NORWEGIAN CHURCH AID

Review of NCA's Health Programme in Eastern Equatoria and Warrap States, Republic of South Sudan

1st May – 17th May 2012

Final Review Report

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Submitted by: Christine Bousquet, Independent Consultant
MSc Community/Public Health & Health Economics

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List of Acronyms

ACT	Artemisinin Combination Therapy
AIC	Africa Inland Church
AIDS	Acquired Immune Deficiency Syndrome
ANC	Ante Natal Care
ART	Antiretroviral Therapy
ARV	Anti retroviral
BBC	Behaviour Change Communication
BPHS	Basic Package of Health Services
BSF	Basic Services Fund
CBO	Community-Based Organisation
CDOT	Catholic Diocese of Torit
CHD	County Health Department
CHF	Common Humanitarian Fund
CHW	Community Health Worker
CPA	Comprehensive Peace Agreement
ECSS	Episcopal Church of South Sudan
EPI	Expanded Programme of Immunization
FBO	Faith-based Organisation
GoSS	Government of Southern Sudan
HBC	Home Based Care
HIV	Human Immunodeficiency Virus
HPF	Health Pool Fund
HQ	Headquarters (NCA)
IEC	Information, Education and Communication
IMR	Infant Mortality Rate
LOWYDA	Lopit Women and Youth Development Organisation
MDTF	Multi-Donor Trust Fund
M&E	Monitoring and Evaluation
MFA	Ministry of Foreign Affairs (Norway)
MoH	Ministry of Health
MoU	Memorandum of Understanding
NGO	Non Governmental Organisation
NOK	Norwegian Kroner
ORS	Oral Rehydration Solution
OVI	Objectively Verifiable Indicators
PBC	Performance Based Contracting
PHC	Primary Health Care
PLWHA	People Living with HIV/AIDS
SDG	Sudanese Pound
SHTP	Sudan Health Transformation Project (USAID)
SMART	Specific, Measurable, Achievable, Realistic and Timely
SMoH	State Ministry of Health
SPLM	Sudan People's Liberation Movement
SSHHS	South Sudan Household Health Survey
TB	Tuberculosis
ToR	Terms of Reference
UN	United Nations
UNICEF	United Nations Children's Fund
U$	American Dollar
VCT	Voluntary Counselling and Testing
VHC	Village Health Committee
WASH	Water, Sanitation and Hygiene

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The consultant met with key actors working on the Programme including Ministry of Health representatives and church-faith based partners. She sincerely appreciates to their efforts to brief hear on their daily activities, operational constraints, and hopes for the future.

The consultant visited a number of rural areas where meetings were held with local authority officials, health staff and community members. She wishes to thank them for willingly giving of their time and experience with the Programme.

Full responsibility for the text of this report rests with the author.

EXECUTIVE SUMMARY

Background to the review
The NCA's health programme is part of a larger multi-sector programme implemented in collaboration with several church-faith partners and local organisations. The programme under review was specifically developed to improve access to and quality of care for poor and marginalised communities and quality of life for people living with or affected to HIV and AIDS. The 3-year programme works in Eastern Equatoria and Warrap states and 3 counties.

The key results established for the programme were to support 31 health facilities through drug supply and training; increase HIV/AIDS awareness-raising with a specific focus on primary schools and; support church and faith-based actors in increasing their capacity to deliver basic health services.

The programme has been allocated a total of SDG 4 825 640. The Norwegian Ministry of Foreign Affairs and the Common Humanitarian Fund have been the main sources of funding.

Evaluation Purpose and Methodology
By May 2012 the programme was more than half-way through its implementation period. NCA decided that a review was advisable in order to assess achievements and recommend future programme direction.

This review was conducted as a joint learning exercise. The consultant reviewed relevant documents pertaining to the design and implementation of the programme. Interviews and qualitative assessments were undertaken through field visits to 9 of the 31 health facilities in which support is being provided.

Summary of findings
The programme objectives were generally relevant to beneficiary needs and priorities, as was the strong emphasis on partnership at all levels. NCA's presence in the three counties has been critical in providing basic health services to communities and supporting a new Ministry of Health in a country emerging from a 21 year civil war. There was a good fit with NCA's Global Strategy.

To a large extent, the programme design has been driven by previous NCA experience. The assessment of the context was not particularly detailed, resulting in many assumptions about capacity, and partnerships that were not entirely correct. One consequence of these was that the programme design largely overlooked priority-setting for activities, especially considering the geographic size and the complexity of the health delivery in South Sudan. This made it extremely difficult for the programme to be highly effective from its start, and to implement it efficiently. It has placed particularly complex demands for the staff who have traditionally been working within the boundaries of humanitarian practice. While overall effectiveness and efficiency have all been less than originally expected, it is considered that NCA staff have worked very hard to achieve annual work plans.

Even though the counties have varying implementation environments, overall the achievements within the Basic Package of Health Services framework have met with limited success. The main focus has been to support health facilities with drug supply, which is not sufficient to impact positively on the well-being of communities, especially considering the burden of communicable diseases in South Sudan.

The most important preventive and cost-effective interventions appeared to be getting relatively underemphasized:

- Routine immunization is not fully operational due cold chain problems and vaccine stock-outs and the supply of Vitamin A capsules is irregular;
- Owing to severe shortage of well-trained community midwives, maternal health services are not adequately developed. Traditionally, most women continue to rely on traditional birth attendants for delivery care and as elsewhere in South Sudan safe delivery remains the major

problem in addressing maternal health needs. Maternal benefits from spacing births have not been systematically promoted;
- Preventive health education of malaria, diarrheal diseases and acute respiratory infections is not always available;
- Access to safe water, latrines and incinerators for medical waste were still problems at many health facilities visited.

The programme is working to strengthen HIV/AIDS at primary schools and to support community-based activities that improve knowledge and behavioural change. There have been efforts to focus in counties with high prevalence rates (e.g. Magwi). However, at facility level, there are no counselling services in place and no programme strategy to address the needs of most at-risk groups.

Despite good collaboration with Ministry of Health counterparts, the programme has achieved limited success in sustained changes. Health system in Southern Sudan has suffered from a period of neglect and decay and continues to be constrained by inadequate infrastructure, insufficient staffing, and the lack of MoH ability to pay salaries. Therefore primary health care system strengthening requires enormous investments that are largely beyond the capacity of a single organisation.

Creating more sustainable health care in Southern Sudan is a long term objective, in which NCA needs to pay a continued and enlarged role, develop more mature relations and expectations of what partners can contribute, broaden its funding base, and consider the Health Pooled Fund as an opportunity for health sector funding in the future.

The complete list of recommendations is provided in the section 5 of this report. **The recommendations for the remainder of the programme are summarized below:**

- Address the deficiencies in drug management system. Immediate attention should be paid to reviewing essential drug management procedures and to providing short-term support to NCA staff in Eastern Equatoria;

- It will be important for church-based partners to become more involved in the long-term delivery of health services. In order to achieve this objective, roles, responsibilities and exit strategy should be clearly delineated and translated into an Action Plan or Memorandum of Understanding;

- In the next design phase, consideration should be given to county-level variation, varying implementation environments, and priority-setting, especially with regard to geographic coverage and scope of work;

- Prevention of HIV/AIDS should be concentrated in counties considered to have higher HIV prevalence. Efforts should be made to reconfigure the HIV component of the programme away from primary schools and more toward a community-based prevention approach that include clinical services and explore the relevance and feasibility of establishing Voluntary Counselling and Testing services at Lohutok and Alek;

- Village Health Committees need more guidance on how to effectively promote healthy practices and raise the demand for services. This will require sustained and long-term efforts, especially in Lopa/Lafon county where the level of education is reported to be low.

- Consideration should be given to conducting a rapid field assessment of infrastructure needs, safe water and sanitation facilities, medical waste disposal and staffing level at health facilities supported in the programme's three focus counties. This assessment would provide a clearer

picture of current infrastructure gaps and suggest short-term and long-term strategies for renovation work and training needs;

- The WASH component at health facilities will require greater attention. Sanitation facilities and the management of medical waste remain substantial problems and there have been varying level of synergies between the health and WASH programmes.

Key Lessons Learned:

- Restoring and improving health services are an essential part of helping individuals and communities successfully recover and restore or create 'normal' life.

- Focus on curative is not sufficient to impact positively on health outcomes. If impact is to be made, it should be accompanied by the provision of preventive activities. Moving away from short-term, relief-focused intervention to systemic and long-term health system work, however, requires a sufficient level of funding. Access to Health Pool Fund modalities needs to be further explored.

- Knowledge and experience of primary health care strengthening in post-conflict settings are specialist subjects in their own right. It is therefore necessary to commit sufficient and appropriate human resources right from the start. These human resources may be local, regional or international.

- NCA needs to be better prepared if it is to respond efficiently and effectively to primary health system strengthening. Suitable procedures and systems for drug management, supervision and follow-up, monitoring and evaluation, and reporting are essential for efficient and effective health programming and implementation.

- Ensuring adequate staffing and the timely provision of salary payments continue to be enormous obstacles to the success of any health programme. NCA and its partners must continue to play an advocacy role with Ministry of Health in working to improve these systemic problems.

1.0 BACKGROUND INFORMATION

1.1 Country context

Sudan's 2005 comprehensive peace agreement (CPA) which was signed by the government of Sudan and Sudan People's Liberation Movement (SPLM) put an end to the civil war and opened opportunities for peace and development. South Sudan became an independent state on 9 July 2011.
Under the terms of the agreement, ten state governments have been established (Figure 1).

Figure 1: Map of South Sudan

The 21-year second Sudanese civil war killed an estimated 1.5 to 2 million people and displaced another 4 million. Furthermore it left the region without a functioning economy, physical infrastructure or social services.

South Sudan has as many as 597 ethnic groups and 400 languages and dialects. According to the 2008 population census, the population is approximately 8.26 million. It is a very young one and largely rural with 83% residing in rural areas.

The people of South Sudan are among the world's poorest, with 51% of the population below the poverty line[1]. Oil revenues constitute more than 98% of the Government of South Sudan's (GoSS) budget. In January 2012, as a result from an impasse in negotiations between Juba ad Khartoum over the financial terms and conditions by which the South would export its oil through Sudan, the GoSS took the decision to shut down oil production. Subsequent government-imposed austerity measures have raised fears about how an already serious under-development situation in South Sudan may worsen.

1.2 South Sudan Health Sector Context

1.2.1 Current Health Status and Burden of Disease

Health services in Southern Sudan remained extremely weak during and after the war, causing the health status of the population to become one of the poorest globally:

- Maternal mortality ratio is the highest in the world, at 2,054/100,000
- Infant mortality rate stands at 102/1,000 and the under five child mortality rate at 135/1,000
- Fertility rate is high at 7.1[2]

Diseases and other aspects of maternal and child health are particular problems. Infectious diseases are the leading cause of morbidity and mortality. Diarrheal and respiratory infections as well as vaccine-preventable diseases account for high levels of child morbidity and mortality. Malaria continues to be a major threat to the survival of children.

Other diseases are tuberculosis (TB), schistosomiasis, river blindness (onchocerciasis) and sleeping sickness. High fertility, malaria, and poor coverage of skilled delivery care are all affecting maternal health[3]. Less than 17.5% of children 12-23 months are fully immunized.

[1] Source: Fast facts 2010; The Republic of South Sudan, National Bureau of Statistics.
[2] Source: South Sudan Household Health Survey (SSHHS), 2010.
[3] According to the 2010 SSHHS results, coverage of skilled delivery care is estimated at 14.7%.

