FORWARD-LOOKING ANALYSIS OF FUNDING AND STRUCTURAL OPTIONS FOR THE HEALTH SECTOR GOING FORWARD, AND HOW THEY COULD BE OPERATIONALISED

For: Delegation of the European Union to South Sudan, and the Ministry of Health – Government of the Republic of South Sudan

February 2018

FINAL REPORT: Narrative report

This study is funded by the European Union

Reference: FED/2017/384-934

Disclaimer: The views expressed in this study do not necessarily reflect the views of the European Union

Prepared as part of "Forward-looking structure and options" assignment; This study is funded by the European Union. Disclaimer: The views expressed in this study do not necessarily reflect the views of the European Union

Contents

Prepared as part of "Forward-looking structure and options" assignment; This study is funded by the European Union. Disclaimer: The views expressed in this study do not necessarily reflect the views of the European Union

1. Executive Summary of the Assignment

Objective

The overall objective of this action is to contribute towards stable, sustainable, value-for-money and equitable arrangements for the delivery of health and other essential services across the whole of South Sudan from 2017 onwards, looking particularly at a five-year horizon, particularly at successor arrangements for current donor funded health programmes, and considering particularly the comparative advantage and role of the European Union. It is intended to put a 'capstone' on EU engagement to this point, that gives a launching point for future service delivery progress, by GRSS, EU, and other partners.

Progress of the assignment

This six month assignment began at the start of May. An inception report was submitted at end May, and approved in June.

MoH availability, and MoH's requirement for a direct exchange with EU, meant that some adaptations were necessary in how the assignment was delivered. The principle of making available a "continuing working draft" for EU, to support engagement with donors and the sector, was sustained.

At the end of August, a "donor information session" was held, hosted by the Delegation of the EU, briefing on analysis to that point, and aimed at building a common understanding of "the story so far" of the South Sudan health sector, following a period of changeover of donor personnel.

At end October, the EU Team Leader Basic Services and Governance was able to meet MoH.

This draft final report is presented in conformity with the timelines for the assignment. It is anticipated that a "postlude" presentation and discussion of the assignment, with EU and MoH, and then with other donors too, will take place in early February.

History of South Sudan Health Sector

Health sector development in South Sudan is, unlike some FCAS contexts, not a matter of reconstruction of a service that previously existed.

Prepared as part of "Forward-looking structure and options" assignment; This study is funded by the European Union. Disclaimer: The views expressed in this study do not necessarily reflect the views of the European Union

South Sudan has a chronically underdeveloped health system and some of the worst health indicators in the world.

Decades of conflict and underinvestment meant that, following the CPA, GOSS and then GRSS assumed responsibility for a dysfunctional system...

...GRSS health expenditures were always inadequate to meet the needs of the population. The economic crisis has reduced the effective value of GRSS spending, by an order of magnitude, compounded by decreasingly reliable budget execution and extended delays in disbursements.

A significant proportion of health services are funded by external donors. Even accounting for this assistance total resources available are inadequate for the provision of even basic services to the whole country. Donor programming is relatively heterogeneous in term of geographic division, service levels, health sector development approaches; there are geographic coverage gaps, and gaps of service.

Conflict and resilience

The health sector in South Sudan has historically demonstrated resilience in times of conflict; however the conflict has inevitably had a major toll on the sector, and especially on women and children.

The current phase of conflict which broke out in December 2013 has hit the sector both in terms of direct impact (destruction of facilities, in some cases deliberately targeted; mass displacement of communities and health workers; interruption of supply lines), and also as a result of the economic crisis caused both by the war and a dramatic fall in oil revenue.

Pre-existing inequities in health care delivery have likely been exacerbated by the current model of service delivery which divides the country into areas served by different donor programmes.

Political decisions made as a response to the conflict have also impacted on the health sector. The decision to create 32 states (33 if the contested area of Abyei is included), increased from the former 10, has the potential to bring services "closer to the people" in the long-term, but in the short to medium term it places stress on highly limited financial and skilled human resources.

Women and children have particularly suffered as a result of the conflict, through displacement, lack of access to basic services (e.g. health and education), increased levels of disease, violent attacks including sexual violence, trauma, and lack of access to basic nutrition.

In 2017 spread to reach almost every part of South Sudan, including former Northern Bahr-el-Ghazal and Warrap States. In the second half of 2017, new

Prepared as part of "Forward-looking structure and options" assignment; This study is funded by the European Union. Disclaimer: The views expressed in this study do not necessarily reflect the views of the European Union

displacement has slowed, there have been fewer large scale offensives reported in the Equatorias, and there have been some returns, notably in Yei Town. In October, President Kiir publicly ordered (predominantly Dinka) pastoralists to move their herds out of the Equatorias.

Programming decisions need to be resilient to a range of conflict and economic scenarios, and adaptable. This report sets out a "ladder" of options for a range of scenarios, as well as proposing a pivot towards more sustainable service delivery arrangements than NGO-led service delivery, towards a more diverse national health sector, and towards steps to regain health's share of GRSS budget.

MOH Priorities and Budget

MOH has demonstrated sustained commitment to reform, but the impact has been undermined by depreciation and administrative redivision

The MOH budget almost doubled in nominal terms from 2016-17 to 2017-18, but this has not been enough to counteract price inflation, implying a fall in the budget in real terms by a factor of more than ten; MoH's share of GRSS budget has almost halved from 2013-14 peak, while security and rule-of-law have gained.

Despite 2016 uprating, GRSS health workers' remuneration is exceptionally low, with most earning less than $12 per month – which they do not consistently receive.

Partners have taken on additional responsibilities in some areas; services have not significantly expanded and there have been gaps in services

Over the last ten years, MoH has made successive reforms, realigning resources to support front-line services through transfers; MoH has continued in this course in 2017-18, albeit with less traction on overall value available than MoGEI: a key challenge is for donors to support this progressive approach – which it would also be prohibitively expensive to substitute for.

In budgeting for different Health Care Levels, MoH has given priority to primary and preventive/community care, in particular, the Boma Health Initiative, which looks to place a three member semi-skilled BHI team in 2500 Bomas (average population coverage of 4000 per team). And MoH has expressed a wider vision in the National Health Policy 2016-2026: community-anchored health system for sustainable health sector development.

International Comparisons

Models for health service delivery and health sector governance from 12 disrupted health arenas were reviewed, as summarised below.

