Evaluation of the South Sudan Health Pooled Fund

Final Report

Final Version

Submitted to:

The Department for International Development (DFID) and Global Affairs Canada

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1.1 Introduction

1.1.1 Background

The South Sudan Health Pooled Fund (HPF) is a multi-donor funding mechanism, currently comprising of DFID (the lead donor), Canada, EU, Sweden and USAID[1]. It has a Steering Committee chaired by the Government of the Republic of South Sudan's (GRSS) Ministry of Health (MoH). Day to day management is provided by a contracted fund manager through a consortium led by Crown Agents for both phases (HPF1 & 2). Implementation is carried out in 23 smaller geographical areas, named 'lots', in eight[2] out of ten former states[3], by contracted NGOs – Implementing Partners (IPs) - using existing MoH facilities and health staff. Drug supply was contracted externally in HPF1, it was included under HPF2 and overseen by the fund manager.

HPF is responding to the huge health needs of South Sudan, exacerbated by many years of conflict and economic crisis, by supporting the implementation of the government's policies, strategies and plans, most notably the Basic Package of Health & Nutrition Services (BPHNS).

The key expected outputs remained broadly the same throughout HPF1 & 2 and focussed heavily on women and children:

- Strengthened service delivery
- Strengthened health systems (HSS)
- Community engagement
- Improved nutrition services (added for HPF2)

The envisaged implementation of Health Systems Strengthening (HSS) at the central level was halted to some extent due to the context in South Sudan. Gender equality & social inclusion (GESI) was included as a specific strategy during HPF2.

1.1.2 Methodology

The evaluation was guided by a number of evaluation questions (see section 2.3, Table 1). It used a mixed methods approach including a document review and interviews with key stakeholders in Juba. We also conducted field work in four counties which involved a beneficiary survey, interviews and focus group discussions, and a health facility observation survey. Given the challenge in obtaining beneficiary feedback, HPF donors asserted the importance of the field data collection. It should be noted that the sample of lots is not entirely representative as it covered only three out of 23 lots.

[1] USAID joined in HPF2 when the two USAID supported states were included in HPF, Australia was part of HPF1
[2] For HPF2; HPF1 only covered 6 states.
[3] These are the former states, as HPF does not follow the new structure with 32 states.

The evaluation had a number of limitations such as the security situation which made field visits impossible for the team members and also reduced the scope of the field surveys. The limited resources allocated to the evaluation limited its scope and depth. Nevertheless, the evaluation team finds that its findings as presented in this report are robust.

The findings were shared with key stakeholders, and their comments have informed the final report.

1.2 Main Findings

1.2.1 Relevance

Overall, the evaluation finds that the programme is highly relevant in that it is generally responding to the health needs of the people of South Sudan. It has paid particular attention to women and children who are especially affected by conflict and the socio-economic situation in the country.

Furthermore, HPF is well aligned to GRSS policies and plans. It has not been possible to fully implement the Health Systems Strengthening (HSS) component, particularly at the central level. Nevertheless, key systems have been strengthened particularly at state level and below.

1.2.2 Effectiveness

Overall, the programme has made significant achievements in meeting many of its targets. For example, since the beginning of the programme it has achieved more than a doubling of both the total patient attendance rate as well as the attendance rate for children under-five[4]. All respondents in Juba expressed favourable views of HPF and beneficiaries surveyed expressed a reasonable amount of satisfaction and indicated substantial improvements in service delivery over the lifespan of HPF. Given the extremely difficult operating environment of South Sudan, and the severe underfunding of service delivery (GRSS & HPF), these achievements must be deemed a substantial success.

The community engagement supported by HPF has already made progress on raising awareness and increasing service uptake. The planned enhancement of this community focus in HPF3 is likely to increase health outcomes for the people.

Attribution of all these results is difficult due to inputs from a variety of sources. However, HPF is assessed to have contributed substantially to the health sector in South Sudan given its size and allocation of around $8.5 per capita for services[5]. Moreover, it supports the majority of health facilities around the country, and health services would most likely not function without it.

[4] Based on HMIS/DHIS data for attendance and state populations provided by HPF
[5] The figure was calculated by using the total managed fund amount and dividing by population data provided by Crown Agents. NB: calculation does not include payment for the fund manager (see Annex 5.6)

Drug procurement and distribution is currently functioning quite well up until “last mile delivery”, the latter constituting an unsolved problem. Stock outs are frequent, in large part due to the significant underfunding of HPF and the GRSS’s inability to fund this area. However, other challenges play a contributing factor such as difficulties in forecasting drug consumption, delays due to weather or unrest, hoarding of drugs by the public when supplies arrive and pilferage.

HPF has contributed greatly to improving the Health Management Information System (HMIS), and it is found now to be reasonably effective in providing data on progress.

While there is almost no documentation or clear strategy around conflict sensitivity, the evaluation determines that programme implementation is most likely conflict sensitive due to the in-depth understanding of the context by local implementing partners. There are however specific issues around the harmonisation of salaries and incentives which do not support a conflict-sensitive approach. Responsiveness to emergencies has been increased by the introduction of the EP&R (Emergency Preparedness & Response) funding mechanism.

Coordination at all levels on HPF is mixed. There is coordination happening through government led bodies, such as the technical working groups, but there is considerable scope for improvements. This is mostly due to the lack of terms of reference, unclear responsibilities and little clarity on expected outputs. Similar problems are seen with the HPF Steering Committee, and the wider coordination body for development partners does not seem to be fully functioning. HPF attends the humanitarian Health Cluster, which appears to be working well, although there is a lack of coordination between development and humanitarian actors.

The nutrition component, implemented with substantial inputs from other partners, has been successful, both in terms of exceeding its targets, and achieving a fair amount of consumer satisfaction.

1.2.3 Gender equality and social inclusion

The HPF programme has made considerable efforts to mainstream gender issues in its programme. This is evident by the improved knowledge and awareness of gender issues among IPs, as well as the existence of some gender focused interventions in the communities and health facilities. However, there has been less attention paid to the social inclusion part of the GESI strategy.

Gaps still exist in implementation, and efforts should be made to encourage an intersectional approach to implementing the GESI strategy.

Service delivery in some gender-related areas seem less satisfactory, including on sexual and reproductive health and HIV/STI counselling and treatment. Moreover, family planning uptake is very low. The lack of specific targeting of youths was also seen as an area for improvement.

1.2.4 Efficiency

Overall, the evaluation concludes that HPF provides value for money (VFM), through its proven support to cost-effective strategies. It provides the right inputs in terms of staffing, drug supplies, support for key strategies, including community engagement, and more recently, on gender equality. Addressing social inclusion issues has so far been lacking, though it was identified as an area to improve in the upcoming phase.

Contributing to VFM is the effective management of HPF, and an implementation model that we find appropriate for the context of South Sudan. Tendering procedures and financial management is also deemed strong, and the long-awaited change from an Excel-based system to dedicated accounting software is underway.

HPF supports outreach activities that are a cost-effective way of addressing the severe lack of health facility coverage. The use of community-based structures has increased efficiency through increasing demand and encouraging positive behaviour change.

One major cause of inefficiency is the underfunding of HPF, as this leads to the low remuneration of facility staff and therefore understaffed facilities led by unqualified health workers. It is also a significant factor in the insufficient drug supply.

1.2.5 Sustainability

There are currently no prospects for long term sustainability in the programme, neither financial nor institutional. Nevertheless, some elements of HPF are likely to have some lasting effect beyond the end of the programme. These include capacity building, health committees, and good health practices promoted by the programme's awareness-raising activities.

1.3 Conclusions

The HPF design and implementation is an example of good practice in a context like South Sudan.

Underfunding of HPF 2 has had a significant negative impact on the programme, particularly regarding inadequate drug supply and insufficient staffing.

HPF has been a major contributor to improved service delivery, and beyond any reasonable doubt, to improving or sustaining health outcomes.

The programme has had some positive effect on health system strengthening such as through the strengthening of HMIS.

GESI activities are important, and many are just starting up. This is an area that needs to be boosted, although the evaluation acknowledges it is not easy given the level of resources and South Sudanese context.

1.4 Overall Recommendations

1. The **Steering Committee** should become more efficient in providing strategic guidance to HPF, and its membership expanded in order for it to function as a coordinating body for service delivery, including the World Bank supported states. It, as well as the **technical working groups,** should have TORs with clear responsibilities and defined outputs.
2. A strong advocacy effort should be mounted by all stakeholders to mobilise much needed **additional funding** for this effective mechanism of providing health services for one of the poorest populations in the world.
3. HPF should develop a **communication and advocacy strategy** for all levels of the organisation, and for external audiences.
4. **Learning** should be improved and systematised at all levels.
5. **Community engagement** should be more bottom-up and demand driven.
6. The issue of "last mile" **drug delivery** and the role of the county health departments (CHDs) should be addressed by the MoH, HPF and other partners.
7. A smooth **transition in contracting from HPF2 to 3** must be achieved to avoid interruptions in service delivery, which could otherwise potentially cost lives.

Other recommendations include:

- Strengthen the staffing at the DFID South Sudan office;
- Support the MoH's intentions of having a more uniform approach between the HPF and the World Bank supported areas;
- Explore the issue of user fees and how to address it if it is a significant problem;
- Document and analyse the issue of drug leakages, to assess whether this is a significant problem, and if so, how to address it;
- Assess if HPF should play a role in strengthening pre-service training institutions in South Sudan;
- Conduct a baseline study of gender issues.

1.5 Overall Lessons

A pooled funding model is an effective modality in fragile states provided its design is based on the context[6], and the evaluation considers the South Sudan HPF a highly successful model given the context. The structure allows for constructive engagement with the government at the sector level through technical staff in the MoH, as well as decentralised structures, even in situations where the donor community has conflicts with the leadership of the country. Success stories, such as the HPF, should be communicated effectively to the international community in order to attract much needed funding.

[6] Pavignani & Colombo, 2017, Recurrent failings of medical humanitarianism: intractable, ignored or just exaggerated?

Acronym List

ADRA – Adventist Development and Relief

ANC – Antenatal Care

BEmONC - Basic Obstetric & Neonatal Care

BHC – Boma Health Committee

BHNP – Boma Health National Policy

BPHNS – Basic Package of Health & Nutrition Services

CAIPA – Crown Agents & International Procurement Agency

CCM – Comitato Collaborazione Medica

CEmONC - Comprehensive Obstetric & Neonatal Care

CHC – Community Health Committees

CHDs – County Health Departments

CIDA – Canadian International Development Agency

CMAM – Community-based Management of Acute Malnutrition

CMR – Clinical Management of Rape

DALYs – Disability-adjusted Life Year

DFAT – Department of Foreign Affairs and Trade

DFID – Department for International Development

DG – Director General

DHIS – District Health Information Software

EDL – Essential Drugs List

EP&R – Emergency Preparedness & Response

EPI – Expanded Programme on Immunisation

EU – European Union

FGD – Focus Group Discussion

FP – Family Planning

GBV – Gender Based Violence

GESI – Gender Equality and Social Inclusion

GRSS – Government of the Republic of South Sudan

HHP – Home Health Promoters

HIV – Human Immunodeficiency Virus

HMIS – Health Management Information System

HPF – Health Pooled Fund

HRIS – Human Resources Information System

HSDP – Health Sector Development Plan

HSS – Health Systems Strengthening

ICCM – Integrated Community Case Management

IDPs – Internally Displaced Persons

IIEC – Information, Education & Communication

IO – In Opposition

IPs – Implementing Partners

KII – Key Informant Interview

LFAs – Logframe Assessment

M&E – Monitoring and Evaluation

MCG – Mother Care Group

MIYCN – Maternal Infant and Young Child Nutrition

MoH – Ministry of Health

MSI – Management Systems International

MTR – Mid-term Review

NGO – Non-Governmental Organisation

OECD – Organisation for Economic Co-operation and Development

PFM – Public Financial Management

PHCC – Primary Health Care Centre

PHCU – Primary Health Care Unit

RMNCH – Reproductive Maternal New-born and Child Health

SC – Steering Committee

SMoH - State Ministry of Health

SRH – Sexual and Reproductive Health

SSA – Sub-Saharan Africa

STI – Sexually Transmitted Infection

TBA – Traditional Birth Attendants

TOC – Theory of Change

TOR – Terms of Reference

UN – United Nations

UNFPA – United Nations Population Fund

UNICEF – United Nations Children's Fund

USAID – United States Agency for International Development

VFM – Value for Money

WaSH – Water Sanitation and Hygiene

WFP – World Food Programme

WHO – World Health Organisation

2 Introduction and Background

2.1 Context of the development intervention

The Health Pooled Fund (HPF) is a multi-donor trust fund led by the Department for International Development (DFID) which aims to establish an effective public health system that will deliver improved access to quality health services in South Sudan and respond to emergency needs where required, with a specific focus on reducing maternal and child mortality. It will reach the end of its second phase in September 2018 and this evaluation will cover the first (2012-16) and second (2016-18) phases of the programme. The third phase will commence in October 2018 with the intention of minimal disruption to service delivery.

The first phase of HPF covered six of the ten former states of South Sudan[7] and was funded by DFID, Global Affairs Canada (formerly CIDA), the Swedish Government, AusAid/DFAT and the European Union (EU). USAID joined HPF in the second phase, bringing with it the two states where it had been funding health, Central and Western Equatoria, while AusAid/DFAT ceased its funding. Since the start of the programme the Government of the Republic of South Sudan (GRSS) has made changes to the number of states, first from the original 10 to 28, and then to 32 states in January 2017. The new states are not formally recognised by the UK government and were not budgeted for in HPF2, and HPF therefore still refers to the original 10 states in its work.

Although most services supported by HPF are implemented by non-government organisations (Implementing Partners, IPs), the GRSS, particularly the Ministry of Health (MoH), remains a principal partner.

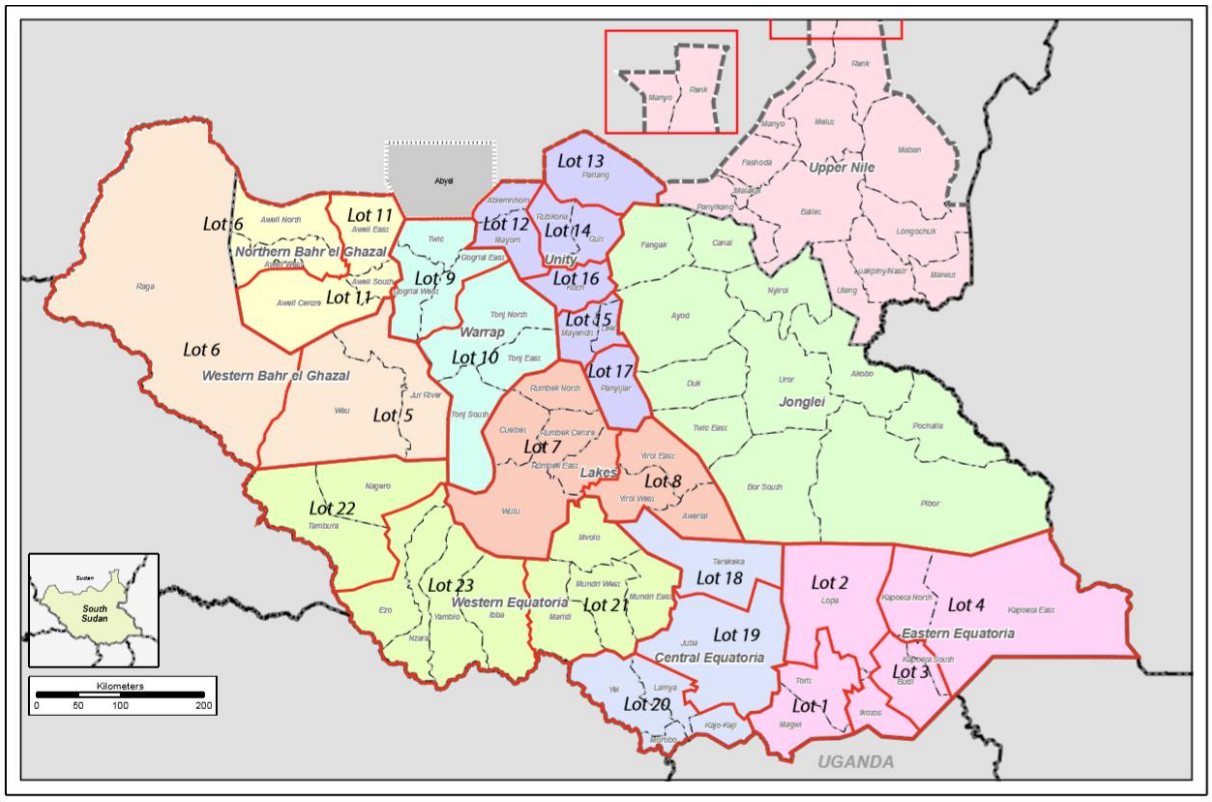
Day-to-day management of both HPF1 and 2 have been led by a fund manager run by a Crown Agents-led consortium. They are based in Juba with representatives in each of the former states. The fund manager contracts IPs to deliver HPF across the country. In HPF1 there were numerous separate contracts for different IPs (different counties, hospitals etc.). This shifted to a lot model in HPF2 with the eight states being split into 23 different lots, each managed by a lot lead, which could be represented by the lead of a consortium of IPs or manage the lot by itself. As of June 2017, there were 16 lead IPs supporting 1,038 health facilities across the HPF states.

Another key part of HPF is the procurement of essential medicines for 1,321 health facilities across the eight former states supported by HPF[8]. In HPF1 procurement and supply of drugs

[7] Warrap, Northern Bahr-el Ghazal, Western Bahr-el Ghazal, Eastern Equatoria, Lakes and Unity.
[8] Health Pooled Fund Annual Report 2016-17,2017, p.10. In 2016 HPF also temporarily supplied the World Bank supported states, after the World Bank had stopped its operations for some time due to unrest.

was managed by an outside actor CAIPA (Crown Agents & IPA), and in HPF2 it became the responsibility of the fund manager, with the consortium partner IPA leading on this element.

Figure 1: HPF2 Lot Boundaries



Map source: HPF fund manager

HPF was designed to respond to the huge health needs in South Sudan, which has some of the worst health indicators in the world, including extremely high levels of maternal and infant mortality at, 789 per 100,000 births and 88 per 100,000 births respectively[9].

The context has become considerably more challenging since conflict broke out in 2013 in some parts of the country. There has been ongoing violence since then, and in 2016 this spread to parts of the country which had previously been relatively stable. This conflict has led to mass displacements of people, and hugely disrupted health service provision. The effects of the fighting in Juba in July 2016 should not be underestimated, with most organisations and donors working on HPF evacuating their staff just before the fund manager was due to contract IPs for HPF2.

The conflict has also had a huge economic impact, with falling government revenue and high levels of inflation affecting individuals and the government budget. This, coupled with a very low percentage of public funding allocated to health, has had a significant impact on the MoH budget with minimal amounts being inputted into the health sector including provision of drug

[9] HPF Logframe 2015 Baseline, UNICEF, World Bank and South Sudan Household Survey data.

supply, rendering it unable to meet the health needs of the population. In January 2018 the Integrated Food Security Phase Classifications estimated that 5.3 million people (48% of the population) were facing acute food insecurity[10] meaning it is likely that health needs will continue to grow.

There are a number of other humanitarian and development actors working in the health sector in South Sudan, although HPF is one of the largest. As mentioned, the World Bank supports the Ministry of Health to deliver services in the two former states where HPF does not operate, Jonglei and Upper Nile. However, service was disrupted for an entire year as the World Bank pulled out of South Sudan completely due to the outbreak of conflict in July 2016. HPF provided funding for one round of procurement, but the two states were left with minimal health service provision otherwise. The current World Bank programme works on a similar model to HPF, with a major difference being that it directly contracts a mix of NGOs and County Health Departments as implementing partners.

HPF donors also fund other health programmes, and there is ongoing work to coordinate these endeavours as effectively as possible. For example, DFID South Sudan's community health programme ICCM (Integrated Community Case Management), funds the training and supervision of community health workers to treat children under-five in hard to reach areas. Where possible, ICCM will be integrated into the Health Pooled Fund for phase three from 2019. This focus on community health is aligned with the Ministry of Health's Boma Health Initiative, which focuses on providing community health care at the most local level.

It is important to understand the wider context that HPF is operating in, one of decreasing international funding to South Sudan. The UN's $1.7 billion humanitarian response plan for South Sudan is less than a quarter funded[11], and all donors report challenges with funding, particularly considering the huge needs in the country. This puts pressure on already existing programmes such as HPF, and on donors working in the country.

2.2 Theory of Change

The key outputs and outcomes of HPF are outlined in the programme Theories of Change and Log Frame Assessments, which have been adapted throughout the life of the programme. The outputs however, remain broadly the same overall and focus largely on women and children and include:

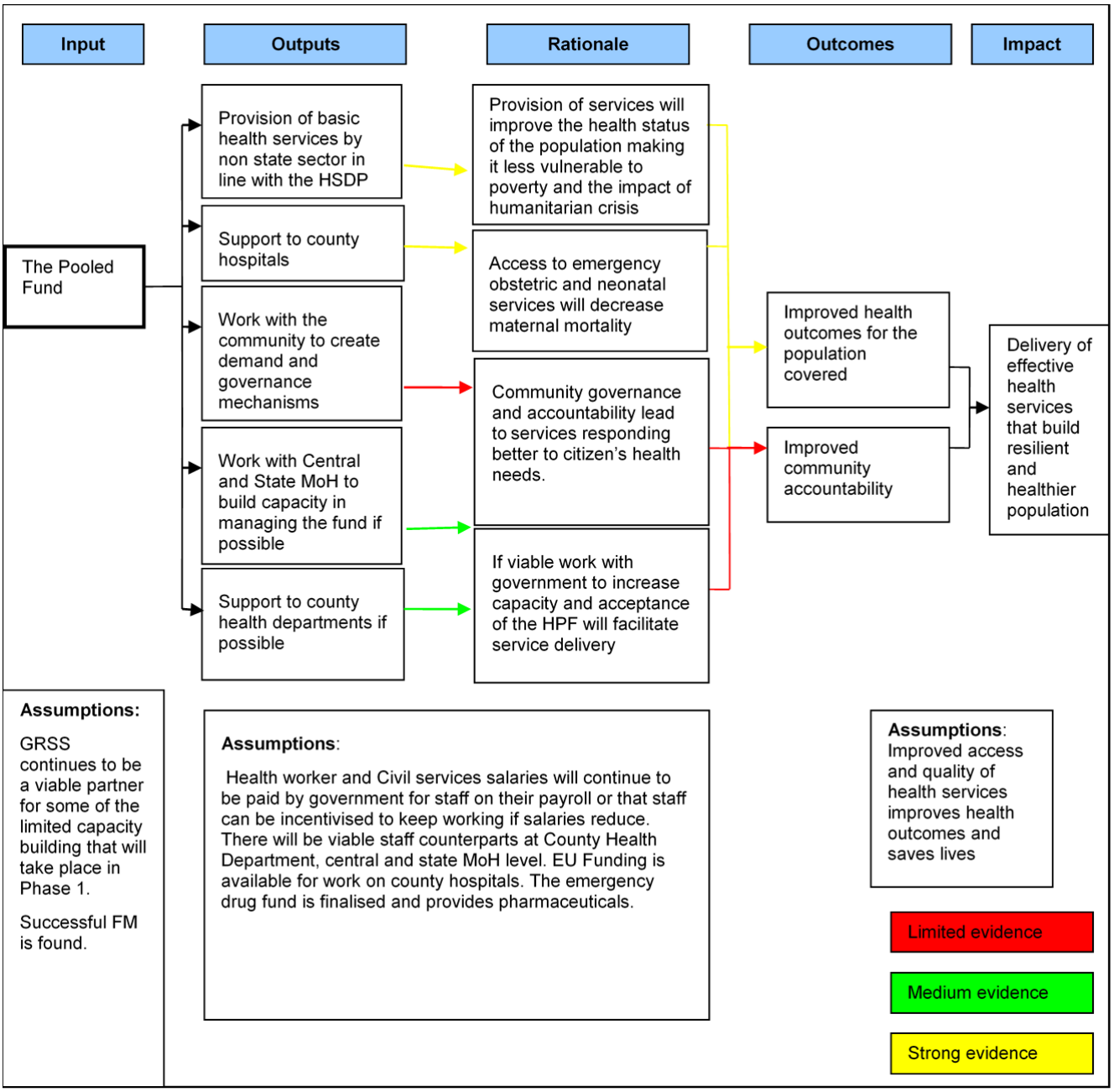
- Strengthened service delivery
- Strengthened health systems
- Community engagement

[10] Integrated Food Security Phase Classification, January 2017, South Sudan: Current (January 2018) and Projected (Feb-Apr 2017; May-July 2018) Acute Food Insecurity and Acute Malnutrition Situation
[11] Reliefweb: https://reliefweb.int/report/south-sudan/south-sudan-suffering-almost-unimaginable-scale-warns-un-relief-chief

- Improved nutrition services

One key difference is the addition of nutrition services as an output in the log frame for the HPF2 and the removal of community engagement as a specific output. While this indicates an increased focus on nutrition, we do not take it as a decrease in importance of community engagement, noting that this aspect has been included under the Health Systems Strengthening (HSS) output (i.e. there is a specific indicator). A large community engagement component has also been included in HPF3. See also Annex 8 regarding the developments of HPF ToCs and LFAs.

Figure 2: HPF2 Theory of Change



The evaluation finds that the rationale linking the outputs with the outcomes in the HPF ToC is for the most part sound, although it was not possible to fully test these linkages because there was no baseline carried out before the beginning of HPF2.

Some of the key assumptions underpinning the ToC have not been born out due to the challenging context in South Sudan, with the government's inability to pay health worker and civil service salaries the most relevant of these.

2.3 Evaluation Questions

The evaluation aimed to respond to the questions outlined in the table below. Our findings section is arranged according to these eleven questions.

Table 1: Evaluation questions as per the evaluation ToR

RELEVANCE
1. To what extent has HPF identified, understood and responded to the essential health needs (as defined by the programme) of women, men, girls and boys in South Sudan?
2. To what extent has the HPF aligned with the health sector priorities of the Government of South Sudan?
EFFECTIVENESS
3. To what extent have the expected outputs and outcomes been achieved, in particular for children under age five and women, and what have been the main factors influencing the achievement or non-achievement of results? Were there unintended and/or negative results?
4. To what extent was HPF programming in South Sudan conflict sensitive, and consistent with the OECD principles and best practices for Fragile and Conflict-Affected States?[12]
5. To what extent was the HPF coordinated with other stakeholders involved in delivering essential health services throughout the country?
6. To what extent has the nutrition component of the programme been successful in integrating nutrition into the package of health services offered and achieving its expected results?
GENDER EQUALITY
7. To what extent has a Gender Equality and Social Inclusion Strategy been implemented?
8. What were the main gender-based barriers and challenges to programme delivery and achievement of outputs and outcomes?
EFFICIENCY
9. Were human and financial resources used in a cost-effective way for the outcomes achieved, in light of the operating context, needs of the beneficiaries, priorities of the MoH, and the organizational and management structures of the HPF? Was the programme implemented in the most efficient way compared to possible alternatives?
10. Has the community-based approach trialled in HPF for treating common diseases in children under five been a cost-effective approach in the context of limited access to formal health facilities?
SUSTAINABILITY
11. What steps have been taken to create or integrate with long-term processes, structures, norms and institutions for sustaining the investments made by HPF?

[12] See, for example, the following list of Organisation for Economic Co-operation and Development (OECD) publications:
OECD, Conflict and Fragility, link.
See also New Deal: Building Peaceful States, last modified in 2015, link.
See also OECD, last modified in 2015, Aid Effectiveness - Paris Declaration on Aid Effectiveness and Accra Agenda for Action, , link.

3 Purpose, scope and methods

3.1 Purpose and Scope

The purpose of the evaluation is - through a performance evaluation - to provide:

- Accountability to each country that has contributed to the Health Pool Fund (HPF);
- Learning for the continuation of HPF, as well as for the health system in general. Including to develop key recommendations for the continuation of HPF that delivers relevant, effective, efficient and sustainable delivery of essential health services for the people of South Sudan.

The specific objectives[13] of the evaluation are to:

- Assess the relevance, effectiveness, and efficiency (including value for money) and sustainability of the HPF, and how gender equality considerations were integrated.
- Identify areas of best practice in programme design and delivery and develop recommendations for the delivery of a future/successor programme.

The scope of the evaluation includes examination of the entirety of HPF1 and 2. The donors to HPF were particularly interested in gathering information on the perceptions of beneficiaries and staff at the county and facility level, given their limited access to field visits. Hence, a lot of the evaluation's resources were aimed at collecting qualitative and quantitative data from the field.

It is important to note that the fund manager for HPF3 was procured during the evaluation, meaning that the findings presented did not inform the design of HPF3. Instead our findings and recommendations aim to inform the implementation of HPF3, which will begin in October 2018. The two former states funded by the World Bank are out of the evaluation's scope, though the team interviewed some relevant stakeholders from the organisation for a contextual understanding. While the evaluation touches lightly on issues around procurement and supply chain management, it does not provide an in-depth analysis which were also out of scope.

3.2 Methods & Team Structure

The evaluation used a mixed methods approach to respond to the evaluation question above. Realist evaluation approaches were also utilised, focusing on how the interventions affected different beneficiaries; i.e. what worked best, for whom and in what context, as well as the effectiveness and efficiency of interventions.

Two principles informed the approach which included maintaining a close dialogue with the client and MoH to ensure alignment with intended outcomes and priorities; secondly, through

[13] As stated in the Evaluation TOR

recognising the findings and recommendations as key in informing the implementation of HPF3, including consultation with a broad range of stakeholders.

Further details on data collection can be found in Annex 4 & 5, alongside data analysis of all data sources in (Annexes 5.1 – 5.5).

The evaluation team consisted of a Team Leader, M&E Expert, Quantitative Expert, Gender and Social Inclusion (GESI Expert), Project Manager and Project Director. The team was supported by a South Sudanese think-tank for the field work component, the Sudd Institute.

The evaluation ran from January-May 2018 with a six-week inception phase at the start. The Team Leader, Project Manager and M&E Expert travelled to Juba for two weeks in February and March to train the field team and conduct interviews with Juba-based stakeholders. The field team deployed shortly afterwards.

The evaluation findings were shared with key stakeholders including the Steering Committee (HPF donors and the Ministry of Health), IPs, the HPF fund manager and other health actors including UNICEF and Health Cluster representatives at a stakeholder engagement workshop on May 2, 2018. It is hoped that alongside its role in informing the implementation of HPF3, the evaluation findings can be a useful resource for those working in the health sector in South Sudan and other similar contexts.

Phase 1: Desk Review

The team conducted an in-depth review of programme documentation to understand the operating context, identify information gaps and understand stakeholder practices. The design of the evaluation and tools were largely based on this information.

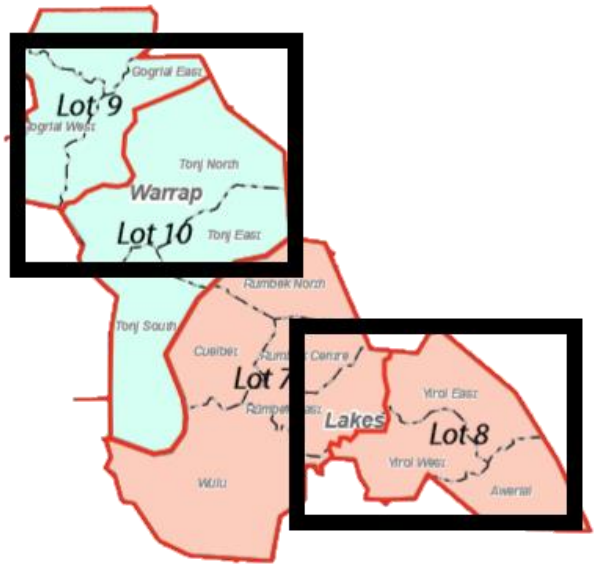
Phase 2: Field work

Our partner, the Sudd Institute, led on the field work outside of Juba, which was carried out across three lots in four counties within two former states. One team travelled to Gogrial East and Tonj North in Warrap (lots 9 and 10) and the other to Yirol East and Yirol West in Lakes State (lot 8). Although lots 9 and 10 are led by different IPs (CCM and World Vision respectively), the county we selected in lot 9 is managed by World Vision (which is a subcontractor in the lot). Both counties in lot 8 are managed by the IP CUAMM.

Field work took place between March 7 and March 26, 2018, and the two teams visited twenty health facilities in total (1 hospital, 8 Primary Health Care Centres and 11 Primary Health Care Units).

We also carried out key informant interviews (KIIs) with key stakeholders in Juba including HPF donors, the HPF fund manager, the MoH, IPs, and other health actors. A full list of interviewees is presented in Annex 7.

Figure 3: Field Work Areas



Field team orientation

To ensure the understanding of the field team regarding the proposed evaluation monitoring process, tools and expected results, we conducted a three-day training session, as well as a pre-test of the tools at Al-Sabbah Children's Hospital and Juba Teaching Hospitals in Juba. The training focused on adhering to the principles of 'do no harm', and ethical data collection, ensuring that only consenting participants were engaged.

Qualitative data collection

We collected qualitative data using focus group discussions (FGDs) and KIIs and developed a set of English and local language tools in the form of semi-structured question guides to facilitate rigorous, quality data collection. The field teams conducted data collection with a range of different groups including beneficiaries, community health committees, health facility staff and MoH at the national, county and state level.

Quantitative data collection

In addition to the qualitative data, the evaluation team developed a beneficiary survey using mobile data collection and the KOBO Toolbox platform to enhance data quality and security in the challenging environment.

Alongside the beneficiary survey we conducted a health facility survey at all twenty facilities visited. The survey included an assessment of patient loads, staff number, accessibility, environment, and drug and equipment availability.

Gender considerations

The evaluation included a gender analysis of key programme outcomes and outputs, which are embedded throughout the entirety of the findings of the report, as well as a focused

analysis in a separate chapter. An intersectional lens was used to understand how gender, age and other societal factors influence the impact of the interventions for target groups.

Phase 3: Data analysis & Quality Assurance

Data analysis involved rigorous evaluation techniques including a thematic content approach to the qualitative data and statistical analysis such as equivalence testing of the quantitative data to determine whether there were significant differences in performance across the various lots. As part of the data quality assurance process, an initial quality check was conducted by the team leader before being shared with the M&E Expert. The M&E expert, along with the analyst and quantitative expert, oversaw the analysis. The gender expert was also involved in reviewing the data and all the findings.

3.3 Conflict of Interest

There was no conflict of interest (COI) in conducting this evaluation. Checks were undertaken of team members as well as our local partner, the Sudd Institute, to ensure that no party had been involved in implementation of HPF 1 or 2. Moreover, the team communicated to DFID that team members had explicitly avowed to not be a part of any bid for phase 3 implementation of the programme.

The team was able to work freely and without interference on the evaluation. There was one issue around team members not being able to travel outside of Juba to conduct fieldwork due to work permit restrictions enacted by the GRSS, which is outlined in more detail in the limitations section of the report (section 5). However, this did not impact on the team's ability to conduct the evaluation and analyse the robust amount of data we received from our local partner.

4 Evaluation Plan

The following section provides an overview of the various methods that will be used to address evaluation questions within the overall five domains (relevance, effectiveness, gender equality, efficiency and sustainability):

4.1 Relevance

Key informant interviews (KIIs): KIIs were undertaken in Juba to elicit feedback from the MoH regarding the extent to which the HPF has identified, understood and responded to the essential needs of the South Sudanese population. Furthermore, they were used to understand whether the HPF has aligned with the health sector priorities of the GRSS.

Programme documentation (HPF, donors and MoH): Key documents were reviewed from relevant stakeholders including the HPF, all donors and the MoH in order to understand the achievements and challenges in the relevance domain.

KIIs & focus group discussions (FGDs): KIIs and FGDs were conducted with beneficiaries in the field and facility staff at both the county and state level to inform the extent to which evaluation questions under the relevance domain were achieved.

4.2 Effectiveness

Programme data and documentation: HPF data and documentation, as well as DFID Annual Reviews were analysed to understand the extent to which the programme has achieved the expected outputs. These were also used to assess whether HPF programming was conflict sensitive, and whether the nutrition component of the programme was achieving its results.

KIIs and FGDs: KIIs were carried out in Juba and in the field to understand HPF's coordination with other stakeholders, the implementation of the nutrition component and the extent to which HPF is conflict sensitive.

Beneficiary survey: A survey was conducted with beneficiaries in three HPF lots to understand uptake and satisfaction with services.

Facility survey: A survey of twenty health facilities was carried out to inform our understanding of the main factors influencing the achievement or non-achievement of results.

4.3 Gender Equality

Gender analysis: A gender analysis was carried out on all documents to evaluate the extent to which the Gender Equality and Social Inclusion strategy had been implemented, and the main gender-based barriers to programme delivery. A gender analysis matrix tool was also developed to assess key enablers and barriers to access.

KIIs: Interviews were conducted in Juba, the field and remotely to triangulate the findings from the gender analysis.

4.4 Efficiency

Document review: We reviewed HPF and DFID documents to assess whether human and financial resources were used in a cost-effective way for the outcomes achieved.

KIIs: We conducted KIIs at the national, state and county level to assess the key costs drivers, the management structure of HPF and cost-effectiveness of the community-based approach.

Beneficiary survey: The survey was used to assess the effectiveness of the community-based approach.

4.5 Sustainability

KIIs in Juba: We conducted KIIs with the MoH, DFID and HPF to understand what steps had been taken to ensure the programme was sustainable.