HIV/AIDs is recognized as potential threat to the country's development because it neighbours countries such as Kenya, Uganda, and Ethiopia, where infection rates are high. Socioeconomic and cultural factors, increased population movements, low levels of awareness and knowledge and limited practice of safe sex all make South Sudan susceptible to HIV and AIDS.

In 2009 the overall HIV prevalence among adults aged 15-49 was estimated to be about 3.0%. The epidemic is extremely heterogeneous, with geographical variations as high as 7.2% in Western Equatoria state to 0.7% in Warrap state. Data from the 2010 SSHHS show that:

- 53.8% of women and 73.0% of men had ever heard of AIDS;
- 41.1% of women and 58.1% of men know they can avoid the AIDS virus by using a condom correctly every time;
- 42.2% of women and 41.5% of men know that AIDS can be transmitted from mother to child during pregnancy.

1.2.2 Current Health System Structure

South Sudan is currently undergoing a major transition from relief to development. This transition involves building strong government capacity to manage and deliver services, including a health system, practically from scratch. This is a major challenge since the country has little health infrastructure, equipment, or trained medical providers, and limited funding for the health sector. In 2011, it was estimated that only 40% of the population of Southern Sudan has access to primary health care (PHC) services[4].

As stipulated in the 2011 – 2015 Health Sector Development Plan, the key objective is to reduce mortality and morbidity through a strategic approach under the overall stewardship of the Ministry of Health (MoH). This is to be achieved by:

- Increasing utilization of health services
- Increasing awareness and improving community health behaviours
- Improving effectiveness, efficiency and equity within the health system.

The 5-year Health Sector Development Plan calls for a focus on providing for a package of basic health services, with a specific emphasis on maternal and child health. The Basic Package for Health Services (BPHS) model is considered to be the most effective integrated approach for delivering PHC. The BPHS also sets norms and standards to guide planning, implementation, monitoring and evaluation at all levels -Primary Health Care Unit (PHCU), Primary Health Care Centre (PHCC), and County Health Department (CHD)-. Planned staffing allocations for health facilities are displayed in Table 1.

Table 1: Planned staffing at PHCCs and PHCUs as of 2009[5]

PHCC	PHCU
• Clinical Officer/Medical Assistant: 1 • Community Health Workers (CHW): 3 • Certified Nurse Midwives: 3 • HIV/AIDS Counsellor: 1 • Nurse: 1 • Laboratory Assistant: 1 • Pharmacy Technician: 1 • Monitoring & Evaluation/Bookkeeper: 1 • Public Health Technician: 1 • Support Staff: 4	• CHW: 2 • Community Midwife: 1 • Support staff: 3

Several issues make however the BPHS implementation particularly challenging:

[4] Source: Joint Donor Team – Fact sheet Health. December 2011.
[5] Source: MoH, GoSS, Basic Package of Health and Nutrition Services for Southern Sudan, January 2009.

- Lack of capacity of the MoH (in numbers and in management skills) to fulfill its stewardship role;
- Chronic and alarming shortage of health care staff in health facilities country wide. In parallel political pressure to expand the health payrolls is affecting the rationalisation of and functioning of basic services;
- Shortage of drugs and lack of solid supply chain management for procurement of drugs and supplies;
- Fragmented health service delivery;
- Challenging operating environment, impacting capacity to respond to needs: South Sudan is a vast territory, with many communities living in remote and hard-to-access areas. The poor state of transport infrastructure and seasonal flooding render many areas impassable, increasing the cost of operations and the time required to deliver supplies.

1.2.3 Health Sector Financing

The sector is funded by both GoSS and development partners. Health care is free at point of delivery and there are no formal cost-sharing mechanisms in place. The percentage of GoSS funding to the MoH has gradually reduced from 7.9% in 2006 to 4.2% in 2010. Funding from the development partners has been estimated at about US$ 214.8 million (2009) and US$ 160 million (2010) [6]. Alignment and harmonization of their contribution to health sector financing is however a challenge.

According to the Joint Donor health fact sheet, in December 2011 about 70% of health services were provided by NGOs through the DfID's Basic Services Fund (BSF); USAID's Sudan Health Transformation Project (SHTP – II); the World Bank's Multi-Donor Trust Fund (MDTF); OFDA and the European Commission Humanitarian office (ECHO). The BSF has been the largest donor of basic health services, supporting about 35% of NGO-supported clinics[7].

Surprisingly there is a lack of information on the contribution of church and faith-based organisations to health service delivery. During times of war, South Sudan's churches have frequently been the only institution able to remain on the ground. Historically they represent a critical form of local and national civil society in South Sudan. They are key development actors, providing a substantial support to social sectors, and helping communities to meet their basic needs.

The three major health service funding mechanisms (BSF, SHTP and MDTF) are expected to come to an end in mid-2012. As shown below, the geographical distribution of technical and financial support has been the main step taken to harmonize and coordinate the assistance efforts beyond 2012:

- World Bank: Upper Nile and Jonglei States
- USAID: Central Equatoria and Western Equatoria States
- Health Pooled Fund (led by DfID and supported by CIDA, AUSAID, SIDA and EU): Eastern Equatoria, Northern Bahr el Ghazal, Western Bahr el Ghazal, Lakes States, Unity State, and Warrap State[8].

A major component of the above post-reconstruction assistance is to support the MoH using mechanisms such as performance based contracting (PBC) of NGOs. This strategy views the contracting of NGOs as a means to facilitate the transition from relief to development by improving the management of, and collaboration with, the CHD teams responsible for managing health services in their respective counties. The whole success of the pooled fund mechanisms is however closely linked to effective and successful public financial management reform and continuous peace and stability. At the moment the possibility of renewed conflict over access to resources or power is

[6] Source: Health Sector Development Plan 2011 – 2015, GoSS/MoH
[7] Source: Joint Donor Team. Fact Sheet Health, December 2011.
[8] The health pooled fund is currently planned for five years, with a long-term vision of up to fifteen years. The initial budget across all donors is estimated at £150 million. Source: Health Care funding in South Sudan, Oxford Policy Management, January 2012.

significant, making long-term commitments and investments from the international community difficult to predict.

1.3 Programme Overview

1.3.1 NCA's Health Programme in South Sudan

NCA's main geographical focus in South Sudan is in Eastern Equatoria and Warrap states. The organisation has been in Eastern Equatoria continuously since 1972, working at grassroots level to address the community needs of the population in an effort to substitute for the missing services. During the very difficult times, NCA and its partners have provided a minimum basic service to the rural populations. They now focus in Lopa-Lafon and Magwi counties, with an estimated population of 106,161 and 169,825 respectively. The county of Lopa-Lafon is vast, isolated and sparsely populated. The county of Magwi borders the Republic of Uganda and has faced a large influx of returnees.

NCA started operations in Warrap State since 1998, mainly focusing in the county of Gogrial West. The state, with a population estimated to be 920,045 (2008 data), is bordered by the disputed region of Abyei to the north. The county itself has a population of nearly 119,000[9]. Warrap state has historically been an underdeveloped state in South Sudan and has suffered from complicated, inter-communal conflict, as well as sensitive cross-border tensions. The state has also received returnees, contributing to growing demands for basic services, job opportunities and land allocation.

In January 2010, NCA submitted a proposal and was awarded a 3-year grant from the Royal Norwegian Ministry of Foreign Affairs (MFA) to support the development of a multi-year programme covering various thematic areas: Peace and Security; Gender Justice; Economic Justice; Health; Water Sanitation and Hygiene (WASH); Education and; Emergency Preparedness. Initially NCA requested a total of 120 000 000 Norwegian Kroner (NOK) to implement the multi-year programme. In order to align with the Norwegian MFA contribution, the proposal was substantially revised in terms of its budgetary requirements and the total funds allocated to the multi-sector programme over the 3-year period amounted half of the original request (i.e. 60 000 000 NOK). The programme implementation started August 2010 and is expected to end December 31 2012.

During the period under review, the major sources of funding for the health programme have been the MFA, the Common Humanitarian Fund (CHF) and ACT Alliance. As previously noted, the MFA contribution to health has been reduced from SDG 4 501 000 to SDG 2 765 240 (Table 2)[10].

Table 2: Approved Annual Budget for health by type of grant, 2010 – 2012[11].

Period	Budget allocated , in Sudanese Pounds (SDG)						
	MFA		CHF		ACT Alliance		Total
	Eastern Equatoria	Warrap	Eastern Equatoria	Warrap	Eastern Equatoria	Warrap	
2010		589 500	1 191 000				1 780 500
2011	481 000	692 000				340 000	1 513 000
2012	452 740	550 000		529 400			1 532 140
Total	**933 740**	**1 831 500**	**1 191 000**	**529 400**		**340 000**	**4 825 640[12]**

[9] Source: Payam Total Population Census Year 2010, Warrap state.
[10] For the purpose of this report, the health programme is referred to as "the programme".
[11] Source: Personal communication with the Senior Programme Coordinator, May 14 2012.
[12] Approximately US$1.8 million.

Based on the above information, the following can be highlighted:

- MFA contributed to 57.0% of the total health budget; CHF to 36.0% and; ACT Alliance to 7.0%;
- The annual contribution remained fairly stable over the 3-year period;
- Out of the total funds, Warrap state received 56.0% of the funds and Eastern Equatoria 44.0%[13].

1.3.2 Objectives and Main Programme Components

The programme's specific objectives are the same as those for the NCA Global Strategy 2011 - 2015: (i) improved access to quality care for poor and marginalized communities; and (ii) improved quality of life for people living with or affected by HIV and AIDS. In order to achieve these, there is to be a particular focus on:

- Supporting three PHCCs and 28 PHCUs, serving approximately 394 986 beneficiaries through drug procurement and supply and training (see Annex 1 for the complete list of health facilities);
- Increasing HIV and AIDS awareness-raising with a specific focus on primary schools;
- Supporting church and faith-based partners and help build their capacity to deliver quality health services and raise awareness on HIV and AIDS.

The programme is working through the following partners:

- State Ministry of Health (SMoH) and CHDs;
- Africa Inland Church (AIC): Founded in 1946, AIC works to strengthen the Sudanese church through training and implementing community development programmes. The programme mainly support drug supply and provision of monthly incentives to 22 PHCC staff and 2 AIC administrators;
- Catholic Diocese of Torit (CDOT): Current support consists of drug supplies to one PHCC and 2 PHCUs[14].

The HIV and AIDS component is also implemented through various partners:

- The South Sudan Aid Commission and the CHDs;
- Church-related organisations, including the CDOT, AIC, Episcopal Church of South Sudan (ECSS);
- Two Community Based Organisations (CBOs): Lopit Women and Youth Development Organisation (LOWYDA) and St Monica's Women Association.

An overview of the programme scope may be found in Table 3.

Table 3: Overview of the programme scope

Location	County	Total Number PHCC/county	Total number PHCU/county	NCA-support	Support to partners
Eastern Equatoria	Lopa/ Lafon	3	23	1 PHCC 10 PHCUs	• Out of 11 health facilities, Lohutok PHCC is supported by AIC. • For HIV/AIDS, support is provided to AIC and LOWYDA
	Magwi	13	36	1 PHCC 9 PHCUs	• Out of 11 health facilities, 3 are supported by CDOT

[13] In 2011 and 2012, CHF has been the main source of funding for Warrap state.
[14] Namely Magwi (PHCC); Pajok and Pogee (PHCU).

					• HIV and AIDS activities are implemented in partnership with CDOT, St Monica's and EPSS
Warrap	Gogrial West	N/A	N/A	1 PHCC 9 PHCUs	• No partners • Mandeng PHCU has been closed in February 2011[15], making the current support to 8 PHCUs and 1 PHCC.
Total	3	16	59	31	• Some facilities are covered under MFA, others under CHF

By the end of 2011, the achievements, as reported in the annual reports, are summarized below.

