

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

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FINAL REPORT ANNEX H: Forward Looking Value for Money Assessment of EU support options to South Sudan Health Sector

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Personal Disclosure Statement:

Hamish Colquhoun is an independent consultant who has been contracted by a range of clients, principally for DFID or DFID implementing partners in the education and health sectors. This includes an ongoing assignment with IMA World Health in the DRC, which included working closely with Dan Pike (then DFID DRC Health Team Deputy Programme Manager, currently Deputy Team Leader for Essential Services at DFID South Sudan) from 2014 to 2015. Hamish has also been working for Mott MacDonald as part of the DFID-funded Girls' Education South Sudan project in South Sudan since its design in 2012.

1. Introduction

Objectives

The objective of this report is to consider 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.

Structure

The report covers three core questions:

- What criteria should be considered in assessing Value for Money in the South Sudan health sector?
- How has existing support performed against these criteria?
- What opportunities might exist for improving Value for Money performance?

Scope

In line with the broader analysis being undertaken, the consideration of historical performance covers the period 2012-16. During this period, three major donor health programmes have been the principal support to health service delivery and systems strengthening in South Sudan – the multi-donor Health Pooled Fund (HPF); the World Bank’s Health Rapid Results Project (HRRP) and USAID’s combined support through the Integrated Service Delivery Project (ISDP) and Health Systems Strengthening Project (HSSP).

The HPF’s £107m first phase, running from 2012 to 2016, covered 6 of South Sudan’s former 10 states with funding from the UK, Canada, EU and Sweden. USAID’s programme covered the two former states of Central and Western Equatoria, with \$85m funding for the ISDP and \$25m for the HSSP. In April 2016 these two states were incorporated into a larger-scale second phase of the HPF, with a further £139m¹ funding for the two years to April 2018. The \$100m² HRRP, which began in 2012 and is currently due to run until the end of 2017³, has been responsible for delivery in the remaining two former states of Jonglei and Upper Nile.

These projects have been the dominant forms of donor support to the health sector in South Sudan since 2012. They will as such be the main focus of the present analysis. Other large-scale donor support has included the Emergency Medicines Fund (the main funding, procurement and distribution mechanism of pharmaceuticals in South Sudan from 2013 to 2016 with joint funding from USAID, DFID and Norway, now effectively incorporated into the second phase of the HPF), DFID’s £31m Integrated Community Case Management (ICCM) programme which ran from 2013 to

¹ Estimated total funding for the HPF evolves with time given the reliance on various donor budgets. This estimate is calculated from DFID’s 2016 HPF Annual Review document, which states a total funding of £246m, of which £107m was disbursed in the first phase of HPF.

² World Bank (14th June 2016), PAD1823, for Proposed \$40m Second Additional IDA Grant for HRRP. Shows (page 2) \$59m already disbursed and proposes a further \$40m spending through to September 2017. Based on conversations with IMA World Health, it is possible that this \$40m has since been reduced.

³ Again based on conversations with IMA World Health – there is some discussion about extending this end date within existing funding limits.

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2016 supporting children under 5 who cannot access formal health facilities (a second £25m phase of this project is currently running for the period January 2017 to December 2018) and Global Fund support focussed on malaria. Where possible, learning from this broader support to the sector has been incorporated into the present analysis.

Constraints

Efforts to undertake this assessment have been constrained by challenges in accessing information. Publically available documents for the projects do not provide sufficient detail to properly understand the underlying dynamics of Value for Money. Had efforts to access more detailed information on Value for Money and financial performance been successful, the present assessment's scope could have been broader. One likely explanation is the concern of a possible future conflict of interest in that the consultancy firm carrying out this assessment might join a consortium to bid for the next phase of the Health Pooled Fund. In the context of the upcoming HPF3 tender process and to benefit all actors active in the health sector in South Sudan, it was agreed from the outset that this assignment (as well as the other chapters) will be made available as a 'sector public good'.