5 Limitations

5.1 Methodology

Our approach was limited by the current security situation in South Sudan and the time and funds available for the evaluation. These limitations meant that we were only able to visit four counties in two former states of South Sudan. These four counties were areas that are relatively more secure and are mainly inhabited by people of the Dinka Tribe. We were guided in the selection of mainly Dinka areas primarily by our national partner the Sudd Institute, who had significant safety concerns around conducting fieldwork in other HPF areas. These concerns also limited the field work to government-controlled areas. Selection of the data collection locations was also guided by the needs and interests of DFID and Global Affairs Canada, who were particularly interested in gathering data from facilities and areas less accessible to donors. These include more rural locations, and some areas that had been affected by intercommunal violence such as Gogrial East and Lakes.

It is therefore important to note that these areas do not present a representative sample of the whole country context, and in fact are comparatively easy areas to implement HPF in terms of security and access. Therefore, findings, conclusions and recommendations should not necessarily be generalised across the whole of South Sudan, though it was determined through data collection that many areas face similar issues but are more exacerbated in conflict-affected regions.

Although it was not possible to fully mitigate the impact of only visiting four counties, we spoke to IPs operating in all eight states during our Juba-based interviews, prioritising those who worked in the most challenging lots[14].

Our methodology was also limited by the availability of data in South Sudan. A baseline was not carried before the programme was started. Baseline data used to measure progress is derived from estimates from the 2006 South Sudan Household Survey. This limits our ability to truly assess the progress of HPF in achieving some of its outputs. As this limitation was known in advance of the evaluation, this has not had a significant impact on our findings.

Although data used regarding health facility coverage is from 2011, there have been not been major construction of facilities, so the data is assumed to generally be valid. We further acknowledge that population figures are based on old data, with each subsequent year's data being estimated by assumed population growth rates. This gives rise to some inaccuracy which is further exacerbated by displacements of population groups within the country. Consequently, the denominator underpinning many rates can sometimes be wrong though we

[14] These areas were confirmed by HPF.

do not think it impacts on our conclusions significantly due to the fact that it can cause rates to be too high or too low.

5.2 Data Collection

We encountered a number of challenges during our data collection in Juba and the field outlined below.

We had planned to interview a number of MoH staff during our two weeks in Juba. Unfortunately, due to a busy travel schedule by many MoH Director Generals (DGs), we were unable to gather as much data from them as we had hoped. However, we were able to present our findings to the MoH and receive considerable feedback on these during a dedicated session in early May attended by five of the DGs and chaired by Dr Baba, the special advisor to the Minister.

South Sudan is an extremely difficult place to collect primary data, with poor infrastructure, insecurity, bad connectivity and unreliable flights. Our field teams were impacted by all of these.

The teams were delayed by irregular and cancelled flights travelling to and from the field. This pushed our timeline back, as it took longer to receive the data. One team leader was particularly affected and had to spend an extra week in the field, limiting his ability to quality assure some of the data. Although we were not able to fully mitigate these issues, we were able to reallocate some of the days for data analysis amongst team members, and the project manager travelled to Juba to debrief with the field teams in person.

We had planned to visit the hospitals in two of the four counties chosen for fieldwork (the other two did not have hospitals). Unfortunately, due to the poor road conditions and long distance in Tonj North, the team were not able to visit Marial Lou Hospital, meaning we cannot compare data between hospitals. Although this limits the findings of our evaluation, hospitals are generally far more accessible than the lower level facilities (PHCCs and PHCUs), with donors and HPF management able to visit most hospitals fairly regularly. This means that the bias of the sample of health facilities to PHCUs and PHCCs should not have too significant an impact on the usefulness of the evaluation findings.

During the inception phase we developed a comprehensive system of quality assurance for the data. Unfortunately, this was affected by a number of factors. One of the most significant was that our M&E expert was not able to accompany the field teams during data collection because of recently introduced laws barring non-South Sudanese from travel outside of Juba without a work permit. Work permits cost 4000 USD and take time to obtain meaning it was not realistic for any of the evaluation team members to travel to the field. In addition, delays to the fieldwork meant that our window for quality assurance was significantly reduced. One of

the key mitigation measures was the debrief between the project manager and the field teams carried out in early April 2018. This allowed us to fill in some of the missing information and gather more information related to the challenges during data collection.

Although the field teams contained enumerators from the areas that were visited for the evaluation, they did encounter some language barriers in Lakes State. Although Lakes is almost entirely a Dinka area (a language our field teams spoke), some areas of Eastern Lakes speak a dialect which is much closer to Nuer. This meant that the teams had to use an interpreter for a small portion of the data collection, potentially losing some of the nuance of the qualitative answers.

One of the counties visited - Gogrial East – had recently experienced intercommunal conflict (late 2017). Local people had fled from the area and were only recently started to return at the time of the fieldwork. This meant that there were lower numbers of patients at the facilities visited who could participate in FGDs and the beneficiary survey.

One of the target groups for the beneficiary survey and FGDs were gender-based violence (GBV) survivors. Unfortunately, neither team were able to access these groups, as they were not able to spend enough time in each area to build the trust of survivors. There was a trade-off in terms of number of facilities visited and our ability to access all the stakeholders planned.

5.3 Data Analysis

A quality review of the data, limitations of the data analysis and mitigation strategies are included in Annex 4.

6 Findings

The findings section is largely structured according to the TOR's Evaluation Questions and the Methodology Framework agreed during the Inception Phase.

6.1 Relevance

This section assesses the appropriateness of the HPF programme to the health needs of the people of South Sudan and to the alignment with country priorities. Overall, the evaluation finds that the programme is highly relevant in that it is generally responding to the health needs of the people of South Sudan and is well aligned to GRSS policies and plans.

Key Strengths and Achievements

- Needs of general population (including women and children) are adequately identified in GRSS HSDP & other key MoH strategies;
- Basic Package of Health Nutrition & Services emphasizes services related to RMNCH including diseases responsible for DALYs lost & disabilities;
- HPF has strengthened the health system despite the context and has worked closely with the MoH.

Key Challenges

- HSS has not been fully implemented, although this is mostly due to the changing context;
- There appear to be missing services aimed at youth & disability;
- No clear evidence on involvement of beneficiaries in design / minimal consultation with state, county and community level on design of HPF 3;
- Lack of clarity around HPF uptake of feedback from health committees, community leaders, state MoHs & CHD staff;
- HPF's continued use of former 10 state structure has led to challenges.

6.1.1 Alignment with needs of the people of South Sudan

The evaluation finds that the needs of the general population as well as women and children are adequately identified in the GRSS Health Sector Development Plan (HSDP 2012-2016) and other key Ministry of Health (MoH) strategies, which is the foundation of the HPF. Guided by this, the programme has a specific focus on reproductive, maternal, new-born and child health (RMNCH), as well as having an objective of equity.

The Basic Package of Health & Nutrition Services (BPHNS 2011), that HPF assists in implementing, puts emphasis on primary care services including those relating to RMNCH, as well as on the diseases responsible for most DALYs lost (disability-adjusted life year) and disabilities. It prioritises community-based health care, that can be delivered close to the client, which is particularly important for the people of South Sudan, given the low coverage of health infrastructure. Furthermore, it emphasizes health promotion, which has the potential of

preventing many of the most prevalent diseases in South Sudan and improve health related behaviour.

Table 2: Snapshot of BPHNS

Component	Sub Component
Integrated Reproductive Health Services	Essential Obstetric Care
	Protective SRH for women
	Adolescent SRH
	Men's SRH
Community Based Health Care	Integrated Essential Health Care
	Management of local endemic diseases
	Community based prevention, care for common injuries & rehabilitation
	Visual health, oral health & mental health
	Disease surveillance & emergency preparedness
Health Promotion	Awareness sensitisation & building community capacity on priority health problems
	School Health & Nutrition
	Community based nutrition & food security
	Community actions for safe environment, water & sanitation
M/E & Operations Research	Routine HMIS, periodic surveys & special studies

As outlined above, the BPHNS is very appropriate in its focus in terms of meeting the population's needs. It is also very ambitious and unlikely to be fully implemented given the current capacity of the government and funding available from the international community.

Considering the priority of the GRSS to increase health system responsiveness to local needs as articulated both in the Boma Health Initiative of 2015 and in the National Health Policy 2016-2025, the HPF, in collaboration with the MoH has been working to enhance the degree of community-level engagement in health service provision. Emphasis on this increased in HPF2, with IPs building into their plans various elements of community engagement including mother-to-mother support groups (MtMSGs) and reviving and revamping the community health committees. The South Sudan health context is characterised by vast areas to cover, many of them insecure, making community health workers and the involvement of community groups that much more relevant, especially in areas that are hard to reach.

A review of programme documents, triangulated with field data, reveals that GESI indicators related to maternal and child health were largely focussed on. Many respondents at the state level and among IPs claim there are more women accessing maternal health care services and nutrition for pregnant women and under five children.

However, there is no information on the depth to which social norms and existing inequities have been addressed, taking into account other vulnerabilities related to ethnicity, disability, socioeconomic status and age. Harmful gender stereotypes that promote specific types of

masculinities and legitimise hegemonic masculinity are underlying drivers of conflict and gender-based violence in fragile contexts like South Sudan.

References to services that would also be used by men are not available, for example syndromic management of sexually transmitted infections (STIs). However, there is mention of male engagement in IP quarterly reports, in the form of sensitisation of reproductive health services. In addition, there is hardly any mention of youth friendly services, and target areas like adolescent health are not specifically addressed. This is a key gap given the high rates of child marriage and teenage pregnancy in South Sudan. Furthermore, adolescents (male and female) are a key target group in conflict settings. A handful of IPs report on health service uptake of youth, specifically regarding reproductive health and family planning. However, in general, the reporting and the structure in which it is formatted is silent on youth, as well as other areas of social inclusion such as disability.

Some IPs use client satisfaction tools, which may give some guidance as to perceived needs. However, the application of these tools is not uniform across all IPs, especially as the HPF did not have a standard tool that the IPs could use. At the time of the evaluation, the programme was deliberating on this, and on engaging the MoH in the process of standardising the process.

Involvement of Beneficiaries

The evaluation finds that although the HPF is responsive to the needs identified by the GRSS, there was no clear evidence of involvement of beneficiaries (including women, men and youth) in the design of either HPF1 or 2. For HPF3, DFID did not find that local consultations were needed given the decision to continue with broadly the same structure and that local level actors are able to shape the ongoing implementation of the programme. Health committees, community leaders, state MoH and CHDs (County Health Departments) staff in the three lots surveyed all indicated that they had not been consulted during the design of HPF3. Community involvement, such as the ongoing work with Community Health Committees (CHCs), ensures some degree of engagement in implementation. Although these community structures are involved in joint periodic meetings with IPs the CHDs and the facility staff at the local level, there is no evidence of how/if this has translated into decision-making of CHDs or HPF over time.

6.1.2 Alignment with government health sector priorities

There is extensive evidence from different sources that HPF is closely aligned with government health sector priorities. As indicated above, we found that HPF builds on and assists in implementing GRSS/MoH strategies and approaches including: National Health Policy (2016-25), National Health Sector Strategic Plan (2015-19), Health Sector Development Plan, the Basic Package on Health and Nutrition Services, the Reproductive

Health Policy & Strategic Plan, and MoH nutrition guidelines. HPF is also guided by the MoH in its procurement, with all key items on the MoH Essential Drugs List, and all decisions on drug procurement cleared with MoH.

The HPF programme is in alignment with the Health Sector development Plan of South Sudan (2012-2016), as its indicators for nutrition and maternal health are incorporated within the programme.

According to MoH, State Ministers of Health, as well as County Health Department (CHD) staff interviewed, the HPF is aligned to the health priorities of the GRSS. A State Minister of Health mentioned, '*The HPF aligns itself to the priorities of the ministry of health because CHD together with the IPs outline activities and plan together before they submit request for funds*.' This is supported by the HPF fund management staff, who were clear during interviews in Juba that their priorities match those of the MoH.

Health System Strengthening

The original design of the HPF anticipated the need to support health system strengthening (HSS). However, this proved difficult due to the political situation causing most donors to withdraw support for the central government. Some of the original elements have also been scaled back, including strengthening public financial management (PFM). Despite this, HPF has supported the MoH in developing a number of strategies, systems and approaches – as outlined above and elsewhere - that are strengthening the health system, and there are numerous examples of how the structure and implementation approach of HPF have helped with this. For example, HPF is working closely with the GRSS, particularly at state and county level; at county level, IPs co-locate with the CHD in some counties, providing mentorship and training to the staff to strengthen their management and oversight capabilities[15]. At the national level, the HPF HSS unit is based within the MoH. HPF is also delivering the programme (health services) through government health workers (including paying incentives) for the most part. HPF has worked to strengthen the Health Management Information System (HMIS) and the Human Resources Information System (HRIS) and supports a number of other government systems such as supportive supervision and quality of care.

Discussions with senior MoH officials indicated that these efforts were appreciated, and perceptions of the HPF were generally positive. On the other hand, due to the low financial capacity of the government and chronic lack of funds allocated to the MoH in the national budget, interviews with other stakeholders revealed that there is an inordinate amount of pressure on the HPF to support the MoH, which has on occasion led to differences of opinion about what HPF can and cannot realistically support. The Steering Committee is instrumental

[15] Although MoH, and some other sources, indicate that in some counties the co-location is not optimal/functional (i.e, on the same compound, but not in same office buildings), or not happening.

in managing these expectations but until recently had been on hiatus for over a year, and currently acts as an information-sharing platform rather than a decision-making body. We heard from senior MoH officials that it was of absolute necessity to develop robust terms of reference for the Steering Committee, particularly in regard to accountability.

Accountability

Comprehensive accountability is difficult in the current political context. However, to the extent possible, HPF has been able to go some way in strengthening this through support to a more robust HMIS system as well as facilitating more inclusive and active Community Health Committees at the local level. For example, the committees oversee the activities of the facilities including staff attendance and drug deliveries (see below on community engagement). One challenge is that HPF, alongside most of the donors, still use the former ten states structure, rather than the new GRSS structure, i.e. the new states (32), delinking HPF staff on the ground from the governance structures in many states.

6.2 Effectiveness

This section presents an assessment of the achievements and the appropriateness of the approaches being used in the various interventions of the HPF. Overall, the programme has made significant achievements, meeting many of its targets.

Key Strengths and Achievements

- Beneficiaries surveyed expressed a reasonable amount of satisfaction and indicated substantial improvements over the lifespan of HPF (see Annex 5.1);
- Community engagement supported by HPF has already been promising in terms of raising awareness and increasing service uptake, and the planned enhancement of community engagement in HPF3 is likely to increase health outcomes for the people;
- Attribution of all these results is difficult, but given the size of HPF, allocating around $8.5 per capita USD for services, and covering almost all health facilities, HPF is deemed to have contributed substantially, and most likely health services would largely not be functioning without it;
- Drug procurement and distribution is currently functioning quite well up until the “last mile delivery”;
- HPF has contributed greatly to improving HMIS/DHIS, and it is found now to be a reasonably robust in terms of providing data on progress;
- Management of HPF is assessed to be effective;
- Responsiveness to emergencies has been increased by the introduction of the EP&R (Emergency Preparedness & Response) funding mechanism;
- The nutrition component, implemented with substantial inputs from other partners, has been successful, both in terms of exceeding its targets, and achieving a fair amount of consumer satisfaction.

Key Challenges

- Drug supply is a key challenge with frequent stock-outs and issues around last mile delivery as previously mentioned;
- While implementation is probably conflict sensitive, there is almost no documentation, and no clear strategy;
- There is coordination through government led bodies, such as the technical working groups, but considerable scope for improvements, due to the lack of terms of reference, unclear responsibilities and little clarity on expected outputs for most of these groups, not least the Steering Committee;
- The coordination body for development partners is severely lacking.

6.2.1 Achievement of outputs and outcomes

Overall achievements

As indicated earlier, it is clear that HPF has strengthened service delivery focused primarily on the needs of women and children. This assessment builds on the following.

Firstly, in assessing achievements across a number of service components in the programme, throughout the duration of HPF (HPF1 & 2) the programme has achieved a fair amount of its targets in service delivery including antenatal care (ANC), facility births attended by skilled personnel, and nutrition targets, which have even been exceeded.

Throughout HPF there was an increase in patient attendance, including children under-five and an increase in the number of deliveries in health facilities and attended by skilled birth attendants (see Table 3). Patient attendance rate almost tripled in total and the attendance rate for children <5 more than doubled with the introduction of the HPF.

Less success has been seen in targets related to family planning (FP) and gender-based violence (GBV); also, the number of children <5 consultations have been below target recently, although it should be noted that half a million more <5's were seen in the year 2016-17, compared to 2015-16.

Table 3: Patient attendance rates[16] (average number of consultations per person per year)

	2011-12	2012-13	2013-14	2014-15	2015-16	2016-17
Consultation All	0.3	0.5	0.5	0.7	0.8	0.7
Consultation <5	0.6	0.9	1.1	1.3	1.4	1.3

These patient attendance figures compare favourably with other countries with much stronger health systems, such as in Tanzania, where total patient attendance rate in 2014 was 0.6 and <5 OP rate 1.4

[16] Calculations done by evaluation team based on DHIS figures supplied by HPF. Years are June-July. The change in HPF coverage in April 2016 has been accounted for (i.e. 6 to 8 states). See raw data in Annex 5.3

These and other indicators appear to plateau during HPF2, and the evaluation did not identify a specific reason for this. However, a fair assumption could be that it is due to the decreased funding and a saturation of demand for the present level of service delivery, also considering that it is comparable to many other Sub-Saharan African (SSA) countries.

Secondly, MoH and UN agency staff expressed favourable views on HPF in terms of the programme being a major contributor to health service delivery in the country. This is corroborated by other sources, including the IMPACT Third-party Monitoring Report[17] which asserts, *"HPF provided a valuable funding stream without which most assessed facilities would be unable to function".* The Mid-term Review[18] provided a similar assessment.

Thirdly, the beneficiary survey (see Annex 5.1) of 287 respondents showed a reasonable amount of satisfaction with a number of services, mostly with malaria, diarrhoea and immunisation, and an average level of satisfaction with other services such as maternal and child healthcare & family planning services.

Table 4 Household Satisfaction[19] - by group average, with outliers indicated (1 = Not at all satisfied; 5 = Extremely satisfied)

Type of Health Service	Not at all satisfied	Somewhat dissatisfied	Neither satisfied nor dissatisfied	Satisfied	Extremely satisfied
TRAUMA & GENERAL CARE	n				
Malaria treatment	282			3.8	
Diarrhoea or other stomach infection treatment	252			3.9	
Vaccination	267			3.8	
Acute respiratory infection treatment	199			3.2	
Emergency care	200		2.8		
Medical treatment after an experience of violence	58		2.5		
MATERNAL & CHILD HEALTH					
Antenatal care treatments	224			3.4	
Child growth monitoring & weighing	206			3.5	
SEXUAL & REPRODUCTIVE HEALTH					
STI treatment	91		2.5		
HIV/STI testing and/or counselling	86		2.9		
Family planning	66			3.3	
Contraceptive services	39		2.4		
NUTRITION					
Nutrition counselling & support	216			3.4	

[17] IMPACT. June 2017, Final Report of Short-Term Monitoring and Verification Exercise for DFID Essential Services Team: HPF South Sudan
[18] Garth Singleton et al., January 2015, Health Pooled Fund South Sudan: Mid-Term Review Report
[19] According to this evaluation's beneficiary survey carried out in three lots

STIs and Contraceptive Use

With regard to STI and contraceptive use, the evaluation found through key informant interviews and focus group discussions, that dissatisfaction was not necessarily due to the lack of services on the ground. Rather, the responses reflect the context of South Sudan where discussion on topics of contraceptives and family planning are culturally taboo, even among some of the health staff. This was a major inhibiting factor to uptake of related services. Interviews revealed a great reluctance among respondents to discuss these issues, the majority of whom would either say they did not know about them or categorically deny ever using them. IP reports across the board indicated very low uptake of these services and acknowledged that these were challenging topics to tackle with the communities.

CHD staff member, Tonj North

'*Efficiency was by far less in phase 1, where there were sufficient resources in terms of funds, and adequate staff members. Yet there were fewer outcomes in regard to intended programs [outputs] to be achieved. In spite of significant budget cut in phase 2 resulting to under-staffing, the degree of efficiency is much higher. But budget cuts reduced salaries by more than 50% leading to loss of technical and specialised staff members, and less medical materials*.'

These findings indicate that the programme will need to gain a better understanding of how to overcome cultural barriers in providing these services to increase uptake. This could be through carrying out targeted studies to identify potential entry points that could support such uptake. For example, field interviews showed that youth in some areas use condoms but prefer to access them secretly. Similarly, informants said that many women prefer injectable contraceptives to avoid involving their husband in the decision.

Funding Levels & Resources in HPF1 and 2

The evaluation used HPF budget figures provided by Crown Agents (see Annex 5.6) and the populations in the states covered to calculate spend per capita which amounted to $8.5 per capita for services. While the amount is significant given the context in South Sudan, we still deemed it insufficient to run a comprehensive health service.

Although some respondents mentioned that HPF2 had demonstrated greater efficiency in terms of achieving results due to a more focused approach, a substantial number of respondents in the field lamented the perceived reduction in funding from the levels of HPF1. However, the budget figures provided by Crown Agents did not support the perception of less funding available for HPF2. Comparing the funding available of per capita spend for the covered population regarding IP, SMOH, NMOH & EP&R spending, it was found that $6.4 per capita was available during HPF1 (Oct. 2012 – Dec. 2016) and $6.2 per capita for HPF2's

regular phase (Dec. 2016-April 2018), representing a minimal difference. It should be noted, that drugs and other supplies were excluded in this calculation and differs from the $8.5 per capita spend for services as the evaluation team was not able to attain data on the funds used for drug supply during HPF1, which were external to the HPF1 budget. One explanation for the discrepancy between perception and actual budget could be that more stringent financial management procedures were applied during HPF2, as commented by DFID.

Field interviews revealed that in several places home health promoters (HHPs) acted as clinical staff due to the general staff shortage, something they would not be qualified for. The facility survey showed a shortage of skilled staff across the board (with Yirol County Hospital a clear exception to this), with most PHCUs staffed by health workers with no formal training or community health workers.

The evaluation assesses that because HPF 1 required more time and resources to set up systems, build relationships and networks, it was bound to have demonstrated lesser achievements in terms of service delivery outputs. These systems and structures were already in place for HPF 2 which also saw a continuation of the fund manager (Crown Agents), meaning that the programme had time to focus on service delivery.

Barriers to accessing health services

Low health facility coverage

A fundamental problem in South Sudan is the low health facility coverage, with only 44% of the population living within 5km of a health facility[20] also supported by the beneficiary survey (see Figure 4). Distance also makes referrals more challenging, with one PHCU in the facility survey more than a seven hour walk from the closest PHCC.

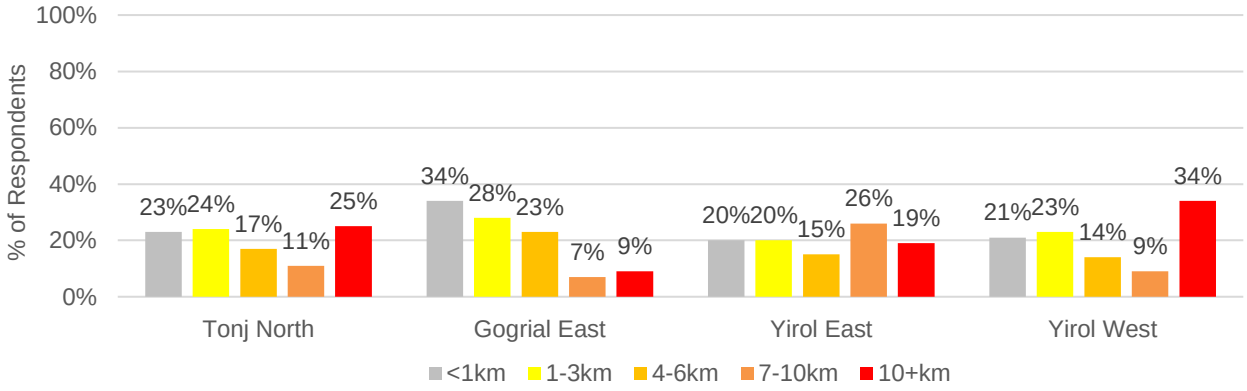
HPF does not engage in construction of facilities, though it contributes to some renovations and improvements of existing facilities. There were reportedly more funds allocated to renovations in HPF1. The GRSS has allocated virtually no resources to the health sector, and local communities rarely have the capacity and financial means for significant infrastructure development[21]. In the beneficiary survey 86%[22] of people not using an HPF facility indicated that this was due to the closest facility being too far. Field interviews also found that uptake of ANC was inhibited by long distances.

The evaluation judges that quality of care is an area for improvement due to unskilled staff at the PHCU level and long distances to larger health facilities. Field data collection also reported

[20] According to MoH and our interview with WHO, Juba, March 2018
[21] Although it was reported by HPF staff that some health committees have been known to round up resources to support infrastructure development, if HPF agrees to provide equipment and staff. A Deputy State Minister of Health also had examples of communities engaging in infrastructure development.
[22] Number of respondents giving this reply was very low.

that HPF health advocacy and education work had led to more individuals seeking health care, therefore increasing the patient load and making it more challenging to provide quality care.

Fig. 4: Approximate Distance to Health Facility Used – By County



Community outreach

Community outreach is essential in mitigating the low coverage of health facilities. There has been a substantial effort by the programme at strengthening community engagement, especially during HPF 2. The revised HPF Community Engagement Strategy (October 2017) foresees an enhanced role for community structures, where they are supported to play a stronger role in health service uptake and facility oversight. The programme has engaged in some community outreach though respondents in the field, especially the HHPs and members of the health committees indicated that the extent to which this was carried out was hampered by lack of adequate transportation for community groups, health committees and HHPs. The qualitative data and reports from the field team suggested that community outreach had increased the use of health facilities, particularly in Tonj North and Eastern Lakes.

Community-based groups – health committees, HHPs and traditional birth attendants (TBAs) – have been involved in awareness raising. A range of respondents acknowledged that there were improvements in child health including lower levels of malnutrition amongst families that sought the necessary nutrition services. The same applied to women accessing ANC services, receiving awareness about breast-feeding, vaccination, general nutrition and WaSH. The approach is generally acknowledged to be cost-effective by other health actors such as the WHO, further augmented by the fact that most community mechanisms work on a voluntary basis.

However, interviews indicated that morale was not high due to a reduction in incentives to community groups, and as a result, there continues to be high rates of attrition amongst members. Consequently, awareness raising activities were not as extensive as they could have been. Additionally, some HHPs are used at facility level to supplement the shortage of staff, leaving them little time to engage in outreach activities.

There is a strong need to support the community outreach component in HPF 3 given the potential impact on raising health awareness and uptake on the ground, and to enhance accountability and management of facilities. This could be done by rationalising the oversight and reporting arrangements of the health committees and integrating them into the decision-making process where they are supported to play specific roles. Community outreach workers should receive training on management and leadership and be provided with supportive tools such as transportation and awareness-raising materials. The roll-out of the Boma Health Initiative will be integral to this component despite being resource intensive and costly.

Cost of health services

A potential barrier to access of health services is cost. Despite the fact that primary services are meant to be free as enshrined in the GRSS constitution[23], 32% of respondents in the beneficiary survey indicate that they pay a user fee, particularly at PHCCs and PHCUs[24]. This is supported by other respondents who reported having witnessed user fees being charged by facilities. The value of user fees paid out was not identified in qualitative comments from the beneficiary survey nor through key informant interviews or focus groups. Furthermore, it is not clear whether these fees were paid to staff (either as an unofficial facility user fee or a bribe) or reflected the cost of buying drugs in the private market due to stock outs. Considering the underfunding of facilities and the poor remuneration of staff, it would not be surprising that facilities try to supplement their resources by charging fees, nor that staff supplement their individual income by illegally charging patients. However, taking into account the impact that user fees could have on affordability of services for more vulnerable people, it would be beneficial for the programme to gain a better understanding of what these costs entail and agree on how to tackle the issue in line with the MoH.

Despite this, only a few respondents indicated cost as a reason for not visiting a health facility. 68% indicated that services were free, and one third mentioned affordable cost as a reason for choosing an HPF-supported facility, indicating that cost does not seem to be a major barrier in the four lots covered by the evaluation.

Referral System

According to field interviews, there is appreciation that issues such as referrals have improved to some extent, but there is also recognition that the situation is far from satisfactory; for example, with regard to the capacity – number and skills – of staff, the number of female staff at the health facilities, and the number of ambulances to support the referral system. The

[23] Primary health care is free according to the Constitution of South Sudan, secondary and tertiary care are not mentioned (source senior staff MoH).
[24] Although our sample for the field only included one hospital

beneficiary survey showed 36% of respondents having been referred to another facility, whether this is satisfactory or not is difficult to say without additional analysis.

Capacity of Health Facility Staff

The evaluation found that all health facilities across the lots covered were understaffed due to HPF's overall funding, within which there is not sufficient funds available to pay for all the staff needed (e.g. as expressed in the MoH staffing norms for facilities)[25] . This is exacerbated by the fact that there are minimal MoH resources contributing to the health sector. Many of the staff working at facilities are underqualified to perform many health services. This was strongly supported by a combination of field interviews, data from the beneficiary survey and interviews in Juba. Moreover, IP reports and interviews indicated that staffing of facilities was hampered by the reluctance of qualified staff to be located in hard to reach areas due to security risks and inconvenience.

IP reports indicated that achievement of targets for number of trained staff varied because of the need to postpone activities due to conflict, health emergencies and lack of funding. Some IPs provided informal training of staff but reports and interviews indicated that more formal training is preferred by the facility staff and CHD officials. Evidence is mixed on which approach is more effective both in terms of cost and impact.

The lack of female staff was mentioned by several respondents as a major barrier for women accessing sexual and reproductive health services. The programme has made efforts to recruit and train female staff exemplified by including the recruitment of female health staff as measurable targets for IPs. However, patriarchal norms in South Sudan mean that fewer girls complete their education compared to their male counterparts and as a result, there are fewer educated women that can become health workers.

According to the 2016 DFID Annual Report, in-service training in the programme has focused more on the mid-level staff cadres. Interviews indicated that there needs to be a greater focus on lower-level cadres as well. This is particularly important in South Sudan as it could support skills-building for women and staff working in remote areas. In light of the reservations expressed by female patients around seeing male staff, it could also strengthen uptake of services by women. Some of HPF's donors and IPs are already carrying out a variety of health staff capacity building and training activities in the country. In HPF 3, the programme should gain a clear understanding of what is currently on offer and how it could partner with these

[25] The results of our facility survey of twenty facilities showed a variety of different staffing structures. Most PHCUs were staffed by nurses without formal training, midwives or traditional birth attendants and sometimes medication dispensers. They were often supported by some form of community outreach volunteers. PHCCs and the single hospital visited were better staffed, usually by clinical officers and nurses with formal training. The hospital also had medical officers. Although our sample was too small to be representative, in our interviews with IPs we heard multiple times about the inadequate levels of staffing at most facilities.

organisations in the training, deployment and supervision of trainees. Moreover, there should be discussions with partners and the MoH on how to rationalise training for the health sector in general.

HPF at the County and State Level

In general, HPF has cooperated closely with State MoHs and CHDs on implementing services as well as strengthening health systems. This includes HPF/IP staff co-locating with CHDs, as well as joint IP and CHD supervision.

All IPs reported having a good relationship with the CHDs, although some had faced challenges around unreasonable expectations of support and conflicts around health worker remuneration.

Respondents said that HPF has an influence on the degree of ownership among government agencies due to the CHDs and SMoHs enhanced involvement in decision-making at the local level. For example, in the selection and recruitment of facility staff, in the planning and supervision of facility activities, as well as in the setting of county priorities in collaboration with the IPs. On the other hand, HPF and IP staff also indicated that involvement of the CHDs in the recruitment process has led to IPs coming under a lot of pressure to hire specific individuals. This is not surprising considering the poverty levels and high unemployment rate in the country but can lead to unqualified or poorly qualified health workers being hired. As much as possible, IPs have resisted these attempts through continued close engagement with the SMoHs and the development of clear job descriptions.

From a health sector perspective, the creation of many new states has been a highly challenging development[26], both because this stretches already thin government capacity, and creates a need for expensive infrastructure. Due to limited HPF funding and DFID's reluctance to adhere to the new state structure, new states are inadequately supported by the HPF in certain areas such as the provision of equipment and transport for state-level MoH officials. We recognise this is not necessarily the responsibility of the HPF. However, CHDs in which counties did not change under the re-structure still retain access to HPF benefits, while CHDs which fall out of the old structure, do not. CHDs in newly created counties also do not benefit from the knowledge sharing and support gained from collocating with IPs. These county-level differences can also impact the state-level. The situation in some places such as Imotong and Namorunyang states, is somewhat alleviated by cooperation between the newly created states. It appears likely that the programme will continue to operate with the same modality of eight (out of 10) former states. Taking into account that this approach has complicated matters not only for HPF management, but more so for the IPs who are in closer contact with these

[26] This is not only the view of development partners, but also shared by senior MoH staff.

structures on the ground, it is essential that an operating model is explored that will lessen the existing tensions. Imotong and Namorunyang states have found a solution in terms of the former State MoH supporting the new one (e.g. on training), and it could be that others learn from this approach. An additional problem according to interviews is that drugs delivered are sometimes considered to belong to the state where the HPF team is located with the authorities, and therefore not fully distributed to new states.

A forum such as the Steering Committee could provide guidance on how to move forward given that HPF funding will likely not support the additional state ministries and CHDs.

Attribution of Results

The issue of attribution is difficult as HPF facilities also receive inputs from other funding sources, such as other bilateral or multilateral agencies as well as international NGOs, faith-based organisations and charities, and non-HPF facilities are included in HMIS/DHIS data that HPF uses for reporting on achievements. However, by all accounts HPF is a very significant player, and most stakeholders interviewed asserted very few non-HPF facilities, although this varied from state to state. Furthermore, non-HPF facilities benefit from HPF supported drug supply[27], supervision and improved HMIS.

Respondents, especially facility and CHD staff, lauded the strengthening of the referral system and attributed this to HPF. Other evidence of attribution includes drops seen in service provision during times of re-contracting on HPF. HPF management claims that due to the protracted transition phase between HPF1 and 2 some services suffered, such as immunisation, where there was a massive drop in the numbers of DPT-HepB-Hib[28] 3rd doses administered in November to January 2016, something not seen the year before and therefore not a regular seasonal drop. A contributing factor could be that renewed conflict in July 2016 delayed IP contracting and therefore delivery of key health services such as vaccination.

Unintended Outcomes of HPF

The reduction in salaries from HPF1 to 2 and the non-harmonised remuneration of facility staff across IPs which resulted in a significant loss of qualified health staff, was identified in the evaluation as a negative unintended outcome, particularly in a context where accessing qualified staff is already a challenge. This is due to underfunding of the programme.

In addition, there is the lack of harmonisation of remuneration rates with other health actors, most notably humanitarian organizations. This has resulted in increased acrimony on the ground where IPs have shouldered the blame for the reduced salaries. Occasionally, this discontent has led to conflict and even violence directed at IP staff.

[27] Because drug HPF kits are split up at CHD and the content distributed to all facilities in the county.
[28] Diphtheria, Pertussis, Tetanus, Hepatitis B, polio and *Haemophilus influenzae* type b vaccine.

6.2.2 Procurement and availability of drugs

Funding for HPF including the drug supply is insufficient. HPF is a major supplier of drugs, albeit not the only one, and only has a budget allocation for 2.3$/cap for drugs (regular phase of HPF2 budget see Annex 5.6)[29]. This amount does not compare favourably with international assessments of drug need, such as the Lancet Commissions[30] which estimates that $13 to $25 per capita is required to finance a basic package of 201 essential medicines in LMICs.[31] It should be noted that HPF donors agreed the funding for drugs provided under HPF2 without a specific study or assessment of the actual need within South Sudan.

While insufficient funding plays a major contributing factor to drug shortages, other causes for stock outs include difficulties in forecasting drug consumption, delays due to weather or unrest, hoarding of drugs by the public when supplies arrive (in itself a sign of insufficient drug availability), and pilferage. It is important to note that the scale of pilferage was not identified by IPs as a substantial reason for stock-outs.

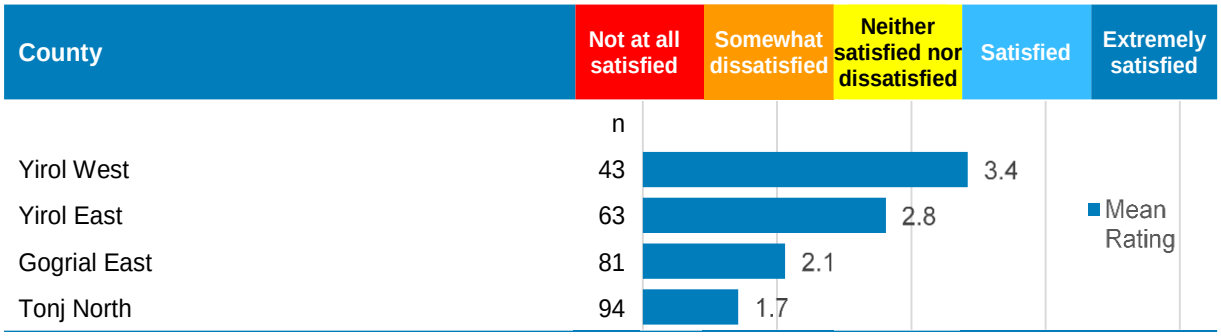
During HPF1 drugs (55 items) were financed by another funding source and implemented by CAIPA (Crown Agents & IPA[32]). In HPF2 funding for drugs (68 items) was included and implemented by the HPF. Senior MoH staff indicated that funding for drugs is insufficient and that the funding for drugs was the same in HPF1 and HPF2, despite the increase in number of drug items provided in HPF2, leading to shortages. However, the evaluation was unable to determine the validity of the statement due to the inability to obtain clear and accurate drug spend data for HPF1 from DFID.