Table 4: Completed activities 2010 - 2011[16]

2010	2011
• 80 CHWs trained on mid level PHC management • 19,600 children under 5 years of age immunized[17] • 5,800 pregnant women and 4,760 women of child bearing age immunized • 43,620 women, men and children benefited from life saving medicines. • 18 health staff trained on Health Management Information System (HMIS) • 5 CHD members trained on HMIS • One CHD office (Gogrial West) supported with two desktop computers, one laptop and printer. • 90 people participated in HIV/AIDS community talks • 10 Village Health Committee (VHC) formed • 36 people living with HIV supported with farm inputs • 60 participants trained to raise awareness on HIV/AIDS. • HIV/AIDS IEC materials designed, printed and distributed	In Eastern Equatoria: • 20,892 persons accessed health services (male: 9,102; female: 11,970) • 7,018 accessed health services • 770 children < 1 year immunized • 33 CHWs in GoSS payroll • 24 VHC members trained • 47 teachers trained in HIV/AIDS club concept • 163 school club members trained • Materials produced • South Sudan AIDS Commission in Magwi county supported with 2 desktop computers, one printer and one digital camera • South Sudan AIDs Commission supported during World AIDS day (state/county level) In Warrap state: • 6521 children under 5 immunized • 7604 children under 5-15 years immunized against measles • 4051 pregnant mothers immunized. • 108 drug kits distributed to 9 PHCUs • 40 CHWs ongoing training • 7 CHWs under payroll • 45 VHCs established • Catholic church and government disseminated HIV/AID information to 5 schools

[15] This is because the person in charge passed way. A community health worker is completing training to replace him.
[16] Sources: Annual Reports, NCA.
[17] All the results achieved for immunization may reflect the number of doses given and not the number of children immunized (See 3.3.5).

1.3.3 General Project Management Structure and Organisation

- **1.3.3.1 Management level**

The main NCA's South Sudan office is based in Juba. Since July 2011, the South Sudan programme has been under the leadership of NCA's Country Representative. In terms of programme management, there is one expatriate position, the Senior Programme Coordinator, working alongside the Gender coordinator and the Monitoring and Evaluation (M&E) officer who arrived September 2011[18]. Until 2009 there were four thematic coordinators to oversee sectoral implementation. Due to funding constraints and capacity-building plans for field-level staff, three coordinator positions were discontinued. Therefore the Senior Programme Coordinator assumes overall responsibility for the multi-sectoral programme. Since 2011, the Gender coordinator has been informally acting as the health coordinator and has been tasked with drug procurement.

- **1.3.3.2 Field level**

At field office level, there is a Programme Manager to oversee and support all programme sectors and their implementation. In Torit office, an experienced Health Officer, a clinical officer by profession, is leading the activities at health facility level. A community mobilizer is specifically tasked with the development of HIV and AIDS activities. Their role is primarily to implement, supervise and monitor health-related activities. A lot of the Health Officer work is also liaising with the health authorities, partners and communities. Both staff report to the Programme Manager and to the Senior Programme Coordinator. In Warrap, the field staffing structure is similar, with a Programme Manager and a Health Officer – a midwife by profession- who has been leading the implementation of health activities for more than 30 years.

2.0 METHODOLOGY

2.1 Objectives of the Review and Scope of Work

This review, covering the period January 2010 – April 2012, aimed to assess the progress made and; to document lessons learned. The results are to be used to inform NCA, field level, and the partners of the progress achieved, and to guide decision making about future programming, offering suggestions for direction and changes. The Terms of Reference (ToR) may be found in Annex 2.

The review was managed by the Senior Programme Coordinator in Juba. It was carried out by one independent international consultant, with expertise in public health and health system development in post-conflict and fragile states. Close collaboration and participation with NCA staff was ensured throughout the review process. A review matrix, developed to provide a framework to guide data collection, fieldwork and analysis, was prepared by the Consultant (See Annex 3).

2.2 Preparatory Work

NCA made a number of documents available at the beginning of the preparatory work. The review therefore started with a desk study, including programme proposal, its Logframe, progress reports, narrative and financial reports, and training resources and materials. Additional programme documents and all relevant MOH documents such as the BPHS and the GoSS health development plan were consulted. The full list of documents consulted may be found in Annex 4.

2.3 Field Work

To answer the review questions, the consultant gathered evidence through work sessions with key programme staff, as well as interviews with health authorities and representatives from Merlin (UK's NGO). The consultant also assessed the key quantitative indicators compiled by the programme.

[18] The M&E position was created in September 2011.

Qualitative assessments were undertaken through field visits to health facilities (See summary matrix for field observations, Annex 5).

Two out of three counties were visited (see 2.5). At county level, the method used to select the health facilities to visit aimed to achieve a balance between the geographic location, the category of health facility, the accessibility constraints, and the number of days for field work. Visits were made to 9 locations in two counties, namely Mura Lopit, Lohutok, Ibonni, Haba and Longiro (Lopa/Lafon county) and Magwi, Pajok, Agoro and Omeo (Magwi county). At health facility level, health staff and community members were interviewed based on their availability and consent. The discussions with health staff provided firsthand evidence on programme achievements and remaining challenges. The detailed list of respondents and programme of activities during the review period may be found in Annex 6 and Annex 7 respectively.

It is considered that visiting 9 (43%) out of 21 health facilities in the two focus-counties of Eastern Equatoria was a sufficiently large sample size to gain an overall overview of the programme, and meet sufficient stakeholders and beneficiaries. The health facilities visited provided the consultant with a variety of implementation environments, ranging from PHCCs to PHCUs, and more remote areas such as Haba and Longiro.

Data collection instruments consisted primarily of open-ended questions to guide the interviews with different categories of respondents and direct observation for qualitative assessment of health facilities. A written questionnaire was also designed and emailed to the head of World Health Organization (WHO) in South Sudan. Details regarding the data collection tools are available in Annex 8.

2.4 Data Analysis and Reporting

The methodology used for the review was able to generate a rich amount of information within a short period of time. The review matrix was the guidance for the data analysis. The interview and assessment notes were collated and analysed. Most of the quantitative data was sourced from the various records available and summarized accordingly. The analysis also built upon triangulating information with programme staff and relevant stakeholders.

Before leaving the field, the consultant presented her preliminary findings to NCA Country Representative and the Senior Programme Coordinator. The comments received were used as appropriate in writing the draft report. The Consultant submitted her first draft to NCA and then revised it according to their comments.

2.5 Limitations

In Eastern Equatoria, the consultant did not encounter major constraints in terms of access to selected sites. Travel worked to plan with logistical support. The NCA staff were helpful and provided full logistical support during the review.

The consultant had her flight to Warrap state twice cancelled due to uncertain weather conditions. This meant that she was not able to visit the county of Gogrial West she had initially hoped to. Instead the NCA Health Officer travelled to Juba to meet her. The two work sessions proved very helpful but there was no opportunity to compare levels of achievements between the two states and triangulate findings on important issues requiring "reality checks". Therefore some of the findings cannot necessarily be generalized across the two states.

There was to be a meeting with the Health Cluster leading agency. As WHO cancelled the interview a written questionnaire was emailed but the consultant received no response.

Other limitation needs to be noted, largely due to the many years of political instability and conflict in South Sudan. The prolonged civil war meant that the establishment of Health Information Management System (HIMS) has been limited.

Surprisingly, despite their focus on curative care, NCA and its partners have given limited priority to health data and where data does exist, it covers only a fraction of the programme period[19] or is seldom being analyzed. This has made it something of a challenge to review the level of activities at health facilities.

The programme indicators, as stipulated in the Logframe, are difficult to monitor, which makes the progress on results achieved partial only. It should be noted however that there is considerable county-level variation in achievements to date. These variations likely reflect difference in health infrastructure, level of NCA staff support, and variable environmental and security conditions.

With hindsight, a lesson learned was that the review should have been conducted earlier. This would have resulted in more corrective actions before the end of the programme.

3.0 Findings and Discussion

3.1 Observations in programme relevance

3.1.1 Context

The health programme was designed and planned in the context of early recovery[20]. The year 2009 was a period during which the country has not yet recovered from its decades of conflict. Despite the existence of health policies, there was a vacuum within the MoH. The BPHS was developed but left with limited human and financial capacity to respond to the overwhelming needs of the population. The period carried out a mix of uncertainty and hope, during which the health sector was waiting to build a momentum and address the dual objectives of ensuring basic health services delivery while simultaneously building health system.

In all three counties, NCA has played a key role in the delivery of basic health services, focussing primarily on substituting/filling existing capacity gaps. The organisation involvement at both facility and grassroots level is very much appreciated. The legacy of previous work, however, has created a wide range of unrealistic expectations among stakeholders and communities as a whole.

3.1.2 Design

As stipulated in the BPHS, building primary health care capacity is a high priority for South Sudan. Therefore addressing basic health care needs has been in line with GoSS priorities, even though there is no direct reference to the BPHS in the programme proposals and a limited contextual analysis in terms of health policies. The breadth of the proposed programme and the lack of detail in it indicate that understanding of the BPHS was limited.

Despite efforts made to strike a balance between shorter term health needs and the longer term system building, the CHF and MFA proposals still reflect a traditionally humanitarian approach (life-saving assistance) in service delivery, irrespective of geographic variations and different implementation contexts. It is worth noting however that over the past twenty years or so this has been the traditional modus operandi for NCA, making it difficult to move away from direct implementation in service provision.

[19] In Eastern Equatoria, monthly routine health facility reports are only available until July 2011.
[20] Early recovery is often characterized by the existence of weak institutions and systems with a lack of leadership and state capacity to fulfill essential state functions, especially in terms of providing basic services.

A strong focus is being placed on providing curative care and supplying drugs rather than moving to preventive care or supplying the health facilities with the tools needed to provide basic drug management. The curative focus needs to be understood in the broader 2009 context. Rapid re-establishment of basic services was a pre-requisite for South's Sudan recovery and the delivery of tangible services was a crucial element to meeting peace dividends.

At the time of proposal writing, neither the 2011 – 2015 NCA's Global Strategy nor the Country Strategy for South Sudan had been finalized. However, the health programme developed core features which are very much aligned to NCA global strategic priorities and closely related to their specific objectives for health. This helped enhance the adoption of common goals and specific objectives.

NCA had pursued a strategy of joint process of strong participation and consultation with SMoH, CHDs, partners and communities, followed with internal review to ensure the urgent needs and priorities were addressed. This process largely ensured that the programme reflected the interests and concerns of stakeholders and beneficiaries. The drawback with this approach is that designing a programme on the basis of perceived needs makes priority-setting extremely challenging. Therefore the design appears to have suffered from a lack of prioritization across the wide range of problems and challenges identified. As a result NCA has taken on many issues, spreading its resources thinly.

The MFA proposal is largely generic rather than reflecting local needs. It suffers from a lack of detail on health facilities and their level of activities (e.g. number of outpatient consultations and services addressing the needs of women and children under 5 years old). It appears to assume that health facilities are uniform across counties. However, during the field visits the consultant noted that health facilities have different levels of infrastructure, staffing and activities, with some health facilities performing better than the others. The current lack of basic information may paint a misleading picture, making it difficult to capture on-the-ground variations and tailor an appropriate response. For instance, the value of supporting PHCUs with less than 5 consultations a day is a questionable strategy as it contributes to take resources off focus and limit health service delivery impact.

The finding in relation to HIV and AIDS situational analysis is more or less similar. The programme response is uniform across the two states and does not fully reflect the on-the-ground reality:

- HIV rates vary widely and appear to be higher in areas which experience greater population mobility (e.g. border areas)
- Rates appear to be higher in towns than in rural areas
- Rates in women are markedly higher than those in men[21]
- The choice of target groups for Behaviour Change Communication (BCC) is not always well-aligned to the health context. For example, the activities target primary schools but are not in any way interlinked with health service providers.

