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USAID South Sudan Health Learning Assessment Summary Report

May 2015

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USAID SOUTH SUDAN HEALTH LEARNING ASSESSMENT

SUMMARY REPORT

MONITORING AND EVALUATION SUPPORT PROJECT

May, 2015

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ACRONYMS

BPHNS	Basic Package of Health and Nutrition Services
CHD	County Health Department
CIP	County Implementing Partner
EMF	Emergency Medicines Fund
EU	European Union
FBO	Faith-Based Organization
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome
HLA	Health Learning Assessment
HMIS	Health Management Information System
HPF	Health Pooled Fund
HRIS	Human Resources Information System
HSDP	Health Sector Development Plan
HSSP	Health Systems Strengthening Project
IDSR	Integrated Disease Surveillance and Response
ISDP	Integrated Service Delivery Program
MOFEP	Ministry of Finance and Economic Planning
MOH	Ministry of Health
MSF	Medicins Sans Frontieres
NGO	Non-Governmental Organization
PEPFAR	US President's Emergency Plan for AIDS Relief
QVV	Quarterly Verification Visits
RRHP	Rapid Results for Health Project
SIAPS	Systems for Improved Access to Pharmaceuticals and Services
SMOF	State Ministry of Finance
SMOH	State Ministry of Health
SSP	South Sudanese Pound
TO	Transition objective
UNOPS	United Nations Office for Project Services
USAID	U.S. Agency for International Development
VHC	Village Health Committee

OVERVIEW

The United States Agency for International Development's (USAID) health portfolio consists of a broad suite of essential, nationwide, vertical programs and state specific support, the majority of which were designed prior to the December 2013 conflict. The purpose of the Health Learning Assessment (HLA) is to provide a better understanding of the current health needs and gaps in the health care system, and make recommendations for immediate and future modifications. It will enable USAID/South Sudan to reach decisions on necessary modifications to improve its health portfolio in light of the current political and economic environment.

The HLA focuses on USAID's specific programs in Central Equatoria and Western Equatoria States - Integrated Service Delivery Program (ISDP) and Health Systems Strengthening Project (HSSP) - the national-level health programs - USAID DELIVER, Integrated Disease Surveillance and Response (IDSR), Systems for Improved Access to Pharmaceuticals and Services (SIAPS) - and briefly touches on HIV/ AIDS commodities and technical support. The HLA also reviews the current political, economic, social and technological situation in South Sudan and USAID's support in relation to the other main donor programs and the Ministry of Health (MOH), across all levels of the health system.

The assessment took place in April 2015 and relied on an extensive document review, key informant interviews, focus group discussions and field visits in both states. The three research questions were:

1. What are the current gaps in the health service delivery and the health systems strengthening programs in South Sudan?
2. What are the strengths and weaknesses of the current model of ISDP and HSSP linking to the broader health portfolio?
3. What new or continued areas (technical, levels and geographical locations) should USAID support, considering USAID/South Sudan's new framework, priorities, and areas of interest?

SOUTH SUDAN

The conflict continues in Jonglei, Upper Nile and Unity states, with no indication of an imminent peace agreement despite ongoing peace talks.¹ This situation affects the health sector most prominently through its economic and social repercussions. Lower oil production² and the relatively low global oil price mean that government revenue has fallen sharply.³ Domestic borrowing to maintain spending, unsupported by foreign exchange revenues, has led to a rapid depreciation of the South Sudanese Pound (SSP).⁴ This has reduced the purchasing power of the MOH, particularly for the procurement of essential medicines. It has also increased pressure on NGOs to pay salaries in dollars.⁵

With over 1.5 million people displaced since December 2013,⁶ Internally Displaced Persons (IDP) camps are presenting additional health pressures: increased birth rates and outbreak risks; and potential for higher gender-based violence. The country suffers from chronically low health-seeking behavior, although this has been improving through increased services and community outreach.⁷

Despite the difficult climate, the government is prioritizing state and county budget allocations to protect basic service delivery, particularly for operating and salary transfers to County Health Departments (CHDs) and State Ministries of Health (SMOH).⁸ The MOH is actively attempting to

¹ Democracy, Human Rights and Governance Assessment Revisited: 2012-2015, USAID April 2015

² US Energy Information Administration analysis, available online at: <http://www.eia.gov/beta/international/analysis.cfm?iso=SDN>