The availability of drugs is a key element of service quality. By all accounts stock outs are frequent and consumers[33] are also somewhat dissatisfied with drug availability (see Figure 5), although half note an improvement during HPF, compared to a quarter saying it deteriorated. This is confirmed by key MoH staff who commented, *"what was meant for three months is consumed in only one and a half months*". In the facility survey more than two thirds of facilities reported stock out of some essential drugs (see more detail in Annex 5.2). This is contrasted with the finding in many recent IP reports asserting 100% availability of the 4 tracer drugs. One explanation for this discrepancy could be that the timing of the evaluation's facility visits only captured the situation at that specific time, meaning that this does not present the normal situation on the ground. However, some of the facilities surveyed had recently received their

[29] Figure calculated by drug spend in HPF2 over population – data provided by Crown Agents
[30] Wirtz et al, 2016, Essential medicines for universal health coverage
[31] We recognise that HPF2 is providing 68 items (not 201) but is still underfunded by around anywhere between 48%-73% of what is needed. This was calculated by determining 68 is 34% of 201. We then calculated 34% of $13 ($4.42) and $25 ($8.5) and determined the percentage difference between 2.3$/per cap compared with $4.42 and $8.5. Although we acknowledge that these figures are not exact, we believe they still provide a general overview of HPF's insufficient funding for drugs supply.
[32] International Procurement Agency
[33] Beneficiary Survey (see Annex 5.1)

drug consignment and yet still had some drug shortages, suggesting that the supply is inadequate, or that patients are stockpiling drugs as soon as they arrive.

Figure 5: Respondent satisfaction with drug availability



46% of respondents indicated drugs being mostly available as a reason for choosing to use an HPF-supported facility in the beneficiary survey. This relatively positive assessment despite the often reported[34] shortages is potentially because HPF facilities are still better stocked than the alternatives, or that in some areas there are no alternative sources of drugs.

IPs reported frequently stepping in to plug the drug shortfalls, and in cases where they could not, patients had to purchase the drugs from pharmacies. For example, when there are shortages in injectables, patients buy the drugs and related supplies (needles and syringes) and bring them back to the facility for administering. Patients are sometimes referred to other facilities if drugs are unavailable. However, due to transportation barriers such as lack of ambulances, patients are not able to access referral facilities due to long distances.

The evaluation did not specifically look at drug quality but given that they are procured from reputable providers, we have no reason to assume that the quality is poor. However, some respondents, including a senior MoH official, reported that some drugs had expired possibly due to poor management at the facilities. Given the rapid consumption of stocks, we judge this unlikely to be a significant issue. The MoH and HPF should enforce the "first in first out" principle of drug storage.

Evaluation respondents reported a few instances of HPF supplied drugs appearing in the private sector. There were reports that patients would queue at the facility when supplies arrived, and stockpile drugs in their homes, presumably as a coping strategy in the face of insufficient availability of drugs. With regard to drug pilferage, this undoubtedly is happening in South Sudan as in any other low-income country. The evaluation did not arrive at a clear understanding of the proportion of the problem, but it is something that could be further investigated through a special study.

[34] Reported in many of our field interviews and beneficiary survey.

We cannot provide an in-depth analysis of HPF procurement and supply chain management as this was beyond the scope of the evaluation. However, we noted some key challenges. For example, HPF changed its logistics team in April 2017, leading to some disruption in drug deliveries. There was a period between consignment two in November 2016 and consignment three in June 2017 where drugs were not delivered to IPs. A number of IPs also mentioned gaps and delays in deliveries, with some emphasising that these deliveries had become more reliable recently. As per HPF monitoring, recent drug deliveries seem to have been reasonably on time, taking into consideration the very difficult context, where the security situation regularly gives rise to delays. This was supported by the field interviews, where respondents indicated receiving drugs every three months.

The evaluation confirmed serious issues with last-mile delivery, which is not part of HPF's responsibility but left to the facilities and community to manage, leading to delays in deliveries in remote or difficult to reach facilities. This problem is compounded by the fact that, according to UNICEF, some counties have no vehicles. This was corroborated by interviews with IPs and with other actors such as MSI. Stakeholders also reported difficulties with forecasting of consumption as a challenge with the drug supply.

Another key challenge in the supply chain is when the drugs reach the CHDs. They are delivered in kits marked for the specific types of facility. The CHDs repackage the kits before further distribution to better respond to consumption patterns/demands, as well as supplying facilities that are not part of the HPF drug supply, including faith-based facilities. While this practice has some rationale, facility staff interviewed saw this as part of the reason for lack of drugs and also increases the risk of pilferage.

Through the MoH Logistical Management Unit, the MoH collaborates with HPF and other partners, such as Chemonics, on establishing a drug forecasting system. This is however a very complex exercise, with which other countries with stronger health systems have struggled.

6.2.3 Effectiveness of M&E

The data used to report on HPF's logical framework indicators is mostly based on HMIS data which we assess to be reasonably robust. We therefore deduce that HPF's M&E systems are relatively effective.

The decision to use the MoH HMIS/DHIS as the foundation for HPF M&E was effective in that it avoided the creation of a parallel system and served to strengthen the existing structure. HPF supports the Strategic Plan for HMIS and national level training but does not have enough funds for training below that. However, HMIS/DHIS is supported by other partners as well such as WHO. There has been improved return of reports by counties/facilities (82% in 2017, almost on target). Consequently, the HMIS/DHIS works much better than at the outset of HPF,

something that was already noted by the Mid-term Review, as well as by the CHD staff interviewed.

There is a fairly strong quality assurance of the HMIS data which include supervisory visits, HPF review meetings with county partners, spot checks and verification by IP and HPF staff, and discussion of data. HMIS software contains in-built data validation checks.

The third-party monitoring reports of MSI[35] in Juba (2016) and Aweil, Wau & Yambio (2017) report good quality data recording. However, a number of people interviewed both at state and Juba level pointed to the lack of registers as a problem. The HSS Assessment in Equatoria States showed HMIS was the best performing element (although only rated 46.7%), particularly on systems in place, though less on use of data. Issues reported in the sampled IP reports include stock out of recording and reporting tools. According to HHPs, they collect data in notebooks, and would prefer to have forms where they can enter this data more easily.

There was also poor quality of reports from some of the health facilities where inconsistencies were a common occurrence requiring additional data quality audits. This was attributed to the generally low level of training of health workers. This was echoed by the facility staff interviewed who indicated some of the challenges around DHIS including the exercise being time consuming, the lack of capacity of staff, and overworked staff who often do not have the time to fill in the data. Facility staff in Yirol East asserted, '*It's time consuming and vital information may not be recorded due to limited time*.' Some of the mitigating measures they suggested for these issues included having a clerk for data entry, as well as having the system computerised to avoid loss of data or running out of data entry registers.[36]

With regard to use of HMIS/DHIS data by staff, health facility staff indicated receiving feedback during the quarterly joint meetings. However, all the HHPs who support the data collection exercise indicated that they do not receive any feedback on the data they collect. Providing feedback would be a step towards enhancing greater understanding amongst HHPs of why they collect data and how it is used to inform implementation. This could be a way of creating more ownership and even enhancing care in data collected as they would see how it is used and the important role they play in the health sector.

Other issues affecting HMIS include insecurity leading to closure of facilities. This has affected the IPs ability to achieve their targets of HMIS reporting. Despite this, all IPs appear to be supporting their health facilities to report and continue improving on HMIS/DHIS reporting.

[35] Management Systems International (MSI) is contracted by USAID to carry out third-party monitoring of programmes they fund including HPF.

[36] Although a computerised system would bring its own challenges, including a need for a consistent electricity supply. Some hospitals have already introduced a computerised system, including Yirol County Hospital. More work could be done to assess the success of these newly introduced systems, and whether they have led to more accurate reporting.

IPs interviewed believed the HMIS was generally reliable, and there was no incentive for MoH staff to over report. In addition, there were some communication issues between staff leading to some patients not being recorded, and errors in recording. The HPF M&E team assessed that quality was improving, and that under reporting was more likely than the opposite. One UN agency found that the new states do not have the capacity to collect data, making HMIS data weaker.

Another important finding related to data validity is that very few IPs use HMIS/DHIS for performance-based financing, something that is known to create incentives to report false data. Those using performance-based financing (Cordaid, ADRA), based it on the punctuality and effectiveness of staff (whether facilities were kept clean etc.) that would not incentivise staff to inflate the indicators monitored by HPF. The evaluation therefore finds it unlikely that IP staff would tamper with data in order to remain working for HPF, and therefore there is no particular reason why overreporting would be prevalent.

6.2.4 Effectiveness of management arrangements

The evaluation looked at the effectiveness of management arrangements at all levels of HPF. HPF management functioned adequately at the time of the evaluation. It has evolved over the lifespan of the programme, many reported that it has specifically improved over the last year. One UN agency highlighted that the frequent change of IPs, mostly due to poor performance, and the associated bidding process created delays in hiring of new staff at county level, which interrupted service delivery. While such changes of low performing IPs are necessary, every effort should be made by HPF to avoid disruptions in service delivery.

HPF Consortium Arrangement

One area that appeared to cause some challenges to management arrangements was HPF's consortium arrangement, where a lead organisation oversees one or more subcontractors with different operational procedures in the same lot. A state minister for health asserted that the differences in operation '*hinder equal service availability across the whole area. The government is unable to intervene. Therefore, there is unequal distribution of resources and shared information.*' It is unclear the extent to which HPF is involved in deciding the consortiums' partnerships, though IPs reported levels of dissatisfaction with the process. In these instances, HPF could potentially intervene through their state coordinators.

HPF, Donor and MoH Coordination

There are regular meetings between HPF and MoH, as well as with DFID and other HPF donors. The relationship between HPF and MoH was described by respondents as having improved over time, particularly in the last year, and is now perceived to be positive.

Although donors generally appreciated DFID's oversight role in managing HPF, some suggested issues with the coordination of how information is shared, largely due to being under-resourced. DFID reported coordination challenges due to high reporting requirements and spending restrictions by some donors.

HPF has a Steering Committee attended by the HPF donors, HPF fund manager and the MoH. The MoH chairs the committee which has begun meeting again after a hiatus of more than one year. The Steering Committee currently appears to function more as an information sharing platform than a decision making one. Several stakeholders including the MoH and donors, reported issues such as agendas and documents not being shared in advance of the meetings. Importantly, it was reported that the Steering Committee lacks clear terms of reference. Moreover, the frequent home leave taken by donor representatives, as well as travel by senior MoH officials, made it challenging to coordinate meetings.

Some actors suggested the Steering Committee should have a broader representation and include all the major players in health service delivery in South Sudan, given that HPF is the main service delivery organisation across the country in the states in which it operates. Such a broader platform could also facilitate strategic discussions between the relevant stakeholders and strengthen coordination.

HFP and IP Management

Some stakeholders in Juba were of the opinion that that HPF fund management is under-staffed and lacking in some areas of technical expertise, and this limited their ability to effectively support the IPs on some technical issues. This was not something we were able to investigate effectively within the scope of the evaluation.

We consulted a significant number of IPs on their relationship with HPF who lamented the high reporting requirements. Most experienced payment delays (reimbursements) from HPF but the cause was not clear. The lack of pre-payment, due to DFID policies, was identified as a barrier by many IPs, as well as other stakeholders, and excludes national NGOs who generally have less funding available to cover the gap. However, HPF highlighted that the consortium model is meant to overcome this, with larger international NGOs responsible for supporting their national subcontractors. Allocating more counties to one partner also exacerbates the problem of lack of pre-financing as they have to shoulder a heavier financial burden in terms of liquidity. On their side, HPF management pointed to problems with timely reporting from a number of IPs.

We observed that there were good attempts by some IPs to fill in qualitative information. However, in general, the evaluation found that the lack of qualitative reporting from IPs posed a challenge in the ability to assess how activities on the ground were contributing to the achievement of planned results such as the trainings provided and the existence of revamped

health committees. While we recognise that the IPs already feel over-burdened by the existing reporting requirements, a compromise could be, a) expanding the existing reporting templates so that qualitative information is more fully captured; or b) requiring half-year qualitative reports.

The evaluation identified a need to strengthen the quality and usefulness of the common forum at which IPs can meet and share practices (initiated recently by HPF), learn from each other and discuss progress. HPF IPs have different areas of expertise and are employing a variety of innovative or adaptive approaches to fit the context; shared learning is therefore crucial. Related to this is the need for the programme to document some of the learning being produced by the programme. This would not only be beneficial for HPF IPs and donors, but also for those outside of the HPF.

HPF learning and sharing of experiences would become most effective if it was supported by a comprehensive advocacy and communications strategy. In HPF3, the programme should consider developing a strategy to guide all communication (internal and external) as well as to support advocacy activities. The IPs all undertake awareness raising in one form or another, and such a strategy could serve to better support this, for example, with Information, Education & Communication (IEC) materials, with focused training on advocacy and communication skills. This approach would also go some way in addressing some of the concerns raised by the donors about the quality of communication with the programme, and it could provide an opportunity for the donors and IPs to engage more directly through, for example, sessions focusing on specific learning topics identified as key during implementation. In practice, another example would be having an IP or a number of IPs that have utilised certain approaches that have been found to work, facilitating a learning session where other IPs and other relevant actors can participate. Considering the number of IPs and actors engaged in the HPF, the key to keeping such sessions manageable, would be to ensure that they are tied concretely to specific learnings.

County, Facility and Community Level Management

At the county level, the co-location of HPF/IP staff with CHDs facilitates easy dialogue, although this is not happening or not optimal in all locations. Based on field interviews it appears that there is some tension between some facilities and the CHD regarding the supply of drugs, particularly in cases where the CHD controls the storage and quantities provided to the facilities. But overall, the relationship between CHDs and facilities was said to be cordial.

At the facility level the relationship between the IPs and the facilities also appears positive. However, one key point of dissatisfaction seems to be a lack of clarity by facility staff and community members about the funding shortfall, with most laying blame on the IPs. Although there are quarterly meetings where the IPs, CHD and facility staff deliberate jointly, the

reasons behind the change in support focus (such as the introduction of GESI), as well as the reasons for changing IPs were not well understood. Although the IPs appear to have communicated to the stakeholders on the ground about these issues, the responses point to a need for changes to be communicated on an ongoing basis. They also highlight the importance of having the support of the state and state Ministry of Health officials in communicating issues at the local level to mitigate any potential fall-outs from the community. This is especially relevant when considering the volatile contexts in which some of the IPs operate, and where lack of precise information could lead to potentially dangerous situations for staff.

At the community level, the community health committees' activities are overseen by the CHDs, but the modalities of how this is done were not clear from the field interviews. A number of health staff thought that the health committees are managed by the facility managers, while others said that oversight is provided by the CHDs, although some committees mentioned not interacting with the CHDs at all in their work. Reporting lines of the committees therefore remain unclear. Interviews with HPF staff revealed that, going forward, this is an area that needs to be streamlined further. The implementation of the Boma Health Initiative is intended to provide clear principles.

The reporting lines of the HHPs are clearer, with their oversight conducted by a supervisor who is also a member of staff attached to the health facility. However, most HHPs reported not receiving substantive feedback from supervisors.

All the respondents were clear that oversight of the facilities is done by the CHDs and IPs, with inputs from the health committees. The facility managers provide monthly reports to the CHD from where it is forwarded to the IP and to the SMoH. Feedback to the facilities is done every quarter when the IP and the CHD hold quarterly meetings, circumstances allowing. Insecurity in some locations affects the frequency of these meetings.

The facility managers hold staff meetings where they provide performance feedback to the staff. This, coupled with the oversight provided by the health committees and the introduction of staff attendance registers, indicates that the HPF has instituted measures for better staff management. However, this is challenged by the lack or poor remuneration of staff.

6.2.5 Sensitivity to conflict and fragile state setting

There is not much formal (written) evidence of HPF and IPs implementing a conflict sensitive strategy, nor that conflict analysis has been part of designing interventions. Moreover, DFID has not rolled out its conflict sensitivity policy to HPF.

Despite this, all IPs in areas affected by conflict provide reporting as part of their standard reporting to HPF, though mitigation efforts are not included. Templates don't include a place

to record this information. However, we are confident that HPF and its IPs are aware of a number of the conflict issues given the context in South Sudan, and we assume that this informs implementation. While few IPs could speak constructively about conflict analysis or sensitivity, certain decisions were made with a conflict sensitive lens. For example, some IPs avoided sending staff from specific groups/ethnicities to areas of the country where their background would put them at risk. Furthermore, IPs were able to identify conflict risks in the areas they were working and adapted their approaches accordingly.

HPF is implemented throughout all parts of the eight states, including opposition controlled (IO) areas. This helps to avoid the perception that certain groups, particularly those supported by the government, are favoured. Accounts varied across interviewees on whether the government tried to block HPF from operating in IO controlled areas. There is no doubt that there are instances of blockages though the problem did not seem to be widespread. Blockages are usually not ordered by the MoH, and instead involve other government actors, such as the military.

Examples of flexibility from HPF in implementation has given IPs the possibility of adjusting to changing circumstances. HPF is often flexible around reporting deadlines and whether indicators can be achieved. However, the costs of managing severe conflict, such as evacuation of staff and use of satellite phones for communication, are absorbed by the IPs, which has reportedly led to some significant challenges.

From the field interviews, although all respondents agreed that there is no specific conflict management strategy in place, IPs do engage in conflict mitigation activities by working with community leaders. They also ensure that they encourage facility staff to take a neutral stance in the provision of services. Beneficiary interviews confirmed that no community or group is denied access to services at the facilities, thought it should be noted that the survey area was predominantly one ethnic group (Dinka).

The perceived reduction in salaries/top-ups paid by IPs in HPF2, as well as the different salary/top-up level across IPs, is a source of much discontent - even hostilities from staff towards IP staff and the evaluation was concerned that this could lead to conflict.

The 2007 OECD “Principles for good international engagement in fragile states and situations”[37], outlines 10 principles, which are not specifically geared towards the health sector. Concretely we find that the HPF design and implementation has taken the context as the starting point including abiding by the principles of do no harm, recognising the link between political, security and development objectives, promoting non-discrimination, aligning with local priorities, providing practical coordination of international actors and staying

[37] OECD, 2010, Monitoring the Principles for Good Engagement in Fragile States and Situations

engaged long enough to give success a chance. The principle of focusing on state building has been particularly difficult in South Sudan, but at least HPF does as much as possible in the situation to stabilise national health systems. It also complies reasonably with the 2012 "New Deal for engagement in fragile states"[38], with the same limitation that it applies to the overall aid rather than the specific issues of the health sector. This relates to the support for one vision and plan, transparency, joint risk-sharing, use of country systems (within the given limitations of the South Sudan context), and timely and predictable aid.

Humanitarian Emergencies

As South Sudan is a fragile state experiencing sustained emergencies across the country, the majority of actors are humanitarian, with those working in health participating in the Health Cluster for coordination. HPF participates in the cluster, but there is not much discussion in this forum around longer-term development[39] programmes due to the on-going humanitarian crises in-country. In terms of addressing humanitarian needs HPF delivers basic health services in most functional facilities in 8 out of 10 states, thereby addressing the health needs for a fairly large part of the population, including displaced people. The field teams confirmed that IDPs (Internally Displaced Persons) were accessing services in the areas visited, although this has put health facilities under great pressure in areas where there are large numbers. Implementation of the GESI strategy has currently focused on building the capacity and knowledge of IPs on GESI, increasing female representation and leadership in health committees, promoting responses to GBV within health centres and improving gender sensitivity of health staff. However, there has been no particular focus on increasing access to services for specific vulnerable groups such as IDPs. The efforts made so far are commendable but not sufficient to address the specific needs of IDPs. Training of implementing partners and relevant health staff on intersectionality and GESI, would provide skills and improve the capabilities of relevant staff to address the specific vulnerabilities faced by IDPs, specifically women, children and adolescents.

HPF established the EP&R (Emergency Preparedness & Response) funding mechanism, which provided fairly rapid and flexible funding during a recent cholera outbreak in Kapoeta East[40]. However, EP&R funding had not been accessed by a number of the IPs because their emergencies did not fall within the requirements. Our review of the EP&R Allocation TOR (draft)[41] assesses that the criteria and limitations for allocating funds seem reasonable, in view

[38] International Dialogue on Peacebuilding and Statebuilding, 2012, A New Deal for engagement in fragile states
[39] Development assistance is long-term, responds to systematic problems and focuses on economic, social & political issues; while humanitarian assistance is (usually) short term, delivered in disaster/emergency effected zones, responds to incidents and focused on saving lives. Source see: http://humanitariancoalition.ca/from-humanitarian-to-development-aid
[40] HPF, January 2018, HPF Emergency Preparedness and Response Allocation Final Report
[41] HPF, March 2017 HPF Emergency Preparedness and Response (EP&R) Allocation Terms of Reference [draft concept]

of the need to apply fairly rigid fund control mechanisms in the South Sudanese context. However, the evaluation was not able to explore whether the guidelines for EP&R allocation were perceived by HPF management as overly restrictive, as this was not mentioned in interviews.

6.2.6 Coordination with other stakeholders

There is evidence of coordination with other actors, both through the Humanitarian Health Cluster (humanitarian aid), which by all accounts is working well, and a health sector coordination body, although the latter seemed not to function well, and by HPF participating in a number of MoH technical working groups together with partners involved in the specific areas.

Recently, HPF has agreed to take over the distribution of UNFPA procured FP commodities. One agency reported that the *"coordination is weak because the fund manager does not involve other health actors like UNICEF, WHO and NGOs not in partnership with HPF in their quarterly reviews at state level".* HPF pointed out that there are different HPF meetings at state level, one with IPs and SMOH and one with a wider range of partners. Senior staff in MoH indicated that there would be a more uniform approach between the World Bank supported and HPF3 supported states, specifically harmonising M&E and other tools as well as conditions of service. One issue specifically mentioned was that HPF supports secondary care[42], something very much appreciated by the MoH.

In field interviews there was an indication that IPs collaborate with humanitarian actors[43] in times of emergency. For example, in Tonj North and Gogrial East, the HPF staff indicated collaboration with other stakeholders delivering essential health services; these include Arkangelo Ali Association known as Triple A, which focused mainly on malaria and TB treatments, as well as collaboration in the delivery of the ICCM programme on malaria, diarrhoea, and pneumonia. They also indicated collaboration with other agencies was informal aside from the operational arrangements in place with major partners such WFP and UNICEF in the provision of nutrition support.

HPF has been involved in a number of activities with MoH including the Health Sector Quality Improvement Framework, developing and supporting the strategic plan for HMIS, the manual on supportive supervision, and HRIS (where IPs report that it has been implemented in many areas) as well as developing the task shifting policy. Co-locating HPF HSS unit with MoH, and the HPF/IP staff with CHDs also strengthened coordination and capacity building. As

[42] Secondary care definition is - medical care provided by a specialist or facility upon referral by a primary care physician or facility; source: Merriam Webster Dictionary
[43] Please note that some IPs are considered humanitarian actors, but other IPs and actors operating in South Sudan (such as some UN agencies) are more development-focused.

discussed earlier in this report, it has been decided not to pursue strengthening of PFM in the current political situation.

The planned salary harmonisation has not yet taken place, due to factors outside of HPF influence such as the lack of willingness among many key players to harmonise. Harmonisation would require uptake of the entire humanitarian sector in South Sudan, which would be extremely challenging given the HPF is having difficulty harmonising between their own IPs. Furthermore, it would require agreement on whether workers are paid in local currency or USD, which would be difficult to make consistent. This problem is well noted by HPF donors and management during interviews. There has been some work to attempt to resolve the issue through meetings between donors and the MoH. However, all stakeholders involved reported that this has been, and will continue to be difficult and complex endeavour. It is important to note that that IPs within the HPF pay different salaries and top-ups. Nonetheless, it was reported that IP salaries and top-ups are still paid out on time more than government salaries, which was perceived as an advantage.

6.2.7 Achievements of the nutrition component

The evaluation found that the HPF targets on nutrition were exceeded. The evaluation team was not able to assess whether, as many actors believe, the targets were set too low. The HPF Nutrition Advisor is responsible for reviewing the targets so there is an internal mechanism for assessing the appropriate target levels. The MoH was meant to deliver a nutrition policy for the whole country but it has not been developed

Without inputs from other sources, HPF would not be able to deliver the nutrition component. For example, approximately 70% of IPs receive resources from UNICEF in the form of nutrition supplements and other support. Given that it is the role of agencies like WFP and UNICEF to supply nutrition related commodities, it is appropriate that HPF's activities are supplementing other actors. However, it is not clear whether there is sufficient coordination between HPF and the other actors. A senior MoH staff pointed out that after an IP has been contracted by HPF it takes half a year to get a contract with suppliers of nutrition commodities (e.g. UNICEF, WFP).

HPF has recently increased its capacity on nutrition, bringing its team up to two people, and a number of training activities have been undertaken by HPF including the Community-based Management of Acute Malnutrition (CMAM) and Maternal Infant and Young Child Nutrition (MIYCN. In addition, the HPF Nutrition Advisor attends the humanitarian health cluster meetings, however it is unclear how much IPs interact with humanitarian actors on nutrition at the state and county level.

The beneficiary survey showed a high availability of nutrition services, and some satisfaction (76% had access to nutrition counselling and support, and 70% were satisfied with it).

Perceptions on the ground are that the nutrition support has had a positive impact on the levels of malnutrition among young children. A SMOH mentioned that the current nutrition support has, '*Significantly reduced malnutrition among the targeted groups, as well as the number of deaths of children being recorded in facilities. However, for much more success that aligns with the set priorities, the current nutrition structure programme requires evaluation*.'

The results being achieved were said to be negatively affected by the improper use of nutrition supplementation provided, where some parents misuse the nutrition supplements as a source of meals for their families. HPF also confirmed this, emphasising that it is difficult for beneficiaries to differentiate between nutrition support and humanitarian food aid. Respondents also mentioned a lack of staff adequately trained to provide nutrition support, as well as long distances to the facilities for some community members as challenges. According to a CHD staff, '*Nutrition supplements are provided by World Food Programme (WFP) and UNICEF but the quantities delivered do not meet reported needs*.' This sentiment was backed by the SMoH who said, '*HPFs implementing partner agent is WFP collaborating with UNICEF. Both provide nutritional supplements distributed by HPF IPs, based on allocation determined at WFP and UNICEF head offices in Juba rather than actual needs on the ground. WFP and UNICEF deliver inadequate quantities despite frequent generated reports that indicate needed quantities.*' The opinion of the Ministry of Health officials on the ground, therefore, is that quantities provided do not match the needs expressed and reported on.

One problem mentioned by IPs is the lack of stabilisation centres in some of the facilities (these would be the PHCC level). Inadequate staffing levels was also mentioned by IPs as a challenge to implementing the nutrition component.

HPF reported that when the nutrition component was introduced at the start of HPF2 there was no explicit guidance received on the budget for nutrition. This meant that funds were not ringfenced at the fund manager level as they had been intended to be. At the IP budget level, the nutrition component is ring-fenced, and cannot be used for other purposes. However, budget allocated by IPs for nutrition are generally small according to HPF Nutrition Advisor and some IPs complained that there were not sufficient resources provided by HPF for nutrition activities (a similar story to GESI).

6.3 Gender equality & social inclusion

This section provides a summary regarding the extent to which the HPF Gender Equality and Social Inclusion (GESI) has been implemented and the main gender-based barriers and challenges to delivery. The full GESI report and analysis is provided in Annex 9. Overall, the HPF programme has made considerable efforts to mainstream gender issues in its programme. However, there is a need to further address wider issues around social inclusion such as disability and age.

Key Strengths and Achievements

- Widespread awareness of GESI strategy among IPs;
- National level Gender Technical Working group within the MoH & collaboration with key actors (e.g. UNFPA);
- Targets for women's participation in lots & village health committee meetings covered by HPF programme have been met;
- GESI indicators focused on maternal and child health;
- HPF strategy is aligned with GRSS Health Sector Development Plan (2012-2016);
- HPF advocacy of GESI issues at the national level.

Key Challenges

- Perception that GESI is an 'add-on' to the programme rather than mainstreaming into all the components;
- Indicators on women's participation are focused on quantity over quality;
- Implementation lacks an intersectional approach and is mainly focused on gender equity (not social inclusion);
- Women's role in leadership and decision-making remains low – restricted by cultural norms;
- No baseline assessment of key knowledge gaps and gender-based barriers to service implementation conducted prior to roll-out of GESI strategy;
- Lack of harmonisation on best ways to implement the strategy among IPs;
- Lack of resources to support implementation in HPF2;
- Lack of clarity around impact of male sensitization activities;
- Service delivery gaps for key populations such as adolescents, people living with disabilities & ethnic minorities.

6.3.1 Implementation and achievements of the GESI strategy

The sustained conflict in South Sudan and the breakdown of infrastructure and social governance mechanisms has resulted in reduced access to health services by the most vulnerable groups. Women, children and adolescents have been the most affected by the conflict. They experience specific challenges to accessing and utilising health care services due to structural inequalities and a dearth of resources due to the ongoing conflict and a weak health system. The maternal mortality ratio in South Sudan is 789 maternal deaths per 100,000 live births, one of the highest in the region; the contraceptive prevalence rate is 4.7%, and the teenage pregnancy rate of 34.5%. Around 84% of all women are illiterate and over half (57%) of all households in South Sudan are female headed (UNFPA 2017, UNICEF 2015, Kane et al 2016).

In April 2013, HPF developed a gender and social inclusion (GESI) strategy and work plan to promote gender mainstreaming across all components of the programme. The goal of the strategy was "to ensure that South Sudan HPF funds activities that are likely to have a transformational impact on poor and marginalised women and girls' health in South Sudan".

The purpose of the strategy was to ensure that women, girls and excluded groups are represented and able to effectively participate in and benefit from programme activities by integrating gender and inclusion considerations and approaches into IP projects, and into the HPF team and HPF2's systems, resources, communications materials and processes.

This section outlines some of the key changes, barriers and enablers encountered during the implementation of the strategy for HPF1 and HPF2.

Achievements Gender and Social Inclusion

Improvement on maternal health outcomes

As discussed above, HPF has aligned itself with the GRSS National strategies on maternal and child health. One of the key outcomes of the HPF programme is to improve uptake of antenatal care (ANC) and provision of basic and comprehensive obstetric and neonatal care. In HPF2, considerable efforts were made to increase the provision of comprehensive emergency obstetric care in many facilities and also provide uterotonics, to reduce the risk of postpartum haemorrhage. Postpartum haemorrhage and obstructed labour are one of the leading causes of maternal mortality in South Sudan. The targets for these outcomes were reached most of the time.

Interviews with different stakeholders including HPF Staff and Heads of health facilities, have linked this increase in uptake to the employment of more female staff at the health facilities. A member from a health facility management team asserted, '*…the number of women in this facility have increase because the IP have employed four women this year compare to last years…the facility has a senior woman and she deals with delivery cases in the facility.'*

Gender equity is difficult to achieve in the absence of sexual and reproductive health. The ability of women and other vulnerable groups to 'realise their sexual and reproductive rights is vital to achieving gender equity in health'.[44][45] Access to maternal health care services as outlined in the table below, as well as other sexual and reproductive health services, including modern contraceptives, safe abortion and HIV/AIDS testing and counselling serve as proxy indicators to assess gender equity in access to health care. We have included a few of these GESI-related indicators in order to provide an overview of the progress the HPF programme has made in these areas.

[44] MacPherson et al, 2013, Gender equity and sexual and reproductive health in Eastern and Southern Africa: a critical overview of the literature

[45] IPPF Vision 2020, 2015, Sexual and reproductive health and rights – the key to gender equality and women's empowerment

Table 6: Sexual & Reproductive Health Indicators related to GESI

Indicator	Baseline (2012)	Milestones 2014	Progress Sep 2014	Achievement 2015/2016	Achievement 2016/2017	HPF Target March 2018	Comment
Percentage of women who attended at least 4 times for ANC during pregnancy	20,500 (8%)	20% (57,000)	21.4% (22.4% excluding Unity) Milestone moderately exceeded	118,901 (27.8%)	118,980 (26.8%)	30%	Target almost reached. There was a marked difference between number of women accessing health services at Visit 1 and Visit 4, a reason for this was attributed to the bridge in contract between HPF1 and HPF 2[46]
Percentage of births attended by skilled personnel	7311 (2.8%)	19,250 (7%)	6.4% (6.8%	46,268 (10.4%)	45,680 (10.4%)	12%	This target was reached, an explanation provided for gap in outcomes was that ANC care was provided at PHCUs, and mostly by a maternal child health worker or Traditional Birth Attendants (TBAs)
No. of facilities with capacity to offer emergency obstetric care (disaggregated BEmONC and CEmONC)	–	All HPF-supported hospitals provide CEmONC*	9 of the 15 HPF-supported hospitals provide CEmONC.	All HPF-supported hospitals (eight MOH, seven faith-based) provide CEmONC.20	27	25	Target was reached and slightly exceeded
	–	25% of all 39 counties have at least one PHCC with BEmONC	38 facilities report BEmONC capacity in 19 (49%) of HPF-supported counties	34	37	37	Efforts were made to equip health facilities and scale up existing infrastructure in HPF2
Number of new acceptors to modern contraceptives	3,500	7000	5,419	10,742 (June 2015)	–	–	Information not available on this indicator in the subsequent review report, though the milestones for 2016 were reached.

Partnership with the GRSS MoH and other stakeholders

At the national level, there has been a commendable attempt by the HPF programme to advocate for prioritisation of gender mainstreaming within the health sector. For example, during interviews with HPF Staff and partners working on GESI, examples of these attempts were provided which included advocacy for national training materials on GESI, as well as a national protocol and training manual on clinical management of rape among health staff. An

[46] It is important to note that there are other reasons women may not uptake the service based on personal choice such as, attending the first visit too late thus not enabling enough time for follow-up visits or deciding to attend two or three sessions only.

output of these advocacy efforts was a training manual on gender mainstreaming and health, that was developed in collaboration with UNFPA.

Additionally, there is a Gender Technical Working Group, with a secretariat at the MoH. The gender adviser of the HPF programme is a member of this working group and uses membership to advocate for GESI priorities. Interviews revealed the existence of support from Ministry of Health Staff who are also members of this working group. (HSDP 2012-2016, HPF2 GESI Strategy).

Capacity building of implementing partners

At the initial stage of the implementation of the GESI strategy, there was little capacity on GESI among the IPs. Most of the IPs had experience in public health and humanitarian assistance but not on issues related to gender and development. This gap was addressed by the HPF Gender Adviser working with UNFPA and other partners by conducting trainings for several IPs in different regions. To a large extent, these trainings have improved the capacity and awareness of different IPs on gender issues. HPF coordinated with UNFPA to make use of existing capacity building materials and this was a strategic way to manage the limited resources available and train the IPs, without duplicating efforts already made to develop relevant training materials.

Implementation of gender-focused interventions

Since the development of the GESI strategy, commendable attempts have been made to increase the representation of women at the village health committees and community health committees. This has been done by community engagement and advocacy by IPs. Female representation in the different village health committees has increased since the start of HPF, likely due to IP advocacy around the area. In 2016, new GESI related indicators focused on SGBV and gender sensitivity training was included (see overview below).[47] Furthermore, considerable efforts were made to reach the milestones. We have classified the progress towards the March 2018 targets using the following three-point scale: limited progress (<50%), moderate progress (50-70%), good progress (>70 percent%). Given the fact that the data available is limited to June 2017, interpretation of the information presented should take into account this limitation. Though, limited progress was made towards most of the targets set for March 2018 by the end of the reporting year in June 2017, we encourage the HPF programme to continue to monitor these indicators and set them as benchmarks for the GESI component of the programme. Efforts were also made by gender technical staff to develop a checklist for IPs to encourage them to improve female participation in the health committees.

[47] We have based the overview on data available up to June 2017, though we acknowledge that more efforts to reach the targets would have been made between then (June 2017) and now (May 2018),

There are also targeted interventions focused on increasing the capacity of health facility staff on the clinical management of rape. This has been achieved through training programmes for IPs and health facility staff, though a challenge has been the absence of national guidelines or protocols on this topic.

Table 7: GESI Indicators for the HPF Programme[48]

Indicator	Baseline (2012/ 2013)	Milestones 2014	Progress Sep 2014	Achievement 2015/2016	Achievement 2016/2017	HPF Target March 2018	Comment
Percentage of health committee representatives that are women	Not available	At least 20% of committee members are women	32% of health committee members female. Outputs substantially exceeded expectations	37% (By November 2016). Milestone: 40%	33%(By October 2017), Milestone: 33%) (2,320/6,969)	38%	Good progress
Total number of health facilities that have documented and adopted protocols for the clinical management of sexual and gender-based violence services	Not available	Not available	Not available	Not available	98	690	Limited progress
Total number and percentage of female health workers	Not available	Not available	- Not available	2,883/6,674 (43%)	2,331/7,238 (32%)	44%	Moderate progress
Total number of CHD and facility staff (disaggregated) who received gender inclusion and SGBV training	Not available	- Not available	Not available	- Not available	164	420	Limited progress
Total number of health workers trained to provide appropriate adolescent and youth services	Not available	Not available	Not available	- Not available	278(130 females)	480	Moderate progress
Total number of health facility staff trained to identify, care and refer SGBV survivors	Not available	- Not available	Not available	- Not available	217(106 females)	690	Limited progress

Use of Mother to Mother groups

IPs formed women's groups for awareness forums on antenatal care (ANC) and Expanded Program on Immunisation (EPI). The mother care group (MCG) model has been widely used to establish mother to mother support groups, which provide support for pregnant women, which involves meetings where pregnant women with young children meet, share experiences

[48] Based on the HPF Annual Report 2016-2017, Annual Review Reports 2012-2017

and information on breast feeding, child rearing, women's health and nutrition. Other similar approaches employed by most IPs to disseminate information on maternal and child health, engaged women through drama and song presentation during meetings or important celebrations.