The requested documents included – HPF 2016 VFM Framework; HPF historical quarterly financial reports and annual financial reports; HPF quarterly project technical reports; HPF Financial Status Analysis June 2014; HPF Annual Implementing Partners Performance Review documents; World Bank June 2015 Mid Term Review of HRRP; World Bank Health Public Expenditure Review; Lot Quality Assessment Survey 2015; Demographic Health Survey; Annual budget data for each county under HRRP to allow for comparison of costs vs. results; Data to show non-direct costs for each NGO under HRRP as a % of their total costs; HRRP quarterly reports; HRRP report setting out the “Statistically significant evidence of the positive impact of PBF on achieving key health indicators such as EPI, ANC, Curative Care, and Health System Management”.

To date, the projects' implementing partners (IMA World Health for HRRP and Crown Agents for HPF) have only been making their quarterly (non-financial) reports public.⁴ In other cases such information is indeed made public - for example, the DFID Girls' Education South Sudan project publishes its quarterly reports on its website. While the focus of the present assessment is forward looking, it is very difficult to make evidence-based recommendations without a consideration of the past.

It is hoped that moving forwards, routine publication of quarterly reports (including financial information), and other documents pertaining to value for money aspects of programme implementation will be more readily accessible.

2. What criteria could be considered in assessing Value for Money in the South Sudan health sector?

Value for Money (VFM) as a phrase has been given increased prominence principally by the UK's Department for International Development (DFID) in recent years. However, as a broad concept it has been in the thinking and planning of all donors for many years. Ultimately VFM is about

⁴ Note given the impossibility of getting data from the implementing partners still on the ground, additional effort was not made to get similar data from the historic USAID projects.

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maximising impact relative to the resources invested into something. This means having a clear statement of what impact an investment is trying to achieve is critical to being able to consider VFM.

Of course, it is often neither easy nor sensible to have a tightly defined impact for a project. This might be considered particularly relevant for the South Sudan health sector where there might reasonably be many objectives that are hard to collapse into a single statement. The HPF has an initial impact statement of “the delivery of effective health services that help build a resilient and healthy population”, with an originally planned transition towards an impact of developing “a Government-led health system that saves lives”. Clearly there is no simple indicator to capture performance against either impact statement which could in turn be related to overall project costs.

In the last six years a particular effort has been made in developing methodological frameworks for understanding VFM in DFID projects. Given the practicality (and publically available nature) of these frameworks, the consistency in approach across a wide range of projects and the fact that the main support programme in the South Sudan health sector (HPF) is currently managed by DFID, their broad principles will be the starting point for the present analysis.

The standard DFID methodology breaks down the understanding of VFM into four categories linked to a project’s logical framework – Economy (the cost of inputs), Efficiency (the rate of conversion of inputs into outputs), Effectiveness (the conversion of outputs into Outcome and Impact) and Equity (how fair the distribution of benefits is).⁵ The separation of these categories allows for deeper analysis of the driving factors of a project’s overall Value for Money. This is most helpful for complex projects with wide-ranging interventions and multiple objectives, as is certainly the case for the major health projects in South Sudan.

Applying this methodology to assess both existing and potential future support to the health sector in South Sudan, there are three critical cross-cutting principles to take note of:

- Overall VFM needs to be assessed holistically, even once analysis has broken it down into its constituent categories, as strong performance on one category might imply weak performance on another;
- Both quantitative and qualitative assessment is required to avoid a bias towards only what is measurable.
- VFM monitoring and reporting should be kept as simple as possible so that it is actually used to improve implementation approaches.

What VFM criteria have been used by the existing health sector projects themselves?

⁵ Note that a DFID logical framework has the following results hierarchy – Inputs lead to Outputs leads to Outcome leads to Impact. HPF has an initial (Phase 1) Impact Statement which is “the delivery of effective health services that help build a resilient and healthy population”. As set out in its Business Case the project intends to move to an eventual Phase 2, at an undefined context-dependent point, with an Impact Statement of developing “a government-led health system that saves lives”. The Outcome statement is “increased access to quality health services, in particular by children, pregnant women and other vulnerable groups”. The Outputs to achieve this Outcome are (i) Strengthened delivery of health services, particularly responsive to the needs of women and children; (ii) Increased ownership, governance and demand of communities for health service; (iii) Strengthened health systems at state and county levels.

