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Health Systems Strengthening Project (HSSP) South Sudan

Project Self-Assessment, March 2015

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Acronyms

CES	Central Equatoria State
CHD	County Health Department
CIP	County Implementing Partner
CTMC	County Transfers Monitoring Committees
DHIS	District Health Information System
HIS	Health Information System
HMIS	Health Management Information System
HSSP	Health Systems Strengthening Project
ISDP	Integrated Service Delivery Project
LM	Leadership and Management
LMO	Leadership and Management Officer
LSSAI	Local Service Support Aid Instrument
M&E	Monitoring and Evaluation
MoH	Ministry of Health
OJT	On-the-Job Training
PFM	Public Financial Management
PHCC	Primary Health Care Center
PHCU	Primary Health Care Unit
PMP	Performance Monitoring Plan
QA/SS	Quality Assurance/Supportive Supervision
RSS	Republic of South Sudan
SIAPS	Systems for Improved Access to Pharmaceuticals and Services
SMoH	State Ministry of Health
TO	Transition Objective
USAID	United States Agency for International Development
VHC	Village Health Committee
WES	Western Equatoria State

Executive Summary

Abt Associates and its partner, the Training Resources Group¹, are implementing the five-year Health Systems Strengthening Project (HSSP) in South Sudan (December 2012–November 2017). HSSP, funded by USAID, is contributing to the expansion of availability of health services in Central and Western Equatoria States, and helping to improve their quality. To strengthen South Sudan's health system and foster an environment conducive to improved health service delivery, the project works with the central Ministry of Health, the State Ministries of Health (SMoH) for Central and Western Equatoria States, county health departments (CHDs), and boma and village health committees (boma/VHCs). HSSP is aligned with the new 2014 USAID/South Sudan operational framework, and with the Government of the Republic of South Sudan's health sector development plan² objective of strengthening institutional functioning in the areas of health system effectiveness, efficiency, and equity.

USAID/South Sudan, in collaboration with the Government of the Republic of South Sudan, will conduct a mid-term assessment of the HSSP; HSSP conducted this self-assessment to support that larger assessment. The self-assessment seeks to take stock of HSSP's achievements and the challenges it has encountered; and to make recommendations to guide the implementation of project activities over the remainder of the project's life. The results of this assessment will also be useful in modifying USAID South Sudan's results framework and strategies in the technical areas of health systems strengthening. Midway through the project, the self-assessment findings will provide evidence of changes since the project's inception in the way HSSP's work is being done and the way decisions are being made.

In **leadership and management**, since its launch in December 2012 HSSP has continued to apply capacity-building methodologies, including workshop face-to-face trainings, coaching/mentoring, and on-the-job trainings. Technical experts from Abt's office in Bethesda, MD, have built the capacity of local trainers and coaches in South Sudan, and a similar approach is being applied to the other thematic areas of the project.

The **health financing** component shows the project's success in adopting a multisectoral approach, involving non-health sectors, to achieve significant results in the health sector. The project has worked closely with the Ministries of Finance and Economic Planning, Labour, Public Service and Human Resource Development; the Local Government Board; and key Technical Working Groups. HSSP has been instrumental in getting results in the health finance thematic area, such as the development of CHD budgets, streamlining the flow of funds to the CHDs, and streamlining payroll preparation. These achievements are largely attributed to the joint efforts of these actors in enhancing SMoH and CHD capacity to adequately plan and manage funds in a decentralized environment.

In **health information systems** (HIS), the project has been able to streamline the flow of data from the facilities through to the CHDs and SMoH, and ensured efficient functionality of the District Health Information System (DHIS) to provide the most up-to-date information to guide the prioritization of health programs. Effective functionality of the DHIS has, in turn, assisted the CHDs and SMoH to identify potential disease outbreaks and monitor morbidity patterns, which might otherwise have gone undetected and led to avoidable deaths. HSSP's assistance to the CHDs in the development of their monthly health data bulletins has helped the CHDs feed back information to the facility level and to policy-makers.

¹ African Medical Research Foundation was originally involved, but is no longer working on the project.

² Republic of South Sudan (RSS). 2012. Health Sector Development Plan 2012–2016, Ministry of Health: Juba. January 2012.

The HSSP's **quality assurance/supportive supervision (QA/SS)** component has supported the CHDs in monitoring and improving the quality of the available health services. Through carefully formulated interventions – for instance, QA/SS refresher trainings, in-depth sessions on Quantitative Supervision Checklist (QSC), and direct financial support to carry out visits – the CHDs are now beginning to take charge of the QA/SS functions in their respective counties. Before the project's intervention, the CHDs were just participants and not the leaders in charge of the QA/SS functions in their respective counties, as the QA/SS visits were led by development partners and not the CHDs. With HSSP support, CHDs are now able to plan and lead their independent QA/SS visits, something that many CHDs were not able to do before. This is critical for building the capacity of the CHDs to sustain the QA/SS functions at the CHD level beyond the life of the project.

Through **strategic coordination and collaboration**, the various partners are being brought together regularly to provide updates on implementation of activities, and to share lessons learned and best practices. For example, some of these coordination meetings have resulted in partners redeploying their staff to more-needy health facilities, and in partners providing needy health facilities with water tanks, microscopes, and night-duty lighting. Various collaborative learning and adapting initiatives have been developed at the hub and state levels, to allow CHDs and the two states to exchange technical information in the programmatic areas within the health system. For example, the County Transfer Monitoring Committees (CTMCs) of Central Equatoria state and Western Equatoria state have been learning from each other about how to more effectively transfer central funds to the CHDs. The HSSP has also been having regular coordination meetings with sister USAID projects (Integrated Service Delivery Project (ISDP) and Systems for Improved Access to Pharmaceuticals and Services (SIAPS)), to share plans and coordinate implementation in the two states. These efforts in coordination have started to bear fruit, as demonstrated by better linkages between the project and the County Implementing Partners, including the ISDP and SIAPS; strengthened linkages with the government stakeholders (CHDs, SMoH, MoH/Republic of South Sudan (RSS)), and improved coordination across the project's thematic areas.

The initiation of the **geographical hubs** has been instrumental in increasing the project's visibility and effectiveness at the lower levels of the health system. It has strengthened the project's networking and relationships with the key health partners, and provided opportunities for the project to rapidly respond to CHD and lower-level health system needs. HSSP's efforts to revamp staffing during Year 2 of the project, with particular emphasis on making staff available to support the CHD level through the hubs (co-located at the CHDs), has also contributed immensely to providing the much-needed health systems technical expertise to implement the project in both states.

The project has also met and dealt with many challenges, which include the initial limited project start-up due to limited available funding at the start; limited capacity of government counterparts; severe government staffing shortages at the CHDs; challenging local transport infrastructure, particularly during the rainy seasons; and the national political conflict that was triggered on December 15, 2013, which led to the evacuation of third country national project staff and suspension of project procurements.

Overall, the project is on course to submit its deliverables and meet its contractual obligations. The most recently updated Performance Monitoring Plan (PMP) shows that HSSP has achieved or exceeded all its performance indicators, except for two. One of these, the mHealth application, had its activity postponed to a later period on the advice of USAID. HSSP cannot implement the other, involving community health data, until the MoH/RSS provides national-level strategic direction. Annex A has more-detailed information on HSSP's success in meeting project targets.

1.0 Introduction

Abt Associates and its partner, the Training Resources Group, are implementing the five-year Health Systems Strengthening Project (HSSP) in South Sudan (December 2012–November 2017). HSSP, funded by USAID, is contributing to the expansion of availability of health services in Central and Western Equatoria States, and helping to improve their quality. To strengthen South Sudan’s health system and foster an environment conducive to improved health service delivery, the project works with the central Ministry of Health, the State Ministries of Health (SMoH) for Central and Western Equatoria States, county health departments (CHDs), and boma and village health committees (boma/VHCs).

Since its launch in December 2012, the project has applied technical expertise and global and in-country best practices to achieve impact at scale, acknowledging USAID’s statement that **a stronger health system is needed** to “ensure that people and institutions, both public and private, undertake core functions of the health system in a mutually enhancing way, to improve health outcomes, protect citizens from catastrophic financial loss and impoverishment due to illness, and ensure consumer satisfaction, in an equitable, efficient and sustainable manner.” The project is contractually mandated to achieve several desired results shown in Table 1; it combines these areas of USAID’s technical assistance into a single consolidated program. To ensure **integration of the three components of the project**, key project activities that cut across one or more of the project’s components are delivered concurrently and/or coordinated for efficiency.

USAID/South Sudan in collaboration with the Government of the Republic of South Sudan is to conduct a mid-term assessment of the project, to identify accomplishments and constraints, with a focus on opportunities and needs for the remaining period. This assessment will also help to establish whether and how the design of the project has affected management, performance, and ability to be responsive to the priorities of the Government of the Republic of South Sudan; and attainment of the Mission’s goals and objectives.

The findings of the assessment will inform USAID/South Sudan future health sector programming, and guide the implementation of project activities. This includes identifying areas that may require corrections or modifications over the remainder of the project’s life. This HSSP self-assessment

provides a description of HSSP achievements, challenges, lessons learned to date, and recommendations for the future direction of the project and beyond. It also examines HSSP achievements against project targets as outlined in the project’s Performance Monitoring Plan.

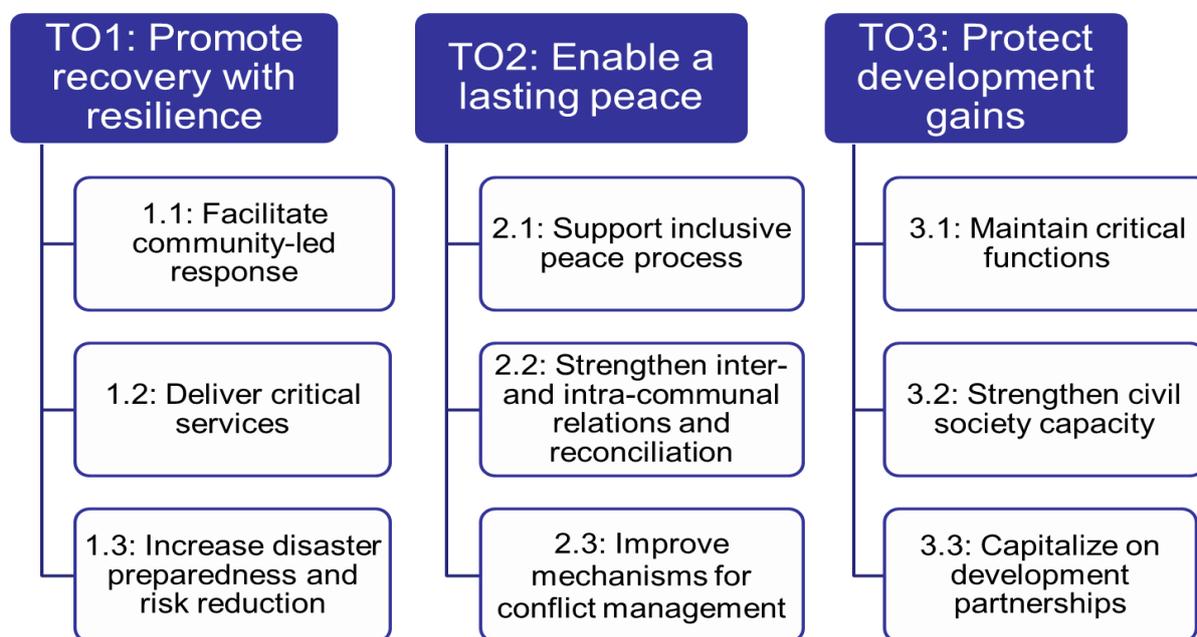
Table 1: HSSP Overview	
Overarching Goal:	<ul style="list-style-type: none"> ▪ Increase ownership and capacity of SMoHs and CHDs to ensure the provision of high-quality primary health care services
Desired Result:	<ul style="list-style-type: none"> ▪ Improved institutional capacity within SMoHs and CHDs to manage and coordinate health service delivery through: <ul style="list-style-type: none"> - Increased Leadership and Management (LM) capacity at SMoHs, CHDs, and VHCs - Strengthened health systems at state and county levels, with particular attention to HIS, financial management, and quality assurance - Increased coordination and collaboration at the state and county levels
Period:	<ul style="list-style-type: none"> ▪ December 2012–November 2017
Funding:	<ul style="list-style-type: none"> ▪ \$24.947 million
Coverage:	<ul style="list-style-type: none"> ▪ Western Equatoria State, 10 counties ▪ Central Equatoria State, 6 counties

