH, and review and reconciliation of the HMIS data. The main findings of these assessments follow.

The HSS assessment was carried out in 2013 in partnership with the central MOH and was undertaken in two phases. The first encompassed Eastern Equatoria, Unity and WBeG States and 11 CHDs; the second phase encompassed Lakes, NBeG and Warrap States and seven CHDs.

The Peer and Participatory Rapid Health Appraisal for Action (PPRHAA) tool was modified to meet South Sudan's context and health manager capacity levels. A mentoring approach was adopted whereby HPF experts worked with health managers selected by SMOHs to conduct assessment exercises in each state.

The analysis of findings covered the six pillars of HSS – health service delivery, HR for health, health information, pharmaceuticals and medical products, health financing and governance, leadership and management.

Generally, the austerity measures had affected the operations of the SMOHs and CHDs as funding was largely limited to payment of salaries of personnel on the government payroll. The oversight function of the SMOH and CHD to ensure quality health service delivery was limited to the provision of a few protocols and procedures. The key drawbacks were related to the inability of the SMOH and CHDs to provide facilities with guidelines on the basic package of health services and on quality of care and management of emergencies. Coordination mechanisms for playing an oversight role in the sector were also weak. HR available at SMOH and CHD levels were grossly inadequate. Guidelines and procedures for ensuring that facilities had the right mix of staff were not developed. In addition, staff appraisal systems and training plans were not available. Efforts were made to improve HR management with the introduction of the HRIS funded by JICA. The system was however yet to be fully functional in all the SMOHs and the CHDs.

The HMIS units had been established and staff trained on the use of the HMIS and DHIS software. Evidence showed these were being used to capture data submitted by facilities, adherence to the national HMIS data flow policy was low, and five mechanisms for assessing the quality of data were yet to be introduced. Data captured were not analysed for use for management and service outputs were not monitored and reviewed.

The provision of drugs and other supplies was based on a push system in line with the national policy. Although drugs were distributed to CHDs quarterly, the information showed stockout of essential drugs and supplies was common. Drugs supplied were not necessarily based on the needs of the facilities providing services in the counties. The situation resulted in weak stock control and stock management systems at both state and CHD levels. Some of the CHDs and SMOHs did not have appropriate storage facilities for drugs and supplies that would guarantee the quality at the point of dispensing them to patients. Asset registers for equipment and buildings were not maintained and plans for routine maintenance of buildings and equipment were non-existent.

The government planning and budgeting procedures were used by the SMOHs to prepare annual budgets and to a limited extent annual plans. The planning and budgeting processes were not participatory as both CHDs and NGO SPs were not involved in determining the SMOH priorities. Systems for periodically reviewing annual plans as well as assessment of sector performance were also weak and hardly used. Annual health sector reports were also not routinely prepared. The

MOH has introduced the QSC but this was not used regularly by the SMOH and CHDs due to the poor funding.

Some of the key intervention areas identified for consideration and inclusion in the implementation plan included the following:

1. Priorities for effective health sector coordination at state and county level are the Three Ones, 'One Plan, One Budget and One Review System', which covers all government, NGO and other health services, led by the SMOH and CHD.
2. The lack of operational budgets is severely restricting essential functions of SMOHs and CHDs.
3. SMOHs and CHDs need to play a greater role in planning, monitoring, supporting and supervising the work of NGOs and overseeing health service delivery.
4. The lack of an effective referral system and inadequate hospital support are key impediments to an effective PHC system.
5. Regular support and supervisory visits from states to counties and counties to facilities are essential for ensuring plans, policies and procedures are implemented.
6. Alongside decentralised responsibility it is necessary to establish clear and direct accountability from facilities to CHDs, from CHDs and hospitals to SMOHs and from SMOHs to the MOH-. Roles and responsibilities at each level need to be clarified.
7. Collection and reporting of health information has improved significantly in recent years; regular analysis and use of this information by management at all levels is now the priority.
8. Many NGOs have significantly improved the quality and coverage of health services, so it is vital that these improvements are carried forward and not lost in any reorganisation of the health system.
9. Harmonisation of salary scales and conditions of service is vital for government and NGO health workers.
10. Realistic, affordable staffing norms are required for health facilities and staff distribution should be based on workloads and follow transparent procedures. A functional human resource information system is essential to establish these HR management procedures and practices.
11. Substantial strengthening is required of drug and vaccine ordering, storage, distribution, monitoring and stock control.
12. The bridging contracts had shown that SPs needed support in quantifying pharmaceuticals, data quality and more regular field visits.