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The Health Pooled Fund developed a short (5-page) Value for Money framework in 2013. This proposed a collection of indicators that could be monitored and reported on. No such reporting is publically available aside from DFID's annual reviews of the project, none of which discuss the specific indicators proposed. The Mid-Term Review (MTR) of the HPF strongly criticised the limitations of this framework and instead helpfully analysed key areas of Value for Money for which information could be found. The MTR recommended that the HPF should develop a new framework, however, this does not seem to have happened. The 2016 Annual Review (completed in November 2016) refers to a new VFM Framework developed in May 2016, however, efforts to access this framework for the present analysis were unsuccessful, with DFID suggesting that it remained in incomplete draft form only.

Non-DFID projects are not required to report explicitly against VFM principles. As such the VFM relevant data from publically available documents is quite limited. Nevertheless, some aspects could be considered and are reported against in Section 3.

The ICCM project set out two VFM indicators in its 2013 Business Case – cost per child treated and cost per DALY averted. This focussed approach actually matches very closely the recommended priority reporting outlined in the following section. It is stated that the project would establish a cost per DALY model in the first six months of implementation, given that none then existed for ICCM treatment of Severe Acute Malnutrition in South Sudan. The 2014 and 2015 Annual Reviews show that this model was still under development. Neither indicator ultimately appears to have been reported against during implementation (the 2016 Annual Review was not available on the DFID website at the (mid-2017) time of writing). Nevertheless, the 2017 Business Case for ICCM2 includes data on cost per DALY that seems to have been modelled in 2016 towards the end of the first phase of the project.

What are the most important VFM indicators that could be looked at?

Given the apparent challenges with reporting on the VFM of existing support, it would be an option for future programming to focus on ensuring only a few top level indicators are consistently and explicitly covered. It should be noted that, concurrent to the present report, DFID have been developing a Business Case for the next phase of the HPF. This Business Case will, as per normal DFID requirements, need to include a VFM framework. While this Business Case has not been made available to the CGA team, it would not be logical to duplicate the effort by proposing from scratch a full set of VFM indicators for the future support to the sector.

Instead, the following aims only to emphasise in broad terms what the top-level priority VFM reporting could be for a future support programme focussed on Health Service Delivery:

Economy

- **Regular external procurement audits covering all Implementing Partners**

These audits would come with a narrative clarifying the extent to which partners are securing the best prices for the purchasing of inputs. Given the broad range of inputs and the extent to which prices fluctuate according to exogenous factors, there is often limited logic in setting specific targets for the price of individual inputs. The audits should incorporate comparisons

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with international prices usually achieved as well as those achieved by other partners within the same project.

Efficiency

- **Cost per beneficiary supported**

It is not helpful to consider this VFM indicator entirely in isolation. To allow comparability within and beyond the programme as well as over time, reporting on this indicator would need to be disaggregated as far as possible (ideally to the county level, but at least for each implementing partner) and make clear exactly what package of services are delivered to each beneficiary.

Effectiveness

- **Cost per DALY averted**

This indicator could be regularly reported on in two ways. First in theory – i.e. comparing the package of services being delivered relative to what is known internationally to be most cost-effective in terms of cost per DALY averted. Second in ex-post practice – i.e. assessing the quality of the health services being delivered and so the extent to which theoretical DALYs averted are likely to be realised in practice. The latter would need to be captured qualitatively through ongoing monitoring reports and more rigorously through periodic sampled surveys. It may also be possible to conduct research to directly model the cost per DALY averted for the project's context.

Equity

- **Geographic breakdown of how many beneficiaries are receiving which services at which level of quality in each county** (ideally expressed as a percentage of total potential beneficiaries in each location).

The geographic disaggregation allows for a separation of rural and urban beneficiaries, which also provides at least a loose proxy for socio-economic differences.

To the extent that other non-service delivery components are supported (i.e. longer term system strengthening), the VFM reporting requirements could again be kept simple but explicit. The key requirement is that project costs would need to be clearly demarcated by project component. This then allows for VFM reporting to focus on comparing a qualitative assessment of what has been achieved against what has been spent.

3. How has existing support performed against these VFM principles

The following section will attempt to provide some answers to the questions set out in the Inception Report for this analysis, while being structured based on the proposed VFM priority categories set out in Section 2. Unfortunately, this is where the present report suffers most from a lack of access to information. Some of the originally envisaged questions are not included below, on account of a complete lack of information, others are answered far less fully than was originally expected to have been possible. It is hoped that the forthcoming evaluation of the HPF will get access to the key data and thus be able to take a deeper look into these questions.

