INCEPTION REPORT: 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
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A - INCEPTION REPORT

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Charlie Goldsmith Associates

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1 Executive Summary

Inception: limited availability of MoH, progress on analytical framework and VfM analyses

The team has been confirmed and mobilised. Jo Ferry MPH coordinates a team of experts including Charlie Goldsmith, Erin Chu, Francis Middleton, Laura Elisama, Liz O'Neill, all with recent relevant South Sudan health sector and MoH experience, and senior figures including Liz Gaere OBE, former head of the Joint Donor Team and recent lead of the Annual Review of HPF, economist Hamish Colquhoun, and senior international health systems experts Mark Beesley RN and Enrico Pavignani MD.

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.

MoH staff have had limited availability because of travel, the Ebola crisis.

The importance of MoH buy-in to the process meant that it would have been counterproductive to approach donors until this step had been properly accomplished, and MoH buy in to detailed approach confirmed.

Analytical framework, hypothesis-driven approach

Progress on the analytical framework, including initial analyses from the Health Mapping work, and a first cut set of top-down value for money analyses is described in this report.

GRSS and partners face tight timescales for decision-making, in particular, ahead of:

- GRSS Budget 2017-18 (to be completed by June 30th 2017)
- End of current phase of RRHP funding in October 2017
- End of extension of Health Pooled Fund, in March 2018

Recognising this, our approach is to work on a hypothesis-driven approach, stating a hypothesis, and refining (or overturning it) through the course of the assignment.

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Developments in the context – conflict, politics, sector

There have been significant developments in the wider political context, and the sector, during the inception period.

In the wider political context May and June 2017 have seen relatively less military activity and Juba remains calm. South Sudan continues to experience significant levels on conflict and insecurity in many parts of the country, with the brunt of violence falling upon civilians.

In the sector:

- The Health Summit focused on making services work in the new subnational configuration, and, in particular, on standing up the Boma Health Initiative, a distributed/community care approach aimed at delivering wide coverage of the most basic care, with referral upwards
- In the framework of the LSS programme, progress has been made towards partially restoring the value of social sectors (including health) transfers in FY17-18, and towards 'straight through' transfers (direct from MoFP to Service Delivery Units (schools and clinics, principally), rather than via SMoFs
- DFID announced publicly, through a Prior Information Notice, their intention to develop "a business case for a programme to follow on from the Health Pooled Fund when this closes in 2018. This is likely to be an evolution of the current programme with the integration of the community-based support for children under 5 currently provided by a separate project (ICCM – Integrated Community Case Management). The focus will likely remain on service delivery but we are open to considering innovative approaches to reaching those most in need."

Core hypothesis: historically informed view:

Based on the health mapping and initial VfM analyses, our core retrospective/historically informed views are that:

- While the 2011 reform of partners' support to the South Sudan health sector succeeded in streamlining service provision at level of 79 Counties, the stated intention to improve service coverage has not been fully achieved, and limited progress has been made from what the Southern Sudan Health Facility mapping survey (2009) found in 2009, that only "44% of people live within 5km of a functioning health facility (data from 6 states)".
- The different approaches and geographical coverage between RRHP, HPF and ICCM offer the potential for a 'quasi-natural experiment' to be made (in particular between RRHP and HPF), comparing the effects of the programmes in regards to inputs and outputs, and building on the disaggregate 'difference-

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in-difference' analysis approach successfully used to assess the impact of interventions in the education sector.

- Insufficient attention has been paid to structural choices about pharmaceuticals procurement and supply chain – resulting in regular stock-outs over the last ten years, and a 'swing of the pendulum' from fully separate arrangements for pharmaceutical supply chain (a division of labour in which USAID handled pharmaceuticals) to current almost full integration under Health Pooled Fund.
- Evidence on the impact of GRSS expenditure is more difficult to reconstruct, because GRSS has, throughout the period, been a minority funder of the health sector, and because the reforms made in 2013-16, refocusing funds on service delivery (83% to transfers in 2016-17), had not reached national coverage before the reduction of the effective value of GRSS funds through rapid inflation, and less reliable execution at national and State Ministries of Finance, disrupted their effect. By 2016-17, GRSS funding for health, at 492m SSP, making up just 1.7% of national budget and worth $8m (at the point it was passed). In both these regards, a comparison can be drawn to the national role that GRSS funding of teachers' wages and school capitation grants have had in the education sector.
- International NGO-led health service delivery is by definition unsustainable, and costly relative to more 'indigenous' approaches. However, subnational government structures have been, as conceded by GRSS' own Local Services Support programme, weakened by repeated *fiat* redivisions.
- Reforms in education that pushed GRSS and partner funds to the level of service delivery units, based on clear requirements and accountability, and the strong response to input-performance based funding under RRHP, suggest an approach along similar lines has the potential for successful scale up.
- Initial top-down analyses of annualised unit costs per person and per facility suggest that to date, RRHP was more expensive per unit than HPF. Further analysis is required to identify whether this is a correct interpretation of the publicly available financial data, and to what extent it is comparing 'apples with apples' – in terms of service package, and in terms of geography and operating context – with RRHP having clearly faced the more challenging conditions.