Prepared as part of "Forward-looking structure and options" assignment; This study is funded by the European Union. Disclaimer: The views expressed in this study do not necessarily reflect the views of the European Union

Country and period	Services/programme/project	Feature/axis of comparison
Democratic Republic of Congo 2012-	Accès aux Soins de Santé Primaire (IMA World Health/DFID)	Transition onwards from NGO service delivery "Co-management" of service delivery by Government and FBOs Public health-led approach. At scale HSS
Somalia 2008-	Health Consortium for the Somali People (incl. relatively advanced forms of contracting in), Joint Health and Nutrition Programme, new DFID SHINE programme	National lead donor role (in this case, played by DFID) Contracting-in for funding of staff (under HCSP); NGOs in technical support role. Different service delivery models in one country (HCSP versus JHNP, and soon SHINE). Operations in severe conflict context (including service delivery in non-government-controlled areas)
Sierra Leone 2010-2015	President's Free Health Care Initiative FHCI	Government-led switch to free at point of use care for priority populations, major expansion of coverage and services. Donor support on-budget and aligned. Pharma supply chain UN++
Liberia	Health Pooled Fund	A much misunderstood case – a health pooled fund that was, at least initially, focused on supportive actions, rather than service delivery
Malawi, Zambia ++	Role of faith-based service delivery in a range of African countries – both stand-alone and contracted (eg CHAM) basis	Indigenous non-governmental service delivery
Ethiopia	Federal Ministry's national roll-out of Health Extension Worker programme	Exceptional UHC coverage of territory with limited resources. Government-led, donor-supported; an exceptional governance context
Rwanda	Para-compulsory National Health Insurance	Unique governance context driving high uptake of insurance scheme
East Timor	Skilled human resource-led local provision	Quarter of workforce are doctors
Uganda 1980s-	Free Health Care initiative and PFM reforms	Indigenous service delivery, with straight-through funding… but crumbling edge of quality and re-emergent user fees

Prepared as part of "Forward-looking structure and options" assignment; This study is funded by the European Union. Disclaimer: The views expressed in this study do not necessarily reflect the views of the European Union

Haiti	Maternity waiting homes	Making EmONC referral work in resource-constrained FCAS context
Afghanistan	Extensive contracting out	

Three core observations: were:

- "No Health without a Workforce": An expansion of the number of skilled health workers, delivering universal health coverage (to each household) can deliver rapid gains in health outcomes (and economic development). A focus on HRH over infrastructure is wiser. ('Good staff in poor buildings' is better than 'Poor staff in good buildings')
- Beware of "It worked in Peru" argument: The pooled fund model (e.g. Liberia, Afghanistan) have been used as blueprints in South Sudan, but key aspects have not been mapped across
- There is no 'empty void': the healthcare space is richly diverse. While donors and host governments focus on government and NGO facilities, a range of faith-based, private and other services are often neglected: "The health space is fragmented and system-less, the whole being less than the sum of its parts." (Source: Pavignani, 2014, Murru et al 2015)

Value for money

A value for money review considered the relative performance of existing support to the health sector to inform recommendations of how greater Value for Money could be achieved in future programming.

Efforts to undertake this assessment have been constrained by challenges in accessing information. Indeed it was not possible to access detailed Value for Money or quarterly financial reports for the projects while publically available documents do not provide sufficient detail to properly understand the underlying dynamics of Value for Money.

.

In future, it is hoped that more such information will routinely be made publically available. Given the significant levels of assistance being provided in the health sector, being able to compare approaches and identify best value-for-money approaches is essential to ensuring the maximum number of people can be reached with the resources available. In both broad and narrow senses, fiduciary-risk management is closely connected to transparency. It is difficult to make deep judgements on Value for Money without access to such data, and in other cases it is indeed made public - for example, the DFID Girls' Education South Sudan project publishes its quarterly reports on its website.

Prepared as part of "Forward-looking structure and options" assignment; This study is funded by the European Union. Disclaimer: The views expressed in this study do not necessarily reflect the views of the European Union

The Value for Money review, nevertheless, on the basis of public information was able to make the following recommendations:

- **Increase the emphasis on VFM reporting itself**. Simply stated, any continued large scale support to the health sector must be accountable against the principles of VfM
- **Simplify the reporting and management burden for VFM** – better to monitor a few key principles clearly and consistently, than to fail to report against an over-ambitious strategy
- **Prioritise focus** on:
    - Economy – Regular external audits of procurement and financial management practices;
    - Efficiency – Costs per beneficiary;
    - Effectiveness – Costs per DALY (in theory and ultimately in practice);
    - Equity – Geographic breakdown of beneficiaries.
- **Extend the 'contracting-in' model as far as possible** to counties which have sufficient capacity. If in Jonglei and Upper Nile 25% of all supported counties were sufficiently strong to be able to handle this modality, it is likely that proportion of counties in all other states could equally manage it given that capacity in the Greater Upper Nile region is often lower than other parts of the country. Evidence from IMA and the World Bank has shown this model to be highly cost-efficient, more resilient to conflict and more inherently sustainable. Were the 50% savings achieved by RHHP per county to be extended to 25% of all counties under the HPF, the potential freed up resources for greater service delivery support would be very substantial.
- **Increase pressure on reducing NGO non-direct costs of delivery** in line with that achieved by the nationwide Girls' Education South Sudan project (24% from 2013 to end of 2016 compared to >30% for HPF).
- **Annually review the package of essential services supported**, including the relative balance between what is delivered in actual implementation, to ensure that it is expected to have the lowest cost per DALY averted in both theory and practice
- **Ensure disaggregation of costs for different components of non-service delivery support** to allow for a qualitative assessment of whether progress against these activities justifies the investment undertaken.
- (To the extent not already done) **develop a real-time publically accessible table that shows in a simple manner the estimate coverage of different services in different counties** (or at least for each state). This could be based on that used for the nationwide GESS project - http://sssams.org/sbrt/equitytable.php, and build on www.southsudanhealth.info. This would allow for a regular assessment of how geographically equitable health service support is.
- **Revitalise attempts to ensure harmonisation of payments to health workers across the country**. This is highly relevant for both sustainability and equity.

Prepared as part of "Forward-looking structure and options" assignment; This study is funded by the European Union. Disclaimer: The views expressed in this study do not necessarily reflect the views of the European Union

- **Continue some level of support to PFM within the health sector given the major costs, particularly in terms of time, required to re-build a PFM system once it has collapsed.** This is important even as government contributions to the sector have become extremely small. At some point in the medium term future it is likely that the government will again be the more dominant funder of the sector, as it was as recently as 2014/15.
- (To the extent not already done) **ensure a rational approach to managing user fees within health facilities.** Data on what happens at the moment is not clear. It is likely that user fees are the largest part of financing of many health facilities, in line with regional experience. It is important that (i) fees are properly managed and accounted for; and (ii) priority services are subsidised, even if non-priority services remain fee-paying.
- **Conduct a comparative analysis of the relative effectiveness of Performance Based Contracting as carried out by HRRP**. The data to conduct this analysis may already exist but has not been publically released. Evidence has shown that it can increase Outputs, but this does not seem to have been related back to what the additional management costs of the modality are. It might be necessary to conduct a further evaluative experiment to directly compare HRRP and HPF modalities in this respect.
- **Increase emphasis on cross-programmatic learning.** The potential advantages of having multiple approaches within the country in terms of learning from which modalities are most cost-effective do not seem to have been grasped (e.g. the lack of any cross-programme review of HPF and HRRP, despite recommendations for this in the 2015 HPF Mid Term Review). It would also be possible to carry out experimentation within one large sector-wide project – indeed this might enable a more effective information flow.
- **Continue to drive forward the integration of health projects within the sector.** Opportunities include incorporating the next phase of ICCM into the HPF, merging the HRRP and HPF, as well as further assessing where consolidation is possible amongst the range of other standalone donor support projects continuing in the sector. It is likely that each separated project carries greater overheads and duplication than could be achieved with one consolidated pooled support programme.

Ground truth sample: Villagers' Access to the Health Network: a frugal and interim option for immediate improvement

An extended "deep dive" was conducted, for more than a month, in two (33 State model) States, Terekeka and Tonj, examining the functioning of health services at local level.