Economy

Regular External Audit Reports

How strong have financial management processes been, including the control of fiduciary risk?

For HPF, from what can be seen from the publically available documents, procurement processes for the purchasing of inputs appear now to have improved following a weaker start to the project. There were apparent issues found during an external Programme Audit conducted in December 2014, that were stated to have been largely addressed by the time of a follow-up Programme Audit in October 2015.⁶ These issues appear to have been around the level of scrutiny of Implementing Partner (IP) financial reports, the programme's own overall financial reporting, a lack of external financial audits of the IPs and the full project itself and the need for more clarity in financial instructions to the IPs.⁷ The project's 2015 Mid-Term Review was extremely critical of the quality of financial management. Indeed it was noted that there had not been any external audit of financial statements for the period 2012 to 2015.

The impression gained from the present assessment exercise, simply in terms of the inability for basic HPF reports to be made available and the apparent non-completion of a Value for Money strategy, is that management challenges remain substantial. Indeed, the national operating context has become more difficult following spikes in insecurity in December 2013 and June 2016. The size and complexity of the HPF will require an ever-increasing investment in high quality and robust management processes.

For HRRP, the project has been regularly audited to ensure financial management processes are robust. The 2016 World Bank Project Appraisal Document setting out the \$40m extension of the project did note some challenges with ensuring sufficient internal controls as well as some slowness to addressing audit recommendations. However, it was stated that there had been no instances of fraud during implementation.

There is limited publically available evidence to comment on procurement processes for other projects, but in general this is an area for which donors seem to have found easier to hold to account through auditing processes than the other categories of Value for Money. An important lesson noted from the Annual Reviews of the ICCM project is that short delays in initial procurement and purchasing of inputs can provoke major delays in distribution when it disrupts intended planning

⁶ 2015 HPF Annual Review, page 9.

⁷ Set out page vi of HPF Mid Term Review (January 2015).

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cycles based on the timing of the dry season. This highlights the need to ensure that procurement systems are not only robust but also efficient.

Efficiency

Cost per Beneficiary

Headline data on costs per beneficiary supported with an Essential Package of Health Services

Data on cost per beneficiary supported is not publically available for any of the existing projects. Ideally the analysis should be of the cost per beneficiary to receive an explicitly defined package of services. Where the package is different in different locations, then the data should be disaggregated to reflect that.

The August 2017 health mapping survey phase 1 report (pages 29-30) provided a rough analysis of estimated total annual spend per (former) state for each of HPF and HRRP based on publically available data (building on an earlier version in the inception report of this assignment).⁸ This can then be compared against the population and the number of health facilities in each state. To the extent that both projects supported all people in each state then it would be possible to estimate a cost per beneficiary (averaging \$5, ranging from \$3.6 in former Eastern Equatoria up to \$11.1 in former Western Equatoria).

However, evidently the provision of an essential package of services has not been available to the entire population of each state. The original 2012 HPF Business Case expected its service packages to in general cover 30% of the population of each supported state (page 23), based on an assumed improvement from the 20% coverage achieved by the preceding Basic Services Fund project. The 30% expectation was for services related to child health, malaria, hygiene & sanitation practices and HIV/AIDS prevention. For maternal health services the expectation was a 20% coverage. For family planning the expectation was only an 8% coverage.

Summary data on actually achieved coverage is not publically available and so requires some assumptions. The August 2017 Health Systems Mapping and Facility Survey found the average rate of provision for a selection of key services for health facilities was 58%. These services do not match exactly those prioritised by the HPF⁹, although there is some overlap. Key overlap where service provision rates were above average include malaria (87%-96% for PHCC, PHCU respectively), antenatal care services (79%) and child health (65%). HPF priority services which had a provision rate below average were HIV (50%); Basic Emergency Obstetric and Neonatal Care (BEmONC) (34%) and Comprehensive Emergency Obstetric and Neonatal Care (CEmONC) (49%).

The latest data for the proportion of the population with access to a functioning health facility varies from 25% to 44%.¹⁰ Taking the more optimistic of these two estimates (44%), this would imply that approximately 26% of the population currently have access to essential health services. This is not too dissimilar (marginally below) the original coverage expectation set out in the HPF Business Case.