The proposal design may not have given sufficient attention to the implementation environment, especially in Eastern Equatoria. Lopa/Lafon and Magwi counties have varying implementation environments but these variations were not taken into account. For example, one important factor to bear in mind is that Lopa/Lafon is an exceptionally difficult environment to work in. Not only do the widely scattered and poorly developed health facilities pose significant challenges, but the virtually non-existent CHD capacity to fulfil its mandate as articulated in the BPHS constraint the extent to which access to and quality of health care can be improved.

[21] According to the Global AIDS response progress report for South Sudan, the high levels of poverty, low school enrolment, rudimentary health system, and low status of girls and women are considered to be factors for the gender differential in HIV prevalence. Source: UNAIDS, March 2012.

In addition a number of questionable assumptions appear to have influenced its design:

- Global strategic objectives of NCA could be replicated in the context of South Sudan
- Sufficient numbers of qualified staff would be available
- Drugs and vaccines could be supplied easily without a management system in place
- Salary support for health and support staff would be provided by MoH
- NCA and its partners would have the capacity to address all of the basic service needs in two counties
- NCA and its partners would have the necessary skills, including how to move from a relief to a transition operation model
- SMoH in Warrap State would have the capacity to take over the 10 health facilities supported by NCA
- Community-based volunteers could be mobilized easily and effectively.

3.1.3 Scope of Work

The scope of health programme largely represents continuity from the previous interventions. Counties selected for the programme are traditional areas of implementation for NCA. The SMoHs have repeatedly emphasised the ongoing and urgent need for continuing support from NCA in delivery of health services. The programme design is therefore based on previous NCA's engagement and basically calls on the organization to undertake an ambitious geographic coverage, especially in Eastern Equatoria.

Attempting to cover 21 health facilities with one Health Officer, when so many facilities lack staff or adequate infrastructure, is an extremely ambitious undertaking. Most health facilities require enormous investments in service delivery capacity building and community-based behaviour change that take time to produce results and that go well beyond the financial and human resource capacity of NCA and its partners.

3.1.4 Observations on MFA programme goal, objectives and outputs

There is no specific programme goal and the only indicator suggested at this level is the number of right-holders. This indicator as a standalone number is unlikely to reflect changes in health status. A more relevant and aligned goal would be to contribute to reduced morbidity and mortality levels, with a clear focus on vulnerable groups (women and children under 5) in order to ensure gender and age equity in the delivery of health services. Also by referring to faith-based actors only, the programme goal formulation is excluding the MoH participation in improved access to health care.

The specific objectives are virtually the same as NCA Global Strategy Goal. While there are relevant, in reality they are too broad and non-specific[22]. The objective for HIV and AIDs is not fully consistent with the proposed outputs and activities, which are mainly related to awareness-raising. Increasing awareness alone is unlikely to result in improved quality of life for People Living with HIV/AIDS (PLWHA) within the time-frame of the programme.

The Logframe process, largely driven by NCA headquarters (HQ) in Oslo, was participatory. There was opportunity for the Health Officers to provide comments and feedback but the level of contribution remained less fruitful than anticipated, possibly because of time constraints, limited experience in and exposure to framework for objectives and indicators. Consequently, the Logframe lacked realistic and measurable targets to aim for, or to measure progress indicators.

3.1.5 Synergies between health and WASH interventions

Given that areas of interventions are prone to disease outbreaks and epidemics, of which water-borne diseases accounts for a large share, one would expect close links between health and WASH

[22]Specific objective must be Specific, Measurable, Attainable, Realistic and Time-bound (SMART).

components at the design stage. But this has not been always the case due to work demands, lack of systematic survey of health facilities and the fact that both programmes have been managed separately.

In practice the adoption of good personal hygiene and sanitation practices remains a significant and unaddressed problem at most health facilities supported by the programme in Eastern Equatoria. Health facilities in the two counties do not have the full package of basic WASH measures; namely latrines, hand washing facilities, and waste pits and incinerators for medical waste. To some extent, the water and latrine problems seem less apparent in Gogrial West county, where synergies between the health and WASH programmes have been developed. The management of medical waste remain however substantial problem in all counties.

3.2 Results achieved

As previously noted most of the Logframe indicators currently being tracked are not measurable. In addition recordkeeping systems at health facilities are not always accurate and well-maintained and facility-based data are not reliably compiled by the programme. All these make it difficult to firmly establish levels of achievement in focus counties.

Document review, discussions and field observations indicate however that not all counties are performing equally or face the same logistical constraints. There appears to be county-level variation in achievements to date, with the county of Gogrial West performing better than the counties of Magwi and Lopa/Lafon.

3.2.1 Health facilities owned and managed by NCA church partners and CHDs are professionally managed

The ownership of health facilities in South Sudan is a sensitive element. Under the CPA, the MoH has endorsed responsibility for rebuilding the health system (See Health Sector Development Plan 2011 – 2015) and has ownership over the health facilities. Steps towards partnership formalization between faith-based actors and public health authorities have not been taken yet. The collaboration and delegation of responsibility are largely informal. As previously noted recognition of the churches' role in coverage and health care delivery appears to be limited.

➢ **50% increase in the immunization coverage for children under 5 and pregnant mothers**

Immunization work going on in most counties is mainly through mass immunization campaigns. In general Expanded Programme of Immunization (EPI) services are not being provided on a routine basis. When they are available, concerns remain with regard to the cold chain system and vaccines supplies:

- The CHDs lack the capacity, administratively and financially, to set up a consistent immunization programme;
- Due to the shortage of human resources for health services, recruitment of competent vaccinators poses a challenge;
- Supply of vaccines, icepacks, syringes, and other vital supplies is erratic. Measles vaccines are not always available owing to temporary stock-outs. In March 2012 Gogrial West county has been experiencing a measles outbreak;
- Vaccine supplies and stocks appeared to be poorly maintained;
- In Lohutok, fridge did not have updated temperature monitor graph;
- Challenges in maintaining cold chain systems, including transportation to remote health facilities. For example, by keeping vaccines in vaccine carriers for 3 days, the efficacy of vaccines is unlikely to be preserved (as observed in Agoro and Omeo);
- An additional challenge is the limited social mobilization and community awareness.

Given the above constraints, the programme is unlikely to reach its objective. In addition the selected indicator is too broad:

- The indicator designed specifically for measuring immunization performance should target children aged under one[23];
- For quantitative targets, denominators should be used to estimate eligible populations. As the total population in the area served by the health facility (catchment population) is unknown, it is recommended to use the county-level population, even though the uncertain quality of county-level census data can be a problem[24]
- Given the low immunization coverage rates in South Sudan and the limited antenatal care (ANC) services, targeting pregnant women is insufficient and a more appropriate target would be women of childbearing age (15 – 49 years old).

Best practice: Immunization

NCA is supporting the installation of a solar freezer at Lohutok PHCC. This can significantly improve the routine immunization activities. In this situation, only monthly transportation of vaccines and kerosene will be required, since the facility will have the capacity to maintain the efficacy of vaccines for the entire month. In return, there will be fewer disruptions of services and the population will have consistent access to immunizations.

➢ **PHCCs and PHCUs received essential drugs and equipment, including cold chain storage**

The focus of facility staff is largely on consultations. Medical supplies, in particular drugs, are therefore an essential feature of the programme. Drug supply is based on the essential drug list and aims to complement the MoH supplies. The procurement of essential drugs through the MoH commodity logistics continues to present challenges and the system is not capable of predictably supplying drugs for PHC system.

At programme level in Eastern Equatoria, the following can be highlighted:

- Frequent stock-outs are noted in health facilities, their causes being multiple. Among these, two are recurrent: (i) difficulties encountered by health facilities in assessing their needs, with adequate estimation of margins. This is due to the lack of an actual information management system on consumption and utilization levels; (ii) the lack of regular stock monitoring by NCA and partners;
- Ordering and receiving of drugs is mainly conducted by NCA without much involvement of partners;
- Without a proper storage and a minimum of monitoring (stock cards), the programme has had major difficulties in managing supplies in a cost-effective manner. Drug storage shelving were not part of the equipment provided. In Lopa/Lafon, due to distance constraints, drugs have been supplied on a quarterly or 6-month basis which creates storage problems because of the limited capacity at health facility level (Figure 2 and Figure 3) [25];

Figure 2: Drug storage in the laboratory room, PHCC in Lohutok, County of Lopa/Lafon

Figure 3. Drug storage, PHCU in Longiro, County of Lopa/Lafon

[23] For the programme to be effective, the child needs to have received BCG, measles and DPT/polio3.
[24] For instance, if the estimated population in the county of Lopa/Lafon county is106 161, the annual target population of children aged under 1 is approximately 4 246. According to WHO/EPI guidelines, children under 1 year represent 4% of the total population. The figure is the same for pregnant women.
[25] Many unopened kits were found in all the facilities visited.

- CDOT has well-developed tools for drug management but health facilities suffer from drug shortages. Drugs supplied by the programme are stored in Kapoeta but the timely provision of drugs from CDOT central store to health facilities is still a challenge. Distribution outcomes might also be affected by CDOT supplying other health facilities with the kits procured by NCA. The absence of follow up on this issue is a programme limitation;
- Some drugs are over-supplied (e.g. dressing material and IV solutions) while others are in chronically short supply, e.g. Artemisinin Combination Therapy (ACT) for treating malaria and some antibiotics);
- Rational drug use is not monitored and it is not clear how procedures and treatment protocols are being followed. There seems to be an over-prescription of antibiotics and the diagnosis in the registers does not always match the treatment, especially at PHCU level (e.g. a headache treated with anti-malarial);
- Some PHCUs were seen inappropriately giving drips without any supervision.

In Warrap, the timely provision of drugs to primary health care facilities is still a challenge but a somewhat more proactive system has been developed whereby NCA supply drugs on a monthly basis, monitor drug flows and use stock cards. As in Eastern Equatoria, anti-malarial drugs and antibiotics tend to be depleted before the scheduled delivery of new supplies.

➢ **All health units receive annual training of auxiliary nurses, midwives and laboratory technicians**

The programme is attempting to enhance the capacity of health staff in the focus counties where NCA and partners are engaged. The above result statement however does not correspond to the staffing patterns of PHCUs and PCCs. Auxiliary nurses, midwives and laboratory technicians are mainly available at PHCC level. At PHCU level, the lack of certified community midwives is a major constraint and only CHW are available. As shown below, NCA concentrated efforts on refresher course for CHWs.

Table 5: Progress achieved against Logframe indicators[26]

Category of health personnel	Target	Achievements			Comments
		2010	2011	2012	
Auxiliary nurses	20	0	0	0	• 80 CHWs trained in Eastern Equatoria • 30 CHWs, 30 TBAs and 32 EPI vaccinators trained in Warrap • Training plan for 2012: 20 CHWs
Midwifes	10	0	0	0	
Laboratory	6	0	0	0	

[26] Data for the tables is taken from the programme annual reports and personnel communication with NCA Health Officers.

technicians					in Lopa/Lafon and 10 community midwives in Warrap

Much of the training to CHWs appears to have been somewhat broad in content and programme reports do not give many details either. Management and treatment of diseases, the proper handling and use of medicines, the monitoring and storage of drug supplies and recordkeeping were priority areas for improvements. In general updated treatment protocols and guidelines were not seen in many facilities. Diagnosis and treatment algorithms for malaria were not always available.