Distribution of staffing and health facilities appears irrational, even in areas which are served by a facility still vary greatly in their ability access care

Prepared as part of "Forward-looking structure and options" assignment; This study is funded by the European Union. Disclaimer: The views expressed in this study do not necessarily reflect the views of the European Union

The provision of health services to rural populations throughout South Sudan in late 2017 is delivered through an archetypal Primary Health Care (PHC) model. There is no typical infrastructure or staffing profile at the facility closest to the rural population, that of the PHC Unit. There may be three members of the health workforce all with rudimentary health training (or none) within a one- or two-roomed infrastructure of local construction or, alternatively, there may be thirteen people, some with diplomas, working from a solid five or six room building. In either case, the team will engage with a queue of individuals who have self-identified as being sick. Some disease-prevention work, most notably that of vaccination, is delivered through mobile teams based at State or even national level. Some facilities conduct other outreach, most often health education.

The national-level Ministry of Health estimates that 44% of the population lives within 5km of a health facility (HFM, 2011 – any expansion in the number of facilities since then has been negligible). This is indicator is considered as a proxy for the number of people with access to services, including PHC Units and the larger PHC Centres, State and County Hospitals. This leaves 56% of the national population without reasonable access to service provision[i]. Given that urban and peri-urban populations will disproportionately use the service and that facilities are deliberately located in population concentrations; deeply rural populations can be expected to have markedly less accessibility to the health network. Areas with the fewest health facilities often have the least rational distribution.

Further, where a facility does exist, the distribution of services *within* its catchment area is constrained. Those living in outlying villages – which may lie some distance away - are markedly under-served. A clear imbalance exists: under normal circumstances those who live in the host village can access services all day, every working day of the year; those outside have no regular services on any day. Hence, there is inequitable access.

Moving beyond the facility would increase coverage and could stimulate greater demand for services; support a step-wise approach to the Boma Health Initiative

An evolution of the existing set-up that will expand the physical coverage without additional resources is both possible and practical. (So far, only proof-of-concept trials have taken place.) Existing health workers could be instructed – and helped – to reorient their focus from *looking at* the acutely sick within their limited health facility towards *looking for* the not-yet-sick within their entire catchment area. In a sense, a better net –rather than a better network – will allow increased coverage.

This approach would support the refinement and step-wise roll-out of the BHI. This would also contribute to the development and implementation of the Boma

[i] Source: Conversation with a NGO project manager derived from briefings on the Boma Health Initiative (BHI). However this figure does not appear in the principal BHI literature and it is not apparent how it has been calculated.

Prepared as part of "Forward-looking structure and options" assignment; This study is funded by the European Union. Disclaimer: The views expressed in this study do not necessarily reflect the views of the European Union

Health Initiative, providing facility-based health workers with a better understanding of the communities they serve and their health needs, gaining experience of conducting outreach and community-level health activities. A greater engagement with communities could help identify the scale of needs and stimulate demand. This would support better matching of resourcing and need, as part of progressive roll-out and deepening of the Boma Health Initiative.

Travelling light – due to long distances (commonly up to two hours' walk) or difficult terrain – the health worker would require, in addition to a few basic items, only his most precious resources: his eyes, ears, brain and mouth[ii]. The objective will be to reach out to villagers in their own village and, using the existing and resilient, traditionally-grounded, local authority structures, seek out at-risk individuals and others and either generate behaviour change *in situ* or refer certain individuals to the base PHC Unit for later assessment and treatment there. (In an unfortunate distortion, the workaday term 'outreach' has come to be seen amongst the South Sudanese health workforce as vaccination work only.)

The Boma Health Initiative (BHI) is both sound in its assessment of need and correct in its sentiment: vigorous and prolonged effort is needed to include and fix the now-marginalised rural population firmly within health service provision.

Evolving sector support context

The earlier [August 2017] version of this document, was written based on the assumption of a transition from the current generation of support to the health sector to a new generation of support happening relatively rapidly, with World Bank funding for RRHP due to end in September 2017, and DFID having stated that they anticipated beginning procuring a new "Health Pooled Fund 3" in early September 2017.

Since that point, RRHP has been extended to March 2018. At the current time, procurement of a new Health Pooled Fund 3 has not yet begun, and it is understood that Health Pooled Fund 2 partners are having their contracts extended to close to the end of 2018.

This changed context potentially enables:

- Trialling of new approaches alongside current service delivery mechanisms, rather than "big bang" choices having to be made in procuring new service delivery arrangements
- Engagement with and potentially significant progress through GRSS Budget FY18-19, building on the progress made by the education sector in FY17-18

[ii] Trained health workers in deeply rural areas are, almost without exception, male.

Prepared as part of "Forward-looking structure and options" assignment; This study is funded by the European Union. Disclaimer: The views expressed in this study do not necessarily reflect the views of the European Union

Forward looking structural and financing options for health sector, with particular focus on positive priorities, and operationalisation options

The table below summarises a set of proposed priorities, and approaches to Operationalisation.

Pillar	Priority	Description	Operationalisation
Service delivery	Transition from NGO-led to country-led Service Delivery	Transition from NGO Service Delivery to a more sustainable, affordable country-led Service Delivery (and associated funding) model: this priority is supported by VfM evidence from last generation of programming, and arguments in terms of sustainability	• See next
Service Delivery	Focus on facilities and County/ local government for support and funding:	Transition to standard incentives, payable through facilities, e.g. on the model of EU IMPACT programme, for service delivery cadres, to reduce churn, improve value, retain government health staff, and bring health remuneration closer to a level that GRSS might be able to afford to support, and into a structure through which GRSS can fund Operational funding based on clear requirements and accountability for facilities and offices, and payable direct to those facilities and offices	• Prioritise continuity of support: pilot, and ideally establish new systems for remuneration and operational grants before transition of existing NGO contracts to new service delivery model (above), and/or before new generation of support programmes; but clearly identify saving that is expected to result • Systems for remuneration need reasonable assurance – eg completing and updating HRISRSS holdings, health worker attendance management; opportunities to leverage synergies with IMPACT systems and field operations

Prepared as part of "Forward-looking structure and options" assignment; This study is funded by the European Union. Disclaimer: The views expressed in this study do not necessarily reflect the views of the European Union

			• For operational funding, systems already in place at MoH and MoFP, but need support – key lacuna is to get Health Transfers Monitoring Committee meeting monthly as education counterpart does, and to put in place stable support to its Secretariat
Service delivery	Structure of service delivery	Focus on MNCH referral, and specifically how women can access CEMoNC services reliably and in good time	What gets measured, gets managed: focus use of www.southsudanhealth.info and DHIS reporting data to drive CEMoNC services being available; consider Behaviour Change Communication approaches to encourage women to move to CEMoNC-available facilities/"birth waiting hostels" nearby in good time ahead of delivery
Service delivery	Embed transition from Primary Health Care to Universal Health Care approach	Implement priority elements of the Boma Health Initiative, from a Universal Health Care perspective, beginning with more rational distribution and deployment of existing resources to cover more territory more equitably	U/S letter on implementation of priority elements of BHI, starting with mandating rational distribution, and new working practices
Service Delivery	Pilot Operational Health Zones approach	In the context of continuing changes to the subnational government map, and building on incremental progress made by HPF in consolidating support to groups of Counties, for economies of scale and more effective referral function, consider piloting	Seek a small number of "volunteer" areas where County, State and existing NGO partners are willing to trial the approach; offer limited additional funds to support it