³ 2014-2015 First Macro Fiscal Report, MOFEP, November 2014

⁴ Note from Department for Macroeconomic Planning, MOFEP – Weekly Exchange Rate Developments, MOFEP, 14th April 2015

⁵ Letter from MOLPSHRD, Clarification on Circular No 8/2012, September 2014

⁶ Source South Sudan Humanitarian Snapshot 15th May 2015

⁷ Field Observations; Interview Notes with CIPs and Focus Group Discussion with VHC

⁸ Interview Notes with MOFEP, SMOHs, CHDs

increase government health worker salaries through the introduction of an Infection Allowance,⁹ to bring government salaries closer to those paid by NGOs according to a harmonized salary scale.¹⁰ New initiatives such as health facility grants are being designed to mirror successes in decentralizing funds to service delivery in the education sector.¹¹

SOUTH SUDAN CORE HEALTH PROGRAMS

There are four core health programs supporting health service delivery and systems strengthening in South Sudan: ISDP and HSSP in Central and Western Equatoria, the Rapid Results for Health Project (RRHP) in Jonglei and Upper Nile, and the Health Pooled Fund (HPF) in the remaining six states.

The programs were split geographically at the request of the MOH, and in agreement with the donor community, have been designed to have a harmonized approach,¹² aligned with the Health Sector Development Plan (HSDP)¹³ and Basic Package of Health and Nutrition Services (BPHNS).¹⁴ In summary, the similarities include: a countywide approach to primary health care service delivery, use of the government Health Management Information Systems (HMIS), a common set of service delivery indicators, joint supervisions of health facilities (NGO and CHD), provision of support to CHDs, and empowerment of Village Health Committees (VHCs).¹⁵ The HPF and RRHP funding end in 2015 (see Figure 3) and ISDP funding ceiling will be reached mid-2016.¹⁶

Fundamental differences have emerged between the core programs including:

- USAID programs are not supporting hospitals unlike HPF¹⁷ and RRHP;¹⁸
- Medicine procurement - supplementary to the Emergency Medicines Fund (EMF) - is carried out by the HPF and RRHP;¹⁹
- Public financial management is not addressed in the RRHP²⁰ or ISDP, however, HPF and HSSP support CHDs with county budgets and transfers;
- RRHP uses a different contracting approach including performance based contracts;²¹
- HPF provides a state supervision fund to each SMOH through a CIP, for operating costs;²²
- HSSP is introducing satellite offices as part of a “hub model”, grouping counties together to provide follow up and training;²³
- HPF embeds staff in the SMOH, and uses national and state oversight committees to coordinate with the MOH;
- RRHP oversight also includes an independent Quarterly Verification Visits (QVV), where health service delivery data is verified by a third party.

An analysis of the broader health sector activities, using the 2014 Donor Mapping, shows:²⁴

⁹ Letter from MOH to MOFEP, Realignment of SSP 37m from Operating to Transfers Chapter, 29th May 2014

¹⁰ Common Salary Scale for Primary Health Care Workers in South Sudan, MOH, 4th April 2015

¹¹ Note from Health LSS Meeting, MOFEP, 26th March 2015

¹² Summary notes from the ‘Financial and Technical Support to Implementation HSDP Workshop’ 29-30 November 2011, MOH.

¹³ Health Sector Development Plan 2012-2016, MOH, 2012

¹⁴ Basic Package of Health and Nutrition Services 2011 (Draft), MOH, 2011

¹⁵ Presentations from the Donor Harmonization Workshop, South Sudan Fund Managers, 2013

¹⁶ Interview Notes with USAID and ISDP

¹⁷ HPF has launched Requests for Proposals for county and state hospitals in 2014

¹⁸ South Sudan - Additional Financing for the Health Rapid Results Project, World Bank Group, 2014

¹⁹ Interview Notes with CIPs, HPF, RRHP and Presentations from the Donor Harmonization Workshop, South Sudan Fund Managers, 2013

²⁰ MOH instructed RRHP that this was MOFEP’s responsibility and the World Bank has separate technical assistance programs in this area.