Core hypothesis: analysis of funding and structural options

On the basis of the logic set out above re sustainability, and in the context of renewed engagement by GRSS, following a change of leadership at MOFEP, in social sector funding for FY17-18, our very tentative hypothesis looking forward re funding and structural options, is that:

- MNCH is the core of service need and service delivery in South Sudan: this demands a focus on ensuring that a core EmONC referral service functions

- Pharmaceutical supply chain should be considered with equal care to service delivery, and commitments made for a similar length of time
- A shift from NGO-managed service delivery, to directly contracting for health service delivery with CHDs where functional, and with PHCC networks where not, with NGOs contracted by geography to provide support and monitoring (similar to the model of the GESS State Anchors and the Health Consortium for the Somalia People), could in principle offer sustainability and cost benefits, while delivering adequate accountability
- To address coverage gaps, when the conflict context makes a major infrastructure programme difficult, an integrated and comprehensive approach to health services and coverage, with comprehensive geographic coverage of CHW/BHI/ICCM, under the management of and referring to PHCUs in a network under a PHCC, could have merit – and could foil well with the priority articulated to the BHI by MoH
- Given capacity constraints, and given positive results from health-education interworking over the last ten years, maximum integration of health and education services at front-line level should be sought: this might include CHWs basing from schools where there is not a PHCU (there are twice as many schools as PHCUs), and directly supporting schools – both to get synergies of services, and support and to strengthen these 'tent-poles of the social fabric'
- an integrated approach to data, making a virtue of necessity in the context of current upheaval of subnational government, needs to taken, by ensuring near-real-time disaggregate management data (this means not just DHIS2, but resources and accountability) is available to support decision-making and accountability: one way could be to develop southsudanhealth.info on the model of SSSAMS in the education sector, and working with GRSS MoH, in particular through the regular Health Transfers Monitoring Committee
- Using improved value for money to release funds to improve coverage

However, it must be clear that VfM evidence will be crucial, and, as described in the previous section, potentially more complex.

Framework for international comparisons and structural options

This inception report sets out objective frameworks for both of these.

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

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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 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.
- 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

3 Inception phase activities

3.1 Team organisation

The following team have now been confirmed:

Name	Role	Tasks	Match to skills committed in proposal	Summary Profile
Jo Ferry	Team Leader	Define overall analytical framework, with PD Prepare workshop and ground truth trip	Extensive knowledge of South Sudan, and health sector in particular Clinical health and public health management skills	MPH >15 years of health sector experience, with successive senior HSS and MNCH NGO and TA positions South Sudan experience Currently handing over role as Resilient Zero Team Leader in
Charlie Goldsmith	Project Director	Analytical writing Strategic design	Extensive knowledge of South Sudan, and health sector in particular Understanding of donor policies and priorities, particularly around South Sudan]	Overseen CGA's (and previously Booz & Co's) work on South Sudan Electronic Payroll System 2008-12, Girls' Education South Sudan (with BMB Mott) 2012-, Health Pooled Fund, 2012- March 2017 (under Crown Agents), IMPACT teacher incentives (with BMB Mott) 2017-, EU-funded Health Mapping work 2016-17, and substantial health assignments in Sierra Leone, Somalia and Dr Congo
Erin Chu Felton	Senior sector analyst	Analyses on southsudanhealth.info data	Clinical health and public health management skills	MPH/MPA Began work in South Sudan in 2006 Worked on MoH payroll system 2008-09, led support to MoHS-GoSL for human resources for health reform 2010-12, led EU-funded South Sudan Health Mapping work 2016- CGA Health Sector lead
Liz Gaere OBE	Senior context adviser Senior development programmes specialist	Review of existing donor practices/will Structure for new in terms of donors and sustainability	Extensive knowledge of South Sudan, and health sector in particular Understanding of donor policies and priorities, particularly around South Sudan	Former senior DFID official Founding Head of the Joint Donor Team (UK + 6) in Juba, that was a major feature of the CPA period landscape Recently led Annual Review of Health Pooled Fund
Hamish Colquhoun	Economist	VfM analyses	Value for Money, political economy, budgeting and costing analysis Understanding of donor policies and priorities, particularly around South Sudan	Specialist economist working across health and education sectors Based Kinshasa, working with IMA World Health on ASSP programme Wide range of experience on business case development for DFID Project Economist for Girls' Education South Sudan and IMPACT teacher incentives programme