Prepared as part of "Forward-looking structure and options" assignment; This study is funded by the European Union. Disclaimer: The views expressed in this study do not necessarily reflect the views of the European Union

		an approach of "Operational Health Zones", based on the Zones de Santé approach successfully adopted in DR Congo, in which, in the context of changing subnational political governance arrangements, operational management is established over an area that makes sense in health terms (radius of referral around a facility that provides CEmONC/basic surgery services, typically serving more than 100,000 people, 24/7), with co-management by government and partners	
Human Resources for Health	Address the wide variation in staffing of even NGO-supported facilities; moving to UHC approach to staffing	Implement staffing norms that exist in core BPHS Improve management of deployment and attendance Good HRH in poor facilities is better than poor HRH in good facilities. But increased HRH numbers need a corresponding increase in management and supervision (otherwise productivity falls)	Cadre definitions already in place. Use management data from www.hrisrss.org and SSEPS (linking with actions re remuneration) to identify outliers in staffing terms Roll-out health worker attendance management, building on experience from HPF and IMPACT Potentially use enrolment on/updating of HRIS to take basic steps to triage workers in terms of potential (eg those who could move up from CHW to Registered Nurse with training)
	Reduce "churn" and making remuneration	GRSS remuneration is unsustainably low and erratic, NGO	Agree simple incentive – NB not salary - rates based on available funding and previous

Prepared as part of "Forward-looking structure and options" assignment; This study is funded by the European Union. Disclaimer: The views expressed in this study do not necessarily reflect the views of the European Union

	effective and sustainable	remuneration unsustainable in affordability terms: link with Service Delivery options above to move to more sustainable approach of harmonised incentives for all health service delivery workers, GRSS, FBO and NGO, with a view to transition to government funding	(eg RRHP and MoH2014) practice • Establish basic processes for facilities to assume management and hire-and-fire of workers
Finance, leadership, governance and partner relations	Make a path to MoH resuming role as principal funder	Service delivery funding via facilities, and health worker remuneration funding, on the model of IMPACT, as set out in the previous two sections, could offer ways to build up systems that will be needed for GRSS to route its funds, in advance of MoH's funding having returned closer to viable levels. Clearly, there will be choices to be made about sequencing and risk appetite by all parties.	Support MoFP and MoH to lead on operationalisation of systems for health worker incentives and operational grants to facilities, both in terms of systems and, ahead of FY18-19 budget, building on successes of MoGEI-GRSS in securing and executing additional funding Possible technical Support for HSWG and HTMC Secretariat functions with Finance and health sector support, at national and subnational levels
	Diversify engagement: "Country" is not identical to "Government"	Sustainable, inclusive and progressive arrangements need to build up the agency of facilities, facility networks, trade unions and faith-based health actors. NGOs' voice has been excluded/missed for the last two years, and needs to be brought back to the	Revise project and sector governance structures to include NGOs, FBOs, trade unions. Reinstate NGO Health Coordinator post.

Prepared as part of "Forward-looking structure and options" assignment; This study is funded by the European Union. Disclaimer: The views expressed in this study do not necessarily reflect the views of the European Union

		table, through participation in governance arrangements, and as a vital contributor to knowledge management. FBOs play a major role in service delivery, and the role of FBOs has been crucial in progress in other FCAS health sectors, at both service delivery and strategic levels. At present, Roman Catholic church is strong at PHCC/District Hospital level, but has limited national representation. ECSS&S Health Commission is less active than Education Counterpart. CHASS (Church Health Action in South Sudan) is moribund, and cut off from member churches.	Consider funding churches directly or via faith-based NGOs to set up national level health offices, either for each denomination and/or as part of South Sudan Council of Churches operation.
	Scale up role of HSWG and HTMC, to improve and integrate project governance	Scale up role of Health Sector Working Group (at senior/heads of mission level, and occasionally) and HTMC (at management level), to take a "Secretariat" role for MoH across major programmes, including its own, on the model of how Education Transfers Monitoring Committee serves as monthly management instance for both major education	Support PFM and sector governance processes with appropriate technical support, in the light of withdrawal of BSI support, and drawing on education sector model. Support needs to be on both finance and sector sides, and, in the context of the proposals above re incentives and operational grants, logically complemented at subnational level too

Prepared as part of "Forward-looking structure and options" assignment; This study is funded by the European Union. Disclaimer: The views expressed in this study do not necessarily reflect the views of the European Union

		sector programmes and all education transfers. Potential for non-executive/oversight role of contributing donors to increase – on similar model to ETMC, which includes both contributing and non-contributing donor partners.	
Pharmaceuticals, medical supplies and equipment	Make medium term commitments for pharmaceutical supply chain	In all likely scenarios, pharmaceuticals will be reliant on partner funding for the medium term – and this is consistent with partners' comparative advantage in at-scale procurements etc. New programming will logically build this in. Consider vertical division of labour within programming. Support country (GRSS +) drug procurement and supply systems in a way that both service delivery programmes can rely upon, and that builds country capacity sustainably towards a sustainable transition. Support resilience – for example, building on example of other African countries of having a faith-based pharmaceutical supply chain alongside the national supply chain.	Donors may wish to consider ways of providing early and extended certainty re drug procurements. See above re targeted support to faith-based organisations to build up capacity.

Prepared as part of "Forward-looking structure and options" assignment; This study is funded by the European Union. Disclaimer: The views expressed in this study do not necessarily reflect the views of the European Union

Infrastructure/ coverage:	Target investment in filling coverage gaps, use education facilities and mobile human resources operating from existing facilities to scale-up coverage efficiently	Coverage of facilities and services is low by international standards, and specifically in the context of the resilience needs. Improving coverage in conflict context: Bringing existing facilities up to a common standard Targeted infrastructure investment focused on where populations are least well served: logic of the original HPF design stands Comprehensive geographic coverage of frugal core of BHI, under the management of and referring to PHCUs in a network under a PHCC Distributing health workers to redress imbalances between Bomas Education-health synergies – e.g. Health services and staff basing from schools where there is not a PHCU (there are twice as many schools as PHCUs), and directly supporting schools	With regard to deployment of health workers to UHC ends, see Detailed Operationalisation plan set out in: "Villagers' Access to the Health Network: a frugal and interim option for immediate improvement" With regard to basing health workers in schools: suggested U/S MoH to U/S MoGEI correspondence to seek green light Taking all practical steps towards the target of one health care unit per Boma, whether or not that unit is in dedicated health buildings, in a school, or, if necessary, constituted only by its human resources
Supervision, Monitoring and Evaluation:	Ensure timely and comprehensive information flows electronically across	Importance of prompt, disaggregate, shared	Monthly reports of up-to-date sector information to HTMC, based on DHIS,

Prepared as part of "Forward-looking structure and options" assignment; This study is funded by the European Union. Disclaimer: The views expressed in this study do not necessarily reflect the views of the European Union

	the sector, using appropriate technology	information, flowing direct from source Changes to subnational government structure have put pressure on government and sector management, data, and monitoring and evaluation systems: it is vital that prompt, disaggregate information can flow direct from (facility/local) source to be available to all actors through, by default, public websites. Information needs consumers: role of HTMC as a monthly reviewer of data, and chaser of progress, as per Social accountability through public data and behaviour change communication (BCC) that creates a national discourse about health management, building on example of BCC re girls' education	www.southsudanhealth.info, www.hrisrss.org etc Consider engaging dedicated broadcast and community-level BCC support, either separate from (eg as a pilot ahead of), or integrated with, new programmes, building on example of GESS in education

Prepared as part of "Forward-looking structure and options" assignment; This study is funded by the European Union. Disclaimer: The views expressed in this study do not necessarily reflect the views of the European Union

.