²¹ ‘The RRHP Project Common Elements and Unique Features’ IMA Presentation of RRHP at June 2013 Harmonization Workshop

²² Support to Enhance State Ministries of Health Supervisory Capacity, HPF, 2013

²³ HSSP introduced six ‘hubs’ (one hub per two-three counties) to provide support at a more local level

²⁴ Donors/MOH Investment Map 2012-2017. Compiled by Embassy of Canada on behalf of Donor Partners Group and presented on April 9, 2015

- There is a gap in funding for procurement of pharmaceuticals after the EMF ends in 2015;
- Canada and the EU provide the most support towards pre-service training;²⁵
- HPF contributes the most funding to Finance, Leadership and Management.

USAID HEALTH PROGRAMS

USAID's health portfolio has several unique support features. The HLA identifies seven areas of technical support and expertise:

1. **Prevention of postpartum hemorrhage through community-based services:** Postpartum hemorrhage is one of the main causes of maternal deaths in South Sudan.²⁶ ISDP has extended support for safe deliveries and the reduction of maternal deaths to include the distribution of misoprostol at the community level.
2. **Quality improvement standards implemented at the health facility level:** ISDP has led the introduction of a quality improvement tool across both states.²⁷ ISDP has focused on infection control standards, an area that the MOH Health Facility Survey identified as a critical gap in health facilities.²⁸
3. **Leadership and management training and mentoring:** HSSP has led the development of a training and mentoring program for leadership and management.²⁹ The program is for three levels: SMOH and CHD managers, health facility in-charges and VHCs.³⁰
4. **Pharmaceutical supply management support:** SIAPS is able to provide pharmaceutical support management at the national, state and county levels, which is not provided by any other partner. At the national level, support includes drug quantification, training, communication across national to county about drug distribution, and coordination of the EMF Technical Working Group.³¹ In 2014, SIAPS also supported the nationwide de-junking process alongside all key donor programs.³²
5. **The EMF procurement and supply process:** DELIVER has led the procurement process for the EMF and other critical health commodities. At the central medical stores it has provided equipment, training, and standardized procedures for storage and inventory control.³³
6. **The IDSR program:** implemented by the World Health Organization, this program provides essential disease surveillance functions at all levels of the health system. Critical functions include: emergency preparedness and response planning, a weekly disease surveillance reporting system, and community based surveillance and training.³⁴
7. **HIV/AIDS commodities and technical support:** PEPFAR is currently the single largest HIV donor,³⁵ and has provided HIV-treatment bridge funding, commodities, and technical assistance³⁶. The US Center for Disease Control and Prevention provides additional lab systems strengthening and quality assurance capacity building,³⁷ Additionally, programs offer extended HIV/AIDS treatment services for pregnant women,³⁸ and the 'Linkages' program will focus on sex workers and high risk populations.³⁹

²⁵ Ibid

²⁶ "Advance distribution of misoprostol for the prevention of postpartum hemorrhage in South Sudan", Smith et al. 2014

²⁷ HSSP Year Two Annual Report, USAID HSSP, 2014

²⁸ Rapid Health Facility Survey, MOH, 2013

²⁹ HSSP Year 2 Annual Report, USAID HSSP, 2014

³⁰ Interviews Notes HSSP, WES

³¹ Interview Notes with SIAPS

³² SIAPS Quarterly Report, Project Year 3, Quarter 4, USAID/SIAPS 2014

³³ Interview Notes with DELIVER

³⁴ Annual IDSR Report: Year 6, USAID, 2014

³⁵ US President's Emergency Plan for AIDS Relief: South Sudan 2014 Country Operational Plan

³⁶ Ibid

³⁷ Interview Notes with MOH HIV Directorate

³⁸ Strengthening Prevention of Mother to Child Transmission through the Option B+ approach

³⁹ Notes from USAID on planned Linkages program

GAP ANALYSIS

Drawing on the interviews, field observations and referenced documents, the assessment highlights gaps in the health system from the national to community level. The findings have been framed across the six pillars of health systems.⁴⁰ The analysis did not delve into the specifics of ISDP's service delivery and community activities as they will be described in the ISDP Mid-Term Evaluation.