HSSP Alignment with USAID's Framework

The overarching goal of HSSP in South Sudan is to increase the capacity of CHDs and the SMOHs to ensure the provision of high-quality primary health care services in Central Equatoria State (CES) and Western Equatoria State (WES). The desired program result is improved institutional capacity within SMOHs and CHDs in CES and WES to manage and coordinate health service delivery. To achieve this result, this project focuses on three components as highlighted earlier. HSSP is clearly aligned with the new 2014 USAID South Sudan operational framework (see Figure 1) whose goal is to **build the foundation for a more stable and socially cohesive South Sudan**. In particular, HSSP is consistent with the three transition objectives (TO) of the framework. Within TO1 of the framework (promote recovery with resilience), HSSP particularly contributes to Sub-objective 1.1 (facilitate community-led response), through HSSP's work with VHCs/bomas, work with the Primary Health Care Center (PHCC)/primary health care units (PHCUs) and work with CHDs. HSSP also contributes to Sub-objective 1.2 (deliver critical services), as HSSP supports key health systems that are necessary for the delivery of critical health services. The work that HSSP is doing in Year 3 on including conflict management in all training materials on leadership and management contributes to both Sub-objective 1.3 (increase disaster preparedness and risk reduction) and Sub-objective 2.3 (improve mechanisms for conflict management). Finally, all the health systems work of HSSP is important in maintaining the critical functions of the health system in South Sudan, which is consistent with Sub-objective 3.1 (maintain critical functions) of the framework. Before this framework was issued, HSSP's work was consistent with the previous USAID South Sudan transition strategy (2011-13).

Figure 1: USAID New (2014) Operational Framework for a Socially Cohesive South Sudan

GOAL: Build the foundation for a more stable and socially cohesive South Sudan



The South Sudan December 2013 Conflict and HSSP Implementation

The South Sudan political conflict that started on December 15, 2013, was a major challenge for HSSP, as it affected project implementation from December 2013 to May 2014. The conflict led the project to

restrict international travel, which meant that the project had limited technical support from Abt's Bethesda, MD office. A procurement freeze prevented the project from buying planned equipment to support SMOHs and CHDs, and from hiring new staff. Five key staff including the project's Chief of Party and the HIS, LM, and Monitoring and Evaluation (M&E) senior advisors had to work from neighboring countries, and were therefore highly focused on the mechanics of remote engagement and communication by phone and email as they worked to follow up on program issues. RSS and its partners in the health sector, including county- and community-level staff, were also slow to return to their workstations, making interaction with HSSP staff and provision of critical information a challenge. This reduced the momentum of project implementation during that period.

In response to the crisis, USAID had HSSP re-focus its efforts to address county- and community-level needs by working with the service delivery partners such as the Integrated Service Delivery Project (ISDP), and the Systems for Improved Access to Pharmaceuticals and Services Project (SIAPS). HSSP revised its activities to focus on the CHD, boma/village levels (PHCCs), PHCUs, and bomas/VHCs. HSSP also identified priority areas for immediate HSSP response during the crisis period, and revised the staffing structure to respond to these new priorities. HSSP created six geographical hubs to more efficiently roll out and enhance the scale-up of project activities to the county and community levels, as explained in the next section.³ Each hub consists of 2-3 CHDs, and the hub office is co-located with one of the CHDs in the hub.

Adoption of HSSP Hub-Based Approach to Serve Counties in CES and WES

During the first two years, the project operated from two offices – Juba (CES) and Yambio (WES). At the lower levels, many stakeholders did not know about HSSP. To increase visibility at these lower levels, and project impact, HSSP created six hubs. Each hub was made up of two to three counties, with each hub office being co-located within one of the hub's CHD or implementing partner offices. These hubs have ensured effective HSSP presence at the lower levels of the health system, and strengthened project networking and relationship-building with the key health partners on the ground, such as the Sudan Evangelical Mission, Mundri Relief and Development Association, Population Services International, Action Africa Help International, and Catholic Medical Missions Board. The hubs have also created opportunities for HSSP to respond rapidly to requests from the CHD and from lower levels. The project co-locates hub offices with County Implementing Partners (CIPs), CHDs or the SMOH, depending on space availability. Two full-time staff, the Hub Manager and the Leadership and Management Officer (LMO), are posted on a permanent basis to each hub to support implementation of activities. The hub managers, in liaison with the SMOH, provide overall oversight and coordination of project activities within the counties in their respective hubs. The LMOs support the CHDs in cascading LM trainings, coordinating post-training follow-up, and providing coaching/mentoring and on-the-job training as appropriate. Both staff members at each hub assist in documenting project best practices and success stories, and support monitoring and evaluation activities.

³ The hubs (headquarters are in boldface) are: (i) **Mundri West**, Mundri East, and Mvolo; (ii) **Maridi** and Ibba; (iii) **Yei**, Lainya, and Morobo; (iv) **Juba**, Terekeka, and Kajo-Keji; (v) **Yambio**, Enzo, and Nzara; and (vi) **Tambura** and Nagero.

2.0 Project Component Achievements, Challenges, and Recommendations for the Future

This chapter describes project achievements, challenges and recommendations, organized by project component and thematic area. We start with LM, before proceeding to health finance/public financial management, the health information system, quality assurance/supportive supervision, and finally strategic coordination and collaboration. In the last section, we examine the overall challenges that have affected the project in multiple ways.

2.1 Component I: Increased leadership and management capacity at VHC, CHD, and SMoH

Strategic and technical approach: When HSSP was launched there was very limited knowledge of LM skills in the two project states and throughout South Sudan. This impeded the strengthening and ultimately the functioning of the health system. This deficit remains acute, particularly at the county, PHCC/U and boma levels of the health system. In response, HSSP developed three sets of training materials, for the SMoH/CHD, PHCC/PHCU, and VHC/boma Health Committee levels. These materials are being used to deliver series of comprehensive trainings for health sector leaders and managers, facilitating their ability to hone the skills necessary for good management and leadership of the health system at the respective levels. LM support tools have also been developed for use by the leaders and managers at the workplace. The LM component of HSSP offers training and coaching/mentoring of health sector leaders and managers to transform the health system in WES and CES. HSSP has trained a pool of facilitators drawn from SMoHs and CHDs to help the rollout of LM training at the three levels. In the meantime, HSSP staff including the LMOs, based at the six hubs, closely monitor the quality of training provided by facilitators, and address gaps to ensure quality and effectiveness. In particular, the LMOs follow up the trained staff, as part of the coaching/mentoring process. HSSP has continued to apply these capacity-building methodologies strategically, and has provided a uniquely tailored needs-based, cross-cutting approach for those at different levels of government, with managers and technical staff across the project thematic areas. The ultimate objective is to increase overall LM capacity of leaders and managers at the CHDs, PHCC/Us, and boma/VHCs to effectively plan and oversee service provider activities in WES and CES.

Key accomplishments to date

- Developed LM training course materials for three levels of the health systems, namely, boma and Village Health Committee, Primary Health Care Centers and Units, and SMoH/CHDs. Training materials have also been developed for coaching/mentoring. The materials include Facilitators' and Participants' Guides, and coaching and mentoring materials. The boma/VHC materials have undergone multiple rounds of simplification to tailor the materials to the target group that has members with low proficiency in English and/or little formal education and training.
- Conducted LM "Training of Facilitators" courses for 24 trainers to support the project's sustainability strategy, which aims to build a core team of local health sector leaders and managers at the SMoH and CHD levels, and health facilities that will effectively guide and support their staff to continually improve LM competencies.
- Developed and distributed job aids to stimulate and enhance effective LM interventions in the SMoH and CHDs of WES and CES, enabling managers to better perform their supervisory and management roles. The job aids are: the performance management cycle, six steps for a delegation conversation, performance monitoring, elements of the feedback message, and situational

leadership. The job aids serve as quick references for the managers, reminding them how to use the knowledge, skills, and best practices gained from the LM trainings.

- Trained 93 leaders and managers at the boma/VHC level. The target group include: community midwives, maternal child health workers, and the Chairman, Secretary, Treasurer and committee members.
- Trained 44 health workers at the PHCC/U level in Juba Hub (n=24) and Yei Hub (n=20). The target group include: health facility in-charges, clinical officers, midwives/nurses, nutrition officers and community health workers.
- Trained HSSP staff (across all the thematic areas), and CHD/SMoH staff, in the principles and best practices of coaching/mentoring, and on-the-job training. The HSSP staff and the trained CHD/SMoH staff are applying these principles and practices in coaching/mentoring and on-the-job training of SMoH and CHD staff in the two states.
- Included conflict management as one of the components of all the HSSP LM trainings in the two states. This was particularly critical after the national conflict in South Sudan triggered on December 15, 2013.

Challenges and resolutions

Low literacy levels among participants at lower levels, especially those at VHC/boma Health Committee levels. Some participants at the trainings at the PHCC/U level and boma/VHC levels have limited education and understanding of the English language and sometimes even Juba-Arabic language.

Recommendation/resolution: The course materials for PHCC/U and particularly the boma/VHC levels have undergone multiple rounds of simplification and been pre-tested with training participants. The participant materials for boma/VHC level have been simplified to be mostly pictorial. HSSP has developed a database of the local language skills of the local facilitators, so as to assign them to trainings in locations where they can, when necessary, use local languages to explain any difficult LM concepts.

Low performance by one of the initial LM subcontractors. During most of Year One, one of the LM subcontractors failed to deliver on its contract obligations. Because this subcontractor was a local organization, the project did everything possible to build its capacity so that these targets could be achieved. However, this partner still did not achieve its deliverables and the work under Component I was adversely affected.

Recommendation/resolution: After several attempts to work with this partner, Abt in close consultation with USAID decided to close out the subcontract and work with only the Training Resources Group on the LM component. At this point, Abt hired the LMOs and a senior capacity-building advisor. With the on-boarding of the new LM staff, activities under the LM component have been revamped and HSSP is on course in meeting the set LM targets.

Difficulty getting female candidates to LM workshops. There are relatively few women in leadership and management positions at the SMoH/CHD, PHCC/U and boma/VHC. For this reason, the LM training workshops have had limited success in their efforts to attract adequate numbers of women to obtain gender equity as earlier envisioned.

