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Baseline Assessment Report

Central and Western Equatoria States, South Sudan

Health Systems Strengthening Project (HSSP)



October 2013

This publication was produced for review by the United States Agency for International Development. It was prepared by the South Sudan Health Systems Strengthening Project, Abt Associates

Baseline Assessment Report: Central and Western Equatoria States, South Sudan

October 2013

Agreement No.: Agreement Number AID-668-A-13-00001

Submitted to: Laura Campbell, AOR
USAID/ South Sudan
United States Agency for International Development

Recommended Citation: South Sudan Health Systems Strengthening project. October 2013. *Baseline Assessment Report: Central and Western Equatoria States, South Sudan*. Bethesda, MD: South Sudan Health Systems Strengthening Project, Abt Associates Inc.

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Acronyms

AMREF	African Medical and Research Foundation
BPHS	Basic Package of Health and Nutrition Services
CES	Central Equatoria State
CHD	County Health Department
CHO	County Health Officer
DG	Director General
DHIS	District Health Information System
DQA	Data Quality Audit
EPI	Expanded Program on Immunization
FBO	Faith-based Organization
HIS	Health Information System
HMIS	Health Management Information System
HPF	Health Pooled Fund
HRH	Human Resources for Health
HRIS	Human Resource Information System
HSA	Health Systems Assessment
HSDP	Health Sector Development Plan (2012-2016)
HSSP	South Sudan Health Systems Strengthening Project
ISDP	Integrated Health Service Delivery Project (USAID-funded)
JICA	Japan International Cooperation Agency
M&E	Monitoring and Evaluation
MCH	Maternal and Child Health
MHI	Mobile Health International
MOFEP	Ministry of Finance and Economic Planning
MOH	Ministry of Health
MOU	Memorandum of Understanding
MRDA	Mundri Relief and Development Association
NGO	Nongovernmental Organization
PEPFAR	President's Emergency Plan for AIDS Relief
PFM	Public Financial Management
PHCC	Primary Health Care Center
PHCU	Primary Health Care Unit
PMP	Performance Monitoring Plan
PSI	Population Services International
QSC	Quantified Supervisory Checklist
RSS	Republic of South Sudan
SCOM	Sudan Christian Outreach Ministries
SMOFEP	State Ministry of Finance and Economic Planning
SMOH	State Ministry of Health

SS	Supportive Supervision
SSP	South Sudanese Pounds
SSRC	South Sudan Red Cross
TRG	Training Resources Group
TWG	Technical Working Group
UNFPA	United Nations Population Fund
UNICEF	United Nations International Children's Fund
USAID	United States Agency for International Development
VHC	Village Health Committee
VSAT	Very Small Aperture Terminal
WES	Western Equatoria State
WHO	World Health Organization

Acknowledgments

The production of this report is a result of efforts from many individuals and institutions. First and foremost, we owe the Ministers of Health – Hon. John Bono (Western Equatoria State) and Hon. Emmanuel Ija Baya (Central Equatoria State) – a large debt of gratitude for their enthusiasm and essential support to making the exercise a success. We acknowledge the contributions of the Directors General of the State Ministries of Health – Dr. Victor Furangi (WES), Dr. Paul Tingwa (CES) – in the coordination and liaison with the state ministries of health (SMOHs) and county health departments. At the SMOH level, special mention goes to Salyi Lolaku (Director, Finance and Administration, CES), Dr. Gamal Hassan Guma (Director, Primary Health Care, CES), Anthony Zangada Angelo (Director, Finance and Administration, WES) and Carmelo Sangu (Director, Primary Health Care, WES).

We thank the various County Health Officers (CHOs) we interviewed for their patience and substantive responses to our questions: Mathew Lobiri (Lainya), Simon Loro Swaka (Yei), Samuel Nigo (Morobo), Selestino Oryem (Juba), Ludia John (Ibba), Ruizi Baangbadi (Nzara), and Dima Hosea (Maridi). This group linked us with their staff: County Monitoring and Evaluation /Surveillance Officer/Mobilizers, Public Health Officers/EPI Supervisors, and colleagues at the *payam* and Primary Health Care Center (PHCC)/ Primary Health Care Unit (PHCU) levels who provided very valuable information. From the workshops, the other CHOs – notably, Thomas Yoseke (Ezo), Raphael Bonnel (Nagero), Peneroma Anaya (Mundri East), Sekwat Simon (Terekeka), Edward Mika (Kajokeji), Lawrence Bone (Mundri West), William Bakata (Tambura) and James Ezekiel (Yambio) – provided substantial contributions. Special recognition also goes to the County Commissioners, Payam Administrators, PHCUs/PHCCs, and other key stakeholders at the state, county, *payam*, and *boma* levels in the two regions who provided data and logistical support. We also acknowledge the input of members of various village health committees.

We extend our appreciation to the government through the SMOHs and the Directorates of Policy, Planning and Budgeting, International Health and External Coordination, and Preventive Health Services for providing leadership and guidance to ensure that health systems strengthening is made a reality in health sector programming. We acknowledge USAID's financial and technical support through the South Sudan Health Systems Strengthening project (HSSP) and, in particular, the technical inputs of Leslie Mackeen, Vikki Stein, and Basilica Modi.

The Abt Associates team was led by Project Portfolio Manager Margarita Fernandez, Technical Director Dr. John Osika, Chief of Party Dr. Wasunna Owino, and Technical Coordinator Rebecca Patsika. Other home office staff who provided technical support included Sarah Dominis (Human Resources for Health Specialist), Jonathan Davitte (mHealth, Health Information System Specialist). Country-based staff included Dr. Omer Mohamed Yahia (Organizational Development and Capacity Building Specialist), Charles Asega (Monitoring and Evaluation Specialist), and Dr. Shadrack Gikonyo (Health Financing Advisor). The Technical Leads for the key health system areas were Michael Rodriguez, Health Information Systems; John Palen, Human Resources for Health; Steve Musau, Health Financing; Paul Purnell (Training Resources Group), Capacity Building; and Adetayo Omoni, Monitoring and Evaluation Specialist. From Nigeria, Oluwaseun Adeleke provided technical support on the supportive supervision component. Thanks also to Jacob Birchard who was instrumental in finalizing the report. Additional technical support was received from AMREF staff: Dr. George Bhoka, Francis Namisi, and Mamo Abudo Qido.

Executive Summary

On December 5, 2012, USAID/South Sudan awarded Abt Associates and its partners, African Medical Research Foundation and Training Resources Group, the five-year South Sudan Health Systems Strengthening Project (HSSP). The project aims to strengthen the overall health system to improve the delivery and access to health services in Central Equatoria State (CES) and Western Equatoria State (WES). To obtain a snapshot of the health system in the two states the project undertook a baseline assessment in late May 2013. The objectives of the baseline assessment were to:

- Identify and prioritize gaps in core leadership and management competencies
- Better understand the planning and budgeting cycle and document the state of public financial management (PFM)
- Identify the greatest needs in health information systems (HIS) and technology
- Determine staffing gaps and staffing patterns
- Assess the effectiveness of the current supportive supervision and health partners' coordination mechanisms

Overall, the findings of the baseline assessment show where South Sudan most needs improvements to its health system to support improved health service delivery. The improvements are grouped into seven areas: leadership and management, health financing, human resources for health (HRH), HIS, technology, supportive supervision, and coordination.

In the area of *leadership and management*, previous trainings and capacity-building initiatives provide impetus for the present work. Key national policy frameworks such as the *South Sudan Health Policy (2007/11)* and *Basic Package of Health Services* give strategic direction to the priorities in leadership and management trainings, coaching, and mentoring. The technical advisors, mostly embedded by development partners at the State Ministries of Health/County Health Departments (SMOHs/CHDs), provide a resource to augment leadership and management interventions. A few areas are in need of urgent attention. Many health managers still have a limited understanding of key leadership and management concepts and responsibilities, and limited support tools. Staff oversight, including performance monitoring, is limited while information sharing is ad hoc and decision making is concentrated among a few Ministry of Health (MOH) officials. This report advocates for improvements in the leadership and management procedures and best practices through the development and effective application of job/desk aids at the workplace and performance management techniques that include planning, delegating, monitoring, and providing performance feedback and on-the-job coaching and mentoring.

In the area of *health financing*, the government is committed to establishing appropriate mechanisms for fiscal responsibility. Through the Ministry of Finance and Economic Planning (MOFEP) and the Local Government Board, guidelines are available to support the SMOH/CHDs to effectively execute planning and budgeting functions and ensure efficient utilization of the funds. The government's budget for 2013/14 also provides a new financing framework that will provide SSP 40m in conditional transfers to the CHDs to support capital and operational costs. Part of strengthening and increasing PFM awareness is to support coordinating mechanisms, such as the local service support aid instrument PFM technical

working group. This creates favorable conditions for the adaptation and implementation of the planning and budgeting guidelines at the SMOH/CHD levels.

A number of other financing issues are also prevalent and need to be addressed. Fiscal decentralization is still evolving, with only limited resources flowing to the CHDs. Audits are conducted irregularly, and planning and budgeting is still carried out through the 'top-bottom' approach. All of these areas are in need of improvement. Potential key remedies include national PFM training of the SMOH/CHDs and the county and hospital health management teams, ensuring PFM dialogue between the county/state transfer monitoring committees and county/state hospitals, and providing technical support to develop county health budgets and strategic plans in line with the available guidelines.

In the area of *human resources for health* the government's production, performance, and productivity is evident. HRH strategic planning occurs every few years at the national level and there are defined staffing standards, based upon requirements for delivery of the Essential Health Package. An evolving national Human Resource Information database is in place, though incomplete and in need of further validation. Performance management guidelines on promotion criteria and the provision for allowances exist at the national level. Several factors, however, constrain SMOH/CHDs' ability to plan, allocate, and manage HRH. The responsibility for HRH appears to be diffused across a number of people and job standards are not available at state and county levels, which adversely impacts career pathways, training, and planning. All levels of the health system lack sufficiently accurate HRH data. The HRH management systems (establishment, appraisal, supervision, promotion, payroll) are deficient in the two states. The recommendations in the HRH area are to update and improve the human resources database into a validated human resources system, develop job standards and leverage current job positions list, review existing employment policies and update them to ensure completeness and understanding, and provide refresher training for managers and the facilitators who will cascade the trainings at the county level on various aspects of HRH.

In the area of *health information systems*, both CES and WES have functional health management information systems (HMIS) units with designated office space and computers installed with the District Health Information System (DHIS) software. Monitoring and Evaluation (M&E) and Surveillance staff are trained in DHIS, are able to utilize the electronic version of the software for processing county and facility level data, and can send the compiled databases to the MOH. HIS and M&E staff at the SMOH and CHD levels also have a clear understanding of the reporting process and importance of the information being captured and reported. There are, however, low HMIS monthly reporting rates (CES, 60 percent; WES, 45 percent); inadequate HMIS infrastructure (e.g., computers, office spaces, personnel); minimal evidence of HMIS data use at all levels; lack of guidance, procedures, and capacity for assessing HMIS data quality; and a lack of data from the private sector. To address these challenges, there is a need to develop an HIS strengthening plan for the CHDs, convene and facilitate quarterly data review meetings at the SMOH and CHD levels to evaluate (and if needed, validate) data, and initiate data quality audit training and validation.

In the area of *technology*, the SMOHs have electricity, but only a few CHDs have access to a constant electricity supply (local grid or solar power). There is limited Internet access throughout the SMOH/CHDs, but the situation is more acute in WES. Both CES and WES have good coverage of voice and data mobile phone services, which would potentially allow them to send and receive data packets.

In the area of *supportive supervision*, there is a clear understanding of the value of assessing performance (against set targets), establishing plans for corrective action, and monitoring progress to improve the quality of health service delivery. A standardized national quantified supervision checklist is available and used by the CHDs with guidance from the SMOH, and the SMOH and CHDs are providing verbal feedback to the health facilities. Supportive supervision was, however, found to be infrequent and primarily driven by development partners. The project recommends developing operational guidelines for supportive supervision, defining measurements of the Quantified Checklist, and linking supportive supervision to key program performance indicators.

In regard to *coordination*, the MOH embraces the National Aid Strategy and has established national health sector coordination mechanisms with links to the states to strengthen synergy and linkages between actors. A national database of health partners is available at the nongovernmental organization (NGO) health forum and plans are underway for mandatory registration of all NGOs with the government. There is, however, incomplete information on the actual number of health partners in CES/WES, limited coordination between these organizations as exemplified by inadequate synchronization of plans and budgets and ineffective coordination meetings, and limited collaboration between the various government tiers. The project recommends undertaking a comprehensive health sector stakeholder mapping in CES and WES using national level tools, developing a health stakeholder's strategic coordination framework, and assisting the CHDs to convene and facilitate monthly county health coordination meetings.

The baseline assessment points to the existence of a relatively small, but significant, for-profit and not-for-profit private sector in *health service delivery*, with strong financial management systems, leadership, and management. There is high attrition of public sector staff to the NGO-operated public health facilities that provide higher salaries; limited coordination with the public health sector actors and; a weak legal and regulatory framework including supervision. The project recommends the establishment of a framework to promote public-private-partnerships; an appropriate legal and regulatory framework for supervision of private sector operations; effective ways of obtaining and using data from the private sector partners; building private sector human resource capacity, and developing an appropriate financing strategy.

Overall, the findings point to a clear need for strengthening health systems to enable improved health service delivery. CES/WES have a moment of opportunity with existing political will and increased goodwill and support from the government and development partners. HSSP will use the findings of this assessment to prioritize activities in the existing project work plan and to inform the design and implementation of subsequent work plans of the project.

1. Introduction

1.1 The Context

The draft Republic of South Sudan (RSS) Strategic Plan (2011–2015) (National Audit Chamber 2011) recognizes the challenges brought about by one of the longest civil wars in modern Africa, which broke out immediately after Sudan’s independence from Britain in 1956. The Comprehensive Peace Agreement, which was signed between the Government of Sudan and the Sudan People’s Liberation Movement on January 9, 2005, brought nearly 50 years of civil strife in Southern Sudan to a halt. The civil war destroyed practically all the infrastructure and social fabric of what became the new country, and caused the death or displacement of more than 4 million people. Even with the independence on July 9, 2011, the RSS continues to face daunting challenges.

Ongoing disputes with Sudan over oil have forced financial austerity measures that adversely affect the nation. A degree of political instability and internal ethnic clashes continue while a large number of displaced citizens are reintegrating into society. This surge in returning citizens currently overburdens the provision of basic services including health. According to the 2011 South Sudan Household Survey, health indicators remain poor, with limited progress recorded since 2006 (Government of RSS 2011a). Apart from low coverage and access to quality health services, the country has the worst maternal mortality rate in the world (2,054 deaths per 100,000 live births), due almost entirely to factors that are preventable – hemorrhage, obstructed labor, abortions, eclampsia, and infections. A key bottleneck to a better maternal mortality rate is the lack of trained midwives and skilled birth attendants: only 14.7 percent of births are attended by a skilled birth attendant and institutional births account for just 12.35 of births (Republic of South Sudan 2012). Child health indicators also are poor: the under-five mortality rate stands at 128 per 1,000 live births, the infant mortality rate at 102 per 1,000 live births.

Box 1: Selected Social Indicators for South Sudan

▪ Population	8.26 million
▪ Life expectancy	42 years
▪ Maternal mortality rate	2,054 / 100,000
▪ Infant mortality rate	75 / 1000
▪ Child mortality rate	105 / 1000
▪ Full immunization (< 2 yrs)	6.3%
▪ Poverty	51%
▪ Adult literacy	27%

Source: Southern Sudan Household Survey 2011

Because many areas are in need of attention, the new government has developed the *South Sudan Development Plan 2011–2013* to establish the priorities for national development. The *Health Sector Development Plan, 2012–2016* (HSDP) reiterates government’s political will and commitment to revamp the health sector by increasing the utilization and quality of health services. It emphasizes improvements to maternal and child health (MCH), scaling up the health promotion and protection interventions to empower communities to take charge of their own health, and strengthening institutional and governance structures to address effectiveness, efficiency, and equity issues. The Ministry of Health (MOH) provides leadership to ensure the health sector goals are met and quality health services are delivered to the people of Southern Sudan.

The management and provision of health services in South Sudan have been decentralized, with the State Ministries of Health (SMOHs) and County Health Departments (CHDs) playing key roles in the delivery

and management of health services. As a policy, decentralization has been embraced to improve delivery, accessibility, and sustainability of public goods and services – most notably, to enhance allocative efficiency, improve service delivery, improve quality, transparency, accountability, and ensure more equitable distribution of resources to the vulnerable through more effective targeting mechanisms.

The above efforts notwithstanding, the RSS continues to encounter health systems challenges as reiterated in its draft (v4) Service Delivery Framework, January 2013 (RSS MOH 2013: p. 25). These include the following:

- *Low levels of capacities and systems* in SMOHs and CHDs. This is caused at least in part by problems with staff recruitment and staff turnover, and the reliance of CHDs on states for recruitment/ approval of recruitment.
- *Current financing of health*, especially for SMOHs and CHDs, does not meet the population’s needs. This manifests itself in a lack of requisite operating funds for SMOHs, CHDs, and facilities to carry out their key functions.
- *Dysfunctional accountability*, so that neither top-down accountability, nor bottom-up accountability are working.
- *Poor sectoral coordination* with nongovernmental organizations (NGOs). NGO’s are not coordinating with, or strengthening CHDs. Instead they are reporting directly to the MOH. Furthermore, there are two parallel procurement systems, which lead to poor coordination in the procurement of medical supplies.

On December 5, 2012, USAID/South Sudan awarded Abt Associates and its partners, the African Medical Research Foundation (AMREF) and Training Resources Group (TRG), the five-year Health Systems Strengthening Project (HSSP) South Sudan. HSSP builds on the RSS’s commitment to implement the National Health Strategy, which will strengthen the health system overall and provide improved health services in Central Equatoria State (CES) and Western Equatoria State (WES). HSSP works with the MOH, SMOHs in the two states (CES and WES), CHDs, Village Health Committees (VHCs), and other development partners to strengthen the RSS’s health system and foster an enabling environment for improved health service delivery. The project focuses on several building blocks of the health system, namely, leadership and management, health financing, human resources for health (HRH), health information systems (HIS), supportive supervision, and coordination.

1.2 Purpose and Objectives of the Baseline Assessment

Overall Purpose

The overall purpose of the baseline assessment is to obtain a snapshot of, and identify the strengths, opportunities, and gaps in, the health system in CES and WES and generate information that will guide the design and implementation of activities relating to the three components of HSSP and the refinement of subsequent work plans.

Specific Objectives

The specific objectives of the baseline assessment are outlined below under HSSP's thematic areas.

- *Leadership and management capacity* – to identify and prioritize gaps in leadership and management core competencies at the MOH, SMOH, CHD, health facilities, payam, boma, and village levels
- *Public financial management* – to better understand the planning and budgeting cycle and document the state of public financial management (PFM) within the context of the local government PFM guidelines and the priorities at county and state levels
- *HIS resource gaps* – to identify where the need is greatest, focusing on determining the availability of reporting forms and reporting manuals, and the number of staff trained
- *HRH* – to determine gaps in staffing and to validate the need for a streamlined and realistic staffing pattern in primary health care centers (PHCCs) and primary health care units (PHCUs)
- *Supportive supervision* – to assess the current supportive supervision mechanisms to ensure that information gathered during supervision is in line with information that should already be routinely collected by CHDs to the facilities they manage, primarily Primary Health Care Centers (PHCCs) and Primary Health Care Units (PHCUs)
- *Health sector stakeholder mapping* – to identify key stakeholders in health and related non-health areas, their roles and interests, available resources, underserved geographic areas, and each county's coordination needs.

The assessment was aligned with similar activities by the Health Pooled Fund (HPF)/Department for International Development¹ to attain complementary processes and synergy.

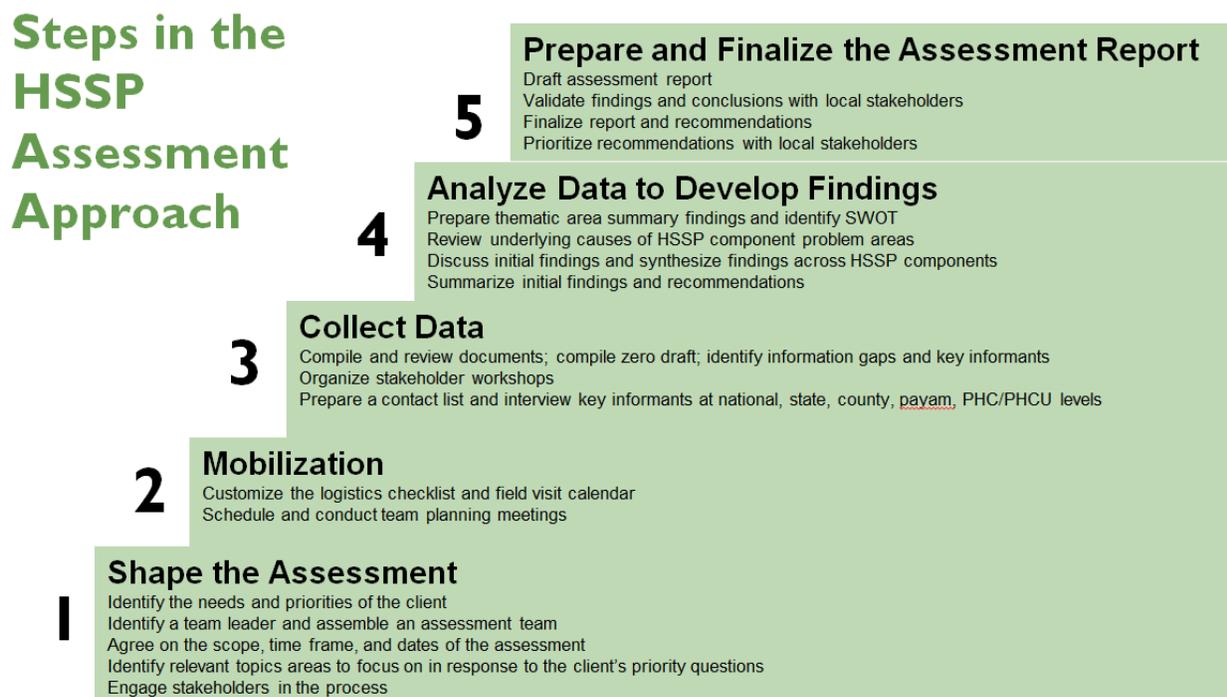
¹ The partners include (1) HPF, comprising the United Kingdom, Canada, Australia, Sweden, and European Union; (2) United States Agency for International Development (USAID); and (3) the World Bank. HPF supports six states (Unity, Lakes, Warrap, Eastern Equatoria, Western, and Northern Bahr el Ghazal), USAID (CES and WES), and the World Bank/ Inter-Church Medical Association (Jonglei and Upper Nile States).

2. Methodology

2.1 The Approach

The HSSP project designed an assessment approach that borrowed from the Health Systems 20/20 Health Systems Assessment (HSA) methodology, used in more than 25 countries to provide an overall snapshot of the health system. Similar to the HSA methodology, HSSP effectively engaged stakeholders throughout the assessment process. However, the assessment team tailored the assessment tool to the specific HSSP components, resulting in an approach that went beyond the national level, and instead addressed the health system at the state, county, *payam*, and PHCC/PHCU/*boma* levels. The assessment team developed interview guides for state, county, *payam*, and PHCC/PHCU/*boma*-level data collection. The assessment tool included questions to capture information for the HSSP Performance Monitoring Plan (PMP) indicators.

Figure 1: Steps to the HSSP baseline assessment (modified from the HSA methodology)



Source: Modified from Health Systems 20/20 (2012).

2.1.1 Shaping the Assessment

The first step in the HSSP baseline assessment was to *shape the assessment* by identifying priorities of the project's three thematic areas and agreeing on a time frame for the assessment in consultation with MOH, SMOH, CHDs, stakeholders in the two states, and USAID/South Sudan. The HSSP Chief of Party had preliminary discussions with different stakeholders in the two states to prepare them for the upcoming assessment. For a list of these partners stakeholders, please refer to annex A-1 and A-2.

2.1.2 Mobilization of the Assessment Team

The second step was the *mobilization of the assessment* team from the home office in Bethesda, Maryland, partner organizations (AMREF and TRG), Abt field office in Nigeria, the HSSP team in South Sudan, and government representatives (notably, the Director Generals (DGs), Finance and Administration Officers, and Directors of Primary Health Care) at the SMOH in CES and WES. Joint planning meetings between the SMOH, CHDs, and HSSP team in South Sudan and home office were held regularly to clarify roles and responsibilities, prepare the HSSP baseline assessment tool, and plan for the operational and logistical aspects of conducting the assessment.

Prior to embarking on the field data collection, the assessment team held kick-off meetings (launch workshops) in Juba (May 14) and WES (May 23). The meetings were presided over by the SMOH top leadership (DGs and State Ministers of Health) and attended by all heads of departments at the SMOH and CHDs, Directors, Monitoring and Evaluation (M&E)/Surveillance Officers, and Finance and Administration Officers or Accountants). All counties in CES and WES participated in the kick-off meetings with the exception of Mvolo, whose staff faced transport challenges.

2.1.3 Data Collection

The third step involved *data collection*, which started with a desk review of background documents before the assessment team arrived in the two states.

At the kick-off meetings, state ministers of health, DGs, and USAID representatives introduced the participants to the purpose and objectives of the HSSP. The participants presented their key challenges with the group as a first step toward assessing the challenges that the health system has. The facilitator then explained the assessment tool and answered questions about the tool and the process to create it. The facilitators saw these group discussions as a significant step in obtaining assessment buy-in, commitment, and active participation of the CHDs, key stakeholders, and other interest groups at lower levels of the health system.

After the kick-off meetings, the assessment team proceeded to collect data using the assessment tool. The team selected three counties in each state,² based on findings from the *Health Facility Mapping Data Analysis Summary Reports*, (Omongin 2010) which reported on the functionality of health facilities in the 10 counties in CES and six in WES. The assessment team then selected a stratified sample of counties within each state, which was defined by functionality (high, moderate, and low) of health facilities. These strata reflect the number of functional health facilities in counties and also served as an indicator of population, with the largest number of functional health facilities being found in the most highly populated areas and the lowest numbers of functional health facilities being found in the least populated areas. Thus, the stratification aggregates the availability of functional health facilities, population density, and also represents geographic diversity. The stratified samples are shown in Table I, with an * indicating those counties selected.

² The remaining counties will be incorporated as the project continues to ramp up. Subsequent baselines will be conducted in the remaining counties in each state by the end of the second year of the project.

Table 1: Selection Criteria for the Counties Studied

Functionality	Central Equatorial State	Western Equatorial State
Comparatively higher number of functional health facilities	<ul style="list-style-type: none"> • Juba County* • Kajo Keji County 	<ul style="list-style-type: none"> • Yambio County • Maridi County* • Ezo County
Comparatively moderate number of functional health facilities	<ul style="list-style-type: none"> • Yei County* • Terekeka County 	<ul style="list-style-type: none"> • Tambura County • Nzara County* • Mvolo County • Mundri East County
Comparatively lower number of functional health facilities	<ul style="list-style-type: none"> • Lainya County* • Morobo County* 	<ul style="list-style-type: none"> • Mundri West County* • Ibba County* • Nanjero County

Source: Adapted from Omongin (2010).

The baseline assessment team used this stratification to select one county (in bold)³ from each stratum as targets for the initial baseline assessment. These selections, in our view, provide a diverse cross-section of counties in each state from which to begin the assessment process. Lainya County was added to the sample at the request of the CES SMOH.

A team of 10 data collectors from HSSP joined by government counterparts visited each state to conduct the assessment with the HSSP team. The SMOHs were assessed in both CES and WES. In the case of the counties, four were assessed in CES (May 16–23) – Juba, Yei, Morobo, and Lainya – and three in WES (May 24–29) – Nzara, Maridi, and Ibba. The assessment team met with the SMOH first, and then went to the county levels joined by a representative from the SMOH. At the county, the team met with the County Commissioner’s Office, the CHD, PHCC and PHCUs, *payam* administrator’s office, and *boma* chair. Structured questionnaires were administered to the appropriate personnel at each level. Questions addressed each of the HSSP thematic areas.

A summary of the individuals interviewed within each of the offices is contained in Table 2. In addition to administering the assessment tool, each data collection team carried a smartphone, preloaded with questions. The data collection teams used the smartphones, loaded with MTN and Vivacell SIM cards, to determine the connectivity of each location for voice and data.

³ Each of the remaining counties will be brought on board in a staggered fashion as the HSSP ramps up over the next 12 months.

Table 2: List of Key Informants

Title	Courtesy	L&M	HF	HRH	SS	HIS	Coord.	Tech
State Ministry of Health								
Director General		X					X	
Director of Primary Health Care					X		X	
Director of Finance and Administration		X	X	X				
Director of Training				X				
M&E Coordinator						X		X
Establishment Officer				X				
County Commissioner's Office								
County Commissioner	X	X						
Executive Director	X							
Director of Planning and Budgeting		X	X	X			X	
Establishment Officer				X				
County Health Department								
CHD Director		X		X			X	
Director of Finance & Administration		X	X	X				
Accountant			X					
M&E/Surveillance Officer					X	X		X
Primary Health Care Center or Unit								
In-Charge			X	X	X	X		
Clerk			X					
Payam Administrator's Office								
Payam Director		X	X	X	X	X	X	
Boma Chair's Office								
Boma Chair		X	X					

Source: field data

Note: L&M=learning and management, HF=health finance, SS=supportive supervision

2.1.4 Data Analysis

The fourth step in the assessment involved *analysis of the data* collected in preparation for a draft assessment report. Analysis focused on the strengths and opportunities in the key assessment areas, the challenges and threats, and the subsequent key recommendations for implementation by HSSP.

2.1.5 Assessment Report Preparation

The fifth and final step in the assessment was the *preparation of the assessment report*. This included the preparation of a draft report, which the project shared with stakeholders during a stakeholder validation meeting. The HSSP assessment team used the recommendations from these workshops to produce the final baseline assessment report.

3. Findings

3.1 Leadership and Management

3.1.1 Background Information on Leadership and Management in South Sudan

A brief, entitled *Capacity Building of County Level Government*, was published in March 2011 by the South Sudan NGO Forum. This brief drew upon a desktop study of 62 county government institutions in South Sudan, across 42 counties and all 10 states, compiled between December 2010 and March 2011. It highlighted several issues that have relevance and implications for leadership, management, and governance capacity building across South Sudan. Some of these issues, findings, and recommendations are referenced below (information not related to CES, WES, leadership, management, or governance was not included).

Study findings indicated that few county departments have formalized management systems. The roles and responsibilities of different levels of government are unclear and the means of coordination among different levels of government are not defined. The study also found that there is generally good upwards reporting to state authorities, and in some cases there is also supervision of, and reporting from, payam-level activities and facilities. However, in many situations, the actual structure of government is unclear (or is contested). It may not be clear, for example, how a county department relates to both the county commission and the relevant state line ministry, and how disputes or conflicting priorities between the two can be resolved. In some instances, the role of county government was unclear, both to citizens and to government officials. In terms of management practices, in many cases decision making was found to be very top-down, dictated by state authorities or county commissioners, rather than being devolved to county departments (or lower). Weaknesses in management systems were also linked to many other challenges, such as the lack of staffing, transport, and communications. The study concluded that it is unrealistic to expect county authorities to 'govern' or provide basic services without adequate management structures being in place to enable them do so. The conclusions presented in this brief are entirely consistent with the objectives of HSSP.

The *Capacity Building of County Level Government* brief includes comments and guidance provided by NGOs involved in capacity building in South Sudan's 10 states as well as general lessons learned. The report highlights the importance of relationships between the capacity-building organization and country officials. Building productive relationships takes time, and requires patience and consistent follow-up. It is helpful if staff providing the technical assistance have skills in the appropriate local language. In addition to relationships with the county department in question, it can also be important to build relationships with the county commissioner to engage his or her support for the capacity building that is taking place. Numerous staffing challenges, including inadequate staffing, were also identified. Suggestions for addressing these key constraints included ensuring at least one person in the county department can serve as an advocate for more support and resources. Once one good person is in place to play this role, it is easier to build capacity around that person, and state authorities are then more likely to be willing to delegate responsibility to the county. If senior staff appear to have been appointed for reasons other than aptitude (e.g., as a reward for previous service), it can be difficult to seek to have them replaced. However, it is important to get well-qualified subordinates in place, who can then provide the necessary skill sets. To ensure capacity building is effective, rather than one-off courses, a continuous approach to training is needed, with frequent repetition of key topics, and ongoing supervision to ensure

that taught skills are adopted in the workplace. In addition, agencies providing capacity-building support (especially in the same area or to the same department) must ensure their work is harmonized. Otherwise, some support may be given twice, while other needed support is not provided at all; or practices of one agency may undermine those of another. There is also a need to develop capacity at lower levels (payam and boma) and to ensure coordination between capacity building at the county level, and at state and other levels, to again ensure consistency and coherence in approaches used. A governance finding was that some communities are willing, and interested, to hold local authorities to account, and they should be supported in playing such a role.

Governance and Accountability Relationships: The RSS MOH, Basic Healthcare Draft (v4) Service Delivery Framework, January 2013, (p. 19), states that, for top-down accountability relationships, there is an absence of both standards for performance and a clear framework for performance monitoring. For bottom-up accountability, the report indicates that the boma health committees that should be providing oversight of health facilities were not functioning as communities and do not know that they should be holding facilities accountable, or how to hold them to account. This report further states that lower levels of government (CHDs and SMOHs) need mechanisms for holding higher levels of government to account.

Health System Strengths and Opportunities in South Sudan: In addition to the numerous challenges faced by the health system in South Sudan, there are parallel strengths and opportunities. The following strengths were identified in the draft RSS Strategic Plan (2011–2015), as follows:

- The existence of the RSS Health Policy (2006–2011), which envisions the MOH's (both RSS and state levels) leadership, governance, and responsibility on the development and implementation of pro-poor policies for South Sudan. This health policy will be an excellent resource to guide HSSP training plan/curriculum development.
- The existence of the RSS Basic Package of Health Services as the key guiding principles in the implementation of the health policy. The principles presented in the package provide important direction for HSSP training plan development and implementation.
- Good partnership among health authorities and their international (mostly NGOs) and local (mostly faith-based) implementing partners in the delivery of health services. These partnerships form a work climate that is conducive to implementation of HSSP leadership, management, and governance training, coaching, and mentoring interventions.
- The existence of several organizations, many of them faith-based organizations (FBOs), that are very active in health service delivery. These organizations have filled the vacuum amidst weak government-owned health facilities, and are likely to lend their support during the leadership, management, and governance training, coaching, and mentoring.
- Existence of many technical advisors at the central MOH and in SMOHs contracted to build the capacity of the National Health System (which includes all government health institutions and the private health delivery system) to effectively deliver health services. These technical advisors are well positioned to support and augment HSSP leadership, management, and governance training, coaching, and mentoring interventions.