Service Delivery: Field observations and interviews demonstrated that primary health care services are heavily supported by ISDP through County Implementing Partners (CIPs), without which service delivery would be difficult to maintain. Gaps exist in critical areas such as family planning and secondary health care.⁴¹ There are also reports of user fees being requested for services, although the degree of formality and extent vary.⁴² There is limited support for strengthening county or state hospitals in the two states compared to other states,⁴³ and there is a weak referral system from primary health care facilities to the hospital level.⁴⁴ A critical gap in secondary health care is imminent, due to the departure of MSF from Yambio State Hospital.⁴⁵

Human Resources for Health: Field interviews showed the majority of skilled health workers are paid through the CIPs, and there is no plan for transitioning staff paid by CIPs to the CHD payroll, which is a key assumption of the ISDP project design.⁴⁶ Demand for health workers is much greater than supply, which creates strong competition for staff between implementing partners. Although there are six pre-service training institutions⁴⁷ in CES and WES, health workers reported that there are not enough opportunities to obtain places at the institutions to upgrade their skills.⁴⁸ There is no overall staff listing showing government and CIP health workers, and there is no immediate plan for implementing the MOH Human Resource Information System (HRIS) in the two states.

Infrastructure: Field observations showed minor renovations and equipment procurement occur through ISDP and HSSP, while responsibility for major renovations fall to the other organizations, including UNOPS, FBOs, CHDs and VHCs.⁴⁹ Even though a CHDs and VHCs are renovating infrastructure, there is nonetheless a major gap in the support of infrastructure construction and renovation.

⁴⁰ As per the six pillars of the health system in the MOH Health Sector Development Plan 2012-2016, based on the WHO building blocks of the health system

⁴¹ Field Observations and Interview Notes

⁴² Field Observations and Interview Notes with CHDs

⁴³ HPF have launched Requests for Proposals for County Hospitals and State Hospitals in 2014

⁴⁴ Interview Notes with Ezo, Yambio CHD, USAID and MOH

⁴⁵ Handover Roadmap for MSF Supported Service in Yambio State Hospital, MSF, July 2014

⁴⁶ ISDP Task Order, USAID, 2012

⁴⁷ Juba College of Nursing and Midwifery, Juba Health Science Training Institute, Juba Nursing and Midwifery School, Kajokeji Health Training Institute, National Health Training Institute-Maridi, Lui Midwifery School

⁴⁸ Interview Notes from facilities, CIPs and CHDs

⁴⁹ Interview Notes with CIPs



Figure 1: (A) Additional building constructed by the VHC, Ezo County - Mariagba PHCU (B) Maternity Unit built by a CIP using externally sourced funds, Ezo County - Naandi PHCC

Pharmaceuticals, Medical Supplies and Equipment: Pharmaceutical supply and management has improved due to the DELIVER and SIAPS;⁵⁰ however, stockouts are expected from October 2015 onwards.⁵¹ The push system continues to operate although the facilities visited did not have enough storage for a three month supply, requiring counties to store a large proportion of deliveries. Although partners recognize the importance of establishing a pull system between the CHD and the facility, no location visited has managed to do this thus far. The county stores are not being used as an organized drug depot but only for storage, and health facility stockouts are dealt with on case by case basis. Key features to make the pull system function were not available at the county stores visited, such as completed stock cards, space to unpack all kits, staff capacity and access to transport other than CIP vehicles.

Supervision, Monitoring and Evaluation: The MOH Quantified Supervisory Checklist is consistently used by CIPs, CHDs and the HSSP; however, there appears to be parallel supervision systems where CHDs supervise facilities (with support from HSSP),⁵² CHDs and CIPs jointly supervise facilities and CIPs independently supervise facilities.⁵³ CHD training on supervision is provided by HSSP.⁵⁴ The HMIS health facility monthly report is being implemented across all the counties and facilities visited, with CHDs and CIPs identifying few issues and high reporting rates.⁵⁵ The IDSR health facility weekly reporting seems to have been implemented inconsistently.⁵⁶

Finance, Leadership and Governance: At the national level, there is a gap in formal strategic coordination across the three core programs.⁵⁷ In 2015, the main health donors, the MOH and MOFEP are drafting a Donor Health Compact outlining responsibilities and benchmarks for the sector. There is no work plan or strategic plan available for the SMOH.⁵⁸

At the local level, no CHD has a county plan that includes the activities of government and all partners or inter-sectoral projects. However, throughout the field visits, interviewees expressed that CHDs have increased their leadership and management roles since the new USAID programs have begun.⁵⁹ At the community level, the majority of facilities are reported to have a functional VHC;⁶⁰ and all facilities visited have functional VHCs and active Home Health Promoters.