Recommendation/resolutions: The project has allowed women participants who are breastfeeding and/or have young children to come to the LM trainings with baby-sitters, provided it does not create extra

expense for the project. The project is also advocating for the recruitment of more women in leadership and management positions at the SMoH/CHD, PHCC/U, and boma/VHC.

Training calendar conflicted with those of other USAID health implementing partners. The project's LM training timetable has occasionally conflicted with those of other partners, notably ISDP and its county implementing partners since the calendars were not coordinated. As a result of these calendar conflicts, some HSSP trainings have had to be cancelled or postponed to a later date.

Recommendation: HSSP held a joint meeting with ISDP and SIAPS and agreed on the areas of focus for each partner. Furthermore, as part of HSSP's coordination work under Component 3, the project developed a joint calendar so that HSSP, SIAPS and ISDP can be effectively coordinate their training efforts and avoid calendar conflicts.

2.2 Component 2: Strengthened health systems at state and county levels, with particular attention to HIS, financial management, and quality assurance

This component focuses on health financing, health information systems, and quality assurance/supportive supervision.

2.2.1 Health Financing/Effective Public Financial Management

STRATEGIC AND TECHNICAL APPROACH: Health financing affects the provision and use of health services, and has important implications for efficiency, equity, and quality. In South Sudan, government spending on health is deficient, and the percentage of the health sector budget that is actually spent remains low. Fiscal decentralization is still evolving, with only limited resources flowing to the CHDs. Audits are non-existent at the CHDs and conducted irregularly at the SMoH, and planning and budgeting is still carried out through the “top-bottom” approach. Community involvement in prioritization of interventions is almost non-existent. Against this background, enhancing SMoHs' and CHDs' capacity to adequately plan and manage funds in a decentralized environment is central to HSSP's support in the two project states of CES and WES.

In order to address the knowledge gap in public financial management among health sector financial managers, and maintain the skills development needed for health sector workers to budget, execute, monitor and report on their disbursed funds, HSSP is applying several strategies to enhance technical capacity-strengthening of the SMoHs and CHDs. The project is supporting different aspects of Public Financial Management (PFM), including planning, budgeting, management of cash and commitments, payroll management, and financial reporting. HSSP is also establishing appropriate and responsive fiscal responsibility through coaching, on-the-job training (OJT), and workshop-type off-site training sessions, and has developed guidelines and other job aids. The objective of all this is to establish appropriate and responsive fiscal responsibility, particularly at the CHD and state levels. Not only does the project work with the MoH/RSS, SMoHs and CHDs, but HSSP has also implemented many appropriate interventions in collaboration with the Ministry of Finance and Economic Planning, the Local Government Board, State Ministry of Labour, Public Service and Human Resource Development, the Local Service Support Aid Instrument (LSSAI) PFM technical working groups, and the Government Accountancy Training Center.

KEY ACCOMPLISHMENTS TO DATE

- Trained 88 CHD staff from CES (n=57) and WES (n=31), notably county medical officers, accountants/bookkeepers, and county staff (county executive directors, county planning officers, and heads of accounts) on planning and budgeting. (Annual Target: 45)

- Developed a standard budgeting template and supported CHDs in the preparation of their budgets for FY 2014/15. The budgets for all of the 6 CHDs in CES and 10 CHDs in WES were approved by the respective county legislative councils and state legislative assemblies, and used as basis for resource allocation.
- Trained 108 county and hospital staff on Financial Reporting (PFM), 57 from CES (M = 48; F = 9) and 51 from WES (M = 49; F = 2). (Annual Target: 32 (CES = 12; WES = 20))
- Trained 109 CHD and SMoH staff (notably, county executive directors, establishment officers and controllers of accounts/heads of accounts, planning officers, accountants/bookkeepers) and Ministry of Labour, Public Service and Human Resource Development on the use of the South Sudan Electronic Payroll System. Forty-seven came from CES (M = 36; F = 11) and 62 from WES (M = 60; F = 2). The same group was trained on the preparation of budget performance reports. (Target of 32 (CES = 12 and WES = 20))
- Trained 80 county and state personnel responsible for payroll on payroll management in CES (18) and WES (62). The trained staff are to participate in cleaning primary health workers' payrolls so that they can qualify for the RSS infection control allowances.
- Supported the establishment of the first-ever County Transfers Monitoring Committee in CES, on November 19, 2014. The committee has visited the counties to oversee FY 2014/2015 budget execution, and is currently reviewing the accountability reports submitted to it by the counties.
- Developed the Key Performance Indicator information collection tool that the CTMCs are using to monitor the performance of the counties/CHDs and enforce accountability and transparency in the use of public funds.
- Facilitated the "unblocking of funds"⁴ in WES, which led to the increased flow of funds from the state to the counties for FY 2013/14. The percentage of funds transferred to the CHDs increased from 12% to 100% within a period of two months (Sept-October 2014) following this intervention.
- Took a leadership role in developing the CHD Annual Operational Plan Guidelines, with contributions from the MoH, SMoHs in CES and WES, World Health Organization, European Union Technical Assistance on PFM and Payroll (EU-TAPP), World Bank Local Government Services Delivery Project (LGSDP), Health Pooled Fund, IMA, and Health Link South Sudan.
- Took a leadership role in coordinating development partners/programs/projects (WHO, EU-TAPP, World Bank LGSDP, Health Pooled Fund and IMA) involved in PFM for the purpose of collaboration, avoiding duplication of effort/resources, and wider coverage in PFM. The first meeting was held on September 18, 2014, and there have been several meetings since then.
- Facilitated the first peer-to-peer learning between the CTMC/CES and CTMC/WES in January 2015. The meetings are now being conducted quarterly.
- Developed job aids for budgeting and financial reporting for use by the health finance managers at the workplace.

CHALLENGES AND RESOLUTIONS

Limited staffing. The project proposal provided for only one health finance staff person (Sr. Health Finance Advisor), which was inadequate. Also, in December 2013, the Senior Health Finance Advisor, who had been recruited at the start of the project, left, and it took about six months to get a replacement. Similarly, the Planning and Budgeting Specialist for WES left in December 2014, and has yet to be replaced.

⁴ This is the subject of the success story entitled "Getting funds when and where they are needed in South Sudan." presented by the Sr. Health Financing Advisor at the Mini U held at George Washington University in early March 2015.

The absence of these key staff adversely affected performance at critical times.

Recommendation/resolution: Two additional Health Finance Planning and Budgeting Specialist positions, one for each state, were created and staff recruited. The Sr. Health Finance Advisor position was filled in May 2014 and the recruitment process is ongoing to provide a replacement for the Planning and Budgeting Specialist.

Lack of health finance policy dissemination to the lower levels. The MoH/RSS has not had an effective mechanism to disseminate the National Policies and Guidelines, including those related to health finance, to the CHDs – yet the MoH/RSS expects the CHDs to implement the provisions of the key policy documents.

Recommendation/resolution: HSSP printed and distributed to the CHDs a number of documents, including the Local Governments Act 2009, the Local Governments Public Financial Management Manual 2013, the Public Financial Management and Accountability Act 2011, Interim Public Procurement and Disposal Regulations 2006 and the Public Service Regulations 1994. These policy documents provided valuable sources of reference during HSSP capacity-building initiatives.

CHDs did not have adequate skills and knowledge in financial management. Health financing is a new area, and many health staff are still struggling to understand what is required of them. Prior to FY 2013/14, for instance, central government funds were not sent directly to the counties, and staff at this level were hardly ever exposed to public financial management issues. The CHDs heavily relied on the County Administration to carry out their finance and accounting functions.

Recommendation/resolution: The project uses a multi-sectoral approach to bring the several stakeholders together to rally support for the SMOH and CHDs. Additionally, the project has moved from face-to-face workshops as a key capacity-building strategy in health finance to the use of coaching and OJT to ensure that adequate knowledge and skills are transferred to the government counterparts. These strategies have been complemented by HSSP-developed job aids, which simplify key messages from the Local Governments' policies, procedures, manuals, regulations and guidelines to support the health managers in effectively undertaking their duties at the workplace.

Exclusion of HRH component from Y2 workplan. Certain components of health finance that are related to HRH were excluded (based on USAID guidance) from the project's work plan starting from Year 2. This has so far made it impossible to implement project activities that relate to payroll and infection control allowances.

Recommendation/resolution: Because the RSS has requested HSSP support in this area and advocated to USAID for it, the project recently asked USAID for additional funding to support the implementation of this activity, starting with two CHDs on a pilot basis, and targeting the other CHDs in Year 4 of the project.

Lack of operation funds for the CTMCs. In spite of its having created the CTMCs to provide oversight functions on the use of central government transfers, the government did not provide for these committees' budget. This has made the CTMCs overly reliant on project funds to undertake their responsibilities, a function that is government's responsibility.

Recommendation/resolution: HSSP has started advocating to the government to include the funding of the CTMC activities in the government budgets, starting with FY 2015/16. Now that these committees are operational, the government can see their value and is more likely to ensure future funding.

2.2.2 Health Information Systems

STRATEGIC AND TECHNICAL APPROACH: Efforts to reform and effectively run the health system require the most up-to-date information to guide the prioritization of health programs and health policy decisions. Routine flow of data from the communities is also helpful to the CHDs in their efforts to identify potential disease outbreaks and monitor morbidity patterns, which might otherwise go undetected, leading to preventable deaths. This notwithstanding, the health information system is experiencing numerous challenges in the project states. There is wide variation among facilities in CES and WES with regard to timeliness, accuracy, and completeness of data reporting. Many facilities in the respective states still face infrastructure challenges that limit the regularity with which data are reported upwards to the CHDs, thus limiting the completeness of data available for analysis. Major gaps also exist in data analysis skills among CHD M&E staff, and the SMOH M&E staff rarely visit the CHDs to review data submissions.

In response, HSSP is building the capacity of CHD-level staff to analyze and use the data they are collecting through the District Health Information System for decision-making. This will ensure easy detection and quantification, and appropriate response to diseases in the community. The project supports county health departments in the development of **monthly health data bulletins** to be used for feedback to the facility level and to policy-makers. Additionally, routine quarterly data review meetings are promoted and a data quality review is incorporated as a component to assure quality. Finally, HSSP collaborates with state ministries of health and county health departments to develop and implement Health Information System strengthening plans. HSSP provides this support through a staffing and support structure that works through hubs across CES and WES.