⁸ The major caveat should be noted, however, that this spending data is based on allocations rather than actual disbursement, given that only the former is publically available.

⁹ As set out in the 2012 HPF Business Case. It is assumed this package of services might have evolved with time, but no public documents on this set such changes out.

¹⁰ HPF MTR, page 18. 2009 mapping survey found only 44% of people live within 5km of a functioning health facility. Ministry of Health estimates in 2013 were that only 25-30% of the population have access to health care.

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There is some data from HPF available on actual achieved coverage for certain very specific services. Notably the percentage of births attended by skilled health personnel (10% achieved by 2016), the proportion of 1-year-olds vaccinated with DPT (47% by 2016),¹¹ the percentage of women who attended at least four times for antenatal care during pregnancy (28% by 2016). In general these were marginally below targets set, which tallies with the broad estimate of coverage calculated in the previous paragraph.

As such, assuming an achieved coverage of 26% of the population, the cost per beneficiary for both HPF and HRRP would on average be of the order of \$20 per year. Despite the limited quality of data underpinning this estimate, it can still usefully be compared with equivalent international experience.

In Somalia, a 2014 study estimated unit costs per person per year for an Essential Package of Health Services as \$5.88 for the HCS project and \$11.66 for the JNHP programme with significant variation across regions. The methodology for estimating these costs seemed to comprehensively include all relevant costs¹² and only considered the relevant catchment population of health facilities, so it is not an unreasonable comparison. Data for other comparable countries (Afghanistan, DRC, Ethiopia, Kenya, Rwanda) suggests a common cost per beneficiary range from \$5 to \$12 for the delivery of an Essential Package of Health Services.¹³

The package of health services and methodology for estimating both spend and beneficiary numbers differs significantly from country to country. Detailed comparison between the comprehensiveness and quality of the package of services offered is required as well. Nevertheless, the notably lower average of costs compared to the current South Sudan estimates, despite similarly difficult operating environments (notably Somalia, Afghanistan and the DRC) suggests that the current performance in South Sudan for this indicator warrants further investigation. Unfortunately, from the publically available data this is not possible for the present assessment. An opportunity could be the upcoming HPF evaluation.

Evidence on differences in cost-efficiency and cost-effectiveness between different service delivery contractual modalities (e.g. contracting-in CHDs rather than NGOs)

The HPF and HRRP adopted different modalities to achieve the delivery of their health services. The most interesting contrast was the HRRP's "contracting-in" of County Health Departments to manage service delivery as opposed to contracting NGOs. The HPF has continued to exclusively contract NGOs for the implementation of services.

The HRRP has adopted this approach in 6 of its 24 counties. The experience has been particularly positive, with three main benefits – (i) greater cost efficiency, with far lower costs than NGOs and apparently equivalent delivery; (ii) greater resilience to conflict (medical and non-medical staff were found to be more likely to remain in their facilities, while NGO personnel usually withdrew

¹¹ HPF 2016 Annual Review, page iv.

¹² Although it is not completely clear if the top-level service provider's management costs are incorporated, rather than just the Implementing Partners' costs.

¹³ See page 18, Blaakman (2014), "Cost analysis of the Essential Package of Health Services in Somalia".

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temporarily when fighting reached their areas); (iii) greater sustainability of activities given increased ownership and capacity development of local authorities.¹⁴

IMA's own estimates are that contracts for County Health Departments were 40-50% less expensive than those for NGOs, by removing the need for expatriate salaries, R&R policies and general NGO overheads including office running costs. It was hoped that the present assessment would have been able to investigate this relative cost efficiency in detail – unfortunately the scrutiny of the necessary financial data was not possible for the reasons set out in Section 1. It would be very important for this analysis still to be done, however. It is nonetheless striking that the cost per beneficiary results for the HRRP states were equivalent to those for all HPF states, despite the operational and conflict status of the period in question being demonstrably worse for the Greater Upper Nile region than the rest of the country.