Coordination with other stakeholders

The HPF GESI advisor strategically aligned the GESI component of the programme with UNFPA and the MoH priorities in South Sudan. This was done through participation in joint stakeholder meetings, gender and health cluster meetings within the MoH, and inclusion of HPF GESI priorities in meeting agendas, as well as taking advantage of existing resources on gender mainstreaming developed by different stakeholders. This was strategic and useful for ensuring sustainability beyond the HPF programme. It was also a cost-effective way of preventing duplication of efforts and using existing resources for implementation.

6.3.2 Main barriers and challenges

Difficulties with addressing 'vulnerabilities' within the strategy

Harmful gender norms & roles

Harmful gender roles and social norms remain a barrier to access in many communities, especially in situations where there is low literacy and high rates of poverty. Some of the main challenges cited with accessing health care for women were the 'rigid roles' set for men and women. For example, in most cases women were expected to continue with domestic chores even if they were ill.

Discourse around gender-based violence (GBV) & unavailability of services

Cultural perceptions of GBV are sometimes different. For example, not all beneficiaries of the programme perceived domestic violence (specifically intimate partner violence) or child marriage as a form of GBV, which undoubtedly impacts on reporting rates. Efforts should be made to promote community outreach programmes that include sensitization activities on GBV.

Another barrier was the lack of services to address GBV, which we define as inclusive of clinical management of rape, psychosocial counselling and medico-legal linkages. There is a learning and knowledge gap on how the current GESI strategies (specifically the increased involvement of women within village/community health committees, as well as training of IPs) will address these sociocultural gender barriers. HPF should determine whether these interventions are sufficient and where there are learning opportunities from other pre-existing programmes that have been able to address these difficulties.

Gender of health workers

Interviews and focus groups revealed that many women refused to access specific services because the health service providers were men. Gender balance needs to be encouraged among health service providers; this should be done in tandem with working closely with community health workers, especially female community health workers. For example, task-shifting interventions and training female community health workers to assist in some basic health service provision, could be considered as a sustainable way of addressing these barriers.

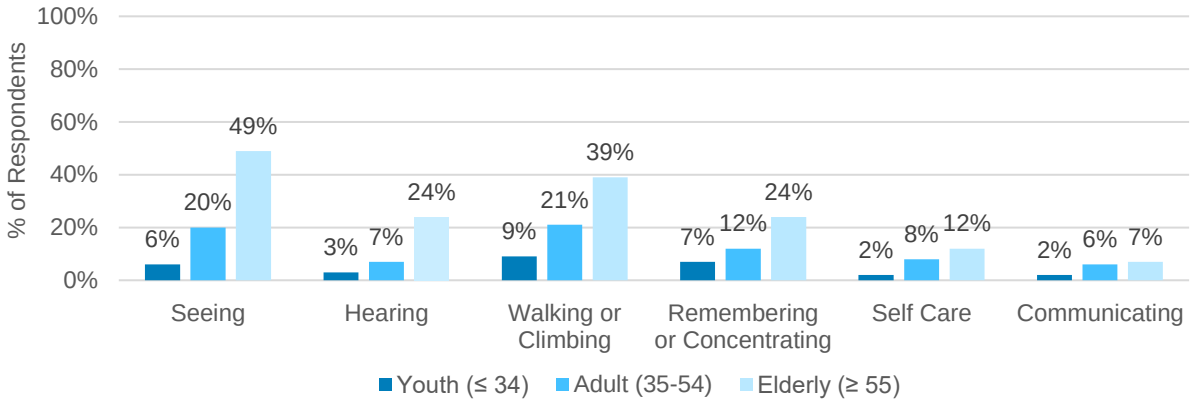
Gaps in the implementation of sexual and reproductive health interventions

Another gap in service delivery is the lack of specific interventions or monitoring indicators around sexual health and sexual orientation. In a fragile context, where gender roles are reified, the necessity to address sexual health needs and issues around sexuality become very important. In a context where resources are scarce, and issues like famine, malnutrition and displacement are paramount, addressing sexual health issues might seem less important. However, the absence of interventions that address these issues will lead to a negative trickle-down effect, as they impact on the sexual and reproductive health of the whole population, specifically targeted groups such as women and children. For example, a high incidence of STIs such as syphilis, gonorrhoea and chlamydia will eventually impact maternal and child health if left untreated, causing morbidities and sometimes high case fatality rates. Furthermore, harmful interpretations of masculinity encourage violent behaviour inclusive of GBV. South Sudan represents an example of a complex context where humanitarian assistance priorities mesh with development goals. The key question is how best to navigate these issues in a way that is not only culturally appropriate and relevant, but also cognizant of the fact that the key development milestones reached now could serve as a building block for more sustainable changes in the future, especially for GESI issues.

Lack of disability services

Another important feature was the lack of services for people living with disabilities. This was also a key feature in the GESI strategy but there was no evidence that this was addressed in health interventions and responses. The beneficiary survey found 46% respondents with at least one difficulty as defined by the Washington Group set of disability questions (see Figure 6).

Figure 6: Disability by Age Group of Respondents



Perception of GESI as an 'add-on' component

Among the IPs, there is a focus on increasing women's participation in community health committee meetings, but the focus is on quantity and not on the quality of participation. A review of the different IP reports indicates that, as mentioned above, targets for women's participation in CHCs were reached. However, women's roles in leadership and decision-making remains low, as women are restricted by cultural norms from holding leadership positions in the community. There is also lack of harmonisation on the best ways to implement the strategy between the IPs and a lack of resources to support the implementation. There is a perception that GESI is an 'add-on' to the HPF programme and not an issue to be mainstreamed all through the different components of the HPF programme. This perception is nurtured by the fact that IPs after having already signed their contracts with HPF were given targets on GESI without any additional funding, something which might explain the discrepancies between IP work plans that are inclusive of GESI related activities but no associated budgeting for the implementation. It must also be noted that implementation of the GESI strategy only began in HPF Phase II.

Barriers at the Health Facility level

A gender sensitivity assessment was done by UNFPA IN 2017. Some of the key findings on barriers to uptake of health services at the facility level are outlined below. These include lack of adequate infrastructure and low staffing. The gender of the health workers was not seen as a barrier to accessing health care services within the UNFPA report. However, interviews with beneficiaries and health staff during our data collection identified this as a significant issue. It should be noted that the sample used in this evaluation may differ to the sample used by UNFPA, which may explain the discrepancy.

Key findings

- Health care providers are aware of the beliefs and values that create barriers for both men and women in achieving optimum health. However, they lack the knowledge on gender-responsive approaches to health care to eliminate the barriers.
- Low staffing numbers and retention, lack of supplies and medications and insecurity is linked to inadequate availability of services.
- Traditional and gender norms results in women's inequity in accessing health services due to lack of power to make decisions about using resources, including costs of services, distance to facilities and lack of knowledge
- The majority of health facilities lacked adequate infrastructure to ensure a GBV survivor's privacy, safety and confidentiality. Many health facilities do not have the needed knowledge and skills to assist GBV survivors particularly the survivors of rape. Findings revealed a lack of GBV and CMR protocols and referral pathways.
- Stigma is a key reason survivors of GBV are reluctant to report cases of rape. There are usually two main reasons women will report a case of rape: 1) because her family wants retribution from the family of the man who raped their daughter (this commonly was reported to be in the form of cattle or forced marriage) and 2) the woman or girl was physically harmed and needs immediate medical attention.

FGD Mayombiong Health Committee

'Most of the young women fear male doctors to take care of them during delivery. Some of the women could not narrate their health problems especially diseases such as gonorrhoea to men.' – Male service providers

6.4 Efficiency

This section explores issues around the efficiency of implementation and value for money (VFM). Overall, the evaluation determines that HPF is operating efficiently and providing VFM although there are areas for improvement, such as community engagement and gender equality.

Key Strengths and Achievements

- HPF supports proven cost-effective strategies by providing the right inputs mainly in terms of staffing and drug supplies but also in terms of support for key strategies;
- Tendering procedures and financial management is also deemed strong, and the long-awaited change from an Excel based system to dedicated accounting software is underway;
- Contributing to VFM is effective management of HPF, and an implementation model that we find appropriate for the context of South Sudan;
- HPF supports outreach activities that are a cost-effective way of addressing the severe lack of coverage with health facilities;
- The use of community-based structures has increased efficiency, including by increasing demand and encouraging positive behaviour change.

Key Challenges

- The underfunding of HPF and the health sector more widely by the GRSS, causes low remuneration of facility staff, leading to too few and often unqualified staff, and contributes to insufficient drug supply;
- Addressing social inclusion issues has so far been lacking, and this will reduce efficiency if not addressed in future.

6.4.1 Overall efficiency

There are mixed experiences with pooled funding mechanisms in fragile contexts[49], including funding delays and very high overhead costs. The "relative failure"[50] of the Multi Donor Trust Fund in South Sudan is one example of a less appropriate design and implementation partly due to very rigid procurement and financial management processes, leading to delays in funding. HPF does not generally incur delays in funding, although increased financial management scrutiny during HPF2 may have caused some, probably unavoidable problems given the need for strict accountability and risk of fraud. Furthermore, the overhead costs seem reasonable given the difficult context. A well designed pooled funding modality could be a highly efficient model to channel funding for service delivery in fragile and conflict-affected states because it ensures better coordination across actors, adherence to common strategies, rationalisation of monitoring and reporting systems, and multi-year funding structure that is predictable. The key requirement is that it is designed to fit with the context. In sum, the evaluation opines that the HPF represents a well-functioning mechanism given the context. It aligns with the needs and policies of South Sudan and prioritises coordination of scarce resources. It enhances efficiency by allocating all available resources against agreed priorities in a balanced and more effective manner. In the case of the HPF, an obvious action would be to coordinate services with the World Bank in Jonglei and Upper Nile. However, there seems to be legal, procurement and other issues prohibiting this from happening, according to World Bank staff interviewed.

While we find the HPF relatively efficient, the overall context of service delivery in South Sudan is not. There are a vast number of different actors that, despite some systems in place, do not coordinate optimally including various UN agencies, bi-lateral donors and humanitarian actors. HPF recently began coordinating with UNICEF, with whom they share around 70% of the same partners, and this is a step in the right direction.

HPF has promoted a "one budget" approach at CHDs, which should improve the coordinated use of different funding sources against priorities. HPF reporting shows that all counties have had one joint plan and budget for all government and HPF funding, at least since 2015. However, it has often proven difficult to get other partners to comply with the "one budget"

[49] Pavignani & Colombo, 2017
[50] Larson et al, 2013, South Sudan's capability trap

principle, as their budget structure and funding cycles may not fit with the GRSS structure. Furthermore, individual donors have reporting requirements in order to stay accountable to their own governments which sometimes do not align with each other. For this reason, it may seem that donors prioritise their own reporting mechanisms over aligning with a one budget principle.

Cost-effectiveness

Generally, HPF seems to be well managed and pays attention to the balance between cost and quality. The IP management and the HPF2 IP consortium model (where the overall number of contracts has been reduced) appears to be a good model for the South Sudan context. The level of indirect cost, i.e. <30%[51], also seems appropriate for the very difficult context.

The HPF is providing proven cost-effective measures, recommended by WHO, as outlined in the GRSS strategies[52]. The cost effectiveness of these measures has further been argued and documented in DFID's Business Case for HPF3. In addition, HPF has continued to invest in community outreach generally considered a very cost-effective approach, and an important intervention given the low level of coverage of health facilities, although UNICEF found that community interventions like integrated community case management of childhood diseases are generally lacking. Some partners raised the issue of the opportunity cost of the high emphasis on GESI in a situation where even basic health services are far from optimal, particularly where there is no additional funding specifically allocated for GESI and nutrition activities.

The key cost drivers are HPF and IP overheads, staff salaries and top-ups in lots (e.g. IPs spend up to 60% on facility staff salaries etc.) and drug supply[53]. At field level staff identified the following key cost drivers including maintenance of vehicles, mismanagement of facility equipment[54], inflation and communication problems. Field problems are exacerbated in hard to reach and insecure areas, with at least two IPs reporting needing to use satellite phones to contact facilities and collect data, or to deploy cars and staff to access the data.

HPF is generally buying the right inputs. However, it is paying too little for health staff at the facility level, leading to inefficiencies, in terms of too few and often unqualified staff. HPF probably pays a reasonable price for drugs, commodities and transportation, which are mostly

[51] According to IP's financial reporting
[52] HSDP, BPHNS
[53] In a number of areas drugs have to be delivered by air
[54] Mismanagement of facility equipment was identified through field interviews, which mentioned that new staff at the facility level were sometimes not familiar with the equipment and would either destroy it or use it for the wrong purpose.

tendered. Moreover, there is close oversight from HPF management on IP purchase of drugs and commodities.

Also, IPs must submit three quotes for any procurement over £7,500 GBP, and all drug procurement approved by HPF management. Although cumbersome, the process provides a fair amount of assurance that prices are competitive. Furthermore, DFID scrutinises all of HPF's main drug procurements.

The 2017 DFID Annual Review opines that HPF is "almost certainly more cost effective" than the humanitarian system. The evaluation team has no reason to doubt this statement. Providing routine basic health services in an efficient manner, as HPF does, invariably will be more cost effective than humanitarian assistance, albeit less geared towards addressing major humanitarian crisis. However, the advantage of having functioning health facilities in an emergency for the humanitarian organisations to tap into should not be underestimated (unless, of course, the emergency leads to closing of facilities due to violence). In addition, an Emergency Preparedness & Response facility (EP&R) was put in place.

Resources

By all accounts resources are not sufficient. Drug availability is poor, funding for salaries is so low, both at the MoH-level and through incentives provided through the HPF, that it is difficult to attract qualified staff, and there is very limited funding for improving and expanding infrastructure. In fact, one respondent raised the issue of whether HPF should reduce the number of states in which it is operating in order to increase per capita funding, and also increase cost-effectiveness in those more limited areas. The fear is that with a per capita expenditure (without IP overhead and fund manager costs) of on average around $8.5 per capita may give rise to an unfavourable trade-off between high geographical coverage and the quality of services provided. This is somewhat offset by other humanitarian and development partners contributing additional funding to South Sudan. Finally, as documented elsewhere in this report HPF achievements are generally good. In sum, we do not assess that the coverage should be reduced. It is, however, important to realise that there is a high cost associated with running the system that lead to sunken costs before any health outputs are produced. These include overheads to the fund manager and IPs, infrastructure, systems (e.g. HMIS), and drug logistics operation. Therefore, additional funding that could diminish the key bottlenecks particularly around inadequate staffing and insufficient drug supply, would most likely have a much higher marginal cost-effectiveness than the average cost-effectiveness of the whole operation. Therefore, any additional investment would be rewarded by a higher return to the investment (i.e. better value for money).

As already mentioned, the issue of no pre-payment to IPs was often raised, and it must be assumed that it leads to some inefficiencies, because IPs may not have the funding available

at the right time. With such a long supply chain (DFID – Crown Agents London – HPF Juba – lot leads – lot subcontractors) delays to payments at each step could and no doubt sometimes have quite a significant cumulative knock-on effect.

MoH and others raised the need for improving and expanding spending on infrastructure, and UNICEF highlighted the lack of solar power for fridges and lighting for facilities providing obstetric services. But this is an area where HPF is not investing much and may not have sufficient funding for doing so. Field staff pointed to the need for investments in laboratory equipment, infrastructure, transport, training and HIV/AIDS related activities.

Furthermore, as HPF3 has been put out for tender, the geographical coverage will be unchanged, and the issue should be addressed by trying to attract additional funding. It should be recognised that this is no fault of HPF as such, nor of the donors supporting it, but of the international community and the GRSS, which allocates a meagre 1.6%[55] of its budget to health, compared to an average of 7% in other Sub-Saharan African countries. It should be noted that the average for Sub-Saharan African countries' health spend is based on data that is approximately ten years old.[56][57] However, the evaluation is confident that this figure would have likely increased over time (not decreased) and highlights the insufficient funding for basic health provision in South Sudan.

VFM Strategy

HPF has a VFM strategy (produced in 2013 and updated in 2016). The most recent version is reasonably apt though still in draft, and not yet fully implemented. HPF is currently working with DFID to revise its VFM framework, and the intentions outlined in the background paper[58] are appropriate. For example, it proposes to use activity-based budgeting as opposed to traditional budgeting – something already recommended by the 2015 Mid-term Review (MTR) - as well as incorporating codified activity and geographical linkages between finance and monitoring/evaluation data.

IPs do not report specifically on VFM although those interviewed had some understanding of it, with one specifically highlighting the impact of conflict on the number of patients they could access, and therefore on the VFM of their work.

HPF Financial Management and Budgeting & Progress of PFM

At present, the budget/accounting structure for IPs is not linked much to outputs but is a mix of programmatic inputs and areas. Linking cost to outputs may not be technically possible

[55] WHO Health Observatory figure for 2015, link
[56] 2015 data shows considerable variation across countries e.g.: Ethiopia 6, Tanzania 7.2 and Liberia 2.7$/cap. Source: link
[57] Data source 2013 analysis building on older data: link
[58] HPF, March 2018, Rethinking the Value for Money Strategy of the Health Pooled Fund

given the South Sudan context, however the current structure makes it more difficult to measure efficiency, and the plan to link it to activities in the future will improve the situation.

HPF financial management has improved over time leading to a better overview of expenditures. We found that there are many checks and balances in place for IPs. The budget and accounting process is quite elaborate, and deviations from budget need approval by HPF management, and can only be up to 10%. Nutrition and community engagement expenditures cannot be reallocated to other areas. Some IPs complained the processes were too rigid and time consuming, although all agreed that HPF had provided support on how to use the template, and that reporting had therefore become simpler over time. Despite the very strong recommendation of the MTR to shift to a dedicated accounting software, the accounting system is still based on Excel, which is not optimal, as in the words of the MTR it "represents a significant fiduciary risk", and a threat to VFM. HPF has explored the possible alternatives, and after some difficulties, has started building a new accounting system based on QuickBooks (dedicated accounting software). Not to have this in place 3 years after the recommendation represents an unreasonable delay.

HPF management arrangements have been evolving and were reviewed and discussed throughout HPF1 and 2. HPF is a very complex undertaking operating in an exceptionally difficult environment and clearly it has been a learning experience, benefiting from six years of continuity of the fund manager and also considerable continuity on the IP side. A lot of experience has been gathered, and informed changes in management, resulting in a more efficient management approach.

The protracted transition phase from HPF1 to 2 with repeated short-term contracts with the fund manager and IPs have resulted in several problems including delayed appointment of staff and delayed top-ups for facility staff, resulting in drops in some service outputs, for example documented by the drop-in immunisations in the latter half of 2016[59].

HPF was originally supposed to strengthen public financial management (PFM). However, due to the political situation, including much distrust between donors and the central government, it was decided for HPF not to contribute to improved PFM. Nevertheless, HPF supported CHDs to access government financial transfers.

6.4.2 Efficiency of community engagement approach

Overall, the use of community-based structures has increased efficiency, especially in terms of knowledge sharing and, to a certain extent, encouraging positive behaviour change.

[59] As pointed out elsewhere, the security crisis in June 2016 compounded the delays in contracting

As pointed out in the 2016 VFM Review, the strategy to provide community outreach services has proven to be particularly effective contributing among other things to achieving immunisation targets.

As indicated earlier, HPF has engaged with the MoH in developing the Boma Health Initiative, which is the government's ambitious strategy and plan to boost service delivery by community health workers and community engagement along the lines of positive experience in other countries. The recognition of the cost effectiveness of such interventions and the fact that about half the population is >5 km from a health facility and will remain so for long time to come, has, as mentioned above, prompted DFID to roll its Integrated Community Case Management (ICCM) program into HPF3.

As discussed, HPF has in line with the BHI supported the reconstitution of community health committees to make them more representative, especially of women, youth and other vulnerable/marginalized groups.

The evaluation found that the IPs engage in a number of community-based health-oriented activities:

- Awareness raising with schools through health clubs
- Mother-to-mother support groups of mothers and expectant women as a peer mechanism to provide support and awareness raising among community members.
- Reconstituting and training of community health committees
- Support to home health promoters
- Training and incentives for traditional birth attendants

Although there is limited qualitative reporting from IPs on the results being achieved by the community engagement activities, information from interviews indicates that these activities have been able to achieve a number of results including:

- More children under-five being treated at the facilities
- More expectant women visiting the facilities for ANC, delivery and for immunisation of children
- Greater awareness about WASH at home, within the general community and among school-going children
- Some awareness around family planning, especially where youth – in deference to the norms and culture – seek to access condoms and other methods secretly; although the extent to which awareness can be raised successfully and more widely is inhibited by the conservative nature of context
- Increased knowledge around nutrition and efforts by parents/families accessing the services
- Restarted and relatively more active health committees and community health workers, despite challenges around payments or incentives
- Enhanced engagement of committees with the health facilities, specifically with regard to oversight of facility activities and staff, as well as participation in joint meetings

With regard to awareness raising, using community-based mechanisms can be said to have enhanced efficiency in that it offers an infrastructure for efficient knowledge dissemination, and for positive behaviour change – elements that are not as easily accessible to agencies or government institutions due to their perceived distance from the day-to-day life of the community members. Behaviour change is especially important here; groups such as the mother-to-mother support groups and school health clubs create peer pressure to influence this positively. In rural communities such as those found in South Sudan, such influence is key to eliciting the kind of behaviour change sought by the programme.

As indicated above, the lack of sufficient funding was said to have had a negative effect and impeded the results achieved by the programme in this regard. HPF 2 was also said to have had minimal training targeted at health committees and HHPs, further affecting their ability to operate effectively, especially considering that the committees were still being revamped, and needed a number of training sessions to be able to effectively undertake their tasks. On the other hand, it is understandable for the programme that training was restricted, considering the high attrition rates of these groups.

According to HPF staff, although IPs did have a community-engagement budget, many did not utilise this sufficiently, especially due to lack of technical community engagement staff on their teams. The recruitment of an HPF community engagement specialist injected new impetus to this activity. For example, IP learning events were organised around community engagement and supported streamlining relevant activities into their implementation, some at no additional cost,[60] thereby resulting in cost efficiency.

6.4.3 Efficiency of GESI

Interviews with HPF staff responsible for implementing the GESI strategy, as well as a review of the financial report (2016-2017) revealed that less than only 0.5% of expenditure was spent on community participation. Clarity on other sources of financing for community engagement activities is needed. The total community engagement budget is about 1% of the total HPF budget as asserted by DFID. From our perspective, community engagement activities are core to addressing harmful gender norms in the community and promoting uptake of related sexual and reproductive health services, including post-sexual violence services. We would therefore encourage a ‘gender sensitive budgeting’ approach during the next phase of the programme. This could involve working closely with a gender adviser during the budget development and implementation phase. The gender adviser should also work closely with IPs in the development of their budgets and implementation plans.

[60] For example, building in community awareness raising sessions into activities such as nutrition events or vaccination drives.

6.5 Sustainability

This section addresses the degree of integration with long term processes, structures, norms and institutions. Overall, there are currently no prospects for long term sustainability, neither financial nor institutional, but some elements of the programme are likely to have some lasting effect, even after the exit of the programme.

Key Strengths and Achievements

- Despite the context HPF has built sustainability where possible, including:
  - Capacity building of CHDs and facility staff;
  - Supporting health committees;
  - Good health practices promoted by awareness-raising activities.

Key Challenges

- Continued use of the former 10 state structure;
- Current South Sudan context and MoH funding levels mean only minimal sustainability is possible.

There are currently no prospects for long term sustainability, neither financial nor institutional, in the programme because of the operating context in South Sudan and the lack of capacity and funding at the MoH, as directly expressed by DFID from the outset of the evaluation. Should the context change, HPF as a funding and implementation modality could be flexible enough to adjust its approach to have more focus on this aspect.

Despite challenges around addressing sustainability, HPF follows national strategies, such as the HSDP, BHNP and MoH Essential Drugs List (EDL), uses MoH HMIS/DHIS data, and co-locates with CHDs, as well as on HSS with MoH. There is generally a good collaboration with state and national level MoHs and CHDs. Utilising the existing government structures to the maximum possible in South Sudan contributes to the longer-term sustainability of the interventions. The reluctance of the HPF donors, while justified by cost, to align with the new state structure could hamper long term sustainability.

HPF does not invest in strengthening or establishing training institutions that could contribute to the adequate supply of health workers in the future. Such investments are being made by other partners, including some contributing to HPF (i.e. Canada and Sweden), and it is beyond the scope of this evaluation to assess whether such “division of labour” is sufficient, or whether it should be a priority to allocate HPF funding to produce more health workers. GRSS systems and capacity building is minimal, particularly at the central level. One issue is the competition for salaries, which could undermine GRSS staffing.

At the local level, however, there are elements of the programme that have the potential for being sustained in the long-term. For the example, the ongoing capacity building that is taking

place with health facility staff – through mentoring – as well as with the revamping of the community health committees to include more women. The rolling out of the GRSS/MoH Boma Health Initiative, supported by HPF, will likely strengthen the role of these committees further.

Another area where the programme is likely to have a lasting effect in the long-term is the awareness raising element possibly leading to behavioural change. However, this is an activity that requires long-term engagement, and continuous awareness raising and advocacy.

7 Conclusions

The sub-section headings are the same as the evaluation questions in the TOR for the evaluation.

Overall

- The HPF design and implementation is an example of good practice in a context like South Sudan;
- Underfunding of HPF2 has had a significant negative impact on the programme, particularly insufficient drug supply and staffing challenges at the facility level. The risk of decreased funding is further exacerbated by uncertainties around future donor engagement;
- Any additional funding into the already operational HPF system would be rewarded by a higher return to the investment given that a significant proportion of the existing funding goes into sunken costs needed to run the programme such as to the fund manager, IP management, HMIS and other systems, infrastructure, drug logistic systems etc. Additional funding would therefore mostly go directly to service delivery, such as additional drugs and better qualified health staff. Conversely, any reductions in funding would render the programme less cost-effective. In practice, this means that more lives (and DALYs) can be saved per dollar if HPF was more adequately funded and would encompass substantially higher VFM.
- HPF has been a major contributor to improved service delivery, and beyond any reasonable doubt also to improving or sustaining health outcomes;
- The programme has had some positive effect on health system strengthening; for example, the strengthening of the HMIS, and the initiation of the HRIS;
- GESI activities are important, and many are just starting up. This is an area that needs to be boosted, although this is not easy given the level of resources and South Sudanese context.

To what extent has HPF identified, understood and responded to the essential health needs (as defined by the programme) of women, men, girls and boys in South Sudan?

HPF has supported the implementation of proven service delivery strategies addressing the major health issues in a country like South Sudan. This included a strong focus on women and children.

South Sudan presents a number of barriers to access; physical, gender and cultural, as well as economic. Given the resources available to HPF the approach is deemed largely appropriate in terms of addressing the needs, although less so regarding gender and social inclusion (see later section).

However, there needs to be a greater emphasis on holding consultations with local level health sector structures, both government and community-based in order to align more closely with the specific needs of people on the ground.

To what extent has the HPF aligned with the health sector priorities of the Government of South Sudan?

HPF has aligned with all MoH (GRSS) health strategies and approaches. Furthermore, HPF has worked closely with MoH at the national and state level, as well as with CHDs, and revived community-based structures. This was further strengthened by co-locating the HPF HSS team with MoH, and HPF and IP staff with State MoHs and CHDs.

Despite not being able to implement a more comprehensive health system strengthening approach envisaged at the beginning of HPF1 due to factors beyond the control of HPF management, the programme has supported the MoH in developing a number of strategies, systems and approaches that are strengthening the health system.

To what extent have the expected outputs and outcomes been achieved, in particular for children under-five and women, and what have been the main factors influencing the achievement or non-achievement of results? Were there unintended and/or negative results?

The South Sudan context is extremely difficult, and funding for the programme is clearly insufficient. Despite this HPF has achieved some impressive results, including:

- A massive and sustained increase in patient attendance and skilled deliveries;
- Meeting a large proportion of its targets;
- Every respondent considered HPF a major contributor to service delivery, probably the biggest;
- The beneficiary survey carried out by the evaluation showed a strong perception of improvement in key areas during HPF; as well as a fair amount of satisfaction with services.

Areas showing less impressive performance were around family planning and sexual and reproductive health services and addressing gender-based violence. Many service indicators have plateaued during HPF2, including OPD rates. This could be due to a saturation of the demand at the present level of service quality and/or the lower funding for HPF2.

The measurement of the programme results relies largely on the country's HMIS/DHIS, and at the outset of HPF the wise decision of strengthening HMIS rather than implementing a parallel monitoring system was taken. The result is a strengthened HMIS, that we assess to be reliable enough to serve as the monitoring tool for HPF performance.

Drug supply became part of HPF in the second phase (HPF2) and has faced a number of problems caused by difficulties in starting up the systems, insecurity, difficult geography and weather conditions, poor infrastructure and the massive underfunding of drug supply. However, within the limitations of the South Sudanese context and the funding available, drug

supply has improved in terms of timeliness, although the last mile delivery, which is not part of HPF, remains a challenge.

The evaluation team has not carried out an institutional assessment of HPF, but from interviews and reports we assess that HPF is quite well managed at this point in time. This has varied over the programme, and both donor and HPF management is hampered by the context, where staff absences and changes are frequent. Given DFID's oversight responsibility, stakeholders felt there was a need for more DFID staff working on HPF.

To what extent was HPF programming in South Sudan conflict sensitive, and consistent with the OECD principles and best practices for Fragile and Conflict-Affected States?

The evaluation found no evidence of a formal approach to conflict sensitivity in HPF, although it should be noted that DFID's approach to conflict sensitivity has not yet been rolled out to the programme. Although donors have not formalised requirements at present, there are plans to engage around this area going forward. Nevertheless, several respondents identified areas where HPF and its IPs were sensitive to the causes of conflict, and in some areas, also engaging in conflict mitigation activities through collaboration with community leaders. Furthermore, the new EP&R mechanism will allow the programme flexibility in responding quickly to emergencies. The evaluation also determined that HPF largely[61] complies with principles for engaging in fragile states and conflict situations promoted by the OECD and the international community at the sector level.

To what extent was the HPF coordinated with other stakeholders involved in delivering essential health services throughout the country?

The evaluation finds that HPF itself is an example of a powerful donor coordination mechanism, though there are areas for improvement. For example, the coordination of development partners is not functioning well, and there is considerable scope for improvement, including with humanitarian actors facilitated by the Health Cluster coordination mechanism. One suggestion to improve this is a widening of the attendance of the HPF Steering Committee to include other key health actors, such as the World Bank, UNICEF, UNFPA and WHO.

Another challenging area of coordination is presented through the lack of progress in harmonising salaries and incentives which has caused considerable problems. Although the issue extends beyond the scope of HPF, the programme should take more action to harmonise IPs within its own programme.

[61] The principles are mostly not designed for sector level engagement, making those which address overall political engagement less relevant.

Coordination between HPF and the MoH has worked well. The technical working groups established by MoH are a good example and are an important forum in establishing dialogue in some areas such as gender.

To what extent has the nutrition component of the programme been successful in integrating nutrition into the package of health services offered and achieving its expected results?

HPF has improved its capacity on nutrition during HPF2, and a number of training activities have been undertaken to improve facility staff capacity. The nutrition component has been very successful in achieving its targets. However, several respondents argued that targets were set too low, something the evaluation team has not been able to assess. It is worth noting that nutrition services are well utilised, and fairly well appreciated by the public according to the beneficiary survey.

To what extent has a Gender Equality and Social Inclusion strategy been implemented?

The HPF programme has made laudable efforts to integrate a gender lens in the implementation of its programme. Women and children have been effectively targeted, and nutrition and antenatal outcomes in many cases have been successfully achieved. However, other gaps regarding gender sensitivity and adequate provision of GBV services at health facilities still exist. Furthermore, there is limited progress at the community level because of the need for capacity building among IPs.

Despite some positive steps, the evaluation finds that the focus on gender without addressing other social vulnerabilities like ethnicity, harmful cultural norms, socioeconomic status and disability, is a weakness in the implementation of the strategy, particularly given the context in South Sudan.

What were the main gender-based barriers and challenges to programme delivery and achievement of outputs and outcomes?

The evaluation found that in some communities, harmful gender norms and the rigid roles for men and women sometimes served as a barrier to accessing health services. The gender imbalance among health staff also served as a barrier to access, as most women would prefer to be treated by female health workers. Medical staff were trained on the clinical management of rape, however, not many of them had the skills to understand the role of harmful gender norms in discouraging access to services.

Were human and financial resources used in a cost-effective way for the outcomes achieved, in light of the operating context, needs of the beneficiaries, priorities of the MoH, and the organizational and management structures of the HPF? Was the programme implemented in the most efficient way compared to possible alternatives?

Given the challenging operating environment in a context such as South Sudan where operating costs are extremely high, the evaluation determines that the HPF is efficiently managed by competent staff and generally pursuing proven cost-effective primary health care interventions, mainly at the facility level, although the programme also carries out some outreach and community engagement.

However, one serious issue is the inadequate funding of HPF which leads to an unfavourable trade-off between high geographical coverage and the quality of services provided. We find that, even with the additional inputs from developing and humanitarian partners, it is insufficient to ensure adequate drug supply, resulting in serious stock-outs, although these are not only caused by lack of funding as outlined in the report. Furthermore, it cannot sustain an appropriate level of facility staffing in part due to the low level of remuneration.

In terms of trade-offs in the context of inadequate funding, the current model seems appropriate despite major issues around inadequate drug supply, low remuneration and other challenges mentioned throughout the report. The alternative option of reducing geographical coverage seems inappropriate because of the tense political situation. Removing support from certain areas could exacerbate existing ethnical and political tensions. Moreover, there is a moral imperative to attempt to cover the whole population given the very high need across all geographical areas. In regard to HPF3, the DFID business case is well made for prioritising community-based services over investing in infrastructure, which we believe will help to maximise service delivery under the current funding model.

The continued use of Excel rather than a dedicated accounting software as recommended in the Mid-term Review, was another area of concern. However, the new software was being rolled-out at the time of the evaluation and HPF accounting systems had improved over time and featured a significant number of checks and balances regarding IPs' budgeting and budget implementation.

Has the community-based approach trialled in HPF for treating common diseases in children under-five been a cost-effective approach in the context of limited access to formal health facilities?

HPF has supported a community engagement approach, including supporting the establishment and running of community health committees (e.g. BHCs), support to HHPs and training of traditional birth attendants, mother-to-mother support groups, and health clubs in schools. According to interviews and IP reports these activities have increased demand and awareness. This has to some extent improved consumer interaction with authorities, and according some respondents increased demand and awareness. However, the degree to which the CHCs/BHCs have informed implementation at the local level remains unclear.

What steps have been taken to create or integrate with long-term processes, structures, norms and institutions for sustaining the investments made by HPF?

Given the current political and economic situation there is currently not much prospect, nor ambition for long term sustainability. Despite this, HPF has taken a number of steps to build sustainability in the programme. For example, HPF follows national strategies and coordinates closely with MoH at all levels, though notably does not follow the new 32 state structure which has caused operational challenges. HPF has also supported the development and implementation of a number of MoH strategies and systems, most notably HMIS. Additionally, HPF's investment in awareness raising may contribute to sustainability through changing people's behaviour in the long-term regarding improved health seeking and avoiding risky behaviour.

8 Recommendations

The recommendations below do not address the design of HPF3 as this had already been developed at the time of the evaluation. Based on the overall findings, we would like to note the following:

- The evaluation commends the HPF donors for ensuring the continuation of the programme, and for including a strong community health worker component, which we consider an appropriate strategy to improve coverage of basic health services;
- The evaluation agrees with the choice of focus areas, i.e. a continuation of present scope in terms of facilities, and the addition of a much stronger community health service component;
- The evaluation supports the current implementation modality and does not believe it requires restructuring.

The following recommendations have been grouped according to the relevant actors though it is recognised that implementation may involve several stakeholders.

8.1 Recommendations for MoH

Higher Priority

1. **The Steering Committee needs to become more efficient** in providing strategic guidance. It has an important role to play in providing strategic direction for HPF, as well as securing government ownership. Given the substantial role HPF plays in all aspects of service delivery, the membership of the committee should be expanded to include other significant partners, development as well as humanitarian, in order for it to function efficiently in giving strategic direction for comprehensive and well-coordinated service delivery. An effort, not least from MoH that it is co-chairing the SC with DFID, and ultimately responsible for the health services of South Sudan, must be made to increase its role and efficiency.
2. The MoH, together with HPF, should **document and analyse the issue of drug leakages**, to assess the size and nature of the problem, and address it accordingly.

Lower Priority

3. The MoH should follow up decisively on its intention to have much more **uniform approach to service delivery between the HPF and World Bank** supported states.
4. The MoH should invest time to **improve the functioning of technical working groups**, including creating clear TORs, responsibilities and deliverables in each of them.

8.2 Recommendations for DFID and other donors

Higher Priority

1. **Strongly advocate for more funding.** HPF is currently underfunded and will like remain so for HPF3[62]. Given the likely considerable impact of investing in HPF for one of the world's poorest and most hard-hit populations, an advocacy effort to attract additional funding should be undertaken.