Accomplishments to date

- Trained 16 CHDs and two SMOHs (WES/CES) on DHIS data cleaning, analysis and use; training involved 19 participants from the two states (Jan 2015)
- Conducted an HIS functionality status review for two states (WES/CES)
- Provided computers (a mixture of laptops and desktops, 12 for CES CHDs and 24 for WES CHDs) and internet access via VSAT to all CHDs in WES and CES, to improve data processing and transmission
- Trained staff from 5 CHDs in WES and staff from 5 CHDs in CES in data analysis, which resulted in the production of a monthly health bulletin in 11 CHDs; two of the CHDs (Kajo-Keji in CES and Nzara in WES) have been assisted in producing two separate monthly health bulletins
- Conducted two quarterly review meetings in CES (Kajo-Keji County, 11/2014 & 2/2015) and one in Yambio (7/2014)
- Collaborated with the Liverpool Associates of Tropical Health in conducting the national DHIS data cleaning and training for WES and CES
- Trained facility-level clinical and administrative staff (25 participants in July 2014 and 19 participants in September 2014) from WES on the appropriate use of registers and their role in the data reporting system
- Delivered 1,098 newly printed registers to WES counties and 1,357 for CES from RSS/MoH, enough to supply all health facilities in both states
- Provided technical support to CHDs during the quarterly review meetings and coordination meetings to guide stakeholders in making informed decisions based on DHIS data (Nagero, Kajo-Keji and Ezo)

- Conducted one-on-one technical support to five CHDs in CES (Terekeka, Lainya, Yei, Kajo-Keji and Morobo) and 4 CHDS in WES (Yambio, Nzara, Ezo and Nagero), including the two SMOHs, on data analysis, presentation and developing health information products
- Produced catchment area maps for the 16 counties to provide background information during supportive supervision and logistical planning
- Produced indicator factsheet for each county to help visualize CHD indicator performance
- Piloted a data quality assessment tool in Kajo-Keji County

Challenges and resolutions

- Staffing. Because the project had challenges identifying and hiring a Sr. HIS Technical Advisor to oversee activities, the original baseline (June 2013) assessment was conducted before this person was eventually hired (September 2013). The process of engagement with the CHDs was therefore slower than it would otherwise have been. Then the Sr. HIS Advisor left HSSP in August 2014 (for further studies), which had a negative effect on the project's continuity of engagement with CHDs on HIS. HSSP has therefore been relying on more extensive short- and long-term technical assistance in the HIS domain than had initially been planned.

Recommendation/resolution: To attract South Sudanese HIS staff, HSSP in consultation with USAID decided to hold off on hiring a new Sr. HIS Advisor. Instead the project will hire three officers, who will receive coaching and on-the-job training. HSSP will promote one of these staff to the more senior position, after evaluating performance and capacity to lead.

- Coordination. The project has faced three key challenges relating to coordination in the HIS thematic area as stated below.
 - Coordination of HIS activities with ISDP, to encourage capacity-building of facility-level staff in areas of data reporting and data quality, did not take place initially.
 - The HIS team could have coordinated its CHD quarterly review meetings more with the LM and/or QA/SS teams' meetings/visits.
 - South Sudan has a myriad of health partners who work closely with the CHDs. Sometimes there is a crush in training programs conducted for the same participants. This affects the timeliness of activity implementation. In addition, the government may have its own activities that require the CHDs to participate, thus affecting our schedules.

Recommendation/resolutions:

- Through HSSP, each of the three USAID key projects (i.e., SIAPS, ISDP and HSSP) created a Google/Gmail account on February 4, 2015 to have a joint consolidated training calendar through which duplication of training efforts can be avoided.
- HSSP is now holding monthly meetings among internal technical staff to review activity calendars and to improve on cross-component collaboration. For instance, HIS data generated in Component 2 is now being used in the monthly coordination meetings (Component 3).
- Continued participation by HSSP technical staff in implementing partner coordination meetings (e.g., M&E Technical Working Group, mHealth technical working group) is critical to have knowledge of what each partner is doing and find areas of complementarity and synergies, including prospects of undertaking joint activities.

- Lack of MoH equipment. As part of its HIS efforts, HSSP promised to buy equipment that HIS officers could use to enter and analyze DHIS data. There was extensive delay in delivering promised laptops and VSAT due to limited funding at the start of the project, and later a procurement freeze due to the December 2013 conflict. This affected the pace at which the project could build CHD capacity in HIS.

Recommendation/resolutions: All computer equipment and related accessories have been procured, distributed, and installed, and are in use at the respective SMoHs and CHDs. The equipment includes: 20 desktops, 20 UPS, 38 laptops, 18 scanners, 8 printers, 18 projectors and 20 copiers.

- Version of DHIS software with lower functionality. District Health Information System version 1.4, the RSS's Health Management Information System (HMIS), is a computer-based software system that requires extensive synchronization of databases in order to harmonize master files (as opposed to a web-based system with a single database to which everyone adds data).

Recommendation/resolutions: The Liverpool Associates of Tropical Health and HSSP (on behalf of the MoH/RSS) conducted a feasibility assessment that found that DHIS2.0 (web-based) is an appropriate solution for RSS. HSSP will support the transition to DHIS2.0, and build the requisite capacity of the CHDs, should the software be recommended.

- Limited HRH capacity at the CHDs. The capacity of the majority of CHD-level M&E/HMIS staff is relatively low in basic data computing and public health analysis, meaning that most of these staff cannot conduct basic analysis regardless of the quality of data being generated by the DHIS.

Recommendation/resolutions: Development of a structured training program to build up the computer and data analysis capacity of the CHD-level M&E staff and provide follow-on training in higher-level analysis as capacity improves. HSSP has plans to implement this training program starting from Quarter of Year 3 of the project. These trainings are designed to be for staff at three levels, namely, basic computing skills, introduction to DHIS, and DHIS data analysis and use.

2.2.3 Quality Assurance/Supportive Supervision

STRATEGIC AND TECHNICAL APPROACH. The development of a strong quality assurance system (which is under the auspices of the SMoH and CHDs) is necessary to monitor and improve the quality of health care, and to support the government's strong commitment to improve the health sector and expand the availability of health services. According to the *Baseline Assessment Report*⁵ and the project's experience in implementing QA/SS activities, the QA/SS system in CES and WES continue to be hampered by limited financial and human resources, lack of capacity within some CHDs to carry out their functions, and geographical and transportation challenges that hinder the ability of vehicles to reach facilities with ease, among other factors. Visits often occur irregularly and are carried out by CHD teams that may not be appropriately versed in all aspects of QA and the QSC. Data, if collected, is often of variable quality and is rarely used to track performance, let alone inform quality improvements.

⁵ South Sudan Health Systems Strengthening project. November 2013. *Baseline Assessment Report: Central and Western Equatoria States, South Sudan*. Bethesda, MD: South Sudan Health Systems Strengthening Project, Abt Associates.

In response, HSSP has carefully formulated interventions to address gaps identified in the QA system. To start with, HSSP continues to build the capacity of CHD teams on service provision components of QA/SS, and is helping them plan and implement independent QA/SS visits. This capacity-building is normally provided through basic QA/SS refresher trainings, in-depth sessions on specific topic areas of the QSC, and financial support from the project to carry out visits, accompanied by HSSP and/or SMoH staff, on an as-needed basis. Before HSSP's intervention, county health departments were not able to conduct independent quality assurance visits, and had to rely on implementing partners to do so.

Key Accomplishments to Date

- Trained all the 6 CHDs in CES and 8 CHDs in WES (except Mundri East and Nagero) to conduct independent QA/SS visits and on how to request QA/SS field visit funds. A total of 31 staff participated in the QA/SS trainings: 21 in WES and 10 in CES. The targets had been 16 in each state.
- Financially supported CHDs to conduct independent QA/SS visits. A total of 9 CHDs (WES = 7; CES = 2) and SMoH/CES conducted independent supportive supervision. This amounts to 50% of the targeted CHDs earmarked to receive financial support from HSSP.
- Developed mHealth implementation proposal to strengthen the QA/SS process, including streamlining data transfer and enhancing feedback by CHDs to health facilities. The stakeholders have approved this proposal for application on a pilot basis starting with two counties, one from each state. QA/SS challenges and solutions.

CHALLENGES AND RESOLUTIONS

Confusion on the QA/SS scope between HSSP and ISDP. QA/SS is within the contractual obligations of both ISDP and HSSP. In effect, both projects implement QA/SS activities in WES and CES targeting the same CHD supervisory teams. This has led to a perception of duplication of efforts, and at times even overstretched the CHDs that have staffing constraints and cannot go on multiple supervision visits.

Recommendations/resolution: HSSP held three joint meetings with ISDP under the guidance of USAID, to obtain clarity and agree on the roles/responsibilities of each partner in QA/SS. In the discussions it was decided that ISDP is to focus on the regular, quarterly, technical QA/SS on service delivery, and the data on this are to be entered into the DHIS. HSSP on the other hand was to support the CHDs in conducting "independent" QA/SS, focusing on their ability to conduct supervision on their own. HSSP also oversees the performance of CHDs on selected HSS performance indicators: strategic direction, oversight of county health services, stewardship of financial resources (i.e., operational grants), health information, and stakeholder coordination.

Limited transport infrastructure. QA/SS field visits are expensive due to the bad roads, high fuel costs, high vehicle maintenance costs and high vehicle hire costs, among others. There are also no government or project vehicles to support CHD-led independent QA/SS visits. Many of the CHDs lack vehicles, and the few vehicles available are in poor mechanical condition and cannot support regular QA/SS field visits.

Recommendation/resolution: HSSP has provided financial and logistical support to the CHD to conduct independent QA/SS through the hubs. Advocacy is also being undertaken by HSSP with the SMoHs to prevail upon the CHDs to use part of the operational grants to support QA/SS.

Limited CHD technical capacity to undertake QA/SS. The County Implementing Partners are more knowledgeable in QA/SS, compared to their CHD counterparts. This lack of capacity has prompted the CHDs to take the back seat during joint QA/SS visits with CIPs.

Recommendation/resolutions: HSSP has increased targeted trainings to the CHDs on QSC, and planning for independent QA/SS to the CHDs through the hubs. As part of coaching, HSSP also joins the CHD staff on selected QA/SS visits to learn what they are doing, and in turn provide any further training in areas of identified gaps and/or corrective measures where possible.

2.3 Component 3: Increased strategic coordination and collaboration at the state and county levels

STRATEGIC AND TECHNICAL APPROACH. The need for strategic coordination and collaboration was apparent even before the December 15, 2013 political conflict in the country. This is because of the need to avoid duplication of efforts, ensure harmonized planning and efficient resource use, strengthen linkages between actors, and share lessons learned and best practices. Since the conflict, there has been an escalated need for coordination, as donors and implementing partners responded to the conflict within their respective areas of competency. This increased the breadth and depth of coordination needed to coordinate stakeholders in the health sector, for example, MoH/RSS, SMoH, CHD, nongovernmental organizations, faith-based organizations, community-based organizations, and private health practitioners. Effective coordination enables partners to have a more complete knowledge of what is happening on the ground and foster synergies within the health sector and local area of operation.

HSSP continues to coordinate with partners including ISDP, SIAPS, the World Bank, the Liverpool Associates of Tropical Health, UNICEF, CES and WES SMoHs, MoH/RSS, CHDs in CES and WES, and others. In particular, HSSP is building the capacity of CHDs to lead the coordination effort in their respective counties. HSSP has supported all the CHDs in the two states in conducting monthly coordination meetings, which all health sector partners operating in the respective county are invited to attend, to discuss health system coordination issues for the respective county. HSSP is building this capacity through initial training of CHDs on how to conduct effective coordination meetings, how to take minutes of the coordination meetings, and how to follow up on the decisions made during the coordination meetings. HSSP also provides financial resources to the CHDs to pay the cost of conducting these monthly coordination meetings. Within the coordination component, HSSP is also coordinating peer-to-peer learning between CHDs and between the two states (WES and CES) as part of collaborating learning and adapting.