2. Structure of the final report package

This final report package:

- Provides an executive summary of the assignment, synthesising all the nine documents produced
- Summarises the objective and purpose of the assignment, narrates progress of the assignment, sets out how the requirements have been delivered, and synthesises the findings of the various analytical deliverables

The various analytical deliverables are then attached as annexes.

3. Objective and purpose: evidence-based proposals for structural options for support to South Sudan Health sector, and analysis of how they could be operationalised

Overall objective

The overall objective of this action is to contribute towards stable, sustainable, value-for-money and equitable arrangements for the delivery of health and other essential services across the whole of South Sudan from 2017 onwards, looking particularly at a five-year horizon, particularly at successor arrangements for current donor funded health programmes, and considering particularly the comparative advantage and role of the European Union. It is intended to put a 'capstone' on EU engagement to this point, that gives a launching point for future service delivery progress, by GRSS, EU, and other partners.

Purpose

The stated purposes of this action are:

- A historically informed, forward-looking analysis of funding and structural options for the health sector for short, medium and long term, and how they could be operationalised.
- To explicitly consider the context of the current and likely future conflict.

Prepared as part of "Forward-looking structure and options" assignment; This study is funded by the European Union. Disclaimer: The views expressed in this study do not necessarily reflect the views of the European Union

- To articulate the plausible range of structural options for the sector, looking across both GRSS and partner funding and provision, and considering both funding and service delivery structures, and prioritise them, in particular against the criteria of likely impact, value for money, and sustainability, and in particular considering ways to move beyond direct service delivery by NGOs. This should include consideration of innovative approaches (task-shifting/community and public health approaches /m-health/e-health systems), and particular attention to GRSS' "Boma Health Initiative".
- To articulate operationalisation considerations and timescales for each principal option, including specifics of their fit with donor and MoH processes, policies and risk appetite
- To consider how, within the constraints, options might support the building of a viable and plural state, for example alignment/shadow-alignment, capacity-building, and the role of government as specifier/monitor
- To consider opportunities for synergies across basic services sectors, and with humanitarian action

4. Narrative of progress of the assignment

The consultant team mobilised in early May.

A kick-off meeting with Dr Richard, MoH took place, after delays at MoH's request, on 15/5/17. A further meeting scheduled for 19/5/17, to follow up, was deferred at MoH's request, because of limited availability.

A range of meetings were held with stakeholders, including donors, fund managers, international organisations and NGOs during the inception period.

An inception report was delivered on 31st May, and was confirmed approved on 22nd June.

The consultant team was reshuffled following the inception phase to adapt to the circumstances. Jo Ferry, having led the initial contacts and led the review of international comparands, handed over leadership of the assignment to Liz Gaere OBE and Francis Middleton. As prospects of the set piece "ground truth" visit for MoH and donors receded, the role of Mark Beesley RN was expanded, to provide a 'deep dive' into ground truth, through extended fieldwork in Terekeka and Tonj States.

The axes along which progress could be made were restricted by:

Prepared as part of "Forward-looking structure and options" assignment; This study is funded by the European Union. Disclaimer: The views expressed in this study do not necessarily reflect the views of the European Union

- MoH's progressively hardened requirement, across all donors, for direct engagement with the donor, which proved challenging for the EU in the context of the evacuation of the delegation. These meant that the envisaged initial workshop was in practice replaced by *seriatim* bilateral engagements, with MoH, and with donors, described above. During June and July, Liz Gaere OBE, working with Francis Middleton, led on this process.
- Challenge from some donors about the nature of the assignment, on the basis of:
    - A misunderstanding, which some donors appeared to have, and which they passed on to MoH, that the assignment was intended to be an "evaluation" of the Health Pooled Fund, for which a separate evaluation was to be procured by DFID, as the fund holder. In June, CGA and EU clarified for donors and MoH that the assignment was aimed at collecting lessons learnt from all past/ongoing support and suggesting best practices and costed scenario for the next phase, and that while theoretically the activity might slightly overlap with a future HPF evaluation, it was demonstrably broader in coverage and narrower in scope and methodology.
    - A suggestion that there could be a conflict of interest between the consultants' role and possible involving in bidding for a possible future HPF. This was dispelled, and it was agreed with DFID in July that any source materials provided to the consultants should also be published, and that products and source materials from this assignment would be made available as "common goods" for the sector
- Specific demonstrated reluctance of some donors and partners, notwithstanding the above, to share information, in particular relating to value for money; these are described in the value for money report

On 28th July, CGA and the Delegation met in Brussels, and agreed a way forward of:

- CGA pushing forward with analytical work, to provide "preliminary findings" to inform EU's engagement; a first set was provided in mid-July
- EU engaging MoH in the course of the Head of Cooperation's visit to Juba at end August
- An information session for donors, during the course of that visit

Unfortunately, EU and MoH were not able to meet during the course of the Head of Delegation's visit. An initial meeting took place on Friday 26th October between Rashideh Yusef, the new Team Leader for Governance and Basic Services, EU Delegation to South Sudan, and Dr Loi, for MoH.

The information session for donors occurred on 31st August. Representatives of EU, Canada, DFID/UK Aid, Sweden, USAID and the World Bank were invited.

Prepared as part of "Forward-looking structure and options" assignment; This study is funded by the European Union. Disclaimer: The views expressed in this study do not necessarily reflect the views of the European Union

The following attended:

- Dan Pike, Georgina Krause, DFID/UK Aid
- Ruth Madison, USAID
- Stefano Ellero, Kenyi Kilombe, EU
- Morten Petersen, Tharwat al-Attas, ECHO
- Catherine Baga, SIDA

Bilateral discussions with Canada and World Bank supplemented.

Six reports were presented, on the following topics:

- A: Health forward-looking structure and options inception report
- B: Historical background to health service delivery and structures in South Sudan, 1899-2017
- C: Implications of the South Sudan conflict for the health sector
- D: Notes on understanding of National /MoH health priorities looking ahead (2017-2022): headlines of MoH 2017/18 Budget & 3rd Health Summit Key Resolutions
- E: International comparands with potential relevance to South Sudan health sector as regards health service delivery and health sector governance
- F: Analysis of forward looking structural and financing options for health sector, with particular focus on positive priorities

A glossary of terms was also provided.

During September and October, CGA also provided a further two reports for discussion:

- G: Value for Money analysis
- H: Report of ground truth sample: pathways to increased health service coverage; this edition of the report was after the first deep dive visit to a State (Terekeka); a revised version, including findings from the second (Tonj) is now presented

To which is now added:

I: Gender and the health sector: key challenges in the context of conflict

In early October, CGA and EU met in Brussels, and discussed the following approach:

Prepared as part of "Forward-looking structure and options" assignment; This study is funded by the European Union. Disclaimer: The views expressed in this study do not necessarily reflect the views of the European Union

- "It would be logical to present the VfM and Ground Truth outputs now delivered to donor group, in the same way that the other outputs were presented
- Given the constraints with regard to MoH engagement (the quest for which has also involved some costs), alternative approaches have been found (eg ground truth "deep dive" in place of the planned sample visit)
- Following bilateral EU and MoH engagement, the full set of draft documents were shared with the MOH. Its feedback has been taken into account, and a formal response will be facilitated after the final presentation of analyses to it.
- Assignment will be completed on schedule

In practice, as described above, the EU-MoH meeting did not take place until 26/10/17.

This final report is therefore presented with a view to a "postlude" presentation to the EU and other health donors of the full set of analytical outputs in earlyFebruary.