3.1.2 Key Findings: Leadership and Management

The HSSP baseline assessment team's findings can be organized along 11 dimensions that were identified to capture the breadth of leadership and management strengths and gaps in Central and Western Equatoria States. These dimensions were observed at five levels of the South Sudanese health system, from the SMOH and CHDs through the payams, PHCCs, and PHCUs, and to the VHCs.

Table 3 summarizes the performance of health sector tiers in CES and WES in key leadership practices as observed by the HSSP baseline assessment team. The table is organized by state and by the capacity dimensions that guide the assessment. Where no finding is given, it means there was not enough information to make the determination. This was only the case at the levels below the CHD (payam, PHCC, PHCU, and VHC).

A detailed summary of the HSSP baseline assessment findings with regard to leadership and management in CES and WES, respectively, from the SMOHs, CHDs, payams, PHCC/PHCUs, bomas, and VHCs is provided in the following pages.

Table 3: Health Sector Performance: Central and Western Equatoria States, May 2013

	CES					WES				
	SMOH	CHD	Payam	PHCC/PHCUs	VHCs	SMOH	CHD	Payam	PHCC/PHCUs	VHCs
Leadership and Management Practices										
Clarity of Roles and Responsibilities	Not well understood	Clear	Not clear	Not well understood	Not clear	Not clear	Not well understood	Not clear	Not clear	Not clear
Performance Monitoring	Fair	Good	-	-	-	Good	Poor	-	-	-
Motivation	Poor	Fair	-	-	-	Poor	Fair	-	-	-
Collaborative Decision Making	Always	Occasionally	-	-	-	Occasionally	Occasionally	-	-	-
Information Sharing	Always	Always	-	-	-	Always	Always	-	-	-
Meetings and Meeting Management	Monthly	Monthly	-	-	-	Monthly	Monthly	-	-	-
Timeliness and Completeness of Tasks	Fair	Poor	-	-	-	Poor	Poor	-	-	-
Leadership and Management Support Tools Needed	Checklists	Supportive Supervision	Staff list/ roster	Supportive Supervision/ treatment guidelines	-	Checklists	Supportive Supervision	Staff list/ roster	Supportive Supervision/ treatment guidelines	-
Service Unit Leadership	Very good	Good	-	-	-	Fair	Fair	-	-	-
Teamwork	Very good	Good	-	-	-	Good	Fair	-	-	-

Central Equatoria State

State Ministry of Health

At the SMOH, the assessment team spoke to respondents to learn more about the roles and responsibilities of SMOH managers, leadership of different units, teamwork, performance monitoring, level of employee motivation, collaborative decision making, information sharing including meetings and meeting management, timeliness and completeness of employee tasks, and type of leadership and management support needed. These areas are key to assessing leadership and management strengths and gaps. Specific findings related to these topics are detailed below.

At the state level in CES, the assessment team interviewed a senior-level manager and a junior-level manager. The interviewees indicated that the overall purpose of the different service units (e.g., administration and finance, pharmaceutical services) is unclear. Management roles and responsibilities are not well understood by those expected to manage. Staff do not have job descriptions, and staff responsibilities were not clearly defined and communicated. This finding will be discussed further in the HRH section.

Managers' assessments of the quality of leadership were mixed, with one assessment of "very good" and one assessment of "very poor." On the positive side, interviewees stated that the minister and unit directors have extensive experience, as they are all doctors and have 15–20 years of experience working in hospitals.

Interviewees mentioned that communication are a challenge and that managers often do not share information on what was happening within the unit, scheduled meetings, necessary contacts, and guidance regarding how staff could best work together. The interview respondents recommended training for managers in administration, noting that most managers have administrative responsibilities for which they have not been trained. Internet access and e-mail are problematic, so most information is shared as hard copy or verbally. Staff have access to printers, but some printers do not work.

Interviewees' assessment of the quality of teamwork at the SMOH level was also mixed. One manager stated that teamwork within the SMOH stands out as among the best of the state ministries. Successful teamwork was attributed to the fact that current managers of health facilities are part of the same team that managed health facilities during the war. This team has managed outbreaks and other challenges and has a history of working together. It was also stated, however, that managers often have more responsibilities than they can manage and that some managers are not qualified to carry out assigned responsibilities. It was further indicated that there is a natural sense of camaraderie at the SMOH central office, but very poor communication across teams. Reportedly when staff get together (e.g., at meetings), they gel very well and are very supportive of one another.

Respondents stated that performance monitoring takes place, but is only done "fairly well." Managers are overworked and, therefore, not always available to directly monitor staff attendance or performance. Managers are frequently called away to respond to emergencies and are unable to regularly visit staff in remote locations. More on performance monitoring will be discussed in the HRH section of this report.

Respondents mentioned that managers are unable to effectively help staff be highly motivated. They indicated that managers are often unable to send staff to training or provide incentives, such as help with transport to and from work. Staff members do not appear to have clear direction on what they are supposed to be doing; as a result, it sometimes appears that staff are not highly productive.

Respondents indicated that collaborative decision making does take place and is most prevalent among senior-level staff. Managers and directors often participate in board meetings where they make decisions together. One respondent indicated that senior managers meet almost every other day and that the board of directors and junior staff meet periodically. Senior managers meet, for example, when there are outbreaks and such meetings occur as often as daily, depending on the importance of the issue. Another respondent stated that junior-level managers participate in meetings only occasionally for the purposes of sharing information and making decisions. At meetings, staff are asked to comment on the health strategy and to identify key CES challenges. The level of staff participation in decision making depends greatly on the manager. Reports on timely completion of tasks varied from usually to not often. It was noted that timely task completion may be hindered by lack of human resources or lack of staff qualifications. It was also noted that staff need to be provided with clearer guidance about task requirements, expected roles, and resources available.

Managers were asked to identify leadership and management tools, such as job aids, that they either used or needed and were also asked to identify management support that they needed. A few managers mentioned that they use management checklists. Some managers reported that they need such checklists and that they also need meeting management tools. No other specific management tools were identified as used or needed, but managers stated that they need support with staff motivation, management training, training on role clarification, and training in general (topics not specified). The most common responses provided when asked about leadership and management support needs were references to operating resources for basic functions such as transport, stationary, human resources (additional staff), Internet, and computers.

County Health Departments

At the CHD level, the assessment team spoke to respondents to learn about topics similar to those addressed with the SMOH including the roles and responsibilities of CHD managers, leadership at different levels, whether a sense of teamwork existed, performance monitoring, level of employee motivation, collaborative decision making, information sharing, meetings and meeting management, timeliness and completeness of employee tasks, and leadership and management support needed at CHDs.

At the CHD level in CES, managers indicated that they were clear about their roles and responsibilities. In most cases, managers provided a list of responsibilities to the assessment team; however, the lists were generally inconsistent with the primary roles and responsibilities referenced in the MOH Basic Package of Health and Nutrition Services (BPHS).

Most managers at this level described their leadership as good or very good. As examples of good leadership, they cited that leaders do not segregate people, that staff cooperate and support one another when required, that leaders promote joint decision making and problem solving, and that

managers conduct planning. The report from Morobo County, however, noted that leadership is poor as evidenced by poor teamwork and low staff morale.

Most managers at the CHD level in CES reported that teamwork is good or very good. Factors identified as contributors to good teamwork include good staff supervision, long-standing relationships (some people have been working together since the war), and a history of volunteerism. Some counties, however, stated that teamwork was poor and morale was low, due to late salary payments.

The assessment of performance monitoring by CES managers at the CHD level was mixed, ranging from very poor to very good. Variance was noted in the amount and quality of performance monitoring provided, depending upon staff work location. Managers are likely to monitor staff working at primary CHD offices more closely than staff working at more remote locations. Challenges related to monitoring staff at remote locations include lack of transportation, limited communication, and reliance on reports that are often incomplete or untimely.

Most managers are aware of the need to help staff feel motivated and the managers try hard to enhance workplace motivation. Interviewees noted that some managers provide staff with regular performance feedback, which contributes to motivation. In the past, managers provided incentives such as promotions, bonuses, and uniforms, but funds to pay for such incentives are now unavailable. The manager interviewed in one county stated that managers themselves are not motivated and, therefore, do little to help staff to be motivated. It was noted that staff are sometimes motivated by training that is provided by the SMOH. Donor support, such as funding to provide electricity, also was identified as an incentive.

The majority of managers interviewed said they involve staff in decision making, at least occasionally. It was clear from interviewee responses that most managers believe that involving staff in decision making is a positive management practice. Some managers said that they use staff meetings and management meetings as forums for collaborative decision making. Participation in the decision-making process may include all staff, but sometimes only includes managers.

Most managers mentioned that they share information with staff during staff meetings. Some managers conduct staff meetings regularly and some do not. One manager stated that information sharing takes place through joint review of checklists and planning for the Expanded Program on Immunization (EPI). This manager also occasionally uses e-mail to share information, but noted that Internet access is unreliable and so modems are sometimes used. The phone is also sometimes used, but an employee has to buy his or her own phone credit.

Managers cited using meetings to plan for supportive supervision and said that they use payam meetings to assess the performance of health workers in the facilities. Meetings were reported to be a primary mechanism for coordination with partners. Most managers reported that meeting minutes are taken, but none was able to produce minutes for review during the interviews. Some managers indicated that the person who takes minutes keeps them and that minutes are not distributed. Most managers conducted staff meetings, though some did not conduct them regularly.

Most managers also indicated that tasks are usually completed on time, in spite of constraints such as lack of transport and limited resources. Reasons cited for timely completion of tasks included that staff

are responsive to mandates and are highly committed to getting work done. However, the manager in one county stated that tasks are usually not completed on time and cited low staff morale, lack of support and feedback from SMOH, lack of stationery, lack of management training, the need for basic computer training, and lack of Internet connectivity as reasons for lack of timeliness.

The assessment team asked managers to identify leadership and management tools, such as job aids, that they either use or need. They did not identify any tools that they currently use and said that they need management checklists for supervisors and tools to help with meeting management. When asked to identify the leadership and management support that they needed, the managers mentioned staff motivation, management training, training on roles, and other training (topics not specified). The needs that managers mentioned most, however, were non-management support items such as transport, stationery, technical training (e.g., for nurses and midwives), human resources, Internet access, and computers.

Payam Health Departments

When asked to describe their roles and responsibilities, most managers mentioned things that were not actually related to their mandate, as referenced in the BPHS. The purpose and functions of the payam level were also not clear to respondents. The payam administrator and health committee members, however, did understand that it is their responsibility to inform the CHD immediately if they observe something wrong or irregular in the operation of the facility. They are responsible to attempt to address problems that arise in the facility, with help from the CHD. Payam managers have a list of all the payam staff and often have a roster for scheduled duties. Interviewees identified several support tools that they lack, including stationery for recording meeting minutes and for writing letters to the CHD, computers, printers, photocopiers, and transport (e.g., motorcycles, bicycles, vehicles).

Primary Health Care Centers/Units

To the assessment team, it was clear that roles and responsibilities do not seem to be well understood at this level. The purpose and functions of the PHCCs are not clear to the managers. It was apparent that the managers of these facilities are not aware of the BPHS that contains descriptions of their roles and responsibilities.

In terms of support tools, facility managers reported that they have treatment guidelines, district health information system (DHIS) registers, supportive supervision registers, and HIV/AIDS posters. Although these tools were mentioned by the managers, with the exception of supportive supervision registers, the items referenced were technical tools rather than leadership and management tools. Interviewees mostly identified the lack of non-management resources including stationery for communication (e.g., meetings and letters to CHD), computers, MOH protocols and guidelines, and means of transport (e.g., motorcycles, bicycles, vehicles).

In terms of governance, interviewees indicated that some health facility management boards/committees understand their roles and responsibilities, although not always. According to respondents, hospital boards/committees have not been oriented in their roles and responsibilities, but plans are underway for this to happen soon.

While these interviewees suggested that some hospital and health facility boards and committees did not have gaps, others mentioned several gaps. When members of hospital boards and health facility management committees are called to attend meetings, they do not always come. One interviewee stated that health facility management committees do not provide adequate oversight and supervision. This respondent explained that committee members are supposed to attend to issues such as poor staff attendance or problems with the delivery of drugs, but they are often absent when such issues arise. The explanation provided for these performance gaps is that committee members are volunteers who have been serving for a long time without being paid. They have no incentive to meet on board/committee issues.

Village Health Committees

Most VHCs were established about three years ago, and their members were selected by their respective communities. The average staff number for VHCs is five, but in most cases, the members are absent and inactive, rendering most of the VHCs dormant and understaffed. The average gender breakdown of the staff is four males and one female. Each VHC has two managers, a chairperson and a health worker, at the health facility. All VHC managers are men.

VHC members were trained by the Multi-Donor Trust Fund in 2010, according to respondents. However, from what respondents reported only a few VHC members, are appropriately executing their roles, some were described as not working productively because they are volunteers and are not being paid. Although committee members are not supposed to be paid, one interviewee suggested that it would be helpful to motivate the committees by providing, once per year, a certain amount of token money, soap, or other incentive.

When asked to describe VHC roles and responsibilities, most chairpersons mentioned responsibilities not related to their mandate, as described in the MOH BPHS. The purpose and functions of the VHCs are also unclear.

VHC managers reported that they do not have support tools to assist them in their work. For example, VHC managers reported that they lack stationery for recording the minutes of their meetings and for writing letters to the CHD. They also do not have transport, such as bicycles, to help them mobilize within and outside of their bomas.

Western Equatoria State

State Ministry of Health

As in CES, the assessment team spoke to respondents at the SMOH level in WES to learn more about the roles and responsibilities of SMOH managers, leadership of different units, whether a sense of teamwork existed, performance monitoring, level of employee motivation, collaborative decision making, information sharing, meetings and meeting management, timeliness and completeness of employee tasks, and leadership and management support needed. These findings are presented below.

The assessment team learned that managers do not have a clear understanding of their roles and responsibilities. When asked to describe their roles and responsibilities, managers did not mention the main roles and responsibilities of their unit. Rather, they identified other issues that they attend to,

including delayed salary payments, lack of transport, and lack of motivation. Managers also seemed unclear about the purpose and functions of their service unit. When asked how the purpose and functions could be made clear, managers identified the need for clear job descriptions that explain the functions.

The managers described their unit's leadership as fair. Managers indicated that staff demonstrate good teamwork, due to respect among the staff. Managers also mentioned that low morale exists due to delays in salary payments, lack of transport for field work, and lack of sufficient workspace and that these factors inhibit effective teamwork.

Managers also stated that staff performance monitoring is regularly carried out. They rated performance monitoring as good and noted that it depends on reports that show how things are going, meetings that are related to performance issues, and attendance lists that reflect actual hours worked and staff commitment.

Managers mentioned that their staff are only occasionally involved in decision making. Respondents said that they share information with their staff during staff meetings. Most managers also stated that they conduct monthly staff meetings and that they always discuss management, finance, and administration issues.

Many respondents indicated that employee tasks are not always completed on time. This is due to a lack of basic management training, understaffed departments, low staff morale due to delayed salary, and lack of transport for field work. These managers mentioned the need for basic management training, recruitment of qualified staff, provision of transport, provision of computers, and Internet connection.

SMOH managers stated that political decision makers are not properly oriented to their roles and responsibilities because they do not address critical issues related to public health consistently. Thus, these respondents said that they do not know whether state political decision makers understand their mandate.

County Health Departments

The assessment team found that most managers at the CHD level did not understand their roles and responsibilities. When asked about this, the managers were not able to mention the main roles and responsibilities that are referenced in the BPHS. The purpose and functions of the service units are also unclear to most managers. Respondents described leadership and overall teamwork at the CHDs in WES as fair. However, some respondents mentioned that managers provide some motivation and acknowledgment to staff, which contributes to teamwork. Factors that inhibit teamwork included lack of basic management training, lack of transport, and delayed salary payments.

Managers interviewed at the CHD level stated that staff performance monitoring is not regularly carried out and that when it is carried out, it is poorly conducted. The reasons cited for these deficiencies are that performance monitoring is dependent on reports that are always submitted late and are incomplete. These interviewees indicated that their staff are only occasionally involved in decision making. Most managers mentioned that they hold staff meetings monthly and that they always discuss delayed staff salary, drug status at the health facilities, delayed and incomplete reports from the health facility, and staff promotion.

Respondents said that they share information by writing letters to bomas, payams, health facilities, and the SMOH. In some cases, they communicate by mobile phones in areas with network coverage and share information with staff during staff meetings and through notice boards. Another issue that respondents mentioned is that employee tasks are not completed on time. Reasons for this lack of timeliness include lack of basic management training, low staff morale due to delayed salary payments, and inadequate operating resources such as lack of transport for field work and office supplies – this is also true at the Payam Health Department and PHCCs.

When asked what leadership and management needs they have at the CHD level, interviewees stated the need for basic management training, recruitment of qualified staff, provision of computers and Internet connection, and provision of stationery and transport.

Payam Health Department

When asked to describe their roles and responsibilities, most managers mentioned responsibilities not related to their mandate, as referenced in the MOH BPHS. The purpose and functions of the payam is also not clear to the managers.

Payam-level managers said that they do not have support tools or desk aids to assist them in their work.

Primary Health Care Centers

The assessment team learned that PHCC staff do not seem to understand their roles and responsibilities. The purpose and functions of the PHCCs are also not clear to the facility managers. It seems that the managers of these facilities are not aware of the BPHS that contains their roles and responsibilities.

Facility managers reported that they do have treatment guidelines, DHIS registers, supportive supervision registers, and HIV/AIDS posters.

Village Health Committees

According to respondents, most VHCs were established about four years ago. The VHC members were selected by their respective communities. The average number of members for VHCs is nine, but in most cases, the members are absent and inactive, making most of the VHCs dormant and understaffed. Respondents indicated that the average gender breakdown for VHC committees is five males and three females. Interviewees said that each VHC has two managers, a chairperson and a health worker from the health facility. The assessment team found that all VHCs managers interviewed were men. There is no gender balance in the composition of those interviewed in VHCs.

When asked to describe their roles and responsibilities, most VHC managers provided answers unrelated to their mandates, described in the MOH BPHS. The assessment team found that the purpose and function of the VHCs was also not clear to the managers.

Leadership and Management Conclusions

In general, the assessment team found that the key findings from CES and WES were similar. In both states, the staffing, resources, infrastructure, systems, guidelines, and policies and procedures required for the effective and efficient operation of public health systems were lacking significantly.

Leadership and Management Concepts Are Not Well Understood

When asked what was needed to improve leadership and management, the most common response received from managers at all levels (SMOH, CHD, payam, boma, and VHC) was transport. When prompted about what was required to support the management of staff, most managers continued to focus on the lack of resources. The resource issues identified most frequently were related to transport (e.g., vehicles, money for vehicle maintenance, fuel), low salaries and inconsistent pay schedule, lack of office equipment and telephones, and lack of incentives (e.g., housing allowances, transportation allowances). Managers also frequently mentioned that training was needed for managers and staff. When asked to identify the specific areas of training that are needed, managers usually identified clinical technical training (e.g., training for nurses or midwives).

Many managers indicated that they need management or supervisory checklists. This was the only management tool or area of support that was frequently mentioned. Managers did not identify needs in areas such as task delegation, monitoring, or dealing with performance or conduct issues among staff. The almost total lack of references to specific management needs, even when prompted, leads the leadership and management interview team to conclude that most managers in the CES and WES health systems have a very limited understanding of leadership and management concepts. There is a need for training focused on the fundamental principles of leadership and management and for organizational development support to design and implement systems and policies that support sound leadership, management, and governance.

Managers Provide Limited Staff Oversight

Managers in the CES and WES health systems have limited opportunities to directly observe and supervise the majority of their staff. The lack of oversight results primarily from logistical considerations such as significant travel distances between facilities and unavailability of transport, computers, and telephones. Managers also described that they were over-extended with their responsibilities, as one manager explained:

“I am supposed to make sure that all of the staff has come to work. I myself may not always come. There are emergencies, like doctors going on strike because they have not been paid. So I cannot determine that staff is here. Some staff is in various locations.”

Most Managers, Staff, and Volunteers’ Determination is Commendable

The majority of CES and WES health system managers and staff demonstrated solidarity and dedication to their work, even though they are working in a challenging environment. Their commitment, despite the difficult circumstances is exceptional. Particularly since their salary is often late, they do not have adequate equipment, and their overall work environment is poor. This was evidenced in the positive attitudes that managers displayed during the interview process. Managers were very patient during the

interview process and provided thoughtful and thorough responses to the interview questions. There was evidence that many managers, staff, and volunteers work diligently despite inconsistent pay and incentive schedules and a serious lack of personnel and material resources. As one manager explained:

“Managers do a good job of helping staff to be dedicated, but there are many barriers. If someone earns a promotion, there is no budget to support it. Providing training can help promote motivation, but we are not able to send staff to training programs. Staff should not appear like civilians. They should have uniforms so that people can identify them and so that they look smart, but we are not able to provide staff with uniforms.”

High levels of dedication were most evident at the county level and below and were less evident at the state level, particularly in CES. At the CES SMOH, evidence indicated that staff lack direction regarding their roles and responsibilities and that the level of productivity is low. The caveat to this statement is that there were not many managers or staff present at the CES SMOH when the leadership and management interview team arrived, so the interview sample was small. As one manager stated:

“[Motivation] is very poorly done. I see a lot of staff who don’t have much to do, who come to work late and leave work early. They don’t seem to have very clear direction on what they are supposed to be doing.”

Most Managers Lack Requisite Skills

While there is a wide range in terms of the level of work experience among managers in CES and WES, most have not had extensive formal management training. Managers also have varying levels of formal education. Some are quite literate and others are not, as one manager explained:

“After the peace, some of the counties are managed by the rebels. You have to accept some people whether they are qualified or not.”

Communication Mechanisms Are Inefficient

Communication mechanisms are in place at all levels of the health systems in CES and WES, but they function erratically. Most managers hold meetings with staff, but some do not hold meetings on a regular basis. When meetings are held, minutes are usually taken, but these minutes are typically not distributed. The infrastructure that supports Internet and e-mail access is problematic and unreliable. Most offices at the county level and below lack electricity and telephone service. Managers and staff communicate regularly with donors and other stakeholders, but there is no formal strategy or structure for relating to these entities or for organizing and coordinating their work.

Governance Is Weak

Governance is a key aspect of health strengthening in South Sudan and currently governance of health facilities, services, and resources is weak. Boards and committees at the VHC level are either nonexistent or function poorly. Where boards and committees exist, many board members do not understand their responsibility to hold health facilities to account and most board members lack the skills required to carry out this responsibility. Board and committee members at the VHC level need a clear understanding of their roles and responsibilities and they need to develop skills in communication, monitoring, meeting management, stakeholder engagement, and financial management.

3.1.3 Leadership and Management Recommendations

The intention of HSSP is to adapt a wide range of capacity-building methods that go beyond traditional training approaches to increase the leadership, management, and governance capacities of selected leaders and managers at the state, county, payam, and village levels. The aim is to enable this group of leaders to become competent and therefore provide the much-needed direction for making both strategic and operational decisions that will contribute significantly to effective and efficient health service delivery. Our approach consists of the following:

- Addressing the practical limitations that hinder good management systems (e.g., a lack of staffing, transport, and communications)
- Supporting the establishment of clear management structures, defining both the responsibilities of county authorities and the way in which they are expected to link to other levels of government
- Introducing or strengthening other supporting management systems (e.g., payroll, sector-specific reporting mechanisms, staff management systems, accountability mechanisms)
- Improving accountability at multiple levels (between government and citizens, between different levels of government, and for individual staff in their roles)
- Promoting the extension of the type of capacity-building initiatives that have been implemented at the RSS level in Juba (such as a focus on personnel and financial management, oversight, and accountability, through support such as embedded technical assistance, counter-parting, and mentoring and coaching) to state and county levels.

The HSSP leadership, management, and governance capacity-building interventions outlined above will be consistent with the recommendations of the brief entitled *Capacity Building of County Level Government*, (South Sudan NGO Forum 2011: p. 8-10). The brief discussed comments and guidance provided by NGOs involved in capacity building in South Sudan's 10 states as well as general lessons learned. HSSP interventions will incorporate recommendations from this brief that are relevant to leadership, management, and governance, as described below:

- Component I of HSSP capacity building will include trainings to address the gaps identified in the baseline assessment and tailored courses to improve the management skills of the different levels of the SMOH, CHDs, and VHCs.
- HSSP will focus on building productive relationships with state and county officials. In addition to relationships with the county department in general, it is also important to build relationships with the county commissioner, to engage his or her support for the capacity building that is taking place. HSSP will involve the county headquarters in some of the tailored trainings and all the workshops in order to have the political support of the county commissioners and also to build the leadership and management capacity of the county headquarters staff.

The HSSP approach will include field visits in between the workshops, coaching, mentoring, on-the-job training, and feedback. The aim is to build the capacity of the staff at the different levels through on-the-job trainings and tailored courses.

- HSSP will consider simplifying the training methods, using simple language, and also translate the training into simple Arabic or local languages to ensure materials are very clear to the participants.

Field visits, coaching, mentoring, and support will be offered in addition to on-the-job training and the tailoring of courses according to any expressed need at the different levels.

- HSSP will involve the county headquarters in some tailored trainings and in all the workshops in order to have the political support of the county commissioners and also to build the leadership and management capacity of the county headquarters staff.
- HSSP will work in close collaboration with the USAID-funded Integrated Health Service Delivery Project (ISDP), Systems for Improved Access to Pharmaceuticals and Services, and other existing NGOs on the ground to avoid any duplication in training and training-related issues.
- HSSP will coordinate capacity-building efforts at state, county, and other levels to ensure consistency and coherence in approaches used.
- HSSP will strengthen capacity in leadership and management at all the departments of the SMOHs.

Initial Interventions

The HSSP project will also incorporate proven principles and guidelines to enhance the effectiveness of capacity development interventions. Examples include:

- HSSP will use a suite of capacity-building interventions that may include training, coaching and mentoring, organization development support, job aids, job tools, and on-the-job training. While training is an excellent mechanism for the development and transmission of knowledge and skills, we recognize that overreliance on training can yield limited results. The knowledge and skills gained through training must be reinforced in the work environment in order for managers to be able to use them consistently and well. HSSP will, therefore, utilize the broad range of capacity-building interventions mentioned above to reinforce and cement the knowledge and skills that will be introduced in HSSP training programs.
- HSSP leadership, management, and governance capacity-building interventions will be highly experiential. We will adhere to sound principles of adult learning. The training and other capacity-building interventions that we employ will enable participants to:
 - **experience** new knowledge and concepts by immersing themselves in doing a task,
 - **analyze** their experience by stepping back from the task to reflect on what has been done and to develop a paradigm (values, attitudes, and beliefs) about the experience,
 - **generalize** a set of concepts to define the situation and link the actual learning experience with the theories that describe it, and
 - **apply** the new understanding by planning for what will happen next in their work settings. This will be done in a variety of ways, such as through action planning or preparing a learning contract.
- HSSP will tailor training programs and other interventions to address specific contexts evident in CES and WES health delivery environments. HSSP will work with managers and staff at the state and county levels to develop case studies and scenarios that depict real challenges and situations.

- HSSP training designers will be aware of and sensitive to logistical and staffing challenges that may affect managers' availability to participate in training. For example, many health facilities are understaffed and this may limit the number of consecutive days that managers are able to be away from facilities to attend training. HSSP will keep such factors in mind as we determine the length of training programs. As much as possible, HSSP will design training programs that include discrete, stand-alone sessions. This will allow HSSP to modify training programs on short notice. If a training program must be shortened from four days to three days, participants will still be able to achieve discrete learning objectives.
- HSSP will develop job and desk aids that will reinforce key management concepts and strategies presented in leadership, management, and governance training programs. These aids may be as simple as laminated cards with printed guidelines that managers can keep on their desks or carry with them; for example, a laminated card that lists the five steps to be completed when delegating a task to a subordinate.
- HSSP will modify training materials and approaches, when appropriate, for individuals who may have limited reading or writing skills. HSSP will also seek to configure training groups so that individuals with similar educational backgrounds will be trained together.
- HSSP will develop a cross-component coaching / mentoring program to support a variety of HSSP capacity-building areas such as leadership and management, HIS, and supportive supervision. Coaching and mentoring will be required to assist managers with the application of new skills in the work environment and the institutionalization of these skills within their institutions.
- HSSP will provide organizational development support to design and put in place systems and policies that support sound leadership, management, and governance practices. Based upon assessment findings, such support may focus on issues such as:
 - developing and implementing guidelines, schedules, and procedures for planning staff responsibilities;
 - developing and implementing protocols and procedures for monitoring staff performance and providing performance feedback;
 - developing and implementing governance guidelines and procedures for political leaders, boards, and committees;
 - developing and implementing incentive programs (mostly non-monetary) to encourage and reward teams and individuals who substantively promote or support sound leadership, management, and governance practices;
 - building effective SMOH and CHD work teams; and
 - establishing clear roles and accountabilities among and between health system governmental authorities at state, county, and local (payam, and boma) levels.
- In addition to classroom training, HSSP will explore the applicability of training that is provided in the workplace. Given the difficulty of travel in South Sudan, it may be appropriate to provide significant training opportunities for individuals at their work locations. Such on-the-job training may be provided to either introduce new knowledge or skill areas or to review or reinforce knowledge

and skills previously obtained. On-the-job training may be provided by HSSP staff or by managers within CES/WES health systems and facilities.

Interventions in the first year of HSPP include the following:

Design and deliver one four-day performance management training course

The HSSP leadership and management team proposes to design one four-day performance management training course in both CES and WES. The performance management tasks targeted in this course are setting goals for health facilities/departments, developing performance plans for staff, delegating tasks, monitoring performance, and providing performance feedback. These tasks are fundamental performance management responsibilities and are necessary to the development of sound performance management practices in CES and WES health systems.

The training program will be experiential and tailored to address specific contexts evident in CES and WES health delivery environments. HSSP will work with managers and staff at the state and county levels to develop case studies and scenarios that depict real-life challenges and situations. Training designers will also be aware of and sensitive to logistical and staffing challenges that may affect managers' availability to participate in training. For example, many health facilities are understaffed and this may limit the number of consecutive days that managers are able to be away from facilities to attend training. Training designers will also take varying educational levels and language preferences into consideration when they design this and other training programs.

HSSP proposes to deliver the four-day performance management training courses only once in each state and then to support the phased roll-out of the same course through local facilitators. The primary target audiences for this course delivery will be managers from the state and county levels. Managers from the central level of RSS will also be invited to participate in the training course, as their involvement will help secure buy-in and consistent application of the targeted performance management concepts and practices.

Identify and train facilitators

Identifying and training facilitators will be an important capacity-building strategy for HSSP. Our team will identify approximately 20 prospective facilitators from among the initial group of participants. Completion of the four-day performance management course will constitute Phase I of the facilitator development program. Phases II and III of the facilitator development program are described under subsequent interventions below.

Develop job and desk aids

HSSP proposes to develop job and desk aids that will reinforce key management concepts and strategies presented in the leadership, management, and governance training program. These aids may be as simple as a laminated card that managers can keep on their desks or carry with them. They may also include automated checklists or other tools easily accessed. One example of a tool is a laminated card with the five steps to follow when delegating a task to an employee. Job aids and desk aids will serve as important reminders that managers will be able to refer to after they leave the training program and return to

their work sites. HSSP will develop several tools to support the performance management training course.

Design cross-component coaching / mentoring

Cross-component coaching / mentoring will be another important capacity-building strategy for HSSP. The term *cross-component* means that coaching and mentoring will be provided in support of a variety of HSSP capacity-building areas such as leadership and management, HIS, and supportive supervision. Coaching and mentoring will be required to assist managers with the application of new skills in the work environment and the institutionalization of these skills within their institutions. While training is an excellent mechanism for the development and transmission of knowledge and skills, such training must be reinforced in the work environment in order for managers to be able to use what they learn consistently and well. Cross-component coaching and mentoring will provide this necessary reinforcement. HSSP will design a system for providing cross-component coaching and mentoring that responds to the needs identified in this baseline assessment.

Subsequent Interventions

Train Facilitators

HSSP proposes to continue training facilitators to deliver leadership, management, and governance courses. HSSP proposes to follow up on the Phase I task, described within the preliminary interventions section, to implement Phases II and III as described below:

- Phase II: Prospective facilitators will participate in a three-day facilitation skills course delivered by HSSP trainers. This course will cover principles of adult learning, facilitation skills (paraphrasing, asking questions, summarizing, and encouraging), course design skills, and co-training skills.
- Phase III: Prospective facilitators will receive instruction on how to deliver the four-day performance management course. This phase will require approximately three days.

Following completion of this training of facilitators' regimen, those who succeed will be qualified to deliver the four-day performance management course. HSSP trainers will be available to co-deliver with CES/WES trainers for their first delivery and as required until they are competent to deliver the course alone.

Develop and deliver additional leadership and management training curriculums

HSSP proposes to design and deliver additional leadership, management, and governance courses. Based on the findings of the baseline assessment, training topics may include motivation, conflict resolution, situational leadership, team building, communication, strategic thinking, planning, and budgeting. HSSP will design experiential learning programs and will pay particular attention to the health delivery contexts of CES/WES.

Develop and deliver governance training curriculums

HSSP proposes to develop and deliver governance training, coaching, and mentoring interventions for VHCs and to implement these interventions during the course of the project. The skill areas proposed

for governance training include communication, monitoring, meeting management, stakeholder engagement, and financial management. The team is confident that training in these cross-cutting skill areas will contribute to good governance, efficient resource management, and effective health care delivery.