B.6 PFM benchmarks

The agreed benchmarks for PFM strengthening are:

Budget

Budget planning timeliness – GRSS and states:

- **Indicator:** GRSS and state budgets passed, county budget at least prepared and presented to County Legislative Council.

Rationale for allocation of resources:

- **Indicator:** Government to set out (either in a budget call or by the South Sudan Fiscal, Financial Allocation and Monitoring Commission (SSFFAMC) and follow, clear rules for horizontal budget allocation of resources for health services (health conditional transfers) to states and counties in each annual budget process. No resources are to flow to a state or county to which resources have been allocated contrary to the rationale mandated for that year in a budget call/by SSFFAMC.

Budget commitments:

- **Indicator:** The percentage of the national budget allocated to health in the states should not be less than the 2012–2013 budget percentage, and should have been accurately mirrored in state budgets. If the milestone is not met, resources cannot flow to states.

Proof of budget execution (transfer releases) in correct amounts:

- **Indicator:** Execution of budgeted health transfer releases, national–state, state–county, in correct amounts and documented in Financial Management Information System (FMIS), yes/no. If the milestone is not met at a given level, resources cannot flow at the same level – e.g. if the national level is not making transfers at correct amounts, resources cannot flow nationally; if state level, not for that state.

Timeliness of budget execution:

Indicator: Over a three month rolling period, two months' conditional health transfers must have made within one month of the target release date (typically the 20th of the month for conditional transfers from Ministry of Finance and Economic Planning), and all within two months of target release dates.

HR/personnel and payroll

HR/personnel data held systematically and links to payroll

- **Indicator:** an upgraded HR database, web-synchronising but with offline operational function, including functionality for storage of scans of key documents, with compatibility with other MOH systems, and forward compatibility to the Ministry of Labour, Public Service and Human Resource Development FreeBalance HR system, to be made operational at the MOH and 10 SMOHs, and an HR database to feed dynamically to the payroll system monthly.

Recruitment, appointment, certification regularised

- **Indicator:** confirmation of process by which the South Sudan Medical Council (SSMC) licences/authorises health workers (the MOH has confirmed that SSMC already performs this function).

Use of SSEPS payroll system

- **Indicator:** MDAs report on time through SSEPS (including counties delegating SSEPS processing back to the SMOH, and exercising their authority via 'paper SSEPS' change forms). The government's own rule is that funds cannot flow to a county that is not reporting. Funds are to be suspended until report received; three late reports in a year lead to extended suspension.

Data in payroll system

- **Indicator:** 95% of staff on payroll to have key data points (three names, job title, work station, grade, increment) populated; 99% pay calculated as per norms.

AMS rolled out

- **Indicator:** basic SMS-based AMS rolled out to all counties where there is network coverage, with paper-based back-up. Funds cannot flow to a county where an AMS is not operational.

Follow-up of non-attendance

- **Indicator:** definition of standards for attendance, and for sanctions; sanctions being processed to standards in >80% of cases of unexcused absence beyond the sanction standard.

Payroll payment execution

- **Indicator:** 1. Sample inspections of payment in each month in each county made by government (any of the state ministry of finance, county administration, or CHD) and reported to the County Transfers Monitoring Committee. 2. Signed/marked paid pay sheets for 75% of govt. health staff per county returned to the county within one month of pay, and 95% within three months.

Operations costs

Implementation of local government PFM manual

Operation costs budgeting at local level

- **Indicator:** The county budget is to contain the budget for health in the correct format/templates (as per the local government PFM manual and budget call), yes/no; and correctly budgeted for health conditional transfers, yes/no.

Maintenance of cash and bank books

- **Indicator:** County quarterly budget performance reports to the County Transfers Monitoring Committee are made, show conditional transfers being spent correctly, and are accepted as satisfactory by the committee.

Reporting to communities and community accountability

- **Indicator:** Monthly lists should be posted at 90% of county facilities for government staff paid there.

Audits and control

- **Indicator:** GRSS must have, in the Centre and states, an audit plan in place that includes plans for counties' audits. Further benchmarks could follow on implementation of the audit plan.