2. **Improve donor coordination**. While the humanitarian Health Cluster seems to be working well, coordination of development partners is lacking, and needs improvement. This includes the interaction between humanitarian and development actors.

Lower Priority

3. Given the severe lack of qualified staff in HPF supported facilities the need for **support for South Sudanese pre-service training institutions** should be assessed, and opportunities for support, within HPF and from other sources, explored.

8.3 Recommendations for HPF management

Higher Priority

1. **A smooth transition in contracting should be prioritized** at all levels (DFID, HPF, IPs) to ensure minimal disruption in service delivery. The contracting processes, not least of the fund manager between HPF1 and 2, was marred by delays sometimes mitigated by stop gap measures, probably hampering service delivery. Smooth transition from one fund manager and IP to another should be made a priority.

2. A **baseline assessment of gender issues** should be undertaken. This is important for understanding the context and exploring issues around social inclusion that include but are not limited to gender. This would inform the development of relevant strategies and promote the use of an intersectional lens in assessing health priorities of the different beneficiaries.

Lower Priority

1. **DFID Juba office needs to be sufficiently staffed.** DFID is carrying a large workload providing day to day oversight of HPF and does not have sufficient staff to do this efficiently. During HPF3 DFID South Sudan should be adequately staffed to carry out the function. This problem is already at least partly being addressed in the plans for HPF3, for example to transfer certain functions to the future fund manager.

8.4 Recommendations for HPF management and IPs

Higher Priority

1. **Improve learning at all levels.** There should be considerable effort around consistent & accessible learning platforms where IPs can engage & learn from each other. HPF

[62] In the HPF3 Business Case shared with the evaluation, figures indicating DFID and expected funding from others were removed.

is an incredibly difficult undertaking, and there has been a lot of learning during the past six years, but it has not been formalised. An effort for more consistent and accessible learning should be part of implementing HPF3. This could be done through periodic learning platforms where IPs can engage to learn from each other. Additionally, periodic learning products should be developed, distilling IP innovations and practices that could be of benefit to other implementing partners as well as other actors in South Sudan or elsewhere. Furthermore, IP reporting is focused on quantitative data with very little qualitative information. To further augment the learning, HPF should encourage collection of qualitative/narrative data that are focused on significant changes experienced during the programme, in addition to quantitative data, IP reporting should become more analytical, i.e. analyse the causes and dynamics underpinning the findings.

2. **HPF needs to address the issues of the last mile delivery and the role of CHDs in distributing drugs**. The pros and cons of the CHD practice of splitting up drug kits and redistributing the content should be assessed, and a decision made in consultation with MoH on the right approach. Last mile delivery up until this year was outside of HPF responsibility; however it is included in IP contracts this year. This will probably not resolve all the issues, and an increased effort from HPF is needed, particularly around supporting IPs given DFID's contractual responsibilities.

3. **HPF should develop a communication & advocacy strategy**, in order to:

    a. Support communications between key stakeholders in the programme: government, donors and other stakeholders;
    b. Streamline and guide communication and advocacy activities at the local level; for example, the awareness raising activities on the ground, the actors to be involved and the channels to be used, including the use of radio for behaviour change and awareness raising activities.;
    c. Communicate the success stories to the outside world, as part of an advocacy to raise the funding needed for HPF to achieve even better results;
    d. This could be guided by a dedicated communications staff embedded within HPF, and/or contracted communication support (with capacity in the quite different aspects of HPF communications).

4. **Capacity building on gender and social inclusion** must be intensified and widened to include aspects of social inclusion such as disability, age, ethnicity and socioeconomic status. There is a need to ensure that a sustained budget is set aside to implement the GESI component.

Lower Priority

1. **The community engagement component should seek to be more demand-driven**. So far, the community engagement has been largely supply-driven, with IPs planning and bringing in community structures to implement the plans. Going forward, and to ensure greater buy-in from the various stakeholders at the grass-roots level, this engagement component should seek to be more demand-driven, where the community structures are involved in the planning and implementation of activities.

2. **HPF should explore the issue of user fees** and address it if it is barrier to access. User fees have been identified as an issue in the beneficiary survey. Whether the findings reflect unofficial user fees charged by facilities, bribes paid to staff or payment for drugs not available at the facility, is not clear, but the findings are serious enough

to explore the impact on access for poor people, and in collaboration with MoH to look at strategies to address the issues.

3. **HPF and IPs should develop approaches to identify and assist low performers** among counties and facilities. The beneficiary survey also identified some striking differences across counties and types of facilities, such as drug supply. HPF could consider a system continuously identifying the outliers and addressing the issues underpinning low performance. This could include elements such as: league tables, capacity building, addressing low staffing or poor infrastructure etc.

9 Learning

9.1 Reflections on the HPF model

A pooled funding model, designed in accordance with the specific context, is a very effective modality in fragile states. By itself it increases donor coordination, and as demonstrated by the South Sudanese HPF, can lead to substantial increase in service delivery for a big proportion of the population. The evaluation considers the HPF in South Sudan a strong example which could inform and inspire efforts in other countries with a similar context.

It is possible to engage constructively with government at the sector level – technical staff in MoH as well as decentralised structures, even in situations where the donor community has strong disagreements which sometimes conflicts with the leadership of the country and leads to a general reluctance in supporting the central government. Overall, we find that the HPF model contributes to better service delivery as well as systems stabilisation.

Success stories, such as this, need to be communicated effectively to the international community in order to attract funding. South Sudan's HPF constitutes an opportunity to contribute effectively to providing health services to one of the poorest and most hard-hit populations on earth.

Understaffing, rigid procedures and difficult working environments can result in delays in contracting, particularly transitioning from one phase to another. When financing health service delivery, delays cost lives and an extra effort should be made to foresee problems, apply procedures flexibly and add the needed administrative resources to avoid such situations.

Adding components without securing additional funding, comes with an opportunity cost. For example, the cost of training health workers on gender issues may mean that they have less medicine (oxitocics) to prevent women dying from post-partum bleeding.

9.2 Reflections on the evaluation

Conducting an evaluation in a fragile environment such as South Sudan is very challenging due to the unstable and sometimes volatile context. We mitigated and managed risks throughout the evaluation by having an in-depth understanding of the local context and daily tracking of the conflict, as well as having close engagement with local partners. We upheld the notion of remaining flexible and adaptive to complexities on the ground, for example, by changing data collection locations as advised by our local partner in coordination with DFID and Global Affairs Canada when crises emerged. Additionally, we anticipated technical challenges around primary data collection in the field which we mitigated by deploying early into the country to provide training to local enumerators and testing data collection tools in advance. We also maintained complete transparency with DFID and Global Affairs Canada throughout the entire process to ensure visibility regarding methodological limitations innate to conducting evaluations in fragile environments.

10 Annexes

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- Annual Operational Plan CHD Juba County
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Annex 2 Methodology

Our methodology was based on our methodology framework, presented in full in the table below:

	Question and issues to explore[63]	Analytical approach	Principal judgement criteria
Relevance	**1. To what extent has HPF identified, understood and responded to the essential health needs (as defined by the programme) of women, men, girls and boys in South Sudan?**		
	• Degree of consultation with the different beneficiaries during the development and implementation of interventions • Opinions about the health priorities of women, men, girls, and boys in South Sudan • Are the essential needs clearly identified by MoH and/or HPF, and if so which are they • How appropriate the response of HPF is to the essential needs of the different beneficiaries/target groups • Identification of specific challenges and barriers to accessing health services for the different target groups • Key changes that have been made during the life of the programme in response to inputs and feedback from beneficiaries (e.g. via the Community health committees) and the effect on the delivery of health services	• Desk study and review of key documents • Gender analysis of programme strategy, reports and budgets • Benchmarking of initial business case and supporting documentation against outputs and outcomes • Benchmarking of expected outputs and outcomes and realised outputs and outcomes against externally available data • MoH, WHO and other relevant documents • Focus groups with key beneficiaries of the programmes and project implementers • Collection beneficiary stories (Most significant Change?) • In-depth interviews with project officers, implementers and health professionals • Health facility observations • Beneficiary survey	• Documents exist showing evidence of whether the HPF has identified, understood and responded to the essential needs of its beneficiaries • # of respondents who perceive HPF identified, understood and responded to the essential health needs of women, men, girls and boys in South Sudan combined with the justification of their opinion • Alignment with government strategies/priorities and their involvement in decision making • Evidence of data and indicators, disaggregated by gender, age and wealth quintile (if disaggregation is possible)
	2. To what extent has the HPF aligned with the health sector priorities of the Government of South Sudan?		
	• Extent of HPF alignment with the GoSS health sector priorities as documented in the health policy, HSDP (Health Sector Development Plan) strategy and the Basic Health Services Package of South Sudan	• Benchmarking of HPF priorities against GoSS health sector priorities (Thematic	• Alignment of HPF and GoSS health sector priorities documented in programme and government documentation

[63] The degree of depth in answering the questions and describe the issues will depend on the data and information available and be subject to the constraints of the limitations of time within the contract.

	• Degree of influence of the HPF on health systems strengthening and accountability of GoSS	analysis of project strategy documents and reports) • KIIs with GoSS, WHO and others • In-depth interviews with policy makers (government and other stakeholders), HPF programme managers and implementing partners	• # of respondents (policy makers, programme managers and implementing partners) who perceive the HPF and the GoSS priorities were aligned • # of respondents who report a change in accountability mechanisms and evidence of plans to implement HSS activities at the GoSS level • # of respondents who think there is an alignment of HPF and GoSS gender and women's health priorities (disaggregated by gender)
			• Evidence of joint consultations and meetings between GoSS key policy makers and HPF programme managers on key intervention areas
Effectiveness	**3. To what extent have the expected outputs and outcomes been achieved, in particular for children under age five and women, and what have been the main factors influencing the achievement or non-achievement of results? Were there unintended and/or negative results?**		

	• Extent to which the following expected outputs and outcomes have been met
	  ○ Strengthened delivery of health services, responsive to needs of women and children in the following key areas: (ANC, Nutrition, ARI, EmONC, PMTCT)
	  ○ Increased ownership, governance and demand for health services by communities (specifically through increased representation of vulnerable groups in HCs and targeted community led interventions outlined in the community strategy)
	  ○ Strengthened health systems at state and county levels (Including capacity building for gender sensitivity at the service provider level) as well as existence of infrastructure and skills-building
		• Analysis of baseline and subsequent data (phase 1 and phase 2)
		• Thematic review of reports
		• KIIs with a range of stakeholders within GoSS and project implementers
		• KIIs and FGDs with project officers and implementers, stakeholders within GoSS, health professionals and community stakeholders (including beneficiaries, and members of the community HCs-Boma and Payam)
		• Benchmarking HPF partnerships arrangement with major stakeholders
			• Evidence of changes (positive or negative) in impact and outcome indicators
			• Number of respondents able to give examples of best practices included into the programme delivery (disaggregated, if possible, by age, ethnicity and gender)
			• Success stories of the programme being adaptive to the context
			• # of respondents who perceive procurement arrangements as being effective/availability of drugs and supplies as being timely

• Degree of attribution of achievements to the HPF, and other factors that could have contributed to these achievements
• Any negative results of the HPF or unintended outcomes, e.g. unintentionally confirming/strengthening of norms around gender inequality, or lack of sensitivity to barriers to access for vulnerable groups
• Situation in regard to procurement and availability of drugs and medical supplies
  ○ Availability and quality of drugs and medical supplies
  ○ Changes experienced between HPF 1 and 2
  ○ Procurement process/drugs supply chain of HPF 1 and HPF 2
  ○ Whether funding for drug supply from all sources is sufficient to avoid stock outs in health facilities
• Procurement and supply chain management arrangements in comparison to those of other health service providers (World Bank, Global Fund, etc.). Procurement arrangements in comparison to those of other health service providers (World Bank, Global Fund, etc)
	involved in delivering essential health services
	• Review of documentation on procurement arrangements
	• Facility observation (observation checklists)	

3.1. How effective are HPF management arrangements?		

• The management arrangements between the following actors and how the function in practice
  ○ MoH and HPF
  ○ DFID and other HPF donors
  ○ DFID/other donors and the HPF Steering Committee
  ○ The donors, HPF and the GoSS
  ○ DFID/other donors and HPF Fund Managers
  ○ HPF and IPs
	• Desk study and review of key documents while in the field (HMIS data, DHIS data, data collection tools, facility supervision logs)
	• Benchmarking of initial business case and supporting documentation against working arrangements
	• KIIs and FGDs with key beneficiaries of the programmes and project implementers
		• Documentation detailing phasing out of phase 2 and launch of phase 3 arrangements (contracts, MoUs)
		• # and arguments of respondents who perceive arrangements as sufficient

○ IPs/Lot Leaders and County Health Departments • Health facilities/county health departments and community health management groups	• In-depth interviews with project officers and implementers and health professionals, incl MoH • Observations done at HPF health facilities	
3.2. What are the M&E arrangements of the HPF?		
• The quality assurance mechanisms that exists in HPF at national and county levels, as well as any QA mechanism the government system may have • The functionality and use of the DHIS and HMIS system and its use for identifying HPF outputs • Alignment of HPF M&E with that of the GoSS.	• Desk study and review of key documents while in the field (HMIS data, DHIS data, data collection tools, facility supervision logs) • Benchmarking of initial business case and supporting documentation against working arrangements • Comparison with GoSS M&E system • KIIs and FGDs with key beneficiaries of the programmes and project implementers as well as GoSS officials • In-depth interviews with project officers, implementers and health professionals • Facility observations (observation checklists)	• Existence of an up-to-date M&E strategy • # of respondents who understand the M&E requirements • Communication and dissemination plan • Existence of HMIS/DHIS platforms and data at facility level • Documentary evidence of supervision visits and supervision plans • Existence of learning platforms/forums • # of respondents who say they are given feedback from reviews and monitoring
3.3. How well have the community engagement arrangements been implemented and what effects have these had on the delivery of health services?		
• How well the community empowerment strategy is being implemented ○ Working arrangements between communities, counties (including NGOs), state and national level ○ Capacity of NGOs/IPs and facilities to operationalise the strategy ○ Capacity of community groups and staff ○ Beneficiary feedback mechanisms ○ Inclusivity/ adequate representation of vulnerable/community groups (gender, PLWDs, IDPs, etc) ○ Involvement of community groups in HFP and MoH governance structures/systems	• Thematic review of documents • KIIs and FGDs with project officers and implementers, stakeholders within GoSS, health professionals and community committees and stakeholders • Site visits • Beneficiary survey	• Community engagement plans at IP and community level • # of respondents who perceive that community engagement arrangements have been put in place • # of reported community consultations with HPF IPs • Characteristics of health committee (HC) representation (representation of vulnerable groups, as well as number in decision making positions) • Existence of a community/beneficiary feedback mechanisms

○ Whether increased community governance has led to increased government and HPF accountability and responsiveness to citizens'		• Evidence of community feedback feeding into programme implementation
• Key results in service delivery and uptake through community involvement		
• Positive or negative effects from supporting enhanced community engagement in health service delivery		
4. To what extent was HPF programming in South Sudan conflict sensitive, and consistent with the OECD principles and best practices for Fragile and Conflict-Affected States?		
• Degree of awareness of the existence of a conflict sensitive strategy • Have a conflict analysis informed the design of interventions from HFP and its IPs • Are there mechanisms, capacity and resources to address the conflict related issues identified • Does the risk management adequately reflect the conflict issues identified	• Benchmarking tools and processes used to deliver the HPF against best practice in conflict sensitivity, OECD principles and best practice for working in FCAS • Assessment of HPF risk management and emergency preparedness • Thematic review of documents • KIIs and FGDs with project officers and implementers, stakeholders within GoSS, humanitarian actors, health professionals and community stakeholders	• Evidence of conflict sensitivity strategy implementation • # of respondents who perceive the HPF's programming was conflict sensitive • # of programmatic documents taking into account conflict sensitivity and referring to OECD best practices • Evidence of conflict sensitivity in the monitoring reports / annual reviews
4.1. How responsive is the HPF to humanitarian needs?		
• How well the HPF collaborates with humanitarian actors • Working arrangements, if any, put in place to respond to humanitarian needs, including of various vulnerable groups (women, adolescents, PLWDs, youths etc.) • How responsive/reactive the HPF is to emergencies	• Mapping of humanitarian and development partners in health • Outlining of key OECD principles relevant for the South Sudan context • KIIs with humanitarian actors, IPs, GoSS, health professionals • Review of documents on working arrangements/plans with humanitarian actors, including on EP&R	• # of respondents who think the HPF's programming is responsive to humanitarian needs • Existence of functional strategic working arrangements/plans in humanitarian situations
5. To what extent was the HPF coordinated with other stakeholders involved in delivering essential health services throughout the country?		

	• Extent of HPF coordination with other stakeholders, including private sector, delivering on essential health services • The status of the planned harmonisation of salaries, improvement of PFM and capacity building of GoSS as well as general HSS on the different levels. What the reason/rationale is for any lack of progress. Whether there have been missed opportunities to take this area forward	• Benchmark HPF partnerships arrangement with major stakeholders involved in delivering essential health services in SS to assess degree of coordination • Evidence of formal mechanisms in place to share learning between the different programmes • KIIs with other stakeholders to assess degree of coordination	• # and arguments of respondents who think HPF coordinated effectively with other stakeholders • Success stories and accounts of failures of cooperation • # number of major stakeholders HPF programming coordinated with at the different levels
	6. To what extent has the nutrition component of the programme been successful in integrating nutrition into the package of health services offered and achieving its expected results?		

	• How well the nutrition component been operationalised
	  ○ Harmonisation of nutrition indicators with Nutrition Information System (NIS)
	  ○ Capacity of staff (health facility and community staff (CHWs and CHVs)
	  ○ The degree of engagement with the humanitarian nutrition cluster
	• The capacity of the HPF and the IPs with regard to nutrition support
	• The key improvements in nutrition support between HPF 1 and 2
	  ○ The results being achieved by this support
	  ○ Whether the results being achieved are positive of negative
		• Review of thematic documents/reports
		• Baseline study of the situation before the introduction of the nutrition component
		• KIIs with IPs, health staff, government actors, community stakeholders, other partners (e.g. WHO, WB)
		• Comparison of the situation between locations where the component was introduced and other locations, if data is/ becomes available
		• Beneficiary survey
			• % of improvement compared to the baseline indicators identified by the Programme
			• % of component outputs and outcomes achieved
			• # of respondents expressing satisfaction with nutrition support provision
			• Existence of nutrition support capacity building material/activities
			• Existence of skilled nutrition staff

Gender Equality	**7. To what extent has a Gender Equality and Social Inclusion Strategy been implemented?**		
	• HPF and IP awareness/ level of knowledge of the Gender Equality and Social Inclusion Strategy (at various levels: beneficiary, community, HPF staff, Steering Committee and Government)	• Use of Gender Analysis Tools (e.g. WHO GAT, Gender responsive programme assessment tool)	• Degree of integration of GESI strategy and principles into operations and organisational practice

○ How it is integrated into operations and organisational plans/practice ○ Specific measures that have been put in place to support this integration (HPF and IP level)	• KIIs and FGDs with HPF and IP and health facility staff, community stakeholders and government representatives • Beneficiary survey • Gender analysis and organisational strategic assessment • 5-Capabilities approach • Site visits for observations	• Existing indicators/data and outputs are disaggregated by gender and age • # of respondents who are aware of awareness raising and advocacy campaigns • # of respondents who perceive GESI activities have had an effect on practice • #of respondents (IPs and HPF staff who have received gender sensitivity training)
• How the strategy has been operationalised including the amount of resources invested in measures to promote the voice and participation of women, youth, minorities and other excluded groups in service delivery strategies		
• Existence of knowledge sharing platforms/advocacy activities on GESI and sharing of best practices at all levels		
• How well is GBV integrated into existing services		
• Results being achieved on GESI integration (National, State, County and community levels, as well as with HPF and IPs) ○ Whether the results are positive or negative		
8. What were the main gender-based barriers and challenges to programme delivery and achievement of outputs and outcomes?		
• Identification of societal norms or customs that restrict access to/uptake of health services for beneficiaries due to their gender or socioeconomic status, and how the programme has managed them	• KIIs and FGDs with HPF, IP, health facility staff, community stakeholders and government representatives • Site visits for observations • Document review (thematic analysis) • Gender analysis of interventions • Beneficiary survey	• # of respondents providing insights into social norms and customs • Documented evidence of customary laws/ practices that prevent uptake of targeted interventions • # of identified gaps and challenges related to gender inequalities from the document reviews and interviews
• Identification of societal norms or customs that restrict participation in community engagement activities for beneficiaries due to their gender or socioeconomic status and degree to which the Programme has identified and mitigated them • Whether there is evidence of reduced access to services at facilities and/or to referrals for women and marginalised and disadvantaged groups		
• Organisational cultures and practices and how gender equality and social inclusion is managed		

Efficiency	**9. Were human and financial resources used in a cost-effective way for the outcomes achieved, in light of the operating context, needs of the beneficiaries, priorities of the MoH, and the organizational and management structures of the HPF? Was the programme implemented in the most efficient way compared to possible alternatives?**		

	• Assessment of whether the chosen implementation mechanisms (modalities, entities and contractual arrangements) are conducive for achieving the expected results. This would include:
	  ○ What are the key costs drivers? How have/are these changing and why?
	  ○ Are we buying the right inputs (e.g. vaccines/medicines) at the right price and appropriate quality?
	  ○ Is there a way to reduce costs without impacting on quality?
	  ○ Are we using the best contract model for the need?
	  ○ Have all planned outcomes (as defined in logframe) been achieved to date?
	  ○ What is the quality of the outcomes/services available?
		• Desk review of documents/reports and guidelines/manuals
		• Budget and accounts analysis and utilization assessment
		• KIIs and FGDs with HPF and IP and health facility staff, community stakeholders and government representatives and key development partners
			• Evidence that a cost-benefit analysis was conducted
			• Existence of an effective costs monitoring system
			• Existence of an effective procurement system
			• Existence of appropriate HPF FM systems
			• Existence of PFM implementation plans and oversight mechanisms
			• The resources correspond to the needs of the action
			• Unit costs of HPF compared to any available benchmarks
			• Cost of HPF service delivery compared to implementation overhead cost

	• Are there issues relating to value for money that could benefit from better coordination?		

	• Whether funds and inputs are available in a timely way and if they are sufficient
	  ○ Whether funds are managed effectively at the various levels
	  ○ Whether budgets and accounting are clearly linked to achieving key objectives and effectively accounted for and audited		

	• Whether funding was allocated specifically to address the GESI strategy (for example programme support for targeted interventions like a GBV centre or capacity building/ training of staff or recruitment of a Gender specialist)		
	• Knowledge about the VFM strategy		

• Efforts made to improve VFM in implementation arrangements (At National, State and County levels, as well as within HPF management and with IPs) • Whether the salaries and other incentives in HPF and MoH sufficient to ensure motivated staff and avoid absenteeism/staff attrition • The HPF FM arrangements that are in place, and how effective they are • Progress, if any, of PFM in the health sector ○ Whether there are other actors that have contributed to these results		
10. Has the community-based approach trialled in HPF for treating common diseases in children under been a cost-effective approach in the context of limited access to formal health facilities?		
• Whether the inclusion of community-based mechanisms in the project enhanced the efficiency of health service delivery	• Desk review of documents/reports • Accounting figures • KIIs and FGDs with HPF and IP and health facility staff, community stakeholders and government representatives • Beneficiary survey	• Documented effects of community engagement • # of respondents who perceive changes in service delivery as a result of community engagement
Sustainability		
11. What steps have been taken to create or integrate with long-term processes, structures, norms and institutions for sustaining the investments made by HPF?		
• Existing arrangements at Government level (National, State and County) aimed at enhancing sustainability of the actions and gains made by HPF • Whether the approach will help or hamper building a future health system under the stewardship of GoSS • Whether an adequate level of human and institutional capacity has been put in place in order to continue delivering the action's benefits (what capacity building has been achieved)	• KIIs with project officers and implementers, stakeholders within GoSS, health professionals • Analysis of the measures planned in the programming documents and MOH policies to ensure sustainability	• # of respondents that perceive an improvement in the capacity of stakeholders in South Sudan (both in the government and health professionals) to support and provide essential health services in a sustainable way • # of respondents, and their arguments, for whether or not increased capacity building of MoH and alignment with GoSS has been possible

Annex 3 Field work Summary

This section presents details on our approach to field work.

To support the data analysis process, the field teams were required to submit data for quality assurance as soon and as often as possible while still in the field. However, due to connectivity issues, this did not occur as often as we would have liked, meaning that data quality assurance was also delayed, largely happening after the teams had returned to Juba. This had an impact on the evaluation team's ability to follow up on arising issues. However, because the data collected was triangulated with other data sources, such as the beneficiary survey, IP and other higher-level interviews in Juba, and with already existing data in HPF reports, this is not considered to have had a negative effect on the veracity of the data and the findings of the analysis.

Additionally, one member of the evaluation returned to Juba to carry out a debriefing with the field teams, and to seek clarifications where there appeared to be information gaps, or where the information was not very clear.

For efficient use of available time and resources, the evaluation team split the data analysis tasks among its various members:

- Review of DFID and HPF programme documents, including of the HMIS data
- Review of field data and a sample of IP quarterly reports
- Analysis of quantitative data collected through the beneficiary interviews
- Review and analysis of facility observation checklists

For the qualitative elements of the analysis, the team developed and worked with a screening tool derived from the methodological framework agreed with DFID and Global Affairs Canada at the inception phase of the evaluation. There were no departures from the original ToR as the methodological framework was derived from the key questions articulated in the in the document. Based on ongoing discussions with the funding agencies, it was later amended to reflect their emerging priority areas, while keeping in mind that this was designed as a process evaluation to derive key areas of learning for the HPF, as well as the contribution and relevance of the programme to the health needs of South Sudan.

Based on the evaluation objectives, data was collected and analysed in the following manner.

Evaluation Objectives	Tools used	Methods of analysis
1. Assess the relevance, effectiveness, efficiency (including value for money) and sustainability of the HPF, and how gender equality considerations were integrated	Document review	Analytical framework involving physical entry of key findings from documentation
	Interview question guides– KII and FGD guides for various cadre of staff and stakeholders	Analytical framework involving entry of interview responses to relevant questions Atlas.ti software was also used to analyse qualitative data
2. Identify areas of best practice in programme design and delivery and develop recommendations for the delivery of a future / successor programme.	Beneficiary survey Facility observation checklist	Excel and SPSS analytical tools Excel and SPSS

Assessment of outcomes and impact

Rather than impact, the evaluation was designed as a process-oriented exercise to learn lessons and practices that could inform the upcoming phase of the programme. With regard to outcomes, the evaluation sought to assess how well the programme was addressing the one outcome of the programme: 'Increased access to quality health services, in particular by children, pregnant women and other vulnerable groups.'

We recognise that, in addition to HPF, there have been and are other actors providing healthcare in the locations where HPF is present. As such, it is not possible to attribute many of the results highlighted in this report to HPF alone. However, as will be noted, there are some areas where the HPF has played a significant role and where the majority of the results can be attributed to the programme; for example, in the streamlining of the HMIS/DHIS.

Ethical considerations

The analysis and reporting were conducted with full consideration to the ethical standards of research. Confidentiality and anonymity were guaranteed to informants, and no respondents are named or identified in the report by name, although there is a list of Juba-based interview respondents. If required, this can be removed in advance of publication. In some cases, for example, when speaking about an HPF staff member, or a State Minister of Health, it could be possible to narrow down the respondent to a small pool of individuals, although not a specific one.

Qualitative Data Figures

Table 3.1: Number of respondents by county and interview method:

Number of participants	Gogrial East	Tonj North	Yirol East	Yirol West	Total
FGDs	79	113	30	23	245
KII	3	14	5	6	28
Total	82	127	35	29	273

Table 3.2: Number of respondents by county and gender:

Number of participants	Gogrial East	Tonj North	Yirol East	Yirol West	Total
Male	55	98	21	15	189
Female	27	32	14	17	90
Total	82	130	35	32	279

Table 3.3: Number of interviews by county and interview method:

Number of Interviews	Gogrial East	Tonj North	Yirol East	Yirol West	Total
FGDs	6	15	4	5	30
KII	3	11	5	5	24
Total	9	26	9	10	

Table 3.4: Number of respondents by county and stakeholder group:

Number of participants	Gogrial East	Tonj North	Yirol East	Yirol West	Total
HHPs	15	34	10	5	64
Ministry of Health	2	4	0	1	7
Health Staff	48	55	4	3	110
Community Leaders	16	34	1	12	63
Beneficiaries	0	15	10	12	37
State Oversight Committee	1	0	0	0	1
Total	82	142	25	33	

*These totals are different from the overall total respondent figure (291) due to some interview transcripts not giving the gender of the respondents. In addition, there are FGDs where the number of participants isn't given. Lastly, there are interview transcripts which will give the name of the state but not the county, which is why there are differences between the two tables above.

Annex 4 Data Quality Review

Field Data Collection

We conducted a review of the quality of data we received from the field in order to be transparent around issues we encountered, explanations and mitigation strategies in dealing with areas of data that appear weaker. In general, it is well-known that primary data collection in South Sudan can be very challenging. Specific challenging areas that we faced included logistical and operational difficulties that precluded the non-South Sudanese team from entering into the field due to work permit restrictions. Some of the quality assurance mechanisms we had in place initially, were therefore not possible. Limited internet connectivity in the field also hampered daily quality assurance processes originally in place. Due to the short timeframe to deliver the evaluation, we were unable to deploy the enumerators back into the field to follow-up on some of the inconsistencies presented in the table below. There were also cultural barriers that limited data collection around taboo areas such as sexual and reproductive health and gender-based violence. However, both the quantitative and qualitative data experts in the team reviewed the data in-depth and conducted statistical analysis around error rates and missing gaps. It was concluded that the overall data was sound and usable for analysis in the evaluation report. In the few instances where it was not, data was excluded from the analysis.

Rating explanation:

0 = No data provided from this source

1 = Very poor quality – extreme inconsistencies in the data; no explanation provided from follow-up with the enumerators; data is not usable

2 = Poor quality – multiple inconsistencies in the data; no explanation provided from the follow-up with enumerators; data is not usable

3 = Moderate quality – some inconsistencies in the data; explanations provided by the enumerators; data is usable though limitations need to be acknowledged

4 = Good quality – little to no inconsistencies in the data; no follow-up required

5 = Very good quality – no inconsistencies in the data; no follow-up required

Quantitative	Data Domain	Missing Gaps (if relevant)	Explanation (if relevant)	Data Quality Rating (1-5) *	Mitigation Strategy (if relevant)
Beneficiary Survey	Gender & age group	None	None	4	None
	Marital status	None	None	4	None
	Ethnicity	None	None	4	None
	Education level	None	None	4	None
	Employment status	Respondents who selected 'Farmer' as their occupation (55%), selected a variety of employment statuses (e.g. full time/self-employed/unemployed/home maker).	A decision was made to not re-code respondents' employment status into 'employed'. A follow-up meeting with enumerators highlighted that many farmers in South Sudan are subsidence farmers and do not earn an income.	3	We held a debrief session with the field enumerators in Juba after completion of the data collection to get clarity around inconsistencies. We will acknowledge limitations in the report.
	Occupation	None	None	4	None
	Disability	None	None	4	None
	Decision-maker	None	None	4	None
	Nearest Health Facility	None	None	4	None
	Reasons for choosing health facilities	None	None	4	None
	User fees	User fees were reported in all counties surveyed even though HPF does not collect user fees.	HPF's ability to control user fees charged by local partners hired by IPs to run the facilities is very limited. Additionally, some facilities charge fees for provision of drugs. Respondents also mentioned that they had to buy drugs from private clinics when drugs were unavailable at health facilities. This was acknowledged as a major	3 (NB: The score does not reflect inaccuracy of the data. The services in which payment was made is unclear.)	This issue was discussed at the stakeholder engagement workshop in Juba with donors, the HPF and IPs. We conducted further analysis to determine which facilities were identified as charging user fees and is included in the beneficiary survey report (Annex 5.1) should HPF wish to follow-up.

			issue by HPF, donors, and IPs during the stakeholder engagement workshop held in Juba.		
	Distance to health facility used	None	None	4	None
	Hospital referrals	Some respondents did not explain the reason for the referral.	Enumerators did not follow-up in the field.	3	We discovered from the debrief session held in Juba, that enumerators did not follow-up this area for more detail. This limitation is acknowledged in the report.
	Complaints	None	None	4	None
	Access to health services	Sample sizes were too small to see a clear pattern between employment, uptake of health services and education, update of health services.	Most respondents reported 'no schooling completed' and 'unemployed' or 'self-employed'; sample sizes for other possible responses were therefore too small	4	None
	Frequency of use	Men reported use of antenatal care	This could be because they were reporting on behalf of their wives, but we were unable to get clarification from the enumerators.	3	We will acknowledge this limitation in the report.
	Satisfaction with health services	Some respondents provided satisfaction ratings with health services, even though they had previously answered that they had not personally accessed the particular service.	Error rates were not more apparent in one state. There were however, some differences in error rates between the various services. The question around accessing health services was aimed at the individual; the question around satisfaction was aimed at the household. According to the enumerators, respondents were most likely responding for their household but it was impossible to distil.	3	This limitation is acknowledged in the report.

			Furthermore, respondents may have accessed a service in the past year, but circumstances could have changed in which they no longer have access. Additionally, they could have been reporting use of a home treatment (e.g. diarrhoea) and did not know they could get treatment at the HPF facility. Based on this, a decision was taken to include the satisfaction ratings.		
	Changes in health services since HPF initiated	None	None	4	None
	Satisfaction with facility	None	None	4	None
	Communities with health committees	None	None	4	None
	Participation in health committee meetings	Some respondents answered that there were no health committees in the area but then provided satisfaction ratings.	A follow-up session with the enumerators highlighted that there are health committees in each area. However, it was asserted that satisfaction ratings should be excluded as many respondents did not know about health committees in their area. We therefore excluded this data based on the guidance of the enumerators.	2	This limitation is acknowledged in the report.
	Impact of health committee on health services				
	Ability to discuss problems with health committees				
	Respondents	No GBV survivors surveyed	Enumerators asserted difficulty in identifying GBV survivors due to cultural factors. Time in each area was insufficient to build the trust of these respondents.	0	This limitation is acknowledged in the report.

Health Facility Observation Checklists	Drug Availability	Three facility surveys (all for Yirol East) used an older version of the facility. In this version there were only two options given for each drug – 'available' or 'not available', with the 'not enough' option missing.	This was due to a printing error in Juba. All other questions matched the other facility surveys.	3	With only 3/20 surveys affected this should not impact too extensively on the results. The limitation is acknowledged in the report, and our results focus on where drugs are completely unavailable, which was captured by all surveys.
	Outpatient Numbers	Outpatient day numbers have some inconsistencies. Some of the daily outpatient numbers are higher than the weekly average.	It is challenging to identify where the error comes from: record keeping at the facility level; enumerator recording errors; or a capacity gap around averaging patient numbers.	2	We acknowledge the limitation in the report and use the facility use data as a guide to how much the facilities are being used, rather than as an exact measurement of the usage the day that the team visited.
	Staff numbers	Lakes team did not record the number of staff present during the facility survey, only the general staffing numbers.	Staff may not have all been available, or this may simply have been an oversight by the field team.	3	Total numbers of staff working at the facility have been recorded by all teams, giving us a good understanding of the issues around staffing where numbers haven't been completed.
	Last shipment date	Some surveys did not include details on when the last shipment arrived.	4/20 surveys did not include the details of the last shipment. This appears to have been an error by the field team.	3	We still have 16 data sources for this question, which allows us to analyse how quickly certain drugs run out. We acknowledge the limitation of our sample in the report.
Qualitative					
Field data collection (FGDs, KIIs)	Relevance	There were not many gaps for most sub-questions, although it appears from the lack of data that beneficiaries were not consulted. Something to follow up with donors/HPF. There was little information from beneficiaries on	We would not necessarily expect this form of data collection to help us establish the answer to the second point. We were unable to interview anybody under 18 because of South Sudanese laws.	4 (for the data we have)	We provide an explanation for lack of interviews with youth and acknowledge it as a limitation in the report.

		whether the essential needs of the people were clearly identified by MoH and/or HPF. The lack of KIIs/FGDs with youth means we have less information on their needs/health services targeted at them.			
	Alignment with GoSS health priorities	These two sub-questions cannot easily be answered from field work.	We would not have expected field work to answer these two questions. Although there is an indication that services are generally better than previously	0	N/A
	Expected outputs and outcomes achieved	There was an information gap around PMTCT - – although there is mention that there is no HIV-related support provided. There was no information around attribution from the qualitative data. Quality of drugs and medical supplies – only one response on this. Changes between HPF1 and 2 drugs supplies. Some interviews report there being more drugs available during HPF1, which does not match with other information we have. Need to follow-up on this using	PMCTCT/HIV information not necessarily asked in interviews and came up as gaps in support provided. Attribution – would not expect to gain many insights into this during field work. Quality only mentioned by SMoH and not by others Management arrangements – not enough probing done by the enumerators DHIS/HMIS – Both questions need to be followed up with HPF. These are more findings than gaps in our data.	3	We followed-up with HPF and IPs at the stakeholder engagement workshop about management on how QA/issues with data are fed back to the facilities, but were not provided with further information. We followed-up with HPF and IPs at the stakeholder engagement workshop about actual reporting arrangements between CHCs and CHDs, but were not given further information. We further probed the secondary data for additional information.

		documentation/speaking to stakeholders. Very little detail on collaboration between CHCs and CHDs regarding management arrangements. But enough to indicate degree of collaboration between CHDs, IP and health facilities. Reporting lines not clear between CHCs and CHDs. There was information about QA but no information around follow-up to the QA. DHIS/HMIS – there was a gap around how data is fed-back into implementation, and especially how facility staff (not in-charge and community structures/groups engage with emerging information (i.e. do they understand why they focus on some things and not others?). There was no information around the community empowerment strategy and capacity of IPs. There was lack of clarity on whether increased community governance has led to increased government	We wouldn't expect to find data for regarding the community empowerment strategy and capacity of IPs from the field. Apart from IPs and HPF staff on the ground, field respondents would not know about the lack of clarity on community governance and its relation to government and HPF accountability.		

		and HPF accountability and responsiveness to citizens. Although it can be surmised that increased engagement of CHDs and health committees in oversight of facilities would lead to this.			
	Conflict sensitivity and humanitarian response	There was no information from the field on HPF responsiveness to humanitarian needs. There were some indications that there is some degree of conflict-sensitivity employed, but not systematically.	The gap on humanitarian responsiveness could be related to the areas that we selected for our field work. Field respondents (community and health staff) would not necessarily know about this area. Having conflict-management strategies is currently not a requirement for IPs, although there were indications that they do this informally to some degree	0	This limitation is acknowledged in the report.
	Coordination with other stakeholders	There was limited information on coordination at the facility level.	Respondents may not have had the information to answer questions around coordination.	0	We have lots of information on Juba and state level coordination and have acknowledged the limitation at the field level in the report.
	Nutrition	There was a lack of specific details around nutrition services. There was no information on nutrition information system. There was no specific information on nutrition improvements between HPF1 and 2.	This could be related to selection of respondents. It could also be related to respondents in the field not being able to distinguish between HPF and other nutrition support. There was no information from any interview stakeholders on	3	This is acknowledged as a limitation in the report.

			the nutrition information system – this could be a gap in our approach.		
	GESI	There was very little information for these questions.	These questions were mostly about how the policy has been rolled out with HPF and the IPs. We wouldn't necessarily expect data on this from the field work.	0	We cross referenced the information with the data from the interviews/other sources to see if this is a general gap or not.
	VFM questions	There was very little information on this section, though there was a small amount of information on cost drivers.	Again, we would not necessarily expect to be able to answer these questions from the fieldwork data. This may also have been an error on our part in the way we designed our tools.	0	We assessed our ability to answer these questions using other data sources. We were able to address VFM issues at a high-level, as it was out of scope for the evaluation to look at it in-depth.
	Community based approach	We have anecdotal evidence around the community-based approach and perceptions of the kinds of results it has achieved. However, the fieldwork data doesn't allow us to say anything clear about impact. There was no data on efficiency.	The data provided gives a good indication that the community-based approach is viewed positively on the ground and is seen to support broader service provision.	4	None.
	Sustainability	There was little data from the fieldwork on the question of sustainability.	We would not necessarily expect respondents to be able to address issues around sustainability, but issues around insufficient drug supply and infrastructure indicated that sustainability was weak.	3	We cross-referenced information from different data sources.

