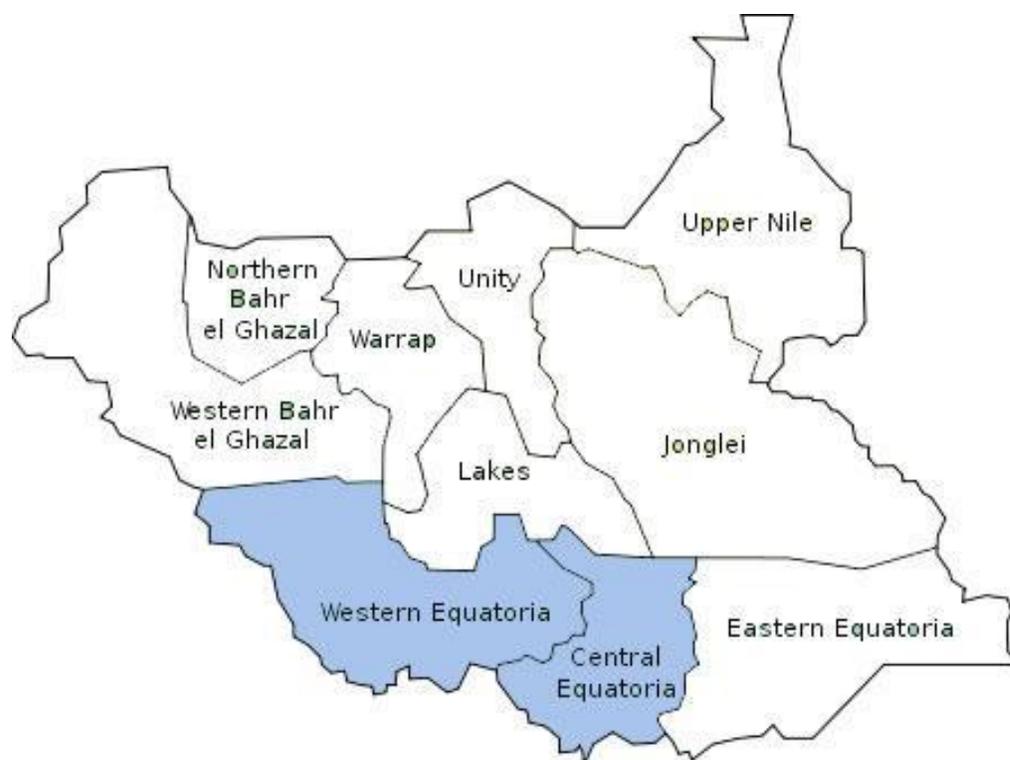


Baseline Assessment Report

Central and Western Equatoria States, South Sudan

Health Systems Strengthening Project (HSSP)
(Abridged Version)



November 2013

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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

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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 (LM) 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 and,
- 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 six areas: leadership and management, health financing, human resources for health (HRH), health information system (HIS), supportive supervision, and coordination.

A few areas are in need of urgent attention. Many health managers still have a limited understanding of key *leadership and management (LM)* concepts and responsibilities, and limited support tools. The report advocates for improvements in the LM procedures and best practices through the development and effective application of job/desk aids at the workplace and performance management techniques.

In the area of *health financing*, the government is committed to establishing appropriate mechanisms for fiscal responsibility. 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. Potential key remedies include national PFM training of the SMOH/CHDs and the county and hospital health management teams 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. An evolving national Human Resource Information database is also in place, though incomplete. Still, performance management guidelines on promotion criteria and the provision for allowances exist at the national level. Constraints to SMOH/CHDs ability to plan, allocate, and manage HRH include lack of job standards, and, sufficiently accurate HRH data and, deficient HRH management systems. The recommendations are to update and improve the human resources database into a validated human resources system, develop job standards, review existing employment policies and update them to ensure completeness and understanding, and provide refresher HRH training for managers and the facilitators who will cascade the trainings.