Provide organizational development support for leadership, management, and governance

HSSP proposes to provide organizational development support to design and put in place systems and policies that support sound leadership, management, and governance practices. Based upon assessment findings, such support may focus on issues such as the following:

- Developing and implementing guidelines, schedules, and procedures for planning staff responsibilities
- Developing and implementing protocols and procedures for monitoring staff performance and providing performance feedback
- Developing and implementing governance guidelines and procedures for political leaders, boards, and committees
- Building effective SMOH and CHD teams
- Providing on-the-ground coaching to follow up on the application of skills learned in the leadership and management training
- Establishing clear roles and accountabilities among and between health system governmental authorities at state, county, and local (payam, boma, and VHC) levels.

The HSSP Component 1 team will coordinate closely with Component 2 team members as the above tasks are related to HRH, supportive supervision, or other technical areas.

Coaching and Mentoring

HSSP proposes to implement coaching and mentoring interventions targeted to managers who have completed leadership, management, and governance training programs. Coaching and mentoring initiatives will be coordinated across all project components and capacity-building elements of the HSSP. We propose to contribute to the development of coaching and mentoring protocols and guidelines that will promote capacity building for CES and WES staff in all of the programmatic and technical areas addressed by HSSP.

Develop Job Aids and Desk Aids

HSSP proposes to continue to develop job aids and desk aids. These aids will support the content of the additional training courses in content areas such as motivation, conflict resolution, situational leadership, team building, communication, strategic thinking, planning, budgeting, and governance.

On-the-Job Training

In addition to training provided in classroom settings, HSSP proposes to explore the applicability of training provided in the workplace. Given the difficulty of travel in South Sudan, it may be appropriate to provide significant training opportunities for individuals at their work locations. Such on-the-job training

may be provided to either introduce new knowledge or skill areas or to review or reinforce knowledge and skills previously obtained. On-the-job training may be provided by HSSP staff or by managers within CES/WES health systems and facilities.

How HSSP Leadership, Management, and Governance Interventions Will Be Similar to and Different from Prior Interventions

Previously, leadership and management training programs in health were conducted in South Sudan by Abt Associates, TRG, AMREF, and Management Sciences for Health, among others. Some training programs covered specific topics in leadership and management (e.g., HIV/AIDS and tuberculosis). There was also a Leadership and Management Development Program. HSSP will build on the lessons learned and successes of these training programs and work with the Directorate of Training and Professional Development of the national MOH to institutionalize these training programs.

Some aspects of HSSP interventions that may be unique include the following:

- HSSP is a five-year program. This is a sufficient amount of time to begin to institutionalize capacity-building successes.
- HSSP leadership and management interventions will focus specifically on health systems strengthening. Some prior interventions involved combined efforts, for example, focusing on both health systems strengthening and community mobilization.
- HSSP will tailor interventions to the specific findings of the baseline assessment.
- Where possible and necessary, HSSP will simplify the terminology used in the training and in some cases will use Juba Arabic for further clarification.

3.2 Health Financing

3.2.1 Background Information on Health Financing in South Sudan

The budgetary allocation for health by the RSS has been generally low, at around 4 percent of the national budget, and the introduction of austerity measures in 2012 following the stoppage of oil flow in the country has made the financial situation even more challenging.

In line with the constitution, the RSS is implementing a decentralized system of government, and part of its funds are to be directed to the states and counties. However, this has not been without challenges, in terms of the volume of funds and the coordination and management of the funds in the decentralized units. Over the past three years, the Ministry of Finance and Economic Planning (MOFEP) has rolled out a common approach to planning and budgeting across the three levels of government (national, state, and county). However, the MOH has not yet engaged the SMOHs in the planning process, and the states face many challenges in managing their budgets and fulfilling their mandates. PFM is weak in the health sector and technical support is required to strengthen PFM systems and to build the capacity of the MOH and SMOH to work effectively within the context of the budget cycle (O'Neill 2013).

PFM deals with all aspects of resource mobilization and expenditure management in government. Managing finances is a critical function of management in any organization, and thus PFM is an essential part of the governance process. PFM includes resource mobilization, prioritization of programs, the budgetary process, efficient management of resources, and the exercising of internal controls. Public expectations regarding the health services provided by the government are placing more demands on financial resources. At the same time, citizens want value for money, thus making public finance management increasingly vital.

This baseline assessment focuses on the PFM strengths that HSSP can build on and identifies areas that need further strengthening for the system to function properly. The assessment measured performance against the practice recommended by the RSS PFM Manual for Local Governments (referred to in this report as PFM manual) (RSS 2013b) and focused on the following areas:

Source of funding: This looks at both the government and donors as a source of funding for health care. It also looks at budget execution rates.

Planning and budgeting: This includes planning and budgeting cycles, common understandings of the cycle, synchrony with the annual operational plans, bottom-up planning and budgeting, participatory approach in planning and budgeting, budgeting tools, and staff competence in planning and budgeting.

Funds flow: This focuses on how resources flow from the central government to the states and the counties. The baseline assessment also examines the structures recommended by the PFM manual for flow of funds to the local government as well as to the facilities.

Funds control: This presents channels for the transfer of funds to the SMOH/CHDs and policies and regulations on petty cash, cash at hand, and banking of monies. Other areas of focus include internal controls such as checks and balances, use of pre-numbered documents, payments authorization and approval, reconciliations, physical controls, policy for handling cash and staff competency in

bookkeeping, financial and technical report writing, custody of accounting documentation, fixed assets management, and inventory management.

Accounting and financial reporting: This addresses performance of the SMOH/CHDs with respect to functions such as preparation and presentation of monthly, quarterly, and annual reports as well as audited reports.

Audits: This addresses the existence of regularly implemented and complete internal and external audit activities and a clear understanding of how audits benefit PFM processes.

Procurement: This includes availability of procurement and disposal guidelines, staff awareness of and training on the guidelines, existence of a procurement unit or department, existence of a functional procurement oversight committee, and competence of staff in procurement.

The health care financing baseline assessment was conducted at the state, county, payam, and facility (both PHCC and PHCU) levels. Interviews were also conducted with VHCs to establish their involvement in PFM at the facilities in their locality. In-person interviews were conducted with 38 interviewees from the various administrative levels. At the SMOH, the finance and administration directors or their designate were interviewed. At the county level, the interviewees included county commissioner, county planning officers, county medical officers, and CHD accountant/book keepers. The team also interviewed facility in-charges.

Despite pressing challenges, it was heartening to witness the staff's commitment to their duty, their positive attitude and willingness to work, their open-mindedness, and above all their enthusiasm for learning and embracing new and better ways of working. This is a strong sign that the counties are willing to do what is necessary to establish PFM systems that will support the efficient and effective delivery of health care to the citizens of WES and CES.

3.2.2 Key Findings: Health Financing

- The HSDP 2012–2016 reflects the political will and commitment of the government of South Sudan to streamline and transform the existing weak health system and the poor quality health services. In PFM in particular, there is an active Technical Working Group (TWG) under the stewardship of the central MOH. Having coordinated efforts is a great opportunity to enhance the success of the PFM efforts.
- Very comprehensive guidelines on PFM have already been developed. The PFM manual, for instance, provides clear frameworks in areas of financial management planning and budgeting, management of cash, procurement, fixed assets and inventory management, reporting, and even auditing. These guidelines have recently been updated, but not all health sector staff are familiar with them. To date implementation of the guidelines is limited. The next step is to ensure that these guidelines are communicated to staff and that their correct implementation is supported.
- The Local Government Board working in collaboration with MOFEP issues annual guidelines on planning and budgeting. These serve as reinforcements to PFM.
- It is a great strength that staff already understand the PFM challenges in the health sector. This awareness will facilitate staff buy-in to PFM-related interventions since the staff will understand their

value. Moreover, they will also understand areas of PFM in which they are weak, as demonstrated in a self-appraisal they did during this baseline assessment.

- There is unwavering staff commitment and dedication to duty. Despite challenges in the system, the financial management staff remain very committed to their work. They are also very eager to learn and adopt better and more efficient ways of working.
- There is an institutional PFM framework in place. There are state-level departments dealing with PFM. Likewise, at the county level, there are structures responsible for PFM.
- Additional funds are scheduled for release to the CHDs for operational costs early next year. The CHDs will thus have the opportunity to gain practical experience in PFM. The additional funding will also be a morale booster for the CHDs because it will further strengthen the health system.

Funding Mechanisms

Government funding. Since 2008, the government has allocated an average of around 4 percent of its budget to health, which is very low for the region. Similarly, the government’s per capita budget on health was only \$9 in 2011, compared to an estimated per capita expenditure on health of \$19 in Ethiopia, \$23 in Kenya, \$40 in Yemen and \$116 in Egypt (Fox and Manu 2012). However, the actual amount spent is lower than the 4 percent allocated, with an average execution rate of just 2.4 percent, as seen in table 4.

Table 4: National Budget for RSS, Health Budget, and Budget Execution/Outturn (South Sudanese Pounds (SSP)⁴

	2010	2011 (through June 30, 2011)	2011/2012
National budget	5,629,539,871	6,787,110,486	5,718,507,687
Health budget	208,260,000	216,260,000	236,260,000
Outturn	132,943,922	118,821,274	170,253,522

Source: Adapted from Hutton (2013a)

Health Care Financing in South Sudan (Fox and Manu 2012) explains the possible causes of the lower execution rate. The report notes that the lower rates compared to the overall budget may indicate that health is not being prioritized compared to other sectors when it comes to actual expenditure. It may also indicate weaker financial management in health compared to other sectors. The report indicates that further investigation is required to understand why the execution has been low and how it can be resolved in future years.

According to Hutton, the year 2012 saw the introduction of austerity measures following the oil supply cut-off through which RSS lost 98 percent of its income (Hutton 2013a). The austerity measures were still in effect in June 2013. The report notes that financial austerity will continue to make the MOH dependent upon donors for supporting the delivery of health services, which will ultimately affect the sustainability of the health system overall.

⁴ The bank exchange rate at the time of the assessment was: 1 USD = 3.02 SSP.

O’Neill (2013) states that under continued austerity, increasing dependency on donors is creeping in and is shifting the focus from government funding streams to external ones. This could eventually have the negative impact of weakening government systems.

Donor funding: To mitigate the health sector challenges South Sudan has been facing, the international community has been providing humanitarian assistance. Several programs, including the Basic Services Fund, Multi-Donor Trust Fund, Sudan Health Transformation Project II, and the Office of U.S. Foreign Disaster Assistance have supported the health sector.

In 2012 the existing funding mechanisms, which were providing support for health service delivery, all came to a close; this was also a mark of transitioning from humanitarian to development assistance.

Donors and the MOH agreed upon plans for succession with all 10 states being covered by adopting a method of having one lead agent per state. Three donors: HPF (UK, Canada, Australia, Sweden, and European Union), USAID, and World Bank took up states as shown in Table 5.

Table 5: Allocation of States in RSS to Donors and Budget for the Projects

State	Donor	Fund Manager	Duration	Amount
Central Equatorial State Western Equatorial State	USAID	Jhpiego Abt Associates	5 years 5 years	US\$ 85million US\$ 25million
Eastern Equatorial State Northern Bahr el Ghazal Western Bahr el Ghazal Warrap Unity Lakes	Pooled Fund Pooled Fund Pooled Fund Pooled Fund Pooled Fund Pooled Fund	Crown Agents (lead)	3.5 years	GBP £123m
Upper Nile Jonglei	World Bank World Bank	Inter-Church Medical Association	12months	US\$ 23m

*Adapted from Hutton (2013b).

The three funding sources (USAID, HPF, and World Bank) have committed to work collaboratively with MOH and each other, to support delivery of health services and enable more targeted outcomes and sustainability.

Funds Flow

Despite the financial challenges that the RSS faces, it is implementing a decentralized service delivery system to state, country, and payam levels. The national government makes grants to the local governments.

The PFM manual states that “Grants are an area of special interest in PFM as they pose a major challenge to the LG [local government] since quite often the grantor/benefactor will desire to seek reassurance that the funds transferred are used properly, for the purpose intended and are accounted for.” This calls for an effective PFM system.

Transfers to States

The states receive two types of grants: conditional grants and block grants. Conditional grants are for a number of priority sectors, including health, and they are earmarked for salaries, operations, and capital expenditures (Table 6). With conditional transfers, the state receives instructions on how to use the money.

In contrast, block grants can be used by the state according to its priorities and are not earmarked by the central level. The SMOH receives both conditional and block grants from the State Ministry of Finance and Economic Planning (SMOFEP).

Transfer of funds from SMOFEP to SMOH. SMOHs submit their budgets to SMOFEP based on a schedule and guidelines issued by SMOFEP to all ministries. The state budgets are subsequently discussed by a council of ministers before being taken to parliament for approval. Upon approval, the SMOFEP will credit the bank account of the SMOH.

Table 6: FY 2011–2012 Transfers and Expenditure

	Conditional transfers			
	21: Salaries	22: Operating	28: Capital	Total
Central Equatoria	7,451,179	1,100,000	0	8,551,179
Eastern Equatoria	4,692,667	1,100,000	0	5,792,667
Western Equatoria	6,281,327	1,100,000	0	7,381,327
Jonglei	5,744,517	1,100,000	0	6,844,517
Upper Nile	8,497,727	1,100,000	0	9,597,727
Unity	5,257,078	1,100,000	0	6,357,078
Western Bahr al Gazal	5,308,950	1,100,000	0	6,408,950
Northern Bahr al Gazal	4,248,224	1,100,000	0	5,348,224
Lakes	6,614,355	1,100,000	0	7,714,355
Warrap	3,607,316	1,100,000	0	4,707,316
Total	57,703,340	11,000,000	0	68,703,340

Source: RSS (2013b)

*In FY 2012–2013, the operating transfers were cut by 50 percent, to SSP 550,000 per state

The SMOH also provided some facilities with direct funding for operations, particularly in CES. For instance, in the current year, the CES SMOH receives SSP 45,883 monthly by the state; the SMOH subsequently transfers SSP 5,000 to three hospitals, and six smaller units receive SSP 2,000 each. This totals SSP 27,000. The balance is what the SMOH uses for its own operations. In contrast, at the SMOH in WES, all the funds for operational expenditures are spent at the state level, with no allocation to facilities; the SMOH only transmits salaries to the facilities. There are no specific criteria developed that

guide how much should be transmitted to the counties or the facilities from the SMOH. This affects equitable access to health services.

County headquarters to the CHD. According to the PFM manual, county departments should plan and budget with the county government. Their funds should also flow through the county headquarters. However, the FY 2013–2014 county planning and budgeting guidelines indicate that CHD resources should flow through the SMOH. In practice, the SMOH receives money from the SMOF and transmits the money to CHD cashiers/accountants to pay for salaries at county and facility levels. The CHDs collect the money *in cash* and transport it to the other levels. This cash system is not subject to normal financial controls and poses a security risk.

In some counties, such as Lainya, the CHDs present their budgets to the county headquarters, while in others, such as Morobo, the CHD links to both the county headquarters as well as to the to the SMOH during the planning process. Budgets developed with the planning office are sent to the SMOH. An attempt in 2012 to involve the donor partners in planning did not materialize. The Morobo county headquarters believe that this process is not properly coordinated.

According to the Yei county headquarters, the CHD may not necessarily present its full budget to the county headquarter because the CHD receives its funds from the SMOH.

Planning and Budgeting

Planning and budgeting are necessary to guide the implementation of activities of the SMOH/CHDs and to monitor their performance based on predetermined targets. Grounded on the premise of good governance principles, the SMOH/CHD envisage the active participation of stakeholders, especially the immediate communities, in the preparation of annual operational plans, accompanying budgets, and monitoring attainment toward performance targets.

According to the Guidelines for County Planning and Budgeting for Fiscal Year 2013–2014, as well as the PFM manual, the law requires the executive council of the local government to prepare an annual budget; that mandate is vested in the planning unit. The manual also provides for the steps in planning and budgeting. It emphasizes that the process must be participatory and the community must be consulted.

The guidelines provide that the county departments should draw up their expenditure budgets based on the budget ceilings provided in the budget call circular and submit them to the County Planning Unit.

States are already developing three-year strategic plans for health (a requirement for all states and counties), although integration of the annual budget and three-year plan needs to be strengthened. Moreover, there is a lack of coordination between central and state in planning as well as the format to be followed in development of the three-year strategic plan. Information on the off-budget funding at state level is also weak (Fox and Manu 2013).

Planning and budgeting cycle. The PFM manual provides the key principles and procedures for the preparation of an annual budget. However, every year, the MOFEP, in conjunction with the Local Government Board, issues the annual state and county planning and budgeting guidelines.

The guidelines contain the principles of budgeting, the steps to be followed in planning and budgeting including the dates, and guidance to budgeting for transfers. The guidelines also provide some templates for budgeting and reporting, issue the budget ceilings, and show the frequency of release of funds.

According to the county planning and budgeting guidelines, county headquarters are advised to widely distribute their guidelines to all their departments since they provide the process of planning and budgeting for the departments including the CHDs. During the team's assessment, none of the CHDs had a copy of the guidelines, nor were they aware of where to obtain them. This negatively affects the planning process, and some facilities, for instance Munuki PHCC, which were not aware of the process, prepare ad hoc budgets for operational costs and capital expenditures, and do not receive funding in return. Facilities putting effort into planning without receiving any resources leads to "planning fatigue" (O'Neill 2013). For example, this was the case at Lainya where staff observed that they exerted effort on budgeting but that does not translate into funding. In other instances, like in Morobo, the county headquarters states that it has a budgeting process; however, it adds that the CHD may not feel obliged to participate since the county headquarters gives no funds to the CHD, and the CHD is assured of getting funds from the SMOH for its salaries. This is also the case at community level. In Yei, the county headquarters sends a budget form to the CHD to complete; after receiving the completed form, headquarters only needs to compile the information.

Common understanding of the budgeting cycle. The RSS financial year runs from July 1 to June 30. This marks a shift from a January to December financial year, which was in place prior to the country's independence. During the cycle, the plans and budgets are sent to the state SMOFEP based on a schedule and guidelines issued by SMOFEP to all other ministries. The expenditure ceiling for the state's budget is included in these guidelines. State budgets subsequently are discussed by a council of ministers before being taken to parliament for approval.

Staff involved in planning at county headquarters and SMOH finance and administration heads are aware of the planning cycles. The county health officers are also aware of the budgeting cycles; however, they admitted that they do not follow these cycles. None of the facility managers interviewed was aware of the budgeting cycles.

Even those interviewees who knew that the budget cycle runs from July to June did not know the guiding principles of the process as laid out in the Guidelines for County Planning and Budgeting, nor did they know when the preplanning and budgeting process starts and ends. The reason for this could be that no one had a copy of the PFM manual. Further, the CHDs were unclear about the county headquarters', SMOH's, and SMOFEP's roles and responsibilities in the planning and budgeting process. This leads to gaps in the process and could cause the process to fail.

Driven by the inadequacy of funds, some facilities present ad hoc budgets to payams requesting financial support from the collections made in the payams; for instance, Munuki PHCC presented a budget proposal to Munuki local council, when they actually should have been presenting the budget to the local council. Because these are ad hoc budgets, they are not synchronized with the budget cycle and do not adhere to the budgeting process. The payams are not involved in the process since their focus in health is largely in public health and includes the licensing of merchants within the payam, as opposed to service delivery.

Alignment to operational plans. Fox and Manu (2013) recommended that a roll-out of operational plans based on the HSDP at the state level be fully aligned with the three-year strategic plans that were already in place so that the SMOHs do not embark on two separate planning processes. They also pointed out that providing clear guidelines and templates is required, as is training on strategic planning.

During the baseline assessment, it became clear that there is alignment between the budget and the operational plans at the SMOH in CES but not in WES. At some county headquarters, for instance, Yei, respondents questioned the relevance of the operational plan given that there were no funds for operations.

Bottom-up planning. There is a need for stronger coordination in planning between central and state levels, particularly in the context where both the state level and central level are involved in planning for the state. In addition, more donor engagement in the planning process is also recommended (Fox and Manu 2013).

O'Neill (2013) observes that SMOH appeared to have a productive relationship with the SMOF, but few formal channels of communication with the MOH to address financial issues. Further, the budgeting process is top-down, with almost no formal opportunity for states to inform the national level of their needs. This applies to the decision-making processes used in budgeting the conditional transfers and setting policy for their use.

The states do not participate in the national planning process despite the fact that they are responsible for the implementation of those plans. The SMOHs observed that they are left out of the MOH's budgeting process.

In CES, until 2011-2012, the SMOH conducted planning and budgeting for the CHDs. However, in the 2012-2013 budgeting cycle, the counties, particularly in CES, were also involved in the planning and budgeting process. In WES, the CHDs are not consulted during, nor involved in, the planning and budgeting cycles. Budgeting process and budgeting templates existed at the SMOH level in CES, although the process execution was not aligned to the prescribed process, but there is no clear process in WES.

Overall, the assessment team found that the bottom-up planning was not being implemented as much as it could be. Planning is often top-down. In some counties, however, representatives from the county commissioner's office stated that they consult with the payams and bomas during the budgeting process and that this process starts in June and ends in July. This was true for Yei and Juba counties.

Donor involvement. The planning process does not involve development partners. In some cases, for example at the CES, SMOH observed that the reason for lack of donor involvement in planning and budgeting is that they do not provide on-budget funding to the government, even though these development partners contribute substantially to the total resource envelope for health. However, there does exist a national forum for NGOs at which level some consultation takes place. In contrast, some county planning staff said that donors and implementing partners often do not share information with them during the planning cycle.

Participatory planning and budgeting. There is a lack of structured consultation with the community during planning and budgeting. This stems from the fear of raising communities' expectations and then letting them down when they do not receive their budgeted funding. This was found to be the case in Morobo

County during the assessment. In Lainya, no participatory planning was happening but the CHD is expected to submit a budget to the county headquarters. Some counties, such as Yei, indicated that there was some community involvement, which happens sometime in June.

At the facility level, some of the facilities visited had an active VHC, (e.g., Sangua II). Although the committee does not have a schedule of meetings, they reported that they met as often as monthly. Loka West also had an active VHC. In other facilities, however (e.g., Munuki PHCC), the VHC reportedly met over three months prior to the assessment. The assessment team members were only provided with minutes of VHC meetings from Loka West. Of the facilities visited, no

Recommendations for Planning and Budgeting

- Orient CHD/county staff on the planning and budgeting cycle
- Make annual planning and budgeting guidelines available to county planning departments and CHDs.
- Adapt generic planning templates to fit the health sector.
- Facilitate community involvement in the budgeting process.

participatory planning and budgeting was taking place. Overall, there seems to be no standard practice when it comes to planning and budgeting, and even more so with use of a participatory approach.

Budget templates. Some CHDs (e.g., Lainya CHD) carry out budgeting and thus have a template. Others (e.g., Munuki PHCC) prepare ad hoc budgets with no standard templates. Some CHDs and facilities do not have templates whatsoever. However, at some locations, such as the CES SMOH, there exists a standardized electronic template that staff use for budgeting and that can be adapted for other levels of government. As in all CHDs and facilities visited, however, the states lack a system, either manual or electronic, to monitor expenditure levels.

Staff competence in planning and budgeting. In planning and budgeting, staff competence will ensure evidence-based allocation and use of funds in areas that are a priority to the community.

According to the PFM manual, in each county, a clear job allocation schedule shall be put in place for the various finance officers to effectively and efficiently handle all PFM tasks, including planning and budgeting. The PFM manual states that the competence of the individual should be taken into account when making the schedule.

The baseline assessment allowed 13 respondents involved in planning and budgeting to evaluate their competence in this area, with guidance from the interviewer, and the results are in Table 7.

Table 7: Competency of Staff Involved in Planning and Budgeting

Score	1	2	3	4	5
Number of respondents	4	6	3	0	0

Source: Survey data

*(Key: 1 Poor; 2 Fair; 3 Good; 4 Very good; 5 Excellent)

Table 7 shows that 10 out of 13 scored either poor or fair in planning and budgeting competency. If they are going to be able to implementing the required PFM systems, the staff will need to be trained in planning and budgeting.

Funds Control

Internal controls are procedures that ensure that an organization is (1) executing orderly, ethical, economical, efficient, and effective operations; (2) fulfilling accountability obligations; (3) complying with applicable laws and regulations; and (4) safeguarding resources against loss, misuse, and damage (Doe and Pattanayak 2008).

In order to manage risk, it is necessary to institute effective and efficient controls to ensure segregation of duties and compliance with policies. Such preventive actions include pre-numbering of key accountable documents (e.g., receipts and invoices), segregation of duties, authorization and approval of payments, and physical control over assets. Detective controls such as regular reviews and reconciliations are also necessary. Observed together, both preventive and detective measures act to deter undesirable events from occurring, as well as detect irregular acts and provide evidence that a loss has occurred.

Checks and balances. The current practices in the flow of funds in the MOH have implications for the proper control of funds throughout the system. Funds flow from the SMOFEP to the SMOH. From the SMOH, salaries are then channeled to the CHD. In CES, the SMOH transfers some funds for operations directly to selected facilities. These funds do not pass through either the county headquarters or the county health departments. This is in line with the State Planning and Budgeting Guidelines, 2013-2014, which states that for the ministries of education and health and the ministry responsible for water, the money flow is from the SMOF to the respective state ministries and then the funds trickle down to the respective county departments. In actuality, the structures created to enforce close financial controls at the county level are bypassed. With proper capacity, county headquarters can have closer oversight since they constitute smaller administrative units than the state.

Bank accounts. The assessment found that the two SMOHs had bank accounts. Of the six CHDs assessed, however, only Yei had a bank account and none of the facilities had a bank account. The CHDs and facilities therefore receive their money in cash, transport the cash to their facilities, and keep it on their premises.

All county headquarters visited had their own bank account. In Morobo, for example, the county headquarters reported that it operates two bank accounts: one for the headquarters and another for the education department. The CHD, however, did not have a bank account and so it receives its funds in cash. The CHD cashier distributes cash to its employees. Similarly, in most of the other counties visited, the CHDs did not have their own bank account. The cash-based system poses security risks, as cashiers have to travel long distances to pay health sector employees in payams and bomas. Some of the financial management staff at the CHD level mentioned that there are several risks to travel, including robbery and land mines.

Pre-numbered documents. Despite operating in cash, the CHDs and the facilities do not have guidelines for operating petty cash, nor do they have relevant pre-numbered forms to fill to request and surrender the petty cash. The rooms where money is kept are not fitted with security features, as observed at the SMOH in WES.

Authorization and approval. At the SMOH, the primary signatory is the director of finance and administration while the secondary signatory is the deputy director of accounts. Both of these individuals must sign to draw funds from the bank account. The accounts are reconciled monthly for the state-level account. In other cases, such as at Morobo county headquarters, the executive director, his deputy and the controller of accounts are the signatories. At least two of them must sign for a transaction. This introduces some control in the bank account.

Key Gaps

- Incomplete audits focusing on cash flow
- Lack of feedback to staff. This is not a transparent way of conducting an audit.
- The external audit is ad hoc and even when they come, they do not look at the whole financial system.

Reconciliations. The SMOF reviews the reconciliations. Some funding agencies, such as the United Nations International Children’s Fund (UNICEF), have opted to open a second bank account where funds are deposited for the ministry to finance earlier approved activities. At the CHD and at the facilities, the salaries and operations funds are not reconciled. When combined with the lack of audits, it becomes difficult to establish whether the funds are used for the intended purpose, or reach the right employees in the case of salaries.

Physical controls. This is the use of physical safeguards such as usage of cameras, locks, and physical barriers (e.g., burglar-proof doors, cash safe box, fire proofing, and even restricted access to protect property). This is particularly important given that the CHDs and facilities keep cash on hand. However, the baseline survey found that there are no safety features in place to protect cash at the facilities.

Competencies in various aspects of accounting: Financial managers should be competent so that they can assist with setting internal control measures and be responsible for operationalizing those internal controls.

Competent staff are more likely to maintain complete records that a manager can easily follow. With complete records, audits trails are improved and thus the auditor can arrive at an informed and more valuable opinion.

The baseline assessment allowed the respondents to do a self-assessment on their level of skills in the areas of bookkeeping, financial reports and technical reporting writing, adherence to RSS regulations in payment, custody of accounting documents, fixed assets management, and inventory management, all with the guidance of the interviewer. The results of the assessment are shown in table 8.

Table 8: Competency of Staff Involved in Areas of Financial Management Related to Financial Controls

Score Technical Area	1	2	3	4	5	Total Respondents
Bookkeeping	3	4	4	1	0	11
Financial and technical report writing	4	3	3	1	0	11
Payment: Adherence to RSS regulations	2	6	3	0	1	11
Custody of accounting documentation	4	5	1	0	0	11
Fixed asset management	5	4	0	1	0	10
Inventory management	4	6	1	0	0	11

Source: Survey data

*(Key: 1 Poor; 2 Fair; 3 Good; 4 Very good; 5 Excellent)

From the assessment, it is evident that competency is skewed toward one and two in all the areas. This indicates that there is a knowledge gap that needs to be filled. The staff should be trained in each of the thematic areas, and in line with the PFM manual.

Audit

To facilitate a good audit, the PFM guidelines prescribe that each service delivery unit shall maintain a *lever arch file* for filing all important accountability documents such as invoices, receipts, signed cash distribution forms, signed attendance forms, and activity reports. Such documents provide an “audit trail” for the expenditure made so that there is evidence of its adherence to procurement regulations.

Internal Audit

According to the PFM manual, the job of an internal auditor is to evaluate the effectiveness of the *fiduciary risk management* procedures, controls, and governance process. The PFM manual lays down the scope of work for the internal auditor: he or she assesses the efficiency and effectiveness with which the local government operations are carried out, reviews to provide reasonable assurance of reliability of the financial reporting, assesses the procedures used to deter fraud, and investigates fraud. The internal auditor also ensures that procedures are in place to safeguard assets from loss as well as examines the processes in order to provide assurance of compliance with the law and regulations. It is, however, clearly emphasized that the responsibility to set up the procedures lies with the county/state management.

Regular audits. This assessment revealed that the SMOH has an internal auditor seconded by the SMOF and domiciled at the SMOH offices for purposes of conducting routine audits. The internal auditor reports directly to the DG and minister, and the finance staff do not get any feedback/queries. However, at the CHD, there are no internal audits.

Completeness. The audit does not appear to cover the whole scope of work as laid out in the PFM manual. The only complete financial records available are for cash transactions, which the internal auditors examine closely. There are no records for fixed assets and inventory and hence no audits. For instance, staff in the WES accounts department stated that they are not conversant with the things in the store and that the records in that store are not up to date. This area is not audited.

External Audit

In the realm of PFM, an external audit is an independent assessment of public finances; it includes practical recommendations for promoting value for money spent that may result in a better quality of life for local people. In South Sudan, the guidelines direct that county accounts must be audited annually by the auditor general, or any firm approved by the auditor general, who should then submit his or her report to the mayor or county commissioner and the Legislative Council on those accounts. External audits must be carried out in accordance with internationally accepted auditing standards (IAAS), or other acceptable standards set by the auditor general. The audit report must be presented by the mayor or county commissioner to the Legislative Council within six months following the end of the financial year.

Regular audits. In practice, there are no annual audits at any SMOH or any of the counties and facilities. At the SMOH, external audits are usually not conducted unless a specific matter is being investigated.

Completeness. The audits, when they are conducted, according to WES SMOH staff, focus mostly on cash flow. To the extent to which an auditor can audit, he or she acts independently. The biggest challenge that an auditor faces is the lack of proper records to enable the formation of an informed audit opinion. The baseline assessment team was not able to obtain any auditors' reports. According to respondents at the CHDs (e.g., Nzaara), they do not control funds except salaries, hence the external audits are not necessary. They also noted that there is minimal financial activity taking place at the health facilities, which according to the interviewees, translates to lack of necessity for audits. There are neither internal nor external audits at the facilities. In effect, neither funds nor processes are audited. Best practices in PFM dictate that an audit happens not only to audit funds, but also to review processes and make recommendations on their improvement through a management letter.

Audit reports: A complete audit should illuminate the gaps that exist in the system to allow for improvement. For that reason, the process should be transparent and it is important that staff know what the audit results were. The baseline assessment reveals that, in some instances, like at the WES SMOH, staff do not understand what the auditors do; they are not informed of audit results, nor do they receive a copy of audit reports.

Financial Reporting

Financial reports are used by various constituents of society; as such, they should accurately reflect the affairs of an organization. Particularly, they need to assist in ascertaining the financial position of the organization for a specific period.

The PFM manual states that there is a need to ensure that timely and accurate financial data are available.

According to South Sudan’s PFM guidelines, the county governments, under which the CHDs operate, are supposed to submit four types of reports as shown in Table 9.

Table 9: Summary of Reports to be Developed by County Governments with Timelines

Report	Timeline	Remarks
Quarterly budget performance reports	Within 30 days of the end of the quarter	Submitted to the Executive Council, and to the State Ministry of Local Government for scrutiny at the County Transfers Monitoring Committee.
The half-year (quarter two) and annual (quarter four) budget performance reports	Within 30 days of the end of the quarter	Presented to the County Legislative Council.
Final accounts	Within three months after the end of each financial year	According to the PFMA Act of 2011, any public officers administering the accounts of any public organization must produce, sign, and submit to the relevant authorities the annual accounts report in accordance with the content and classification of the budget.
Audited accounts	Within six months of the end of the financial year	Section 85 of the LGA, 2009, requires that the final accounts of local governments are “audited annually by the Auditor General, or any other audit firm appointed by the Legislative Council and approved by the Auditor General.”

Source: Adapted from the PFM guidelines

The SMOFEP in Eastern Equatoria was developing a template for monthly reporting based on some work with the SMOH. This is in line with reporting standards from the SMOFEP and therefore should be applicable to all SMOHs. However, introducing this extra role for SMOHs will be a challenge if there is little expectation of an increased allocation through the conditional transfer mechanism (O’Neill 2013).

With some support, CES SMOH is in a strong position to introduce monthly reporting standards, given its relatively good budget execution systems.

Monthly reports. The SMOHs are required to send a monthly report to the SMOFEPs detailing what they have received, how much they have spent and on what, and the balance remaining.

The facilities to which funds are sent are also supposed to send reports to the SMOH and if they do not send them, they do not receive funds for the subsequent month.

Similarly, the facilities to which funds are sent are also required to submit comparable reports to the SMOH; otherwise, they do not receive funds for the subsequent month.

CHDs, Nzaara for instance, observed that they do not receive any funds for operations and thus do not submit financial reports.