5. How the results have been delivered

Results to be achieved by the Contractor	Approach	Delivery
Initial workshop bringing together the MoH, MoFEP, and representatives of major funding (DFID, EU, Canada, Sweden, USAID etc), multilaterals (WHO etc) and implementing partners (NGO and faith representatives), to agree an analytical process, and possible 'ground truth' sample visit	A kick-off workshop was planned to take place during the inception phase, bringing together major stakeholders. The aim of the workshop was to introduce the assignment and, in the context of transition of major partner programmes, to initiate an open and realistic dialogue. This included discussion on how the process ought to be implemented, and identification of some of the key considerations with regards to the next	**Partially Revised** Due to limited in-country availability of EU officials, it was not possible for the MoH to have a chance to engage directly with the EU as part of the commencement of the project. The MoH expressed a desire to participate in the assignment, but with a prerequisite that the initial bilateral take place ahead of any other activities. Separate, informal meetings were held with

Prepared as part of "Forward-looking structure and options" assignment; This study is funded by the European Union. Disclaimer: The views expressed in this study do not necessarily reflect the views of the European Union

	phase of health programming. A possible 'ground truth' visit was planned to gain a better understanding amongst partners and the MoH as to the state of health services, and to see that the planning and implementation correspond to realities on the ground. The assignment is divided into the following chapters: A) Analysis of forward looking structural and financing options for health sector B) The historical background to health service delivery and structures in South Sudan C) Implications of the South Sudan conflict for the health sector D) MOH Policies, Priorities and Budget E) Health service delivery and health sector governance: international comparands F) Forward looking value for money assessment of EU support options to South Sudan health sector	the MoH (specifically the Minister and the DG Policy Planning and Budgeting) The Ministry was given the opportunity to input on the areas of focus and process, it identified a number of priority areas that it would like included in the assignment. At the end of August a donor information session was hosted at the EU Compound, with representatives from the EU, DFID, USAID, SIDA, and ECHO. During this session each of the chapters were discussed, and in several areas additional information was requested. In lieu of the 'ground truth' visit, and in response to the MoH's priorities, two 'deep dive' visits were undertaken. During these visits the feasibility of implementing the Boma Health Initiative was checked, whether the current facility-based provision of services was the equitable and efficient. A set of small changes to working practices could significantly increase access to services for many people, especially amongst those whose own village or boma does not host a facility. An increased focus on community-level care could be an effective way

Prepared as part of "Forward-looking structure and options" assignment; This study is funded by the European Union. Disclaimer: The views expressed in this study do not necessarily reflect the views of the European Union

	G) Gender and the health sector: key challenges in the context of conflict H) Human resources for health **I)** Taking health services to the boma	to build up the local capacity and experience to support the implementation of the Boma Health Initiative) The EU met with the MoH at the end of October, clearing the way for a stakeholder workshop and greater MoH buy-in, especially at senior levels.
Summary analytical report providing an evaluation, in qualitative and quantitative terms, of the impact of health funding modalities in South Sudan 2012 – 2016; this report is to be practically focused on findings that are applicable to the next phase of support other health sector in South Sudan, rather than on a purely 'academic' analysis	The assignment is divided into nine chapters, each of which addresses a key area of consideration for planning the next round of health programming. These were selected with input from range of stakeholders. The reports are designed to be accessible and serve as a basis for practical decision making, with recommendations drawn from the findings of both the Health Mapping and the HSO comparisons	**Delivered** The chapters include the historical background to the health sector; implications of conflict; MoH policies, priorities, and budgets; health service international comparisons; value-for-money analysis; gender and the health sector; human resources for health; and community-level care.
Report presenting analysis of options for the health sector going forward, on the basis of the retrospective analysis above, and drawing on demonstrable examples of "what works" in health systems in conflict and other dysfunctional contexts, and on health technical, public policy and donor policy skills, and in the context of donor and MoH processes,	Each of the chapters supports recommendations with easy read across from lessons elsewhere and under different programmes. Report presenting is **analysis of options for the health sector going forward**, on the basis of the retrospective analysis above, and drawing on	**Delivered** J) Implications of the South Sudan conflict for the health sector D) MOH Policies, Priorities and Budget E) Health service delivery and health sector governance: international comparands

Prepared as part of "Forward-looking structure and options" assignment; This study is funded by the European Union. Disclaimer: The views expressed in this study do not necessarily reflect the views of the European Union

policies and risk appetite delivered	demonstrable examples of "what works" in health systems in conflict and other dysfunctional contexts, and on health technical, public policy and donor policy skills, and in the context of donor and MoH processes, policies and risk appetite rammes	I) Taking health services to the boma
Workshop bringing the partners listed above back together to review and prioritise these options	It is planned to hold a final workshop inviting all key stakeholders to participate, to present the findings of the project and also to facilitate conversations between the MoH and partners	**Pending** A final debriefing workshop will be held for donors in early February. A separate debriefing session will be held with the MOH, following earlier meetings and engagement with the Undersecretary
Report on how these options might be operationalised delivered	The 'deep dive' fieldwork conducted in Tonj and Terekeka States provided a lot of useful information regarding how the network of facilities is managed (or not) and their links to the communities they serve.	**Delivered** The reports prepared on Tonj and Terekeka support the idea of a better use of existing resources, and a move out of the facility. As well as providing justifications for such approaches in theory, it also provides practical guidelines on what barriers need to be overcome, and what could start being implemented tomorrow

Prepared as part of "Forward-looking structure and options" assignment; This study is funded by the European Union. Disclaimer: The views expressed in this study do not necessarily reflect the views of the European Union

1 Summary of analytical materials and how they deliver against Inception Report workplan

The table below provides a summary of analytical materials and how they deliver against the tasks set out in the Inception Report workplan:

Tasks	Rubric	How delivered
1. A **framework for the analysis** should be established and described as part of the inception period.	"To provide a series of summary analyses, based on the health mapping project currently being executed, as well as additional publicly-available and 'grey' primary and secondary data , of overall needs, demands and supply of health services across South Sudan and their geographical coverage, distribution".	Inception Report
2. **Initial workshop**, bringing together MoH, MoFEP, and representatives of major funding (DFID, EU, Canada, Sweden, USAID etc), multilaterals (WHO etc) and implementing partners (NGO and faith representatives), to agree an analytical process...		Through bilateral meetings, and 31/8/17 donor information session
3. ...and possible **'ground truth' sample visit**		Through Report G: "Report of ground truth sample: pathways to increased health service coverage"
	To explicitly consider the context of the current and likely future conflict.	Through Report C: Implications of the

Prepared as part of "Forward-looking structure and options" assignment; This study is funded by the European Union. Disclaimer: The views expressed in this study do not necessarily reflect the views of the European Union

		South Sudan conflict for the health sector
4. 12 pages inception report within four weeks of contract start date [2nd May]		Inception Report
5. **Summary analytical report** providing an evaluation, in qualitative and quantitative terms, of the impact of health funding modalities in South Sudan 2012-2016; this report is to be practically focused on findings that are applicable to the next phase of support to the health sector in South Sudan, rather than on a purely 'academic' analysis	"To make qualitative assessment of the impact, value for money, and sustainability of current service delivery and funding arrangements"	Through reports • B: Historical background to health service delivery and structures in South Sudan, 1899-2017 (qualitative) • G:Value for Money analysis (quantitative) • F: Analysis of forward looking structural and financing options for health sector, with particular focus on positive priorities, and report
6. Interim and final analysis is to be presented through **consultative workshops** to engage sector stakeholders in a participatory way.		Through 31/8/17 donor information session, and donor debriefing workshop in early February
7. The options for support to the health sector will consider **international examples of best practices and lessons learned**. They will be associated with the capacities and appetites		Through report E: International comparands with potential relevance to South Sudan health sector as regards health service delivery and