In the area of *health information systems*, both states have functional health management information systems (HMIS) units with designated office space and computers installed with the District Health Information System (DHIS) software. Staff is also in place with a clear understanding of the reporting process and importance of the information being captured and reported. There are, however, low HMIS monthly reporting rates; inadequate HMIS infrastructure; minimal evidence of HMIS data use; lack of guidance, procedures, and capacity for assessing HMIS data quality; and a lack of data from the private sector. 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 *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. 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. There is, however, incomplete information on the actual number of health partners in both states, limited coordination between these organizations 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. The project recommends the establishment of a framework to promote public-private-partnerships and effective ways of obtaining and using data from the private sector partners.

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.

I. Introduction

I.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.

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

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

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 bottoms-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/RSS. Furthermore, there are two parallel procurement systems, which lead to poor coordination in the procurement of medical supplies.

The five-year USAID Health Systems Strengthening Project (HSSP) addresses some of these gaps. The project aims at strengthening 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

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. The approach involved five steps, namely:

- *Shaping the assessment* by identifying priorities of the project's three thematic areas and agreeing on a time frame for the exercise in consultation with MOH, SMOH, CHDs, stakeholders in the two states, and USAID/South Sudan.
- *Mobilization of the assessment team* from the home, on-site and, Nigeria offices, partner organizations, and government representatives. Prior to embarking on the field data collection, the assessment team held kick-off meetings in Juba (May 14) and WES (May 23).
- *Data collection*, which started with a desk review of background documents before the assessment team arrived in the two states. 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 (see Table 1)

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 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. Table 2 provides a list of the informants reached for purposes of the assessment.

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.

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 Informants Interviewed

<p>SMOH</p> <ul style="list-style-type: none"> ▪ Director General ▪ Director of Primary Health Care ▪ Director of Finance and Administration ▪ Director of Training ▪ M&E Coordinator ▪ Establishment Officer <p>County Commissioner's Office</p> <ul style="list-style-type: none"> ▪ County Commissioner ▪ Executive Director ▪ Director of Planning and Budgeting ▪ Establishment Officer 	<p>County Health Department</p> <ul style="list-style-type: none"> ▪ CHD Director ▪ Director of Finance & Administration ▪ Accountant ▪ M&E/Surveillance Officer <p>Primary Health Care Center or Unit</p> <ul style="list-style-type: none"> ▪ In-Charge ▪ Clerk <p>Payam Administrator's Office</p> <ul style="list-style-type: none"> ▪ Payam Director <p>Boma Chair's Office</p> <ul style="list-style-type: none"> ▪ Boma Chair
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- *Data analysis was largely qualitative*, focusing on the strengths and opportunities in the key assessment areas, the challenges and threats, and the subsequent key recommendations for implementation by HSSP.
- *Preparation of the assessment report* 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

In this section, we examine the six components of the HSSP that were included in the baseline assessment in greater detail—the key findings also referred to strengths and opportunities, challenges and gaps, and recommendations.

3.1 Leadership and Management

The assessment team sought to learn more about the ways to increase capacity at the SMOH, CHD, and VHC levels in WES and CES, including the ability to plan and oversee service provider activities.

The findings point to the existence of a *conducive work climate* for the implementation of HSSP leadership, management, and governance training, coaching, and mentoring interventions. First, there exists key policy documents--RSS Health Policy (2006–2011) and, RSS Basic Package of Health Services--which provide excellent resources to guide HSSP training plan/curriculum development. Two, previous trainings and capacity-building initiatives provide impetus for the present work. Three, many of the non-government organizations (NGOs) that are very active in health service delivery provide a good foundation to mount LM initiatives. Fourth, the technical advisors, mostly embedded by development partners at the SMOHs and CHDs, provide a resource to augment leadership and management interventions

The key challenges include:

- unclear understanding of the governance and management systems including roles and responsibilities of the different levels of government, reporting structures, standards for performance and, framework for performance monitoring. The situation is worsened by the lack of clarity regarding the overall purpose of the different service units (e.g., administration and finance, pharmaceutical services).
- short supply of key basic knowledge in LM principles and concepts and, LM skills such as effective communication; task delegation; dealing with performance, motivation, or conduct issues among staff; budget monitoring; and use of data for decision making. Many of the managers have not had extensive formal management training and are taking on more responsibilities than they can manage or are not qualified to carry out assigned responsibilities.
- limited opportunities by the managers to directly observe and supervise the majority of their staff. As a result, it sometimes appears that staff are not productive. The lack of oversight results primarily from a lack of job descriptions; lack of clarity regarding staff responsibilities and, logistical considerations such as significant travel distances between facilities and unavailability of transport, computers, and telephones.
- inefficient communication mechanisms as evidenced by irregular meetings between managers and staff, failure to take minutes of meetings and/or failure to distribute the minutes when the meetings are held, problematic and unreliable internet and e-mail access, lack of electricity and telephone services and, lack of a formal strategy or structure for relating to the donors and other stakeholders.
- weak governance structure as demonstrated by the nonexistence of, or poorly functioning, boards and committees, at the VHC level. Lack of clarity regarding the purpose and functions of the various tiers – SMOH, CHD, PHCC/Us, payam, and the roles and responsibilities of the health facility management boards/committees, VHCs and, hospital boards/committees.

The assessment *recommends* the adaptation of 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. The assessment calls for the:

- design and delivery of leadership and performance management trainings focusing on setting goals for health facilities/departments, developing performance plans for staff, delegating tasks, monitoring performance, providing performance feedback, team building, communication, strategic thinking, planning, and budgeting.
- identification and training of facilitators to enhance the cascading effect of LM capacity building at various levels within the health system in both states. This course should cover principles of adult learning, facilitation skills (paraphrasing, asking questions, summarizing, and encouraging), course design skills, and co-training skills. HSSP trainers should be trained to co-deliver with CES/WES trainers for their first delivery and as required until they are competent to deliver the course alone.
- development of job and desk aids that will reinforce key LM concepts and strategies. These aids may be as simple as a laminated card that managers can keep on their desks or carry with them.
- provision of coaching and mentoring support in HSSP capacity-building areas such as LM, PFM, HRH, HIS, coordination and supportive supervision. This will assist managers with the application of new skills in the work environment and the institutionalization of these skills within their institutions. On-the-job training may also be necessary to either introduce new knowledge or skill areas or to review or reinforce knowledge and skills previously obtained.
- development and delivery of basic governance training, coaching, and mentoring interventions for VHCs paying attention to communication skills, monitoring, meetings, management, stakeholder engagement, and financial management.
- provision of organizational development support to the SMOH, CHD, PHCC/Us, payams to design and put in place systems and policies that support sound leadership, management, and governance practices. Such support may focus on:
 - 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.
 - establishing clear roles and accountabilities among and between health system governmental authorities at state, county, and local (payam, boma, and VHC) levels.

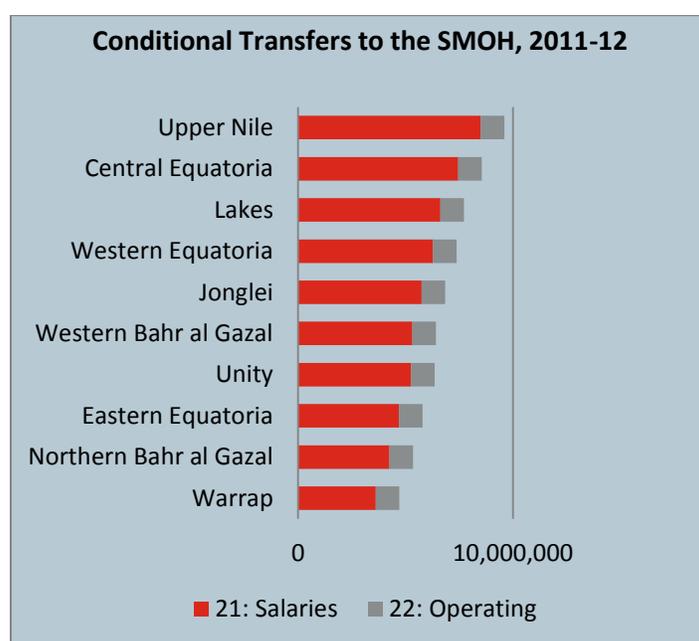
“[Motivation] is very poorly done. I see a lot of staff who don’t have much to do, who come to work late and leave work early. They don’t seem to have very clear direction on what they are supposed to be doing.”