Secondly, despite a lack of access to the hard data, the impression given is that HPF non-direct costs have been far higher than those achieved by HRRP. The 2015 Mid-Term Review (pages 59-60) found HPF Implementing Partner non-direct costs to be 38% (i.e. only 62% of spending was actually for supporting service delivery). In the subsequent year this apparently fell to a still high 31%.¹⁵ While it is not possible to compare this with HRRP without data, it can be compared to the experience of GESS, the major education project in South Sudan which covers all states across the country with implementation on the ground led by a network of NGOs. For GESS, to the end of 2016, the cumulative non-direct costs for the NGOs was 24%.¹⁶

Two clear conclusions can be drawn:

- **Contracting-in of County Health Departments seems to be highly cost-efficient compared to contracting NGOs.** It also comes with added benefits of sustainability and resilience. It would seem important that this approach is extended beyond the two HRRP states. While HRRP did select the higher capacity CHDs within its states, it seems most probable that average CHD capacity will be higher in the non-HRRP states.
- **HPF Implementing Partners non-direct costs are high in absolute terms** (even without being able to compare with HRRP data). A comparable large-scale DFID Education project has managed to achieve far lower non-direct costs for its implementing partners which operate in every county across the country in the exact same context.

¹⁴ See World Bank (2016), PAD1823, page 45, "Proposed Second Additional IDA Grant for Health Rapid Results Project". And IMA World Health, "Repositioning Primary Health Care in South Sudan: Transitioning from NGO-Managed to MOH-Directed Primary Health Care Service Delivery".

¹⁵ HPF 2015 Annual Review.

¹⁶ GESS, VFM Annex – Full VFM Indicator Reporting – Update to 31st December 2016.

Effectiveness

Cost per DALY averted

Have the differing mix and quality of intervention packages been the most cost-effective in terms of DALYs averted?

It is challenging to assess exactly which package of essential services has been provided by both projects based on public documents. For HPF the 2012 Business Case sets out a strong rationale for those services originally selected based on international cost effectiveness experience. The package selected by the HRRP project seems similar¹⁷, although the specific differences in emphasis cannot be assessed from the publically available documents.

Based on available information, an impression is given that the HPF did not give an explicit emphasis to cost-effectiveness considerations during implementation (e.g. no VFM strategy developed or reported on since 2013). Notably, the 2015 Mid-Term Review highlighted that some activities dropped during implementation, such as those aimed at increasing the use of insecticide-treated bed nets, are some of the most cost-effective internationally in terms of DALYs averted. The recommendation was made to conduct “an analysis of interventions undertaken, to ensure that they prioritise those known to be most effective in terms of DALYs averted”. It is not clear whether this has been done – it is not referred to in the subsequent Annual Reviews.

Interestingly, the 2017 Business Case for ICCM2 estimates a cost per DALY averted for the project far lower than HPF’s estimate (£19 vs £180). The evidence base for both estimates is likely relatively weak, although ICCM did repeatedly emphasise an intention to model the cost per DALY and apparently finally did so in 2016 ahead of the Business Case development. Nevertheless, given the vast difference between the two estimates it would seem important to ensure a sufficiently rigorous analysis has been conducted of what the optimal package of services for the health sector should be. This would need to be based both on the theoretical international evidence and also the practical reality of delivery in South Sudan (including the actual quality of services provided).

Effectiveness of Non-Service Delivery Support

How cost-effective has non-service delivery support been (including health system strengthening and community engagement)?

There is various evidence provided for both HPF and HRRP of progress made with activities related to health system strengthening and community engagement. Indeed both projects have indicators for assessing progress in these areas. From the publically available data, however, it has not been possible to relate any such progress against the investments that have been made. It is not clear whether this has been done. Such an analysis is not included in the Mid Term Review or Annual Review for HPF or the HRRP 2016 Extension PAD.

The HRRP ‘contracting-in’ model, however, would seem an example where progress has been made on system strengthening with an effective reduction in cost compared to the counterfactual of

¹⁷ As can be seen to some extent in the World Bank (2016), PAD1823, “Proposed Second Additional IDA Grant for Health Rapid Results Project”.

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contracting through an NGO. Again this would suggest that opportunities to extend this model to the HPF should be explored.

Equity

Geographic breakdown of beneficiaries

How equitable has existing support been in terms of geography and socio-economic need?

