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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FINAL REPORT ANNEX B: The Historical Background to Health Service Delivery and Structures in South Sudan, 1899-2017

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Introduction: 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
- The following slides set out a brief historical perspective on service delivery and structuring

Health services and structures 1899-2005: starting from a base of minimal, church-managed, services; MoH established 1972; role of NGOs in second civil war

- Anglo-Egyptian Condominium 1899-1923, and British colonial rule 1923-1955: minimal social provision, reliance on church structures
- 1955-1972 (Independence 1956): First Civil War period; nationalisation of missionary service provision 1957-1964; some hospital development
- 1972 Addis Ababa agreement, High Executive Council, establishment of MoH in Juba, Dr Toby Madut Parekh the first Minister of Health; establishment of the three teaching hospitals
- 1983-2005: 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 (notably NPA) and churches (notably RC Diocese of Torit network of health facilities)

Health services and structures 2005-2011 - the CPA period: increased coverage of health facilities and services, a wide range of increasingly coordinated NGO support

Government

- MoH-GoSS was established in 2005 following CPA
- *Unlike* MoEST, MoH did not assume principal responsibility for primary service delivery, and its budget reflected this: in 2009 just 39m SDG out of a total MoH Budget was for Conditional Salary Transfers (compare MoEST, 170m SDG Conditional Salary Transfers)
- There were some limited increases in GRSS funding for services, but a 2009 survey found that NGO-funded staff remained in the majority
- Normative structure of:
  - Teaching Hospitals
  - State Hospitals
  - PHCC
  - PHCU
- Normative Basic Package of Health Services and core BPHS

Partners

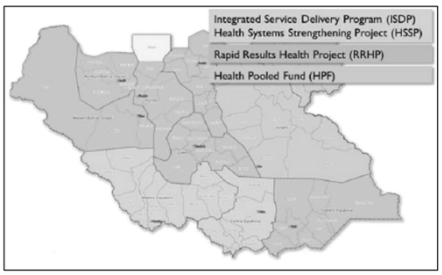
- In 2005-, under BSF (DFID + partner governments), OFDA, SHTP (USAID), cluster: NGOs bid to (build and) provide clinic services at specific locations against target metrics, and based on a range of geographical priorities. Multiple funders and NGOs worked in some Counties, while others were barely supported.
- World Bank MDTF State Lead Anchors model did not get consistently get traction at scale. Issues re balance of resources between resources for hospitals and secondary/primary services...
- ... 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. Staffed NGO Health Coordination structures 2006-2015.
- Successive partner-funded drug procurement programmes

Health services and structures 2011- (1) - partners' division of labour: County model, consolidation into three main programmes, then two from 2016

- Redesign of DFID and the other BSF partners' support, working with MoH, USAID and World Bank, led to (effective 2013):
  - Streamlined primary service provision at level of 79 Counties (a lead NGO – but see below - per County)
  - geographical division of labour for funding of service delivery, with DFID and partners supporting 6/10 States, USAID 2 States, USAID, 2 States
  - drugs funded by USAID DELIVER, then under HPF
  - Integrated Community Case Management programme in selected Counties 2013-
- The systematic expansion of geographical coverage within each County envisaged in 2011 HPF design was lost en route to substantive operation in 2013.
- Instead, partners' engagement with the service delivery model stuck at supporting the facilities that existed under the Basic Services Fund, with management/support reordered to streamline geographical division of labour among NGOs
- Coverage of facilities under HPF largely remains as it was during the Basic Services Fund (and, factoring the current crises, even fewer are operational)
- HPF added window for dedicated support to referral hospitals
- Lacking viable NGO partners in some Counties, IMA World Health began to 'contract in' with CHDs and Facilities
- Interruption in RRHP funding for former Upper Nile and Jonglei June 2016-May 2017

Map of major health programmes as at 2015

With thanks to Aid Works



Health services and structures 2011- (2) GRSS: MoH's progressive reforms have had their effect blunted by economic collapse, and changes of subnational structures

- In the 2010s, MoH, as a leading participant in the Local Services Support programme, pursued an aggressively pro-poor policy of pushing funding down to front-line services, in return for improved accountability.
- This included:
  - Restructuring of MoH budget to push resources to front line services:
    - 413/492m SSP transfers budgeted in FY16-17
    - Harmonised salary scale for NGO staff (2012 RRHP, 2014 MoH), and use of SSEPS payroll system, to facilitate planned transition onto GRSS paybill
    - "Infection allowance" to bring GRSS health workers' remuneration closer to NGO staff's
    - Establishment of 'National Service Delivery Units' (HSIs and Hospitals) as separate entities, rather than MoH departments
  - Facilities grants programme, on the model of the school capitation grants, through which funding was put directly to PHCCs' bank a/cs, which received on behalf of their local network of PHCUs.
  - Establishment of Health Transfers Monitoring Committee
- 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 – capacity, experience and resources spread more thinly, some new Counties' functionality currently nominal
- The design of the HPF had been based on a planned transition of responsibilities, in particular for health service delivery staff, to MoH.
- The more than halving of the world oil price 2014, and the cost of the conflict, caused MoH's budget to lose value as a %age of GRSS budget (1.66% in Budget 16-17) and in absolute terms, as value of SSP fell from 3 SSP : 1 USD at Independence to beyond 150 SSP : 1 USD

Main priorities as per the MoH National Health Policy 2016-2026: community-anchored health system for sustainable health sector development

- Improved community-based care, with deployment of around 2,500 Boma Health Teams to provide health education, basic services, surveillance, and referrals at the boma level
- Increased training and deployment of skilled health workers, with an emphasis on mid-level workers, clinical officers, nurses, midwives, and laboratory technicians
- Expansion of service coverage through the Boma Health Initiative, expanded workforce, and construction of new facilities
- System of decentralised service delivery, with transfers from the MOH to State MOHs, County Health Departments, Hospitals, Health Training Institutes, and Primary Health Care Centres
- Strengthened, integrated Health Management Information System with harmonised reporting from different partners to ensure completeness and comparability
- Improved coverage of quality service provision as set out in the Basic Package of Health and Nutrition Services
- More reliable supply of pharmaceuticals with improved stock monitoring/reporting and coordinated procurement

Summary of understanding of current partner plans: HPF3 planned to start Summer 2018, for “4-5 years”

- DFID have begun a process to design, and, subject to Ministerial approval, contract, a Health Pooled Fund Phase 3, to begin in “Summer 2018”, for “4-5 years”. DFID have said that:
  - this would integrate support to services currently programmed under HPF and ICCm programmes
  - This would be of “similar size and scale to the previous programme but will be dependent on other donor money”
  - “a formal Break Point could be incorporated into the programme after a period of 2 or 3 years to provide an opportunity to join this programme to the other main service delivery programme funded by the World Bank”
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