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Francis Middleton (in country) + Liz O'Neill (remote)	Health sector finance and governance analyst	Financial analysis MoH plans	Extensive knowledge of South Sudan, and health sector in particular Understanding of donor policies and priorities, particularly around South Sudan	Francis Middleton was ODI Fellow in MoH-GRSS, then embedded PFM Adviser in MoH/GRSS, under Health Pooled Fund, led first phase of Health Mapping South Sudan work
Imke van der Honing	CGA South Sudan Coordinator	Operational oversight	Extensive knowledge of South Sudan, and health sector in particular	>12 years' experience in South Sudan, >30 years' management experience across Africa, leading for CGA in South Sudan since 2012, including on Girls' Education South Sudan and Health Pooled Fund assignments
Simon Acuil	CGA implementation, systems and analysis	Support to field work Analytical support	Extensive knowledge of South Sudan, and health sector in particular	Former GRSS official, working since 2011 for CGA on SSEPS, HPF, Health Mapping assignments ++
Laura Elisama	CGA implementation, systems and analysis	Support to field work Analytical support	Extensive knowledge of South Sudan, and health sector in particular	Former State Coordinator and then PFM lead for Health Pooled Fund
Mark Beesley RN	Senior sector systems adviser	Structural options analysis Conflict analysis	Value for Money, political economy, budgeting and costing analysis Clinical health and public health management skills	Highly experience public health expert, with extensive experience working with MoH-GRSS serniors
Enrico Pavignani MD	Senior sector systems adviser	Structural options analysis Conflict analysis	Value for Money, political economy, budgeting and costing analysis Clinical health and public health management skills	*Enrico Pavignani worked in Mozambique from 1980 until 2002, first as a district doctor, then as a trainer of mid-level health workers, and subsequently as a planner and policy analyst posted at the Ministry of Health. He has studied the health systems of Angola, Tanzania, Afghanistan, Sudan, DR Congo, Somalia, Liberia and Palestine. Presently he is working on the Middle Eastern crisis complex. He holds an*

				MSc in Public Health from the LSHTM. His main interests are planning and evaluation of health services, human resource development, PHC provision, management of external aid, analysis of war-torn healthcare arenas and post-conflict reconstruction. His independent research is focussed on studying new developments in global healthcare provision, and on devising innovative responses to them. He runs the renowned Pisa Course on Health Systems through Crisis and Recovery, and has written, often working with Mark Beesley, the key readings on FCAS systems
Howard Tytherleigh	CGA Technical Manager	Additional analyses coding etc	Value for Money, political economy, budgeting and costing analysis	Technical Manager with >30 years' coding experience, ten years' experience working in FCAS locations, including South Sudan, Somalia, Sierra Leone Created www.sseps.org, www.sssams.org, and, in the health sector, www.hrisrss.org and southsudanhealth.info

3.2 Mobilising and briefing team

Jo Ferry MPH, arrived in London w/c1/5/17 for a briefing with Charlie Goldsmith, Project Director, and Erin Chu Felton MPH, Senior Sector Analyst, and then arrived in South Sudan w/c 8/5/17, to join Imke.

Team briefings took place, and an introductory set of slides (Annex 2) was produced, ahead of briefing meetings with MoH.

3.3 Meetings with MoH

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.

MoH staff have had limited availability because of travel, the Ebola crisis, and the Health Summit, which brought together subnational officials.

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The importance of MoH buy-in to the process meant that it would have been counterproductive to approach donors until this step had been properly accomplished, and MoH buy in to detailed approach confirmed.

The initial workshop to define analysis and scope, followed by field visits, will therefore need to follow in June/July.

There has recently been a change in the Director General for International Health and Coordination at the MoH. The new DG, Dr Loi Thuou, has transferred from the Directorate of Secondary/Tertiary Healthcare.

3.4 Meetings with fund managers, donors and international organisations

Working-level meetings with two key existing fund managers, the Crown Agents-led Consortium managing HPF, and IMA World Health, managing RRHP, occurred, with Sonja Nieuwenhuis, HPF, Dr Campbell Katito & Dr Martin Mayen, HPF, Dr Mounir Lado, IMA .World Health, to brief them on the assignment.

Given DFID's role as key stakeholders, as fundholders of the principal current fund supporting health services in South Sudan, Charlie Goldsmith met Dan Pike, DFID South Sudan team, in London, to brief him on the assignment, building on earlier briefing by EU to donors.