Quarterly, half yearly, and yearly reports. Although the PFM manual recommends that quarterly and half yearly reports be prepared and submitted to the Executive Council within 30 days, none of the CHDs and facilities visited prepares or submits the reports.

Audit reports. Audits are irregular and incomplete. This means that audit reports are also not produced consistently.

Templates. The PFM manual includes generic templates for reporting; however, these templates are not implemented because of low reporting rates. Even those counties and facilities that do report, such as Munuki PHCC, employ their own format.

Staff competency in financial reporting. Like in any area of financial management, the quality of skills staff possess will affect their efficiency, as well as the quality of work they produce. Thirteen respondents were asked to evaluate their skills in financial reporting with the guidance of the interviewer. The results are tabulated in Table 10.

Table 10: Competency of Staff in Involved in Financial Reporting

Score	1	2	3	4	5
Number of respondents	6	4	2	1	0

*Source: Survey data

*(Key: 1 Poor; 2 Fair; 3 Good; 4 Very good; 5 Excellent)

In this area, 10 out of 13 respondents scored either “poor” or “fair.” These results point to a skills gap that needs to be filled for the staff to perform optimally with regard to financial reporting.

Procurement

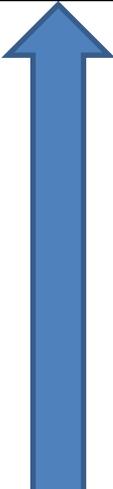
According to the PFM manual, the MOFEP, through its Directorate of Procurement, has oversight responsibility over all procurements by government institutions in South Sudan.

The desirable qualities of a good procurement system are transparency, competitiveness, and grievance resolution. The PFM manual clearly spells out the process to be followed for the procurement of goods and services to ensure the above qualities are met.

The Public Procurement Bill has not yet been passed by Parliament in South Sudan. The PFM manual was developed in anticipation of approval of the bill, but it was also made consistent with the existing framework set out in the Interim Public Procurement and Disposal Regulations, 2006, which currently form the legal framework for all public procurements and disposal.

Table 11 shows the various stages of the procurement process, and the various actors involved at each stage.

Table I I: Overview of Five Stages in the Procurement Process

What Stage		Who Is Involved?
5. Contract Close out		For general goods, payment of the supplier closes out the contract; for long contracts, the contract administrator advises the chief administrator to issue a completion/takeover certificate and any final payment is made by the director of finance.
4. Contract Administration		According to the PFM manual, the contract manager – the engineer or head of user department; procurement unit process pavement claims, the finance director and the chief administrator pay contractors/suppliers.
3. Solicitation & Selection		The procurement/logistic officer, tender evaluation panel, tender committee, chief administrator, and tenderer.
2. Requisition		User sector head/head of department, the chief administrator, and the procurement/logistics officer
1. Requirement		LG sector/department officials and various stakeholder groups during the annual LG planning and budgeting. For community-driven procurement, the members of the respective communities.

Source: Adapted from the PFM manual

Note: LG=local government

The PFM manual requires that all counties establish a procurement unit and a procurement committee. It also requires that counties establishment a procurement evaluation committee and ensures proper management of the procurement process. The PFM manual also provides guidelines on ethics in procurement, a complaints handling mechanism, and the criteria for how to correctly select suppliers.

Awareness on the procurement policies and regulations. Most staff members were unaware of the existence of the Interim Public Procurement and Disposal Regulations, 2006. During the assessment, the only time the regulations were available was at the WES SMOH, where one of the staff had a copy of the regulations. Even then, the guidelines were not being followed.

Procurement unit/officer. The finance and administration department handles procurements at the SMOH in both states. At the county level, none of the six counties had a procurement unit or a procurement officer, on which the PFM manual places a lot of responsibility.

Procurement oversight committees. In spite of the general requirement that a procurement committee be established for the purpose of having oversight over any procurement process, the baseline assessment revealed that procurement committees are more often formed on an *ad hoc* basis to handle specific tasks, after which they are dissolved. For instance, at the SMOH in CES, a procurement committee is only constituted when a major procurement is taking place, and the committee is dissolved afterwards. In most other instances, such as CHDs, there are no procurement committees.

Training on procurement guidelines. Among the staff interviewed at the CHD level, none had been trained on the Interim Public Procurement and Disposal Regulations, 2006. At the SMOH in WES, only one of the staff had been trained on the guidelines. This leaves a gap in the staff's competency and handling of procurements. Compliance with the guidelines also becomes a challenge without proper training. As a result, single or sole sourcing is a common practice and states are not getting the best value for their money.

Competency of the staff in procurement. Assessment findings indicate that out of the 13 respondents interviewed at the SMO, CHD, and facility level, eleven scored either “one” or “two” on a scale of one (poor) to five (excellent) with regard to their competency in the procurement process (Table 12). This means that some of the regulations on procurement likely are not being adhered to, due to low competency levels and lack of awareness.

Table 12: Competency of Staff in Procurement

Score	1	2	3	4	5
Procurement	7	4	1	1	0

Source: Survey data

*(Key: 1 Poor; 2 Fair; 3 Good; 4 Very good; 5 Excellent)

Since 11 of 13 respondents scored only one or two, it will be important for them to receive some training on procurement regulations and procedures.

Targeting Resources to Poor, Underserved, and Hard-to-Reach Groups

User fees or cost sharing fees are charges levied at the point of use for any aspect of health services. For instance, they may be charged as registration fees, consultation fees, fees for drugs and medical supplies, or charges for any health service rendered, such as outpatient or inpatient care.

The South Sudan Health Policy (2007–2011) and the RSS Interim Constitution (2005) prescribe that primary health care services shall be provided free at the point of consumption. Once the economic situation in the country substantially improves, the government plans to gradually introduce user fees for secondary, tertiary, and specialized health services. The revenue generated from such fees will be used to improve the quality of services provided to the people of South Sudan. According to the HSDP (2011–2016), an exploration of the feasibility of the gradual introduction of user fees, when and where appropriate, needs to be conducted. The results of the feasibility study would help the RSS develop guidelines for the introduction and management of user fees, which would be developed and disseminated to all levels of the health system.

Guidelines for introduction and management of user fees. These guidelines are yet to be developed and disseminated. However, results of the baseline assessment show that facilities collect cost-sharing money from the clients. None of the facilities we visited had pre-numbered receipts or any evidence of client payment, thus clients pay and do not receive any record. This constitutes a gap in accountability. There are no records of what was collected or what the money was used for. Financial controls need to be strengthened since it is currently not possible to measure how much money is collected or how it is used. This means it is not possible to reconcile or audit accounts. In addition, facilities do not have a policy on spending funds collected within the facility yet all collections received from patients are spent within the facility without any banking.

Segregation of duties. In some instances, such as at Loka West, there is no specific cashiers’ office where patients are supposed to pay for the services they received. Instead, the levy is charged at the point of service provision. This is a gap in segregation of duties. In some instances, staff admitted that the money collected is also distributed among the staff when they have financial difficulty, especially when salaries are late, or they need motivation.

Exemption criteria. According to the staff in the field, the fees for health services are supposed to be minimal in order to keep the services within reach of the population. Most facilities ask for SSP 2 for outpatient services. In order to ensure that the poor and vulnerable are able to access health care, fee waivers could be applied. Facilities face the challenge of designating a specific officer to decide who qualifies for a waiver and who does not. The fact that there are no objective criteria for fee waivers, e.g. all children below a certain age shall receive free treatment, further complicates the process. This lack of objective exemption criteria could affect the equitable access to health services.

Community involvement. According to the SMOH at CES and WES, any funds collected should be used to develop the facility in consultation with the VHCs, or to purchase extra supplies that may be needed at the facility. However, at many facilities, the VHCs are not regularly involved in decision making for they may not meet frequently enough (as is the case in Munuki PHCC). In other cases, such as at Loka West, even when the VHC meets, they do not create plans and budgets; instead, money is used for gaps that come up without consultation with the VHC.

3.2.3 Health Financing Recommendations

Funding mechanisms. As contained in the HSDP, without additional investment of financial and human resources in the health system, health personnel, and the corollary of appropriate, acceptable, and accessible service delivery facilities, South Sudan will most likely fall short of HSDP targets. In order to achieve the HSDP objectives and reach optimal health for every South Sudanese citizen as entitled by the constitution, there is an obvious need to invest more in health and put in place a sustainable model of financing health care. There is also a clear need to strengthen the PFM system to enhance the health sector's ability to plan and execute budgets.

Planning and budgeting. There is a need to increase community involvement in the budgeting process, where the lower level informs the upper level of the priorities. It is imperative that standardized planning and budgeting tools along with a tool to monitor fund expenditure is developed to allow for comparisons between states and county's from year to year. This requires that staff are trained on planning and budgeting.

Funds transfer. Objective criteria on how funds received by the SMOH will be allocated to the CHDs and facilities are needed. Some of the factors to be considered include the population of a county and the catchment population of a facility. Greater clarity is also needed to show how the funds flow from the SMOH to the CHDs.

Controls. South Sudan's reliance on a cash system presents serious security risks and makes the health system vulnerable to irregularities. The institutionalization of checks and balances in the system will address some of these vulnerabilities and the need for documentation, while at the same time help build staff competency in their areas. It is necessary to institute the use of pre-numbered financial documents and to have proper custody of all records. For funds kept in cash, physical controls such as restricted access, cash safe boxes, burglar-proof doors, and security cameras should be installed. With over 60 percent of respondents scoring either poor or fair in any of the categories, it is important to train and mentor the staff to increase their competence so they better understand development and implementation of internal controls.

Audit. In order that audit reports can provide a true and fair view of the units, the scope of the audits should be widened to include audit on fixed assets, inventory, debtors, and creditors, as well as compliance to the stipulated laws and regulations on PFM. In addition, in order to promote sound financial management and proper record keeping, annual audits should be conducted at both the state and county levels.

Procurement. At the SMOH and CHD levels, procurement oversight committees should be constituted, trained, and strengthened to offer oversight to procurement activity taking place in their respective organizations. Staff involved in procurement should be trained on the provisions of the Interim Procurement and Disposal Regulations, 2006, as well as on procurement provisions as per the PFM manual and general best practices in procurement.

Reporting. To provide information that can be used for decision making at the state and central levels, it is important that there is a PFM information system that facilitates data capture and reporting. Facilities use such a system to record and report information. The system should have templates for standard recording of data as well as templates that report information into the rest of the system in a manner consistent with PFM requirements.

Revised Year One Indicators

Based on the findings from the baseline assessment, we have revised one of the health financing indicators in the Year One PMP as follows in table 13:

Table 13: Proposed New Year One Indicators

Health Financing									
Indicator #	Indicator	Definition	Indicator Type	Baseline	End of YRI Target	Data Source	Method of Collection	Frequency	Person Responsible
13	Number of budgets developed and approved for use at state and county levels	The number of budgets developed and approved for use at state and county levels	Process	n/a	2	Program records	Program monitoring	Once	Health Financing Advisor, M&E Specialist

Revised Five-Year Indicators

Based on the findings from the baseline assessment, the following new indicators in table 14 are proposed for inclusion in the Five-Year PMP:

Table 14: Proposed New Five-Year Indicators

Health Financing												
#	Indicator	Definition	Indicator Type	Baseline	Y1	Y2	Y3	Y4	EOP	Data Source	Method of Collection	Frequency
1.	Number of CHDs with evidence of collaboration with county offices in planning and budgeting	The number of CHDs with evidence of collaboration mechanisms between CHDs and county offices, i.e. that the county offices involves the CHDs in planning and budgeting and there is documentation of the communication and feedback between the CHD and the county office	Out-come	0	0	6	9	12	16	Correspondence between county offices and CHDs and other admin records, e.g. letters, e-mails, reports, minutes of meetings, etc.	Document reviews	Annually
2.	Number of CHDs submitting monthly financial reports to the county commissioner’s office using local government PFM reporting templates	The number of CHDs submitting monthly financial reports to the county commissioner’s office using local government PFM reporting templates	Output	0	0	6	9	12	16	CHD admin records	Document reviews	Monthly
3.	Number of CHDs with county health strategic plans	The number of CHDs with county health strategic plans developed	Out-come	0	0	6	9	12	16	CHD records	Document reviews	Annually
4.	Number of CHDs from which staff have been trained on various themes in PFM, by number and theme	The number of CHDs with an implementation plan for their county health strategic plan	Out-come	0	0	6	9	12	16	CHD records	Document reviews	Annually

3.3 Human Resources for Health (HRH)

3.3.1 Background Information on HRH in South Sudan

South Sudan’s HSDP identifies adequate HRH and service delivery facilities accessible to the community, as the two most critical factors for achieving the vision of a healthy and productive population. In 2009, the BPHS called for decentralization of service delivery and management. However, although more than 90 percent of South Sudan’s population of 8,260,490 lives in rural areas, the plan estimates that only about 10 percent of civil service posts are filled by qualified health workers, and these workers are concentrated largely in urban areas (Southern Sudan Center for Statistics and Evaluation 2009). Human resource management systems are characterized as weak on all fronts, and have contributed to high staff turnover and absenteeism (RSS 2013b). To address these issues, the HSDP commits to a sustained focus over the next five years of enhancing the HRH production, performance, and productivity to ensure adequate numbers of health workers with the right skill mix.

The HSSP’s mandate in HRH is to support the RSS’s commitment to enhancing HRH at the state and county levels through developing the capacity of SMOHs and CHDs for planning, allocation, and management of human resources. HSSP will provide technical assistance to rationalize the HRH workforce planning and cost forecasting, improve human resource management, review and update HRH policies, and improve quality and health system performance. Upon the conclusion of the HSSP, the CES and WES SMOHs and CHDs will be able to maximize efficient and effective use of the available resources to ensure the BPHS is delivered by appropriate skilled, well-distributed, and motivated human resources.

The HRH baseline assessment was completed at the state, county, payam and facility levels. Interviews were not conducted at the boma level, as HSSP determined through consultation with stakeholders that the boma does not play a significant role in the management of HRH. In-person interviews were conducted with all staff members available at the SMOH, CHD, county commissioner’s office, payam office, PHCC, and PHCU that claimed responsibility for any aspect of HRH management or training. The titles of staff members performing HRH management or training roles varied slightly across the interview locations, with the greatest variation at the county level. A total of 27 interviews, which lasted approximately 1 to 1.5 hours each, were conducted, as shown in Table 15 below.

Table 15: Interview Respondents, by Title

Title	(#) in WES	(#) in CES
State Ministry of Health		
Director of Finance and Administration		1
Director/Deputy Director of Training		2
Establishment Officer	1	
HRIS Officer	1	
County Commissioner Office		
Director of Planning and Budgeting		1
Establishment Officer		1
County Health Department		

Title	(#) in WES	(#) in CES
Director	2	1
Director of Finance and Administration		1
M&E and Surveillance Officer	1	
Senior Establishment Officer		1
Medical Officer		1
Public Health Officer		1
Facility and Payam		
Primary Health Care Center or Unit In-Charge	4	4
Payam Director	2	2

Note: HRIS=human resources information system

3.3.2 Key Findings: HRH

This section provides a description and analysis of the information gathered from the country HRH assessment. The key findings regarding the roles, responsibilities, and functionality for HRH activities at the various levels of government (state, county, and payam) and the facility service delivery level are presented. Reflected in these findings are highlights of key systemic strengths that should be supported for greater impact and important gaps that exist within the government and facility systems.

Government Roles and Functions in HRH

The RSS is currently working to respond to the 2009 call for decentralization of service delivery and management for the BPHS. National policy documents and interviews with respondents provide further delineation of the current division of roles and functions between the levels of government institutions.

- The national MOH provides the health sector with the overall strategic direction and sets policies and procedures for the governance of the sector (e.g., HRIS, compensation structures, recruitment processes, and pre-service training).
- The SMOH is the critical link between the national MOH's vision and policies and the implementation that occurs within the counties. SMOH translates the national MOH's strategic priorities into practical strategic plans, determines workforce needs, makes final decisions on hiring, and oversees HRIS, payroll, and training.
- The CHD is responsible for the delivery of services through health facilities and working with the county commissioner's officer for planning and budgeting.
- The boma, payam, and health facilities are responsible for direct management of the health workforce providing services to the community.

The specific roles and functions of the different levels of government institutions in the six key HRH areas outlined in this report – HRH strategic planning; staff complement and shortages; HRIS; performance management; workforce recruitment, deployment, and compensation; and workforce training – are included in Table 16.

Table 16: HRH Roles and Functions by Government Institution

Government Institution	HRH Role and Function					
	Strategic Planning	Staff Complement	HRIS	Performance Management	Recruit, Deploy, Compensate	Training
MOH	Develop country strategic direction for health	Set national staffing standards based on BPHS	Own and oversee implementation of the national database (JICA)	Set employment policies (Public Service)	Set recruitment processes, compensation structures; release payroll to states	Sponsor training for health workers; manage some training institutions
SMOH	Develop three-year health strategy for state	Determine workforce gaps using payroll data and staffing standards	Oversee collection of payroll data and data entry	Maintain confidential staff files; final approval of promotions	Advertise for recruitment and make final hiring decisions; maintain payroll roster; process and release payroll to counties	Develop training plans; distribute training opportunities among counties; support training institutions; sponsor some trainees
County Commissioner Office	Support to CHD for strategic planning; integrate all county strategies for submission to state	Monitor county workforce and report to state	No role.	No role in health sector	Support appointment, implementation of workforce policies, incremental pay, etc., in accordance with Public Service	Support training planning
CHD	Develop CHD strategy with workforce requirements	Provide SMOH updated payroll information and capacity gaps	Some CHDs facilitating data collection (currently using payroll data)	Review facility recommendations for promotions; review attendance records	Advertise positions; recommend candidates to state; deploy new hires; dispense salaries	Analyze training needs; recommend individuals for training
Payam	No strategic planning	Provide county the payam staffing capacity and needs	No role	Recommend individuals for promotion	Recruit casual labor for program objectives; notify CHD and county commissioner of hiring needs	Submit training needs to county
Boma	No strategic planning	Provide county the boma staffing capacity and needs	No role	Recommend individuals for promotion	Notify CHD and county commissioner of hiring needs	Submit training needs to bounty
Facility	No strategic planning	Notify CHD of vacancies	Complete data forms	Recommend individuals for promotion; keep attendance registers	Notify CHD of hiring needs	Submit training needs to bounty

HRH Strategic Planning

Key Strengths and Opportunities

- Strategic planning for HRH is occurring fairly consistently at the state level, ranging between every three years for the health strategic plan to annual updates for the training plan.
- Counties, payams, and bomas were invited to provide input into the state strategic planning process, although input has fallen off recently due to lack of resources for implementation follow-through.
- The defined staffing standards, based upon requirements for delivery of the Essential Health Package, provide a clear reference point for determining workforce gaps. There were high levels of awareness of the staffing standards among sources at both the state and county levels, with indications that they use the standards as the base to determine the workforce gaps.
- Strategic plans are shared with partners through interagency and stakeholder meetings.

Key Gaps

- The scope of the strategic plans for HRH is limited to determining the gap in workforce numbers.
- Payroll information is used to determine staffing numbers, but several sources noted payroll is inconsistently updated and does not provide information on the qualifications of the staff.
- Strategic plans are not implemented, ostensibly due to severe budgetary limitations.

Overarching Findings in HRH Strategic Planning

Further information on the strategic planning processes at the state and county levels is included in the Health Financing section of this assessment report.

Strategic planning for the required staff complement is based on national staffing standards required by the 2009 BPHS, summarized in Table 17. All states and counties conducting strategic planning exercises used these standards to determine their workforce gaps.

Table 17: Required Staff Complement for the BPHS

Job Title	CHD	PHCC-Comp.	PHCC-Basic	PHCU	Payam Health Dept.
County Medical Officer	1				
Disease Surveillance Officer	1				
M&E Officer	1				
County Nursing Officer	1				
Clinical Officer		3			
Medical Assistant		2	2		1
Enrolled/Community Certified Nurse		5	3		
Community Midwife		2		2	
Theatre Assistant		2			

Job Title	CHD	PHCC-Comp.	PHCC-Basic	PHCU	Payam Health Dept.
Nutritionist	1	2	2		
Laboratory Assistant			2		
Pharmacy Assistant	1		2		
Dispenser		2	2	2	
Statistical Clerk		2	2	1	
Public Health Officer					1
Field Staff (Nurse, Public Health Technician, and Nutrition Assistant)		3			
Health Education and Promotion Officer					1
Community Health Worker (Vaccinators)		2	2	2	
Maternal Health Coordinator					1
Guard/Cleaner		2	2	1	
Support Staff	2				1
Total	8	27	21	8	5

Source: MOH (2009)

State Ministry of Health Findings

Strategic Plan. The SMOH has primary responsibility for strategic planning. Both states have developed health strategic plans, which include a component on HRH. The CES SMOH reported developing a three-year plan for 2012–2015 that had not been approved by the Council of Ministers yet. In the WES SMOH, a strategic plan was developed in 2010, but was not implemented, and subsequently was lost when the laptop containing it was stolen. In addition to the overall health strategic plan, the CES SMOH develops annual strategic plans for pre-service training, which are updated as needed because of emergencies such as outbreaks. The HRH component of the strategic plans focuses on the number of staff required and provides information on the number of individuals that must be trained to meet these staffing requirements. The plans do not specify recruitment or deployment strategies.

Planning Process. A board of directors is responsible for developing the strategic plan. Each unit develops a plan, and the board of directors integrates this into the SMOH strategic plan. The CES SMOH reported that it is now incorporating strategic plans from the counties and incorporating input from the payams and bomas to inform the strategic plan. Previously it developed the strategic plans without input from the counties, especially as the cost of bringing county representatives to the state for planning is prohibitive. The state is now considering sending representatives to the counties for strategic planning.

Data Sources. The states compare the staff numbers, based on payroll data, to the staffing requirements defined for the BPHS (2009). At the CES SMOH, the HRIS is used as a tool to determine where gaps lie.

Stakeholder Involvement. Some stakeholder input is sought in the development of the strategic plans, particularly from development partners such as the World Health Organization (WHO), UNICEF, and USAID, as well as smaller NGOs when discussing an issue of particular concern to them. Upon completion of the 2012–2015 plan in CES, a stakeholder meeting was organized by the national MOH to

disseminate the information and coordinate funding and implementation. In WES, the strategic plan was shared with the DG, but not distributed further.

Prioritization and Budgeting. The strategic plans were informally prioritized in both CES and WES, based upon two factors: emerging urgent needs and financial resources. Although budgets were developed for the strategic plans, the SMOHs do not receive resources from the Finance Department based on their budget request. The SMOHs must lobby NGOs for resources and follow up with the Finance Department, but the financial resources they receive provide only for salaries, with little leftover for operational costs. The priorities for the CES SMOH fall as (1) salaries; (2) service (e.g., maintaining cars); (3) development (e.g., building new PHCCs); and (4) training (although it was noted that training requests are rarely respected). In WES, the money received from the national MOH covers only the 814 classified staff in the state, but the state maintains a payroll of 1,053, including unclassified staff. The state must negotiate with the MOFEP to cover the gap, leaving little for operations. CES faces similar financial challenges.

Implementation. In both CES and WES, implementation has not occurred, with the exception of initiatives directly funded through the national MOH, such as training individuals outside the country, or post-graduate studies. CES has been able to sponsor a few individuals for training at the Health Sciences Institute, while WES has been able to obtain sponsorship for training from NGOs.

County Health Department Findings

The counties were mixed in their approaches to strategic planning. Three respondents reported that they did engage in strategic planning. One of these counties, located in CES, has an annual process that includes all departments within the country. They visit the payams to find out what is lacking and use the needs they discover there to determine the plan. In addition, the state occasionally gives them priorities to plan around. The HRH component of the strategic plan is focused on staffing gaps. The county works with planners, the establishment officer, and the executive director from the county commissioner's office to finalize and budget the plan. The SMOH and Ministry of Local Government usually call this county for information to inform their strategic plan, although last year the state did not ask for input because the severe budget limitations discouraged strategic planning, and this year the county is still waiting for approval from the state. When the plan is completed the county also shares it with NGOs working in the county to obtain support for implementation. The other county that reported having an HRH strategic plan included it as part of its annual plan. An NGO assisted with the planning process, which centered on identifying and prioritizing the health workers that were required within the county. There was no budget attached to the plan. Both counties reported that the budget was the primary limiting factor for implementation.

The balance of county-level respondents (seven) reported that they saw strategic planning as the responsibility of the state and had no county-level strategic plan. Of these, three reported that they assisted the states in their strategic planning processes by providing their workforce needs. One county noted that, as there is no budget for implementation, those who plan, "plan just to be busy."

Payam Findings

The payams are sometimes invited to take part in county strategic planning, and Muniki Payam, which supports a large number of cleaners for the health facilities, develops annual budgets for their staff.

Facility Findings

The facilities reported no involvement in strategic planning.

Staff Complement and Distribution

Key Strengths and Opportunities

- Plans are being finalized to upgrade the quality of nurses and midwives serving in the country.
- Policies for gender equity are increasing the number of opportunities for women to be trained for and service in government posts.
- Staff are committed to their posts. Many served in the war together and feel committed to serving their new country with their fellow former servicemen.

Key Gaps

- Information on the actual number and mix of staff by facility is limited and difficult to obtain.
- Both counties reported difficulty meeting the staffing minimums stipulated by the BPHS, had misdistribution of staff favoring urban areas, and had high vacancy rates.
- Due to unrest during the war and current staffing shortages, many health workers are performing jobs for which they are not qualified. A workforce capacity assessment has not been conducted to assist in standardization of titles and qualifications.
- While women make up at least half of the health workforce, there is a dearth of women in higher positions, particularly in management positions at the state and county levels.

Overarching Findings in Staff Complement and Distribution

Staffing Shortages. Respondents at all levels reported severe staffing shortages within health facilities, but even the SMOH and CHDs were not fully staffed. The HSDP reports a ratio of 1.5 physicians and 2.0 Nurses/Midwives for every 100,000 citizens. The CES Strategic Plan 2012-2015 summarizes staffing shortages by county as shown in Table 18. The WHO recommends 230 doctors, nurses, and midwives per 100,000 citizens to deliver essential MCH services (WHO 2013). The HSDP notes that these cadres are disproportionately based in urban areas, and our interviews confirmed that the distribution of more skilled cadres was skewed toward urban areas. For example, of 1,053 staff in WES, 667 work in urban areas (SMOH, Yambio Hospital, Lui, Miridi, Nzara Hospital, and Tumbara Hospital). The mix of classified and unclassified staff was unavailable for the WES urban/rural analysis. In CES, physicians were concentrated in urban areas (90 versus 67 in rural), while 106 nurses served in urban areas versus 203 in rural areas. However, the distribution of nurses by qualification was unavailable, making further analysis of the skill level of the nurses serving in rural areas impossible.

Table 18: Health Facility and Health Workforce Indicators in CES, 2008/2009

Facility & Workforce Ratios	Terekeka	Juba	Lainya	Yei	Morobo	Kajo-Keji	CES
Hospitals/Population	-	1:92,109	-	1:201,443	-	1:196,387	1:183,926
Health Facilities/Population	1:2,674	1:1,401	1:3,308	1:1,722	1:3,837	1:3,069	1:1,999
Doctors/Population	-	1:4,139	-	1:40,289	-	1:98,211	1:11,376
Nurses/Population	1:11,106	1:1,032	1:8,932	1:2,289	1:14,800	1:2,398	1:1,981
Midwives/Population	1:13,125	1:2,856	1:14,886	1:16,787	1:34,534	1:10,912	1:6,165

Source: CES (2012)

Staff Qualifications. The level of qualifications of the current workforce is of great concern to management at the SMOH and CHD levels. A respondent noted that, due to the severe staffing shortages, the MOH has encouraged the acceptance of health workers applying for positions regardless of their qualifications. Staffing lists developed from payroll data do not contain information on qualifications, and the qualifications contained in the Japan International Cooperation Agency (JICA) human resource database are incomplete and have not been validated. Anecdotally, there are large numbers of health workers who have claimed titles without the requisite qualifications. As a result of the war, the health workers currently serving have a wide variety of degrees from many different countries and training institutions, and many have learned and advanced on the job to positions well beyond their formal level of education.

Workforce Capacity Assessment. There is no workforce capacity assessment tool in use. Assessments of training needs are done by the Training Department, and results are sent directly to the DG in collaboration with the director for human resources. In addition, the director of primary health care requests the facility in-charge to confirm that the staff that are supposed to be working in the facility are currently there.

Cadre Changes. There has recently been a shift in the cadres approved to practice within South Sudan. Community health workers, village midwives (12-month training), and traditional birth attendants (two-month training) are being phased out of practice. They will be replaced by enrolled nurses and enrolled midwives.

Gender. Women make up the majority of the workforce on SMOH payrolls; however, respondents stated that most of these women held lower-level positions than men, including unclassified positions. Only three women held positions as a CHD director, M&E/surveillance officer, or accountant in WES, and none had such positions in CES. However, a gender analysis of information provided by interviewees on the classified staff in CES found male physicians outnumbered females (95 to 62), but were greater or equal in other professions (116 male nurses to 193 female, 1 male midwife to 24 female, 4 male pharmacists to 5 female, and 42 of each gender serving as laboratory technicians). A thorough workforce analysis is required to accurately determine gender distribution. New policies to encourage gender equity in the workforce are in place, giving women new opportunities to be trained for and serve in government posts.

The SMOHs were readily able to provide information on the total staff complement working in the public sector, including classified and unclassified staff, within the state, based upon payroll figures. The

SMOHs were also able to name the medical officers serving within the state. CES's director of primary health care was able to provide the breakdown of staff by cadre and gender; figures by cadre but not gender were provided in WES by the HRIS officer, based upon the JICA human resources database. The distribution of staff within facilities was difficult to obtain. Information on the health workers in the private sector was entirely unknown. Both states noted that getting updated information regarding the actual staff working on the ground was problematic due to rare facility visits and infrequent and inconsistent information sharing.

County Health Department

Counties relied on payroll data to provide staffing numbers. All respondents could give the total number of staff in the county from memory, and many could also list the physicians working in the county. The total breakdown by cadres was not available in most of the counties visited, however. Counties were aware of the faith-based facilities in their counties and listed the number of staff they were supporting in each facility, but they did not know the total number of staff working in the private sector facilities. All counties reported that they had significant vacancies, but did not have the budget to hire additional staff.

Payam

The payams have extremely limited health staffing. By far the most comprehensive of those interviewed, Muniki Payam, had an establishment officer responsible for the payam staff, which includes 85 cleaners employed by the payam to clean health facilities. Other payams were limited to having only a public health officer and sometimes an assistant.

Facility

Most health facilities assessed were operating with a minimum of staff. In several facilities, vacancy rates were close to 50 percent.

Human Resource Information Systems

Key Strengths and Opportunities

- Efforts to establish an HRIS have been championed at the national level, leading to a national human resources database that is used by the states.

Key Gaps

- States and counties rely nearly exclusively upon payroll data for information on the workforce.
- A database has been developed and implemented countrywide, but trust in the database is low due to poor quality data-collection techniques and incomplete/unverified data.
- The existing HRIS is a database rather than a system, limiting access to the data for real-time data use at the state and county levels.

Overarching Findings

At each level of the health system, our interviews revealed almost no awareness of a human resource information database or system, although the JICA has been working in the country for several years to

establish such a database. JICA has partnered with the MOH to develop the database, through the office of the Director of Human Resource Management.

HRIS Database Design. The JICA HRH database is a Microsoft Access database housed at the MOH level. Trained HRIS officers at the SMOH are responsible for maintaining the database and sending regular reports for integration into the national database. The database captures a number of indicators on all staff employed in the health sector, both public and private:

State, Health Facility, County, Payam, Department, Staff Name, ID or Passport Number, Staff ID No., Staff No., Social Status, Gender, Number of Family Members, Date of Employment, Engagement, Date of Birth, Place of Birth, Job Title, Health Professional Qualification, Qualification Country, Qualification Year, Nationality, Grade, Degree/highest level of education, Name of School Attended, Year Graduated, Residence Status, Address, Employer, Status at work, Contact, Retirement, Date of Retirement, Reason for Retirement

The back-end of the database is complex, but it is capable of producing a number of reports for use in human resource planning, management, and budgeting. The JICA project team has begun to write a user manual, which they expect to complete before the project ends in June 2013.

HRIS Database Data Collection. The JICA project was funded to develop and manage the database at the central level. However, the project did not have sufficient funding to collect the data, and instead relied upon CHDs and NGOs to collect and return the data using a structured data collection form. JICA provided short trainings to the staff members who would be collecting the data. Some counties sent the data forms with the clerk who dispensed salaries. Others gave the forms to the payams and asked them to ensure the forms were completed. Still others had the NGOs ensure the forms were completed. The county representatives return the paper forms to the SMOH HRIS officer when it is convenient for the representative.

HRIS Database Comprehensiveness and Updates. As a result of the informal data collection processes, there is significant variation in data quality and completeness. Counties that trained the clerks who dispensed salaries had the highest return rate. Forms were initially completed in 2011, and processes to update the information are still nascent. WES is considered one of the most advanced states in the country, but the officer there believes that the data are only about 75 percent complete and contain many inaccuracies and missing information. CES is considerably further behind. Information on individuals' professional qualifications is often missing or inconsistent with the training their job titles would imply. Database numbers are inconsistent with the official payroll numbers from the states for reasons that have been hypothesized but not verified.

HRIS Data Sharing and Use. The problems with data collection procedures, as well as the inconsistencies between database and payroll figures, have contributed to a widespread distrust of the database information. The WES HRIS officer reported only five inquiries for data in the last year: two each from the state hospital and the SMOH, and one from a development partner.

Data are sent from the SMOH to the MOH electronically for inclusion in the database. JICA has limited data sharing with the counties, providing only hard copies to them upon request. Information is not shared with the facilities.

HRIS Database Findings. The development of the database has highlighted a number of systemic issues within the workforce. Over 700 titles were identified when the database was initiated in 2011. JICA developed a rudimentary structure to facilitate categorization; however, the categories were not approved by the MOH. In May 2013, JICA redeveloped a categorization structure, based upon WHO standards and differentiated by education level. The new structure is under review by the MOH, but requires further refinement for use.