Respondent

3.2 Health Financing

Health financing affects the provision and utilization of health services and has important implications for access, efficiency, equity, and quality. The health financing component of the assessment focused on public financial management (PFM) to better understand the planning and budgeting cycle and document the state of PFM within the health sector, in context of the local government PFM guidelines and other relevant regulations⁴. PFM includes resource mobilization, the planning and budgetary process, prudent budget execution, maintenance of complete and accurate records, proper management of resources including fixed assets, and the exercising of internal controls. The assessment focused on examining the sources of health funding; planning and budgeting at various levels of government with focus on health sector; funds flow; funds control; accounting and financial reporting; internal and external audits and, procurement.

Table 3: List of Informants Interviewed



The assessment points to several strengths that include:

- government 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. There is also 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.
- provision of additional conditional transfers (SSP 50m) to the CHDs to support capital and operational costs as evidenced in government's budget for 2013/14. There are also transfers to states and hospitals. The total state transfer for CES amounts to SSP 9,030,589 and the five

⁴ Public Financial Management & Accountability Act, Interim Public Procurement & Disposal Regulations, 2006

hospitals in CES will receive SSP 1,029,410 in total. The total state transfer for WES is SSP 7,948,973 while the four hospitals in the state receive SSP 1,117,646 in total.

- availability of a recognized PFM institutional framework. There are state-level and county level departments dealing with PFM. Staff are aware of, and own up the PFM bottle necks that face them in PFM. They are eager to get solutions to the challenges

The challenges include:

- low government budgetary allocations to health--4 percent of the national budget-- with a low budget execution rate of just 2.4 percent. The introduction of austerity measures in 2012 not only worsened the situation, but increased government dependency on donors to support health services. Even then, there are remarkable efforts by the government in providing conditional grants from the SMOFEP to the SMOH. Upper Nile state obtained the largest share, while Warrap State the least. Operations grants were divided equally among the states (SSP 1.1m). In the FY 2012-13, the operating transfers were cut by 50 percent, to SSP 550,000 per state, due to fiscal austerity measures. With a low government health budget, donor contributions are quite significant which poses sustainability challenges. There are three key funding mechanisms supporting health services delivery in the country (i) Health Pool Fund (UK, Canada, Australia, Sweden, and European Union-200m, 3.5 years), (ii) US Agency of International Development (US\$ 110m, 5 years), and (iii) World Bank (US\$ 23m, 1 year)⁵
- lack of coordination between central and state governments in planning and budgeting as well as the format to be followed. There is a gap in inter-ministerial coordination at state level to address planning and budgeting for lower levels. There also exists top-down and less participatory planning and budgeting process, with almost no formal opportunity for the donors, states, counties, payams and bomas to inform the national level of their needs. Information on off budget is often not available making it difficult to estimate the total health resource chest available to the counties/states.
- lack of awareness about the planning and budgeting guidelines. The new standardized planning and budgeting guidelines as well as templates are not available at the SMOH and CHDs and, there is a lack of a system, either manual or electronic, to monitor expenditure levels. This problem is compounded by lack of a common understanding of, and/or adherence to, the new planning and budgeting cycle (July – June) and, including the roles and responsibilities of the key actors at county headquarters', SMOH, SMOLG and SMOFEP in the process.
- existence of 'planning fatigue' occasioned by inability of the government to honor previous budgets and, county headquarters to give operation funds to the CHD on grounds of obtaining substantial support from the development partners
- limited staff competence in public financial management areas such as: bookkeeping, financial and technical report writing, RSS payments regulations, custody of accounting documentation and fixed asset management and, inventory management. Staff at lower levels are not aware what

⁵ USAID operates in Central Equatorial State and, Western Equatorial State. Health Pool Fund--Eastern Equatorial State Northern Bahr el Ghazal, Western Bahr el Ghazal, Warrap, Unity, Lakes and, World Bank -Upper Nile and, Jonglei.

reports they should prepare, to whom they are due, and when. More than three in four managers rated their competency levels in financial management to be fair and below.