It is planned that the EU will provide a briefing to other donors on the assignment, following which it will then be possible to approach each donor in turn with a view to participating in the initial plenary meeting.

3.5 Local Services Support and other PFM Reform

The team have engaged in detail with the GRSS and Advisers Local Services Support team. A major development in prospect is material resumption by GRSS of its role funding basic services in FY17-18: in the framework of the LSS programme, progress has been made towards partially restoring the value of social sectors (including health) transfers in FY17-18, and towards 'straight through' transfers (direct from MoFP to Service Delivery Units (schools and clinics, principally), rather than via SMoFs.

In education, the CGA team are also involved in the IMPACT project, which is rolling out in the education sector the HRIS rolled out in 5.5/10 States for health, in support of a programme to pay incentives to teachers through their schools, on the basis of strong accountability, including for daily attendance.

These twin elements of PFM could present a particular opportunity in regard to building on the 'infection allowance' and 'facility grant' approaches already piloted in health.

3.6 WHO

As South Sudan is one of the target countries for the Universal Health Coverage (UHC) Partnership, we will engage with WHO to look at strategic analysis and policy options within the scope of this project: this engagement will take place as soon as MoH buy-in is confirmed.

4 Workplan and approach

Workplan

See Annex 2 for outline workplan, including approach to the tasks.

The original organisation and methodology had set out that "It is expected that the contract can be completed within three months (April to June 2017)". Delay in contracting affected availability of key staff, and MoH limited availability has also had an impact. It is now expected that we will deliver the draft final report in mid-September – however see below re the 'hypothesis-driven' approach that will give earlier.

Interface with Health Mapping assignment

Annex 4 shows a first set of analytical reflections arising from the health mapping assignment, and the powerful analytical tools that it provides – both for horizontal, or subnationally disaggregated, and longitudinal, or diachronic, comparisons: as coverage, which has been delayed by MoH availability, now scales up rapidly, exploiting synergies with the IMPACT HRIS roll-out, this can be expected to provide progressively greater levels of confidence to support analytical findings for this assignment.

Hypothesis-driven/"Permanent working draft"/client ready approach

GRSS and partners face tight timescales for decision-making in Q2 and Q3 2017, in particular, ahead of:

- GRSS Budget 2017-18 (due to be completed by June 30th 2017)
- End of current phase of RRHP funding in October 2017
- End of extension of Health Pooled Fund, in February 2018 (for service delivery – close-out in March 2018) – and current DFID process to develop a business case

Recognising these tight timescales, our approach is to work on a hypothesis-driven approach, stating a hypothesis, and refining (or overturning it) through the course of the assignment.

We will maintain a "Permanent working draft"/"keep it client ready" approach, so that, at whatever moment decisions need to be taken, they can benefit from the work on this assignment done to that point: an example of the 'best being the

enemy of the good' would be to produce a complete report in September 2017 that was fully complete and comprehensive, but came after key decisions had been taken, on less evidence.

5 Framework for the analysis

Requirement

The requirement is 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.

Our analysis will include a qualitative assessment of the impact, value for money, and sustainability of current and recent service delivery and funding arrangements, including:

- Basic Services Fund
- SHTP1 and SHTP2
- IISD
- HPF
- RRHP
- ICCM
- GoSS and GRSS-funded and managed services
- DELIVER, EMF ++

It will articulate clear and plausible structural options for the sector, looking across both GRSS and partner funding and provision, and considering both funding and service delivery structures. Our analysis will encompass service delivery in a broad sense, from community through primary and secondary to tertiary health service delivery, and encompassing pharmaceutical supply chain and HRH.

We will prioritise the articulated options against clear criteria, including likely impact, value for money, and sustainability. For ease of reference, a grid-style analysis will be included.

We will pay attention not only to comparands within the sector, and in health sectors elsewhere, but also to comparisons across sectors, in particular to the education sector, following the example of reforms in South Sudan over the last twelve years, in which health and education have successively borrowed and adapted reforms from each other, organically, and then structurally, through the Capacity Building Trust Fund, the Local Services Support mechanism, and synergies between GESS and HPF.

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Quantitative analytical approach: quasi-natural experiment, results and resources focus

The different approaches (HPF: NGO service delivery, separate fund manager layer; RRHP: contracting in, fund manager and NGO layers part-consolidated) and geographical coverage between RRHP, HPF and ICCM, and GRSS funded staffing and operational spend, offer the potential for a 'quasi-natural experiment' to be made (in particular between RRHP and HPF), comparing the effects of the programmes in regards to inputs and outputs, and building on the disaggregate 'difference-in-difference' analysis approach successfully used to assess the impact of interventions in the education sector.