Health workers are also claiming titles for which they do not qualify. The health workers have a wide variety of educational backgrounds and training, and many have advanced in titles well beyond the level they are qualified for. For example, the database lists medical officers who have only secondary school degrees. Due to limitations in the data collection, it is impossible to know whether such medical officers failed to produce evidence of a degree but are actually qualified, or have claimed a position for which they have not been trained.

HRIS Database Sustainability. JICA is set to close operations in June 2013. To date, a long-term succession plan has not been determined. The MOH is keen to continue the database; however, issues with buy-in at the state and county levels have limited its impact on HRH planning, budgeting, and training. As a result, negotiations with potential partners for support of the database are ongoing and the outcome uncertain.

State Ministry of Health

Findings regarding an HRIS at the SMOH level were mixed. The director of training at the CES SMOH acknowledged the JICA database, and stated that he used the information to assist in his annual planning cycles. The other respondents stated that the only staffing information available was from payroll data.

County Health Department

The counties do not have access to an HRIS, and they typically rely on data from payroll. Yei County reported receiving monthly reports from facilities on their staff, including attendance registers. Although CHDs are allowed by law to go collect information from the facilities at any time, most CHD respondents did not feel it necessary as they are able to gather the information from the health workers who visit the county regularly.

JICA Database. Staff from one county reported that they had received training from JICA on how to complete the data forms for the JICA database. The CHD staff reported, however, that they still had the forms sitting in their office, as they had not found time to complete them. The county's partner NGOs were supposed to assist in completing the forms, but have also not been able to find the time or resources to complete the forms.

Payam

There is no HRIS at the payam level.

Facility

Facilities are responsible for reporting changes in staffing to the CHD.

Performance Management

Key Strengths and Opportunities

- Criteria for promotion were reported uniformly by respondents: promotions are instigated by facility in-charge recommendations and are based on attendance registers and facility in-charges' perception of employee performance.
- Attendance registers are reported to be kept faithfully by all facilities. Absenteeism rates are uniformly reported to be low – between 0 and 5 percent.
- The Medical Council Act, Nursing Council Act, and Allied Health Cadre Act have been submitted to the Ministry of Legal Affairs and will be approved by parliament to allow the creation of professional councils for the regulation of training institutions and health care providers.

Key Gaps

- Promotion opportunities do not happen regularly for all facilities. Responses to questions regarding the promotion cycle varied between annually, every four years, or only upon the death of an incumbent.
- Employees do not undergo a formalized and regular performance review, and as a result do not get regular performance feedback. Promotions are based on the in-charges' report when requested for recommendations, rather than annual performance review results.

Overarching Findings

Professional Councils. Professional councils provide oversight of the quality of the health workforce. Prior to independence, South Sudan relied upon the legal frameworks and professional councils of the north. Since its independence, South Sudan has not had a regulatory framework to ensure the quality of the health workforce. Recently, the Medical Council Act, Nursing Council Act, and Allied Health Cadre Act were submitted to the Ministry of Legal Affairs and it is expected that they will be approved by Parliament to allow the creation of professional councils for the regulation of training institutions and health care providers.

State Ministry of Health Findings

The SMOH is responsible for all health facilities in the state. However, the states are not involved in the performance management of the facilities that fall under county jurisdiction. Some large hospitals, such as the Children's Hospital in Juba, fall under the SMOH's purview. However, the SMOHs do not have performance management plans for the staff and are limited by transportation issues in their ability to check performance at the facilities.

Performance Appraisals. Performance appraisals are not completed. The state maintains confidential files on staff, as do the counties, which document serious performance issues. The establishment officer in WES SMOH has requested the SMOH begin doing annual reports on staff, but the request has not been acted upon.

Promotion. The SMOH makes the final decision on staff promotions, based on the confidential recommendations made annually by the CHD. CES SMOH noted that promotions happen occasionally,

while WES SMOH has not been able to give promotions or incremental pay increases since the beginning of the ministry due to budget constraints.

County Health Department

Supportive Supervision. The counties do not have performance management plans, but some plan and implement supportive supervision, as transport permits. The counties using supportive supervision listed this as their primary tool for performance management of facilities and staff. For further information, reference the Supportive Supervision section of this assessment report.

Attendance Registers. All counties noted that it was their role to check the attendance registers. For counties not doing supportive supervision, the attendance registers were viewed as the primary tool for ensuring performance.

Promotions. The counties make recommendations to the state for promotions of staff. They conduct an appraisal of the individual through speaking with the staff member's supervisor and reviewing attendance records. One county noted that appraisal forms are provided by the SMOH, and the completed records are kept at the SMOH. Two counties reported doing the appraisal and promotion process annually; the others reported a very irregular schedule with extremely limited promotion opportunities.

Payam

Performance management at the payam level is limited to supervisor oversight of the payam's employees and day laborers.

Facility

Management of staff at the facility level is conducted by the facility in-charge. The in-charge ensures that the staff members do their job with a good attitude and quality, and notes any performance problems to the CHD when asked for recommendations for promotion. In addition, the in-charge tracks the health workers' attendance.

Absenteeism. Facilities are given an attendance record from the CHD. Staff members are required to sign in and out each day. Absenteeism was uniformly reported to be low by facility in-charges – from 0 to 5 percent. In-charges noted that staff is sometimes late, but they do not fault them as the low salaries mean staff must use unreliable transportation. In-charges at facilities that have a mix of government and NGO staff members report lower motivation and greater absenteeism among government staff.

Performance Issues. If a staff member has a performance issue, the facility in-charge usually handles the problems in-house, speaking to the individual about the performance issues. If an employee fails to show up, the facility in-charge initiates a formal process of written warnings and reporting to the CHD.

Promotion. The facility in-charge is asked to present recommendations to the CHD for promotions during semi-regular promotion periods. In addition, staff members who have completed additional training can request promotion by writing a letter to the county administrator. The facility in-charge presents its impression of the health worker's performance and their attendance records for consideration by the county. Some facilities reported that they had received promotions in the recent

past (on an annual or four-year cycle), while others stated that it had never occurred – promotions only happened when someone else left a post or died, opening up an opportunity.

Workforce Recruitment, Deployment, and Compensation

Key Strengths and Opportunities

- Policies have been established for providing the workforce with allowances. When austerity measures end, the MOH is in a strong position to have the allowances reinstated.
- Salary structures are uniform, based upon Public Service pay grades.
- Recruitment has begun to be decentralized to ensure that health workers are recruited from their home areas for improved retention.
- Despite resource limitations, many respondents listed strong intrinsic motivators. In addition, a number of the staff, particularly at the SMOH and CHD levels, had worked together during the war, leading to strong relational ties with their co-workers.

Key Gaps

- Salaries are uniformly low, and salary payments are frequently delayed. With inadequate and infrequent income, most health workers must farm to ensure they are able to support their families. The low salaries contribute to migration to higher paying NGOs.
- Salaries for many counties are physically carried from the state to the facilities at great personal risk for the individuals carrying the funds, and also at risk of attrition of funds.
- Although employment policies do exist, developed through the Ministry of Public Service, awareness of the policies is extremely low at all levels.
- Recruitment and deployment is driven nearly entirely by availability of funds rather than a rationalized hiring and deployment plan based upon population health needs.

Overarching Findings

Compensation. Compensation structures are uniform, but extremely low. All staff members responding noted that the salaries did not cover basic expenses. Staff at all levels must farm to supplement their salaries. Due to infrequent promotions, salaries do not reflect the number of years served or the quality of service. Salary structures in NGO's are usually significantly higher. For example, one NGO, which has subsequently completed its project, had a salary scale that paid drivers within its facilities the same salary as the government pays directors within the CHD.

Allowances. There are no allowances provided to staff within the ministry. The policies for allowances exist (transport, infection, and accommodation), but have been suspended due to austerity measures. Numerous staff noted that MOH staff still receive allowances; however, this claim could not be verified.

Salary Delays. Salary payment delays are extremely common, and may range from one week to two months. The government's austerity measures have delayed the allocations from the MOFEP to the states. Revenue streams at the national level are not consistent, and although the SMOHs do generate

some revenue, the money is required to go to the SMOFEP's block accounts and cannot be retained for the SMOH's salaries.

Retention. There is no retention policy or strategy in place for health workers. Trained health workers do not want to be deployed to rural areas in which they have no roots, as they will not have assistance with obtaining housing, schooling their children, or other resources that are readily available in urban areas or home towns. As a result, the states have begun prioritizing training and recruiting staff from rural areas and deploying them back into their own communities. This strategy has increased retention, but is difficult to implement as few individuals meet the admission criteria for health training programs, and few of them are attracted to the profession because the salaries are low. The MOH developed a policy of providing medical officers an incentive of SSP 2000 to work in rural facilities, but the payments did not come regularly, discouraging the workers and causing attrition. There is also considerable attrition of trained health workers to the NGOs due to significantly higher salary structures. Because the NGOs support service delivery, the talent is usually retained within the county, but this contributes to understaffed government facilities. In addition, when the NGOs phase out, attrition of all staff is high, as the workers are not content to return to the government's compensation structure. One respondent estimated that 5 percent of medical officers, 10–15 percent of clinical officers, 10 percent of nurses, 2 percent of midwives, and 3 percent of laboratory technicians go to NGOs.

State Ministry of Health

Recruitment. Recruitment plans are included in the SMOH strategic plan, and they are based on the gaps identified through comparing payroll to the staffing requirements. WES SMOH has a plan from 2010 for recruiting for hospitals and PHCCs, but acknowledges that the real manpower issues are in the rural communities. Many more staff are needed to cater to those communities, but budget shortfalls limit recruitment. The state works closely with the CHD to recruit staff – advertising for positions, reviewing recommendations sent from the CHD, and making the final decision on whom to hire.

Deployment. Both SMOHs have deployment policies, although respondents were unsure as to whether they were written or simply verbal policies. CES SMOH supports training for individuals and plans for immediate deployment of trainees upon completion of their course of studies. Both CES and WES try to deploy according to the gaps, considering the number of vacancies and the relative need of the community compared to what they already have. They note, however, that the hiring process through the Ministry of Public Service can take as long as 3–4 months, leading to high attrition among applicants.

Salary Distribution. The state has primary responsibility for salary distribution. The SMOH is responsible for checking the payroll, and then the State Ministry of Public Service confirms that the salary matches their records. Once approved, the Ministry of Public Service sends the payroll list to the MOFEP, which disburses the money to the SMOH's bank account. Salaries are then sent to the bank accounts of the counties that have them. Counties that do not have bank accounts are notified that the salaries are ready and send their cashiers to physically pick up the cash from the state bursar.

County Health Department

Recruitment and Deployment. The recruitment procedures follow the Public Service structure, where primary responsibility for recruitment rests upon the states. Counties that conduct strategic planning

activities inform the state of their overall staff requirements, and staff are recruited as the budget allows. The counties are also informed of absences by the facilities and convey the vacant position to the state for recruitment. The counties can also advertise for the position within the county. If the county has an individual they would like to consider for the position, they collect the original documents from the applicant and submit them to the SMOH. The state verifies the documents and submits them to Public Service for hiring. This process of making recommendations to the state is preferred, since centrally recruited staff who are relocated the counties rarely stay in their posts for long. Deployment takes, on average, about three months.

Salary Distribution. The counties receive their salaries directly from the state. Salaries are either wired to the county's bank account or picked up by the cashier in a suitcase for road transport from the SMOH to CHD. The CHD administrator and directors sign off on the monthly payroll list, and the salaries are then dispensed through cash payments directly to health workers at the facilities. The reasons given for this cash-based system were varied – some counties reported not having an approved bank within their county, while elsewhere the CHD rely on cash transport because the “MOH doesn't want to pay for wire fees,” despite all of the other ministries using bank wires to transfer money. Another respondent said that they began receiving payments through the bank in 2011, but when SSPs were introduced, they reverted to cash payments. All respondents using the cash transfer system emphatically noted the risk involved in this process. In addition, the counties reported regular delays in payments, with occasional delays of up to three months.

Employment Policies. The Ministry of Public Service provides written employment policies to the counties. However, awareness of the policies was low, with the majority of respondents reporting that there were no policies in place.

Payam

As with the other levels, hiring within the payam is extremely limited by the budget. One payam noted that it used casual labor to cut costs and move work forward quickly when finances allowed.

Facility

Recruitment. Facilities assist in identifying candidates in their community for training to fill open positions. The facilities look for individuals who have the capacity to succeed at the training, are young enough that the investment will yield years of dividends, and are firmly rooted in the community. When an appropriate candidate has been found, the facility in-charge will encourage the candidate to apply for the position and will also recommend the candidate to the county administrator.

Job Descriptions. Respondents had a number of different experiences with job descriptions. Most had seen a job description at one point – one was given to them upon employment, annually, or upon a promotion – while others had requested and never received a job description. Only one respondent, at a faith-based facility, was able to produce a written job description (for an administrator).

Employment Policies. Respondents were also mixed regarding their employment policies. A number of respondents said they had never seen employment policies, while a few mentioned knowing about one or two of the following policies: absenteeism, leave, sick leave, or maternity leave. Some had received the policies with their contract, while others knew of the policies through verbal communication.

Compensation. Facility staff had a number of concerns regarding compensation. They felt that compensation was low, forcing them to “dig for supper”; salaries were frequently very late in being dispensed; there were inequities in pay grades among staff within the same cadre; and they did not receive allowances. Staff working in NGO-supported facilities reported shorter salary delays than government staff: up to one week versus up to two months.

Motivation. Staff working in faith-based facilities reported that their faith in God kept them motivated to continue providing services, while for several of the government facilities, staff cited the satisfaction of providing services to a community that needs them. When asked what would motivate them further, the facility in-charges stated that their staff want more training, tools to do their job, and the reinstatement of allowances for transport so that staff members can arrive on time for the job.

Workforce Training

Key Strengths and Opportunities

- The SMOHs develop annual training plans based upon workforce needs. This allows the state and counties to prioritize and use limited training funds wisely.
- Recruitment for pre-service training has shifted from centralized selection of candidates to facility and county-guided selection. This contributes to improved retention of graduates in rural areas.

Key Gaps

- Training is the lowest priority for the ministry’s budget. Addressing the health worker shortage will require aggressive training of new health workers, but there is insufficient funding for pre-service training.
- In-service training is largely funded by NGOs, an unsustainable source.
- Health workers have many different training backgrounds and qualifications. Standardizing the skills of existing staff will require a training plan with multiple entry points to accommodate the existing disparities.
- Existing pre-service training programs have a limited number of slots for trainees. In addition, there are no training programs within South Sudan for a number of essential cadres and none for any specialties.
- Several cadres that have historically provided a number of vital services (community health workers, village midwives, and traditional birth attendants) have been phased out in favor of more qualified cadres. However, a plan to guide the transition as the country waits for the scale-up of the more qualified cadres has not been developed.

Overarching Findings

Rural Service Requirements. Upon completion of SMOH- or MOH-sponsored training, graduates are required to return to their county and/or payam to work. However, many graduates who are dissatisfied with the pay scale or with being deployed back to their community seek employment with NGOs and receive no penalty for failing to meet the requirements of their education subsidy.

Discontinued Cadres. Community health workers, village midwives, and traditional birth attendants have been phased out in favor of enrolled nurses and midwives. However, until these new cadres are sufficiently scaled up, the discontinued cadres are continuing to practice. Current policies discourage providing any support for the cadres, but some practical updates are still being organized by NGOs or the SMOH for the cadres to try to maintain quality of services.

Pre-service Education Programs. A number of pre-service training programs are provided in South Sudan's training institutions.

- **Physicians:** Physicians are trained at University of Juba, Upper Nile, and Bahr el Ghazal.
- **Nurses:** Registered nurses are trained at Upper Nile, Bahr el Ghazal, and Juba Nursing and Midwifery College.
- **Midwives:** Midwives are trained at Juba Nursing and Midwifery College.
- **Enrolled Nurses and Midwives:** A new basic training program for enrolled nurses and midwives is beginning in Juba. Approval has been received for the program, and the MOH is currently making arrangements for renovating the premises and recruiting faculty. Currently an intake of 30 nurses and 30 midwives is planned, but plans are on hold as they wait for the government to approve the students' salaries while they are in training.
- **Public Health:** Public health officers are trained at Upper Nile.
- **Laboratory Assistants:** Laboratory assistants are trained at the College of Health Sciences, where they graduate with a diploma. Some are trained abroad.
- **Cadres Trained Outside South Sudan:** A number of cadres are trained abroad. Pharmacy technicians and pharmacy assistants, X-ray technicians, dentists, anesthesiology assistants, ophthalmology technicians, and psychiatry assistants, among others, are sent for training outside the country, or recruited from other countries.

State Ministry of Health

The SMOH is responsible for ensuring the training of health workers, in collaboration with the MOH, and frequently with the support of NGOs. The SMOH makes recommendations for how many staff should be trained in each area and distributes the emerging training slots among the counties.

County Health Department

The counties are responsible for identifying individuals for training when the state allocates training slots. As the SMOH has an extremely limited number of slots for training to distribute, the counties rely heavily on NGOs to sponsor pre-service training and provide in-service training. Still, the annual graduate numbers are low. Nzara County, for example, had one clinical officer, one certificate nurse, one nutrition officer, and six community midwives graduate in the past year.

Payam

The payams did not state any training requests, nor note any in-service training opportunities.

Facility

Facilities requested increased training opportunities and noted that in-service training opportunities are rare.

Resource Needs

Key Strengths and Opportunities

- Most SMOH and CHD offices have Very Small Aperture Terminal (VSAT) Internet equipment. Although currently not functioning, the equipment could be quickly reinstated by paying for the services.
- All SMOH and CHD offices have at least one functioning computer, and many have additional computers that could be brought into service through some maintenance.

Key Gaps

- SMOH, CHD, and payam offices, as well as the facilities, are functioning without basic equipment, supplies, and transport. This severely limits the capacity of these offices and facilities to perform basic job functions.

Overarching Findings

Innovative Technology. There is no evidence of innovative technologies in regular use within the states assessed. Some staff have access to computers, and most use their own cell phones for communication. Although Internet satellites were set up by UNICEF, in many SMOH and CHDs, the Internet was not functional in any location assessed due to unpaid subscriptions.

3.3.3 HRH Recommendations

South Sudan has made considerable progress in establishing systems for HRH since independence. A number of systems are in place and in use, particularly the systems for recruitment, deployment, and compensation. As South Sudan continues to strengthen its HRH structures and systems, this assessment has identified a number of opportunities for the MOH to focus on to lay a strong foundation for HRH in the country. The following recommendations are not comprehensive, but rather focus on the essential first steps that should be pursued to lay a foundation for future reforms.

Strengthen strategic planning processes: Strategic planning currently focuses on identifying staffing gaps and the number of health workers who must be trained to meet the gaps. However, strengthening HRH within the country will require a regular and thorough strategic planning process at all levels of the health system. Strategic planning for HRH includes a number of steps and considerations currently not being implemented within the SMOH and CHDs, specifically, the following:

- Identifying the types of data needed for HRH planning, and defining how to use the data to identify and describe key HRH activities and gaps.
- Establishing a planning cycle that links with budgetary and staffing cycles.

- Defining the role of the various government entities and stakeholders in the planning process from national to local planning and implementation.
- Identifying methods of monitoring an HRH plan, how to identify shortfalls in the implementation of the HRH reforms in real time, and how to share planning outcomes with the appropriate government agencies and stakeholders responsible for implementing reforms.
- Delineating ways to implement costing and resource mobilization as a key element in the planning continuum.

Strategic Planning Recommendations

- Strengthen the HRH planning process through training of state and county staff responsible for HRH planning on the fundamental steps in a good HRH planning process.
- Establish a training of trainers to train government staff in comprehensive HRH planning
- Support SMOHs and CHDs to implement a full HRH planning cycle, which includes input from all levels of the health system, including down to the payam and health facility levels

Increase availability of appropriate and equitably distributed health workers: Ensuring the availability and equitable distribution of health workers requires a strong information system that provides reliable and comprehensive information on the health workforce numbers, qualifications, deployment, compensation, training needs, and planned retirement date, among other information. A strong computerized online system allows real-time updates and data use at all levels of the system. In addition, a reliable system requires data collection and verification by trained data collectors, with regularly scheduled updates. The JICA HRIS database, due to issues with data collection and design, is limited in its ability to support human resource management.

Health Workers Distribution Recommendations

- Finalize job standards to include job titles and required qualifications
- Establish consensus through a high-level meeting on what is needed from an HRIS, how to use it, and how to collect information
 - Assess the current HRIS database to determine best practices, lessons learned, and systems or information that may be used in an improved HRIS
- Redesign database into an information system that comprehensively meets country HRM needs
- Establish a data collection system that utilizes trained data collectors and regular updates.

Improve health worker performance: Performance management in South Sudan is focused on attendance registers and a defined but irregular promotion cycle. A comprehensive performance management structure is an essential tool for the SMOH to manage the quality of services provided by the workforce and increase job satisfaction and retention. A comprehensive health workforce performance management system must go beyond attendance registers and include regular assessments tied to rewards and compensation.

Health Worker Performance Recommendations

- Train SMOH and CHDs on performance management and how to implement a user-friendly system that can improve the overall ability of the management team to monitor the quality of care provided by providers
- Design and implement a user-friendly system that includes regular performance assessments and is tied to promotions
- Support the development of professional councils to register and license health workers to ensure the quality of the workforce

Attract and retain the required health workers: The workforce recruitment, deployment, and compensation procedures require strengthening to increase the numbers of health workers serving within the government system. Stronger recruitment procedures support the rapid deployment of health workers and encourage retention through recruiting health workers from rural areas to serve in the same areas. Low compensation and no allowances, coupled with late salary payments, discourage the workforce.

Health Workers Retention Recommendations

- Scale up recruitment and training of individuals from rural areas to serve in their county or payam to increase retention
- Realign recruitment procedures to allow the county to have greater input on the individuals hired and deployed
- Establish job standards to regulate the qualifications required for each position
- Harmonize the payroll in line with job standards and health worker qualifications
- Transition cash-based payroll system to a bank system
- Lobby at the national level for the reinstatement of allowances and development of a retention policy to increase retention of staff.

Train and build capacity of the health workforce: Addressing the acute workforce shortage requires a significant scale-up in training of new health workers. The current acute shortfalls in funding for training institutions are severely undermining the scale-up of the workforce. However, there are a number of opportunities for the MOH to strengthen training, even in the face of limited resources. The current workforce has a wide range of backgrounds, and many workers are not qualified for the positions they hold. Addressing these challenges is essential to achieving a qualified health workforce, and developing the policies and frameworks to guide implementation must be a top priority.

Capacity Building Recommendations

- Establish career pathways to support the upgrade of current staff to meet qualifications defined in the job standards
- Develop a plan to transition between the current community health workers, village midwives, and traditional birth attendants to enrolled nurses and midwives without negatively impacting services as the new workers are trained

- Institute a comprehensive strategic planning cycle for training, including costing and resource mobilization to support targeted training of health workers
- Support the development of professional councils to accredit pre- and in-service training institutions.

Revised Year One Indicators

The results of the baseline assessment have informed HSSP's year one work plan and indicators to ensure that the goals of the program are met through activities appropriate to South Sudan's current situation. The proposed changes to year one indicators are listed below, in Table 19.

Table 19: Proposed New Year One Indicators

Human Resources for Health		Definition	Indicator Type	Baseline	End of YRI Target	Data Source	Method of Collection	Frequency	Person Responsible
1.	Existence of report on the assessment of existing HR database	The existence of a report on the in-depth analysis of JICA database to determine function and usability	Output	n/a	1 report	Program records	Program monitoring	Quarterly	Human Resources Planning & Management Advisor, M&E Specialist
2.	Number of SMOH and CHD staff trained in HRH strategic planning	The number of SMOH and CHD staff trained on fundamentals of HRH strategic planning including purpose, process, and tools	Output	n/a	16	Program records, Training records	Program monitoring	Quarterly	Human Resources Planning & Management Advisor, M&E Specialist
3.	Number of SMOH and CHD staff trained in performance management	The number of SMOH and CHD staff trained on fundamentals of performance management, including purpose, process and tools	Output	n/a	16	Program records, Training records	Program monitoring	Quarterly	Human Resources Planning & Management Advisor, M&E Specialist
4.	Existence of job standards proposed for RSS MOH approval	Revised job standards defining staff positions, structures, and qualifications	Output	n/a	1 document	Program records	Program monitoring	Once	Human Resources Planning & Management Advisor, M&E Specialist

Proposed Indicators to Be Removed from Year One PMP

- Indicator #17 - Existence of report on health worker staffing patterns and gaps at the state and county facilities level
- Indicator #21 - Existence of approved workforce capacity assessment tool to determine health worker staffing requirements
- Indicator #22 - Number of SMOH and CHD staff (training of trainers) trained to implement the workforce capacity assessment tool to determine health worker staffing requirements (disaggregated by gender)
- Indicator #23 - Number of CHDs conducting workforce capacity assessments to determine health worker staffing requirements
- Indicator #24 - Number of health facilities in which workforce capacity assessments are conducted.

Revised Five-Year Indicators

One previously approved indicator in the five-year PMP was found to be insufficiently specific to adequately measure program impact. Two new indicators to measure human resource management capacity within the SMOH and CHDs are proposed in table 20.

Table 20: Proposed New Five-Year Indicators

Human Resources for Health	Definition	Indicator Type	Y1	Y2	Y3	Y4	Y5	Target	Data Source	Method of Collection	Frequency
5 Number of SMOHs and CHDs implementing a performance management system	The number of SMOHs and CHDs actively implementing a standardized performance management system	Outcome	TBD	TBD	TBD	TBD	TBD	18 (100%)	Program records	Health System Assessment, Program monitoring, mentoring/ supervision visits	Semi-annually
6 Number of SMOHs and CHDs implementing key human resource management policies and procedures	The number of SMOHs and CHDs regularly implementing HRM policies and procedures	Outcome	TBD	TBD	TBD	TBD	TBD	18 (100%)	Program records	Health System Assessment, Program monitoring, mentoring/ supervision visits	Semi-annually

Proposed Indicator to Be Removed from Five-Year PMP

- Indicator #27 - Number (and percentage) of CHDs and SMOHs demonstrating core competencies in human resources management (disaggregated by state)

3.4 Health Information Systems

3.4.1 Background Information for HIS in South Sudan

The health management information system (HMIS) in South Sudan, which comprises the monthly health statistics reporting form and the weekly disease surveillance report from facility to national levels, has made significant strides in improving the capture and reporting of key health information. Since the country's independence in 2011, the MOH has managed to harmonize a significant number of indicator reporting formats, donor requested processes, and many disparate levels of understanding within the health system about how and what to report. In addition, the RSS has successfully designated the DHIS system as the official electronic reporting system for all HMIS data and has rolled this system down to the level of the CHD.

The HMIS component of the baseline assessment had multiple objectives. The first objective was to determine the extent to which the HMIS in CES and WES is supporting the planning needs of the health system as RSS transitions from emergency operations to sustainable and effective health programs. The assessment was also intended to provide the first introduction of the HSSP team to HIS personnel at state, county, and PHCC/PHCU levels, thus providing the opportunity to build collaboration from the onset of the project and to ensure country ownership of the activities implemented to strengthen the health system. The final objective was to document the current status on key HMIS indicators, namely (1) *the number and percentage of CHDs submitting timely HMIS monthly reports to the SMOH* and (2) *the number of CHDs and SMOHs using HMIS data for developing their annual health plans*. Documenting these elements in the primary stages allows the HSSP project to monitor HMIS progress in an objective and measureable manner.

3.4.2 Key Findings: Health Information Systems

State-level Findings

Both CES and WES SMOHs have a functioning HMIS unit with designated office space. Site visits and interviews to SMOH offices in Juba and Yambio confirmed that the staff persons responsible for HMIS data are employed full time, have dedicated office space for their work, and have a clear understanding of the HMIS reporting process. In the CES SMOH, the lead HMIS staff person is an epidemiologist/statistician, while in WES, this role is played by an M&E manager. Interviews with staff at the two offices indicated that the lead HMIS staff are trained in and able to use the electronic DHIS software for the purposes of importing county- and facility-level data and for sending the compiled databases to the national MOH on a routine basis. Lead HMIS staff in both offices appeared to have a clear understanding of the epidemiological importance of the information being captured and reported.

The staff's ability to complete HMIS tasks, however, is hampered by significant gaps in technical infrastructure for they often do not have Internet connectivity. In the case of CES, Internet access was financially supported by a donor partner under the Multi-Donor Trust Fund up until October 2012; since then the SMOH has not been able to pay for continued Internet access through a local Internet service provider. Currently the staff use their own computers and wireless modems (without receiving reimbursement) in order to fulfill their HMIS reporting requirements. There did not seem to be significant delays in the reporting of HMIS data from SMOH to the national level (completed by e-mailing copies of the updated SMOH-level databases). While the HMIS staff interviewed were able to demonstrate their ability to navigate the basic functions of the DHIS software and had been trained by

the Liverpool Associates in Tropical Health under the Technical Assistance to Health Priorities Programme in 2011, there seem to be significant gaps with regard to the use of HMIS data for program planning purposes. Interviewees reported that no routine SMOH-level meetings are held to discuss the data submitted, the patterns emerging, or potential interventions appropriate to the situation defined by the data. Neither was there any evidence of SMOHs providing routine feedback to the county levels on the data that had been submitted by them, beyond confirming whether or not data had been routinely received. A discussion of the team findings regarding the county-level data from the SMOH offices in WES and CES is below, under the county-level findings.

There was no indication that HMIS data are used at the SMOH level in support of the annual health plan process. While the SMOH routinely reviews and uses surveillance data, it does not compile the data into a consolidated HMIS report.

County-level Findings

As with the SMOHs, the assessment team found that there is relatively good HMIS capacity at the county levels visited. Counties visited in both WES and CES have at least one staff person trained in the DHIS software and specifically assigned to the role of HMIS oversight (including surveillance). Most of the counties have computers, although access to Internet connectivity is lacking; this was often due to the conclusion of a health project that had been paying for these services, similar to the situation found at the state level. For more information, Internet connectivity is discussed in detail in the Technology section of this report.

The assessment team was able to review data produced by WES and CES HMIS officers from the DHIS, disaggregated by county within each state. The data showed a wide variation in the percentage of health facilities in each county that reported on a timely basis over the previous six months (October 2012 to March 2013). In CES, Juba, Terkeka, and Lainya counties had the lowest percentage of facilities reporting on time, with 32 percent, 47 percent, and 58 percent averages, respectively, for the six-month period. At the other end of the spectrum, Morobo County averaged a 95 percent reporting rate for the period, with 100 percent reporting on time over the last five months. Of note, Juba County had the highest number of total facilities (119) expected to report, while Morobo had the lowest at 13. Table 21 presents a summary of the data for the six-month period.

Table 21: CES Health Facilities Reporting on Timely Basis

Central Equatoria State Ministry of Health Number of Facilities Expected to Report (A) versus Number of Facilities that Reported (B)																
	(A)	(B)														
CHD Name	"# of Facilities	October 2012		November 2012"		December 2012		January 2013		February 2013		March 2013		April 2013		CHD Averages
Juba	119	34%	41	34%	41	29%	35	35%	42	27%	32	34%	41	33%	39	32%
Terkeka	46	41%	19	50%	23	39%	18	50%	23	37%	17	46%	21	63%	29	47%
Lainya	22	64%	14	55%	12	41%	9	68%	15	82%	18	14%	3	91%	20	58%
Kajo-Keji	45	71%	32	67%	30	64%	29	60%	27	60%	27	64%	29	44%	20	60%
Yei	41	73%	30	78%	32	61%	25	54%	22	73%	30	71%	29	76%	31	69%
Morobo	13	85%	11	100%	13	77%	10	92%	12	100%	13	100%	13	100%	13	95%
Total facilities in CES	286	51%	147	53%	151	44%	126	49%	141	48%	137	48%	136	53%	152	49%
	Monthly Averages:	57%		57%		47%		53%		56%		46%		61%		

Source: Mila (2013)

WES had similarly wide variations in the number and percentage of facilities reporting on a timely basis over the six-month period reviewed. Nzara, Mundri East, and Ibba counties had by far the lowest percentages of reporting for the period, with 0 percent, 9 percent, and 17 percent, respectively. At the upper end of the reporting spectrum, Ezo and Mundri West had monthly reporting averages of 80 percent and 89 percent, respectively, for the period of review. It is also worth noting that the number of facilities expected to report across WES jumped from 201 in December 2012 to 277 in January 2013. This 37 percent increase in the number of facilities expected to report was due to the 76 facilities brought online during 2012. While the facilities themselves began operating at different times throughout the year, they were incorporated into the HMIS reporting process all at once (January 2013), which accounts for the dramatic increase in the number expected to report. It is also worth noting that there was not a significant drop in the actual number and percentage of facilities reporting in January 2013, which one might have expected. A summary of the WES data for the period is provided in Table 22.

Table 22: WES Health Facilities Reporting on Timely Basis

Western Equatoria State Ministry of Health Number of Facilities Expected to Report (A) versus Number of Facilities that Reported (B)																			
	Oct 2013			Nov 2013			Dec 2013			Jan 2013			Feb 2013			Mar 2013			Avg. %
	Exp'ctd	Rec'd	%	Exp'ctd	Rec'd	%	Exp'ctd	Rec'd	%	Exp'ctd	Rec'd	%	Exp'ctd	Rec'd	%	Exp'ctd	Rec'd	%	
Nzara	20	0	0%	20	0	0%	20	0	0%	28	0	0%	28	0	0%	28	0	0%	0%
Mundri East	17	7	41%	17	1	6%	17	0	0%	22	1	5%	22	0	0%	22	0	0%	9%
Ibba	13	0	0%	13	0	0%	13	0	0%	20	9	45%	20	11	55%	20	0	0%	17%
Nagero	10	5	50%	10	5	50%	10	0	0%	11	4	36%	11	5	45%	11	4	36%	36%
Yambio	38	12	32%	38	19	50%	38	19	50%	61	21	34%	61	21	34%	61	14	23%	37%
Tambura	20	16	80%	20	16	80%	20	0	0%	29	19	66%	29	20	69%	29	0	0%	49%
Maridi	25	25	100%	25	24	96%	25	24	96%	39	25	64%	39	0	0%	39	0	0%	59%
Mvolo	11	9	82%	11	6	55%	11	9	82%	12	10	83%	12	11	92%	12	3	25%	70%
Ezo	28	28	100%	28	28	100%	28	28	100%	36	20	56%	36	23	64%	36	21	58%	80%
Mundri West	19	15	79%	19	18	95%	19	16	84%	19	19	100%	19	18	95%	19	16	84%	89%
Total facilities in WES:	201	117	58%	201	117	58%	201	96	48%	277	128	46%	277	109	39%	277	58	21%	45%

Source: WES SMOH (June 2013)

Staff interviewed at Juba, Morobo, and Yei counties reported that they directly input the facility monthly reporting data into the DHIS software and then transfer the data over the Internet to the SMOH. For facilities that are extremely difficult to reach, Juba County and Morobo County reported using phone calls to gather the data for the monthly DHIS report, and Morobo also reported that the ISDP project provided motorbikes to help them collect the monthly data.