- limited segregation of duties to ensure internal controls and compliance with policies and, incomplete internal audits with lack of feedback to staff. The external audit is ad hoc and even when they occur, they do not look at the whole financial system.
- implementation of user fees contrary to government's policy on free primary health care services. There are no guidelines on the mobilization, management and, use of these resources and, no mechanisms to mitigate against adverse effects of the fees on access to the services by the vulnerable.

Areas that need further strengthening for the public financial management system to function properly include:

- strengthening the PFM system to enhance the health sector's ability to plan and execute budgets and, developing simple job aids to reinforce the trainings delivered.
- supporting the health sector to have strategic plans so that annual plans fit into a pre-developed and long term goals.
- increasing community involvement in the budgeting process, with the application of standardized planning and budgeting tools
- building staff competency in PFM going beyond the traditional training workshop approach to include coaching and mentoring and, on the job training. The health managers also need to be enlightened on the reporting requirements, and supported to meet the reporting requirements to ensure they receive subsequent funds.

3.3 Human Resources for Health (HRH)

South Sudan's Health Sector Development Plan 2012-2016⁶ identifies adequate human resources for health (HRH) and its corollary, service delivery facilities accessible to the community, as the two factors that will be most critical for achieving the vision of a healthy and productive population. The *HRH component of the assessment sought* 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).

The assessment found the following strengths in the HRH component:

- MOH/RSS, SMOH, CHD, boma, payam and health facilities have clear roles and functions in HRH providing the overall strategic direction, policies and procedures for the governance of the health workforce.
- HRH Strategic Planning occurs 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

⁶ Government of South Sudan, 2012. "Health Sector Development Plan: 2011 – 2015: *Transforming the Health System for Improved Services and Better Coverage*," Ministry of Health: Juba.

bomas are 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.

- significant efforts are being made to establish an HRIS at the national level, leading to a national HR database that is applied by the States and Counties.
- staff promotions are available and being instigated by facility in-charge recommendations. The promotions are based on attendance registers, which are kept faithfully, and facility in-charges' perception of employee performance. Policies have been established for providing the workforce with allowances, although they are on hold due to austerity measures. 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.
- the SMOHs develop annual training plans based upon workforce needs, allowing the prioritization and use of limited training funds wisely. Recruitment for pre-service training has shifted from centralized selection of candidates to facility and county-guided selection, contributing to improved retention of graduates in rural areas.

The assessment points to several challenges in HRH.

- the scope of the strategic plans for HRH is limited to determining the gap in workforce numbers, and strategic plans are not implemented, ostensibly due to severe budgetary limitations. Payroll information is used to determine staffing numbers, but several sources noted payroll is inconsistently updated and does not provide information on staff qualifications.
- information on the actual number and mix of staff by facility is limited and difficult to obtain. There are also difficulties meeting the staffing minimums stipulated by the BPHS, misdistribution of staff favoring urban areas, and high vacancy rates. Also, while women make up at least half of the health workforce, there is a dearth of women in higher-level positions.
- trust in the HRIS is low due to poor quality data-collection techniques and incomplete/unverified data. States rely nearly exclusively upon payroll data for information on the workforce. The existing HRIS is an Access database rather than a system, limiting access for real-time data use at the state and county levels.
- promotion opportunities do not happen regularly for all facilities, varying 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 rather than standardized performance appraisals.
- salaries are uniformly low, and the payments are frequently delayed, contributing to migration to higher paying NGOs. Although employment policies do exist, awareness 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.
- training is the lowest priority for the ministry's budget and, there is insufficient funding for the extensive training of new health workers required. There are also no training programs within

the country for a number of essential cadres and none for any specialties. In-service training is largely funded by NGOs, an unsustainable source. Existing health workers have many different training backgrounds and qualifications—standardizing the skills will require a training plan with multiple entry points to accommodate the existing disparities.