Prepared as part of "Forward-looking structure and options" assignment; This study is funded by the European Union. Disclaimer: The views expressed in this study do not necessarily reflect the views of the European Union

of specific funders – including GRSS - to ensure they are realistic and also consider likely future scenarios within South Sudan in regards to politics, security, and the economy.		health sector governance
8. Report presenting is **analysis of options for the health sector going forward**, on the basis of the retrospective analysis above, and drawing on demonstrable examples of "what works" in health systems in conflict and other dysfunctional contexts, and on health technical, public policy and donor policy skills, and in the context of donor and MoH processes, policies and risk appetite	To articulate the plausible range of structural options for the sector, looking across both GRSS and partner funding and provision, and considering both funding and service delivery structures, and prioritise them, in particular against the criteria of likely impact, value for money, and sustainability, and in particular considering ways to move beyond direct service delivery by NGOs. This should include consideration of innovative approaches (task-shifting/community and public health approaches /m-health/e-health systems)	Through report F: Analysis of forward looking structural and financing options for health sector, with particular focus on positive priorities, and notes on operationalisation J) Costings of Option for further support
9. Workshop bringing the partners listed above back together to review and prioritise these options		Through 31/8/17 donor information session, and final donor debriefing session in early February
10. Report on **how these options might be operationalised**	"to articulate operationalisation considerations and timescales for each principal option, including specifics of their fit with donor and MoH processes, policies and risk appetite to consider how, within the constraints, options might support the building of a viable and plural state, for example alignment/shadow-alignment,	Through report F: Analysis of forward looking structural and financing options for health sector, with particular focus on positive priorities, and notes on operationalisation

Prepared as part of "Forward-looking structure and options" assignment; This study is funded by the European Union. Disclaimer: The views expressed in this study do not necessarily reflect the views of the European Union

	capacity-building, and the role of government as specifier/monitor to consider opportunities for synergies across basic services sectors, and with humanitarian action"	J) Costing of options for future support Community-level Health Care
Final narrative report		Through final narrative report (this document)

Prepared as part of "Forward-looking structure and options" assignment; This study is funded by the European Union. Disclaimer: The views expressed in this study do not necessarily reflect the views of the European Union

2 Annexes

- A: Health forward-looking structure and options inception report
- B: Historical background to health service delivery and structures in South Sudan, 1899-2017
- C: Implications of the South Sudan conflict for the health sector
- D: Notes on understanding of National /MoH health priorities looking ahead (2017-2022): headlines of MoH 2017/18 Budget & 3rd Health Summit Key Resolutions
- E: International comparands with potential relevance to South Sudan health sector as regards health service delivery and health sector governance
- F: Analysis of forward looking structural and financing options for health sector, with particular focus on positive priorities
- G: Value for Money analysis
- H: Report of ground truth sample: pathways to increased health service coverage
- I: Gender and the health sector: key challenges in the context of conflict
- J: Implementation and Costing of Key Options
- Action note of 31/8/17 donor meeting

Prepared as part of "Forward-looking structure and options" assignment; This study is funded by the European Union. Disclaimer: The views expressed in this study do not necessarily reflect the views of the European Union

ANNEX 1 HSO Deliverables

The ToR sets out specific requirements

Deliverable set out in Terms of Reference	Approach	Outputs Delivered
A series of summary analyses based on the health mapping project currently being executed, as well as additional publicly-available and 'grey' primary and secondary data, of overall needs, demands and supply of health services across South Sudan and their geographical coverage	A comprehensive summary report covering information from several individual chapters, individual aspects which fall outside these chapters, and a set of practical recommendations. These cover: 1) Areas initially identified during the project design with the EU, and with input from other partners 2) Priority issues requested by the Ministry of Health 3) Additional pieces in response to feedback from Donor Information Session Information used from the health mapping, including facility surveys, information systems mapping and partner mapping. Publicly available project reviews/evaluations, financial and	A) Inception Report: Analysis of forward looking structural and financing options for health sector B) The historical background to health service delivery and structures in South Sudan C) Implications of the South Sudan conflict for the health sector D) MOH Policies, Priorities and Budget E) Health service delivery and health sector governance: international comparands F) Structural and Financing Options for Health Sector, with focus on positive priorities and operationalisation options G) Villagers' Access to the Health Network: a frugal and interim option for immediate improvement

Prepared as part of "Forward-looking structure and options" assignment; This study is funded by the European Union. Disclaimer: The views expressed in this study do not necessarily reflect the views of the European Union

	fiduciary data for major projects (HPF, HRRP, ICCM) 'Deep dive' visits to Terekea and Tonj Participated in South Sudan Health Summit; Health Sector Strategic Plan Meetings with DG Policy Planning and Budgeting, Hon. Minister for Health, DG Primary Health Care, Special Adviser for Boma Health Initiative MoH official policies (BPHS/HSDP, HSSP, Transfers, Health Worker Grading and Remuneration) and annual budgets/expenditure data Third-party published reports on conflict, gender, and economic issues in South Sudan Publicly available documents, data and reports on health systems in comparands	H) Forward looking value for money assessment of EU support options to South Sudan health sector I) Gender and the health sector: key challenges in the context of conflict

Prepared as part of "Forward-looking structure and options" assignment; This study is funded by the European Union. Disclaimer: The views expressed in this study do not necessarily reflect the views of the European Union

Explicitly consider the context of the current and likely future conflict	There are specific chapters for conflict and gender (the latter one of the 'additional pieces') These draw on first-hand international experience and published reports, articles and policies on the effects of conflict on health systems, the provision of health services in dysfunctional contexts, and gender considerations around health services and the impact of conflict. At the Donor Information System participants requested that the scenarios considered for the evolution of conflict in South Sudan be expanded and more detailed. There was also significant interest in gender issues, in response to which a dedicated chapter on gender was added. The draft MoH 'Gender Mainstreaming Strategy for the Health Sector	C) Implications of the South Sudan conflict for the health sector I) Gender and the health sector: key challenges in the context of conflict
Qualitative assessment of the impact, value for money, and sustainability of current service delivery and funding arrangements	The Forward Looking Value for Money Analysis looks primarily at the two major primary healthcare projects (HPF and	H) Forward looking value for money assessment of EU support options to South Sudan health sector

Prepared as part of "Forward-looking structure and options" assignment; This study is funded by the European Union. Disclaimer: The views expressed in this study do not necessarily reflect the views of the European Union

	HRRP) and the Integrated Community Case Management project. Publicly available data garnered from project reports (quarterly, annual) and reviews. Many of the documents which it had been planned to use, could not be obtained. Either they had not been released or they had not apparently been finalised. Rough comparisons with VFM analyses in other regional countries (Somalia, DRC) The chapters on the historical evolution of the sector, international comparisons, MOH priorities and financing, conflict and forward looking options also speak to specific considerations around impact, sustainability, and broader approaches to improved value for money. The results from the first phase of the Health Mapping and, less structured, from the 'deep dive' visits to Terekeka and Tonj States, provided insight not only into the variation in service levels, infrastructure, staffing and supplies, but also the	B) The historical background to health service delivery and structures in South Sudan C) Implications of the South Sudan conflict for the health sector D) MOH Policies, Priorities and Budget E) Health service delivery and health sector governance: international comparands Summary of Health Mapping – Pilot Phase findings. G) Villagers' Access to the Health Network: a frugal and interim option for immediate improvement