Some HMIS staff interviewed reported producing simple graphs from the HMIS data, although there was no evidence of such graphs nor other information products displayed anywhere in the CHD offices. Likewise, the feedback of information and analysis to the PHCCs/PHCUs did not appear to be a routine part of their work, tied to the fact that most facilities are not being visited independently of any implementing partner support being provided.

PHCC/PHCU-level Findings

The payam levels in the health system are clearly the most challenged in terms of HMIS overall. The assessment team did find that there were dedicated staff with sufficient knowledge at the PHCCs/PHCUs to reasonably collect the data and compile the information. There was, however, wide variation as to whom these tasks were assigned: in some places it was a statistician, while in others it was the facility in-charge. Many of the PHCCs/PHCUs reported that they only compile the monthly health data when someone comes to collect it, which is very infrequently. In addition, the collection of information was performed by external staff, i.e., a surveillance officer would come to the facility and pull the information together.

The greatest challenges in terms of HMIS for the PHCCs/PHCUs was infrastructure. They uniformly lacked basic infrastructure such as dedicated HMIS staff, HMIS work spaces, minimal electricity, functional computers, and/or Internet and telephone connectivity. In addition, most facilities located outside of the state capitals (Yambio and Juba) were only accessible via non-paved and poorly maintained roads. These conditions create significant barriers for many of the PHCCs/PHCUs to effectively compile and report their routine HMIS. They also create barriers for structuring effective and routine data and information feedback to the PHCCs/PHCUs, minimizing the value of the information they collect.

None of the facilities visited by the assessment team reported that routine data quality checks take place. This is consistent with the findings at the county and state levels, leading to the expectation that a data quality assessment is likely to find significant issues. It is worthwhile to note, however, that in some cases staff at other levels did check for quality at the facility level in an ad hoc way, for example, by calling facilities to obtain explanations when they see a discrepancy in the data or verifying data received against a facility logbook.

3.4.3 HIS Recommendations

As detailed above in the Findings section, a number of HIS components work well in CES and WES. Namely, the SMOHs have been adequately trained and are functional with the DHIS as a reporting tool for surveillance and monthly HMIS reporting. Although they face challenges with the availability of government-provided Internet connectivity, this does not appear to significantly impact the timeliness of their reporting of county- and facility-level HMIS data to the national level. The greatest gap in reporting is clearly between the PHCCs/PHCUs and CHD levels, due in large part to the infrastructure gaps the country as a whole faces with challenging roads, electricity, telecommunications, and Internet

connectivity. It is incumbent upon the RSS to embark on significant infrastructure investment in these domains to improve the long-term sustainability of the health system.

Against this backdrop, the South Sudan HSSP can undertake focused technical support to the SMOHs and CHDs over the next two years in an effort to strengthen the HIS, improve the use of HMIS data for decision making, and promote an environment of quality focused health care. The following are key activities that will target the findings from the HIS baseline assessment.

- Meet with the SMOHs in CES and WES to develop an HIS strengthening plan for the CHDs in their states. The planning process should promote the SMOH HIS officers as the owner of the plans, with HSSP providing key inputs and technical support. The plans should be for a one-year period and call out the resources that need to be provided by the SMOH and those to be provided by HSSP. A key focus of the plan should be to prioritize support to CHDs where low levels of facility reporting are taking place (e.g., Nzara, Mundri East, Ibba, and Juba).
- Promote the convening of a quarterly data review meeting at the SMOH level to evaluate (and, if needed, validate) data from the CHDs. This quarterly meeting will focus on addressing the challenges faced by CHDs in reporting, the quality of the data being reported, actionable items resulting from the review of data (e.g., disease outbreaks or population coverage) so that the value of data for program planning is promoted, and work plans for promoting usage of information at the lower levels. One objective of the early meetings should be to identify potential information products (e.g., summary reports, graphs, or maps) that can be produced with the data so that the data have value for those staff members producing data at the PHCC/PHCU levels. The longer-term objective will be to develop a performance-based incentive plan that provides either financial or non-financial incentives to CHDs based on timely reporting *and* evidence of data use for planning purposes.
- Promote the convening of a quarterly data review meeting at the CHD level to evaluate (and, if needed, validate) data from the PHCCs/PHCUs. This quarterly meeting will focus on addressing the challenges faced by PHCCs/PHCUs in reporting, the quality of the data being reported, actionable items resulting from the review of data (e.g., disease outbreaks or population coverage) so that the value of data for program planning is promoted, and work plans for promoting usage of information at the lower levels. One objective of the early meetings should be to identify potential information products (e.g., summary reports, graphs, or maps) that can be produced with the data so that the data have value for those staff members producing the data at the PHCC/PHCU levels. The longer-term objective will be to develop a performance-based incentive plan that provides payments (or other incentives) to providers based on timely reporting *and* evidence of data use for planning purposes.
- In order to validate the quality of the data currently being reported and to further inform the one-year HIS strengthening plans at the SMOH level, HSSP will initiate a standardized data quality audit (DQA) training and validation activity. This activity will entail HSSP staff training SMOH HIS and M&E staff on conducting DQAs, interpreting the results, and incorporating Routine Data Quality Assessments (RDQA) into the supportive supervision process with the CHDs and PHCCs/PHCUs. The full activity will entail HSSP conducting two SMOH-level trainings on the DQA methodology (one in WES, one in CES) in a train-the-trainer model; piloting the DQA in collaboration with the SMOH HIS staff in two CHDs in each state (four in all); supporting the analysis of data resulting

from the DQA; and supporting the SMOH HIS officers in convening a discussion and dissemination meeting (to coincide with the quarterly data review meeting) with the CHDs.

- In conjunction with the activities outlined above, the use of information at the PHCC/PHCU levels is considered a key objective. In order to achieve this, the HSSP team will work with SMOH and CHDs to define the information products that will be most useful to the PHCCs/PHCUs and then implement a training program to ensure the capacity to produce these products at the CHDs and use these products at the PHCCs/PHCUs. Given the absence of computers and limited resources at the PHCC/PHCU levels, production of products will likely be low-tech at those levels (such as handwritten graphs or charts), while the CHDs will leverage the electronic data available to them to produce products for the PHCCs/PHCUs. HSSP will use the quarterly review meetings as the initial venue for defining the information products needed and for training (as needed) the CHD staff on producing them.

3.6 Supportive Supervision

3.6.1 Background on Supportive Supervision in South Sudan

Regular, effective, and integrated supportive supervision is necessary for good management as well as to ensure ongoing on-the-job capacity building. A foundation of supportive supervision entails working with health staff to establish goals, monitor performance, identify and correct problems, and proactively improve the quality of service. Supervisors and health workers work together to identify weaknesses, create action plans to address the identified weaknesses, and recognize and encourage good practices. Components of high-quality supportive supervision include observation of performance and comparison to standards, provision of corrective and supportive feedback on performance, provision of technical updates or guidelines, use of data to identify opportunities for improvement, joint problem solving, and follow-up on previously identified problems. While supervision has the potential to be a highly participatory process, traditional supervision visits often focus more on inspection and fault finding rather than problem solving to improve performance. Components of traditional supervision include inspection of the facility, review of records and supplies, decision making primarily by the supervisor, reactive problem solving by the supervisor, and little or no feedback or discussion of supervisor observations (Marquez and Kean 2002). Consequently, health workers often receive limited guidance or mentoring on how to improve their performance. In addition, supervisors often lack the technical, managerial, or supervisory skills needed to effectively evaluate health facilities across various health domains. Supportive supervision requires investment to function: staff time, travel costs, and infrastructure such as vehicles and roads, to name a few. However, in many countries, including South Sudan, limited budgets do not allocate sufficient funds or personnel to conduct supportive supervision, making regular visits difficult to finance and coordinate.

One of the key objectives of South Sudan's BPHS is "to improve the quality of care through the delivery of specified norms and standards of services" (MOH 2009). In South Sudan, supportive supervision by the CHDs to the facilities they manage, primarily PHCCs and PHCUs, is the cornerstone of facility-level quality assurance and quality improvement required to bring this objective into reality. However, supportive supervision in South Sudan's health system remains weak, even where quality assurance and quality improvement plans exist within the states and CHDs.

The primary objective of South Sudan HSSP technical assistance for supportive supervision is to support the CHDs to conduct regular, effective facilitative supervision visits to health facilities within the county, primarily PHCCs and PHCUs, and support the utilization of data derived from those visits for decisions about health programming, staffing and resource allocation. The supportive supervision component of the HSSP baseline assessment explored the following questions:

- What is the understanding of supportive supervision?
- What are the institutional roles and responsibilities for supervision?
- Who are the personnel responsible for completing supervision visits?
- What is the process for conducting supervision visits by the CHDs to the PHCCs/PHCUs?
- What tools are available to assist in the completion of supervision visits?
- How do current supervision practices generate, record, and provide performance feedback?

Interviews for this component concentrated on participants at the CES and WES SMOHs, seven CHDs among the two states (4 CES, 3 WES), and nine PHCCs/PHCUs (4 CES, 5 WES).

Supportive supervision can encompass a wide range of supervision practices: supervision by the SMOH to the CHDs, supervision of health facilities to community-based services, supervision of health facility personnel by the facility in-charge, supervision of state hospitals by the SMOH, and many more. While these supervision practices are important, the scope of the supportive supervision component of the HSSP baseline assessment focused primarily on supervision of health facilities by the CHDs and the role of the SMOH in helping the CHDs fulfill their mandate. This focus is consistent with the previously stated objective of South Sudan HSSP technical assistance for supportive supervision.

Findings in the following sections are broken down by the supportive supervision questions above as well as by the SMOH, CHD, and health facility levels.

Understanding of Supportive Supervision

Components of supportive supervision include observation of performance and comparison to standards, provision of corrective and supportive feedback on performance, provision of technical updates or guidelines, use of data and client input to identify opportunities for improvement, joint problem solving, and follow-up on previously identified problems (Marquez and Kean 2002). By comparison, components of traditional supervision include inspection of the facility, review of records and supplies, decision making primarily by the supervisor, reactive problem solving by the supervisor, and little or no feedback or discussion of supervisor observations. These components are summarized in Table 23. In summary, key differences in the terminology distinguishing “supportive” versus “traditional” supervision include feedback, improvement, inspection, joint problem solving, and follow-up.

Table 23: Comparison of Components of Traditional versus Supportive Supervision

Traditional Supervision	Supportive Supervision
<ul style="list-style-type: none"> • Inspection of the facility • Review of records and supplies • Decision making primarily by the supervisor • Reactive problem solving by the supervisor • Little or no feedback or discussion of supervisor observations 	<ul style="list-style-type: none"> • Observation of performance and comparison to standards • Provision of corrective and supportive feedback on performance • Provision of technical updates or guidelines • Use of data to identify opportunities for improvement • Joint problem solving • Follow-up on previously identified problems

Responses regarding the understanding of supportive supervision varied widely across the CHDs interviewed. The terms “feedback,” “problem solving,” and “follow-up” were not articulated in any of the seven CHD responses. Two definitions provided by the CHDs identified the health worker as the target for supportive supervision, but did not highlight the provision of continuous support to the health worker to help them achieve their duties. In addition, only two of 14 responses referred to the importance of target-setting and using targets as a basis for measuring health worker performance. Two other definitions identified information capture as the focus of supportive supervision: one CHD respondent specifically stated that supportive supervision “enables a person to take information from the various facilities.” One CHD respondent identified the national Quantified Supervisory Checklist (QSC) (described in detail in a later section) as their source of understanding for supportive supervision: “When I say supportive supervision, I think the checklist.” (MOH 2009). This variety in understanding of

supportive supervision at the CHDs could be attributed to the high variance in staff responsible for conducting supervision visits: M&E, surveillance, and other technical staff all were identified as persons responsible for conducting supervision visits. Supervision staff composition and roles will be discussed in detail in a following section.

At both the SMOH and the PHCC/PHCU levels, supervision was generally seen as an M&E and/or surveillance process. Consequently, answers were often skewed toward health facility inspection rather than supportive supervision. Interviewees at both CHDs and health facilities did not emphasize continuous systematical mentoring and coaching of the health worker in the context of their understanding of supportive supervision. Many of the respondents did generally speak about the purpose of the supportive supervision process as improving performance; however, responses varied between a focus on health worker performance and a focus on health facility performance, or both.

3.6.2 Key Findings: Supportive Supervision

Institutional Roles and Responsibilities

The BPHS for Southern Sudan states that “county hospitals are responsible for oversight, technical support, and capacity strengthening especially in diagnostic and curative related services at household, PHCUs, and PHCCs. The CHDs are responsible for all community-based health activities within communities” (MOH 2009).

Despite the definition referenced above, the current supervision process for the PHCUs and PHCCs rests within the mandate of the CHDs as outlined in the guidance for the QSC (MOH 2011). This is consistent with interview responses at the SMOH and CHD level that placed the responsibility for PHCC/PHCU supervision with the CHDs. Respondents interviewed at all seven CHDs stated that they conducted supervision visits to health facilities. The process, timing, and structure of these supervision visits will be discussed in a later section. Of the nine PHCCs/PHCUs interviewed, five respondents identified that the CHD had conducted supervision visits to their facilities. The remaining respondents either had not witnessed a supervision visit during their tenure at the facility, or, in the case of one respondent, the facility had been visited for supervision by the NGO supporting service delivery partner and not by the CHD.

Two PHCCs interviewed in CES reported direct supervision by the SMOH rather than the CHD. This was primarily due to transportation, as these facilities reported that the SMOH supervision staff had better access to transportation in comparison with their CHD counterparts. In Juba County, the Juba Payam Health Department reported that they were responsible for supervision visits to all urban facilities while the Juba CHD held responsibility for supervision in rural facilities. No other payams interviewed in this assessment claimed responsibility for supervision visits.

The HSDP places responsibility for management of county and state hospitals with the respective SMOH (MOH 2009). While the BPHS identifies CHDs as responsible for supervision of community health services, CHDs’ implementation of supervision largely focused on use of the QSC, which focuses on PHCC/PHCU health services and does not explore performance of community health services. This is not surprising considering that community-level services are fairly limited within the two states. Evidence of community health activities and an attempt at supervising these activities was only found at one facility.

Supervision Personnel and Team Composition

Responsibility for supportive supervision is currently diffused across a number of positions at both the SMOH and CHD levels. Generally, responsibility for supervision is divided between one of three types of personnel: M&E personnel, surveillance personnel, or health service technical personnel. At the CES SMOH, responsibility for coordination of PHCC/PHCU supervision by the CHDs is held by the deputy director of primary health care. At the WES SMOH, this responsibility is found with the SMOH M&E manager.

At the CHD level, supervision team roles, supervision team size, and supervision team composition varies greatly. Five of the seven CHDs interviewed identified an M&E officer as a member of the supervision team. Five of the seven CHDs also reported a surveillance officer as a member of the supervision team. Three CHDs identified the CHD surveillance officer or M&E officer as the sole personnel responsible for conducting supervision visits. Team compositions for supervision by other CHDs included the following:

- *Three personnel:* M&E officer, two representatives from partner NGOs supporting service delivery in the county
- *Three personnel:* M&E officer, CHD medical officer, surveillance officer
- *Four personnel:* M&E officer, EPI personnel, surveillance officer, and MCH officer
- *Five personnel:* M&E officer, CHD administrator, accountant, CHD director, surveillance officer

Training of SMOH and CHD personnel for conducting supervision visits also varies greatly. At the SMOH level, only WES reported receiving training in 2011 on the QSC. At the CHD level, two CHDs reported that they had never received training on supportive supervision. The remaining five CHDs reported attending at least one training on the QSC, although the majority reported receiving their training over two years ago. None of the health facility staff interviewed reported receiving training on the supervision process. Job descriptions of CHD staff responsible for conducting supervision visits were generic; none of the job descriptions provided specific guidance on roles and responsibilities for supportive supervision and implementation of the QSC to the PHCCs/PHCUs.

Supervision Process

Guidance for the QSC states that supportive supervision visits to the PHCCs/PHCUs by the CHDs should be conducted on a quarterly basis (MOH 2011). However, throughout the assessment process, understanding of how often supervision visits should occur differed vastly when reported by CHDs. Three of the seven CHDs stated that supervision visits should be conducted quarterly, another three CHDs reported that supervision visits should be held monthly, and one CHD reported that supervision visits should occur four times per month. Only one CHD reported having a schedule for supervision visits. There may be an opportunity to explore the periodicity of supervision visits vis-a-vis providing better support to health workers.

An important note here is that although the CHDs could clearly state the frequency of how often supervision visits were expected to occur, few CHDs were able to successfully achieve these targets. None of the seven CHDs stated that they were able to complete supervision visits to all facilities within the time period identified. All seven identified lack of transportation as a major challenge to making

supervision visits. Other challenges stated included lack of support for supervision staff allowances, condition of roads, distance to facilities, lack of support for vehicle maintenance, and weather. As a result, supervision visits in many of the CHDs were entirely dependent on the availability of support from the service delivery partner NGO. In the absence of the partner NGO, supervision visits by the CHDs stopped completely or were significantly reduced in frequency.

Only one of the seven CHDs identified that there was a supervision planning session prior to visiting the PHCCs/PHCUs. The majority of interviewees indicated that the health facilities were informed of supervision visits prior to the date of supervision. Length of supervision visits was also highly variable, from as short as 45 minutes to as long as six hours, not including time for transit. For health facilities that are particularly hard to reach, more time is spent in transit to the facility than in conducting supportive supervision.

Six of the seven CHDs reported using the QSC for supportive supervision visits. How this checklist was completed differed depending on team composition: one person could be responsible for filling out the entire checklist, or each person on the team could be responsible for completing different checklist components. The QSC was filled out either by the supervisory personnel in conjunction with clinic staff or by the supervisory personnel individually without assistance from facility staff. In six of the seven CHDs interviewed, data from supervision visits were collected by writing on the checklist. All CHDs reported being able to collect all supervision data during a single supervision visit. Guidance for the checklist indicates that two copies of the checklist should be completed at the same time: one done by the supervisor and one by the in-charge. However, this process was not described in the interviews with CHDs and the health facilities.

Three of the seven CHDs reported that there were national guidelines for the supportive supervision process; however, none of the interviewees was able to provide a copy of those guidelines. While there is a national guidance document describing how to complete the QSC, the assessment team did not find other guidance documents detailing the supervision process by CHDs, including guidance on team composition, roles and responsibilities, feedback, information flow, and reporting.

Supervision Tools

Currently, the primary supervision tool for CHDs is the QSC. The checklist provides objective, quantified measurement of seven quality of care components: infrastructure, equipment, human resources and management, HMIS, pharmaceuticals, service provision, and utilization of services (Ministry of Health 2011). The stated purpose of the checklist is to “identify achievements but most importantly bottlenecks that cause deterioration of health care services.” (RSS MOH, 2011). In identifying these bottlenecks, the checklist should enable the facility staff and CHD to ameliorate or solve identified issues.

Six of the seven CHDs interviewed identified that the QSC was available; all six CHDs were able to show the assessment team at least one copy of the checklist. None of the CHDs stated that different checklists were required for use at the NGO-supported government health facilities. All CHDs interviewed reported that the checklist, as well as facility registers required to complete the checklist, were routinely available at the health facilities during supervision visits. Some facilities reported having different, program-specific checklists for EPI supervision, internal quality supervision, and other responsibilities.

Analysis of the QSC by the assessment team identified limitations in the tool. Currently, the majority of responses are limited to “Yes” or “No” answers that are assigned percentage values based on the number of questions in the component. If there are 10 questions in the component, each question is given a value of either 10 percent or 0 percent. As a result, the majority of responses are not weighted based on their contribution to health service performance. In addition, measurement of the current indicators does not facilitate easy comparability against previously obtained data or against performance standards or targets. For instance, one Yes/No indicator is “All curative consultations increased (last 3 months).” To better measure progress, this indicator could record the number of curative consultations in the last three months and provide a comparison with previous values as well as national performance targets. Although the current checklist does cover the BPHS at the PHCC/PHCU level, there is an opportunity to support the capture of these indicators using health facility data instead of supervisor observation, providing more specific measurement and the ability to measure performance in relation to previous supervision visits or county, state, and/or national performance targets.

Supervision of TB and HIV programs is not captured by the current QSC. These programs are evaluated using different, program-specific checklists. However, less than 10 percent of the health care facilities in South Sudan currently provide TB and/or HIV services. The facilities that usually provide these services are largely limited to state hospitals or large county hospitals (MOH 2011). Should the provision of TB and HIV services expand to a significant number of the PHCCs/PHCUs, supervision checklists for these programs could potentially be integrated with the QSC.

Feedback and Follow-up

The provision of targeted feedback, joint problem solving, and follow-up actions are key features that differentiate supportive supervision from inspection. These features are essential to making the supportive supervision process more than a data-gathering exercise for monitoring performance. Feedback, joint problem solving, and follow-up provide continued value to the supportive supervision intervention beyond the actual supervisory visit.

Overall, the assessment team found that feedback is currently not being systematically provided to the health facilities by the CHDs. Interviews revealed wide differences between the CHDs in the analysis of data collected to produce feedback, content of feedback delivered, timing of when feedback is provided, format in which feedback is given, follow-up of problems identified, and documentation of feedback for reference.

Each of the seven CHDs stated that some form of verbal feedback was provided during the supervision visit, although the content of the verbal feedback varied. For example, one CHD stated that verbal feedback provided was mostly limited to how registers were completed. Another CHD reported having a meeting with the facility in-charge at the end of the supervision visit to discuss any gaps identified and encourage any positive practices observed. Findings from the health facilities were consistent with CHD findings. Nearly all PHCCs/PHCUs reported that feedback was most often verbal. Only two of the nine PHCCs/PHCUs interviewed received any written documentation from the supervision visit.

In regard to how feedback was generated, three CHDs reported using the scoring system within the QSC to generate feedback. Three CHDs reported that data collected during the supervision visit was not analyzed to provide feedback; the feedback provided was primarily based on personal knowledge and observations. One CHD did not conduct supervision visits with the QSC. Rather, this CHD had a

register to record supervision findings including purpose of the visit, department/unit supervised, findings, and recommendations. According to the CHD, copies of the findings were produced, allowing one copy to remain with the health facility, one copy to be stored at the CHD, and one copy to be sent to the SMOH. Findings from previous supervision visits are documented in the register, but no evidence existed that copies belonging to the CHD or SMOH were disseminated. This register was not found at any of the other health facilities interviewed.

When supervision visits identify a problem or a gap, five of the seven CHDs interviewed reported only following up on action items during the next supervision visit. None of the CHDs reported penalties for health facilities that failed to achieve action items identified in the previous supervision visit. Corrective action was largely confined to the time when the problem was identified. For example, if inconsistencies were found in the recording of patient data in the registers, corrective action was taken immediately by showing the health worker how to correctly fill out the register.

Feedback documentation and storage differed in each CHD. Two CHDs reported they provide verbal feedback to the facilities during the supervision visit followed by sending a written report to the SMOH. However, in both cases, this written feedback/report is only provided to the SMOH and not the health facilities. Three CHDs reported storing hard copies of completed QSCs at the CHD; one CHD sent hardcopies directly to the SMOH without retaining its own record; one CHD stored copies of its custom supervision register at the facility, CHD, and SMOH; and the remaining CHDs either did not store/archive feedback or could not identify clearly how any feedback provided was stored/archived.

Three of the CHDs interviewed reported holding countywide meetings to discuss supervision findings with health facilities. However, none of the health facility respondents indicated that they had attended any countywide meetings where supervision findings were discussed. Although both CES and WES SMOHs do hold quarterly state coordination meetings with the counties, findings from supervision visits reportedly do not usually make it into the agenda.

Strengths, Challenges, and Opportunities

This section summarizes findings from the supportive supervision component and identifies potential opportunities for strengthening the CHD supportive supervision process. Findings described in Table 24 are generalized among the SMOH, CHDs, and health facilities.

Table 24: Summary of Supportive Supervision Assessment Findings

Assessment Area	Strengths	Challenges	Opportunities
Understanding of Supportive Supervision	<ul style="list-style-type: none"> General understanding among respondents that there is value in supervision process 	<ul style="list-style-type: none"> Supervision generally viewed as an M&E/surveillance activity Lack of focus on feedback, problem solving, and follow-up 	<ul style="list-style-type: none"> Clarify the meaning and importance of supportive supervision within South Sudan in the context of the SMOH, CHDs, and PHCCs/PHCUs
Institutional Roles and Responsibilities	<ul style="list-style-type: none"> Clearly identified CHDs as responsible for supervision of PHCCs/PHCUs 	<ul style="list-style-type: none"> CHDs often unable to fulfill supervision responsibilities due to infrastructure, funding, transport, staff, remoteness of facilities, etc. 	<ul style="list-style-type: none"> Empower the CHDs to own the supportive supervision process with support from the SMOH

Assessment Area	Strengths	Challenges	Opportunities
Personnel and Team Composition	<ul style="list-style-type: none"> All CHDs able to identify personnel responsible for conducting supervision visits 	<ul style="list-style-type: none"> Team size and composition varies between each CHD Lack of training for personnel on how to complete supportive supervision 	<ul style="list-style-type: none"> Need for guidance on the ideal composition of supervision teams Training required on supportive supervision process for supervision team members
Supervision Process	<ul style="list-style-type: none"> All CHDs were able to report how often health facilities should be visited for supportive supervision Majority of CHDs used the QSC to guide the supportive supervision process 	<ul style="list-style-type: none"> CHDs unable to achieve supervision visit targets due to transportation, staff allowances, road condition, distance to facilities, vehicle maintenance, and weather When NGO partner support ends, CHDs often do not conduct supervision visits Lack of planning prior to supervision visits Lack of operational guidelines for CHDs on supportive supervision implementation 	<ul style="list-style-type: none"> Explore innovative methods of enabling CHDs to complete supervision visits Ensure that supportive supervision process can be sustained by CHDs without NGO support Develop operational guidelines on the process of conducting supportive supervision
Supervision Tools	<ul style="list-style-type: none"> Standardized national QSC available and used by majority of CHDs for supervision Documented guidance on how to complete the each indicator within the QSC Facility registers consistently available for examination 	<ul style="list-style-type: none"> Responses largely confined to “Yes” or “No” Majority of responses are not weighted based on their importance for health service provision Indicators are often general, making measurement subjective rather than based on health facility data Inability to compare responses against county/state/national performance targets (if they exist) 	<ul style="list-style-type: none"> Define specific measurement of QSC indicators to base measurement of these indicators on health facility data Provide performance targets at the CHD and state levels for performance indicators Identify tools to facilitate indicator measurement, analysis, recording, and comparison to performance targets Potentially integrate TB and HIV performance indicators into checklist as these services scale up to more PHCCs/PHCUs

Assessment Area	Strengths	Challenges	Opportunities
Feedback and Follow-up	<ul style="list-style-type: none"> • Verbal feedback being provided to health facilities in majority of supervision visits • Clear understanding of the importance of feedback in improving performance 	<ul style="list-style-type: none"> • Feedback primarily verbal • Supervision data not used to generate feedback • Feedback content limited to supervisor knowledge and observations • Feedback documentation inconsistently provided to health facilities, CHDs, and SMOH • Lack of follow-up on gaps, opportunities, or action items identified during supervision visits • No analysis or discussion of supervision findings across all facilities in a county or within the state 	<ul style="list-style-type: none"> • Identify tools to facilitate supervision data analysis and produce detailed, documented performance feedback • Standardize supervision information recording and transfer from health facilities, to CHDs, to the SMOH • Support development of documented action plans for health facilities; explore incentives for addressing action items • Provide supervision feedback documentation to health facility reference • Facilitate countywide and statewide analysis of supervision findings • Provide countywide and statewide venues for discussion of supervision findings

3.6.3 Supportive Supervision Recommendations

This survey has not only unearthed gaps that need to be overcome as a prerequisite to building a functional supportive supervision system in South Sudan, but also has provided information that will be useful to place intervention approaches within the proper context. Also itemized are opportunities in the system that could be channeled toward overcoming challenges identified. Key among this is the need to clearly articulate a functional system of supervision that will systematically and actively engage health workers in identifying and addressing gaps in the overall health facility's performance. The intervention will also explore innovative approaches to making the process of supervision more efficient. The following are strategies proffered in this regard:

- Develop supportive supervision operational guidelines for the CHDs describing in detail: target facilities; frequency of visits; supportive supervision tools; process of completing supportive supervision visits; documentation of findings; content, provision, and documentation of feedback and action items; follow-up procedures to action items; and information flow of supportive supervision findings and documentation from health facilities, to CHDs, and to the SMOH. This is recommended for year two of the project.

Although basic guidelines are available that describe how to complete the QSC, there is an absence of specific guidance for CHDs on the actual implementation of supportive supervision visits using the checklist. Creating specific guidance for the CHDs will help clarify the process, standardize the supportive supervision intervention across counties, highlight the importance of feedback, and enable improved supervision feedback mechanisms, as well as create clear guidance for information flow.

- Improve measurement and analysis of QSC indicators including weighting indicators based on importance in health facility performance, basing indicator measurement on data available at health facilities, developing county and state targets for performance indicators, and providing a systematic method of comparing indicator progress against performance targets. This is recommended for year two of the project.

The presence of a nationally standardized supervision tool is an important strength of South Sudan's supportive supervision system. Given that the tool already exists and is well-known to health facilities, counties, and states, efforts should be focused on improving this existing tool rather than on the development of an entirely new supervision tool. As stated in the Supervision Tools section, a key weakness of the current checklist is the measurement of the indicators. This weakness in measurement hinders the ability of the current checklist to systematically measure performance and compare health facility performance across counties, states, and even nationally. Efforts should be focused on further defining measurement of these indicators and basing indicator measurement on facility-level data where possible. Improved measurement of these indicators will facilitate better tracking of health facility performance and comparison against established targets.

- Identify tools to assist supportive supervision teams in completing supportive supervision visits using the QSC according to operational guidelines; provide training to CHD supportive supervision personnel on operational guidelines and use of tools. This is recommended for year two of the project.

Currently, there is a severe lack of training for CHD supervision staff on the implementation of supportive supervision visits using the QSC. Part of this training gap can be attributed to the lack of operational guidelines for the CHDs. Once operational guidelines have been developed, tools for assisting CHDs to carry out their supportive supervision tasks must be explored. One tool example could be a mobile phone application that facilitates the capture of facility data, automatically conducts calculation of checklist indicators, provides analysis indicator performance both against previous visits to the health facility as well as county/state performance targets, and assists in the documentation of action items for follow-up. Regardless of tool development, trainings for CHD supervision staff should be completed on operational guidelines as well as on supportive supervision best practices.

- Explore methods of consolidating supportive supervision data, findings, recommendations, and progress across the counties and states and facilitate venues for discussion of general findings from this consolidation. This is recommended for year three of the project.

Supervision findings are not being systematically documented. As a result, these findings are only relevant during the supervision visit and do not impact planning or policy at the county and state levels. Exploring methods to consolidate supervision findings across health facilities within the counties and states can enable counties and states to, among other things, identify opportunities for countywide and statewide support and identify performance trends. This will make the supportive supervision process more relevant to the SMOH and CHDs, beyond improving health facility performance.

3.8 Technology

The availability of technology and technology infrastructure impacts every assessment component. Although technology is not a health system component in and of itself, its availability and use have significant effects on health system performance. Furthermore, the availability of technology infrastructure will largely determine the feasibility of the RSS's, HSSP's, and other development partners' intervention approaches. For example, in areas where mobile data networks are present, interventions can capitalize on numerous, sustainable mHealth approaches to increase the reach of health system activities, more efficiently conduct health system activities, and/or improve the quality of health system activities.

The technology component of the HSSP baseline assessment recorded findings on the availability of four key technology infrastructure components: electricity, personal computers, Internet connection, and mobile phone service including both voice and data connection. The questionnaire was administered in CES and WES SMOHs, seven CHDs (4 CES, 3 WES), and seven county-level PHCCs (4 CES, 3 WES). Mobile phone service was confirmed by members of the assessment team using basic, data-enabled smartphones on the Vivacell network to determine the availability of voice service, availability of a mobile data connection, and connectivity of mobile data connection to a basic Internet application. Findings are broken down in Table 25 and narrative below by the infrastructure components as well as at the SMOH, CHD, and health facility levels.

Table 25: Summary of Technology Assessment Findings

Technology	SMOH (n=2)	CHD (n=7)	Health Facility (n=7)
Electricity (regular access)	2	2 + 5 intermittent	2 intermittent
Personal computer	2	7	0
Internet connection	0	2	0
Mobile network*			
Voice	2	7	2
Data	2	6	2

*Assessment only included Vivacell network

Electricity. Juba is one of three towns in the nation that have partial access to diesel stations for electricity. A power plant is under construction in Yambio in WES. Currently, residents must provide their own electricity, either via generators or through autonomous renewable energy systems such as solar panels or windmills. Access to a consistent power supply was available at the SMOHs in both CES and WES. Two CHDs reported connection to a consistent power supply. The remaining five CHDs had intermittent access to electricity – primarily through solar panels. No health facility reported access to a consistent power supply. Two PHCCs stated that they received some power through solar panels; however, the remaining PHCCs did not indicate any access to electricity.

Personal Computers. Personal computers, including both desktop and laptop computers, were available in both CES and WES SMOHs, as well as at all seven CHDs assessed. None of the PHCCs reported having access to a personal computer. A limitation of this assessment component is that it did not examine the capacity of staff to use personal computers beyond use of the DHIS system (outlined in the HIS section

of this report). It is possible that where computers are available, staff capacity for use is low and specific activities that require computer use outside of the DHIS have not been fully implemented.