KEY ACCOMPLISHMENTS TO DATE

- Trained 81 CHD staff (WES = 31, CES = 50) on how to effectively conduct and manage monthly county coordination meetings. This training has helped to build CHD staff stewardship capacity to improve program implementation and to conduct the coordination meetings themselves.
- Conducted health stakeholder mapping in CES and WES to provide the much-needed information to improve communication among health partners and with the CHDs, and enhance joint planning, monitoring, and evaluation of health activities.
- Initiated county monthly health coordination meetings in all the CHDs in the two project states. The meetings are now being held regularly and being used to share partners' updates on the achievements, challenges and way forward. There are now calls to develop One Joint Work Plan in each county. The meetings have also enabled close working relations between the SMoH and CHDs on the one hand and the facility in-charges, community leaders, payam Administrators, paramount Chiefs, and CIPs on the other hand.

- Trained six CHDs Coordination Committees on how to effectively use HIS data for decision-making during the monthly coordination meetings. HSSP also provided additional (refresher) training on how to conduct good meetings and in particular on how to take good minutes, for seven County Coordination Committees.
- Facilitated one consultative meeting between MoH/RSS and SMoH CES with CHDs and CIPs, which brought together 38 participants from the SMoH, CHDs and CIPs in CES to discuss, in the presence of the MoH/RSS, some of the achievements, challenges and ways forward to improve quality health services delivery and strengthen health systems in the state.
- As mentioned above (under Health Financing), HSSP facilitated the first peer-to-peer learning between the CTMC/CES and CTMC/WES in January 2015. This peer-to-peer learning is now institutionalized and is being conducted quarterly.
- Conducted one “peer-to-peer” learning experience to enhance collaborative learning and adapting in Mundri West Hub for 18 health managers and leaders from the CHDs within the hub, namely Mvolo, Mundri East and Mundri West CHDs. From the deliberations, the forum provided a good opportunity for the staff to exchange technical information on: how to apply knowledge and skills from the LM trainings at the workplace; effective use of HIS data in decision-making; budget preparation processes and procedures; and effective ways to conduct independent CHD QA/SS visits and manage monthly county coordination meetings.

CHALLENGES AND RESOLUTIONS

- Difficulties in updating the ever-changing stakeholders’ database. There has been an influx of stakeholders to provide humanitarian support to the health sector in WES and CES, with many of the stakeholders moving in and out abruptly. This development has made it a challenge to maintain an updated stakeholders’ mapping data base.

Recommendation/resolutions: The HSSP hub staff available on the ground at CHD level can now support the updates on a regular basis, and the resulting database will be subjected to further verification at such key forums as the monthly county coordination meetings and health cluster meetings, and during the joint SMoH/CHD meetings. That will ensure that rapid changes (including movement of partners) within each county are accurately and promptly updated in the database.

- Non-adherence to time schedule for the monthly coordination meetings. In spite of the availability of project funding to support monthly county coordination meetings, the meetings have been held irregularly and/or cancelled at the last minute. This development has been attributed to poor advance planning and to the limited number of CHD staff, who are compelled to choose between several training and capacity-building activities.

Recommendation/resolutions: The HSSP hub staff have improved the coordination and collaboration with the CIPs on the ground at county level through the development of joint monthly calendars and advance planning. This move has minimized the cancellation of the monthly county coordination meetings.

- Restricted movements to attend meetings due to inaccessible roads. Some CHDs such as Nagero and Mvolo in WES are inaccessible during the rainy season because of bad roads and broken bridges. This situation has adversely affected the movement of project staff to attend monthly coordination meetings. In effect, the project has found it challenging to facilitate monthly coordination meetings in the inaccessible CHDs during the rainy season.

Recommendation/resolutions: The project is to accord priority in program implementation to the inaccessible areas during the dry season. Additionally, the project will plan in advance for the conduct of the monthly coordination meetings, whenever possible (without the project staff) during the rainy season.

3.0 Overall challenges and resolutions

Apart from the program-specific challenges, the project faced several issues that affect each project area in multiple ways. Table 2 shows each of the overall project challenges, and describes how the HSSP team addressed them.

Table 2: HSSP Challenges and Resolutions, January 2013-January 2015

	Challenges	Resolutions
1	Limited initial project funding leading to limited project start-up	Limited the scope of work, restricted recruitment, and postponed office space rental
2	Lean initial staffing plan at the onset of the project	Provided more-robust staffing by adding 2 Planning and Budgeting Specialists, 2 HIS Officers, 1 Team Leader (WES), 1 QA/SS Officer, 6 Hub Managers, 6 LM Officers, a Communication Specialist, and a Program Assistant
3	Managing very high expectations by the stakeholders, who were sometimes misinformed about the project's mandate	Increased explanation of project's mandate during stakeholder consultations; quarterly performance review workshops and other forums
4	Improper sequencing of some activities in Year 1	Discontinued some Y1 planned activities to avoid duplication of efforts: e.g., planning and budgeting templates, workforce assessment
5	Limited capacity of government counterparts	Adopted a more diverse capacity-building initiative, applied a combination of structured people development interventions (notably, training, coaching/mentoring, OJT) Introduced peer-to-peer learning, hub-to-hub exchange programs, inter-CHD learning forums
6	Severe staffing shortages at the CHDs. Although the MoH/RSS <i>Basic Package of Health and Nutrition Services for Southern Sudan</i> report of 2009 recommended CHD staffing levels, ⁶ there are severe staffing shortages, particularly in WES. As a result of staff shortages, many staff roles and responsibilities (e.g., HIS data analysis, convening meetings) have been carried out by HSSP or CIP/nongovernmental organization staff.	Prioritized activities at hubs that had relatively better capacity, starting with Yei, Juba, Mundri West, and Tombura Advocated to the SMoH to recruit more staff using the new government operational grants
7	Inaccessibility to some project sites (e.g., Nagero) during rainy season – increased project costs, unavailability of counterparts to project workshops	More attention devoted to such areas during the dry season
8	Difficulties in recruiting LCNs, especially qualified women candidates	Headhunt, posted advertisements in NGO noticeboards and public notice boards – SMoH, MoH/RSS, CHDs, reached out to MoH/RSS staff for contacts
9	December 2013 conflict – evacuation of some staff, procurement freeze, insecurity in some areas in WES, unavailability of government staff and partners	Developing a more responsive work plan (for “interim crises”) Restricted travel to insecure areas Improved on the security arrangements – contracted a security advisor, updated the evacuation plan
10	Dropping Human Resources for Health component in Y2	Incorporated some of the key components of HRH into HF/payroll

⁶ The report recommended eight staff for each CHD: CMO, disease surveillance officer, M&E officer, county nursing officer, nutritionist, pharmacy assistant, and two support staff.

4.0 HSSP progress to date on Performance Monitoring Plan (PMP) indicators

Reporting: HSSP staff collect, classify, analyze, interpret, and aggregate data, and prepare the activity reports that are submitted to the HSSP Juba office, using the template developed by the project. These reports are accompanied by hard copies of deliverables that are kept at the HSSP hub offices. Data pertaining to quantitative indicators is kept in an Excel database. HSSP submits quarterly and annual reports to USAID on its performance against expected results, including both its successes and areas identified for improvement. The PMP is a key document in preparing these reports, since it contains information on all performance indicators. Additional data on project progress is collected using the narrative sections of the quarterly reports and data collected during regular field visits. The annual report is prepared in a format and guidelines acceptable to USAID.

Sharing performance results: HSSP key principles of performance management include sharing of performance data across all stakeholders. HSSP tackled this by sharing information during routine meetings bringing together the attention of various staff in the different states to determine whether the program is “on track” or if new actions are needed to improve the chances of achieving results. These meetings were used to promote shared learning through dissemination of lessons learnt for improvement of the program.

Data quality management: HSSP supports accurate decision making by management and information use for reporting purposes informed by quality data. In order to measure and attribute results accurately for both reporting and management needs, HSSP ensures that performance management data meet the following data quality criteria:

Validity: Data should clearly and accurately measure what is intended. While proxy data can sometimes be used, especially in less quantifiable circumstances, these will as closely as possible approximate what is believed to be true about the phenomenon or change being measured.

Integrity: Data that are collected, analyzed, and reported should have established mechanisms in place to reduce the possibility that they have been intentionally manipulated for political or personal reasons.

Precision: Data should be sufficiently precise and present a fair picture of performance, in order to enable management decision-making at the appropriate levels.

Reliability: Data, and the methods of collection and analysis should be consistent, stable and dependable over time so that if measurements are repeated, will give the same results. HSSP ensures that progress toward performance targets reflects real changes rather than variation in data collection methods. When data collection and analysis methods change, the PMP will also be updated.

Timeliness: Data should be timely enough to reflect real changes and guide management decision-making at the appropriate level. Through regular reports, the program ensures that data is made available early enough.

As much as possible, HSSP integrated data quality assessment into ongoing activities, e.g., it performed random checks on site data during site visits. This minimized the costs associated with structured data quality assessment. While conducting data quality assessment, HSSP used data validation approaches such as taking counts from primary data collection tools and comparing them with reports, requesting briefings

from staff to get a better understanding of how they collect and analyze data, on-site observation, review of reports to ensure what is being reported is consistent and accurate, and comparing central office records with records kept at field sites/states.

Updating, reviewing and revising the PMP: This PMP serves as a document that HSSP uses to guide its performance management. One of the key principles of effective performance management is the use of performance information to assess progress in achieving results and to make management decisions on improving performance. Therefore, the PMP has been updated annually with new performance information as implementation goes on. The PMP was reviewed and revised at least annually (during the annual project review/planning meetings) and as necessary. This involved a critical assessment of performance indicators and data sources to make sure that indicators are still measuring what they were intended to measure and that the right information is being collected. When reviewing the PMP, HSSP considered the following;

- Are the performance indicators working as intended?
- Are the performance indicators providing the information needed?
- How can the PMP be improved?

If HSSP makes significant changes to the PMP such as adding, dropping or changing an indicator, data sources, or data collection methods, then the rationale for adjustment is documented. The program will make major changes to the PMP only if there is a compelling need. For example, an indicator can be dropped if it is found to be unsuitable, or if there is no funding for it.

5.0 Conclusion

Although HSSP started at a slower pace than expected, because of limited availability of funding for YI activities, in May 2013 the project accelerated its activities and set up effective financial management and operational systems. There was rigorous implementation of activities across the components, starting with LM, HF and coordination, followed by HIS and QA/SS, despite delays in recruiting qualified technical staff within each technical area. The momentum of activity implementation once again stalled following the December 2013 crises, exacerbating public health challenges. The whole health system was greatly affected during the conflict, and to make a greater impact, USAID asked the project to re-focus its efforts to address needs at the county and community level with clear links to the service delivery partners.

After the conflict ended, the project made significant achievements across the thematic areas. This was enhanced by establishing geographical hubs and scaling up the staffing plan. Although the project has faced many challenges, HSSP is on track to submit its deliverables and meet its contractual obligations. The most updated Performance Monitoring Plan shows that HSSP has achieved or exceeded all its performance indicators, except for two. One of these, the mHealth application, had its activity postponed to a later period on the advice of USAID. HSSP cannot implement the other, involving community health data, until the MoH/RSS provides national-level strategic direction. Annex A has more-detailed information on HSSP's success in meeting project targets.

Annex A: HSSP Indicator Performance Tracking Table

Below are the performance indicators that track progress towards achievement of HSSP South Sudan goals and objectives. The indicators shaded in grey are Length/Life of Project (LOP) Indicators and are tracked throughout the length of the project. Those shaded in pink are LOP plus implementation year 3 indicators; they are “active” in the present implementation year, as well as continuously tracked over the length of the project. Those without shading are the yearly indicators, developed at the start of the year, to monitor progress towards targets set at the beginning of the respective implementation year. These are mainly lower-level indicators at the process and output level. The numbering and column “indicator type” indicates the respective year in question.