We will thus look at public documents from the periods in which both programmes were active, to make comparisons on a set of key indicators summarising the programmes' health outcomes, efficiency, productivity, value for money, etc.

In doing so, the results of this analysis can highlight differences in approaches and aspects of each programme that were more/less effective in health service delivery.

This approach must be applied with caution:

- The shorter timespan of RRHP, the year now elapsed since RRHP Part One (contrasting with continuous service delivery under HPF since 2013), and possible differences between RRHP Part One and RRHP May-Oct 2017, are evident confounding factors...
- ...while issues of ensuring a like-for-like comparison will include the comparability of the service packages on offer, the remoteness/accessibility of the locations served

In a context of finite resources, we will apply a particular results focus, seeking to analyse outcomes/services/cost per capita (on consistent basis)/sustainability.

Top down and bottom up

We will triangulate findings from:

- Top down: working from aggregate figures in Annual Reviews and equivalent
- Bottom up: building on health mapping work, and drawing out qualitative analyses from the very dense data gathered on individual facilities as part of tat work

VfM analytical framework and literature survey

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The Value for Money analysis will consider the relative performance of existing support to the health sector to inform recommendations of how greater VFM could be achieved in future programming. The approach will combine quantitative and qualitative data with a particular emphasis on comparative analysis – between different projects (RHHP, HPF, ISDP etc.), between partners and counties within the same project and relative to international experience.

There is a huge quantity of documentation already produced on the performance of the existing and previous health projects in South Sudan. The first stage of analysis has focussed on the review of the publically available documents to get an initial understanding of the VFM of existing support to the health sector. Immediate initial findings include:

- VfM monitoring and reporting has been relatively limited across all projects with apparently insufficient reporting that links specific spending with specific results;
- Non-direct costs of implementation have been very high, notably in relation to equivalent experience in the education sector (GESS);
- RRHP piloted the model of directly contracting CHDs rather than NGOs; this was only in 5 counties but did imply significantly reduced costs in those counties compared to others in the same States where NGOs were contracted. This approach has the further benefit of more directly building the government health system.
- The package of services delivered varies within projects as well as between projects – crude cost comparisons between counties and states (such as per capita and per facility) should not be over-emphasised given a need to consider the type and quality of services provided.

The next phase of analysis will seek to dig deeper into the data. There could be a challenge in both the existence and the availability of the required data. This will become clearer as the assignment progresses. Particular attention will be focussed on the following questions:

- How cost-efficient have different service delivery contractual modalities been (e.g. contracting-in CHDs rather than NGOs; facility vs. county vs. state-based models)?
- Have the differing mix and quality of intervention packages been the most cost-effective in terms of DALYs averted?
- How cost-effective has non-service delivery support been (including e.g. health system strengthening and community engagement)?
- How equitable has existing support been in terms of geography and socio-economic need?

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- How effective has the collaboration between donors, government and implementing partners been in terms of synergies, complementarities, dissemination of best practice and avoided duplication?
- Has non-donor (particularly GRSS) funding for the sector been effectively leveraged?
- How strong have financial management processes been, including the control of fiduciary risk?
- Has performance based contracting improved VFM where it has been piloted?
- What potential is there for other innovative approaches (e.g. task-shifting, m-health and e-health systems) to improve overall VFM?

In each case the analysis will be focussed on the forward looking implications – how should any new phase of support be designed to maximise VFM given the lessons learned from previous support. Given apparent limitations with previous VFM reporting, there will be a particular exploration of how VFM could be more consistently and usefully targeted in future programming.

Analysis informed by context and recent history

South Sudan's health situation is among the world's worst; service delivery is a matter of construction, not reconstruction

South Sudan's health situation is one of the world's worst: health indicators, to the extent they were known, remained among the lowest in the world before the current cycle of conflict. Three years of conflict and displacement are not likely to have improved them.

Service delivery is not, as in some other contexts (Somalia e.g.), a matter of reconstruction of a service that previously existed: in particular, we note the minimal social service provision, and reliance on church structures, in the Condominium and1923-1956 eras, and limited progress made in development of services in the first civil war period, on account of conflict, and the focus of resources on Khartoum.

The CCSS and CANS during the Second Civil War made some measure of expansion of service delivery, CCSS serving primarily the towns, and CANS the liberated areas, with extensive reliance on NGOs.

CPA period coverage and services

MoH-GoSS was established in 2005 following CPA. Unlike the then MoEST, MoH did not assume principal responsibility for primary service delivery.