Internet Connection. Internet connections were largely unavailable. Neither the CES SMOH nor the WES SMOH had active Internet connections. The hardware for VSAT Internet connection was available at the CES SMOH; however, it was currently not functioning due to an inactive service subscription. For immediate Internet needs, staff in the CES SMOH reported using a personal mobile USB Internet adapter. In the WES SMOH, staff would walk to the nearby WHO building when access to an Internet connection was required. Two CHDs reported having access to a current Internet connection; two other CHDs reported having the hardware for a VSAT connection but no active service subscription. The remaining three did not report having access to any connection. Where Internet connections were not available at the CHD, often CHD staff would use connections at neighboring NGOs. No health facilities reported having connection to the Internet. This finding is consistent with the lack of access to personal computers, which are a prerequisite for the ability to use an Internet connection.

Mobile Phone Service. There are two primary mobile phone service providers in WES and CES: Vivacell and MTN. One limitation of this assessment is that access to mobile phone service was only assessed on the Vivacell network. It is possible that places where we did not find a connection to the Vivacell network may have active connection on the MTN network. Coverage of mobile networks, including mobile data networks, will likely increase over time as demand increases. As both the CES and WES SMOHs are located in urban settings, it is not surprising that connection to voice and data mobile networks was present. Six of the seven CHDs had connection to both voice and data networks. Only one county, Ibba County, had connection to voice service and no connection to data service. While the majority of PHCCs assessed had access to voice and data mobile service, these findings are not generalizable to the health facility level in CES and WES. The health facilities that were included in this assessment were often within a short distance from the CHD and main town. Many of the health facilities in these states are located in remote locations where access to voice mobile service is uncertain and access to mobile data service even more so.

Opportunities. Based on these findings, there is evidence to support the use of technology, including computer, Internet, and mHealth applications at the SMOH and CHD levels. Electricity, personal computers, and Internet connections are largely unavailable at the health facility level. The question of whether personal computers and Internet connectivity are necessary to improve service delivery should be explored further prior to engaging in the design of interventions using technology at the health facility level. The use of mobile phone data connection presents a significant opportunity in South Sudan. One of the major challenges expressed in nearly every interview was the issue of transportation. Mobile applications, particularly mobile data applications, can help alleviate some of the need for transportation and provide support for health system functions over large geographic areas. Mobile applications may present a more cost-effective approach, especially when factoring in the cost of vehicles, fuel, transportation, staff travel per-diems, etc.

While some technology applications may be feasible at each level, sustainability of technology approaches by the RSS must be addressed prior to intervention design and implementation. In addition, the capacity of target staff to use technology (i.e., computers and smartphones) requires careful attention to identify gaps, as well as to develop plans for capacity building.

3.9 Strategic Coordination and Collaboration

3.9.1 Background on Strategic Coordination and Collaboration in South Sudan

South Sudan has two complementary frameworks that set out how donors and government should work together. The 2011 National Aid Strategy⁵ provides the operating principles and coordination mechanisms for all aid operations in the country, while the New Deal for Engagement in Fragile States⁶ proposes new ways of working on principles of peace and state building. These two frameworks are closely harmonized and complementary, working at the national and international levels.

The national aid strategy presents a set of best practice principles for aid delivery in the country and is developed to ensure aid is well coordinated, aligned with the government's core priorities, and strengthens national capacity and institutional development.⁷ It stems from the recognition that vast sums of aid resources are being wasted because of the inefficient ways in which aid was being delivered. The strategy also sets out a new

way of doing business, where government and development partners will work collectively toward six benchmarks (see Box 2). Finally, the strategy presents a set of mechanisms for coordinating aid:

Box 2: Aid Strategy Benchmarks

1. Aid is aligned to government policies and plans
2. Aid is managed by government institutions and strengthens government systems
3. Aid is aligned to the government budget cycle and PFM systems
4. Aid supports institutional capacity and systems
5. Aid is oriented to the achievement of outcomes
6. Aid fragmentation is avoided

- *High-Level Partnership Forum* – forum that outlines key strategic policy issues of interest to senior members of the government and development partners
- *Quarterly Government-Donor Forum* – central mechanism for coordination and information exchange between the government and development partners
- *Inter-Ministerial Appraisal Committee* – committee reviews and approves donor country strategies and flagship projects expected to disburse in excess of \$20 million
- *Sector Working Groups* – the nexus of coordination between government agencies and donors at the sector level
- *Aid Information Management System* – an online database through which donors are required to report multiyear commitments annually and expenditures semi-annually.

These mechanisms have been created to address the challenges stemming from a multiplicity of competing organizations that may duplicate program support, create parallel projects, pull health workers away from routine duties, and disrupt planning processes. In order to make the most of the gains made and to ensure future success in the implementation of health interventions, strategic

⁵ **MoFEP/RSS 2011**, Aid Strategy for the Government of the Republic of South Sudan, Ministry of Finance and Economic Planning, Republic of South Sudan: Juba, November (www.goss.org).

⁶ International Dialogue on Peace building and State building 2011, "A New Deal for Engagement in Fragile States," Fourth High Level Forum on Aid Effectiveness, 29 November – 1 December, Busan: Korea.

⁷ South Sudan Health Sector Stakeholders Collaboration Workshop April 26–27, 2013, Regency Hotel, Juba.

collaboration is essential between the government, the development partners, international and local NGOs, stakeholders, and other interest groups. Close working relationships facilitate close collaboration of project activities, ensuring greater reach, avoiding duplication of effort, and making the most of available resources. It also enables the stakeholders to identify best practices, share lessons learned, and develop innovative and realistic approaches to provide consistent, time-tested inputs at all levels of the system. The ultimate aim is to establish a mechanism at county level resulting in a single consolidated county plan, with one coordination mechanism, one supervisory and monitoring system, and one health information system under the leadership of the CHD with all supporting agencies converging to this plan.

In realization of these benefits, the baseline assessment addressed issues of strategic coordination and collaboration in CES and WES. This focused on understanding how harmonization of planning, efficiency in the use of resources, and strengthening of linkages between various actors and the SMOH and within the ministry itself works in practice. In addition, the baseline worked to examine ways to share lessons learned and best practices from certain CHDs. The assessment was also meant to determine whether or not the strategic coordination frameworks in both states are consistent with the Paris Declaration and Accra Agenda for Action against which the national aid strategy is established and which seeks to, among other things, harmonize donors' support while supporting country ownership of the development process at the SMOH, CHDs, payams, and bomas.

In addressing the above objectives, the baseline assessment team started with a review of key coordination policy documents, notably, the 2011 National Aid Strategy, New Deal for Engagement in Fragile States, and HSDP, to determine the existence and effectiveness of the coordination frameworks within the MOH. The Partners' database at the Health NGO Forum (MOH/RSS) also provided a valuable source of information for health stakeholders' mapping. As a complement, the recommendations of the national Health Sector Stakeholders Collaboration Workshop held in April 2013 were also considered to determine effective ways of coordinating aid within the health sector in the two states.

Primary data were obtained through focus group discussions and face-to-face interviews with the DG, SMOH; directors of primary health care; county health officers, and lead staff from the PHCCs and PHCUs in the two states. The ISDP program managers and representatives of the county implementing partners – Action Africa Help International (AAH-I) (in Yei River and Ibba counties), AMREF (Morobo), South Sudan Health Association (SSUHA) (Lainya), Norwegian People's Aid (NPA) (Juba), Maltezer (Maridi), and IMC (Nzara) and key partners in coordination (WHO and UNICEF) – provided additional information. In total, the assessment team held 24 interviews, which lasted about two hours each, with these groups. In the next section, we present the findings.

3.9.2 Key Findings Strategic Coordination and Collaboration

This section presents the findings on the coordination component of the baseline assessment. An examination of the coordination mechanisms considered, before proceeding to partners mapping, challenges and ways to address them. The section ends with a review of the key findings categorized into strengths/opportunities and gaps or weaknesses, summarized in table 27. The findings provide several pointers as detailed below.

Adaptation of the National Aid Strategy by the MOH

The RSS MOH has embraced the national aid strategy and established several health sector coordination mechanisms. The health sector has in place several coordination mechanisms that aim to achieve the national aid strategy benchmarks. These include the following:

- *Weekly senior board management meetings.* This is the formal decision-making body of the MOH that is chaired by the minister of health. It provides the broader aid coordination mechanism within the health sector and coordinates the activities between MOH and development partners, paying attention to the harmonization and alignment of financial and technical support within the frameworks of the South Sudan Vision 2020, South Sudan Development Plan, and the HSDP. Its aim is to avoid duplication and parallel processes during the planning and implementation of health sector programs.
- *Bi-annual consultative meetings with the SMOH.* Representatives of the SMOH are invited by the RSS MOH to provide updates on planned and executed activities, discuss challenges, and build consensus on the way forward.
- *TWGs in key areas.* These include Reproductive Health, Malaria, TB, HIV/AIDS, EPI and Health System, Human Resources Development, and Guinea Worm. The TWGs are mandated to meet on a monthly basis or as and when need arises to coordinate activities within their respective technical areas; share key policy documents and reports; facilitate discussions of challenges, opportunities, and gaps; and ensure adherence to government policies, strategies, and guidelines.
- *Other coordination mechanisms within the MOH.* These include the country coordinating mechanism that oversees Global Fund grants and that operates according to an agreed-upon governance manual, and the Health e-mail Communication Forum, for technical exchange of information via electronic media.
- *State/county/payam/community coordination mechanisms.* The assessment confirmed the existence of five main coordination mechanisms at the state and county levels – the Ministerial Departmental Meetings, State Coordination Meetings, SMOH Coordination Meetings, County Health Coordination Meetings, and Emergency Meetings. (Table 26 lists all the entities identified.) All are linked to the national-level mechanisms listed in Box 2, and their agendas are quite similar to those of the national level entities: they exchange information on planned activities, review past performance, share achievements and lessons learned, review performance indicators against set targets and challenges, and agree on ways to address the challenges. On occasion, they hold training and capacity-building workshops on topics of concern or interest. The forums at the county levels and below normally share copies of their minutes with the SMOH for follow-up on specific actions.

Table 26: Coordination Mechanisms at the State, County, Payam, and Community Levels

Mechanism	Leadership	Regularity	Performance	Comments
Central Equatoria State				
<i>Ministerial departmental meetings</i>	SMOH, DG, or Minister of Health	Monthly, quarterly	4 - very good	Tend to be participatory
<i>State coordination meetings (to be supported by WHO)</i>	Chaired by governor, includes all NGOs working in the state	Monthly	3 - good	Frequently postponed
<i>SMOH coordination meetings (supported by UNICEF)</i>	MOH, DG, or Minister of Health	Quarterly	3 - good	n/a
<i>County health coordination meetings</i>	County medical commissioner	Monthly	2 - fair	Lack of funds to convene meetings
<i>Emergency meetings</i>	WHO	Three times annually, and in emergencies	n/a	n/a
Western Equatoria State				
County Health Coordination Forum	CHO chairs, County Implementing Partners take minutes	Quarterly	3 - good	Rotational donor funding support
Ministry departmental meetings	Quarterly	Quarterly	5 - excellent	Participatory, all-inclusive, rich in agenda and exchange of ideas among counties
CHD Management Team	CHO chairs, County Implementing Partners take minutes	Monthly	3 - good	n/a
Health and nutrition coordination meetings	DG/SMOH	Quarterly	n/a	CHD attends on behalf of the partners
Boma Health Committee meeting	Chair, VHC	Monthly	2 - fair	No minutes taken, no follow-up actions
Quarterly health care delivery coordination meetings	SMOH/DG	County coordination meetings SMOH	3 - good	Major policy decisions made, CHD reports presented and reviewed, plans are shared, outbreak discussed, managers encouraged to produce good reports
Health emergency meetings	Chaired by the SMOH, co-chaired by the WHO and World Vision	Monthly	3 - good	n/a
Partners' forum	Chaired by the governor	n/a	n/a	Attended by all development partners in the various fields Line ministries present on progress with respect to the implementation of activities

Source: Survey data

Forums are also held at the community (payam and boma) level, although not regularly. They are used to train volunteers who work on activities such as nutrition and surveillance or on specific health campaigns. For instance, during the National Immunization Days, the volunteers move from one payam to another to do social mobilization and help different groups – women’s union, church leaders, chiefs, payam administrators, health committee members – organize for the event. The forums also are a platform for local leaders to mobilize their constituencies in support of the agenda. Health staff may be invited to address community concerns that they may have (e.g., how to address side effects of some of the interventions). Development partners often support these community-led meetings.

The VHCs provide good linkage between the communities and the formal health sector. Building VHC capacity to actively engage with the mainstream coordination mechanisms is critical to improving the coordination and implementation of community health activities. The HSDP considers VHCs key to enhancing community participation and ownership, providing referrals to the formal health system, and improving surveillance and, M&E. This is in addition to strengthening PHCC/PHCU monthly work planning, outreach health programs, health education and promotion, and health campaigns and awareness programs. But VHCs currently are limited in what they can do, primarily due to inadequate operating funds and lack of capacity in key areas such as planning, leadership, and management.

The government has provided sound leadership to the coordination forums in spite of capacity constraints. The meetings at the SMOH are normally led by the SMOH DG. At the county level, donor coordination meetings are chaired by county health officers (CHOs). CHOs also chair payam meetings, with the county administrator participating as a guest of honor. In the meantime, the volunteer coordination meetings are chaired by the CHD surveillance officer and social mobilizers; meetings normally held before the implementation of health campaigns are chaired by the CHD surveillance officer or the CHO. While the situation may appear satisfactory, government’s capacity to provide stewardship to such forums on a sustainable basis is constrained by lack of staff and lack of funds for refreshments at the meetings. In addition, lack of funds for vehicle fuel, maintenance, and repairs limit transportation to the coordination venues. For these reasons, health partners (notably, WHO and UNICEF) tend to coordinate and run many of the meetings. Government’s participation has been reduced to attendance and chairing the sessions. There is an urgent need to strengthen the stewardship capacity of the government staff such as the SMOH DGs and the CHOs.

Stakeholders Mapping

Baseline assessment completed because of the absence of a complete stakeholders’ mapping of the health partners: According to the baseline assessment, there are six USAID-funded lead agents in CES and 10 in WES (one for each county), providing primary health service delivery (Table 27). The lead agents have contracted over 25 NGOs in each of the two states to provide a mix of medical services and interventions relating to the BPHS (see Annex A-1 and A-2). These services include: HIV antiretroviral therapy, voluntary counseling and testing, prevention of mother-to-child transmission services, HIV advocacy, tuberculosis and leprosy treatment, maternal health services, malaria prevention (distribution of nets), neonatal child health and nutrition, and EPI. The interventions will include community mobilization/sensitization, water and sanitation (e.g., drilling boreholes and water treatment), provision of essential medicines, polio campaigns, training and capacity building (especially for health promoters, midwives), provision of fuel for supportive supervision transportation vehicles, strengthening of referral services (e.g., ambulance services), vehicle repairs and maintenance, medical equipment, and bedding. A

few of the NGOs provide for staff salaries, especially in understaffed areas, renovation of health facilities, and capacity building and women’s empowerment in income-generation activities.

Unfortunately, the states and counties do not have complete information about the partners on the ground, though the situation is much clearer in CES than in WES. Lainya County is a good example of where attempts have been made toward stakeholders mapping. The CHD uses a map of the payams and all health facilities in the county to agree on where each of the partners will operate on a regular basis and on specific occasions such as National Immunization Days. Currently, the SMOH relies on the partners to inform it of their presence on the ground.

Table 27: Health Partners Operating in WES and CES

State	County	Lead Agent (level of support in US\$)	Other Partners
Central Equatoria State	Yei River	Action Africa Help International (AAH-I) (\$1.2m)	<ul style="list-style-type: none"> Population Service International (PSI); St Bakika Health Center; Martha PHCC; Episcopal Church of South Sudan (ECS) South Sudan Methodist Church
	Morobo	African Medical and Research Foundation (AMREF) (\$750,000)	<ul style="list-style-type: none"> PSI; Sudan Christian Outreach Ministries (SCOM)
	Kajokeji	ARC International (ARC) (\$1.1m)	<ul style="list-style-type: none"> South Sudan Health Association (SSUHA), local NGO Kajokeji AIDS Program (KAP), local NGO County AIDS Commission (CAC), local NGO Mobile Health International (MHI) International Medical Corporation (IMC) Comboni Missionaries
	Lainya	SSUHA (\$650,000)	<ul style="list-style-type: none"> South Sudan Red Cross (SSRC) PSI ZOA
	Terekeka	Adventist Development and Relief Agency-South Sudan (ADRA-SS) (\$1.3m)	<ul style="list-style-type: none"> Africa Medical Research Foundation (AMREF-SS) Magna-Children at Risk People in Need -Czech Republic
	Juba	Norwegian People’s Aid (NPA) (\$2m)	<ul style="list-style-type: none"> SSRC; PSI AMREF; Organization of Volunteers for International Cooperation (OVCI); Caritas; Marie Stopes; Aids Resistance Trust
	All counties	USAID Health Systems Strengthening Project	<ul style="list-style-type: none"> All partners
Western Equatoria State	Maridi	Maltezer (\$800,000)	<ul style="list-style-type: none"> AAH; AMREF; German Leprosy and TB Relief Assn (GLRA); ZOA
	Mvolo	NPA (\$600,000)	n/a
	Mundri West	AAH-I (\$700,000)	<ul style="list-style-type: none"> Sudan Evangelical Mission (SEM) SSRC International Aid Services (IAS) Mundri Active Youth Association (MAYA),

State	County	Lead Agent (level of support in US\$)	Other Partners
			community-based organization
	Mundri East	Mundri Relief and Development Assn (MRDA) (\$900,000)	<ul style="list-style-type: none"> ▪ UNICEF; ADRA, Colegion Universitario Aspirante Medici Missionari (CUAMM); SSRC; PSI; ZOA
	Ibba	AAH-I (\$600,000)	<ul style="list-style-type: none"> ▪ ZOA
	Yambio	World Vision (\$1.1m)	<ul style="list-style-type: none"> ▪ n/a
	Ezo	World Vision (\$800,000)	<ul style="list-style-type: none"> ▪ n/a
	Nzara	IMC (\$700,000)	<ul style="list-style-type: none"> ▪ IMC ▪ Catholic Medical Mission Board (CMMB) ▪ World Vision ▪ Episcopal Church of South Sudan (ECS)
	Tambura	IMC (\$750,000)	n/a
	Nagero	Johanniter (\$600,000)	n/a
	All counties	USAID Health Systems Strengthening Project	All partners

Source: Field Survey

Most recently, the CES SMOH requested all the county health commissioners to provide information about all the partners working in their counties. According to the CES director of primary health care, the response was good, though key information was missing from the responses – for instance, specific areas of support, target population, project duration, funding support, and key contacts for effective and regular communication. This was probably due to the lack of a template in which to enter each piece of requested information. In interviews, the assessment team learned that some international NGOs (especially in CES) that obtain direct approvals from the RSS MOH bypass the states and counties and go directly to the communities. In other cases, some of the NGOs send their performance reports directly to the national level, bypassing the SMOH. In response, the minister of health⁸ has called for the enforcement of a policy that mandates registration of all the health NGOs operating in the country and an update of the NGO matrix on a regular basis. The minister also called for the signing of a memorandum of understanding (MOU) between the NGOs and the MOH to formalize the partnerships, including the detailing of the activities being implemented and the funding levels.

Challenges

The coordination mechanisms face numerous challenges.

- Low turnout to the meetings due to:
 - Unavailability of government staff – It was observed that government staff are usually away attending workshops and do not give the coordination meetings priority.

⁸ Remarks made at the “South Sudan Health Sector Stakeholders Collaboration Workshop (April 26–27, 2013)”, Regency Hotel, Juba.

- Lack of substantive items in the agenda – Respondents commented that the coordination meetings are poorly run. In the words of one informant: “The agenda appears to be the same and there is no rhythm in the quarterly coordination meetings and consultations.” For this reason (and others), the development partners (notably, the international NGOs) tend to send to the meetings junior officers who do not have authority to make policy decisions.
- Low motivation among government staff – According to letters of complaint from one of the CHDs and information obtained during the assessment, government staff are paid less than their NGO counterparts doing similar work. This creates tension when the two groups work together, for example, in coordination activities. The government workers asked for raises to match the salaries of their NGO counterparts. When this issue was not addressed, many government staff resigned, adversely affecting the quality of services.
- *There is limited funding to convene and facilitate meetings.* According to CHD staff, funding is not available for logistical support, including travel, accommodation, and lunches for those coming from long distances for the meetings. This problem is compounded by the lack of adequate communication equipment (e.g., computers, printers, mobile phones, fully functional Internet services, and stationery to write invitation letters and minutes of the meetings, which are usually handwritten). Where IT equipment was found to be available, as in Morobo CHD, which has four laptops, three desktop computers, and a functioning VSAT satellite Internet systems, the staff have not been trained in their use. The situation has improved, however, in CES with the coming of the lead agencies that have provided support in some of these areas.
- *Poor synchronization of plans and budgets with the CHD annual operational plan.* The coordination meetings between the CHDs and the NGOs and donor agencies are meant to provide joint planning and budgeting opportunities for all key players at the state and county levels and to sort out who would support which programs, but this has not been realized. According to our findings, the development partners, including the international NGOs, are rarely involved in the county work planning process and have been accused of lack of transparency on planning and budget issues. According to one informant in CES, “Every development partner appears to be keeping their budgets, activity plans, and reports to themselves and do not share them with the CHDs.”

An informant in WES noted that, “Every partner here is moving alone in their vehicles and conducting their activities alone.” In light of these developments, the partners are being urged to develop and maintain a climate of transparency, openness, accountability, and honesty in all relations and transactions with the CHDs.

These perceptions notwithstanding, many partners in the counties assessed share their work plans during the consultative meetings and are involved in joint appraisal of performance with the SMOH and CHDs. The CES SMOH is also directing new partners to liaise with the lead agencies to avoid overlaps in the implementation of activities. Lainya CHD is one of the most successful examples of a CHD attempting to align and harmonize the work plans of various partners to minimize the cost of delivering aid. Through an MOU and joint planning, the key partners now have specific tasks and areas of operations allocated to them. For instance, South Sudan Red Cross is to focus on EPI and HIV activities, while PSI focuses on child survival, training, and capacity building, and ZOA South Sudan focuses on water and sanitation.

The problem of coordination in planning and budgeting was also found to exist between the CHD, SMOH, and county commissioner's office. Although the latter is supposed to support the CHD in meeting operational costs, this rarely happens. Instead, the CHDs obtain their funds directly from their respective SMOH. The county commissioner's office argues that the CHDs in both states obtain funding from the development partners and should not expect additional funds from the government. It also argued that some counties get additional revenue that is not reported to the county commissioner's office and that this should be used to support the CHDs.

- *Limited collaboration between the various government tiers.* The recent Health Sector Stakeholders Collaboration Workshop identified the lack of an effective coordination mechanism for the SMOH and the RSS MOH, especially in regard to the training of nurses and doctors. The states indicated they were ready to provide feedback to the MOH on a regular basis and highlighted the need of a coordination officer at MOH to deal with issues coming from the 10 states. This assessment also found limited coordination among the SMOH, counties, payam, and the PHCU/PHCCs. At times, this has led to duplication of efforts, as in the case of supportive supervision and inspections. The SMOH staff rarely visits the other groups except during special campaigns (e.g., National Immunization Days and in emergencies). There is also lack of clarity on the coordination of roles and responsibilities and the departments appear to work in 'silos' with no focal person(s) to initiate interdepartmental meetings. Lainya County is a good example of where duplication has been avoided through harmonized joint planning. Through MOUs with the health partners, the county has arranged with ZOA South Sudan to focus on hygiene trainings and on drilling boreholes, PSI concentrates on child survival and malaria activities, South Sudan Red Cross works on activities relating to the EPI, and all the NGOs support government staff with transportation.
- *Lack of a clear coordination framework.* When asked about the types of coordination tools or frameworks available at the different levels, interviewees provided many answers, such as strategic plans, organograms, MOH policy and guidelines, HIS tools, treatment guidelines, and BPHS. From these answers there appears to be a lack, or misunderstanding, of tools or frameworks that are required for effective coordination. It seems to be assumed that an MOU or meeting between stakeholders produces coordination, whereas it only starts the process. More work needs to happen if coordination and ultimately health sector targets are to be achieved.

Weak communication among the partners. Although virtually all the CHDs interviewed allege that their staff take minutes of the coordination meetings, these minutes are rarely archived and were not available for review during the assessment interviews. In addition, there is very little follow-up on issues raised in the meetings. In one extreme case, a CHO alleged that his predecessor took all the office documents, including the minutes, with him when he was fired. In other instances (Munuki Payam, Juba County), minutes of the coordination meetings were taken but hardly ever shared. These developments provide challenges in leadership, management, and governance.

3.9.3 Strategic Coordination and Collaboration Recommendations

The first three recommendations outlined below address the gaps highlighted above, and outlined in table 28 below, and will likely constitute the main activities of HSSP in year one with regard to coordination and collaboration. The last one is meant to be a longer-term objective, which would constitute part of HSSP's year two activities.

- *Undertake stakeholder’s mapping of the health partners in CES and WES – To avoid duplication and foster synergy with the national NGO database, the assessment recommends the use of the Health NGO Forum stakeholders mapping tool.*

The mapping exercise will be accompanied by the design and delivery of a brief training module to develop the capacity of the states and counties so they can carry out similar activities on their own in subsequent years. With good information, the project will begin to develop a website for each state to share the information more widely. Effective stakeholder mapping will provide more accurate and updated information on health partners in terms of ownership, funding sources, geographical coverage, and scope of interventions.

- Commission and operationalize county monthly coordination meetings – To foster synergy and complementarity with the UNICEF and WHO coordination efforts, there is a need to support the monthly county coordination meetings which now have only modest support.

The meetings will be used by all the partners in the county to develop and share work plans and budgets; update each other on progress, achievements, and challenges with respect to the implementation of activities; follow up on performance reporting; develop action plans; track performance against the target indicators; address program performance constraints; and provide hands-on training in areas of interest to the groups. The forums will be chaired by the county medical officers and attended by SMOH representative as a way of strengthening the SMOH stewardship role in coordination.

- Develop a strategic coordination framework to guide regular coordination of stakeholder meetings, ensure frequent communication among the partners, provide effective leadership to the forums, ensure follow-up on action items and promote consensus-based decision making by the partners.

Contents of such a framework could include, but are not restricted to:

- Defining the operational policy framework within the context of the national aid strategy adopted by the MOH
- Setting the objectives and approaches to the coordination forums
- Establishing the coordination frameworks
- Establishing the functions, roles, and responsibilities of each partner through the coordination of implementing activities
- Organizing the structure and roles of the various partners and the government
- Creating institutional linkages and relations with other health and non-health institutions
- Developing a constitution and/or MOU to guide partners participation and operations
- Defining expectations of each partner
- Defining how business is conducted among the partners – agenda, leadership, discipline, elections/appointments, committees, induction of new partners, and order of meetings (frequency, convener, reporting)
- Developing strategies to strengthen collaboration and partnerships

- Creating an enabling environment, resource envelope, and management support services
- Providing logistical support to the coordination of activities and training
- Creating effective networking and performance monitoring mechanisms
- *Enhance the leadership capacity of the VHCs.* This will provide technical and financial support to the VHCs to (1) strengthen linkage with the health facility management teams through regular consultations to exchange technical information, update each other on the implementation of work plans, and address any challenges; (2) develop simple and culturally appropriate materials for use in health education and advocacy on promotive and preventive health at the community level /primary health care updates; and (3) sensitize immediate communities on health education.

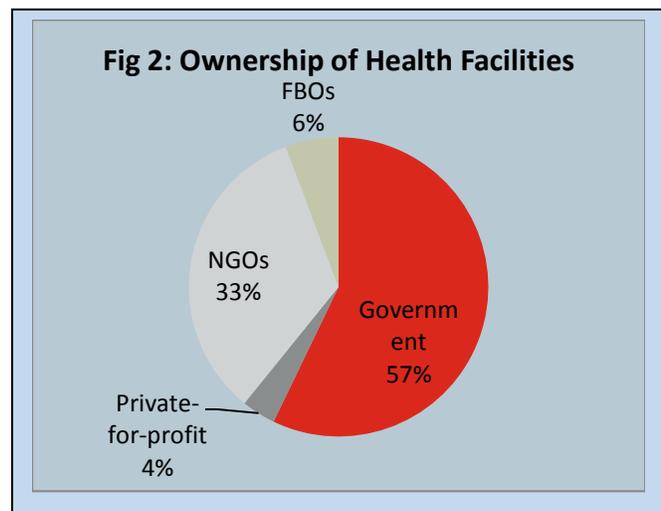
Table 28: Strengths, Opportunities, Gaps, and Weaknesses

	Strengths/Opportunities	Gaps/Weaknesses
Stakeholders mapping	<ul style="list-style-type: none"> ▪ Existence of the NGO forum at the national level with templates that can be adapted to the county/state conditions ▪ National NGO Health Matrix/Tools are available for replication ▪ NGO registration with the government is now part of requirement by the minister of health, so compliance / response should be better 	<ul style="list-style-type: none"> ▪ Expensive and time-consuming exercise
Coordination mechanisms / <i>County Monthly Coordination Meetings</i>	<ul style="list-style-type: none"> ▪ An enabling environment supported by strong will and commitment by the government—there is an overarching RSS aid strategy that the county/state coordinating mechanisms can use ▪ Existence of coordination mechanisms (WHO/UNICEF) at the state and counties that formally link naturally to the center ▪ These meetings can serve as an opportunity to present issues and could easily feed into state coordination meetings ▪ Existence of the sister project (ISDP) on the ground could be exploited to create system to improve reporting, communications, etc. 	<ul style="list-style-type: none"> ▪ Limited government funding to operationalize the mechanism, situation worse with the financial austerity measures ▪ Long travel distances between counties and state headquarters, poor infrastructure provides hindrance to coordination
Communication	<p>Availability of good IT equipment and communication, especially in CES</p> <p>Existence of communication mechanisms that can be built on:</p> <ul style="list-style-type: none"> ▪ Verbal reporting: from community to health providers (e.g. community-based organizations, churches, VHC, HIV advocates to health providers) ▪ Paper reporting: from health facilities to CHD (i.e., outbreaks, disease trends, stock-outs) ▪ Electronic reporting (DHIS) from CHD to SMOH (county-based needs and responses) 	<ul style="list-style-type: none"> ▪ Low literacy levels / language barrier (English/Arabic) ▪ Inadequate IT equipment especially for the WES ▪ Expensive to provide

4. Private Sector Participation

The baseline assessment had originally not intended to examine the private sector in detail. Even then, in the course of the assessment, many issues touching on the private sector (that is, for profit and, not-for-profit (NGOs/FBOs) became more prominent and could not be ignored. Therefore, the team agreed to have a section on the private sector to examine its contributions in HSS in both states. This part of the assessment relied on data from two not-for-profit private health facilities that agreed to provide information. Additional information was volunteered by the informants during the interviews for the other components. Due to the limitations in sample size, caution is needed when interpreting the findings in this section as some of them may not be generalizable for the entire population. The limitations notwithstanding, the assessment provides pointers that have a direct bearing on overall health systems strengthening in WES and CES. Among others, the assessment points to the existence of:

- *A relatively small, but significant, private sector:* The for-profit private sector is relatively small in the health sector in South Sudan (see Fig 2)⁹, with its contributions not substantially studied or documented. Even then, when the non-public sector is combined (that is, FBOs and NGOs), the contributions are quite significant as also found by the EmOC study from 2003. The not-for-profit sector is more strategically positioned to deliver the country's basic package of health services, particularly in the remote and hard-to-reach areas. Together, non-public sector and the public sector, have great potential when effectively mobilized, to reduce the appalling levels of MMR, U5M, IMR, among others, as also realized by the Health Sector Development Plan (p. 25)¹⁰.



- *Stronger financial management systems in not-for-profit sector:* Financial management systems in place at the private-for-profit facilities observed were found to be much more organized and systematic than those of the public health facilities. The former had well executed planning and budgeting frameworks and, regular financial and technical reporting through the Diocese or, Secretariats. They also had well-kept financial record books, weekly meetings with staff to reconcile the record books, and often agreed on new purchases which were later recorded. The record keeping system was more transparent as the health facilities recorded every item they spent their money on, for example, soap or medicine for patients. There were clear segregation of duties, especially in payments and procurement, and fairly well established systems for accounting documentation. Where user charges were affected, those responsible at the facility

⁹ Data obtained from the: Ministry of Health. Government of Southern Sudan 2013. South Sudan EmONC Needs Assessment Draft Report

¹⁰ The estimate is based on health facilities providing emergency obstetric and newborn care EmONC services (ibid, p19)

had consistent knowledge of fees (for instance, registration-SSP 2-3; admissions - SSP 5 and, laboratory services - SSP 4). These fees have been monitored by the state or CHDs as would otherwise be expected. The staff in charge of the not-for profit health facilities that were examined, indicated that they do not get salaries on a consistent basis. Many times the payment is delayed by a month or a month and a half. Employees stay “because they are Christians,” otherwise they would leave.