At the broadest level the principal health delivery programmes have coordinated coverage at a national level across all states and counties. The ICCM programme has also complemented the HPF and HRRP projects by reaching individuals within states who might otherwise not be supported by a health facility. As shown by the analysis earlier in this report, it is probable that significantly more than half the population does not access essential health services. The former Jonglei and Upper Nile states also suffered from a lack of support while the HRRP was paused during the period 2016/17. While there has been no equivalent full-scale pause of the HPF, there have also been gaps in service when there were changes in Implementing Partners for certain counties. Periods of insecurity across both projects have seen local level interruptions of service – IMA findings were that this was particularly the case where delivery is led by NGOs rather than County Health Departments – while for the HPF it has led to central management being cut down to a ‘skeleton’ level only during key periods.

From the publically available data it is difficult to assess the extent to which the support that is provided is equivalently available in all counties and states. HPF Annual Reviews only make very brief reference to Equity (e.g. 2016 Annual Review – “there have been no equity surveys done to date”). In the education sector, the large-scale Girls’ Education South Sudan project has publically available real-time data on how its components (in particular cash transfers to girls and capitation grants to schools) are taken up in every county in the country – see <http://sssams.org/sbrt/equitytable.php>. This data might exist for HPF and HRRP but is not available publically. The ideal would be to have an equivalent table updated on a real-time basis with county-by-county information on which services are provided where. Unsurprisingly the education programme finds that significant variations in the take-up of support do exist across the country, but this information is used in an ongoing manner to try and address equity concerns (i.e. increasing focus on under-performing areas). It is not clear how systematic the attempts by the health sector programmes are in the same sense.

One area where there was considerable progress made in a nationwide equitable approach to service delivery was in the harmonisation of government and NGO health worker salaries. Remuneration is the biggest area of spending of both HPF and HRRP. Unfortunately, the collapse in the value of the SSP has meant that government salaries are worth increasingly less¹⁸ and there now seems to be a divergence again in approaches on how to ensure adequate remuneration to health workers. This can have a greatly distorting effect, with government unable to retain staff who join the NGOs or leave the profession, with potentially significant consequences in terms of equity and sustainability. It is strongly recommended that renewed efforts are pursued to ensure a national approach to health sector pay is re-asserted.

¹⁸ 67% of government health workers earn less than \$12 per month, far below the international global poverty line of \$57 per month.

Cross-Cutting VFM Questions

- **Has non-donor (particularly GRSS) funding for the sector been effectively leveraged?**
(Relevant to both efficiency and effectiveness)

Government funding for the health sector has decreased in both relative and absolute size during the past 5 years. In 2016/17 the approved health budget was just 1.7% of the national budget and only worth \$8m¹⁹ (492m SSP). Relative to the substantial scale of the HPF and HRRP projects, alongside various other donor support to the health sector, the government has become only a marginal contributor (less than 10% to total support).

This is a major contrast from the relatively recent past, where in 2014/15 the Ministry of Health budgeted to spend \$123m, representing 3.3% of the national budget and making it the single biggest funder of the health sector covering about 60% of the estimated total combined government and donor funding of around \$200m.

The 2017/18 has seen a very marginal increase in the relative share of health in the national budget to 2.3% but a continued fall in absolute USD terms to \$6.6m²⁰. There are as such two key issues – government prioritisation of health has apparently fallen and the economic value of government support has completely collapsed. This has a detrimental effect on the VFM on any donor support to the sector.

Taking a long-term view at some point the economy and government budget will rebound. It would seem critical that donor support to the sector does not neglect the potential importance of government financing in the medium-term future, given that just 3 years ago it was the dominant funder of the sector. Aside from questions of national ownership and sustainability, technical support to ensure that government support to the sector is prioritised, well managed and appropriately allocated remains important even as amounts flowing through the system are relatively small. International experience hints at the hugely expensive and extremely slow process of re-building PFM systems which are allowed to completely collapse (e.g. DRC, Somalia).

The other form of non-donor funding to the sector is principally user fees. There is not clear data on how user fees differ in different facilities for different services, nor on the extent to which such fees fund the system. In other similar contexts, such as the DRC, user fees are by far the dominant source of funding for the sector, despite donor investment on a scale similar to South Sudan. There are often drives (principally from donors) to simply abolish user fees through the principle of Universal Health Care. This would seem potentially mis-guided if some services are considered more essential than others (e.g. in terms of cost per DALY averted). An approach to ensuring minimal fees for the most essential services, while accepting some fees for other services might be the most efficient form of financing a health sector that currently falls short of supporting all South Sudanese with even the top priority essential services. It is not clear from public documents what the approach of the HPF and HRRP are towards this issue, but it would seem worthy of further analysis.