To enhance the HRH production, performance and productivity to ensure adequate numbers of health workers with the right skill mix, the assessment recommends:

- strengthening of the HRH strategic planning processes by: 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 process, and establishing an effective monitoring mechanism for the plan.
- building sustainable in-country capacity for HRH Strategic Planning by training state and county staff responsible for HRH planning on good HRH planning process, establishing a pool of training of trainers (TOTs). The SMOHs and CHDs also need technical support to implement a full HRH planning cycle, which includes input from all levels of the health system.
- maintaining 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. There will be need to redesign the HRIS database into an information system that comprehensively meets country HRM needs, and one that can be used to determine best practices, lessons learned, and systems or information that may be used in an improved HRIS. The process will require establishing job standards to regulate the qualifications required for each position.
- improving health worker performance by training the managers 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, designing and implementing a user-friendly system that includes regular performance assessments and is tied to promotions, and supporting the development of professional councils to register and license health workers to ensure the quality of the workforce.
- strengthening the workforce recruitment, deployment, and compensation procedures by scaling up recruitment and training of individuals from rural areas to serve in their county or payam to increase retention, and realigning recruitment procedures to allow the counties to have greater input on the individuals hired and deployed. Training and building the capacity of the health workforce by establishing career pathways to support the upgrade of current staff to meet qualifications defined in the job standards, developing 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, instituting a comprehensive strategic planning cycle for training, including costing and resource mobilization to support targeted training of health workers and, supporting the development of professional councils to accredit pre- and in-service training institutions.

3.4 Health Information Systems

The 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. The HMIS component of the baseline assessment sought 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 focused on documenting the current status on key HMIS indicators and (2) the number of CHDs and SMOHs using HMIS data for developing their annual health plans.

The assessment indicates several strengths in HIS which include:

- existence of functional 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

Challenges noted by the assessment team include:

- 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.
- significant gaps in technical infrastructure--lack of Internet connectivity, HMIS work spaces, minimal electricity, functional computers, and/or Internet and telephone connectivity--to fulfill their HMIS reporting requirements.
- low HMIS monthly reporting rates with 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). (see Table 3)

Health Facilities Reporting on Timely Basis					
CES		WES			
Juba	32%	Nzara	0%	Maridi	59%
Terekeka	47%	Mundri East	9%	Mvolo	70%
Lainya	58%	Ibba	17%	Ezo	80%
Kajo-Keji	60%	Nagero	36%	Mundri West	89%
Yei	69%	Yambio	37%	Tambura	49%
Morobo	95%	Average			45%
Average	49%				

Sources: Mila (2013); WES SMOH (June 2013)

- limited use of HMIS data for program planning purposes or for use in support of the annual health plan process. 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.
- feedback of information and analysis to the PHCCs/PHCUs does not appear to be a routine part of the work of the CHDs, tied to the fact that most facilities are not being visited independently of any implementing partner support being provided.
- limited routine data quality checks except for a few facilities that did it 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.

To strengthen the HIS including the processes of data capture and analysis, with particular emphasis on CHDs as the integral link between health facilities and the SMOHs, the assessment recommends:

- the development of an HIS strengthening plan for the CHDs in their states. 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).
- convening of quarterly data review meetings at the SMOH/CHD levels to evaluate (and, if needed, validate) data from the CHDs. 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.
- initiation of 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. Use of information at the PHCC/PHCU levels-- 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.

3.5 Supportive Supervision

Regular, effective, and integrated supportive supervision is necessary for good management as well as to ensure ongoing on-the-job capacity building. The supportive supervision component of the HSSP baseline assessment examined the: understanding among staff on what the process entails; institutional roles and responsibilities; personnel responsible for completing supervision visits; process for conducting supervision visits; tools being used; and, how the current supervision practices generate, record, and provide performance feedback.

The assessment findings point to several strengths which include:

- 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.

- availability of a standardized national quantified supervision checklist which is being used by the CHDs with guidance from the SMOH, and, provision of verbal feedback by the SMOH and CHDs to the health facilities.
- existence of clearly defined institutional roles and responsibilities with the CHDs being responsible for supervision of PHCCs/PHCUs. All CHDs are able to identify personnel responsible for conducting supervision visits and, to report on how often health facilities should be visited for supportive supervision.