- *Attrition of staff to the NGO operated public health facilities:* The NGOs/not-for-profit private sector were found to have better opportunities to hire much of their health workforce from within the country, from the public sector and, from outside the country. It was alleged by the private sector (for profit) health facilities managers that the NGOs pay significantly higher salaries than the State, leading to significant attrition from State facilities. In the clinics where government and NGO staff are working side by side, there is significant disparity in pay between them, even among the same positions. The States indicated that most of the attrition of their health workers is to NGOs, rather than to other States or countries. Given the NGOs’ significant role in HRH, the project will need to work with them to strengthen HRH in the States. First, the staffing standards that the project intends to develop, need to be applied to both public and non-public health workers—regardless of the type of health facility. All health workers should fall under the same types of titles, and should meet the minimum training standards, and comply with required skills updates. Still, the HRIS needs to be updated to capture non-public health workers. Also, as part of the realignment and reorientation of workforce supply, the project will need to take into consideration where the NGOs are working and their staffing numbers. Again, in as much as possible, HSSP will need to work closely with the NGOs to align salary scales and employment policies in accordance with the Council of Ministers’ Resolution 108/2012 dated 8th June 2012, to ‘tighten up the payroll and remove ghost workers’.
- *Limited coordination between the for-profit-private sector and the other actors:* According to the assessment, the government is not actively engaging with the for-profit private sector and the SMOH/CHDs have not demonstrated interest in collaborating with the private (for profit) health sector. Currently, there is no mapping of the private (for profit) sector players and the sector does not provide HIS data. The for-profit private sectors financial contributions to overall health financing in South Sudan, including WES and CES, remain unknown. This lack of basic information provides one of the greatest barriers to public sector understanding of the for-profit-private health sector. Still, even though the for-profit private sector is part of the health system, it is rarely involved in the SMOH/CHD coordination meetings, public sector trainings, or other capacity building initiatives.
- *Weak legal and regulatory framework for the for-profit private sector participation:* During the assessment, there was a perception among public sector workers that, many of the private (for profit) clinics, pharmacies and drug shops are run by unqualified people. Unqualified health professionals are also reported to continue to practice privately in both states, despite some well publicized crackdowns by the SMOH and CHDs. Further, there is no regular inspection for quality assurance and, no active board to legally regulate the practice of these groups. It was not within the mandate of the present assessment to verify these allegations, but, it may be necessary to undertake a comprehensive study on the private sector to address the policy and regulatory aspects.
- *Limited government supervision of for-profit private sector health facilities:* An examination of supervision practices in two of the not-for-profit health facilities indicates that, the State takes little or no responsibility for the supervision of not-for-profit health facilities, with the exception of provision of registers and drugs, and occasional courtesy visits. The FBO examined has a

parallel structure headed by the diocese which oversees over 4 arch-deaconries distributed across different geographic areas of the county. In the framework, supervision activities are more elaborate and extend from the health facility to the community. The church provides clearly defined community health activities which need to be monitored. For instance, the training of home health promoters who promote healthy lifestyles in the community and also make referrals to the facility should be supervised. From the assessment, there is a general consensus that the private health sector, for profit and not-for-profit, has an important role to play in the health systems of WES and CES. There is an important opportunity here for the MOH/RSS to provide the needed stewardship of increasing private sector participation. Issues in need of urgent attention include establishing: an institutional framework to promote public-private-partnerships; appropriate legal and regulatory structures to facilitate growth of the sector; effective ways of obtaining and using information from the private sector; building private sector human resource capacity and, appropriate financing strategy for the private sector.

5. Data Validation

As part of stakeholder engagement, stakeholders from WES and CES attended validation workshops of the assessment findings on July 31 and August 27, 2013, respectively. Overall, the workshop participants found the assessment findings consistent with their views of the health system in the two states. They also identified ten recommendations (out of a total of thirty-four recommendations from the assessment team) that they believed deserve a high priority for implementation. To select the top ten recommendations, the workshop participants in both states were divided into six break-out groups representing each of the key HSSP thematic areas. Each group reviewed the assessment recommendations that pertained to their own area of expertise and identified their top three recommendations for that thematic area. In plenary sessions that followed these break-out meetings, the eighteen identified priority recommendations (three recommendations in each of the six areas) were reviewed, and the participants selected their top ten. Table 29 shows the top three priorities noted by each group, and the final ten priorities, with their plenary rank and score in both states. In all, the table provides the following pointers.

- *Interventions are needed in each of the project's thematic areas.* Going by the local stakeholders' reflection of community needs and the realities on the ground, the project now has strategic guidance in areas to target support.
- *Similarities in top priorities:* an examination of the top priorities by thematic area indicates that both states have at least two similar activities among the top three. Therefore, there are opportunities for HSSP to adopt similar strategies and approaches in the implementation of the planned activities in Year 2. This is in addition to increased opportunities for sharing best practices and promoting learning exchanges among the states, counties, and peer groups.
- *LM accorded top most priority:* LM ranks as the top most priority of both states, as it provided the highest number of activities (by thematic area) in the top 10 priority activities for both groups. It was followed by HRH, HIS, Coordination and, Health Financing. This finding is important for the HSSP Year 2 work planning.
- *Similar priorities in HIS and SS:* Both States chose the same top three activities in HIS and SS, with the priority rankings being identical for HIS. This ranking could be an indication that both states face similar challenges and, possibly have similar solutions. This is important considering that, these activities are driven by the MOH/RSS.
- *Low prioritization for health care financing:* This outcome comes as a surprise considering the huge PFM capacity gaps evidenced in both states. Perhaps, the SMOH and CHDs may not be taking PFM as a key role within their mandate as they have traditionally fallen in the domain of the MoFEP or, County Commissioner's Office. With the decentralization and planned direct transfers of SSP 50m to the CHDs, the CHDs will be increasing their roles in resource mobilization, prioritization of programs, the budgetary process, efficient management of resources, and the exercise of internal controls.
- *Low prioritization of internet connectivity in WES:* This outcome comes as a surprise (especially for WES) considering the linkage between the availability of technology and technology infrastructure, and positive effects on health system performance in such areas as HIS, SS, Coordination.

Priority recommendations of stakeholders during the baseline assessment validation workshops

Thematic area	Top 3 priorities of stakeholders by thematic area		Top 10 priorities of stakeholders by state	
	WES	CES	WES	CES
Leadership and Management				
▪ Design or adapt leadership and management training curriculum for all the health systems components. Roll out training from the SMOH to the CHDs and lower levels	1	2	8	2
▪ Develop job/desk aids and support their implementation	2	-	-	-
▪ Enhance on- the-job training, coaching, and mentoring efforts	3	1	5	1
▪ Enhance the capacity of the village health committees in leadership, management and governance	-	3	-	6
Health Financing				
▪ Empower SMOH/CHDs to productively engage with the state/county Transfer Monitoring Committee	1	-	-	-
▪ Cascaded training of trainers aligned with PFM implementation guidelines	2	3	-	-
▪ Strengthen bottom-up planning with structured involvement of VHCs and payams	3	2	5	-
▪ Hands-on technical support to develop CHD strategic plans/budgets	-	1	-	2
HRH				
▪ Provide training for managers/training of trainers (state and county /payam level) on strategic planning. Extend training to health facility managers	1	1	1	2
▪ Develop job standards, leveraging current job positions	2	-	-	5
▪ Provide refresher training for managers/ training of trainers (state and county level) on performance appraisal process	3	2	8	-
▪ Conduct in-depth assessment of JICA data base, processes, trainees to identify resources that can be used, best practices, gaps and pitfalls	-	3	-	-
HIS				
▪ Develop HIS strengthening plan for the CHDs in their states	1	1	1	9
▪ Initiate a DQA training and validation	2	2	-	-
▪ Support quarterly/monthly data review meetings at SMOH/CHD level to evaluate (and if needed, validate) data from CHDs	3	3	10	10
Supportive Supervision				
▪ Identify tools to assist supportive supervision teams in completing visits using QSC according to operational guidelines	1	1	5	-
▪ Develop supportive supervision operational guidelines for CHDs. Consolidate SS data, findings, recommendations, and progress across the Counties and States and facilitate discussions on the findings	2	3	3	-
▪ Provide training to CHD supportive supervision staff on operational guidelines and use of the tools	3	2	-	-
Coordination				
▪ Monthly county health coordination meetings	1	2	4	-
▪ Strengthen the capacity of MOH support to SMOH and SMOH to CHDs	2	-	-	-
▪ Develop health stakeholders strategic coordination framework	3	1	-	7
▪ Provide support for the use of technology, including computer, internet, and mHealth applications for HSS	-	3	-	4

Source: Data from the validation work shops

6. Assessment Conclusion and Recommendations

Conclusions

The purpose of the baseline assessment was to provide a snapshot of the health system in the two South Sudan states where HSSP operates (CES and WES). The assessment looked at the strengths, opportunities, and gaps in the state and county health systems to inform the implementation of current and future HSSP work. The assessment focused on seven thematic areas, namely, LM, health financing, HRH, HIS, technology, SS, and strategic coordination. The findings suggest that interventions are needed in each of these areas. The validation of the findings and, prioritization of interventions by the local stakeholders reflect on urgent community needs based on the realities on the ground and, further provide strategic guidance on areas in need of targeted support. This focus on buy-in and local ownership has great potential to build sustainability into HSSP work and, increase the potential for HSSP success.

From the assessment, it is also evident that, more resources will need to be targeted to WES that faces relatively more challenging HSS issues including limited technology, as also found by the EmOC Assessment Study (MOH/RSS, 2013). With LM and, HRH among the areas being accorded top most priorities, the project will need to urgently address the acute workforce challenges. It may be necessary to build on the general trainings through workshops and go further into the application of a combination of structured people development interventions, notably, training, coaching and, mentoring and, on-the-job trainings. This approach would be more favorable given the wide range of backgrounds of the current workforce and, the fact that, many workers are not qualified for the positions they currently hold. Embedding HSS staff may also be necessary in some SMOH/CHDs with acute staff shortages.

More work will need to be undertaken by the project in HF as it appears that, the SMOH/CHDs still do not see themselves as active players in this area which has predominantly been under the jurisdiction of the MoFEP. Undoubtedly, HF interventions require more close collaboration with the Ministries of Finance and Economic Planning and, Local Government to ensure the PFM skills and knowledge are transferred to the SMOH/CHDs as devolved units. In HIS and SS, interventions will require similar approaches in both states as the perceptions regarding priority interventions are the same. Strategic coordination between the various thematic areas of the project and, with the other partners (especially USAID key projects) will especially be key to increasing scope and reach of HSSP activities and, to foster possible synergies.

As the assessment did not cover all the states, follow-up assessments will be needed in the other 10 states to capture certain unique gaps that may not have been revealed by the present study. This will enable the project to be more responsive in addressing the unique HSS needs of each county. With emerging issues in HSS, there will be need for complementary surveys, on a regular basis or, *'as and when need arises'*, to guide implementation of activities in the future.

Overall, the outcomes of the baseline assessment including validation, call for a shared responsibility in the strengthening of the health systems in both states. The stakeholders need to provide complementary support through strategic coordination. With all these groups working in tandem and, with the existing political will and, increased support from partners to strengthen the overall health system, both states have a moment of opportunity to foster an enabling environment for improved health service delivery.

Recommendations

Based on the validation and prioritization exercises, priority recommendations for HSSP interventions, which also cut across the thematic areas of the project, are as follows:

1. Provide training for managers at state, county, and payam (extending to facility) levels on strategic planning. The assessment found that there is a limited capacity for strategic planning at state, county, payam and facility levels. During the assessment, respondents involved in planning and budgeting mostly evaluated their own competence in this area, as either 'poor' or 'fair'. It is therefore essential that training is provided to these staff in the areas of planning and budgeting given their own admission of this need and the fact that they are currently expected to carry out planning and budgeting for their respective level.
2. Develop an HIS strengthening plan for the CHDs. While the DHIS is the standard tool for electronic data capture at the county level, the capacity to enter, analyze and use data, varies widely across CES and WES. The SMOH does not have regular meetings to analyze and discuss data submitted by CHDs and there are few indications that HMIS data is used at the SMOH level to inform the annual health planning process. The assessment recommends the development of sustainable HIS strengthening plans for the CHDs. HIS and M&E Officers are recommended as the key stakeholders in the local-ownership of the HIS strengthening plans.
3. Provide training to CHD SS staff on SS operational guidelines and the use of SS tools. The manner in which SS is implemented varies between and within states and counties. CHDs understanding of critical details, such as required frequency of SS visits, appropriate documentation of findings, and feedback processes, varied and in most cases was limited. Basic guidelines exist on how to complete the integrated supportive supervision checklist, but there is no specific guidance for CHDs on the actual implementation process of supportive supervision visits using the checklist. The project recommends providing these missing operational guidelines and conducting trainings with CHDs to help standardize the supportive supervision process.
4. Ensure that monthly county health coordination meetings are held. Many of the coordination mechanisms in WES and CES face numerous challenges ranging from low attendance at meetings, lack of logistical and administrative support, lack of harmonization of plans and budgets by partners and, and no clear coordination framework. While WHO, UNICEF, and other development partners have provided support to address these issues, none of the agencies support the monthly county coordination meetings. The recommendation is to address this gap in support for the monthly county coordination meetings.
5. Strengthen bottom-up planning with the involvement of the payams and VHCs. Stronger coordination is needed for planning between the central and state levels, particularly since the central level at times plans on behalf of the state in a top-down fashion. It is critical that counties have the capacity to involve and get input from lower levels, so that plans and budgets are more accurate and accountable to the communities that they serve. While current planning practices are often top down, the assessment recommends providing training, coaching and mentoring to eventually lead to a long-term bottom-up strategic planning process.
6. Enhance on-the-job training, coaching, and mentoring efforts related to health systems strengthening. While there have been previous efforts to train health sector staff off-site, in the form of workshops, they are often not effective in influencing behavior change and/or staff do not share what they have learned when they return to their work site. There are also often several workshops on the same topic that are not coordinated. The baseline assessment recommends interventions (for all thematic areas) which go beyond workshops to include on-the-job training, coaching and mentoring. The

assessment also recommends 'cross-component' coaching and mentoring, which means that coaching and mentoring, will be provided to support the HSSP thematic areas.

7. Identify tools to assist SS teams in completing SS visits using the QSC according to operational guidelines. There is a lack of training for CHD supervision staff on the implementation of SS visits using the QSC. Part of this training gap can be attributed to the lack of operational guidelines for the CHDs. Once operational guidelines have been developed, tools for assisting CHDs to carry out their SS tasks must be explored. One tool could be a mobile phone application that facilitates the capture of facility data, automatically calculates the checklist indicators, and provides analysis by indicator performance, both against previous visits to the health facility as well as county/state performance targets, and assists in the documentation of action-items for follow-up.

8. Design/adapt LM training curricula for all health system components. The baseline assessment identified the need to develop a capacity development plan to address the specific LM gaps at the state, county, health facility, payam and boma/VHC levels. LM training and capacity-building materials will be needed to implement the capacity development plan. These materials will include comprehensive curricula that specify the purpose, learning objectives, activities, and intended outcomes. They will also include facilitator guides, participant manuals, and PowerPoint presentation.

9. Provide refresher training on performance appraisal processes for state and county-level managers. In both CES and WES, assessment of staff performance is not carried out regularly, and is usually only done as part of a bid to provide a promotion to the employee. Performance management is focused on attendance registers and a defined, but irregular promotion cycle. A comprehensive health workforce performance management system must go beyond attendance registers, and include regular assessments. The training of SMOH and CHDs on performance appraisal is a step in strengthening the health workforce performance management system. The development and implementation of a full performance management structure is an extended process, with this step being one element of this development process.

10. Support quarterly data review meetings at the SMOH level to evaluate (and if needed, validate) data from the CHDs. DHIS data is not routinely used for decision-making and planning. The assessment recommends the use of quarterly data review meetings at both the SMOH and CHD levels to evaluate and, if needed, validate data from the CHDs and facilities. These quarterly meetings should focus on addressing the challenges faced by CHDs and facilities in reporting, the quality of the data being reported, actionable items resulting from the review of data (e.g., disease outbreaks or population coverage), so that the value of data for program planning is promoted. One additional objective of the early meetings will be to identify potential information products (e.g., summary reports, graphs, or maps) that can be produced with the data so that the data have value for those staff members producing data at the CHD and PHCC/PHCU levels.

Annex A – Health Partners and Stakeholders

Table A-I: Health Partners and Stakeholders in CES

Partner	Funding Agency	Field of <u>Key</u> Intervention and Activities	Timeline and Duration	Amount of Commitment (US\$ amount if available)	Project Location	Counterpart
Juba						
Norwegian People's Aid (NPA)	USAID (through JHPIEGO)	Lead agency on ISDP	2010-2012	Information not available to the Payam	SMOH	ADRA
South Sudan Red Cross		Pharmaceuticals			PHCCs – Mangalla, Gumba, Kwerjik	
Population Services International (PSI)		Malaria/distribution of nets and water guards				
AMREF		Training and capacity building/water and sanitation			Mangalla	
OVC	ANC				PHCC - Ustratuna, Kator, Nyakuron, Muniki	
Caritas		FBO facilities Pharmaceuticals				
Marie Stopes		Family planning			Juba County	
Aids Resistance Trust	Social	Social mobilization			Payams - Liryia, Lokiliri, Lobonok,	

Partner	Funding Agency	Field of <u>Key</u> Intervention and Activities	Timeline and Duration	Amount of Commitment (US\$ amount if available)	Project Location	Counterpart
					Northern Bari	
Yei						
Action Africa Help International (AAH-I)						
Population Service International (PSI)						
Across						
St Bakika Health Center	Catholic Diocese of Yei					
Martha PHCC	ECS Diocese of Yei					
EPC	South Sudan Evangelical Church					
South Sudan Methodist Church						
Lainya						
SS Sudan Red Cross		Heath facilities construction Drug supply, EPI & HIV/AIDS Staff incentives	Two years, beginning in January 2013	They pay the vaccinators	Lomilikin PHCU Logwili PHCU	
SSUHA	USAID (through JHPIEGO)	Lead agency on ISDP	Feb. 2013 - 2015.		Lainya County	
PSI	USAID	Child survival Operational support for supportive	Not sure when project began; it has been about		Lainya County	

Partner	Funding Agency	Field of <u>Key</u> Intervention and Activities	Timeline and Duration	Amount of Commitment (US\$ amount if available)	Project Location	Counterpart
		supervision (fuel) to Lainya Hospital Training and capacity building Hire staff Lainya hospital	four years now and seems to be continuous.			
ZOA		Train health promoters Water and sanitation	Three years now; may end soon, this year.		Payam – Kopera, Wugi PHCC – Jamara, Limbe PHCC.	
Kajojeji						
ARC International	USAID (through JHPIEGO)	Lead agency on ISDP Maternal and child health Referrals (ambulances) Staffing, renovations				
South Sudan health Association (SCHA), Local NGO	SSUHA	IGAs, HIV advocacy (PLHIV) (Loving Club)				
Kajojeji AIDS Program (KAP), Local NGO	UNICEF	HIV AIDS advocacy/sensitization				
County AIDS Commission (CAC), Local NGO	National HIV/AIDS Commission	Policy making				
Mobile Health International (MHI)	FBO	Preventive including sanitation, mobile clinics	Since 2010			

Partner	Funding Agency	Field of <u>Key</u> Intervention and Activities	Timeline and Duration	Amount of Commitment (US\$ amount if available)	Project Location	Counterpart
IMC International	MOH/RSS	Midwifery training				
Comboni Missionaries	FBO, charity from the church	Primary health care				
Morobo						
AMREF	USAID	ISDP	2013-to date	Information not available to the CHD	All the county 13 health facilities	PSI
Core gp polio p	Bill & Melinda Gates Foundation	Immunization, community mobilization	2011-to date	Information not available to the CHD	All the county 13 health facilities	-
PSI	USAID	CSI,	2009-to date	Information not available to the CHD	4 payms	AMREF
SCOM		Agric, health	1997-to date	Information not available to the CHD	1 PHCc, Alto in Odabi payam	-
AMREF		EPI				
PSI		Child survival (fuel)				
SCOM		Staffing-vaccines, drugs, safe delivery				
Terekeka						
Adventist Development and Relief Agency-South	USAID (through	Lead agency on ISDP	2010			

Partner	Funding Agency	Field of <u>Key</u> Intervention and Activities	Timeline and Duration	Amount of Commitment (US\$ amount if available)	Project Location	Counterpart
Sudan	JHPIEGO)	Maternal and child health				
ADRA-SS		Referrals (ambulances), Staffing, renovations				
Africa Medical Research Foundation (AMREF-SS)		Maternal neonatal child health Sensitization on women's rights, staffing (CHWs) Phones for community mobilization support supervision	to close in 2013			
MAGNA-CHILDREN AT RISK		Medical aid for population in crisis (human and developmental assistance) HRH, vehicle repairs and maintenance	2013			
PEOPLE IN NEED-Czech Republic		Medical equipment, bedding and beds Essential drugs, staffing	2013		Kuda PHCU	

Source: Field Survey

Table A-2: Health Partners and Stakeholders in WES

Partner	Funding Agency	Field of <u>Key</u> Intervention and Activities	Timeline and Duration	Amount of Commitment (US\$ amount if available)	Project Location	Counterpart
UNICEF		Basic package of health, nutrition services and HIV	2006-2009		Mundri East	
MRDA		Community sensitization/mobilization			Mundri East	
AAH-I (Action Africa Help-International)	USAID	PMCTC services	2008-2012	\$1.900,000	Mundri West	MRDA
MRDA	USAID	Maternal, neonatal and child health & nutrition	2012-todate	NA	Mundri east	
ADRA	DANIDA	Health & Nutrition	2011-todate	NA	Mundri east	MRDA
CUAMM	Italian Government	TB, HIV & Leprosy Prevention & Treatment	2009-todate	NA	Mundri east	MRDA, ADRA
SSRC	German Government	Health education & promotion, Construction of health facilities	2011-todate	NA	Mundri east, Mundri West & Mohole	AAH-I, MRDA,NPA
PSI	USAID	WASH, health education	2009-todate	NA	Mundri east, Mundri West	AAH-I, MRDA,ADRA
AAH-I	EED (Germany Organization)	Hospital training, primary health care services, Nurse & Midwife Training School	Sine 1994	NA	Maridi	ZOA, Malteser
AMREF	UNFPA, Italy, France, Germany	Medical training, hospital staff (Interns)	2012-todate	not available	Maridi	Zoa, AAH-I, Malterer
GLRA		Staff salaries, TB/Leprosy			Maridi County	

Partner	Funding Agency	Field of <u>Key</u> Intervention and Activities	Timeline and Duration	Amount of Commitment (US\$ amount if available)	Project Location	Counterpart
Maltezer	USAID (MCHIP/ISDP)	Direct service delivery (PHC)	2012- to date	Information not available to the CHD	All the county 13 health facilities	ZOA, AAH-I, AMREF
ZOA		HIV/VCT	2009- to date	Information not available to the CHD	Maridi County, Ibba County, Mundri East	AMREF, Malteser, AAH-I
MSA		HIV/VCT				, Ibba County
IAS (International Aid Services)	EU, USAID	Health education, HIV/AIDS	2000- todate	na	Mundri West	AAH-I
MAYA (Mundri Active Youth Association) CBO	UNICEF, Oxfam	WASH, HIV/AIDS	2000- todate	na	Mundri West	AAH-I
SEM (Sudan Evangelical Mission)	EU, FCI AF	Eye Care Services	1998- todate	\$3,000,000	Mundri West, Mundri East, Movolo, Maridi	MRDA, AAH-I, ADRA
ZOA		Sanitation/ HIV				
JEN		Water and sanitation (bore holes)				
SUA		New				
International Medical Corp (IMC)	Based in the United Kingdom (NGO)	Essential medicine, staff salaries for primary health care staff	January 2013, for three years.	Monthly salaries: 564 SSP-CHW, MCW worker 1,400 SSP-midwife. 1,700 SSP-clinical officer. 458 SSP-	Nzara	World Vision, through coordination meetings.

Partner	Funding Agency	Field of <u>Key</u> Intervention and Activities	Timeline and Duration	Amount of Commitment (US\$ amount if available)	Project Location	Counterpart
				watchman. 458 SSP-cleaner.		
CMMB (Catholic Medical Mission Board)		HIV (VCT / PMTCT)	Since 2009. Signed 10-year contract.	No financial support.	Based in Yambio. Also operate in Nzara.	Coordinate with UNICEF and World Vision.
World Vision		EPI/ polio program.	Operated for 2 years.	staff salaries (vaccinators, mobilizers)	Based in Yambio.	UNICEF, MOH and CHD.
Episcopal Church of South Sudan (ECS)		HIV / TB	Since before the war.		Based in Nzara	SMOH other organizations, CHD
TB and Leprosy Control Hospital		HIV / TB				

Annex B. South Sudan Health Systems Strengthening Project Assessment Key Stakeholders and Contacts

Name	Title/Position	State	Organization	Phone Number	e-mail Address
Leadership and Management					
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Dr. Lolaku Samuel Salyi	Director of Administration and Finance	Central Equatorial State	Ministry of Health	211 (0) 912 493 337	salyilolaku@yahoo.co.uk
Alfred Lubang	County Medical Officer (outgoing/retiring)	County Health Department (CHD), Juba, CES		211 954683185	
Celestino Oryem	County Medical Officer (incoming)	Juba, CES	County Health Department (CHD)	+211 (0) 919 646 219	Celestinooryem@gmail.com
Matthew Lobiri Lawrence	County Medical Officer		County Health Department (CHD), Lainya, CES		
Samuel Lukudu	Village Administrator	Lainya County, CES	Loka West Boma	+211 (0) 955 041 579	

Name	Title/Position	State	Organization	Phone Number	e-mail Address
Franco Kamanda	County Surveillance Officer and Acting Chief Medical Officer	Nzara, WES	County Health Department (CHD)	+211 (0) 956 647 078	
Natale Edward	Chairman	Nzara County, WES	Sangua II Village Health Committee,		
Mary Steven Lupai	Establishment Officer	Juba County, CES	Munuki Payam	211 956257068	
Lydia Gumba	General Medical Assistant	Juba County, CES	Munuki PHCC	211 956244281	
John Mawa Apolo	Chief of Boma & Chairperson of the Boma Health Committee	Morobo County, CES	Kindi Boma		
Samuel Nigo	County Medical Director	County Health Department (CHD) Morobo, CES	County Health Department (CHD)	211 977237047	
Antony Ayuku Wani	Head Nurse	PHCC Morobo County, CES	PHCC	211 977242302	

Name	Title/Position	State	Organization	Phone Number	e-mail Address
Antony Angolo	Director for Administration and Finance	Yambio, WES	State Ministry of Health (SMOH)	211 921476335	
Dima Hosea	County Medical Director, Maridi	CHDMaridi	CHD	211 921243472	
Tito Taban	Clinical Officer	Maridi, WES	ESC Beth Saida PHCC		
Jermahia Mbodo	Chairperson BHC of Kowanga Boma, Maridi	Maridi (Boma level)	Chief of Kowanga Boma		
Health Financing					
Dr. Salye Lolaku Samuel	Director, Finance & Administration	Central Equatorial State	Ministry of Health	955603992	Salyilolaku@yahoo.com
Samson Banza	Controller of accounts	Western Equatorial State	State Ministry of Health		
Alphonse Lolinga Margo	Chief Cashier	Western Equatorial State	State Ministry of Health		
Raphael Joseph Sanoka	Head Accountant Partners & Donation Fund	Western Equatorial State	State Ministry of Health		
Biringi Amtai Amu	Inspector of Accounts	Western Equatorial State	State Ministry of Health		

Name	Title/Position	State	Organization	Phone Number	e-mail Address
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Samuel Aliga	Hospital Administrator	Western Equatorial	County Health Department	928403713	aligasamuel@yahoo.com
Franco Kamanda	Ag. County Medical Officer	Western Equatorial State	County Health Department, Nzara		
Louis Baangbadi	Incoming County Medical Officer, Nzaara	Western Equatorial State	County Health Department, Nzara		
Simon Raphael	Store keeper, Nzaara	Western Equatorial State	Nzara PHCC	955845239	
Florence Give	Nurse	Western Equatorial State	Nzara PHCC	921025744	
Simon Loro	Director, Finance & Administration	Central Equatorial State	Yei County		
Alex Khamis	Certificate Nurse, Facility in-charge	Central Equatorial State	Lora PHCC	955141765	
Mathin Khamis	County Health Officer	Central Equatorial State		955034963	

Name	Title/Position	State	Organization	Phone Number	e-mail Address
Guya Mowen	M&E Officer	Central Equatorial State	Lainya CHD		
Elia Haiga	PHCC supervisor	Central Equatorial State	Lainya CHD		
Emmy Emmanuel Lanirik	Inspector for planning and Budget	Western Equatorial State	Maridi County HQ	921133774	emmye500@yahoo.com
Lydia Gamba	Medical Assistant	Central Equatorial State	Munuki PHCC		
Franko Kamanda	County Medical Officer	Western Equatorial State	Nzara CHD	956647078	
Louis Baangbadi	County Medical Officer	Western Equatorial State	Nzara CHD	912753118	
Francis Boriako	SMOH, M&E Department	Western Equatorial State	Nzara CHD	911983704	
Allison Abbas	Deputy Director of Accountants	Western Equatorial State	State Ministry of Health	918928207	
Somson M Banza	Chief Cashier	Western Equatorial State	State Ministry of Health	927183071	

Name	Title/Position	State	Organization	Phone Number	e-mail Address
Bringi Amtai Amu	Inspector of Accounts and sub-cashier, Mundri	Western Equatorial State	State Ministry of Health	956281010	
Joyce Edward	Clinical Officer, Yei	Central Equatorial State			
Edward Sebit Elias	Cashier	Western Equatorial State	Morobo CHD	955400768	
Joseph Abdala	Book keeper	Western Equatorial State	Morobo CHD	956639745	
James Tengi		Western Equatorial State	Morobo CHD	954375353	
Tometa Ismail	County Store Keeper (works on procurement)	Western Equatorial State	Morobo CHD	977629715	
Jemal Buget	Book Keeper	Western Equatorial State	Morobo CHD		
Asid Moses John	Inspector/Cashier,	Western Equatorial State	Morobo CHD	977221555	

Name	Title/Position	State	Organization	Phone Number	e-mail Address
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Mango Martin	Planning officer	Western Equatorial State	Morobo CHD		
Sabrina Beckmann		Western Equatorial State	GIZ	+211 956 820 143	
John Banju Tuya	head accountant SMOH	Central Equatorial State	Juba CHD	934514958	
James John Logwuru,		Central Equatorial State	Juba CHD		
Natale Edward	Chairman, Village Health Committee	Western Equatorial State	Nzara County		
Samuel Lukudu	Village administrator	Western Equatorial State	Loka West Boma		
John Benson	Director Planning and Budgeting	Central Equatorial State	Yei County Commissioner's Office		

Name	Title/Position	State	Organization	Phone Number	e-mail Address
Human Resources for Health					
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Hilary Okanyi	Director of Training	Central	State MOH		
Frueensio Gore	Deputy Director of Training	Central	State MOH		
Charles Bey Bulli	Dean of Health Sciences	Central	Training Institute of Juba		
Lydia	In-Charge	Central	Juba PHCC		
Mr. Paulino Laku	Director	Central	Gulumbi Payam, Morobo County		paulinopitia@gmail.com
Olympio Leju Tombe	Senior Establishment Officer	Central	Juba County Health Department		
David Laila Faruk	Payam Administrator	Central	Kenyi Payam, Lanya County		
Matthew Lobir	County Medical Officer	Central	Lanya County Health Department		
Alex Khamis	Nurse in Charge	Central	Lora PHCC, Kenyi Payam, Lanya County		
Juma Cirillo Laku	Public Health Officer	Central	Morobo County Health Department	956640004	
Mary Steven Lupai	Establishment Officer	Central	Muniki Payam		

Name	Title/Position	State	Organization	Phone Number	e-mail Address
Consguia Ali	Administrator	Central	Yei County Health Department		
Justin Duku	Establishment Officer	Central	Yei County Commissioner	956999800	
John Benson Yona	Deputy Director of Planning and Budget	Central	Yei County Commissioner	956400479	
Simon Loro	Director	Central	Yei County Health Department		
Unknown	In-Charge	Central	Ombassi PHCC, Yei County		
Silvanu July David	CHW	Central	Kajelu PHCU, Yei River County		
Unknown	Director	Western	Ibba County Health Department		
Elisha Taban	Facility in Charge	Western	PHCC Ibba		
Christo Taban	M&E Officer and Surveillance Officer	Western	Maridi County health Department		
Tito Tasan Matatia	Clinical Officer In-Charge	Western	Bethsaida PHCC, Maridi County		
Franco	Surveillance Officer/Acting County Health Director	Western	Nzara County Health Department		
Clemen Bullen Wande	Executive Officer for Local Government	Western	Nzara Payam	0929726212, 0956657191	

Name	Title/Position	State	Organization	Phone Number	e-mail Address
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Mr. Kuol Arop	Director HRM	National	Directorate of Admin and Finance	955816165	a.kuolarop@yahoo.com
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Dr. Hilary Okanyi	Director for HRD and Training	Central	State MOH	956065076	
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Ms. Clementina	Senior Statistician	Central Equatoria	Mubuki Primary Health Community Clinic		
Ms. Rebecca	Statistician	Central Equatoria	Mubuki Primary Health Community Clinic		
Supportive Supervision					
Jamal Hassan Jumal	Director, Primary Health Care Department	Central Equatorial	State ministry of Health		
Hassan Ali Joma	Director, Preventive Services Department	Central Equatorial	State ministry of Health		
Justin Nyoma	County Surveillance Officer	Central Equatorial	Juba County Health Department		
Guya Nowe	M&E Officer and PHC Supervisor	Central Equatorial	Lanya County Health Department		

Name	Title/Position	State	Organization	Phone Number	e-mail Address
Alex Khamis	In-Charge	Central Equatorial	Kenya Health facility, Lanya County		
Mrs. Lydia Gambia	In-charge	Central Equatorial	Munuki Health Centre, Juba County		
Mr. Richard Todoko	County M&E Officer	Central Equatorial	Morobo County		
Anthony Ayuku Wani	County Surveillance Officer deputized for In charge at facility who was not around	Central Equatorial	Morobo PHCC, Morobo County		
Joyce Salia Cnemenet	M&E and HIV/AIDS Program Officer	Central Equatorial	Yei County		
Siama Dennis	Nutrition Officer	Central Equatorial	Yei County		
Emenida Reja	Data System/ Data Entry Officer	Central Equatorial	Yei County		
Tabal Lawrence	Assistant Administrator	Central Equatorial	Yei County		
Lasuva Michael Edward	M&E Officer	Central Equatorial	Yei County		
Oleya Jane	Bookkeeper/Secretary	Central Equatorial	Yei County		
Silvano July David	Community Health Worker/Auxiliary Nurse	Central Equatorial	Kaaagelu PHCU, Yei County		
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Name	Title/Position	State	Organization	Phone Number	e-mail Address
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Ram Bisti	M&E Manager	Western Equatorial	State Ministry of Health		
Bernard Boroyote	Acting M&E Officer	Western Equatorial	Ibba County		
Elisha Taban	Clinical Officer / In-charge	Western Equatorial	Ibba Central PHCC, Ibba County		
Martin Beeyo	Clinical Officer / In-charge	Western Equatorial	Paul Riani's Memorial Clinic - Private Non-for Profit PHCU		
Christo Taban	M&E & Surveillance Officer	Western Equatorial	Maridi County		
Tito Taban Matatia	Clinical Officer / In-charge	Western Equatorial	Beth-Bida PHCC, Maridi County		

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