HSSP Indicator Performance Tracking Table

S/N	Indicators	Indicator Type	Cumulative Achievement	End of Year 3 Project Target	Progress Towards Achieving Indicator	Comments
1	Number of SMOH and CHD staff who received leadership and management training (disaggregated by gender)	LOP+YR3	130	120	108%	On target
1a	Number of Female SMOH and CHD staff who received leadership and management training*	LOP+YR3	46	30	153%	On target
1b	Number of Male SMOH and CHD staff who received leadership and management training*	LOP+YR3	84	90	93%	On target
2	Number of VHC members trained in LM approaches to improve committee performance** (disaggregated by gender)	LOP+YR3	200	160	125%	On target
2a	Number of Female VHC members trained in LM approaches to improve committee performance**	LOP+YR3	51	52	98%	On target
2b	Number of Male VHC members trained in LM approaches to improve committee performance*	LOP+YR3	149	108	138%	On target
3	Number of women in leadership and management roles at SMOH, CHD and VHC levels	LOP	21	15	140%	Surpassed target
4	Percentage of trained CHD and VHC staff with a clear understanding of overall institutional roles and responsibilities (disaggregated by gender)	LOP	0	60	0%	Training ongoing; pre- and post- training data to be compiled annually at end of YR3
4a	Percentage of trained Female CHD and VHC staff with a clear understanding of overall institutional roles and responsibilities	LOP	0	22	0%	Training ongoing; pre- and post- training data to be compiled annually at end of YR3
4b	Percentage of trained Male CHD and VHC staff with a clear understanding of overall institutional roles and responsibilities	LOP	0	38	0%	Training ongoing; pre- and post- training data to be compiled annually at end of YR3
5	Percentage of trained CHD and VHC staff who demonstrate leadership and management skills on the job (disaggregated by gender)	LOP+YR3	0	60	0%	Data to be compiled at end of YR3 following mid-term evaluation/survey
5a	Percentage of trained Female CHD and VHC staff who demonstrate leadership and management skills on the job	LOP+YR3	0	22	0%	Data to be compiled at end of YR3 following mid-term evaluation/survey

S/N	Indicators	Indicator Type	Cumulative Achievement	End of Year 3 Project Target	Progress Towards Achieving Indicator	Comments
5b	Percentage of trained Male CHD and VHC staff who demonstrate leadership and management skills on the job	LOP+YR3	0	38	0%	Data to be compiled at end of YR3 following mid-term evaluation/survey
6	Percentage of trained CHDs and SMOH managers using at least 2 leadership and management tools in course of their work (disaggregated by gender)	LOP+YR3	0	80	0%	Data to be compiled at end of YR3 following mid-term evaluation/survey
6a	Percentage of trained Female CHDs and SMOH managers using at least 2 leadership and management tools in course of their work	LOP+YR3	0	25	0%	Data to be compiled at end of YR3 following mid-term evaluation/survey
6b	Percentage of trained Male CHDs and SMOH managers using at least 2 leadership and management tools in course of their work	LOP+YR3	0	55	0%	Data to be compiled at end of YR3 following mid-term evaluation/survey
7	Number of leadership and management mentors oriented at SMOH, CHD and VHC levels** (disaggregated by gender)	LOP+YR3	12	18	67%	In progress
7a	Number of Female leadership and management mentors oriented at SMOH, CHD and VHC levels**	LOP+YR3	3	6	50%	In progress
7b	Number of Male leadership and management mentors oriented at SMOH, CHD and VHC levels**	LOP+YR3	9	12	75%	In progress
8	Number of SMOH and CHD managers who received post-training coaching and mentorship support in leadership and management practices (disaggregated by gender)	LOP+YR3	0	80	0%	Mentoring and coaching support ongoing; data due to be compiled semi-annually and at end of YR3
8a	Number of Female SMOH and CHD managers who received post-training coaching and mentorship support in leadership and management practices	LOP+YR3	0	30	0%	Mentoring and coaching support ongoing; data due to be compiled semi-annually and at end of YR3
8b	Number of Male SMOH and CHD managers who received post-training coaching and mentorship support in leadership and management practices	LOP+YR3	0	50	0%	Mentoring and coaching support ongoing; data due to be compiled semi-annually and at end of YR3
9	Number of health facility administrators trained in health facility management*	LOP+YR3	62	160	39%	In progress
9a	Number of Female health facility administrators trained in health facility management*	LOP+YR3	20	52	38%	In progress

S/N	Indicators	Indicator Type	Cumulative Achievement	End of Year 3 Project Target	Progress Towards Achieving Indicator	Comments
9b	Number of male health facility administrators trained in health facility management*	LOP+YR3	42	108	39%	In progress
10	Existence of leadership and management capacity assessment report disseminated to stakeholders	LOP	1	1	100%	On target
11	Existence of Citizens Report Card for use by CHDs and VHCs to obtain client feedback on effective access to health services	LOP	0	1	0%	Data to be collected end of year 3
1.1	Number of leadership and management capacity assessment tools developed	YR1	2	2	100%	On target
1.2	Number of leadership and management capacity assessments conducted among staff at MOH/RSS, SMOH, CHD, health facilities, Payam, Boma and Village levels	YR1	1	1	100%	On target
1.3	Existence of training plan/curriculum for new LM courses	YR1	1	1	100%	On target
1.4	Number of leadership and management training and capacity building materials developed	YR1	5	5	100%	On target
1.5	Number of leadership and management support tools revised and/or developed	YR1	2	2	100%	On target
1.6	Number of trainers trained in leadership and management capacity building principles at State and County levels (disaggregated by cadre, gender)	YR1	16	16	100%	On target
1.6a	Number of Female trainers trained in leadership and management capacity building principles at State and County levels	YR1	5	5	100%	On target
1.6b	Number of Male trainers trained in leadership and management capacity building principles at State and County levels	YR1	11	11	100%	On target
2.1	Number of sets of customized course training materials developed for CHD staff	YR2	1	1	100%	On target
2.2	Number of sets of customized course training materials developed for facility managers and PHCC/PHCU staff	YR2	1	1	100%	On target
2.3	Number of sets of customized course training materials developed for Boma/VHCs	YR2	1	1	100%	On target

S/N	Indicators	Indicator Type	Cumulative Achievement	End of Year 3 Project Target	Progress Towards Achieving Indicator	Comments
3.1	Number of support tools developed and distributed for PHCC/U level	YR3	0	2	0%	Data to be collected end of year 3
3.2	Number of LM facilitators trained	YR3	99	160	62%	In progress
3.2a	Number of Female LM facilitators trained	YR3	25	30	83%	In progress
3.2b	Number of Male LM facilitators trained	YR3	74	90	82%	In progress
12	Number (and percentage) of CHD annual Budgets approved by SMOH	LOP+YR3	16	6	267%	Surpassed target
13	Number (and percentage) of CHDs with evidence of collaboration with county offices in planning and budgeting* (disaggregated by state)	LOP+YR3	50%	50%	100%	On target
14	Number of CHDs submitting monthly financial reports to the county commissioner's office using local government PFM reporting templates.	LOP+YR3	16	9	178%	Surpassed target
15	Number (and percentage) of CHDs submitting financial reports within the statutory period prescribed in the local government PFM Manual	LOP+YR3	16	6	267%	Surpassed target
15a	Number (and percentage) of CES CHDs submitting financial reports within the statutory period prescribed in the local government PFM Manual	LOP+YR3	6	4	150%	Surpassed target
15b	Number (and percentage) of WES CHDs submitting financial reports within the statutory period prescribed in the local government PFM Manual	LOP+YR3	10	2	500%	Surpassed target
16	Number of SMOH and CHD staff who have completed all appropriate modules of PFM training relevant to their roles (disaggregated by gender)	LOP+YR3	57	40	143%	Surpassed target due to adoption of a more holistic approach to budgeting, involving key players, namely County Executive Directors and Local Government staff instead of CHDs alone. To be scaled up through coaching and mentoring and on-the-job training for CHD.

S/N	Indicators	Indicator Type	Cumulative Achievement	End of Year 3 Project Target	Progress Towards Achieving Indicator	Comments
16a	Number of Female SMOH and CHD staff who have completed all appropriate modules of PFM training relevant to their roles	LOP+YR3	9	12	75%	On track to meet target due to adoption of a more holistic approach to budgeting, involving key players, namely County Executive Directors and Local Government staff instead of CHDs alone. To be scaled up through coaching and mentoring and on-the-job training for CHD.
16b	Number of Male SMOH and CHD staff who have completed all appropriate modules of PFM training relevant to their roles	LOP+YR3	48	28	171%	Surpassed target due to adoption of a more holistic approach to budgeting, involving key players, namely County Executive Directors and Local Government staff instead of CHDs alone. To be scaled up through coaching and mentoring and on-the-job training for CHD.
17	Number (and percentage) of CHDs conducting bottom-up planning and budgeting (disaggregated by state)	LOP+YR3	16	6	267%	Surpassed target
17a	Number (and percentage) of CES CHDs conducting bottom-up planning and budgeting	LOP+YR3	6	4	150%	Surpassed target
17b	Number (and percentage) of WES CHDs conducting bottom-up planning and budgeting	LOP+YR3	10	2	500%	Surpassed target
18	Number (and percentage) of CHDs with evidence of collaboration with SMOHs in planning and budgeting* (disaggregated by state)	LOP	7	8	88%	On track to meet target
18a	CES number (and percentage) of CHDs with evidence of collaboration with SMOH in planning and budgeting* (disaggregated by state)	LOP	4	4	100%	On target
18b	WES number (and percentage) of CHDs with evidence of collaboration with SMOH in planning and budgeting* (disaggregated by state)	LOP	3	4	75%	On track to meet target 3
1.7	Number of PFM assessment tools	YR1	5	5	100%	On target
1.8	Number of PFM assessments conducted at state and county levels	YR1	1	1	100%	On target

S/N	Indicators	Indicator Type	Cumulative Achievement	End of Year 3 Project Target	Progress Towards Achieving Indicator	Comments
1.9	Existence of documentation to PFM gaps and interventions at state and county levels	YR1	1	1	100%	On target
1.10	Existence of documentation of planning and budgeting gaps identified at state and county levels	YR1	1	1	100%	On target
2.4	Number of CHDs that have completed and submitted budgets to the central level	YR2	6	5	120%	Surpassed target due to adoption of the hub approach
2.4a	Number of CES CHDs that have completed and submitted budgets to the central level	YR2	3	2	150%	Surpassed target due to adoption of the hub approach
2.4b	Number of WES CHDs that have completed and submitted budgets to the central level	YR2	3	3	100%	On target
2.5	Number of CHD staff trained in the use of the South Sudan Electronic Payment System (SSEPS)	YR2	96	96	100%	On target
2.5a	Number of CES CHD staff trained in the use of the South Sudan Electronic Payment System (SSEPS)	YR2	36	12	300%	Surpassed target due to adoption of the hub approach
2.5b	Number of WES CHD staff trained in the use of the South Sudan Electronic Payment System (SSEPS)	YR2	60	20	300%	Surpassed target due to adoption of the hub approach
3.4	Proportion (number) of CHDs submitting Accountability reports to the CTMCs (disaggregated by state)	YR3	0	7(40%)	0%	Data to be collated end of year 3
3.4a	Proportion (number) of CES CHDs submitting Accountability reports to the CTMCs	YR3	0	3 (50%)	0%	Data to be collated end of year 3
3.4b	Proportion (number) of WES CHDs submitting Accountability reports to the CTMCs	YR3	0	4(40%)	0%	Data to be collated end of year 3
3.5	Number of SMOH/CHD Staff trained in preparing Accountability reports for the CTMCs/STMC	YR3	57	30	190%	Surpassed target due to adoption of the hub approach