⁵⁰ Interview Notes with SIAPS, CIPs, CHDs

⁵¹ Interview Notes with CIPs and USAID programs

⁵² Interview Notes with CHDs

⁵³ Interview Notes with CIPs and ISDP; Annual Report October 2013-September 2014, USAID/Jphiego, 2014

⁵⁴ Interview Notes with HSSP

⁵⁵ Interview Notes with CIPs and CHDs

⁵⁶ Interview Notes with CHDs

⁵⁷ Interview Notes with National MoH and donors

⁵⁸ Strategic Plans for Western Equatoria and Central Equatoria State 2011-2015 are available for the state, with little information on health

⁵⁹ Interview Notes with CIPs, national MOH, HSSP

⁶⁰ 305 out of 364 facilities reported in the ISDP Annual Report October 2013-September 2014, USAID/Jphiego, 2014

ISDP AND HSSP MODEL ANALYSIS

Overarching Strengths and Weaknesses: The split of service delivery and health systems strengthening responsibilities between ISDP and HSSP has meant that both programs are able to focus and concentrate on a more specialist mandate.⁶¹ The design of each program ensures that there is greater presence, support and coordination at decentralized levels of government, particularly at the county level. Both programs have a presence in the Central and Western Equatoria state capitals and the programs engage in regular county and state coordination platforms; the monthly County Coordination meetings and the Quarterly Review meetings respectively.

Each program has separate offices, support staff, vehicles and equipment, which has an impact on day-to-day coordination and duplicates overheads and project administration. The targeted focus on county level support has unintentionally bypassed the state level administration. As well as less support at state level, there is no decision making platform between ISDP and HSSP, and the SMOH and CHDs to strengthen the SMOH's oversight and stewardship roles. There is also no strategic coordination forum for the three core programs, donors and the MOH to discuss progress, responsibilities or transition.

Service Delivery Strengths and Weaknesses: The ISDP program design was based on the BPHNS and a harmonized approach to basic service delivery with the other core programs. The introduction of CIPs means that CHDs have one main partner with whom to work and coordinate. This simplifies project coordination and helps reduce gaps.⁶² The model focusses on the link between health facilities and their community, with support to VHCs and HHPs.

At the community and facility levels, there are multiple structures supported by HSSP and ISDP- CIPs, creating potential duplication of efforts. This includes CIPs establishing Community Mobilization Teams independent from HSSP's work with VHCs and without either's role being clearly defined.⁶³ There is also potential overlap arising from CIPs, HSSP and CHDs all conducting data quality assurance activities.⁶⁴ ISDP is unable to include secondary care, procure additional pharmaceuticals in the event of stockouts, and conduct major infrastructure development.⁶⁵ A key assumption of the ISDP design is that the MOH would be able to transition staff paid by CIPs to the MOH payroll;⁶⁶ there is no plan for such a transition to occur.

Systems Strengthening Strengths and Weaknesses: The HSSP design allows focused systems strengthening support to CHDs. HSSP has supported higher execution rates of the Conditional Operating Transfer, implemented the leadership and management program, supported improved CHD HMIS monthly reporting and developed regular HMIS bulletins.⁶⁷ The hub model introduced by HSSP, has provided CHDs a platform for meeting regularly to share information and lessons learned.⁶⁸

There were several omissions observed from the design of ISDP and HSSP towards systems strengthening: varying support for county to facility pharmaceutical supply management, no support to pre-service training, and limited coordination between the USAID programs at the local level (e.g. HSSP, ISDP, IDSR and SIAPS). The hub model, bypasses the SMOH-CHD link with little engagement

⁶¹ Interview Notes with CHDs, HSSP, Abt Associates, ISDP, CIPs

⁶² Interview Notes with CHDs

⁶³ Interview Notes with CIPs and HSSP; Field Observations

⁶⁴ Interview Notes with CIPs, HSSP and CHDs

⁶⁵ ISDP Task Order, USAID, 2012

⁶⁶ ISDP Task Order, USAID, 2012

⁶⁷ Ibid

⁶⁸ Interview Notes with CHD

with the SMOH. This model will be costly due to the need for hub officers to travel frequently between counties; the resultant, short visits may also limit their impact.⁶⁹

CONCLUSIONS

As program end dates approach for ISDP, HPF and RRHP, USAID has an opportunity to harmonize approaches with other donors nationwide; both to fill gaps in its own program locations using other donor unique features, and to roll-out USAID's unique technical expertise more widely. Figure 2 summarizes the activities supported by donors in South Sudan,⁷⁰ highlighting activities that are unique and common in the health system. Medicines procurement and infrastructure are noted in the diagram, but are not unique features of any particular program.