The number of trained CHWs is an impressive achievement but training alone is unlikely to achieve greatest impact. Owing to implementations constraints (logistics, rainy season, CHW absenteeism), it is often difficult to provide good follow-up after training completion. This may leave CHWs ill prepared to use their skills effectively.

Best practice: Training of health staff

NCA in the county of Gogrial West has undertaken an interesting initiative. At the PHCU level, there is no community midwife. In the future, this category of health staff, with more education than most TBAs, is likely to become the frontline maternity care worker. The NCA Health Officer, a trained midwife, has appropriately identified existing gaps. In collaboration with the CHD, the programme will support a 9-month course for ten young women to become community midwives.

- **NCA partners have assumed full responsibility for management of their health facilities as well as operational responsibility for the procurement and distribution of material assistance**

The programme appears to have had a mixed success in engaging church-partners. NCA and partners had not entered a specific programme commitment with reciprocal obligations and duties and shared responsibilities. The partnership objectives remain vague with unclear distribution of responsibilities and relatively high expectations with regard to the level of support. The absence of reporting to NCA on the part of CDOT and AIC is an impediment to programme accountability, even though there seemed to be confusion regarding who is responsible for reporting.

It was noted that CDOT and AIC have different capacity levels. CDOT has access to various sources of funding and has been able to leverage resources for qualified staff recruitment and development. It has also well-established systems in place (e.g. drug management; M&E). At PHCC and PHCU level, there are well-qualified nurses capable of ensuring health service delivery to acceptable standards. In many aspects, the partner has more capacity than NCA itself and the programme assistance to CDOT has mainly focussed on drug purchase and supply to Kapoeta central store in order to support three health facilities. Therefore the value added of the current support is questionable and will likely warrant discussion between CDOT and NCA on how to ensure the adequacy of support, including the possible direct transfer of funding to CDOT to assist the 3 health facilities.

The situation is slightly different for AIC. Capacity-building efforts are constrained because not much is known, beyond claims, about the number of AIC-supported health facilities. With the notable exception of Lohutok, the consultant found little evidence of AIC-supported activities in the six PHCUs[27]. The two staff supported by the programme are administrative staff and their contribution to the programme is not fully clear. AIC has no functional vehicle and has not been making supervisory field visits. The partner is still facing serious problems in providing accurate and timely reports. The consultant also observed that AIC does not currently have the capacity to fully appreciate the health

[27] From the discussions with AIC programme manager in Torit, AIC-supported health facilities include Lalanga; Ibonni; Mura-Lopit; Logonawati; Haba and Longiro (all PHCUs) and Lohutok PHCC.

policy environment and guidelines. In Lohutok, there are expatriate medical doctors who appear to work in isolation from the health system.

➢ **Number of CHWs on government payrolls**

The payment of salaries for facility-based service providers and support staff continues to be a major problem and the most constant complaint heard by the consultant. In most counties, the MoH does not pay salaries to its staff, resulting in an enormous obstacle to the BPHS implementation as it impacts staff morale and leads to absenteeism. NCA has played an advocacy role with MoH in working to overcome this systemic problem and have made some headway in improving the situation (Table 6).

Table 6: Progress achieved against Logframe indicators

Category of health personnel	Target	Achievements			Comments
		2010	2011	2012	• The indicator does not provide meaningful information (no total number of CHWs, no targets and partial information in the annual reports)
Lopa/Lafon	N/A	N/A	33	N/A	
Magwi	N/A	N/A		N/A	
Warrap	N/A	N/A	N/A	7	

The CHWs have also raised this issue many times with NCA but long-term permanent solutions are largely outside the ability of any single donor funding such as the MFA or CHF. Lasting solutions will require system-wide approaches involving effective collaboration between the donor community and GoSS.

The programme is currently providing support for incentives to PHCC staff, in both Lohutok and Alek[28]. This arrangement was appreciated, even though payments in Lohutok were late by as much as three months. Interviewed staff could not give clear explanations as to why there were delays in payments.

It may also be the case that this sort of arrangement could be attracting more staff than needed, with the result that staffing levels could be unnecessarily high. For instance, the PHCC in Lohutok could well be over staffed compared to the services provided but this is difficult to quantify in the absence of activity reports.

➢ **NCA-supported activities in Warrap state handed over to the authorities by 2011**

This output is no longer relevant as NCA observed that CHD did not have the capacity to manage the ten health facilities in the county of Gogrial West. Also, since October 2010 South Sudanese people have returned home to Warrap state with virtually no social services to support their reintegration, putting pressure on already over-stretched health services. Therefore NCA decided that a long-term support was advisable in order to fill any gaps.

3.2.2 Communities have knowledge of preventive health measures as well as knowledge of HIV and AIDS

➢ **Number of health committees established at *payam and poma* level in Magwi and Lafon counties conducting monthly meetings addressing health issues**

Community mobilization initiatives are critical if health status of local populations is to be improved. The programme achievements in relation to Village Health Committees (VHC) show mixed results (Table 7).

Table 7: Progress achieved against Logframe indicators

[28] 22 staff in Lohutok and 15 in Alek.

Location	Target	Achievements			Comments
		2010	2011	2012	
Lopa/Lafon	120	10 VHC formed	24 members trained		• Indicator not specific and difficult to monitor. • Inconsistent information in the annual reports (confusion between number of members and number of VHCs) • Warrap state not included in the indicator but out of 37 members trained in Gogrial West, 22 are still active
Magwi		N/A	N/A		
Warrap	N/A	37 members trained			

In Eastern Equatoria the first training session provided to VHC members by NCA occurred over an 8-day period. The second final session has not started yet and the delays between the two sessions appear to impact VHC motivation.

The training curriculum for VHCs is comprehensive. However, it appeared to the consultant that the messages being provided are too many and too diffuse to be effective.

Best practice: Community involvement

In Magwi one VHC was found to be working. Factors in Agoro that appear to play an important role in this success include two active and motivated CHWs and committed community leaders.

Exceptions were also noted in the county of Gogrial West where VHCs were monitoring the drug supply and conducting health awareness and education programmes in their communities. The VHC members have been consistently recruited, trained and at the time of the review, out of nine health facilities six did have a functional VHC.

In Lopa/Lafon VHC members did not appear to clearly know their role and responsibilities in health promotion and mainly pointed out inadequate drug supply. It should be noted that their low level of education may limit their understanding in mobilizing communities for primary health care.

➢ **HIV/AIDS awareness-raising**

Due to the broad programme design and the various monitoring gaps, it has been difficult to understand the results achieved for the HIV and AIDS component. The community-based prevention efforts were to engage local organisations (i.e. primary schools and church groups). In order to achieve the two expected results (information programme disseminated by local governments and NCA partner churches and; 6,000 people reached by HIV and AIDS awareness – raising) the programme in Eastern Equatoria has adopted the following strategies:

- Support to three local partners (See Table 3)
- Support to the South Sudan Aids Commission through training and specific events such as the National AIDS day
- Training in primary schools for pupils and teachers

As shown in Table 4, different groups have been trained but mechanisms for follow up are unclear. Once again, the approach taken reflects the lack of priority setting and therefore ran the risk of implementing a response that is under-funded, too piecemeal, and of limited potential impact.

Prevention efforts were planned regardless of the difference in prevalence levels and there is currently no programme strategy to concentrate in counties known to have higher prevalence rates (e.g. Magwi). The potential synergies with the health facilities were not considered. While peer educators were

trained in prevention messaging, they deliver the messages in the community without plans to engage health staff. At PHCC level, the HIV and AIDS component is on hold. There are no trained counsellors and no Voluntary Counselling and Testing (VCT) services in place.

Local partners were universally positive about the NCA support they had received. One partner, St Monica's, believe they have improved their skills in planning and proposal writing and would like to access other sources of donor funding. Among the three targeted partners, St Monica's seems to present a strong technical and management structure and is clearly focused on PLWHAs. Small grants have also been allocated to help support PLWHAs in income-generating activities. This type of support appears to be somewhat ad hoc and it is unclear how the impact and benefits of grants are being monitored.

3.2.3 Church health delivery is fully supportive of national, state and county policy framework and coordination mechanisms

- **Government coordinated HIMS adopted and implemented by all health sector delivery actors in Magwi and Lafon counties**

The programme has taken steps to improve the functionality of facility-based reporting with the distribution of new registers based on MoH guidelines and the training of CHWs in completing these forms. The accuracy and timely reporting of activities is still a challenge. There were some PHCUs where staff did not record the patient diagnosed. There were also complaints because the new registers supplied by the MoH did not have sufficient space for recording symptoms and drugs prescribed.

The source of information which is available for the programme to build upon is the routine monthly health facility report which represents the HMIS backbone. The current format is very cumbersome with a list of 47 indicators and it is unrealistic to expect CHWs to fill out the form accurately and completely.

The consultant noted that it was very common for columns to be left blank. In most PHCUs the CHWs only entered data pertaining to consultations, which clearly reflect the absence of preventive care (See Annex 9a and 9b). In Eastern Equatoria, problems also included missing data, and confusion about how to complete the vaccines and pharmaceuticals section of the report. As a result the fundamentals of reporting are not yet in place. This raise concerns about the validity of aggregated data being reported by the programme (e.g. number of right-bearers). These concerns are discussed more extensively in the M&E sub-section below.

At CHD level, efforts have been invested in training staff and ensuring proper data management using the available HMIS tools. However, out of the 10 CHD staff trained, five left their work because the MoH did not have the resources to make timely salary payments[29]. As the NCA Health Officer pointed out, once staff members become more qualified, they also become more attractive to other organisations. In Warrap State in particular, it seems that NCA has been an important training ground for individuals who have become senior members of other organisations.

- **Major health sector delivery actors, including churches, participate in state and county coordination meetings**

In Eastern Equatoria NCA and CDOT are participating to monthly and quarterly health sector meetings. AIC is not active in this respect, possibly because the two staff appointed in Torit are not health professionals. Also the partner seems ill-equipped to understand MoH policies and may not fully appreciate the importance of sectoral meetings.

[29] This is the case for the county of Gogrial West.

At both state and county level, the tendency to sideline local partners in favor of international organizations was noted. During the interviews and meetings, the SMoH and CHD staff made no mention of AIC. This corroborates the impression that there is no explicit recognition of the partner contribution to the health sector.

3.2.4 Other observations

- **The case of medical waste**

The spread of diseases such as cholera and the introduction of the HIV virus have reemphasized the need to minimize the risk of exposure by both patients and health staff. Rural health clinics are generally the most critical health service delivery points. Unless proper precautions are taken, they may become a source of infection. Hand washing to avoid cross infection and maintain sanitary premises and dispose of waste safely are amongst the essential elements of universal precautions.

Facilities have not uniformly good sanitary facilities, sharp boxes and hygiene in place. Only one health facility visited has a secure incinerator in place[30]. For the others there is unprotected borehole and the adherence to the respect of and monitoring of the safe medical disposal remain largely neglected. Much more could be done in order to facilitate access to medical waste disposal if a systematic consideration of this issue was taken during the assessment and planning stage.

- **PHCU and PHCC health infrastructure**

Nine PHCUs are very basic (traditional mud huts)[31]. This is an issue if quality of care is to be maintained. This deficiency will require considerable facility construction and renovation work. The programme budget is totally inadequate for addressing existing infrastructure needs but opportunities for undertaking additional construction and renovation work would need to be explored, possibly in coordination with other donor support.

Lohutok PHCC has no adequate space for drug storage. The laboratory is under-equipped and has no essential reagents for testing.