The key HIS challenges facing WES and CES include:

- infrequent supportive supervision, primarily driven by development partners. CHDs are often unable to fulfill supervision responsibilities due to adverse conditions relating to infrastructure, funding, transport, staff, remoteness of facilities and, weather. Infrequent supervision ultimately challenges the prospects of systematic quality improvement
- unsystematic feedback to the health facilities by the CHDs, with verbal feedback being most common. Supervision is generally viewed as an M&E/surveillance activity and, there is a lack of focus on feedback, problem solving, and follow-up. Feedback content is also limited to supervisor knowledge and observations and, the SS feedback documentation is inconsistently provided to health facilities, CHDs, and SMOH.
- reported data are often of poor quality and inconsistent, thereby compromising the integrity of the HIS as a whole.
- lack of training for personnel on how to complete supportive supervision checklists
- lack of planning prior to supervision visits and, lack of operational guidelines for CHDs on supportive supervision implementation and, lack of follow-up on gaps, opportunities, or action items identified during supervision visits and, limited analysis or discussion of supervision findings across all facilities in a county or within the state

To build a functional and supportive supervision system in WES and CES that will monitor, access, and advance the quality of health care, the assessment recommends:

- developing supportive supervision operational guidelines for the CHDs describing, among others, target facilities; frequency of visits; tools; process of completing SS visits; documentation of findings; follow-up procedures to action items. CHD supportive supervision personnel should be trained in their use.
- improving measurement and analysis of QSC indicators including better weighting of the 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. Identifying tools to assist SS teams in completing SS visits using the QSC according to operational guidelines.
- exploring 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.

3.6 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. 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.

According to the assessment findings:

- 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. (see Table 4).

Table 4: 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

- 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.
- 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. Even then, other CHDs where computers were available, staff capacity for their use was low and specific activities that require computer use outside of the DHIS was not fully implemented.
- internet connections were largely unavailable due to an inactive service subscription in CES and, lack of connection in WES. SMOH/CHD staff normally used connections at neighboring NGOs. No health facilities reported having connection to the Internet. 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. 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.

Based on these findings, there is evidence to support,

- 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.
- Use of mobile phone data connection. 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-diem, etc.
- Address the sustainability of technology approaches 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.

3.7 Strategic Coordination and Collaboration

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. The identified strengths in the coordination component include:

- existence of the NGO forum stakeholders mapping templates that can be adapted to the county/state conditions.
- existence of communication mechanisms that can be built on. Verbal reporting is common especially from community to health providers (e.g. community-based organizations, churches, VHC, HIV advocates to health providers). Paper reporting is also available from health facilities to CHD (i.e., outbreaks, disease trends, stock-outs). Still, the electronic reporting on DHIS data from CHD to SMOH provides yet another opportunity that can be tapped.
- existing state and county coordination mechanisms facilitated by WHO and UNICEF serve as an excellent opportunity for the project to support monthly county coordination meetings. The existence of ISDP on the ground also creates favorable conditions to improve reporting, communications, etc.
- MOH/RSS embracement of the national aid strategy by establishing several health sector coordination mechanisms to achieve the national aid strategy benchmarks. These coordination mechanisms include: weekly senior board management meetings; bi-annual consultative meetings with the SMOH; Technical Working Groups (TWGs) in key areas; Global Fund country coordinating mechanism and; MOH/RSS Health e-mail Communication Forum. Similar coordination mechanisms also exists at the state and county levels under the stewardship of the government (see Table 5).

Table 5: Coordination Mechanisms at the State, County, Payam, and Community Levels

Mechanism	Leadership
Ministerial departmental meetings	SMOH, DG, or Minister of Health
State coordination meetings (to be supported by WHO)	Chaired by governor, includes all NGOs working in the state
SMOH coordination meetings (supported by UNICEF)	MOH, DG, or Minister of Health
County health coordination meetings	County medical commissioner
Emergency meetings	WHO
County Health Coordination Forum	CHO chairs, County Implementing Partners take minutes
Ministry departmental meetings	Quarterly
CHD Management Team	CHO chairs, County Implementing Partners take minutes
Health and nutrition coordination meetings	DG/SMOH
Boma Health Committee meeting	Chair, VHC
Quarterly health care delivery coordination meetings	SMOH/DG
Health emergency meetings	Chaired by the SMOH, co-chaired by the WHO and World Vision
Partners' forum	Chaired by the governor

Source: Survey data

- six USAID-funded lead agents in CES and 10 in WES (one for each county), provides primary health service delivery in both states (Table 5). 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.