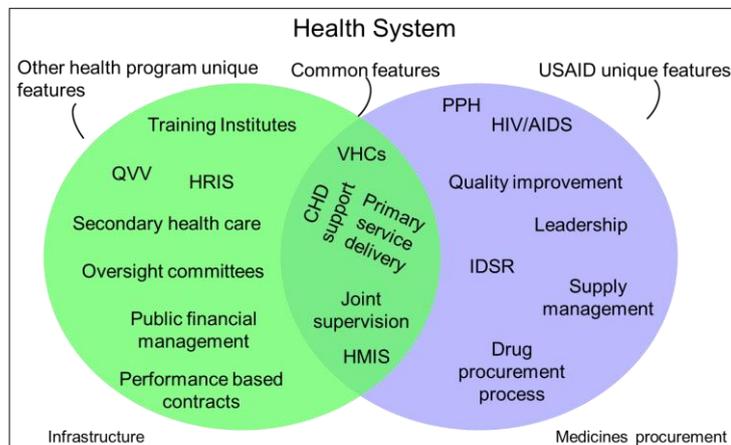


Figure 2: Unique features of USAID and other donor programs

Other further design opportunities include:

- Address weaknesses in the current ISDP/HSSP design through stronger collaboration between the two programs, vertical programs and other stakeholders (including FBOs).⁷¹
- Lessons from other core health programs, such as the HPF's approach to establishing state oversight committees or RRHP's contracting approach.
- Utilize the increased capacity of the VHCs and CHDs by handing over more responsibility to them, allowing programs to focus on other priority areas.
- Utilize the HRIS as a step towards addressing staffing shortages and enabling the decrease in salary gap between government and NGO health workers through the Infection Allowance.
- Make better use of drug consumption data and support SIAPS' role. This data would support strengthened pharmaceutical supply management (PSM) at the county and facility levels.

The South Sudan environment is fragile with many issues that should be factored into the future design of health support. The continued conflict has led to massive displacement and an increased risk of outbreaks. The uncertain future supply of essential medicines is a critical threat for service delivery, with ISDP CIPs unable to procure medicines to cover stockouts.

Some donors have increased their responsibilities in the current program cycles, potentially backsliding from previously made development gains. Without capitalizing on development partnerships and unique features, it is likely that contributions from each individual donor, even if maintained, will lead to gaps. ISDP funding may be exhausted in mid-2016 due to the continued support for health worker salaries.

⁶⁹ Field Observations and Interview Notes with HSSP and CHDs

⁷⁰ Focus of the diagram is donor programs hence MOH features are not included

⁷¹ For example, the Comboni Sisters in Ezo County are supporting secondary and tertiary care, improving the referral system.

RECOMMENDATIONS

Recommendations have been split into immediate - those that should be implemented within the current ISDP and HSSP program timeframe - and future - those that relate to the next program cycle. Three potential South Sudan scenarios were considered in order to make realistic recommendations – deteriorating, unchanged, and improving

If the situation deteriorates, USAID's focus should be on maintaining service delivery and continuing support for the EMF. If the situation stays the unchanged or improves, a modified design described in this next section is recommended. It is envisaged that the improving situation will not have a major impact on health activities until the next program cycle begins.

IMMEDIATE CHANGES WITHIN THE CURRENT FUNDING ENVELOPE

The HLA recommends the following:

- Continue to support basic service delivery as USAID is the main mechanism delivering primary health care services in Central and Western Equatoria.
- Increase oversight responsibilities of the CHD. Full responsibility for the county coordination meetings and HMIS should be a short term goal.
- Support the development of comprehensive county and state plans. This provides an additional opportunity to identify overlaps, gaps and improve coordination across all partners.
- Simplify supervision at the health facilities, by organizing one main supervision system
- Increase emphasis on improving the IDSR systems, by working in partnership across USAID programs.
- Embed staff or co-locate in the CHD and SMOH to provide one-to-one support to increase their functionality. Innovative methods should be looked at, including partnerships between HSSP and CIPs.
- Transfer all responsibility for community activities to the CIPs, including roll out of HSSP leadership and management training, under HSSP technical oversight.
- Initiate activities for designing the next phase activities through USAID standard processes.