In 2005-, under BSF (DFID + partner governments), OFDA, SHTP (USAID), cluster: NGOs bid to (build and) provide clinic services based on target metrics.

The World Bank MDTF State Lead Anchors model was largely unsuccessful – with a scandal re hospital contracts, and some contracts handed back. A key issue was that NGOs and other suppliers were not able to work on the scale of a whole State (under ten State model) – the clearest exceptions being the NPA-led consortium in Central Equatoria, and IMA's work in Upper Nile.

Through the CPA period, there was some progressive consolidation of NGO support, but services remained NGO-managed. There were some limited increases in GRSS funding for services, but a 2009 survey found that NGO-funded staff remained in the majority.

2011 reform

The redesign of DFID and the other BSF partners' support, working with MoH, USAID and World Bank, led to streamlined service provision at level of 79 Counties, and a geographical division of labour for funding of service delivery, with DFID and partners taking 6/10 States, . But the systematic expansion of geographical coverage within each County envisaged in the 2011 design of the HPF was lost in contracting and implementation en route to substantive operation in 2013.

Instead, partners' engagement with the service delivery model is effectively ossified at supporting the facilities that existed under the Basic Services Fund, with management/support reordered to streamline geographical division of labour among NGOs: the coverage of facilities under HPF largely remains as it was during the Basic Services Fund (and, factoring the current crises, even fewer are operational).

The situation that persisted from June 2016 to May 2017, where funding for services in (former) Upper Nile and Jonglei was suspended, clearly added an extra dimension of inequity/ conflict-insensitivity/doing harm, and could put other actors in the sector at risk.

International NGO-managed service delivery is, by its nature, unsustainable and unit costs have risen sharply

The HPF model uses NGO-managed service delivery, predominantly by International NGOs. The NGO-managed service delivery model is not, by its nature, wholly sustainable: but many of the NGOs have now been engaged in it in South Sudan for twenty-five years or more.

Its unit costs are believed to have risen in the course of the current conflict, as costs of movement within South Sudan, and restrictions on who can safely deploy where, have increased. Not all the value invested stays in South Sudan, with some going out to INGO overheads and imported skilled service delivery staff. A key

analysis will be on direct versus indirect costs of service delivery – with some preliminary indications that the ratio of the latter is relatively high.

There is clear logic to integrating support to community health work with support to primary care: at present, DFID funds separate primary and community case management projects, but has announced its intention to join them.

RRHP PBF/contracting-in with facilities in Upper Nile and Jonglei: a different approach, in a tough operating environment

Under the RRHP programme, which ran to June 2016, IMA World Health (under pressure of local necessity, and building on their experience in DRC and other FCAS locations) partially broke away from the NGO-managed model that had dominated service provision since the second Civil War, and began to contract directly with facilities and Counties to support services, with striking results from this aspect of the programme (though being clear that a minority of programme funds went direct to facilities). A core analytical task is to understand how what was done under RRHP can be compared to HPF, in cost and output terms.

Subnational organisation: the practical core of services, following successive redivisions of subnational government, are PHCCs ("County Hospitals") and PHCUS around them

In the 2010s, MoH pursued an aggressively pro-poor policy of pushing funding down to front-line services. This included a restructuring of salaries budgets, and the successful establishment of a facilities grants programme (with support from HPF, which CGA provided), on the model of the GESS school capitation grants, through which funding was put directly to PHCCs, which received on behalf of their local network of PHCUs.

Successive re-divisions of subnational government (from 10 to 32+1 States, and 79 to ?>250 Counties) have set back but not overturned steps taken to make decentralised administration work.

6 Current context and likely future scenarios related to conflict, politics, and the economy

A short account of key features of the current context and likely future scenarios related to conflict, politics, and the economy is given here, as a prelude to a more comprehensive analysis paper, drawing on the insights on health and conflict of Dr Enrico Pavignani, Mark Beesley and others.

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Spread, and focused character, of conflict, 'Agreement for the Resolution of the Conflict in South Sudan'; conflict as a given

Civil war prevailed in South Sudan from 1955 to 1972, and again from 1983 to 2005. Following the Comprehensive Peace Agreement and Referendum, South Sudan became independent on July 9th 2011. Less than two and a half years later, following a reshuffle which had changed the balance of the GRSS, fighting broke out on the night of 15/12/13.

In 2014, conflict was confined to Greater Upper Nile, and had some elements of field conflict between opposing forces. Successive government and associated forces campaigns in 2015 and, following the brief ARCSS interlude, in 2016, expanded the conflict across Western Equatoria, Western Bahr-el-Ghazal, and then Central and Eastern Equatoria. Characteristic elements included concentration and displacement of civilians. Increasingly, government forces came to control towns, while opposition activities focused on roads. With the end of the ARCSS, the participation of significant elements of the opposition in the civilian political process ended.