Sampling Approach

Given the size of the HPF programme, and the time and resources allocated to this evaluation, we were not able to review all programme documentation for every implementing partner (IP). Given we were limited in the number of locations where we could collect data, to ensure a proportional representation of a broad range of implementation contexts represented by the programme, we sampled a wide range of IPs and lots in our desk review and Juba-based interviews. We interviewed representatives from eleven IPs, including those operating in the most challenging areas. Although, as acknowledged in the limitations section, our sample was restricted by our inability to visit a more representative selection of locations, this was somewhat mitigated by our desk review and interview sample.

Desk Review and Interview Sample

Lot and IP	State	Budget	Total Health Centres	HPF functional facilities	HPF non-functional facilities	Level of accessibility - HPF assessment
1 - Save the Children	Eastern Equatoria	4,581,000	80	61	18	Partially inaccessible
3 – Cordaid	Eastern Equatoria	1,669,384	30	29	0	Accessible
4 - ARC	Eastern Equatoria	1,495,883	34	33	1	Accessible
5/6 – HealthNet TPO	Western and Northern Bahr el Ghazal	7,461,761	155	97	30	Partially inaccessible
7 - CUAMM	Lakes	3,793,274	75	55	2	Accessible
11 – IRC	Northern Bahr el Ghazal	1,500,000	65	58	0	Accessible
12 – ARC	Unity	966,000	19	11	0	Accessible
14 - Cordaid	Unity	1,690,329	26	11	0	Partially inaccessible
15 - UNIDO	Unity	1,068,887	21	20	0	Inaccessible
16 – UNIDO	Unity	743,000	7	3	4	Inaccessible
17 - IRC	Unity	702,000	25	12	0	Accessible
18 - ADRA	Central Equatoria	1,499,985	45	42	0	Accessible
20 - AAHI	Central Equatoria	4,958,000	135	52	80	Inaccessible
21 - CUAMM	Western Equatoria	3,258,000	80	50	29	Inaccessible

22 – World Vision	Western Equatoria	1,551,001	34	28	1	Accessible
23 – World Vision	Western Equatoria	3,200,000	102	75	6	Accessible

Field work sample

State	County	Lot	IP	Number of functioning HPF facilities
Lakes	Yirol East	8	CUAMM	9 PHCU 2 PHCC No Hospital
	Yirol West			8 PHCU 2 PHCC 2 Hospitals
Warrap	Tonj North	10	World Vision	9 PHCU 4 PHCC 1 Hospital
	Gogrial East	9	World Vision	12 PHCU No PHCC 2 Hospitals

Annex 5 Data

Annex 5.1 Beneficiary Survey

Respondent Profile

Gender & Location

In March 2018, a total of 287 beneficiaries completed feedback surveys on services delivered through the Health Pooled Fund in South Sudan. Of these, 38% of responses were obtained in the Lakes State and 62% were completed in Warrap State. Approximately one-third of surveys were completed for each of the three implementing partners.

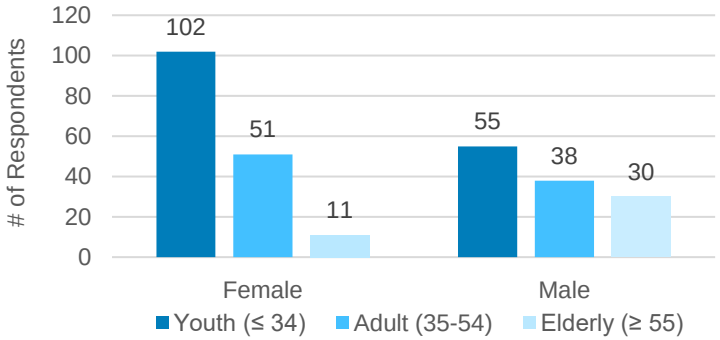
Table 5.1.1: Number of Respondents by State and County

State	County	Lot	IP	Female Respondents	Male Respondents	TOTAL Respondents
Lakes	Yirol East	8	CUAMM	41	24	**65 (23%)**
	Yirol West	8	CUAMM	25	19	**44 (15%)**
Warrap	Tonj North	10	CCM	53	41	**94 (33%)**
	Gogrial East	9	World Vision	45	39	**84 (29%)**

Gender & Age Group

There was a significantly larger representation of female (57%) compared to male (43%) survey respondents[64], which is consistent with the planned sampling methodology to emphasize expectant women and mothers of young children. The gender distribution was consistent across all four counties. Just over half (55%) of survey participants were youth, 31% were adults, and 14% were elderly. Youth comprised the majority of respondents in Yirol East (71%) and Yirol West (66%) and about half of the respondents in Tonj North (50%) and Gogrial East (42%).

Figure 5.1.1: Gender & Age of Respondents

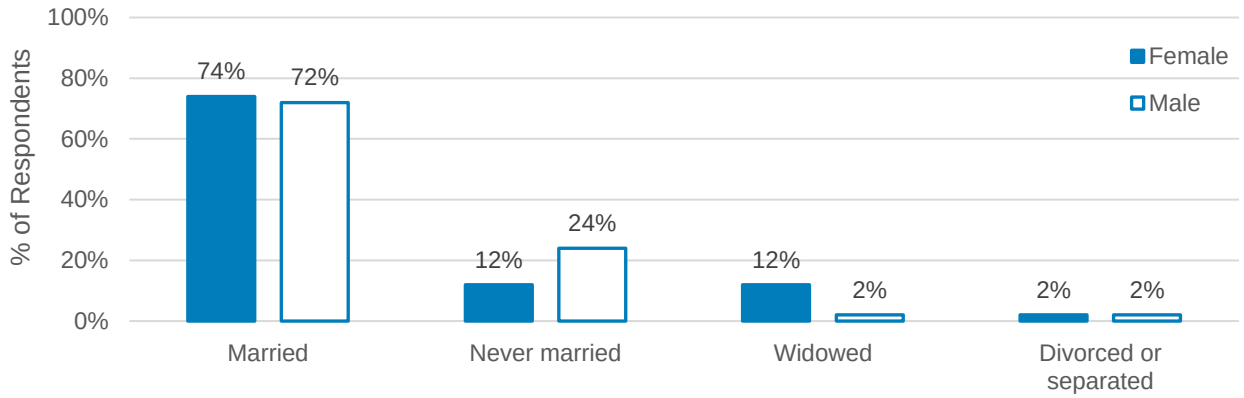


[64] $\chi 2$ (1, N = 287) = 5.857, p = .016

Marital status

At the time of participating in the survey, equal proportions of male and female respondents were married, divorced, or separated. However, more men were single because they had never been married whereas more women were single because they had been widowed. This gender difference was statistically significant.[65]

Figure 5.1.2: Marital Status of Respondents



Ethnicity

Consistent with the ethnic composition in the Lakes and Warrap states, 94% of survey respondents self-identified as belonging to the Dinka ethnic group. Other ethnicities represented in the survey included Bari (3%), Shuluk (1%), Nuer (<1%), and other groups (2%). This ethnic distribution was comparable across male and female respondents.

Education Level

Education levels were very low with the majority (65%) of respondents having not completed any schooling. Men had a significantly higher level of education as a greater proportion of them had completed primary or secondary education while more women had not completed any schooling. [66]

Table 5.1.2: Highest Education Level

Education Level Completed	Female Respondents	Male Respondents	TOTAL Respondents
No schooling completed	76%	49%	**65%**
Cannot read and write[67]	5%	4%	**5%**
No schooling completed but can read and write	4%	4%	**4%**
Nursery to primary education	7%	16%	**11%**
Secondary education	6%	20%	**12%**

[65] $\chi 2$ (3, N = 287) = 17.234, p = .001, V = .245
[66] $\chi 2$ (6, N = 287) = 29.993, p < .001, V = .323

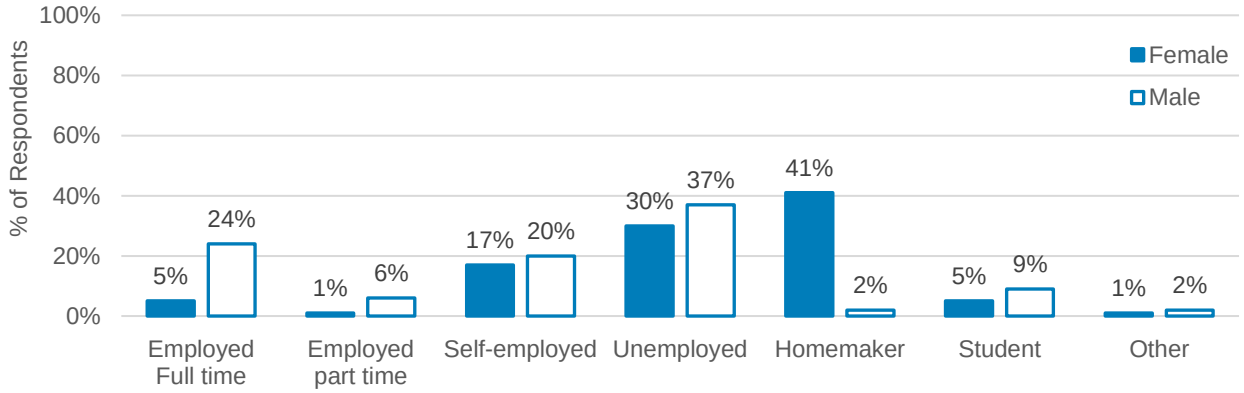
[67] This illiteracy figure is much lower than would be expected given levels of literacy in South Sudan. This could be because our sample is not representative, or it could suggest that only literate people are accessing services. We are unable to draw a conclusion based on the data that we have.

Post-secondary education – vocational	1%	2%	**1%**
Post-secondary education – university	1%	5%	**3%**

Employment Status

Most respondents were either unemployed (33%), a homemaker (24%), or self-employed (18%). Other respondents included those employed full time (13%) and part time (3%), students (7%), and other (2%). Respondents who selected 'other' indicated that they were either disabled and not able to work or were retired. Men were more likely to be employed full time whereas women were more likely to be a homemaker, and this gender difference was statistically significant.[68]

Figure 5.1.3: Employment Status of Respondents



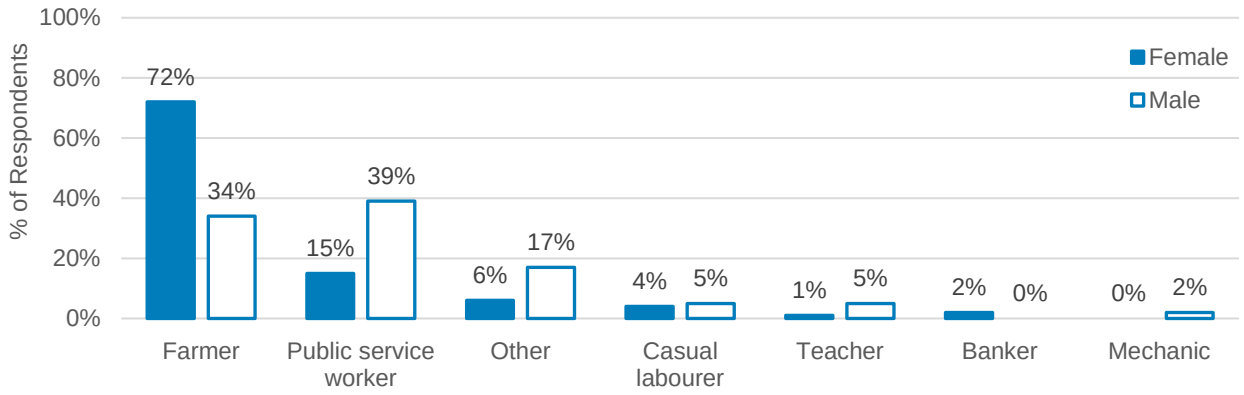
Occupation

Out of a total of 287 respondents, 147 (51%) identified an occupation. The most common occupation was farmer including cattle farmers (55%) and a greater proportion of farmers were women. About 25% of respondents were public service workers (e.g., health workers, tax collectors, watchmen, village chief, soldiers) and most of these were men.[69] "Other" (11%) occupations included trader, tailor, butcher, small retailer/ business man, restaurant worker, and truck driver.

[68] $\chi 2$ (6, N = 286) = 69.962, p < .001, V = .495

[69] These are observed differences as sample sizes in each cell were too small for statistical analysis.

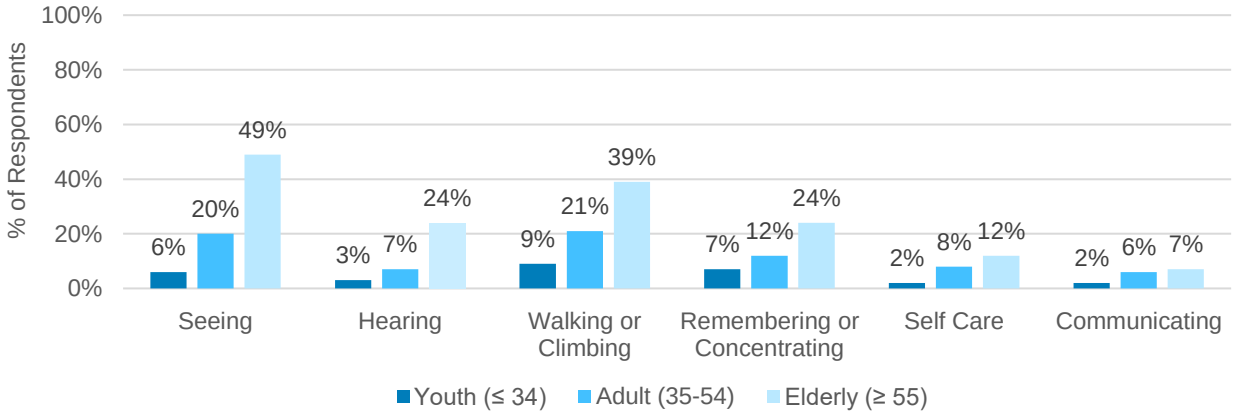
Figure 5.1.4: Occupation of Respondents



Disability

Respondents were asked if they had difficulties performing various common tasks and 46% (91/287) reported having some difficulty, a lot of difficulty, or could not perform the task at all. The prevalence of these difficulties was comparable between men and women with 33% (40/123) of men and 31% (51/287) of women reporting at least one difficulty. The prevalence of these difficulties was similar across the four counties of Yirol East (26%), Yirol West (30%), Gogrial East (35%), and Tonj North (34%). When compared by age group, elderly respondents reported significantly more difficulties seeing, hearing, walking or climbing, and remembering or concentrating.[70]

Figure 5.1.5: Difficulties by Age Group of Respondents

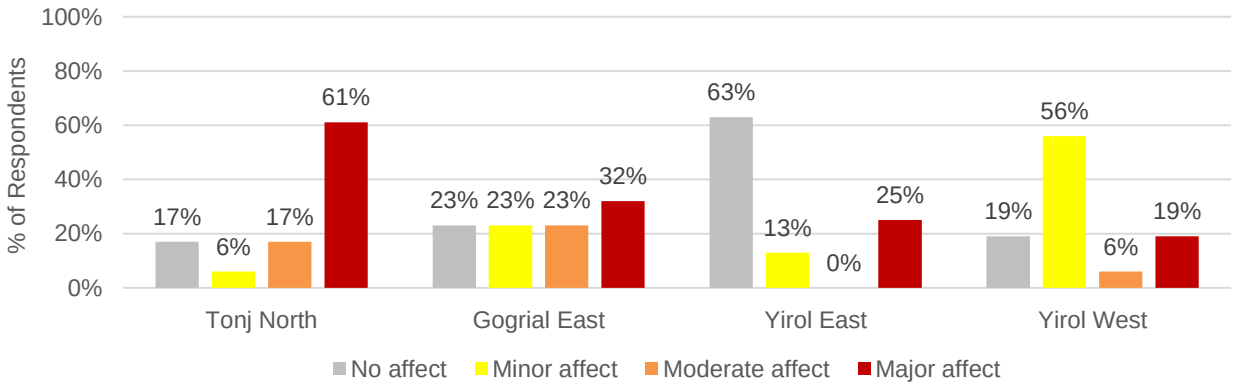


Of the respondents who reported at least one difficulty, 70% (64/91) rated the extent to which the difficulty affected their ability to access health services. Overall, 25% reported 'no affect', 25% reported a 'minor affect', 14% reported a 'moderate affect', and 36% reported a 'major affect'. These proportions were comparable by age group and gender. However, when

[70] Seeing: $\chi 2$ (2, N = 287) = 43.120, p < .001, V = .388; Hearing: $\chi 2$ (2, N = 287) = 21.620, p < .001, V = .274; Walking: $\chi 2$ (2, N = 287) = 22.479, p < .001, V = .280; Remembering/Concentrating: $\chi 2$ (2, N = 286) = 10.001, p = .007, V = .187

compared across counties, respondents living in Tonj North and Gogrial East counties (Warrap State) had more difficulties accessing health services due to a disability than respondents living in Yirol East and Yirol West (Lakes State); this difference across counties was statistically significant.[71]

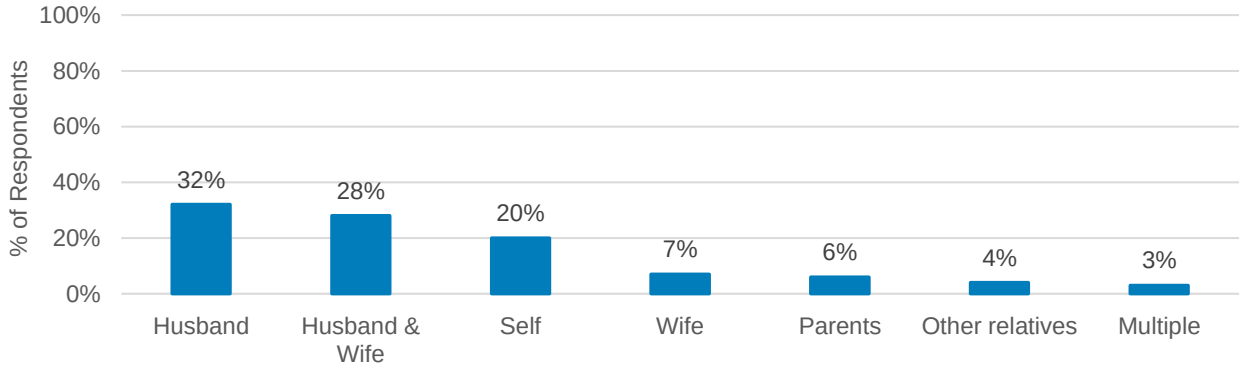
Figure 5.1.6: Affect of Disability on Access to Health Services



Decision-maker

The most common health care decision-maker in the family was the husband, the husband and wife jointly together, or the individual deciding for themselves. When compared by marital status, respondents who were widowed, separated, or divorced more frequently made health decisions alone. Those who were never married either made their own health care decisions or decided together with multiple family members. When compared by age, youth often identified a parent or other relative (e.g., uncle, grandfather) as the primary decision-maker.

Figure 5.1.7: Primary Decision-maker in Family for Health Care Decisions



[71] $\chi 2$ (9, N = 64) = 22.753, p = .007, V = .344 (parametric tests could not be performed due to violations of normality)

Accessibility of Health Services

Nearest Health Facility

Primary Health Care Units (PHCU) were the closest health facility for 50% of Beneficiary Survey Respondents, and this was especially true for respondents in Gogrial East. PHCUs and Primary Health Care Centres (PHCC) were equally close for respondents in Yirol East and Tonj North. Yirol West had the greatest proportion of respondents (27%) who lived near a hospital. Overall, 5% of respondents provided multiple responses for their nearest health facility and are not included in analyses at the facility type level.

Table 5.1.3: Nearest Health Facility Type – By County

Facility Type	Tonj North		Gogrial East		Yirol West		Yirol East		TOTAL	
PHCU	47%	44	61%	51	46%	20	45%	29	**50%**	**144**
PHCC	46%	43	30%	25	25%	11	52%	34	**39%**	**113**
Hospital	0%	0	4%	3	27%	12	0%	0	**5%**	**15**
Multiple responses	7%	7	6%	5	2%	1	0%	0	**5%**	**15**

Survey respondents reported their closest HPF health facilities as shown in the table below. Only facilities with five respondents or more will be included in analyses at the facility level.

Table 5.1.4: Nearest Health Facility – By County (single responses only)

Facility Type	Tonj North	n	Gogrial East	n	Yirol West	n	Yirol East	n
PHCU	Kirrik	**13**	Mayombiong	**14**	Is Aruau	**14**	Lekadeku	**15**
	Parasika	**12**	Matiel	**12**	Is Pabur	**5**	Is Malek	**14**
	Aporlang	**10**	Malaia	**11**	Is Pankar	**1**	Is Acigor	**0**
	Awul	**8**	Pinydit	**11**	Is Agany	**0**	Is Billing	**0**
	Pagol	**1**	Mayomchol	**1**	Is Batoi	**0**	Is Kap	**0**
	Lurcuk	**0**	Yiikadoor Aajogo	**1**	Is Mageng	**0**	Is Langmatot	**0**
	Pagakdit	**0**	Angeranger	**0**	Is Pandit	**0**	Is Pagarau	**0**
	Pankot	**0**	Awuutawut	**0**	Is Wouwou	**0**	Is Shambe	**0**
	Rualbet	**0**	Kuajok Hospital	**0**			Is Thonabut-Kok	**0**
			Majaknhyuom	**0**				
			Panacier	**0**				
			Ruot	**0**				
PHCC	Warrap	**20**	Lunyaker	**13**	Is Aluakluak	**6**	Is Adior	**19**
	Aliek	**13**	Liethnhom	**12**	Is Anuol	**5**	Is Nyang	**15**
	Akop	**8**						
	Alabek	**1**						
Hospital	Marial Lou	**0**	Mother Teresa	**3**	Is Yirol	**12**		
					Is Mapuordit	**0**		

Reasons for Choosing Health Facilities

Of all respondents, 97% (279/285) reported having used the HPF facility that was nearest to them. When asked why they had chosen to use the facility, the most common response was that services were free of charge and that the medical treatment was good. Reasons for choosing HPF facilities varied across counties (see Table 5 below). Among respondents who selected 'other', 11/16 noted a limitation of the facility that drugs were not always available. For the seven respondents who used a non-HPF facility, their main barrier was distance (e.g., 7-10 km or 10+ km).

Figure 5.1.8: Reasons for Using HPF Health Facilities (n = 279)

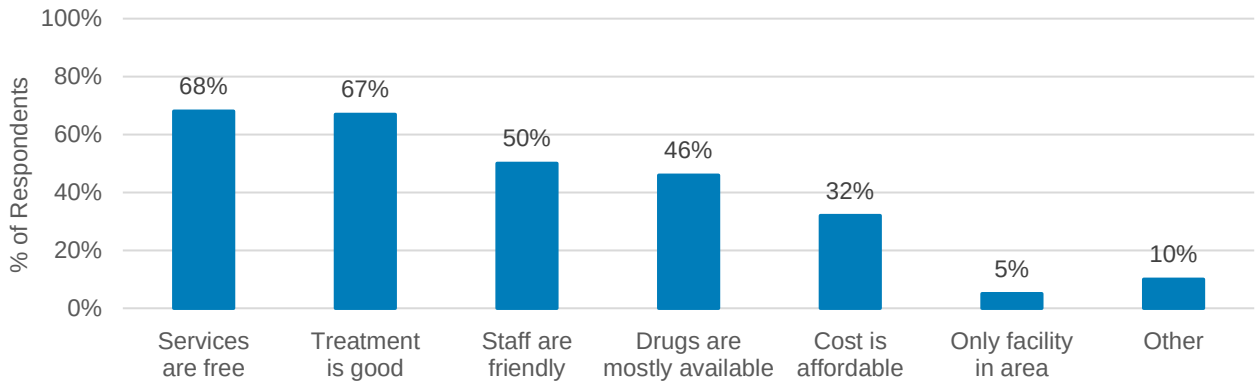


Figure 5.1.9: Reasons for Not Using HPF Health Facilities (n = 7)

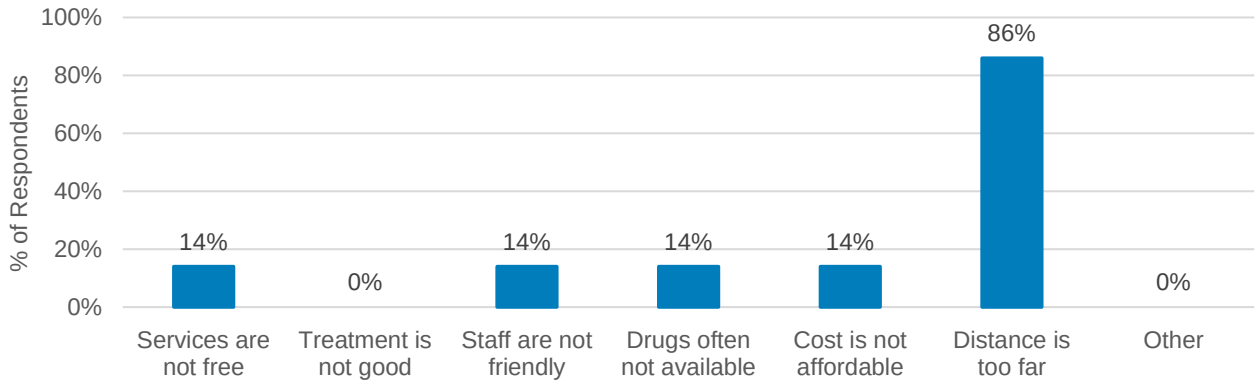


Table 5.1.5: Reasons for Using HPF Health Facilities – By County

Reason for Use	Tonj North	Gogrial East	Yirol West	Yirol East
It is close by*	78%	94%	61%	91%
The services are free*	50%	78%	82%	69%
The cost is affordable*	36%	51%	9%	17%
Staff are friendly*	43%	68%	39%	45%
Treatment is good	62%	76%	57%	69%
Drugs are mostly available*	40%	63%	41%	38%

*Differences across counties were statistically significant ($p < .05$) with a near medium effect size ($V = \geq .30$) or more.

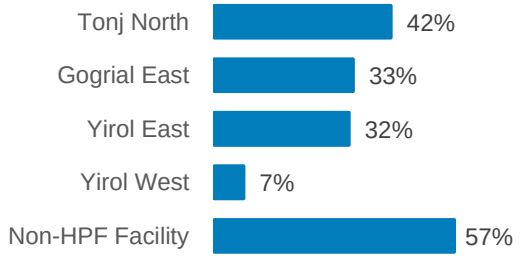
User fees

In total, 32% (88/276) of respondents reported paying user fees at an HPF health facility, but this was not comparable across counties.[72] User fees were most frequently reported in Tonj North and least frequently reported in Yirol West; this is consistent with the high proportion of beneficiaries in Yirol West reporting that services were free (see Table 5).

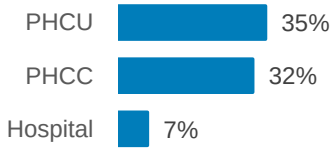
About one-third of respondents reported paying user fees at both PHCUs and PHCCs; fewer reported paying fees at hospitals. When compared by gender, the proportion of men (29%) and women (34%) who paid user fees were comparable.

Figure 5.1.10: User Fees Paid at HPF Health Facilities (≥ 5 respondents)

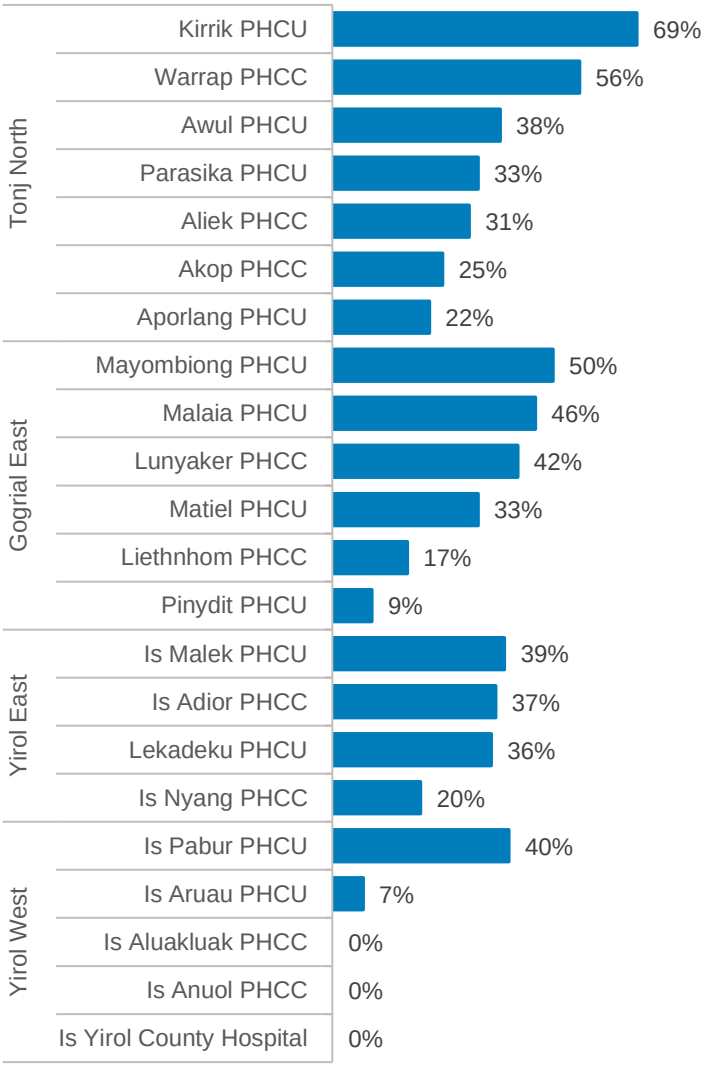
By County



By Facility Type



By Facility

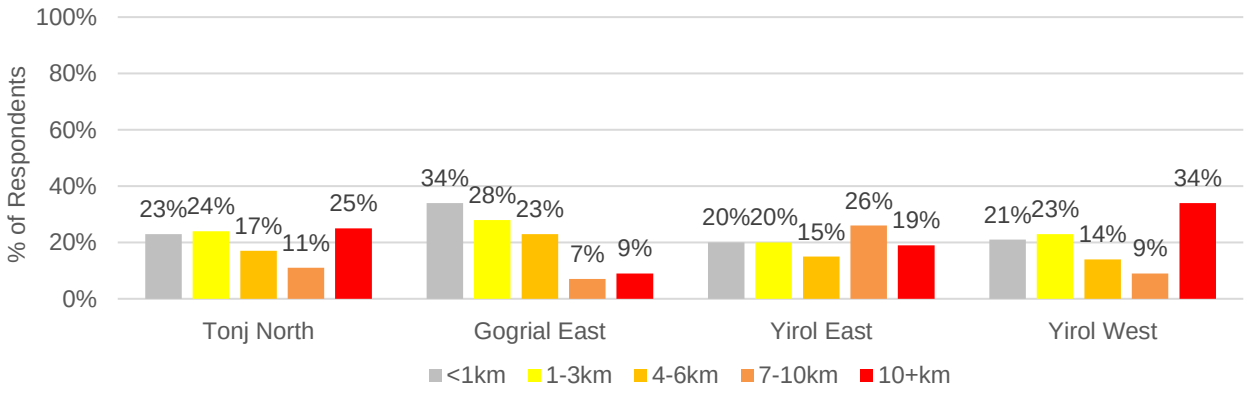


[72] $\chi 2$ (3, N = 278) = 17.263, p = .001, V = .249

Distance to Health Facility Used

Beneficiaries in Gogrial East reported the least amount of travel with over half of respondents living within 3 kilometres of the health facility that they used.[73] Yirol West had the highest number of respondents travelling over 10 kilometres to reach the health facility, which is consistent with the low proportion (61%) of respondents who indicated that the nearest HPF health facility was close by (Table 5). There were no significant differences in travel distances based on age group or gender.

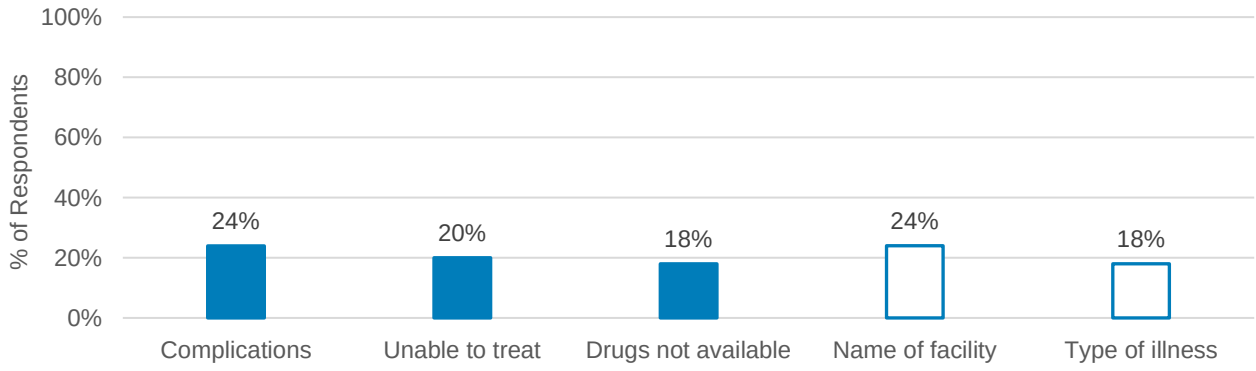
Figure 5.1.11: Approximate Distance to Health Facility Used – By County



Hospital Referrals

Of all respondents, 36% (103/286) reported being referred to a different hospital when they had visited one of the health facilities, and this was consistent across all four counties. The most common reasons for referral were due to either medical complications, the facility not having the expertise or equipment to treat the ailment (e.g., anaemia, eye infection, operation, x-ray, lab tests, etc.), or the facility did not have the required drugs/medications. Some respondents named the hospital that they were referred to (e.g., Yirol, Warrap, Wau, etc.) or the type of illness they had been referred for but did not explain the reason for the referral.