Prepared as part of "Forward-looking structure and options" assignment; This study is funded by the European Union. Disclaimer: The views expressed in this study do not necessarily reflect the views of the European Union

	differences between SMOH/CHD and IP capacity and performance	
Plausible range of structural options for the sector, looking across both GRSS and partner funding and provision, and considering both funding and service delivery structures	These are summarised in the summary chapater on forward looking analysis The chapter on the historical evolution of services provides insight into different structural options for the health sector. The VFM analysis provides a more detailed comparison between key aspects that differ in the projects structuring. Primarily between the 'contracting-out- model under HPF and the 'contracting in' approach under HRRP. Additionally it compares cost of service between these and the community-based ICCM project, as well as neighbouring countries with different models. The mapping of partners and information systems under the Health Mapping provides information on the extent to which systems and structures exist, and the	B) The historical background to health service delivery and structures in South Sudan H) Forward looking VFM assessment of EU support options to South Sudan health sector E) Health service delivery and health sector governance: international comparands C) Implications of the South Sudan conflict for the health sector D) MOH Policies, Priorities, and Budget GRSS approaches (LSS, Transfers) and Education Sector

Prepared as part of "Forward-looking structure and options" assignment; This study is funded by the European Union. Disclaimer: The views expressed in this study do not necessarily reflect the views of the European Union

	allocation of resources between different parts of the country The pieces on conflict and international comparisons inform judgements regarding the sustainability of different structural approaches	
Operationalisation considerations and timescales for each principal option, including specifics of their fit with donor and MoH processes, policies and risk appetite		F) Structural and Financing Options for Health Sector, with focus on positive priorities and operationalisation options D) MOH Policies, Priorities and Budget B) The Historical Background to Health Service Delivery and Structures in South Sudan; E) Health Service Delivery and Health Sector Governance: international comparands
How options might support the building of a viable and plural state, for example alignment/shadow-alignment, capacity-building, and the role of government as specifier/monitor		C) Implications of the South Sudan conflict for the health sector; I) Gender and the health sector: key challenges in the context of conflict D) MOH Policies, Priorities and Budget

Prepared as part of "Forward-looking structure and options" assignment; This study is funded by the European Union. Disclaimer: The views expressed in this study do not necessarily reflect the views of the European Union

Opportunities for synergies across basic services, and with humanitarian action		C) Implications of the South Sudan conflict for the health sector B) The historical background to health service delivery and structures in South Sudan E) Health service delivery and health sector governance: international comparands G) Community-level Health Care H) Forward looking value for money assessment of EU support options to South Sudan health sector
Workshop bringing together MoH, MoFEP, and representatives of major funding (DFID, EU, Canada, Sweden, USAID etc.), multilaterals (WHO etc.) and implementing partners (NGO and faith representatives) to agree an analytical process, and possible 'ground truth' sample visit		Donor information session 'Deep dive' visits to Terekeka and Tonj States Engagement with MoH: 3rd South Sudan Health Summit, Health Sector Strategic Plan process, FY17/18 Budget, Health Mapping, Health Transfer Monitoring

Prepared as part of "Forward-looking structure and options" assignment; This study is funded by the European Union. Disclaimer: The views expressed in this study do not necessarily reflect the views of the European Union

		Committee (and associated LSS, MOFEP, and BSI engagement) NGO/partner mapping and discussions of operating context with HPF, RRHP, and IPs operating Challenges around internal movement in-country; serial delays in EU-MOH engagement
Analytical report providing an evaluation, in qualitative and quantitative terms, of the impact of health funding modalities in South Sudan 2012-2016, practically focused on findings that are applicable to the next phase of support to the health sector		H) Forward looking value for money assessment of EU support options to South Sudan health sector D) MOH Policies, Priorities and Budget / E) Health service delivery and health sector governance: international comparands / G) Villagers' Access to the Health Network: a frugal and interim option for immediate improvement

Prepared as part of "Forward-looking structure and options" assignment; This study is funded by the European Union. Disclaimer: The views expressed in this study do not necessarily reflect the views of the European Union

		F) Structural and Financing Options for Health Sector, with focus on positive priorities and operationalisation options J) Implementation and Costing of Key Options
Report presenting analysis of options for the health sector going forward, on the basis of the retrospective analysis above, drawing on demonstrable examples of 'what works' in health systems in conflict and other dysfunctional contexts, and on health technical, public policy and donor policy skills, and in the context of donor and MoH processes, policies and risk appetite		B) The historical background to health service delivery and structures in South Sudan E) Health service delivery and health sector governance: international comparands H) Forward looking value for money assessment of EU support options to South Sudan health sector F) Structural and Financing Options for Health Sector, with focus on positive priorities and operationalisation options J) Implementation and Costing of Key Options

Prepared as part of "Forward-looking structure and options" assignment; This study is funded by the European Union. Disclaimer: The views expressed in this study do not necessarily reflect the views of the European Union

Workshop bringing partners back together to review and prioritise these options Report on how these options might be operationalised		Donor information session Delayed bilateral meeting caused challenges for engagement. Final donor debriefing session early February 2018 F) Structural and Financing Options for Health Sector, with focus on positive priorities and operationalisation options J) Implementation and Costing of Key Options
This is in the specific context of the EU's role as a contributing donor to the DFID-led Health Pooled Fund, but with limited staff availability to engage with the sector, and of the possibility that DFID may not wish to continue as the fundholder/lead donor of future donor funding structures.	EU Delegation, Ministry of Health (including CHD and SMOH representatives), HPF donor partners, Implementing Partners/NGOs, WHO, World Bank	
Contractor will work closely with MOH colleagues and partners, through an	• Engagement with DG Policy Planning Budgeting, Minister • HSSP process, health summit	

Prepared as part of "Forward-looking structure and options" assignment; This study is funded by the European Union. Disclaimer: The views expressed in this study do not necessarily reflect the views of the European Union

inclusive process of analysis, interviews, field visits and participatory workshops.	• Information session • Deep dive visits to Tonj and Terekeka	
The source of the analysis should include primary data collected from the health mapping exercise, as it has progressed, other MOH/RSS policies and information. Gather information from MOH officials, donors/partners, implementing partners and other stakeholders through a series of interviews and interactions to build a picture of the current situation and status, and flows and channels of government funding of health sector programmes	• Health Mapping data • HSSP, Health Summit • Budget process, transfers, LSS • BHI and HR • Systems mapping	
A framework for the analysis should be established and described as part of the inception period	Inception Report	
The options for support to the health sector will consider international examples of best	• International comparisons • Partner mapping	

Prepared as part of "Forward-looking structure and options" assignment; This study is funded by the European Union. Disclaimer: The views expressed in this study do not necessarily reflect the views of the European Union

practices and lessons learnt. They will be associated with the capacities and apperities of specific funders – including GRSS – to ensure they are realistic and also consider likely future scenarioswithin South Sudan in regards to politics, security, and the economy	• Conflict piece • VFM • Costings	
Interim and final analysis is to be presented through consultative workshops to engage sector stakeholders in a participatory way.		

Prepared as part of "Forward-looking structure and options" assignment; This study is funded by the European Union. Disclaimer: The views expressed in this study do not necessarily reflect the views of the European Union