- **BPHS implementation**
  - Oral Rehydration Salts (ORS) were available in most health facilities;
  - Vitamin A was not found in all facilities and records did not clearly show use;
  - Malaria is one of the most common health problems being treated at health facilities but the supply of ACT remain a key challenge in all health facilities;
  - Malaria paracheck kits were not always seen;
  - The capacity to treat complicated malaria cases is limited (injectable quinine was not seen at PHCU level);
  - Efforts to increase the correct use of bednets have been made in some health facilities;
  - The supply of insecticide-treated bednets by the MoH has been irregular.

3.3 Use of Resources

3.3.1 Programme Management

During the period under review the Senior Programme Coordinator has had direct responsibility for programme oversight. The Gender Coordinator has assisted with drug procurement.

It has already been noted that the programme's context was difficult, and that its scale was too broad and ambitious. For understandable reasons, the need to cover a range of sectoral interventions, plus responding to the staff requests and enquiries, is extremely demanding. As a result of the amount of

[30] PHCC, Lohutok (built with the support of local politicians).
[31] 5 in Lopa/Lafon and 4 in Gogrial West.

work and competing needs and priorities, it has not always been possible to give the programme the attention and priority it required.

Overall NCA is very committed to local staff development. By delegating responsibility to Health Officers, there has been a significant level of ownership. Clearly, both staff have exhibited good situational awareness and motivation and demonstrated a longstanding experience in relief work.

Notwithstanding these positive elements, primary health care strengthening calls for a different working approach, whereby technical and strategic guidance are critical. The lack of suitably qualified and experienced staff to guide the development and implementation of the programme has been a limiting factor and it is considered that some inappropriate situations encountered in Eastern Equatoria could probably have been avoided if appropriate levels of support and technical expertise had been present from the outset.

Throughout the period under review, NCA Oslo has been providing extensive headquarters support to the programme. Due to the lack of health expertise at this level, technical input has been more limited. The recruitment of a Health Adviser in the 3rd quarter 2011 is very welcome and holds the promise of bringing greater consistency to the programme.

3.3.2 Supervisory Support to Health Facilities

NCA Health Officers have made good efforts to undertake supervisory visits of health facilities in their counties but the consultant noted considerable variations in supervisory support. In general ssupervision is more frequently concerned with process – drug supply, training sessions than with quality of care. In the counties of Lopa/Lafon and Magwi, these visits were described as lasting only one hour and consisting of little more than the delivery of drugs and the collection of completed reporting forms[32].

The consultant could not find evidence of supervisory schedule and standardized supervisory checklist. NCA's supervision of health facilities in Eastern Equatoria appeared to be quite weak overall due to four constraints:

- At Torit office management level, there may not be a full appreciation for the supervision demands (e.g. more frequent visits, longer visits at health facilities, more engagement with health staff where present, etc.). Also it is unclear whether the budget allocated to supervision is sufficient;
- Inadequate number of staff to conduct regular supervision at 21 health facilities: it is unrealistic to expect that one staff can adequately supervise and provide good follow-up to so many scattered and under-developed facilities;
- Security restrictions due to localized tribal conflicts;
- Difficult road conditions often impassable during the rainy season.

One positive element however is that NCA Health Officer has been helping to organize joint supervisory visits with CHD staff. These joint visits promoted collaboration but were less effective in addressing problems associated with staffing, salaries and the delivery of good quality care.

In Gogrial West, NCA Health Officer was able to present a monthly supervisory schedule. Overall it appears that the nine health facilities enjoy more rigorous attention, including regular and longer visits, more engagement with health staff and VHCs, and greater efforts to solve implementation issues.

3.3.3 Monitoring & Evaluation

At the beginning of the programme there was no well laid plan regarding: (i) continuous data collection (ii); frequency of data collection; (iii) body responsible for collection; (iv) collection forms to be used; and (v) the verification of data collected. However NCA has taken steps over the past year

[32] The latter is contradicting the fact that reporting forms are missing, starting July 2011.

to improve the functionality of M&E with the recruitment of an M&E officer for the overall programme sectors[33], the training of staff on Project Cycle Management, the development of Project Monitoring Internal Checklist based on ACT Alliance Handbook, and a field visit to Warrap state to monitor progress.

Despite these efforts, NCA does not have a coherent and institutionalised M&E strategy in place yet. In general there does not seem to be a sufficient understanding of the need for and value of having good health information to help with planning and decision making. As a result, the programme does not have a strong element of M&E built into it. This will require greater time allocated to the field to better understand on-the-ground reality and some experience with HMIS and health indicators. It will also require developing an appropriate M&E plan, harmonize supervisory tools that currently exist but are not in use, and train NCA staff in their use to ensure consistency and improve ownership.

As there is no consensus on NCA's intended methodology to collect, monitor or manage facility-based data, NCA Health Officers have typically developed their own methods. In Eastern Equatoria, hard copies of monthly reports have been recorded up to mid-2011. Shortly after July 2011, monthly reports are no longer available, which means that NCA has partial information on the activities performed by the 21 health facilities supported under the programme. There did not appear to be a clear reason for this problem. Also, given all the information gaps, it is not clear how the cumulative number of right-bearers is being recorded.

The absence of adequately maintained and accurate drug stock records is a limiting factor in programme monitoring. As previously mentioned, in the absence of proper inventory and records, it is difficult to say whether drug stocks are at appropriate levels or not.

Best practice: Managing health data

It is worth noting that recordkeeping and the reporting of activities appeared to be proceeding more smoothly in Gogrial West. Due to shortages of data managers at CHD, the NCA Health Officer has taken the lead in HMIS. She has entered monthly data using individual Excel spreadsheet for each facility. The computerisation of data storage has allowed for indicators to be tracked (e.g. number of consultations per age group; number of malaria cases treated, etc.).

Two limitations, however, were observed: (i) links are missing between the different monthly spreadsheets, making manual summations time-consuming and increasing the chance for error; (ii) data is not analyzed, limiting use for decision-making.

Understanding of the relevance of the Logframe at field level is still rather low and keeping in line with the proposal targets has been challenging. Reports are narrative rather than Logframe-based and the information collected is not necessarily linked to the indicators. The fact that indicators are not adequate has resulted in gaps in the information system which cannot be easily filled retrospectively. A revised Logframe related to MFA proposal is however proposed for the remainder of the programme (Annex 10).

The MFA proposal did not make provision for evaluations but in October 2010 an external evaluation took place to assess the overall sectoral programme impact in Warrap state and develop an exit strategy. It should be noted that the results for the health programme were not supported by evidence, especially with regard to reduced level of communicable diseases, morbidity and mortality. However the evaluation was useful in that it provided relevant and operational recommendations for construction and renovation work, including the need for secure incinerators. Most of the recommendations were incorporated into the 2012 work plan.

[33] No M&E officer was in place before September 2011.

A baseline survey was conducted in all three counties in the third quarter of 2011 but there is no evidence that it added any value to the programme. The objective of conducting the exercise one year after the start of the programme and the extent to which the reports were used to address the health problems identified are unclear. Some findings are not consistent with the results of national surveys (e.g. high proportion of the respondents using bednets) and should be interpreted with caution due to the survey and sample design limitations. A more reliable source of information would have been to use the results of the SSHHS 2010. Furthermore, while the baseline informed the programme of the main areas of concern and the activities needed, there was no priority-setting in the list of recommendations and the baseline values were not incorporated in the Logframe, possibly because the survey indicators did not match the programme indicators.

3.3.4 Reporting

It was observed that NCA Health Officers were not using a common form. This lack of common implementation modalities may allow discrepancies to develop. It did not appear that results from annual reports were used to identify discrepancies and shortfalls. Field validation procedures to verify the accuracy of reporting have not yet being implemented.

Reporting formats being utilized by the programme do not allow for the disaggregation of data by gender and age. Therefore it is not clear whether they are different treatment patterns by gender or age. There is no major reason why such information could not be more accurately compiled by the programme since reporting health facility forms routinely record the gender and age of patients (See Annex 9a).

3.3.5 Resource mobilization

Budget allocation per main group of activity is presented below.

Figure 4 : Budget allocation by activity, Eastern Equatoria state

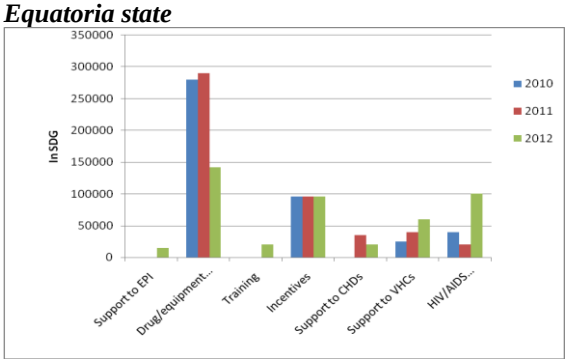
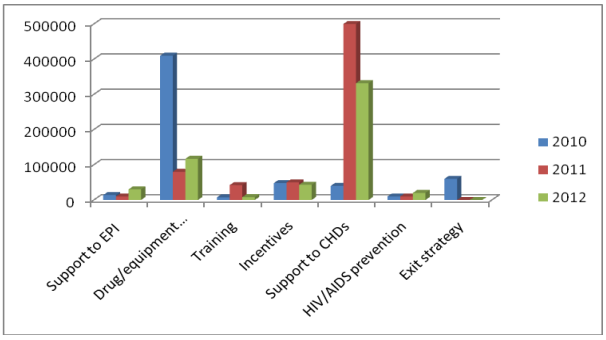


Figure 5: Budget allocation by activity, Warrap state



The following comments can be made:

- Understandably there is an important share of the budget allocated to drug supply, which is consistent with the field observations. It should be noted that provision of equipment represents a very small proportion of the budget compared to drugs;
- Support to promoting EPI and trainings is so small that it can hardly meet even the most basic needs.

This support does not match the cumulative number of children immunized in 2010 (See Table 4). The result is actually surprisingly favourable given the low amount of budget to EPI and the low level of immunization services. While the result could be influenced by special immunization campaigns not attributable to the programme alone, the possibility of double counting when children are given different vaccines should not be excluded. In fact, considering the way immunization is recorded in monthly routine reports at health facilities, the relatively high programme results for EPI seem

misleading and may reflect the number of doses given, not the number of children immunized (See Annex 9b, part 2).

The consultant acknowledges that the available budgets are totally inadequate for addressing geographic coverage and thematic scope of work. Although regrettable, the reduction in MFA budget may have been in the best interests of NCA, especially considering the existing capacity in human resources and systems at the time of the proposal and during implementation.

In 2009, the implementation of BPHS in Eastern Equatoria state has been estimated to cost $4.1 million per year[34], representing approximately $US4.5 per capita. Extrapolations from this estimate suggest that, in order to cover the basic health needs of the population in the programme's 3 counties, NCA would require $US 1.1 million per year[35]. Only a major donor like World Bank or the Health Pooled Fund (HPF) has the level of funding to make this possible.

3.4 Sustainability

Partnership has been the most important element of programme sustainability

3.4.1 Partnership with MoH counterparts

Sustainability is a problematic concept in Southern Sudan and highly dependent on a large range of complex and interrelated political factors, most of which are outside the control and even influence of the programme. Some of the most important amongst these are how quickly the capacity, legitimacy and accountability of MoH can be built at all levels; and whether sufficient revenue will continue to be available. The sheer magnitude of the health system needs has been another important obstacle to sustainability. Ultimately, even though many of the activities under review are fitting within SMoH and CHD structures, austerity measures have affected the functioning and future sustainability of basic health services (e.g. staff salaries, plan for construction and renovation work, supplies, etc.).

Good collaboration with the CHDs was noted in all counties. There is joint operational planning for some activities (e.g. for the running of vaccination campaigns and distribution of vaccines). CHDs have also received support in terms of office equipment, including computers and printers. While Magwi is notable for having an exceptionally engaged County Health Director, in Lopa/Lafon, the programme has had less success in engaging the CHD staff, mainly because of the limited capacity and leadership of County Health Director.