By April 2017, according to OCHA, 1.74m people had been made refugees, with Uganda seeing a continuous stream of refugees since mid-2016, and 1.88m IDPs (the supermajority of whom in host communities, rather than in PoC camps).

With so many people on the move, it is vital that health services are able to adapt quickly and efficiently to an evolving population map and evolving distribution of those it is seeking to support: this is likely to imply a dynamic, and thus potentially formula-based and mobile, rather than static and territory- or infrastructure-based, approach to service funding and delivery. It is also vital that the package of services offered can adapt to the needs of a population on the move and/or fragilely housed.

Similarly, we are clear in our analytical approach that, on the basis of all evidence since 1955, it is reasonable to take conflict as a given in short and medium term planning for the health sector in South Sudan – and brief periods of absence of hot conflict, as in parts of the period 2005-2013, relatively exceptional.

Implications of the conflict and conflict political economy for health services

Subnational institutions: more quantity, capacity spread more thinly

Successive unilateral redivisions of subnational governance since December 2015 have, apparently prioritising inclusivity in distribution of resources, dissipated already thinly spread capacity, from ten States and 79 Counties, to 28, then 32 (33) States and >250 Counties.

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For health services, this has entailed the extremely rapid distribution, of established and scarce skilled human and infrastructure resources from the former SMoHs and CHDs to a much wider range of locations: to take a simple example, whereas previously WHO supported connectivity for most CHDs, this task is now considerably more complex, with a threefold increase in such institutions, and by the admission of GRSS' own LSS process, some Counties unable, in human and/or infrastructure capacity terms, to discharge their responsibilities.

Economic collapse: high and sustained inflation, fall in value of SSP against hard currencies

The more than halving of the world oil price in 2014 had a major effect on South Sudan's economy, with government dependent on oil for well over 90% of its income. This was compounded by fields going off stream as a result of conflict, by borrowing, extensive resort to monetary financing, and by government's choice to prioritise spending of the resources it did have on security sector. All of these reduced the effective value of the SSP: having been launched at Independence in 2011 at 3.1 SSP : 1 USD, the SSP has recently traded as low as 200 SSP : 1 USD. Price inflation has also been extremely rapid.

The rapid fall of the effective value of the currency and its income has had a dramatic effect on the value of funds that GRSS can budget to the health sector, which fell to as low as the equivalent of $8m p.a. at the time the FY2016-17 budget was passed, and to the reliability with which budget can be executed – with several months' gap in releases from MoFP in early 2017.

The volatility of the currency also creates practical challenges for both GRSS and partners, in getting value for money: for example, a casualty of currency volatility has been some of the progress made 2013-15 on harmonisation of health worker remuneration, to reduce churn.

Selected aspects of the practical operational context

Reporting and monitoring may suffer from breakdowns in the mobile phone network, either where government requires the network to be shut down in an area, or where towers cannot be refuelled, because of insecurity, broadly defined.

The worsening economic situation has left the government facing a weakening security environment and increasing levels of criminality. Widespread food insecurity and lack of access to even basic services continue to tighten the already constrained environment in which ordinary South Sudanese people are living, with consequences for the health status and outcomes of citizens, and for the operations of health facilities.

There are increasing demands in some parts of government for the security apparatus of the state to have oversight of, or even be involved in the processes of

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social and humanitarian sectors. This can create challenges in terms of equity, and of Do No Harm.

The role of health service provision in sustaining the social fabric

Recent academic work by historian Eddie Thomas has highlighted that education, and social services, including health, more generally are crucial as:

- Ways in which South Sudanese people respond to conflict and modernity – with striking increases in enrolment during periods of conflict since the Independence of Sudan
- With churches and clinics, being some of the last multi-tribal institutions
- Anchors of communities in their locations, and 'pull factors' for returns

Sustaining health services is a way of sustaining the social fabric, and the pattern of settlement, at a time when there are those who would upset both.

Equally, inequalities in health service provision can, whether deliberately or inadvertently, run counter to 'do no harm' principles – with both direct and indirect negative effects. In particular, the extended period (almost a year, from June 2016) for which health services in former Upper Nile and Jonglei States were not supported, and the currently temporary reprieve that they have.

Resilient and adaptive approach

The conflict has evolved significantly even within the four weeks of the inception period; our analytical approach will be resilient and adaptive to the evolving context – and the flexible specification of the southsudanhealth.info website supports this.