Table 6: 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), 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)	n/a
	Ezo	World Vision (\$800,000)	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

Several challenges constrain the coordination efforts in WES and CES as detailed below.

- states and counties do not have complete information about the partners on the ground. Some international NGOs (especially in CES) that obtain direct approvals from the RSS MOH tend to bypass the states and counties and go directly to the communities. Also, some of the NGOs send their performance reports directly to the national level, bypassing the SMOH.
- limited funding to convene and facilitate meetings and, low turnout to the meetings;
- poor synchronization of plans and budgets with the CHD annual operational plan;
- limited collaboration between the various government tiers, lack of a clear coordination framework and; weak communication among the partners;

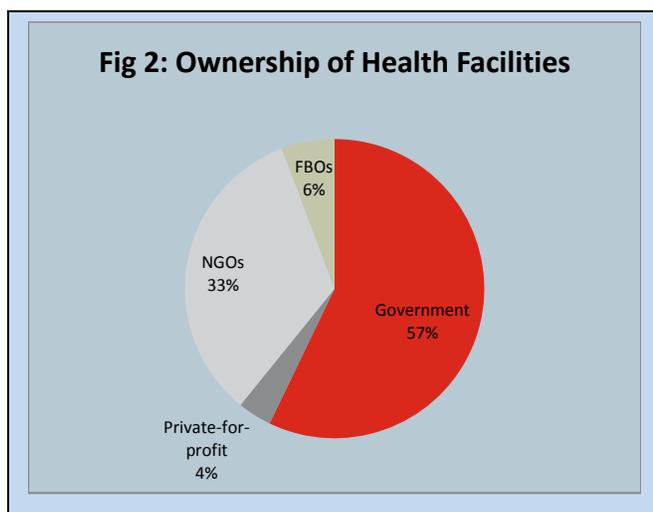
In order to address the gaps highlighted above, the assessment recommends:

- conducting a stakeholder 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.
- commissioning and operationalization of county monthly coordination meetings to share work plans and budgets; provide updates on progress, achievements, and challenges; follow up on performance reporting; address program performance constraints; and provide hands-on training in areas of interest.
- development of 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.
- enhancing the leadership capacity of the VHCs to (1) strengthen linkage with the health facility management teams; (2) develop simple and culturally appropriate materials for use in health education and advocacy on promotive and preventive health; and (3) sensitize immediate communities on health education.

4. Private Sector Participation

The assessment examined private sector contributions in HSS in both states⁷. The assessment points to the existence of:

- relatively small, but significant, private sector. The for-profit private sector is relatively small in the health sector in South Sudan (see Fig 2)⁸, 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.
- stronger financial management systems in not-for-profit sector. Financial management systems at the private-for-profit facilities were found to be much more organized and systematic than those of the public health facilities.
- attrition of staff to the NGO operated public health facilities. 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 a significant disparity in pay between them, even among the same positions. The MOH/RSS has initiated a process of aligning the NGOs salary scales with those of the public sector.
- limited coordination between the for-profit-private sector and the other actors. 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. There is no mapping of the private (for profit) sector players and the sector does not provide HIS data.
- weak legal and regulatory framework for the for-profit private sector participation. Allegedly, 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 authorities
- limited government supervision of for-profit private sector health facilities with the exception of provision of registers and drugs, and occasional courtesy visits.



⁷ 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.

⁸ Data obtained from the: Ministry of Health. Government of Southern Sudan 2013. South Sudan EmONC Needs Assessment Draft Report

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 (see Table 7). 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 as shown in Table 7. 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 6 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.

Table 7: 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

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.

From the discussions, the following conclusions could be derived from each of the areas:

- critical shortages of human resource capacity are hindering health system development.
- weak public financial management is adversely affecting SMOH/CHD ability to provide health services.
- low reporting and use of HIS data constrains the ability of the SMOH/CHD to effectively plan and, program for health services.
- ineffective supportive supervision is limiting health performance monitoring, adversely impacting on the quality of health services.
- ineffective collaboration has constrained the potential for the partners to have full knowledge of what is happening on the ground and fostering possible synergies.

The findings and conclusions 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 which faces 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.

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