S/N	Indicators	Indicator Type	Cumulative Achievement	End of Year 3 Project Target	Progress Towards Achieving Indicator	Comments
3.5a	Number of CES SMOH/CHD Staff trained in preparing Accountability reports for the CTMCs/STMC	YR3	19	11	173%	Surpassed target due to adoption of the hub approach
3.5b	Number of WES SMOH/CHD Staff trained in preparing Accountability reports for the CTMCs/STMC	YR3	38	19	200%	Surpassed target due to adoption of the hub approach
3.6	Number of SMOH and CHD finance staff trained to use Guidelines for County Planning and Budgeting for Fiscal Year 2015 – 2016, as well as the mandated budget preparation process and format	YR3	0	30	0%	Training ongoing; training data to be compiled annually at end of budget cycle
3.7	Number of participants who have benefited from the planning and budgeting Coaching/Mentoring sessions conducted at the SMOH and CHDs (disaggregated by state)	YR3	0	25	0%	Coaching and Mentoring sessions ongoing; training data to be compiled annually at end of budget cycle
3.7a	Number of CES participants who have benefited from the planning and budgeting Coaching/Mentoring sessions conducted at the SMOH and CHDs	YR3	0	9	0%	Coaching and Mentoring sessions ongoing; training data to be compiled annually at end of budget cycle
3.7b	Number of WES participants who have benefited from the planning and budgeting Coaching/Mentoring sessions conducted at the SMOH and CHDs	YR3	0	16	0%	Coaching and Mentoring sessions ongoing; training data to be compiled annually at end of budget cycle
3.8	Number (and percentage) of CHDs that have developed at least 1 costed workplan during the financial year	YR3	0	8	0%	Data compiled annually; collected at end of year 3
3.9	Number of SMOH and CHD staff trained to prepare and submit financial reports using PFM Manual (disaggregated by state)	YR3	9	8	113%	Surpassed target due to adoption of the hub approach

S/N	Indicators	Indicator Type	Cumulative Achievement	End of Year 3 Project Target	Progress Towards Achieving Indicator	Comments
3.9a	Number of CES SMOH and CHD staff trained to prepare and submit financial reports using PFM Manual	YR3	6	6	100%	On target
3.9b	Number of WES SMOH and CHD staff trained to prepare and submit financial reports using PFM Manual	YR3	3	2	150%	Surpassed target due to adoption of the hub approach
3.10	Number (and percentage) of State assemblies and county legislative councils which have benefited from financial management training (disaggregated by state)	YR3	0	8	0%	Training ongoing; training data to be compiled annually at end of year 3
3.10a	Number (and percentage) of CE State assemblies and county legislative councils which have benefited from financial management training	YR3	0	6	0%	Training ongoing; training data to be compiled annually at end of year 3
3.10b	WES number (and percentage) of State assemblies and county legislative councils which have benefited from financial management training	YR3	0	2	0%	Training ongoing; training data to be compiled annually at end of year 3
3.11	Number (percentage) of SMOH and county budgets printed and distributed. (Disaggregated by state)	YR3	6	8	75%	In progress
3.11a	CES number (percentage) of SMOH and county budgets printed and distributed.	YR3	6	6	100%	On target
3.11b	WES number (percentage) of SMOH and county budgets printed and distributed.	YR3	0	2	0%	In progress
19	Number of CHD and SMOH staff trained by the program to use health information for decision making (disaggregated by gender)	LOP+YR3	67	50	134%	Surpassed target due to adoption of the hub approach
19a	Number of Female CHD and SMOH staff trained by the program to use health information for decision making	LOP+YR3	17	10	170%	Surpassed target due to adoption of the hub approach

S/N	Indicators	Indicator Type	Cumulative Achievement	End of Year 3 Project Target	Progress Towards Achieving Indicator	Comments
19b	Number of Male CHD and SMOH staff trained by the program to use health information for decision making	LOP+YR3	50	40	125%	Surpassed target due to adoption of the hub approach
20	Number (and percentage) of CHDs submitting timely HMIS monthly reports to SMOH* (disaggregated by state)	LOP+YR3	16	16	100%	On target
20a	Number (and percentage) of CES CHDs submitting timely HMIS monthly reports to SMOH*	LOP+YR3	6	6	100%	On target
20b	Number (and percentage) of WES CHDs submitting timely HMIS monthly reports to SMOH*	LOP+YR3	10	10	100%	On target
21	Number (and percentage) of CHDs and SMOHs using DHIS/HMIS data for developing annual health plans* (disaggregated by state)	LOP+YR3	18	18	100%	On target
21a	Number (and percentage) of CHDs and SMOHs using DHIS/HMIS data for developing annual health plans* (disaggregated by state)	LOP+YR3	7	7	100%	On target
21b	Number (and percentage) of CHDs and SMOHs using DHIS/HMIS data for developing annual health plans* (disaggregated by state)	LOP+YR3	11	11	100%	On target
22	Number of instances in which DHIS/HMIS data was used by SMOH for decision making (disaggregated by state)	LOP	8	10	80%	In progress
22a	Number of CES instances in which DHIS/HMIS data was used by SMOH for decision making (disaggregated by state)	LOP	4	5	80%	In progress

S/N	Indicators	Indicator Type	Cumulative Achievement	End of Year 3 Project Target	Progress Towards Achieving Indicator	Comments
22b	Number of WES instances in which DHIS/HMIS data was used by SMOH for decision making (disaggregated by state)	LOP	4	5	80%	In progress
23	Number of instances in which DHIS/HMIS data was used by CHDs for decision making (disaggregated by state)	LOP+YR3	0	64	0%	Data to be collated end of year 3
23a	Number of instances in which DHIS/HMIS data was used by CES CHDs for decision making	LOP+YR3	0	24	0%	Data to be collated end of year 3
23b	Number of instances in which DHIS/HMIS data was used by WES CHDs for decision making	LOP+YR3	0	40	0%	Data to be collated end of year 3
24	Number of SMOH and CHD staff trained on data quality methodology (disaggregated by state and gender)	LOP+YR3	0	4	0%	Training ongoing; data due to be compiled semi-annually, and at end of YR3
24a	Number of Female SMOH and CHD staff trained on data quality methodology	LOP+YR3	0	2	0%	Training ongoing; data due to be compiled semi-annually, and at end of YR3
24b	Number of Male SMOH and CHD staff trained on data quality methodology	LOP+YR3	0	2	0%	Training ongoing; data due to be compiled semi-annually, and at end of YR3
25	Percentage of routine SS visits conducted during the year that incorporate data quality reviews (disaggregated by state)	LOP+YR3	0	75%	0%	Activity ongoing, data to be collated end of year 3
25a	Percentage of routine SS CES visits conducted during the year that incorporate data quality reviews	LOP+YR3	0	75%	0%	Activity ongoing, data to be collated semi-annually and at end of year 3
25b	Percentage of routine SS WES visits conducted during the year that incorporate data quality reviews	LOP+YR3	0	75%	0%	Activity ongoing, data to be collated semi-annually and at end of year 3

S/N	Indicators	Indicator Type	Cumulative Achievement	End of Year 3 Project Target	Progress Towards Achieving Indicator	Comments
26	Number of data quality review reports showing improvement in data quality (disaggregated by state)	LOP+YR3	0	10	0%	Activity ongoing, data to be collated semi-annually and at end of year 3
26a	Number of CES data quality review reports showing improvement in data quality	LOP+YR3	0	4	0%	Activity ongoing, data to be collated semi-annually and at end of year 3
26b	Number of WES data quality review reports showing improvement in data quality	LOP+YR3	0	6	0%	Activity ongoing, data to be collated semi-annually and at end of year 3
27	Number of quarterly M&E meetings held at the state level with county health departments to review data and priority health issues (disaggregated by state)	LOP+YR3	0	2	0%	Activity ongoing, data to be collated semi-annually and at end of year 3
27a	Number of quarterly M&E meetings held at the CES level with county health departments to review data and priority health issues	LOP+YR3	0	2	0%	Activity ongoing, data to be collated semi-annually and at end of year 3
27b	Number of quarterly M&E meetings held at the WES level with county health departments to review data and priority health issues	LOP+YR3	0	2	0%	Activity ongoing, data to be collated semi-annually and at end of year 3
28	Number of quarterly M&E meetings held at the county level to review data and priority health issues	LOP+YR3	0	10	0%	Activity ongoing, data to be collated semi-annually and at end of year 3
28a	Number of CES quarterly M&E meetings held at the county level to review data and priority health issues	LOP+YR3	0	4	0%	Activity ongoing, data to be collated semi-annually and at end of year 3
28b	Number of WES quarterly M&E meetings held at the county level to review data and priority health issues	LOP+YR3	0	6	0%	Activity ongoing, data to be collated semi-annually and at end of year 3
1.11	Number of detailed HIS gap analyses focused on human, financial and material resource requirements	YR1	2	2	100%	On target

S/N	Indicators	Indicator Type	Cumulative Achievement	End of Year 3 Project Target	Progress Towards Achieving Indicator	Comments
1.12	Existence of report on health worker staffing patterns and gaps at the state and county facilities	YR1	1	1	100%	On target
1.13	Existence of HRIS planning capacity report by state and county	YR1	1	1	100%	On target
1.14	Number of HR management capacity assessments conducted at SMOH and CHD levels	YR1	1	1	100%	On target
1.15	Existence of HR management capacity assessment report by state and county	YR1	1	1	100%	On target
2.6	Existence of an updated HRIS database	YR2	1	1	100%	On target
3.12	Number of CHDs with an HMIS Monthly Bulletin	YR3	0	4	0%	In progress
3.13	Number of months HMIS bulletin received by at least one PHCC/PHCUs in county	YR3	0	4	0%	In progress
3.14	Number of CHD-level action plans for HIS improvement resulting from quarterly review meetings	YR3	0	4	0%	In progress
3.15	Number of SMOH and CHD Staff trained as part of HSSP efforts in HIS Strengthening	YR3	0	6	0%	In progress
29	Number of CHD staff trained in Quality Assurance using appropriate SS tools approved by the MOH * (disaggregated by state, gender)	LOP+YR3	0	32	0%	In progress
29a	Number of CES CHD staff trained in Quality Assurance using appropriate SS tools approved by the MOH *	LOP+YR3	0	16	0%	In progress
29b	Number of WES CHD staff trained in Quality Assurance using appropriate SS tools approved by the MOH *	LOP+YR3	0	16	0%	In progress