IMMEDIATE CHANGES REQUIRING ADDITIONAL FUNDING

The EMF (or a similar arrangement) should continue as there are few other options. To compliment this, supply management at the county level must improve to better utilize and store the essential medicines already procured.

Support should be given to roll-out USAID's unique service delivery programs described previously. The HRIS should also be implemented in CES and WES as soon as possible to support the Infection Allowance.

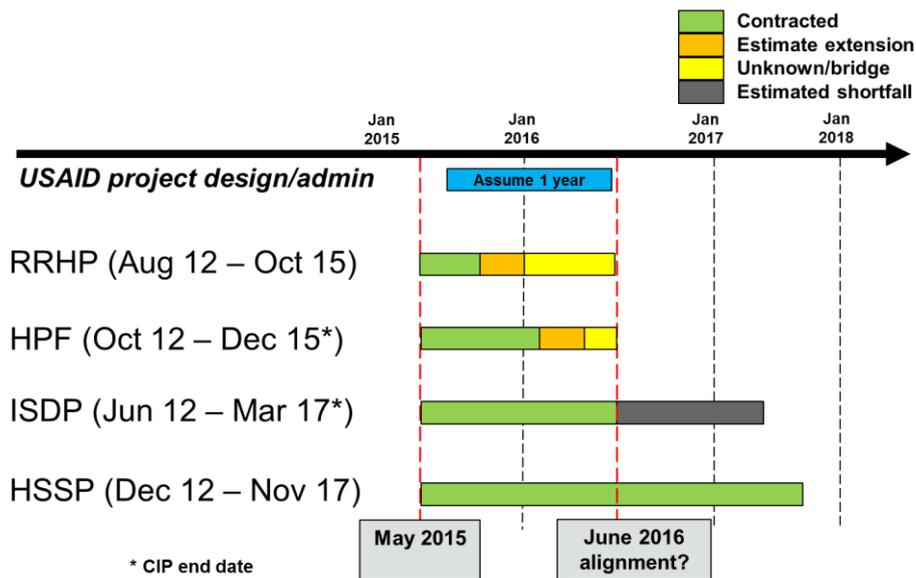
FUTURE RECOMMENDATIONS

The limited resources, increased responsibilities of donors, and unique features of each donor, mean that a different approach is needed to capitalize on development partnerships. USAID should move towards contributing to a national pooled fund mechanism for service delivery and health systems strengthening. Such pooling will reduce transaction costs and allows donors to share unique features, under the stewardship of the MOH and SMOH. A larger pooled fund will also allow greater harmonization of activities across the country.

The estimated timelines of core health programs provide an ideal opportunity to start discussing the new model design in June 2015, aiming to align programs by June 2016, as illustrated in Figure 3.⁷²

⁷² Although ISDP ends in March 2017, the funding ceiling may be reached as early as June 2016

Figure 3: Potential alignment of key programs against design processes, with bridging contracts⁷³



Although there are some weaknesses in the current HPF model in South Sudan identified in its recent Mid-Term Review, there is a general consensus from MOH and partners of the advantages in such a mechanism. As there is an opportunity for HPF to be improved in its next phase, discussions amongst partners and MOH around the design need to commence now.

The seven unique features of USAID’s health portfolio described above should be expanded under nationwide technical leads. Procurement of essential medicines and long term solutions for county storage infrastructure are critical factors for future programming, which also require a collaborative approach across donors and MOH.

Key factors for future design include: trade-offs necessitated by USAID funding constraints, appetite for a revised model among donors, bridging contracts to harmonize implementing partner contract end-dates, assignment of technical leads for nationwide system strengthening and service delivery, applying other lessons learned from core programs, comparing contracting models used and expected government contributions.

The next steps are to start discussions and analysis on the feasibility of the pooled fund. USAID should commence discussions with the donors and MOH, and consider holding a joint review of the core health programs to collate countrywide lessons learned. USAID should also start developing costing models and design details for the health portfolio.

⁷³ Timelines marked “estimate extension” and “unknown/bridge” are not funding extensions committed by donors. They are theoretical estimates.