3.4.2 Partnership with churches and faith-based organizations

In Eastern Equatoria, in addition to direct implementation, NCA has taken partnership and funding roles. NCA and partners have conducted organizational capacity assessments in 2010, and developed plans for capacity building which are currently being implemented. However, the level of funding has limited the implementation of training plans. Furthermore, brain drain has affected partner capacities and in 2011 a number of trained staff left their work for better opportunities. All these have had disruptive effects on the effectiveness of capacity-building.

In some respect the programme attempted to be too partner-oriented. The level of partnership has often demanded a lot of attention and it would have benefited from a more pragmatic consideration of the level of cooperation and participation that were feasible, especially considering the human resources available to the programme as well as to each partner.

[34] Source: Partnership for Democratic Governance: Contracting out Government Functions and Services: Emerging Lessons from Post-Conflict and Fragile Situations, OECD Report, 2009; Table 3.3. BPHS cost in four states, pp 91.
[35] The programme has spent an estimated $US1.8 million for the 3-year period (See table 2).

A previously noted, NCA and its partners do not always work side-by-side. The support received seems to be more donor than partner-oriented and there are high expectations toward NCA, particularly with regard to operational costs. Also partnerships did not enhance sustainability as much as expected because most of the partners lack long-term and diverse sources of funding and are therefore faced with financial constraints, thus limiting the extent to which they could plan for continued activities.

3.5 Ways forward

3.5.1 Present situation

The 2009 – 2012 period was supposed to be a transition for South's Sudan health system, with the move away from emergency response toward health system reconstruction. However, the austerity measures have forced the MoH to scale back on its health development plan and the expectations that it would slowly begin assuming more running costs such as salaries and drugs supplies are unlikely to be fulfilled in the short-term.

In the current context, no short term decrease in need is forecast and talk of exit strategies does not relate to any contextual reality. Decades of marginalization and war have left households with little ability to absorb health challenges. Therefore, in the years to come, there is unlikely to be a neat-dividing line between the humanitarian and the developmental agenda. Even in the event of rapid development progress, humanitarian and longer-term assistance will probably coexist, with transition characterized by a protracted interplay between meeting humanitarian needs, providing basic services, and building capacities to sustain those services.

3.5.2 Options for NCA

NCA has a presence in two states and provides humanitarian assistance to populations. Currently the organization does not have the sufficient resources and systems in place to cope with the scale of need and the complexity of primary health care strengthening. The results of the review suggest that there is a need for moving away from the current approach, both strategically and programmatically.

➢ **Option 1 - Withdrawing from the health sector**

The impact of NCA withdrawing from health in South Sudan would be significant:

- To a large extent, the viability of 28 health facilities in the three counties is dependent on NCA funding[36];
- Even if the programme impact appears to be limited, NCA contribution plays a significant role in building peace dividend;
- There is no other organization prepared to take over.

More widely the impact on the health system as a whole would also be strongly felt. NCA is widely acknowledged as the main driver of implementing health activities, especially in Lopa/Lafon and Gogrial West. Without continued investment, these activities would undoubtedly lose momentum and the health system likely to collapse. Withdrawal is not a favourable option unless appropriate improvements and suitable adjustments to the programme are found to be impossible to implement.

➢ **Option 2 – Provide assistance through the Health Pooled Fund**

While MFA or CHF funding modalities may be appropriate in a chronic emergency environment, this short-term mechanism is not sufficiently resourced to respond to health system development needs. The HPF mechanism is consistent with the BPHS policy, which makes clear that progress in primary health care strengthening requires a coordinated approach. Such a funding mechanism is therefore considered to be one of the main drivers for a coordinated, strategic and prioritised international response to health system development in South Sudan. Given its experience in the three counties and

[36] This excludes the three health facilities supported by CDOT.

its trust and linkages with communities, NCA has potential comparative advantages vis-a-vis INGOs and it will be to the benefit of NCA in the future to pro-actively explore this option.

- **Option 3 – Portfolio approach (short-term plus long-term)**

The reality is that some areas of the country may not yet be ready to transition away from humanitarian assistance. This option will allow a flexible response at scale that support both humanitarian and longer-term needs in Warrap and Eastern Equatoria state.– with the former focused on enabling meeting humanitarian need (though it does also have some system strengthening benefits) and the latter on health system development.

In summary:

- Even though Gogrial West is a geographic area of focus for the HPF, an interim humanitarian support may be required to help deliver basic emergency services, while continuing to support primary health care strengthening. More information on the HPF modalities in Warrap state is needed.

- In the county of Magwi, a gradual phase out from direct delivery support should be explored. The responsibility of Magwi PHCC and Pajok and Pogee PHCUs could be transferred to CDOT by end of 2012. The remaining seven health facilities could be handed over to CHD and/or potential NGOs contracted under the HPF.

- In the county of Lopa/Lafon, there is a need to build AIC capacity to take over health facilities, and therefore to concentrate efforts in this county. Given the current situation, this is a long-term plan, which will require a significant level of resources, possibly through the HPF. This will require NCA and AIC to embrace the concept of HPF, establish - in collaboration with the MoH - a shared understanding in the number of health facilities to be supported and develop a strategic approach to reinforcing partner capacities.

4. CONCLUSIONS

4.1 Programme design

In summation, it can be said that the core principles of the health programme were relevant to the conditions that pertained during the 2009 period. However it is considered that the implication of working with many health facilities was not well appreciated.

The challenge has been for NCA to target support in a focused way, in particular:

- If resources and internal capacity are limited, it is impossible to provide everyone with every effective intervention they might need or want. Priority-setting was not given enough attention. The programme design was far too broad and ambitious in that it attempted to address nearly all of the critical issues facing the health system;
- The MFA proposal did not take into account county variations and partner differences, making it difficult to target support in a strategic and meaningful way and to set priorities and sequences for capacity building;
- Insufficient focus has been given to high impact services, including preventive services and community mobilisation, and the programme was not as obviously relevant to the specific needs of women and children under five;
- The large geographic scope has allowed NCA to promote activities at the level of three counties. However, in Eastern Equatoria NCA may have overstretched its limits. The breath of the programme – the high number of locations, the various partners– causes resources to be spread too thinly while limiting impact.

4.2 Programme implementation

At more than the mid-point of the programme, progress has been mixed, even though it must be acknowledged that NCA has made great efforts to deliver timely activities as envisioned in the annual work plans. Also it is fair to point out that major implementation constraints impeding the achievement of programme objectives are, to a considerable extent, beyond the control of the programme. In particular PHC delivery continues to be constrained by inadequate infrastructure, insufficient staffing, and the lack of MoH ability to pay salaries to its staff.

The consultant observed that progress has been uneven across the programme's focus counties in strengthening drug procurement and storage capacity, improving the supervision of health facilities, providing training and guidelines for improving service delivery, and building the capacity of CHD staff.

In summary:

- Activities and levels of achievement vary considerably across counties owing to highly varied implementation environments;
- In the three counties, the programme has achieved success in developing good working relationships with SMoHs and CHDs;
- Much of the work has been centred on supplying drugs and basic equipment and providing training to facility-based staff and VHCs. The programme has made little progress in strengthening VHCs as community mechanisms that promote greater involvement in PHC;
- Drugs were available, although their consistent and timely provision has been a challenge in some counties. While the supply of anti-malarial drugs was often depleted before the arrival of new supplies, maintaining adequate levels of drugs was a formidable challenge due to difficulties in forecasting the right quantities, irrational prescribing and lack of effective drug management system.
- The deficiencies in drug management in Eastern Equatoria have impeded the ability of NCA to implement this activity in an effective and efficient way. Considering the large amount of money which is being invested in drug procurement and supplies this constitutes the largest disappointment of the programme.
- The provision of child health services is limited. Immunization is irregular and concern remain with regard to the cold chain system and vaccine supplies;
- High impact services, most notably safe delivery and birth spacing, are not available, owing largely to the lack of trained midwives;
- Prevention of HIV/AIDS has shown some advance, especially in IEC messaging and community mobilization strategies. Linkages with health facilities and established VCT services are not well-developed.
- Many health facilities continue to have problem with functional sanitation facilities and adequate waste disposal measures. Since there has been no comprehensive survey of health facilities, it is not clear how many of them in different counties have WASH and waste disposal facilities.

Maintaining an appropriate balance between service delivery ("peace dividend") and building capacity and ownership has been difficult. While the strong emphasis on partnership is good, in some respects the programme expected unrealistically high levels of partnership from partners who either did not have the capacity or who were not clear about the programme objectives.

The CDOT and AIC appeared to assume that the mere provision of their assistance activities was evidence of their good results. In a context of limited resources and concern about quality, there should now be much more analysis and scrutiny of health interventions demonstrated by monitoring and accountability mechanisms.

4.3 Programme management

The long-term experience of local staff has been of high value to the programme. However, the need to mentor them was not sufficiently considered, especially given the shift from pure relief assistance to post-conflict reconstruction of the health system. The skills required for this transition period have been overlooked and staffing arrangements would have been more effective if technical and strategic guidance had been included in the programme from the beginning.

Due to management loads and lack of specific health expertise, NCA in Juba may not have been sufficiently attentive to problems being encountered by the programme. Even though the recruitment of a mid-level manager/adviser may not prove to be a cure-all for supply, supervision or monitoring problems, such position would likely reduce management burdens within NCA's Juba office and contribute to improve systemic problems.

Other factors that contributed to low efficiency include the little in-house experience in M&E; irregular supervision; insufficient analysis of health data; poor record keeping; and limited convergence achieved to implement the use of common reporting. The MFA programme indicators are, for the most part, quite broad and relatively difficult to measure.

4.4 Resource mobilization

In the next phase, the programme's design should benefit from a more pragmatic consideration of the scope of work proposed against limited resources. The level of funding committed by either MFA or CHF is largely insufficient for building the capacity of the health system as a whole.

Quality health care services in most counties will not be developed and sustained unless capacities of the health system at state and CHD levels are greatly strengthened. The HPF approach and its subsequent resources appear to be the main funding mechanism over the long-term, while offering organizations like NCA and its partners an opportunity to make important contributions to the health sector. There is a need however to consider the ability of the organization to rapidly scale-up its activities to the level prescribed by the BPHS framework and utilize a higher level of funding.

5. RECOMMENDATIONS

5.1. Overall recommendations

The recommendations below are intended **to better focus, prioritize, and set realistic expectations for programme activities.** The next phase must pay more attention to priority-setting. This will continue to be challenging while the MoH remain weak and ineffective.

5.1.1 Design phase: toward contextualized programming

1. NCA experience with the 3-year programme should now produce greater appreciation for the constraints that characterize post-conflict settings.

2. NCA Global Objectives and sectors should serve as guidance. They should be flexible and fine-tuned to the health context in South Sudan. The programme goal should be clearly linked to the Millenium Development Goals (i.e. contribute to reduced maternal and child mortality).

3. While it is important to involve all stakeholders and beneficiaries in the assessment phase, the risks of creating expectations that cannot be fulfilled should be carefully balanced against the benefits of such an exercise.

4. NCA should ensure appropriate technical input into health programme design. Input from the Health Adviser in Oslo HQ should be encouraged.

5. Improving the information base to support evidence-based decision making is an important first step. Needs assessment should include a review of key health statistics**.** The proposal should clearly refer to the BPHS and contain an analysis of facility-based activities, in particular[37]:

- Number of curative consultations by gender and age, disaggregated by location
- Number of malaria, pneumonia and diarrheal cases under 5 years
- Number of Vitamin A doses supplemented to children aged 6 -59 months
- Number of antenatal client 1st visit
- Number of DPT 3 administered to children under 1 year old

6. Consideration should also be given to conducting a rapid field assessment of infrastructure needs, WASH facilities, including disposal of medical waste, and staffing (number and category) at all health facilities. This assessment would give a clearer picture of current infrastructure gaps and staffing levels and suggest short-term and long-term strategies for renovation work and training needs. Data collected during this assessment should be put into a database.