Figure 5.1.12: Reasons for Referral to a Different Hospital

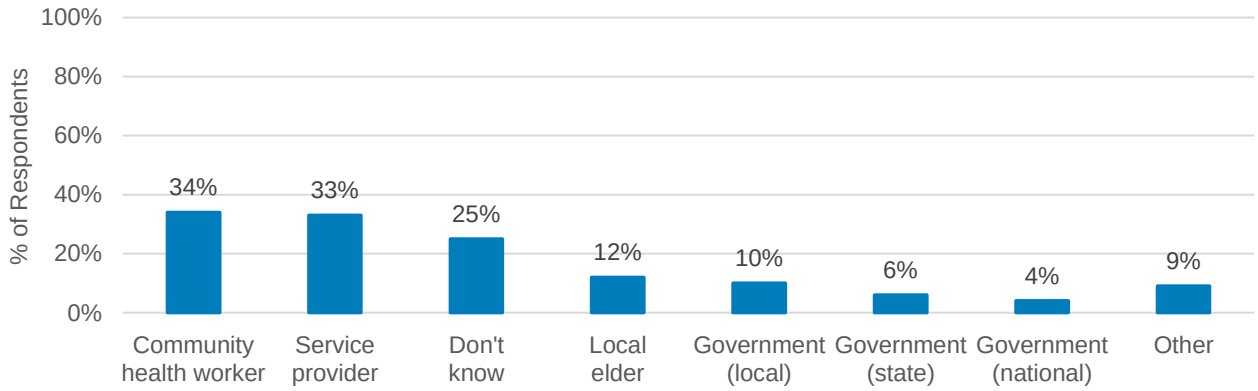


[73] $\chi 2$ (12, N = 271) = 27.174, p = .007, V = .183

Complaints

Beneficiaries were most likely to speak to a community health worker or the service provider if they had a complaint about the facility or services. A quarter of respondents did not know who to go to if they had a complaint. Patients were more likely to complain to a local elder or the local government than to the state or national government. For those who selected 'other', some noted that they did not have a reason to complain about the services and others identified other people they would complain to, such as members of their family or community.

Figure 5.1.13: Contact for Complaints about Health Facilities or Services



Uptake of Health Services

Access to Health Services

A very high proportion of respondents reported that their household had access to trauma and general care services, maternal and child health services, and nutrition services. A quarter to a third of respondents did not have access to emergency care, family planning, or treatment for an acute respiratory infection. About half of the respondents did not have access to medical treatment following a violent experience, HIV/STI testing and/or counselling, or contraceptive services; there was also a high proportion of respondents who did not know if they had access to these services.

The level of access to each type of health service was comparable across age groups and levels of ability/disability. Men and women reported equivalent access to all services except for HIV/STI testing and/or counselling, for which more men (58%) than women (37%) did not have access.[74]

[74] $\chi 2$ (2, N = 287) = 11.995, p = .002, V = .204

Table 5.1.6: Household Access to Health Services

Type of Health Service		Yes	No	Don't Know
TRAUMA & GENERAL CARE – TOTAL		**72%**	**21%**	**7%**
Malaria treatment		99%	1%	0%
Diarrhoea or other stomach infection treatment		92%	7%	1%
Vaccination		92%	6%	2%
Acute respiratory infection treatment		68%	25%	7%
Emergency care		58%	33%	9%
Medical treatment after an experience of violence		25%	55%	21%
MATERNAL & CHILD HEALTH – TOTAL		**79%**	**13%**	**8%**
Antenatal care treatments		82%	12%	6%
Child growth monitoring & weighing		77%	14%	9%
SEXUAL & REPRODUCTIVE HEALTH – TOTAL		**24%**	**41%**	**36%**
STI treatment		33%	39%	28%
HIV/STI testing and/or counselling		30%	46%	24%
Family planning		21%	33%	46%
Contraceptive services		9%	45%	45%
NUTRITION – TOTAL		**76%**	**15%**	**9%**
Nutrition counselling & support		76%	15%	9%

Frequency of Use

If a respondent confirmed that they had access to a health service, they were then asked how frequently they had used each service over the past 12 months. Sexual and reproductive health services were mostly accessed on a yearly basis, although many also accessed family planning or SIT treatment each month. Both nutrition and maternal and child health services were accessed by most people monthly. Trauma and general care services were mostly accessed monthly, although use of emergency care was less frequent (i.e., yearly). Medical treatment after an experience of violence was the only service that was most often accessed daily.

Although confirming that they had access to the services, a high percentage of respondents reported never having used medical treatment after an experience of violence, STI treatment, HIV/STI testing and/or counselling, contraceptive services, or emergency care.

Frequency of use was comparable by gender for all health services except for antenatal care treatments, which were more frequently used by women.[75]

[75] $\chi 2$ (5, N = 233) = 13.419, p = .020, V = .240

Table 5.1.7: Respondents' Frequency of Health Service Use (past 12 months)

Type of Health Service	N/A	Never	Yearly	Monthly	Weekly	Daily
TRAUMA & GENERAL CARE – TOTAL	**17%**	**19%**	**17%**	**28%**	**9%**	**10%**
Malaria treatment	20%	3%	19%	29%	15%	15%
Diarrhoea or other stomach infection treatment	20%	14%	18%	21%	12%	15%
Vaccination	12%	12%	18%	50%	5%	3%
Acute respiratory infection treatment	17%	26%	16%	24%	5%	12%
Emergency care	21%	37%	21%	13%	5%	3%
Medical treatment after an experience of violence	4%	64%	3%	7%	6%	16%
MATERNAL & CHILD HEALTH – TOTAL	**16%**	**18%**	**16%**	**33%**	**16%**	**1%**
Antenatal care treatments	17%	17%	22%	32%	11%	1%
Child growth monitoring & weighing	15%	20%	9%	34%	22%	1%
SEXUAL & REPRODUCTIVE HEALTH – TOTAL	**12%**	**46%**	**20%**	**16%**	**3%**	**4%**
STI treatment	12%	59%	10%	12%	1%	6%
HIV/STI testing and/or counselling	9%	45%	25%	14%	3%	3%
Family planning	15%	26%	26%	28%	3%	2%
Contraceptive services	19%	44%	19%	15%	4%	0%
NUTRITION – TOTAL	**12%**	**22%**	**5%**	**37%**	**23%**	**1%**
Nutrition counselling & support	12%	22%	5%	37%	23%	1%

Table 5.1.8: Respondents' Frequency of Health Service Use (past 12 months) – By Facility Type

Type & Location of Health Service	n	N/A	Never	Yearly	Monthly	Weekly	Daily
Malaria treatment							
PHCU	142	15%	4%	17%	29%	19%	17%
PHCC	110	24%	2%	18%	30%	14%	13%
Hospital	13	0%	0%	54%	31%	8%	8%
Diarrhoea or other stomach infection treatment							
PHCU	135	16%	12%	14%	22%	17%	19%
PHCC	101	23%	17%	22%	20%	8%	11%
Hospital	12	0%	42%	25%	25%	0%	8%
Vaccination							
PHCU	133	6%	12%	20%	53%	8%	2%
PHCC	104	16%	13%	14%	51%	2%	4%
Hospital	12	0%	8%	42%	42%	0%	8%
Acute respiratory infection treatment							
PHCU	91	10%	28%	17%	31%	6%	10%
PHCC	86	23%	26%	13%	20%	5%	14%
Hospital	9	0%	33%	44%	11%	0%	11%

Emergency care							
PHCU	82	18%	37%	18%	15%	6%	6%
PHCC	66	17%	38%	26%	15%	5%	0%
Hospital	8	25%	63%	0%	0%	13%	0%
Medical treatment after an experience of violence							
PHCU	41	2%	66%	2%	7%	10%	12%
PHCC	26	8%	65%	4%	8%	0%	8%
Hospital	2	0%	0%	0%	0%	0%	0%
Antenatal care treatments							
PHCU	114	12%	18%	25%	33%	13%	0%
PHCC	95	17%	19%	21%	33%	8%	2%
Hospital	12	17%	8%	25%	33%	8%	8%
Child growth monitoring & weighing							
PHCU	116	12%	18%	12%	32%	26%	0%
PHCC	84	14%	23%	5%	38%	18%	2%
Hospital	7	0%	43%	14%	14%	14%	14%
STI treatment							
PHCU	41	7%	51%	10%	17%	0%	7%
PHCC	44	5%	73%	5%	7%	2%	5%
Hospital	7	14%	29%	43%	0%	0%	0%
HIV/STI testing and/or counselling							
PHCU	22	5%	55%	5%	27%	9%	0%
PHCC	50	12%	48%	26%	10%	2%	2%
Hospital	10	0%	10%	80%	0%	0%	10%
Family planning							
PHCU	28	7%	21%	32%	36%	4%	0%
PHCC	27	22%	33%	19%	22%	4%	0%
Hospital	3	33%	0%	33%	0%	0%	33%
Contraceptive services							
PHCU	12	17%	67%	17%	0%	0%	0%
PHCC	12	17%	33%	17%	33%	0%	0%
Hospital	1	0%	0%	0%	0%	100%	0%
Nutrition counselling & support							
PHCU	117	9%	19%	2%	40%	30%	0%
PHCC	81	11%	30%	7%	36%	15%	1%
Hospital	8	0%	25%	25%	13%	25%	13%

Quality of Health Services

Satisfaction with Health Service

Most respondents who had used HPF health services were satisfied or extremely satisfied with the treatments for diarrhoea (84%) and malaria (81%), as well as vaccination services (80%). They expressed moderate levels of satisfaction with nutrition counselling (70%), antenatal care (68%), child growth monitoring (68%), treatment for respiratory infections (57%), HIV/STI testing or counselling (55%), family planning (53%), and emergency care (45%).

The lowest satisfaction ratings were given for STI treatment (36%), medical treatment after an experience of physical or sexual violence (35%), and contraceptive services (28%). These were also the most infrequently used services (see 'n' column below for the number out of 287 respondents who had used each type of health service).

Mean satisfaction ratings were statistically equivalent between men and women. When compared at the county level, facilities in Yirol West received significantly higher ratings for antenatal care treatments[76] and HIV/STI testing and/or counselling[77], particularly when compared to Gogrial East.

Table 5.1.9a: Household Satisfaction with Health Services

Type of Health Service	Not at all satisfied	Somewhat dissatisfied	Neither satisfied nor dissatisfied	Satisfied	Extremely satisfied	n	Mean Rating
TRAUMA & GENERAL CARE							
Malaria treatment						282	3.8
Diarrhoea or other stomach infection treatment						252	3.9
Vaccination						267	3.8
Acute respiratory infection treatment						199	3.2
Emergency care						200	2.8
Medical treatment after an experience of violence						58	2.5
MATERNAL & CHILD HEALTH							
Antenatal care treatments						224	3.4
Child growth monitoring & weighing						206	3.5
SEXUAL & REPRODUCTIVE HEALTH							
STI treatment						91	2.5
HIV/STI testing and/or counselling						86	2.9
Family planning						66	3.3
Contraceptive services						39	2.4
NUTRITION							
Nutrition counselling & support						216	3.4

[76] F (3, 220) = 4.630, p = .004, η_p^2 = .06
[77] F (3, 82) = 3.253, p = .026, η_p^2 = .11

Table 5.1.9b: Household Satisfaction with Health Services

Type of Health Service	Not at all satisfied	Somewhat dissatisfied	Neither satisfied nor dissatisfied	Satisfied	Extremely satisfied
TRAUMA & GENERAL CARE	n				
Malaria treatment	277			3.8	
Diarrhoea or other stomach infection treatment	237			3.9	
Vaccination	250			3.8	
Acute respiratory infection treatment	164			3.3	
Emergency care	153			2.9	
Medical treatment after an experience of violence	42			2.6	
MATERNAL & CHILD HEALTH					
Antenatal care treatments	206			3.5	
Child growth monitoring & weighing	190			3.5	
SEXUAL & REPRODUCTIVE HEALTH					
STI treatment	59			2.7	
HIV/STI testing and/or counselling	62			3.3	
Family planning	45			3.6	
Contraceptive services	14			3.1	
NUTRITION					
Nutrition counselling & support	192			3.5	

There were seven health services that received significantly different satisfaction ratings based on facility type. PHCCs received significantly higher satisfaction ratings than PHCUs for emergency care and treatment of STIs, malaria, and acute respiratory infection. PHCCs and Hospitals received significantly higher satisfaction ratings than PHCUs for vaccinations, HIV/STI testing and/or counselling, and antenatal care treatments. PHCUs did not receive significantly higher ratings than the other health facility types for any of the health services measured.

Mean satisfaction ratings by facility type and results of statistical comparisons (one-way ANOVA, effect size, and post-hoc tests) are presented in Table 10.

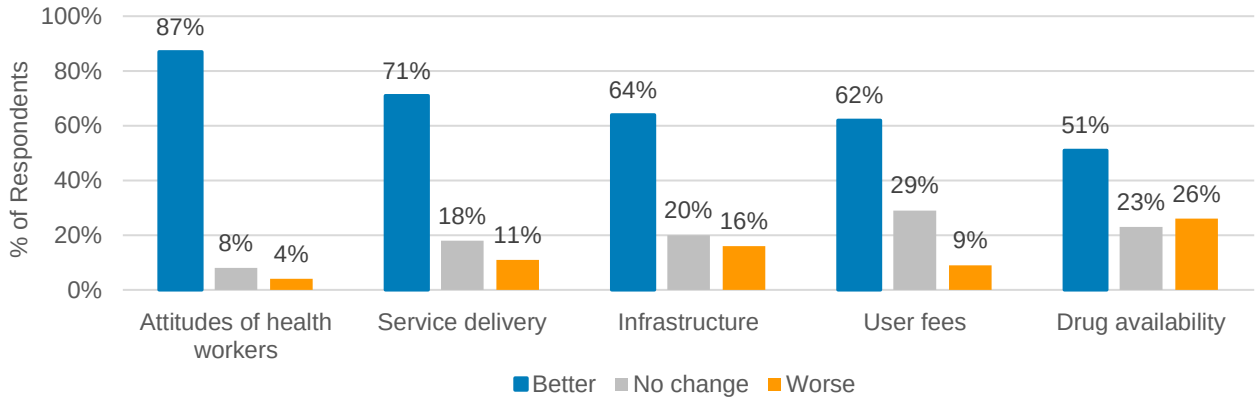
Table 5.1.10: Household Satisfaction with Health Services – By Facility Type

Type of Health Service	PHCU	PHCC	Hospital	p	η_p^2	Differences
Emergency care	2.4	3.1	3.0	.005	.06	PHCC>PHCU
Antenatal care treatments	3.2	3.7	3.8	.001	.06	Both>PHCU
STI treatment	1.9	3.1	3.0	.000	.18	PHCC>PHCU
HIV/STI testing and/or counselling	2.1	3.3	3.5	.000	.21	Both>PHCU
Vaccination	3.5	4.0	4.3	.000	.07	Both>PHCU
Malaria treatment	3.6	4.1	3.3	.000	.06	PHCC>PHCU
Acute respiratory infection treatment	2.8	3.6	3.1	.000	.09	PHCC>PHCU

Changes in Community Health Services Since HPF Initiated

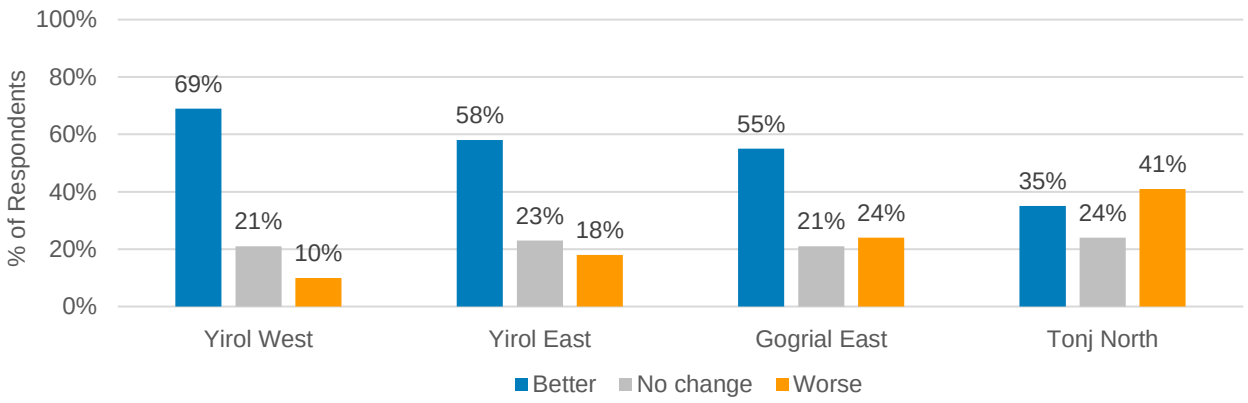
Since the HPF was initiated in 2012, beneficiaries have observed improvements in the attitudes of health workers, the timeliness and variety of services delivered, development of infrastructure, and a decrease in the prevalence of user fees. Drug availability had seen the least amount of improvement with one half of the respondents rating that it had gotten better and half rating it the same or worse. These perceptions were comparable across age group, gender, and disability.

Figure 5.1.14: Perceived Changes in Community Health Services



When compared by county, perceptions of change were comparable for attitudes of health workers, service delivery, and infrastructure but different for drug availability and user fees. Compared to the other three counties, more respondents in Tonj North thought that drug availability in their community was worse than in 2012.[78]

Figure 5.1.15: Perceived Changes in Drug Availability – By County



[78] $\chi 2$ (6, N = 273) = 21.609, p = .001, V = .199

Respondents in Gogrial East and Tonj North reported the most change in user fees since 2012; most reported that it had gotten better but a minority thought it had become worse. Respondents in Yirol East and Yirol West generally reported less change in user fees since 2012.[79]

Figure 5.1.16: Perceived Changes in User Fees – By County

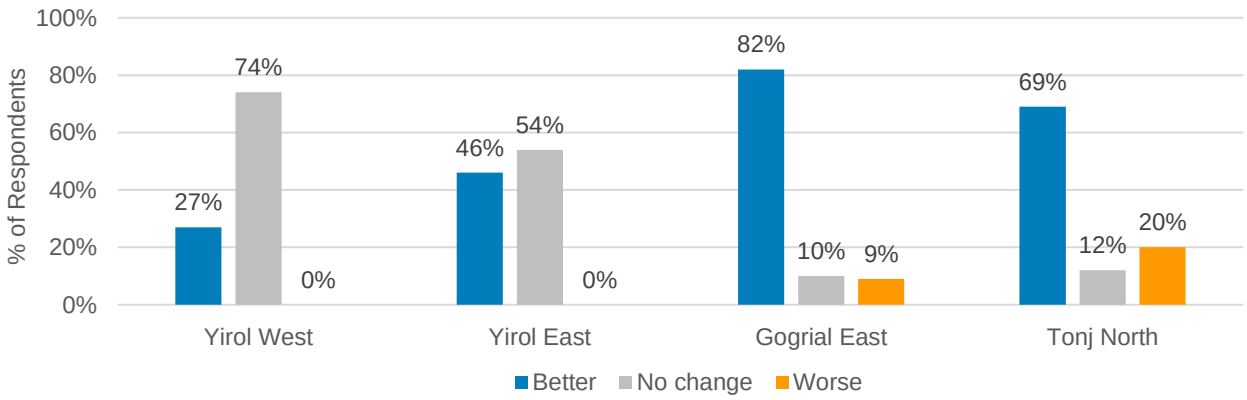
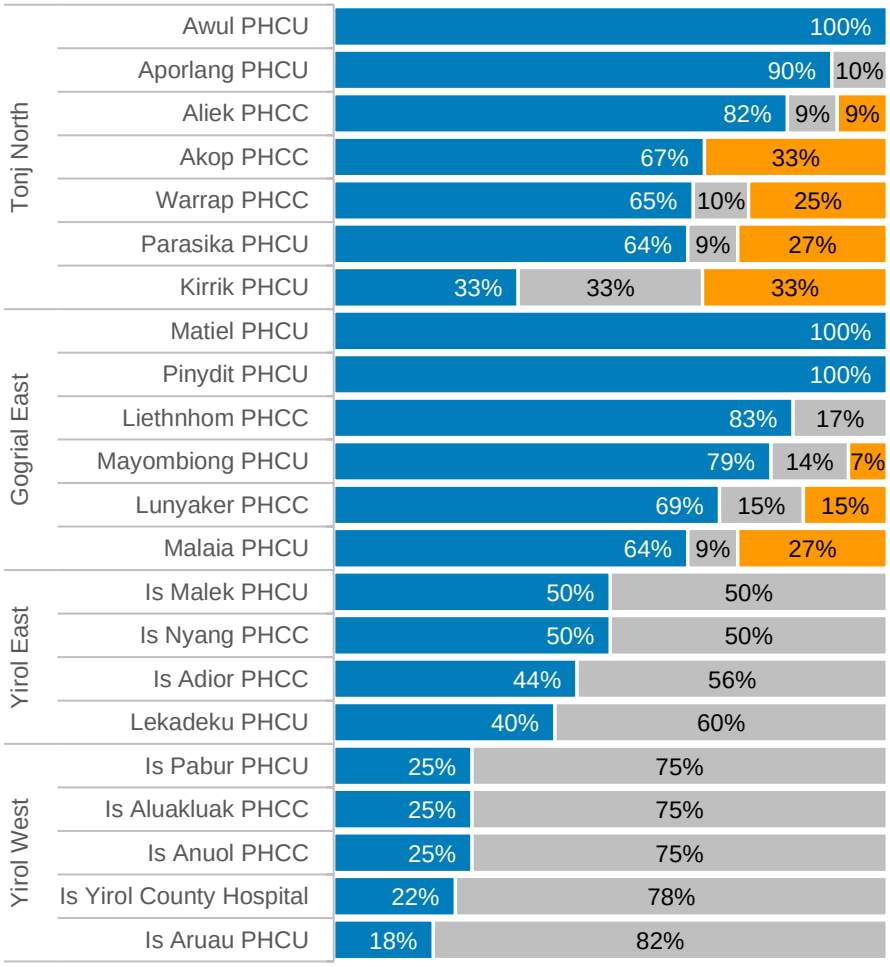


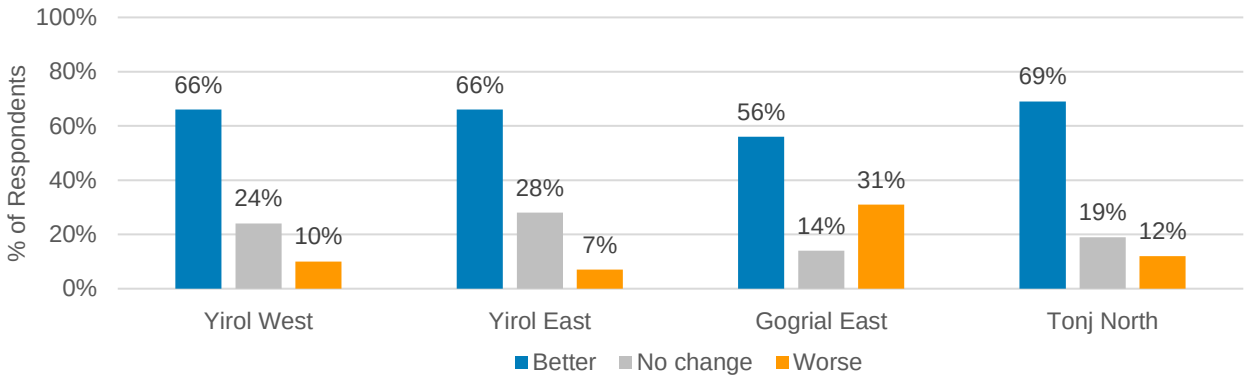
Figure 5.1.17: Perceived Changes in User Fees – By Facility



[79] χ2 (6, N = 259) = 89.502, p = .000, V = .416

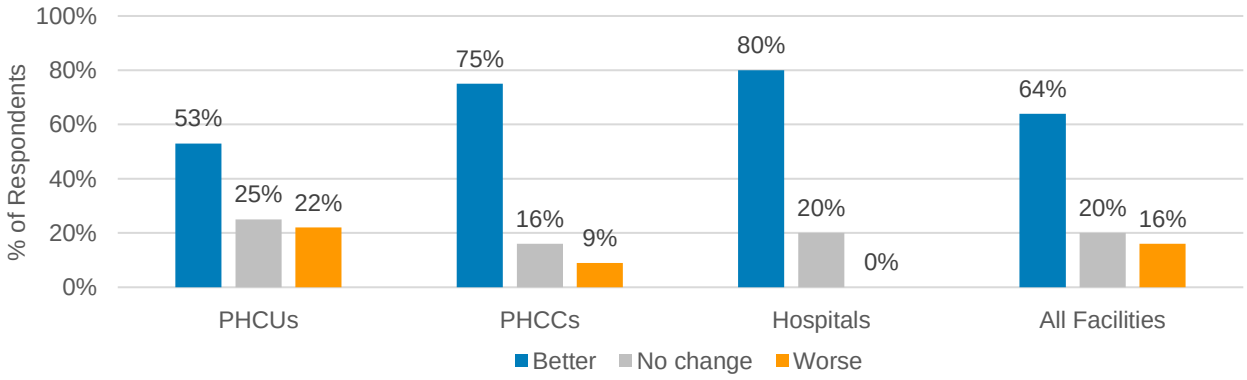
Perceptions of change in infrastructure were comparable across all four counties.

Figure 5.1.18: Perceived Changes in Infrastructure – By County



Perceptions of change in service delivery, attitudes of health workers, user fees, and drug availability were comparable across PHCUs, PHCCs, and Hospitals. However, more respondents thought the infrastructure of Hospitals and PHCCs had improved when compared to PHCUs.[80]

Figure 5.1.19: Perceived Changes in Infrastructure – By Facility Type



[80] $\chi 2$ (4, N = 258) = 15.042, p = .005, V = .171

The results of a Spearman correlation did not find a consistent relationship between changes in drug availability and changes in user fees.[81] However, when compared at the county level, a significant negative relationship was found in Yirol West where user fees tended to get better when drug availability got worse or stayed the same.[82]

Table 5.1.11: Changes in Drug Availability and User Fees

		Change in User Fees – All Counties			Changes in User Fees – Yirol West		
		Worse	No change	Better	Worse	No change	Better
Changes in Drug Availability	Worse	12.3%	24.6%	63.1%	0%	0%	100%
	No change	13.0%	24.1%	63.0%	0%	57%	43%
	Better	5.4%	30.0%	64.6%	0%	83%	17%

When perceived changes in community health services were compared by facility, the following positive and negative outliers were identified:

Table 5.1.12: Perceived Changes in Community Health Services – Facility Outliers

Health Services	'Worse' ratings > 10% Total	'Better' ratings > 10% Total
Attitudes of health workers	Kirrik	Aporlang, Is Aluakluak, Is Aruau, is Pabur, Lunyaker, Pinydit,
Service delivery	Aliek, Kirrik, Malaia, Pinydit	Aporlang, Liethnhom, Is Aruau, Is Pabur, Warrap
Infrastructure	Awul, Is Aruau, Malaia, Pinydit	Aporlang, Liethnhom, Is Pabur, Is Yirol, Lunyaker, Matiel, Mayombiong, Warrap
User fees	Akop, Kirrik, Malaia, Parasika, Warrap	Aliek, Aporlang, Awul, Liethnhom, Matiel, Mayombiong, Pinydit
Drug availability	Aliek, Aporlang, Kirrik, Malaia, Lekadeku, Parasika, Warrap	Akop, Liethnhom, Is Adior, Is Anuol, Is Aruau, Is Nyang, Is Pabur, Pinydit

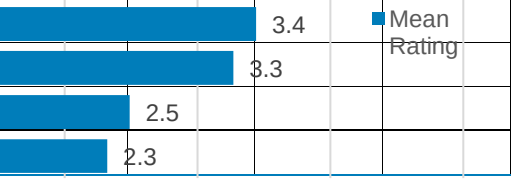
Satisfaction with Facility

Most respondents were either satisfied or extremely satisfied with the friendliness and courtesy of HPF health facility staff (82%), the cleanliness of the facility (71%), the skill and competency of the staff (65%), and the efficiency of treatment and care (63%). The proportion of respondents who were satisfied with the waiting time (36%) and drug availability (31%) were much lower with an average rating of 'somewhat dissatisfied'. Satisfaction ratings were comparable across age group, gender, and ability/disability.

[81] $r_s(249) = .039$, $p = .544$
[82] $r_s(33) = .422$, $p = .014$

Table 5.1.13: Respondent Satisfaction with Facilities & Services Delivered

Facilities & Services Delivered	Not at all satisfied	Somewhat dissatisfied	Neither satisfied nor dissatisfied	Satisfied	Extremely satisfied
	n				
Friendliness and courtesy of the staff	285			3.7	
Cleanliness of the hospital, centre, or clinic	282			3.5	
Skill and competency of the staff	278			3.4	
Efficiency of treatment and care	284			3.3	
Waiting time	284		2.5		
Drug availability	281		2.3		



When compared by facility, the facilities listed below were identified as outliers in terms of either receiving very low mean satisfaction ratings (≤ 2) or very high mean satisfaction ratings (≥ 4).

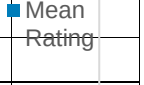
Table 5.1.14: Respondent Satisfaction with Facilities & Services Delivered – Facility Outliers

Facilities & Services Delivered	Lowest Rated Facilities (*M* ≤ 2)	Highest Rated Facilities (*M* ≥ 4)
Friendliness and courtesy of the staff	--	Akop, Is Anuol
Cleanliness of the hospital, centre, or clinic	Malaia	Aporiang, Is Aluakluak, Is Anuol, Is Aruau, Is Pabur, Liethnhom, Lunyaker, Matiel
Skill and competency of the staff	--	Akop, Aporiang, Anul, Is Aluakluak, Is Anuol, Is Pabur, Lunyaker, Matiel, Pinydit, Warrap
Efficiency of treatment and care	--	Akop, Is Anuol, Pinydit
Waiting time	Aliek, Aporiang, Awul, Kirrik, Lunyaker, Malaia, Matiel, Mayombiong, Parasika, Pinydit	--
Drug availability	Aliek, Kirrik, Lekadeku, Liethnhom	--

When compared by county, satisfaction levels were comparable except for the availability of drugs at hospitals, clinics, or health centres. Consistent with previously reported ratings, beneficiaries in Tonj North were the least satisfied with the level of drug availability and this difference across counties was statistically significant.[83]

Table 5.1.15: Respondent Satisfaction with Drug Availability – By County

County	Not at all satisfied	Somewhat dissatisfied	Neither satisfied nor dissatisfied	Satisfied	Extremely satisfied
	n				
Yirol West	43			3.4	
Yirol East	63			2.8	
Gogrial East	81		2.1		
Tonj North	94		1.7		

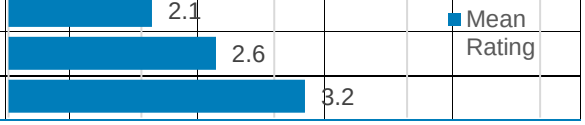


[83] F (3, 277) = 24.221, p < .000, η_p^2 = .21

When compared by facility type, satisfaction levels with drug availability were significantly higher at hospitals and PHCCs when compared to PHCUs.[84]

Table 5.1.16: Respondent Satisfaction with Drug Availability – By Facility Type

County	Not at all satisfied	Somewhat dissatisfied	Neither satisfied nor dissatisfied	Satisfied	Extremely satisfied
	n				
PHCU	143	2.1			
PHCC	110	2.6			
Hospital	13	3.2			



Community Engagement

Communities with Health Committees

On average, 71% (202/285) of respondents confirmed that there was a health community committee in their area; this proportion was comparable across all four counties surveyed.

Table 5.1.17: Communities with Health Committees – By County

State	County	n	Yes	No	Don't Know
Lakes	Yirol East	65	77%	22%	2%
	Yirol West	44	75%	21%	5%
Warrap	Tonj North	94	72%	25%	3%
	Gogrial East	82	62%	34%	4%
TOTAL		**285**	**71%**	**26%**	**3%**

Participation in Health Committee Meetings

Of the respondents who reported that a health committee existed in their area, 52% (104/200) indicated that they participated in committee meetings. More respondents participated in the Lakes State (Yirol East and West counties) than in the Warrap State (Tonj North and Gogrial East counties) and this difference was statistically significant.[85] Reported participation rates were comparable across age group, gender, and ability/disability.

Table 5.1.18: Respondent Participation in Health Committee Meetings – By County

State	County	n	Yes	No
Lakes	Yirol East	50	62%	38%
	Yirol West	33	67%	33%
Warrap	Tonj North	66	42%	58%
	Gogrial East	51	45%	55%
TOTAL		**200**	**52%**	**48%**

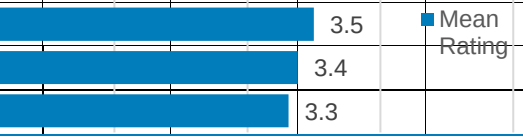
[84] F (2, 277) = 7.356, p = .001, η_p^2 = .05
[85] $\chi 2$ (3, N = 200) = 8.245, p = .041, V = .203

Impact of Health Committee on Health Services

Overall, 76% (150/198) of respondents agreed that the health community committees have had an impact on the health facility services in their area; this proportion was comparable across all four counties surveyed. Beneficiary perceptions of committee impacts were comparable across age group, gender, and ability/disability.

Table 5.1.19: Health Committee Impact on Community Health Services – By County

County	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree
	n				
Yirol West	33			3.5	
Yirol East	48			3.5	
Gogrial East	50			3.4	
Tonj North	67			3.3	

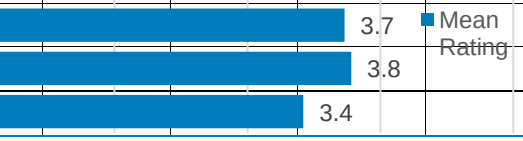


Ability to Discuss Problems with Health Committee

Overall, 81% (159/196) of respondents agreed that they could discuss health problems with the health community committee in their area; this proportion was comparable across all four counties surveyed and across age group, gender, and ability/disability.

Table 5.1.20: Ability to Discuss Health Problems with Health Committee – By County

County	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree
	n				
Yirol West	31			3.5	
Yirol East	49			3.7	
Gogrial East	50			3.8	
Tonj North	66			3.4	



Annex 5.2 Facility Surveys

As part of the fieldwork the teams conducted facility surveys in twenty different facilities across the four counties. This included one hospital, eight PHCCs and 11 PHCUs. In keeping with the areas that were visited, the majority of the facilities (14/20) were in rural areas, with four categorised as peri urban and one as urban (Yirol County Hospital).

Table 5.2.1: Type of facility

Facility	Frequency	Percent (%) of Total
Hospital	1	5
PHCC	8	40
PHCU	11	55
Total	20	100

Table 5.2.2: Type of facility by region

		Type of facility			Total
		Hospital	PHCC	PHCU	
County	Gogrial East	0	1	4	5
	Tonj North	0	3	3	6
	Yirol East	0	2	2	4
	Yirol West	1	2	2	5

This annex will explore the data from these facility surveys, which has also been used to inform our overall findings. The overall picture from the surveys is that the facilities are generally understaffed and undersupplied with equipment and drugs, although there are exceptions to this such as Yirol Hospital. PHCUs often have almost no trained staff, and referrals in some areas are hampered by lack of network and long distances to the closest PHCC.

Accessibility

We asked the field teams to assess the accessibility of facilities. Both teams highlighted the impact of the rainy season on the accessibility of facilities. The team in Warrap also noted that a lack of mobile network was also a problem for some of the facilities they visited (Akop PHCC, Aliek PHCC etc.).

The distance of some of the PHCCs from some community members was also noted (one PHCU was a seven hour walk from the closest PHCC).

Patient Load

The enumerators also collected data on the patient load for each facility. We have sme concerns around how accurate all the data is for this, and these are detailed further in the data quality review annex (4).

Despite this it is clear that some areas are seeing an extremely high outpatient load, with some PHCCs and PHCUs seeing over 200 outpatients a day.

Inpatient numbers were not particularly high, although the enumerators noted this was because most PHCCs were already over their inpatient capacity. For the facilities where we had the information there was on average two beds for inpatients. Two PHCCs in Warrap reported that when they had an inpatient load that was too high, patients were forced to lie on the ground.

Different systems were being used to record patient numbers. In Yirol County Hospital the IP had implemented computerised patient logs.

Table 5.2.3: Number of outpatients by type of facility (age and gender)

Type of facility/Age group	Number of outpatients Number	Adult male	Adult female	Under 5 Male	Under 5 female	10 to 19 male	10 to 19 female
Hospital	1,315	300	490	250	270	NA	N/A
PHCC	2,033	307	602	321	362	190	252
PHCU	3,368	692	760	721	530	307	42

Table 5.2.4: Number of Outpatients by County (age and gender)

Region/Age group	Number of outpatients	Adult male	Adult female	Under 5 Male	Under 5 female	10 to 19 male	10 to 19 female
Gogrial East	1,565	236	359	255	265	195	255
Tonj North	1914	267	594	333	345	153	230
Yirol East	583	172	193	73	86	48	71
Yirol West	2654	624	706	631	466	101	122

Disabled Access/Facilities

Only 2/20 of the facilities had wheelchair access, with one of these being Yirol County Hospital. Again, only 2/20 facilities had systems in place to support differently abled people access the facility. The hospital had an ambulance and one PHCU had access to a motorbike to pick up patients.

Privacy

Of the facilities that reported, 8/20 reported some level of privacy for consultations. The majority of facilities had no privacy for patients.

Facility staffing

In our sample only the hospital had medical officers, with the PHCCs usually having one clinical officer and some trained nurses. Most of the PHCUs were staffed by untrained nurses. On the pharmacy side, most of the PHCCs had pharmacists, although some were staffed by medication dispensers. 4/10 PHCUs had neither medication dispensers nor pharmacists. Most facilities had either midwives or TBAs. 7/8 PHCCs had lab technicians, while the hospital had 1. All facilities had some form of community outreach or community health worker staff. A number of the facilities (5/20) reported having guards/watchman.

9/19 facilities had staff wearing uniforms, with 1 facility with only some of the staff wearing uniforms, and 9 with no staff in uniforms. None of the facilities had staff wearing name tags.

'There is need to increase medical consultants. All patients that visit the facility are seen by one clinical officer that works long hours and is on call when off-site few hours to attend to medical emergencies.' PHCC, Warrap

'Patients are examined by in-charge, a holder of certificate in community health work taking the role of clinical/medical officer. Further investigations that require a laboratory do not take place. High referral rate to PHCC.' PHCU, Warrap

Facilities and Infrastructure

Of the twenty facilities surveyed 9/20 had maintenance plans, with maintenance mostly overseen by the IP responsible. Of these nine facilities, five of them had maintenance schedules.