Has performance based contracting improved VFM where it has been piloted?

¹⁹ Exchange rate from the point at which budget was passed.

²⁰ At market rates, which are slightly below official rates, but reflect more fairly what the SSP is actually worth.

ANNEX H: Forward Looking Value for Money Assessment of EU support options to South Sudan Health Sector

The HRRP piloted performance based contracting for its implementing partners. This modality involved providing performance based financial incentives for implementing partners, County Health Departments and health facilities. For example, health facilities could earn up to around \$600 per month based on achieving certain quantitative indicators such as numbers of priority vaccinations or consultations given. IMA ensured that all health workers within a facility would benefit from these payments, developing a standard process that assured distribution to all workers according to their position. The pilot was found to have a significant effect on results including opening hours of facilities and higher outputs. As such the modality was expanded to all NGOs and CHDs.

IMA produced a report demonstrating the “statistically significant evidence of the positive impact of PBF on achieving key health indicators such as EPI, ANC, Curative Care, and Health System Management”. Unfortunately this was not made available for this assessment. To assess what lessons could be taken from this experience that might determine the relevance of this approach to the broader HPF, an independent analysis on this would be required. In particular, while the benefits are likely clear, there also needs to be a full consideration of the costs of the approach. Potential costs could include a greater administrative burden for partners and health facilities as well as greater management and monitoring costs for IMA itself. Were the benefits to significantly outweigh these costs then it would seem sensible for the approach to be trialled within the HPF as well.

How effective has the collaboration between donors, government and implementing partners been in terms of synergies, complementarities, dissemination of best practice and avoided duplication?

At the top level, donor coordination with government has been strong, in the sense that all States have been supported with a programme targeting the delivery of essential health services. The differences in approach between these programmes has given the opportunity for learning which approach is most effective. Unfortunately this opportunity does not seem to have been grasped until now, with the design of the next phase of the HPF having taken place before any apparent cross-project evaluation exercise. The HPF Mid-Term Review had recommended such an analysis, but this has not yet been taken forward. The current assessment does attempt to provide some level of analysis in this respect, but given the lack of data made available it cannot go into the depth that is truly required. The next opportunity is the full HPF Evaluation.

The integration of the previous large-scale pharmaceuticals procurement projects into both HPF and HRRP should enhance overall sector efficiency. The large-scale ICCM2 project, which started in 2017, remains separate from HPF because of the perceived complexity of adding it on to an existing project and the imperfect geographical overlap (two already supported counties fell outside of HPF’s coverage). Planning could already begin for how any successor to this project could be integrated into a future sector-wide project such as the next phase of the HPF.

There continues to be a plethora of other donor projects across the country, beyond the core programmes of the HPF and HRRP. These include programmes from WHO, UNICEF, UNFPA, Global Fund, GAVI and numerous others. This level of proliferation is common across the region. Nevertheless, it does highlight that there will continue to be significant opportunities for further sector-wide programmatic consolidation, not least to reduce aggregate overheads.

4. What opportunities are there for improving Value for Money with future support to the health sector in South Sudan

The following are the recommended focus areas for improving VFM with future support to the health sector:

- **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 strategy²¹.
- **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). The Girls’ Education South Sudan project achieved this through a procurement process that prioritised low cost national organisations over international NGOs, alongside a heavy emphasis during implementation on well-planned budgets.
- **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

²¹ Or, as in the apparent HPF case currently, to fail to have a strategy at all.

least for each state). This could be based on that used for the nationwide GESS project - <http://sssams.org/sbrt/equitytable.php>. 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 (avoiding undermining the national ownership of the health system) and equity (given the distortionary effects on equity of delivery where major salary differentials are not part of a deliberate nation-wide strategy).
- **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.

It is worth a final re-iteration that the above recommendations are made based on an incomplete picture of available information within the sector. The spirit of the recommendations would likely remain very similar even with complete data availability. However, a couple of the recommendations may already have been taken forward further than the present assessment could review. The upcoming HPF Evaluation is an excellent opportunity to review these recommendations in more depth. It is critical that this evaluation is presented fewer restrictions in its access to information and also prioritises taking a cross-sector view beyond the HPF.