7. No single actor will ever satisfy all basic health needs arising from a 21-year conflict country. If NCA is limited in terms of resources, it must stay focused on activities that will achieve greater impact and concentrate its resources on fewer health facilities:

7.1. Thematic focus: to strengthen the primary healthcare model proposed by the BPHS

- Improving women's and children (under five) access to basic health should be a top priority for NCA South Sudan. Although consolidated data are currently scarce, it is clear that women and children suffer a disproportionate burden of disease. Safe delivery and supporting safe childbirth should be given high priorities at PHCC level and in locations where there is a community midwife;

- There is a need to give greater emphasis to high impact services that are currently seriously deficient, especially child health services, including immunizations, provision of Vitamin A, staff training on Integrated Management of Children Illnesses, and WASH;

- The HIV and AIDS component should not be implemented in isolation of the health system. An in-depth situation analysis of HIV and AIDS trends should be conducted and appropriate strategies contextualized based on a set of epidemiological data and county-level analysis. In particular, consideration should be given to:

a. Establishing a VCT in Lohutok PHCC, Lopa/Lafon, and training one HIV counsellor;
b. Focusing BCC strategies on high-risk groups in Magwi county, health care providers and VHCs;
c. Training peer educators;
d. Exploring the possibility of collaboration with the Voluntary Service Overseas (VSO) adviser for developing the capacity-building of St Monica to access funding outside NCA;
e. Revisiting the current approach with the ECSS and LOWYDA
f. The value of micro-grants are questionable in the absence of monitoring and evaluation of their relevance and effectiveness

7.2 Scope of work: to gradually move away from direct support

a. Scale down the geographic coverage of interventions in Eastern Equatoria and design a strategy whereby AIC is empowered to take over (see 3.5.2);
b. Improve priority-setting in Eastern Equatoria: For 2013, **if there is no possibility to access the HPF**, the focus should remain on Lohutok PHCC and a maximum of ten PHCUs with a minimum level of committed and qualified staff and activities (hence the importance of facility-based data analysis, see recommendation n°5)

[37] The basis for this analysis should be Routine Monthly Report by Health Facility

c. PHCUs with no staff, offering only sporadic curative care and displaying a low level of activities, should not be included. If those PHCUs have a low level of activities, drugs supply from MoH should be sufficient to cover their needs.

8. Developing a comprehensive monitoring plan should be included in the design phase (See Annex 11 for an indicative template). Quarterly indicator tracking tables should also be developed during the design phase.

9. NCA should base health programmes on appropriate and realistic indicators to avoid confusion and ensure there are comparable cross time. The number and percentage should be both emphasized. Denominator should be given. The language to be used to describe achievement or results should be able to tell the change during the period. Few examples are given below:

Child health:
Number of children less than 12 months of age who received DPT 3 in programme-supported health facilities
% of children less than 12 months of age who received DPT 3 in programme-supported health facilities
Maternal health:
% of women with one ANC visit in programme-supported health facilities
% of deliveries with a skilled attendant in programme-supported health facilities
Health system strengthening:
Number of health personnel trained in immunization, diarrhoea and acute respiratory infection management
Number and % of supported health facilities that submit their HMIS monthly reporting forms within one-month of the reporting period

5.1.2 Programme implementation

10. Improving access and quality will require NCA and partners to focus on the following:

- **Culture of data/Focus on results**: There needs to be more attention paid to the quantitative aspects of health management. The review recommends that NCA develops monitoring charts for key indicators that allow NCA Health Officers to track performance on a quarterly basis. Health information and data quality issue should also be addressed.

- **Training, improved supervision and follow-up**: Training of health staff remains a top priority, especially in the following programme areas: malaria management; EPI; diarrhoea and acute respiratory infections; HIV/AIDS; hygiene and sanitation and; health information and its routine data collection. Updated MoH treatment protocols and guidelines should be provided. In order for training to be effective, follow-up and supportive supervision of health staff and VHCs should be enhanced. Efforts should be made to develop supervisory tools and to train staff in their use to ensure consistency. Adequate support to supervision at NCA field-office level should be encouraged.

- **Focus health education approaches:** There is a need to focus on health promotion as a way of building knowledge of important interventions. The use of VHCs needs to be thought through more clearly. It is recommended to focus on fewer messages directly related to achieving the BPHS objectives, such as ANC, breastfeeding, immunization and prevention of HIV/AIDS. It could also be beneficial to create women's groups to empower women on reproductive health and development issues and give them a greater voice.

- **Drug management** is a normal procedure for health programmes with a medical care component. Given the state of the existing system, there is a serious concern with the waste of

drugs. It is recommended that more focus on system improvements be given using short-term expertise and the tools developed by MoH (See recommendation n° 22). In addition, consideration should also be given to equipping health facilities with adequate shelving for appropriate storage of the different categories of drugs;

- **Infrastructure:** There are significant challenges with infrastructure. Based on the health facility assessment, priority should be given to addressing the most glaring deficiencies, e.g. insufficient capacity for drug storage and laboratory at PHCC Lohutok and poor medical waste management.

5.1.3 Programme Management

11. If NCA wishes to continue supporting the delivery of health services and be seen as having expertise in the sector, it would need to ensure that it has the necessary technical capacity and quality assurance systems to lead implementation.

12. In order to respond more appropriately and more effectively to future programming and implementation challenges, a qualified health professional with health system development skills and experience in post-conflict settings should be actively sought. Mapping out the existing resources within partner organizations in South Sudan or in the region should be encouraged. The position should be field-based, and relevant time allocated to each location. Given the extent of needs and capacity-building, greater time may be allocated to Eastern Equatoria.

13. Continuity in the advice and support given by the Health Adviser in NCA HQ should be encouraged. The Health Adviser should also play a lead role in programme quality assurance.

14. The promotion of adequate monitoring procedures and accountability should be enhanced. Before applying indicators, there is a need to train local staff on the M&E concepts and the monitoring processes. As far as possible reporting formats should be harmonized and directly linked to the reporting required to track a programme's progress – timing, indicators, and therefore its Logframe.

5.2 Recommendations for the remainder of the programme

There is little scope to reorient the programme and bring tighter geographical and strategic focus for more effectiveness and efficiency prior to its conclusion. The recommendations below however are intended **to prioritize key actions before December 2012**.

5.2.1 Strategic level

15. The collaboration between the MoH and the faith-based actors needs to be adapted to the evolving context of authority that will supposedly be with the CHD in the future. The distribution of roles and responsibilities need to be clarified. NCA and its partners should contribute to put the issue of positioning faith-based actors in national health system on the MoH agenda.

16. NCA is insufficiently resourced to respond to the demands of the BPHS, which is being implemented in complex and demanding circumstances and a large geographical area, with limited local resources. There is a need for NCA and its partners to consider the long-term context and to ensure that their health interventions are connected with future services and/or health funding strategies. NCA and its partners should therefore discuss and clarify their future role in the context of HPF. The possibility of forming alliances should be maximized.

17. Senior NCA staff in Juba should explore the Health Pooled Fund modalities and contact the Joint Donor Group in order to get more information on the funding possibilities for Eastern Equatoria and

Warrap states and funding application processes. The contact person would be Ms Dia Timmermans, Senior Health Adviser, Joint Donor Team[38].

18. There is a concern that if the salary issue is not addressed in a truly effective and cohesive manner, situation of beneficiaries and health workers could lead to further tensions and frustrations. NCA should continue lobbying with the MoH in Juba and SMoHs in focus-states.

19. Few synergies may have been created between health and WASH, despite the similarity of their work, and the impact of each one upon the other. The upcoming WASH review should look at the possibility and comparative advantages of merging and/or combining some aspects of the health and WASH programmes.

5.2.2 Operational level

Before the next design process (i.e. September 2012):

20. NCA and the CDOT should attempt to work out a hand-over strategy and identify opportunities for:

- Transferring the 3 health facilities (Magwi, Pajok and Pogee) to CDOT by December 2012;
- Planning the gradual transfer of the remaining seven health facilities either to CDOT or the potential lead-NGO under the HPF;
- Mapping out the human and financial resources required for the phasing out;
- Developing a specific health-related MoU to delineate role and responsibilities between NCA and CDOT in Torit and the county of Magwi.

21. The capacity of the AIC is currently not adequate for supervising primary health care facilities in the county of Lopa/Lafon. NCA needs to work with its partner to address the problems that have developed. NCA and AIC should make efforts to reconfigure the current support away from simply supplying drugs and move toward a more effective and pro-active capacity-building approach with a long-term view of transferring gradually the responsibilities for health facility support in Lopa/Lafon to AIC (see 3.5.2).

22. The minimum requirements for this approach should be as follows:

- AIC is willing to play a more strategic role in the health sector;
- One AIC health coordinator is appointed full-time to Torit;
- NCA provides guidance to support the integration of AIC in the health system (See recommendation n° 12)

23. In Eastern Equatoria, immediate priority should be given to addressing the deficiencies in drug management system, especially at PHCC level and active PHCUs. It is recommended that the existing MoH training modules (developed by Management Sciences for Health) and tools serve as a basis. Given the current workload, NCA should consider identifying one staff with previous experience in drug management. This should include short-term support to the NCA Health Officer, possibly up to 3 months. If this type of support is not available within NCA or its partner organizations, sharing best practices with NGOs may help identify the resources required. For example Merlin has been gradually improving its drug management system under the BSF support and may have access to a pool of qualified persons.

24. An organization such as NCA should also have a routine data collection and analysis to track the situation at facility-level and guide the further planning. The good practice noted for Warrap state should be used for Eastern Equatoria. The M&E officer and/or IT officer should train Health Officers on how to optimize data storage and use formula to link between Excel spreadsheets.

[38] The consultant made an attempt to contact her by email but did not succeed in getting feedback.

25. The indicators in the MFA Logframe should be revised to better reflect the implementation reality (see Annex 10 for modified version). However, the existing M&E and reporting gaps are limiting to the possibilities for improvements.

6. LESSONS LEARNED

Delivery and scaling up of health services in post-conflict settings is more difficult than other low-income settings due to poorer governance, and severe human resources and financial constraints.

There is recognition that there is no simple, single approach that will work. Health programmes tend to consist of multiple elements, not only focusing on service delivery but also addressing causes of low service utilisation, investing in staff and HMIS, and improving community awareness and participation.

The health needs in South Sudan cannot be adequately met by short-term, localised, project-specific and relief-focused intervention. The widespread structural deficit can only be addressed by working on a systemic and long-term basis and to scale-up aid interventions from local projects to national policies.

This requires a legitimate and competent MoH which can determine and coordinate national policy and resource health structures through which the BPHS can be implemented. In South Sudan the MoH simply does not have the capacity. How then should this process of scaling up proceed? One option is to follow through the logic of HPF which represents a potential mechanism for delivering assistance in a more effective and coordinated manner.

It should be recognized that one person cannot do everything. It is therefore necessary to commit sufficient and appropriate human resources right from the start, especially for specialist technical subjects and complex and demanding post-conflict situations. These human resources may be local, regional or international.

Health programming requires systems and monitoring framework. Development of a well-thought-out monitoring system with measurable indicators is also an integral component for good programme management and for transparency and accountability. Committing skills to this at the beginning of the programme will quickly bring useful returns. Training local staff on concepts new to them, for example Logframe, will also be important.

ANNEXES