7 International examples of best practices and lessons learned

A full-scale paper on international examples of best practices and lessons learned will be produced in June. The approach will be a semi-structured one of:

Refining from a longlist of potential comparands to a shorter list

Assessing comparands, potential and selected, on a framework of 'axes of comparison'.

Example relevant comparands from FCAS and emerging contexts, and notably relevant features, include:

Country and period	Services/programme/project	Feature
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 Public health-led approach At scale HSS
Somalia 2008-	Health Consortium for the Somali People (including 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 soone 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

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		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
Uganda 1980s-	Free Health Care initiative and PFM reforms	Indigenous service delivery Straight-through funding

The axes of comparison will include:

- Health sector management and structuring
- Donor and partner approaches, in particular a continuum of approaches from pooled funds through alignment to full on-budget support
- Responses to fragility and conflict

Where there is a specific technical relevance, it may be possible to organise a short study visit for relevant MoH officials – building on our team's experience of the successful visit by MoGEI officials to Kenya to meet the Hunger Safety Net Programme and MoE Capitation Grants teams in 2015.

8 Options for the health sector going forward – scoping

As described above, we will articulate a set of structural options.

We anticipate that the axes of these options will include:

- Division of labour between government and partners

- Pooling (efficiency and economy, but also principal/agent issues) versus geographical division of labour/ lotting (efficiency and economy implications, but also resilience)
- Possible vertical and horizontal divisions of labour between partners and government – in particular considering the fit between pharmaceutical procurement and supply chain and service delivery
- Balance between traditional infrastructure-based and mobile and/or technology-enabled service delivery
- Role of International and National Non-Governmental actors, Faith-Based and Private providers

Options will be analysed in terms of costs and risks – see next section for the fit between options and operationalisation.

9 Approach to operationalisation considerations

The requirement is "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"

We will assess each option against a core set of operationalisation criteria. These are likely to include:

- Fit with donor processes, policies and risk appetite, for each of the principal donors active in the sector
- Fit with donor resources
- Fit with government policy, and alignment with government systems – prioritising policy alignment over seeking 'wooden dollar' transactions
- Resilience to downside scenarios – within and across organisational boundaries

10 Declarations of interest

Charlie Goldsmith is married to Dr Sarah Goldsmith, a DFID Health Adviser. Dr Goldsmith was the contract adviser responsible for the original design of the Health Pooled Fund for South Sudan in 2011, and then the DFID Health Adviser in DR Congo 2011-2014 responsible for the design and specification of the ASSP

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project there. Dr Goldsmith is presently in a headquarters role with DFID, and is shortly due to take up a posting to Zambia.

Charlie Goldsmith Associates was involved in the delivery of Health Pooled Fund, as subcontractors to Crown Agents, from 2012 until early 2017, when they withdrew from the consortium. Charlie Goldsmith Associates had been part of a consortium led by IMA World Health and BMB Mott MacDonald to bid for the abortive Health Pooled Fund 2 procurement in 2015-16.

Erin Chu Felton is married to Andrew Felton, a World Bank official, based in London.

Hamish Colquhoun's clients include IMA World Health, for their work in DR Congo, including on the ASSP programme.

In regard to possible participation of the consultants in any bid for, or work on, the possible future HPF3, it is noted that:

- This assignment relates to upstream discussions and decisions about the structure of the sector: it is neither a evaluation nor a design of a specific programme
- There is no intention, on the part of the EU or the consultants, to interfere with DFID's role. If materials from the funding and structural options assignment prove useful, on their merits, in HPF3 "design", all the better.
- It is expected that the products and source materials of this assignment will be made available as a 'common good' for the sector – thus confirming their objectivity, and demonstrating that no advantage, of information or otherwise, is gained thereby

Annex 1: logframe

Project Description	Indicators	Source of verification	Assumptions
Purpose To 'contribute to reducing maternal and infant mortality and improving the overall health status and quality of life of the South Sudanese population'	Infant and child mortality rate Maternal death rate	MICS	n/a
Results 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 the	A realistic plan for sustainable, value-for-money, equitable arrangements for delivery of health services from 2017 onwards.	EU health planning and budgeting documents for South Sudan	EU remains an active development partner in the health sector

comparative advantage and role of the European Union.			
Activities To provide a series of summary analyses of overall needs, demands and supply of health services across South Sudan and their geographical coverage, distribution. Articulate a 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	Number of participatory workshops held Field visits conducted with key stakeholders Number of detailed interviews conducted Number of final reports submitted	Inception report submitted Final report submitted with operationalisation options	Government, donors and other partners agree to participate in the exercise, in providing information and contributing to understand correct policies, plans, risk appetite.