S/N	Indicators	Indicator Type	Cumulative Achievement	End of Year 3 Project Target	Progress Towards Achieving Indicator	Comments
30	Percentage of facilities with complete QSCs submitted to SMOHs on a quarterly basis following facility SS visits (disaggregated by county and state)	LOP	0	8(50%)	0%	In progress
30a	Percentage of CES facilities with complete QSCs submitted to SMOHs on a quarterly basis following facility SS visits	LOP	0	4(50%)	0%	In progress
30b	Percentage of WES facilities with complete QSCs submitted to SMOHs on a quarterly basis following facility SS visits	LOP	0	4(50%)	0%	In progress
31	Number of trained CHD teams conducting mHealth-driven QA visits (disaggregated by State)	LOP	0	4	0%	Activity slated to be implemented in YR 4
31a	Number of trained CES CHD teams conducting mHealth-driven QA visits	LOP	0	2	0%	Activity slated to be implemented in YR 4
31b	Number of trained WES CHD teams conducting mHealth-driven QA visits	LOP	0	2	0%	Activity slated to be implemented in YR 4
1.16	Existence of Report on current supportive supervision mechanisms in CES and WES	YR1	1	1	100%	On target
1.17	Existence of finalized integrated checklist for supportive supervision which is approved by MOH	YR1	1	1	100%	On target
2.7	Number of CHDs supported to undertake QA through routine independent support visits	YR2	8	9	89%	On target
2.7a	Number of CES CHDs supported to undertake QA through routine independent support visits	YR2	4	2	200%	Surpassed target
2.7b	Number of WES CHDs supported to undertake QA through routine independent support visits	YR2	4	7	57%	On target

S/N	Indicators	Indicator Type	Cumulative Achievement	End of Year 3 Project Target	Progress Towards Achieving Indicator	Comments
3.16	Number of counties with a minimum of one CHD staff trained in QA using appropriate SS tools (disaggregated by state, gender, thematic area)	YR3	0	16	0%	In progress
3.16a	Number of CES counties with a minimum of one CHD staff trained in QA using appropriate SS tools	YR3	0	6	0%	In progress
3.16b	Number of WES counties with a minimum of one CHD staff trained in QA using appropriate SS tools	YR3	0	10	0%	In progress
3.17	Percentage of CHD staff conducting independent supportive supervision visits with timely submission of QSC reports	YR3	0	25%	0%	In progress
3.18	Percentage of counties receiving HSSP funds on a quarterly basis to independently carry out SS visits (disaggregated by state)	YR3	50	50	100%	On target
3.18a	Percentage of CES counties receiving HSSP funds on a quarterly basis to independently carry out SS visits	YR3	25	19	132%	Surpassed target
3.18b	Percentage of WES counties receiving HSSP funds on a quarterly basis to independently carry out SS visits	YR3	25	31	81%	On track to meet target
3.19	Percentage of facilities with complete QSCs submitted to SMOHs on a quarterly basis following facility SS visits (disaggregated by county and state)	YR3	0	50%	0%	In progress
3.19a	Percentage of CES facilities with complete QSCs submitted to SMOHs on a quarterly basis following facility SS visits	YR3	0	50%	0%	In progress

S/N	Indicators	Indicator Type	Cumulative Achievement	End of Year 3 Project Target	Progress Towards Achieving Indicator	Comments
3.19b	Percentage of WES facilities with complete QSCs submitted to SMOHs on a quarterly basis following facility SS visits	YR3	0	50%	0%	In progress
3.20	Percentage of facilities with complete QSCs entered into DHIS following SS visits (disaggregated by county and state)	YR3	0	5%	0%	In progress
3.20a	Percentage of CES facilities with complete QSCs entered into DHIS following SS visits.	YR3	0	5%	0%	In progress
3.20b	Percentage of WES facilities with complete QSCs entered into DHIS following SS visits.	YR3	0	5%	0%	In progress
3.21	Proposal for pilot initiative for mHealth-supported SS visits approved by SMOH and USAID	YR3	0	1	0%	Activity slated to be implemented in YR 4
3.22	Number of trained CHD teams conducting mHealth-driven QA visits (disaggregated by State)	YR3	0	2	0%	Activity slated to be implemented in YR 4
3.22a	Number of trained CES CHD teams conducting mHealth-driven QA visits (disaggregated by State)	YR3	0	1	0%	Activity slated to be implemented in YR 4
3.22b	Number of trained WES CHD teams conducting mHealth-driven QA visits (disaggregated by State)	YR3	0	1	0%	Activity slated to be implemented in YR 4
3.23	Percentage of facilities where QA visits were conducted on a quarterly basis by CHDs using mHealth technology (disaggregated by county, state, and quarter)	YR3	0	75%	0%	Activity slated to be implemented in YR 4

S/N	Indicators	Indicator Type	Cumulative Achievement	End of Year 3 Project Target	Progress Towards Achieving Indicator	Comments
3.23a	Percentage of CES facilities where QA visits were conducted on a quarterly basis by CHDs using mHealth technology (disaggregated by county, state, and quarter)	YR3	0	40	0%	Activity slated to be implemented in YR 4
3.23b	Percentage of WES facilities where QA visits were conducted on a quarterly basis by CHDs using mHealth technology (disaggregated by county, state, and quarter)	YR3	0	35	0%	Activity slated to be implemented in YR 4
3.24	Scale-up Feasibility report finalized	YR3	0	1	0%	Activity slated to be implemented in YR 4
3.25	Finalized Addendum LM QSC list	YR3	1	1	100%	On target
3.26	Number of CHD supervisory staff trained on additional LM Elements in QSC	YR3	0	16	0%	In progress
3.27	Percentage of Addendum LM QSC tools entered into database (Denominator = No. of main QSC tools entered into DHIS database)	YR3	0	50%	0%	In progress
32	Number of CHDs supported in revising existing coordination mechanisms and tools (disaggregated by state)	LOP	16	16	100%	On target
32a	Number of CES CHDs supported in revising existing coordination mechanisms and tools	LOP	6	6	100%	On target
32b	Number of WES CHDs supported in revising existing coordination mechanisms and tools	LOP	10	10	100%	On target
33	Number of existing coordination mechanisms and tools revised by CHDs with program support*	LOP	7	6	117%	On target

S/N	Indicators	Indicator Type	Cumulative Achievement	End of Year 3 Project Target	Progress Towards Achieving Indicator	Comments
34	Number of instances in which the strategic coordination framework is used by county coordinating units to establish a system or process to strengthen collaboration (e.g., joint planning, budgeting, trainings, SS, etc.) (disaggregated by state)	LOP+YR3	9	6	150%	Surpassed target
34a	Number of CES instances in which the strategic coordination framework is used by county coordinating units to establish a system or process to strengthen collaboration (e.g. joint planning, budgeting, trainings, SS, etc.)	LOP+YR3	4	3	133%	Surpassed target
34b	Number of WES instances in which the strategic coordination framework is used by county coordinating units to establish a system or process to strengthen collaboration (e.g. joint planning, budgeting, trainings, SS, etc.)	LOP+YR3	5	3	167%	Surpassed target
35	Number of coordination units managed by CHDs* (disaggregated by state)	LOP+YR3	12	12	100%	On target
35a	Number of coordination units managed by CES CHDs*	LOP+YR3	4	4	100%	On target
35b	Number of coordination units managed by WES CHDs*	LOP+YR3	8	8	100%	On target
36	Number of CHDs meeting routinely and recording outcomes of those meetings* (disaggregated by state)	LOP+YR3	12	12	100%	On target
36a	Number of CES CHDs meeting routinely and recording outcomes of those meetings*	LOP+YR3	4	4	100%	On target
36b	Number of WES CHDs meeting routinely and recording outcomes of those meetings*	LOP+YR3	8	8	100%	On target

S/N	Indicators	Indicator Type	Cumulative Achievement	End of Year 3 Project Target	Progress Towards Achieving Indicator	Comments
37	Number of on-site support visits by MOH (RSS) Directorate of Planning and Coordination to SMOHs (disaggregated by state)	LOP+YR3	0	4	0%	In progress —Planning of visits ongoing
37a	Number of on-site support visits by MOH (RSS) Directorate of Planning and Coordination to CE SMOHs	LOP+YR3	0	2	0%	In progress —Planning of visits ongoing
37b	Number of on-site support visits by MOH (RSS) Directorate of Planning and Coordination to WE SMOHs	LOP+YR3	0	2	0%	In progress —Planning of visits ongoing
38	Number of instances in which actions are taken by MOH (RSS) to address or remove identified barriers to collaboration (disaggregated by State)	LOP+YR3	0	8	0%	In progress
38a	Number of CES instances in which actions are taken by MOH (RSS) to address or remove identified barriers to collaboration (disaggregated by state)	LOP+YR3	0	4	0%	In progress
38b	Number of WES instances in which actions are taken by MOH (RSS) to address or remove identified barriers to collaboration	LOP+YR3	0	4	0%	In progress
39	Number of effective formal coordination committees functioning at the state county on/about project completion* (disaggregated by state)	LOP	16	12	133%	Surpassed target following the adoption of the hub approach
39a	Number of CES effective formal coordination committees functioning at the state county on/about project completion*	LOP	6	6	100%	Surpassed target following the adoption of the hub approach
39b	Number of WES effective formal coordination committees functioning at the state county on/about project completion*	LOP	10	6	167%	Surpassed target following the adoption of the hub approach
1.18	Existence of stakeholder mapping report	YR1	1	1	100%	On target

S/N	Indicators	Indicator Type	Cumulative Achievement	End of Year 3 Project Target	Progress Towards Achieving Indicator	Comments
2.9	Number of CHD monthly coordination meetings established/conducted with HSSP support	YR2	12	8	150%	Surpassed target; high-level support and interest from the Director Generals (DG) (SMOH/CHDs) especially after the country crisis in YR 2
2.9a	Number of CES CHD monthly coordination meetings established/conducted with HSSP support	YR2	6	4	150%	Surpassed target; high-level support and interest from the DGs (SMOH/CHDs) especially after the country crisis in YR 2
2.9b	Number of WES CHD monthly coordination meetings established/conducted with HSSP support	YR2	6	4	150%	Surpassed target; high-level support and interest from the DGs (SMOH/CHDs) especially after the country crisis in YR 2
2.30	Number of people trained in the conduct and management of county coordination meetings, disaggregated by gender	YR2	81	50	162%	Surpassed target; high-level support and interest from the DGs (SMOH/CHDs) especially after the country crisis in YR 2
2.31	Number of CHDs who received county level health stakeholder mapping results in a usable format	YR2	16	16	100%	On target
2.32	Number of stakeholder workshops held to review and validate the draft coordination framework	YR2	1	1	100%	On target
3.28	Number of CHD coordination committees trained on how to use data for decision making	YR3	0	16	0%	Training ongoing; data due to be compiled semi-annually, and at end of YR3
3.29	Number of CHDs trained on the skills of writing good coordination minutes and reports	YR3	2	16	13%	Training ongoing; data due to be compiled semi-annually, and at end of YR3
3.30	Number of inter-CHD learning forums convened to share learning experiences across CHDs	YR3	0	4	0%	In progress
3.31	Number of Quarterly mentoring and coaching reports produced	YR3	0	24	0%	Activity ongoing. Reports to be collated at end of Year 3.

S/N	Indicators	Indicator Type	Cumulative Achievement	End of Year 3 Project Target	Progress Towards Achieving Indicator	Comments
3.32	Number of minutes of the joint MOH/RSS and SMOH consultative meetings	YR3	0	8	0%	Activity ongoing. Reports to be collated at end of Year 3.
3.33	Percentage of HSSP-procured equipment in working order	YR3	80%	80%	100%	On target
3.34	Number of staff provided with computer training	YR3	0	48	0%	In progress