In keeping with our qualitative findings, nearly all of the facilities (17/19) were reported as 'In need of repair'. Maliai PHCU was described as a 'thatched hut' with a single room used for both storage and consultations with patients.

Most health facilities visited had very poor WASH facilities, with 6/20 having water harvesting facilities and 11/20 with access to clean drinking water. The number of facilities with toilets was higher (17/20), and the majority of those (14/17) had separate toilets for women and men. However, of those with toilets, only 8/17 had handwashing facilities to serve them. The results on handwashing facilities for health staff in work areas were slightly higher (12/20).

17/20 facilities had a waste disposal system, with most of them reporting this was some form of incineration/burning, sometimes in a hole/pit. Only 4/17 reported that this waste disposal

area was far enough away from the general facility area, and 6/17 that this area was protected. 10/20 facilities had a waste segregation system.

The qualitative data reported insufficient toilets across a number of facilities. Two of the facilities that didn't have toilets had pit latrines, and one facility did not have access to toilets of any type.

'The consultations between the patient and the health worker happens through the window.' PHCC, Lakes

Image 1 and 2: Maliai PHCU, Gogrial East, Warrap

'The grass thatched one room is where drugs/medical supplies are stored, examination and consultation area. Risks include leakage during rain, thatched roof likely to be blown away during strong winds, high likelihood of hut catching fire as it is located near a local market where there are food restaurants. There is a need to construct an equipped structure to serve the area with a degree of quality health service.' Field team comment on Maliai PHCU

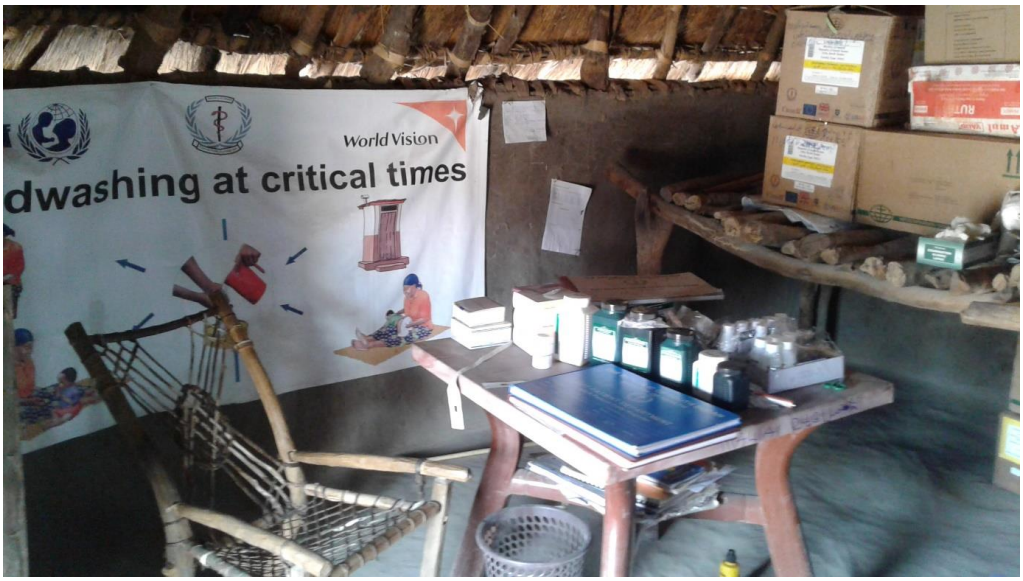


Table 5.2.5: Maintenance by type of facility

	Hospital		PHCC		PHCU		Total column	
	# of facilities (n=1)	%	# of facilities (n=8)	%	# of facilities (n=11)	%	# of facilities	%
Does the facility have a maintenance plan?	1	100	5	52.5	3	27	9	45%
Are there water harvesting facilities?	1	100	3	37.5	2	18	6	30%
Does the facility have clean drinking water?	1	100	5	52.5	5	45	11	55%
Does the facility have toilet facilities?	1	100	7	87.5	9	82	17	85%
If yes, are there separate facilities for women and men?	0	0	6	75	8	73	14	70%
Is there a maintenance schedule?	1	100	3	37.5	2	18	6	30%

Table 5.2.6: Maintenance by County

	County							
	Gogrial East (n=5)		Tonj North (n=6)		Yirol East (n=4)		Yirol West (n=5)	
	# of facilities	%	# of facilities	%	# of facilities	%	# of facilities	%
Does the facility have a maintenance plan?	1	20%	6	100%	0	0%	2	40%
Are there water harvesting facilities?	0	0%	1	17%	2	50%	3	60%
Does the facility have clean drinking water?	1	20%	4	67%	2	50%	4	80%
Does the facility have toilet facilities?	4	80%	6	100%	3	75%	4	80%
If yes, are there separate facilities for women and men?	3	60%	6	100%	3	75%	2	40%
Is there a maintenance schedule?	1	20%	4	67%	0	0%	1	20%

Table 5.2.7: Cleanliness of the Environment by Facility

	Type of facility or service							
	Hospital (n=1)		PHCC (n=8)		PHCU (n=11)		Total column (n=20)	
	# of facilities	%	# of facilities	%	# of facilities	%	# of facilities	%
Are the toilet facilities clean?	1	100	8	100	8	73	17	85
Are there hand washing facilities to serve the toilets?	1	100	4	50	3	27	8	40
Are there handwashing facilities for health staff in all work areas	1	100	6	75	5	45.5	12	60
Is there a waste disposal system for the health facility?	1	100	8	100	8	73	17	85
Is the waste disposal area protected to avoid tampering?	1	100	4	50	1	9	6	30
Is the waste disposal system located far enough from the general facility area?	0	0	1	12.5	3	27	4	20
Is there a waste segregation system?	1	100	6	75	3	27	10	50

Table 5.2.8: Cleanliness of the Facility Environment by County

	County									
	Gogrial East (n=5)		Tonj North (n=6)		Yirol East (n=4)		Yirol West (n=5)		Total column (n=20)	
	# of facilities	%	# of facilities	%	# of facilities	%	# of facilities	%	# of facilities	%
Are the toilet facilities clean?	3	60	6	100	3	75	5	100	17	85
Are there hand washing facilities to serve the toilets?	0	0	1	17	3	75	4	80	8	40
Are there handwashing facilities for health staff in all work areas	1	20	4	67	3	75	4	80	12	60
Is there a waste disposal system for the health facility?	5	100	6	100	3	75	3	60	17	85
Is the waste disposal area protected to avoid tampering?	0	0	1	17	3	75	2	40	6	30
Is the waste disposal system located far enough from the	0	0	2	34	2	50	0	0	4	20

general facility area?										
Is there a waste segregation system?	2	40	5	83	2	50	1	20	10	50

Drug Storage and Availability

16/19 facilities reported that drugs were stored in separate room, with all of these reporting that the room was locked. Of the 17 facilities that reported, 13 had essential drugs out of stock (68.4%). There were various reports on when these drugs had run-out, from December 2017 to a week before the field teams visited. There were also a variety of reports on when the last consignments of drugs had been delivered. Most of Lakes had received a consignment in early March. Some of Gogrial East had received the most recent shipment of drugs, while facilities in Tonj North reported the last consignment arriving in December 2017 or January 2018.

Table 5.2.9: Drug Storage by Facility

	Type of facility or service							
	Hospital (n=1)		PHCC (n=8)		PHCU (n=11)		Total column (n=20)	
	# of facilities	%	# of facilities	%	# of facilities	%	# of facilities	%
Are the drugs stored in a separate room?	1	100	7	87.5	8	73	16	84
Are there essential drugs that are out of stock?	1	100	4	50	8	73	13	68
Is the room locked?	1	100	7	87.5	8	73	16	84

Table 5.2.10: Drug Storage by County

	County							
	Gogrial East (n=5)		Tonj North (n=6)		Yirol East (n=4)		Yirol West (n=5)	
	# of facilities	%	# of facilities	%	# of facilities	%	# of facilities	%
Are the drugs stored in a separate room?	4	80	5	83	4	100	3	60
Are there essential drugs that are out of stock?	3	60	6	100	2	50	2	40
Is the room locked?	4	80	5	83	4	100	3	60

Equipment availability

Equipment availability was also mixed, although there were some clear outliers. Only 4/20 (20%) of facilities had bed pans, and 2/20 (10%) had weighing scales. Better results were seen with neonatal kits for childbirth (80%), needles (95% and syringes (80%).

Table 5.2.11: Availability of Equipment and materials by Facility

	Type of Facility							
	Hospital (n=1)		PHCC (n=8)		PHCU (n=11)		Total column (n=20)	
	# of facilities	%	# of facilities	%	# of facilities	%	# of facilities	%
Bed pans	1	100	2	25	1	9	4	20
Blood pressure cuffs	0	0	7	87.5	7	64	14	70
Delivery Kit	0	0	7	87.5	7	64	14	70
Hand washing soap	1	100	7	87.5	6	54.5	14	70
Neonatal kit for childbirth	1	100	7	87.5	8	73	16	80
Rape kit	1	100	7	87.5	1	9	9	45
Weight scales	1	100	0	0	1	9	2	10
Antiseptics	0	0	7	87.5	4	36	11	55
Detergents	1	100	6	75	3	27	10	50
Gauze	1	100	6	75	2	18	9	45
Gloves	1	100	7	87.5	4	36	12	60
Needles	1	100	8	100	10	91	19	95
Stethoscope	1	100	7	87.5	4	36	12	60
Syringes	1	100	7	87.5	8	73%	16	80
Thermometers	1	100	8	100	4	36	13	65

Table 5.2.12: Availability of Equipment and materials by Facility

	County							
	Hospital (n=1)		PHCC (n=8)		PHCU (n=11)		Total column (n=20)	
	# of facilities	%	# of facilities	%	# of facilities	%	# of facilities	%
Bed pans	1	100	2	25	1	9	4	20
Blood pressure cuffs	0	0	7	87.5	7	64	14	70
Delivery Kit	0	0	7	87.5	7	64	14	70
Hand washing soap	1	100	7	87.5	6	54.5	14	70
Neonatal kit for childbirth	1	100	7	87.5	8	73	16	80

Rape kit	1	100	7	87.5	1	9	9	45
Weight scales	1	100	0	0	1	9	2	10
Antiseptics	0	0	7	87.5	4	36	11	55
Detergents	1	100	6	75	3	27	10	50
Gauze	1	100	6	75	2	18	9	45
Gloves	1	100	7	87.5	4	36	12	60
Needles	1	100	8	100	10	91	19	95
Stethoscope	1	100	7	87.5	4	36	12	60
Syringes	1	100	7	87.5	8	73	16	80
Thermometers	1	100	8	100	4	36	13	65

Contraception Availability

There was generally very low availability of modern contraception in the health facilities visited, with the exception of condoms, which were available at 14/20 facilities (70%). Many of the facilities surveyed will not have received the UNFPA materials delivered in HPF consignment 5 at the time of the data collection.

Table 5.2.13: Contraception available by facility

	Type of facility or service							
	Hospital (n=1)		PHCC (n=8)		PHCU (n=11)		Total column	
	# of facilities	%	# of facilities	%	# of facilities	%	# of facilities	%
Combined pill	1	100	5	62.5	2	18	8	40
Hormonal injections	1	100	5	62.5	1	9	7	35
Intrauterine device	1	100	2	25	1	9	4	20
Progesterone only pills	0	0	3	37.5	1	9	4	20
Condoms	1	100	6	75	7	64	14	70

Table 5.2.14: Contraception available by County

			Type of facility or service							
	Gogrial East (n=5)		Tonj North (n=6)		Yirol East (n=4)		Yirol West (n=5)		Total column (n=20)	
	# of facilities	%	# of facilities	%	# of facilities	%	# of facilities	%	# of facilities	%
Combined pill	0	0	2	34	2	50	4	80	8	90
Hormonal injections	0	0	3	50	1	25	3	60	7	85
Intrauterine device	0	0	1	17	1	25	2	40	4	20

Progesterone only pills	0	0	2	34	1	25	1	20	4	20
Condoms	2	40	6	100	3	75	3	60	14	70

General Drug Availability

It is important to stress that the data on drug availability is simply a snapshot and is not representative of overall availability at the facilities visited. Our sample may also have been affected by fact that a number of facilities (at least six) had received the most recent consignment in the two weeks before our field teams visited. Our more general findings on drug availability (triangulated between the facility survey, KIIs and the beneficiary survey) are presented in the findings section.

The teams found that drug availability was mixed, although not terrible. The only drugs found to be available at all facilities were urine pregnancy test strips and Vitamin A. The drugs that were least available were Ciproflaxacin injections, Syringe Luers of all sizes, Chlorpheniramine and Multivitamins.

A common complaint from all our datasets was that antimalarials were not always available. In our sample quinine was found to be available in only 40% of facilities and Doxyclycline in 60%. Malaria RDTs had better availability at 75%.

The table below details the drugs availability in different sizes of facility. The findings highlighted in red are not delivered to PHCUs as part of the HPF standard pack. The presence of non-PHCU drugs in these facilities can be explained either by other supply chains or by errors in our data. It is not possible to identify the reason at this stage.

Table 5.2.15: Essential drugs availability by facility

	Type of facility or service							
	Hospital (n=1)		PHCC (n=8)		PHCU (n=11)		Total column (n=20)	
	# of facilities	%	# of facilities	%	# of facilities	%	# of facilities	%
Amoxicillin (dry powder)	1	100	6	75	8	73	15	75
Artesunate (100mg)	1	100	6	75	10	91	17	85
Artesunate (25mg) infant	1	100	7	87.5	10	91	18	90
Artesunate (child)	1	100	7	87.5	10	91	18	90
Artesunate (toddler)	1	100	6	75	9	82	16	80
Artemether (40mg)	1	100	6	75	1	9	8	40
Artemether (80mg)	1	100	4	50	1	9	6	30
Azithromycin 200mg	1	100	4	50	4	36	9	45
Azithromycin 250	1	100	7	87.5	8	73	16	80

Ceftriaxone Powder	1	100	4	50	1	9	6	30
Ciprofloxacin injection	1	100	2	25	2	18	5	25
Cotrimoxazole 100mg	1	100	7	87.5	10	91	18	90
Cotrimoxazole 400mg	1	100	6	75	6	54.5	13	65
Diclofenac injection	1	100	6	75	1	9	8	40
Diclofenac sodium	1	100	4	50	1	9	6	30
Ferrous Sulphate	1	100	7	87.5	9	82	17	85
Gentamycin 10ml	1	100	4	50	5	45.5	10	50
Gentamycin 40mg	1	100	6	75	1	9	8	40
Low sodium ORH	1	100	6	75	9	82	16	80
Malaria RDT	1	100	6	75	8	73	15	75
Metronidazole dry powder	1	100	7	87.5	10	91	18	90
Paracetamol suspension	1	100	6	75	8	73	15	75
Quinine injection	1	100	6	75	1	9	8	40
Quinine sulphate	1	100	6	75	1	9	8	40
Sodium Chloride	1	100	6	75	1	9	8	40
Sodium Lactate	1	100	7	87.5	1	9	9	45
Syringe luer 10ml	1	100	3	37.5	1	9	5	25
Syringe luer 2ml	1	100	8	100	1	9	10	50
Syringe luer 5ml	1	100	8	100	1	9	10	50
Urine pregnancy test strips	1	100	8	100	11	100	20	100
Vitamin A	1	100	8	100	11	100	20	100
Water for injection	1	100	8	100	1	9	10	50
Zinc Sulphate	1	100	6	75	10	91	17	85
Albendazole	1	100	7	87.5	8	73	16	80
Amoxicillin	1	100	6	75	9	82	16	80
Benzathine	1	100	6	75	1	9	8	40
Benzylpenicillin	1	100	6	75	1	9	8	40
Chlorpheniramine	1	100	3	37.5	1	9	5	25
Ciprofloxacin	1	100	7	87.5	3	27	11	55
Dextrose	1	100	8	100	1	9	10	50
Doxycycline	1	100	7	87.5	4	36	12	60
Fluconazole	1	100	6	75	3	27	10	50
Hyoscine	1	100	7	87.5	10	91	18	90

Methyldopa	1	100	6	75	4	36	11	55
Metronidazole	1	100	8	100	10	91	19	95
Multivitamin	1	100	3	37.5	1	9	5	25
Oxytocin	1	10	6	75	1	9	8	40
Paracetamol	1	100	6	75	9	82	16	80
Povidone	1	100	7	87.5	10	91	18	90
Promethazine	1	10	7	87.5	4	36	12	60
Ranitidine	1	100	5	62.5	1	9	7	35
Salbutamol	1	100	5	62.5	1	9	7	35
Sulphadoxine	1	100	6	75	7	63	14	70
Syphilis	0	0	7	87.5	4	3	11	55
Tetracycline	1	100	6	75	7	63	14	70

Table 5.2.16: Essential drugs availability by County

	Type of facility or service									
	Gogrial East (n=5)		Tonj North (n=6)		Yirol East (n=4)		Yirol West (n=5)		Total column (n=20)	
	# of facilities	%	# of facilities	%	# of facilities	%	# of facilities	%	# of facilities	%
Amoxicillin (dry powder)	5	100	3	50	3	75	4	80	15	75
Artesunate (100mg)	5	100	4	67	4	100	4	80	17	85
Artesunate (25mg) infant	5	100	5	83	4	100	4	80	18	90
Artesunate (child)	5	100	5	83	4	100	4	80	18	90
Artesunate (toddler)	5	100	4	67	3	75	4	80	16	80
Artemether (40mg)	1	20	3	50	2	50	2	40	8	40
Artemether (80mg)	1	20	1	17	2	50	2	40	6	30
Azithromycin 200mg	2	40	2	34	3	75	2	40	9	45
Azithromycin 250	4	80	4	67	4	100	4	80	16	80
Ceftriaxone Powder	1	20	0	0	2	50	3	60	6	30
Ciprofloxacin injection	1	20	0	0	0	0	4	80	5	25
Cotrimoxazole 100mg	5	100	5	83	4	100	4	80	18	90
Cotrimoxazole 400mg	4	80	2	34	2	50	5	100	13	65
Diclofenac injection	1	20	3	50	2	50	2	40	8	40

Diclofenac sodium	1	20	1	17	1	25	3	60	6	30
Ferrous Sulphate	5	100	3	50	4	100	5	100	17	85
Gentamycin 10ml	4	80	1	17	3	75	2	40	10	50
Gentamycin 40mg	1	20	2	34	2	50	3	60	8	40
Low sodium ORH	5	100	2	34	4	100	5	100	16	80
Malaria RDT	5	100	2	34	4	100	4	80	15	75
Metronidazole dry powder	5	100	4	67	4	100	5	100	18	90
Paracetamol suspension	5	100	2	34	4	100	4	80	15	75
Quinine injection	1	20	1	17	2	50	4	80	8	40
Quinine sulphate	1	20	1	17	2	50	4	80	8	40
Sodium Chloride	1	20	1	17	2	50	4	80	8	40
Sodium Lactate	1	20	2	34	2	50	4	80	9	45
Syringe luer 10ml	1	20	1	17	1	25	2	40	5	25
Syringe luer 2ml	1	20	3	50	2	50	4	80	10	50
Syringe luer 5ml	1	20	3	50	2	50	4	80	10	50
Urine pregnancy test strips	5	100	6	100	4	100	5	100	20	100
Vitamin A	5	100	6	100	4	100	5	100	20	100
Water for injection	1	20	3	50	2	50	4	80	10	50
Zinc Sulphate	5	100	4	67	4	100	4	80	17	85
Albendazole	4	80	3	50	4	100	5	100	16	80
Amoxicillin	5	100	4	67	4	100	3	60	16	80
Benzathine	1	20	2	34	2	50	3	60	8	40
Benzylpenicillin	1	20	2	34	2	50	3	60	8	40
Chlorpheniramine	1	20	1	17	1	25	2	40	5	25
Ciprofloxacin	1	20	3	50	3	75	4	80	11	55
Dextrose	1	20	3	50	2	50	4	80	10	50
Doxycycline	2	40	5	83	2	50	3	60	12	60
Fluconazole	1	20	3	50	4	100	2	40	10	50
Hyoscine	5	100	5	83	4	100	4	80	18	90
Methyldopa	2	40	4	67	3	75	2	40	11	55
Metronidazole	5	100	5	83	4	100	5	100	19	95
Multivitamin	1	20	1	17	1	25	2	40	5	25
Oxytocin	1	20	2	34	2	50	3	60	8	40
Paracetamol	5	100	3	50	4	100	4	80	16	80
Povidone	5	100	5	83	4	100	4	80	18	90

Promethazine	3	60	3	50	2	50	4	80	12	60
Ranitidine	1	20	1	17	2	50	3	60	7	35
Salbutamol	1	20	2	34	2	50	2	40	7	35
Sulphadoxine	3	60	3	50	3	75	5	100	14	70
Syphilis	2	40	5	83	2	50	2	40	11	55
Tetracycline	4	80	1	17	4	100	5	100	14	70

BMoNC (Basic Maternal Obstetric and Newborn Care)

There was only one hospital included in the observation, and it performed all the procedures under BMoNC and EMoNC (Emergency Maternal Obstetric and Newborn Care), removal of retained products assisted vaginal delivery, blood transfusions and assisted birth surgeries were not being done at the PHCU level. Only 3/11 of the PHCU's performed manual placenta removal. Most of the PHCCs performed the procedures under BMoNC. However, only one, 12 percent of the PHCCs provided blood transfusion, and none of the PHCU's provided this service. Almost all the PHCCs had Uterotonic drugs and Parenteral antibiotics (88%) and only 18 percent of PHCU's provided this service.

Table 5.2.17: Counties and EMoNC procedures available

	Gogrial East (n=5)		Tonj North (n=6)		Yirol East (n=4)		Yirol West (n=5)		Total column (n=20)	
	# of facilities	%	# of facilities	%	# of facilities	%	# of facilities	%	# of facilities	%
Type of procedure	0	0	3	50	1	25	2	40	6	30
Assisted vaginal delivery	1	20	3	50	3	75	4	80	11	55
Manual placenta removal	0	0	3	50	2	50	4	80	9	45
Neonatal resuscitation	0	0	4	67	2	50	4	80	10	50
Parenteral Antibiotics	0	0	2	34	1	25	3	6	6	30
Parenteral anticonvulsants	0	0	2	34	2	50	2	40	6	30
Removal of retained products	0	0	4	67	2	50	4	80	10	50
Uterotonic drugs	1	20	5	83	3	75	5	100	14	70

Table 5.2.18: Type of facility by EMoNC

	Type of facility or service							
	Hospital (n=1)		PHCC (n=8)		PHCU (n=11)		Total column (n=20)	
	# of facilities	%	# of facilities	%	# of facilities	%	# of facilities	%
Assisted vaginal delivery	1	100	5	62.5	0	0	6	30
Manual placenta removal	1	100	7	87.5	3	60	11	55
Neonatal resuscitation	1	100	7	87.5	1	20	9	45
Parenteral Antibiotics	1	100	7	87.5	2	40	10	50
Parenteral anticonvulsants	1	100	4	50	1	20	6	30
Removal of retained products	1	100	5	62.5	0	0	6	30
Uterotonic drugs	1	100	7	87.5	2	40	10	50

Annex 5.3 DHIS data on HPF progress

The data below are from HMIS/DHIS and supplied by HPF.

Table 5.3.1: HMIS/DHIS Outcome and output indicators (July 2012 – June 2017)

	Jul 12/June 13	Jul 13/Jun 14	Jul 14/Jun 15	Jul 15/Jun 16	Jul 16/Jun 17	Comments
Outcome indicators						
OC 1 Percentage of 1-year olds vaccinated with third dose of DPT /Penta	91910	111018	132957	147472	171320	For all indicators data for 6 States until March 2016, from April 2016 data is for 8 States
OC4 Percentage of birth attended by skilled health personnel	10593	17479	26050	38644	46528	Penta was introduced in early 2014 around Feb (shift in reporting meant that both DPT3 and Penta were reported till Sept 2015)
Output Indictors						
OP1.1 Total Consultation under 5 years male and female	811942	998237	1508393	1850430	2367953	
Total Consultation 5 years and older male and female	1311190	1655329	2470095	3055024	3918961	
OP1.2 Number/% of under 5 years with diarrhoea who received ORT	78,5%	78,1%	83,4%	88,1%	90,6%	
Diarrhoea Treated with ORS	130013	157047	248509	312891	375089	
Diarrhoea Cases	165619	201186	297996	355260	414069	
Op 1.3 Percentage of women who attended at least four times for antenatal care during pregnancy	45637	59347	89627	96151	120075	
OP 1.4 Number of acceptors new to modern contraceptives	5670	7342	10437	11485	18470	HMIS tool updated the indicator to methods distributed, reporting in this started from July 2015 to date
OP 1.6 % of antenatal care (ANC) attendees who received second dose or more of intermittent presumptive treatment for malaria (IPT2)	47095	65695	86608	113596	135789	HMIS tool updated form IPT 2nd dose to IPT 2nd dose or more, reporting changed from IPT 2nd Dose only to IPT 2nd dose or more in Jan 2015. That meant the two were reported until July 2015

Annex 5.4 Performance Framework Results

The data below is mainly compiled from DFID Annual Reviews.

Table 5.4.1: DFID Outcome and output indicators (September 13 – August 2017)

	September 2013	September 2014	June 2015	November 2016	August 2017
Outcome Indicators					
OC 1 Percentage of 1-year olds vaccinated with the third dose of DPT vaccine	38408	73250	82945	76565	175.320
Target	36080	75000	81800	81800	229570
OC 4 Percentage of births attended by skilled health personnel	9907	18700	25495	39012	47377
Target	7833	19250	42870	42870	86930
Output Indicators					
OP1.1 Total consultations, under5 male and female Progress	878950	1539747	1905317	7963952	5394235
Target	825000	1300000	1800000	1800000	4553113
(2014) OP 1.2 Number (%) of children < 5 ears with diarrhoea who receive ORT	n/a	78%	83%	87%	90%
Target	n/a	80%	90%	90%	90,85%
OP 1.3 Percentage of women who attended at least four times for antenatal care during pregnancy	15%	21%	30%	28%	28%
Target	10%	20%	38%	38%	27%
OP 1.4 Number of acceptors new to modern contraception	4760	5419	10742	12934	n/a
Target	4500	7000	9000	9000	n/a
OP 1.5.1 Number of facilities with capacity to offer BEmONC	n/a	19	34	34	37
Target	n/a	10	34	39	37
OP 1.5.2 Number of facilities with capacity to offer CEmONC	n/a	9	16	20	24

Target	n/a	15	20	20	24
(2015) **OP 1.6** % of ante-natal care (ANC) attendees who received second dose of intermittent presumptive treatment for malaria (IPT2)	n/a	n/a	60%	52%	51%
Target	n/a	n/a	50%	50%	51%
(2014) **OP 2.1** No. of health facilities with a health committee in place for communities to give feedback regarding health services.	n/a	80%	81%	97%	94%
Target	n/a	80%	100%	100%	94%
(2014) **OP 2.2** Number of documented joint meetings between the CHD/IP and the health committee and facility staff.	n/a	50%	33%	50%	30%
Target	n/a	50%	50%	50%	27%
OP 3.1.1 Number of HPF Steering Committee meetings chaired by the Government of the Republic of South Sudan	4	9	12	15	16
Target	5	10	14	14	20
OP 3.1.2 Number of States with x number of Oversight Committee meetings held	0	3	0	5	(cumulative) 46
Target	6	5	5	5	(cumulative) 48
OP 3.2 Number of facilities with quarterly integrated supportive supervision visits conducted by county health department using the QSC tool	6%	33%	72%	74%	56%
Target	19%	50%	70%	70%	55,50%

OP 3.3 Number of health facilities submitting HMIS reports through the DHIS (according to the data flow policy)	n/a	78%	88%	88%	84%
Target	n/a	70%	80%	80%	82%
OP 3.4.1 Proportion of counties with one joint plan for all government and NGO health services	n/a	100%	100%	100%	100%
Target	n/a	50%	75%	75%	100%
OP 3.4.2 Proportion of counties with one budget for all government and NGO health services	n/a	n/a	100%	100%	100%
Target	n/a	n/a	60%	60%	100%
(2014) OP 3.5.1 Number of counties submitting South Sudan Electronic Payroll System (SSEPS) forms for IP staff	n/a	34	39	39	n/a
Target	n/a	29	39	39	n/a
(2015) OP 3.6 % of counties in which HRIS is implemented, disaggregated by (a) facility staff and (b) CHD staff	n/a	n/a	39	36	44
Target	n/a	n/a	39	37	47

Annex 5.5 Field Data Brief

The following notes are a synthesis of the issues discussed with respondents in the field. They are organised according to the key questions of the evaluation matrix, with the exception of questions on sustainability that were not included in the interviews. This was in recognition of the fact that with a programme like HPF, the issue of sustainability is inferred from a variety of other data sources rather than from discussions with field respondents.

To what extent has HPF identified, understood and responded to the essential health needs (as defined by the programme) of women, men, girls and boys in South Sudan?

Perceived degree of consultation

Interviews with health committees, community leaders, state ministries of health and CHD staff all indicated that they had not been consulted during the design of HPF 3. For community leaders, their sentiments were more general around being consulted about HPF implementation and setting priorities. However, it is apparent that that by virtue of being involved in the health committees, leaders are engaged in the quarterly feedback and review sessions that IPs organise on the ground, which also comprise the CHDs, IPs and health staff at the facility.

According to HPF, DFID has carried out consultations with the government about HPF 3, but it is not clear how far down the implementation chain these consultations went.

Health priorities

All respondents confirm that the HPF is addressing relevant health issues. Top of the list of common ailments mentioned were malaria, diarrhoea, typhoid, pneumonia (upper respiratory tract infections), physical injuries (gun shots and spear wounds),urinary tract infections, syphilis and delivery complications. Although there is appreciation that issues such as referrals have improved to some extent, there is also recognition that the situation is far from satisfactory. For example, with regard to the capacity – number and skills – of staff, the number of female staff at the health facilities, and the number of ambulances to support the referral system.

The lack of female staff was mentioned several times by women as a particularly important barrier when it comes to their comfort in using health facilities for deliveries, or even seeking treatment for sexually transmitted diseases and general sexual and reproductive health.

Responsiveness of HPF and uptake of services

There was also an indication that the needs of males – adults and youth – as well as of people with disabilities, are not well incorporated into the health services provided. There was mention of the fact that the health facilities do not focus on HIV & AIDS cases, and that they should.

With regard to STIs, the degree of uptake of services is minimal, and this finding is supported by the various other data collected by the programme. The reluctance of health staff to talk about sex-related issues due to cultural reasons was mentioned as a factor by the state level HPF and NGO staff interviewed. This means that it is not necessarily the lack of STI treatment at the facilities, but the reluctance of both the community and the health staff to discuss these issues openly that inhibits uptake.

With regard to uptake of health services, in addition to the above, the lack of drugs, medical equipment and skilled personnel were mentioned as issues that limit the appetite for community members visiting the health facilities. As a community leader in Yirol East mentioned, '*The services have declined because the number of health workers was reduced in 2017, and drugs are not always available; hence we are referred to pharmacies in the market. These changes have absolutely been negative, because there is always overcrowding at the facilities*.' A number of beneficiaries also mentioned the long distances that they need to walk to facilities, sometimes to find that there are no drugs there. These are some of the factors that could reduce the level of uptake of health services.

Analysis using Atlas.ti revealed that in general, HPF was found to be responsive to the needs of women and children, specifically immunisations and antenatal care. Analysis and comparison of positive access to health care, responsiveness to beneficiary needs and prevalent diseases across the different respondents revealed this as a key finding.

'*Yes, the program has enabled women to deliver in health facilities. It reduced the number of people going to seek traditional healers and coming to health facilities; vulnerable people are able to get modern health services within their localities; EPI outreach programs has increased the number of children vaccinated against measles polio and whooping cough, among others*.' HPF staff state level

Beneficiaries and village health committees identified the prevalent health diseases to be Malaria, Typhoid, Measles, Pneumonia, Malnutrition, Diarrhoea, Tuberculosis, Syphilis and Gonorrhoea. However, in many cases there were drug stock-outs of antimalarial medication. Many health facilities reported a non-discrimination policy; however, there were no existing targeted programmes for vulnerable groups. A possible explanation for this could be a focus on service delivery as opposed to demand generation, or a lack of understanding of barriers to access, and budgetary allocation to support targeted intervention beyond vaccination, nutrition and antenatal health care.

'*Typhoid, Malaria cases, there is no enough admission wards in Akop (PHCC) but sometimes admission takes paced under the tree. There are no enough beds in facility and drugs due to the congestion. Malaria drugs got finished quickly because it is a common disease in the area.'* Community Health Committee, Luonyaker.

To what extent has the HPF aligned with the health sector priorities of the Government of South Sudan?

According to State Ministers of Health, as well as CHD staff interviewed, the HPF is aligned to the health priorities of the GRSS. They mention, '*The HPF aligns itself to the priorities of the ministry of health, because CHD together with the IPs outline activities and plan together before they submit request for funds*.' State Minister for Health

However, they all lament the reduction in funding from the levels of HPF 1. Although they do mention that HPF 2 has demonstrated greater efficiency in terms of achieving results with lesser funds, they also indicate that there are areas that have suffered as a result: '*There were more skilled staff members and medical supplies during HPF1 compared to HPF2, which is marked with very inadequate skilled staff across facilities and shortages of supplies.*' CHD staff, Gogrial East.

, '*Efficiency was by far less in phase1, where there were sufficient resources in terms of funds, and adequate staff members. Yet there were fewer outcomes in regards to intended programs [outputs] to be achieved. In spite of significant budget cut in phase 2 resulting to under-staffing, the degree of efficiency is much higher. But budget cuts reduced salaries by more than 50% leading to loss of technical and specialised staff members, and less medical materials*.'

So, despite aligning with GRSS health priorities, and the degree of efficiency achieved in the second phase, the issue of funding is perceived to have affected the capacity of health facilities to remain adequately responsive to the health needs of the people.

On the other hand, HPF was said to have an influence on the degree of ownership among government agencies due to their enhanced involvement in decision-making at the local level. For example, in the selection and recruitment of facility staff, in the planning and supervision of facility activities, as well as in the setting of county priorities in collaboration with the IPs.

Using Atlas.ti for additional analysis, and by using key codes associated with alignment of HPF with national priorities, a link between nutrition, child health and alignment with national priorities was assumed. However, on examining the codes and relationships, this link was limited to child health, while responsiveness to other target groups was limited. A network view was used to examine the relationship between the different codes and see if there was overlap with the interview responses to explore if there was any difference in views among the different respondents.

'*To an extent health priorities at county level are being met. New born and below 5years mortality rate is significantly improved, prevalent illness are being managed, mortality rate among expectant women and during delivery is by far improved. Most of HPF programs target*

women, children and elderly but hardly address men especially adults/youth health related issues.' State Minister of Health.

'There is need to also have programs that target the latter gender age group.' State Minister of Health

'National ministry of health developed a treatment protocol. IMNCI – integrated management of newborn and child health illnesses. This tool uses collections of signs and symptoms. If it is used it has been proved that it can health save lives. Asking partners to provide training on this. Most partners did the training but there, HPF – realised there wasn't budget for this and therefore printed themselves.' State Minister of Health

Among HPF and MoH staff there is a recognition of the budget and capacity limitations of the Ministry of Health. However, both parties felt it is important to align their objectives and work despite the limitations and budget restrictions DFID might impose on the MoH. Among other actors, there is a feeling that MoH policies are not a priority for HPF.

'*DFID had allocated some money to the MoH but put a number of restrictions on the way that it needed to be spent. MoH has no budget but is still chairing the technical working groups and officially has a leadership role. It is important to keep the MoH as the lead on health care*.' HPF Staff

To what extent have the expected outputs and outcomes been achieved, in particular for children under age five and women, and what have been the main factors influencing the achievement or non-achievement of results? Were there unintended and/or negative results?

Strengthened delivery of health services

EmONC facilities appeared to be not so common, with many respondents mentioning that delivery complications are most often referred to other facilities. However, this is likely to be related to the kinds of facilities visited by the field teams. There was also mention that although there are ambulances procured by HPF, they were far too few and many patients still end up using their own means to get to larger facilities. ANC and nutrition care services are being supported by HPF and its partners, and they are well appreciated. However, uptake of ANC is still inhibited by the long distances some patients have to travel to a facility, prevailing strong cultural norms that prevent women from seeking medical assistance at all – and early enough during the pregnancy – as well as gender-related factors such as husbands still having a strong control over the reproductive health issues of their wives, where, for example, they would prevent a woman from attending a facility in preference of a local medicine man.

The shortage of female health staff also affects RH uptake as indicated by both the beneficiaries and facility staff, '*Some expectant women decline to access the facility when*

they learn the midwife at the facility is a male.' Health Facility In-Charge – Tonj North. With regard to women, the most frequently mentioned shortfall was the availability of maternity wards.

Services related to HIV, for example, PMTCT were not mentioned. Although this is not an indication that they do not exist at all, respondents indicate that there are not dedicated or sufficient HIV services.

Child-related services were said to have improved, and many more children were being brought to the facilities. Diarrhoea-related deaths were also said to have reduced. However, the numbers attending facilities were still inhibited by the preference for more traditional options, such as traditional medicine healers – referred to as witch doctors.

With regard to family planning and contraceptive use, without fail, almost all beneficiaries mentioned either not knowing about contraceptives or not using them. This relates closely to the results recorded in IP reports where there is extremely low uptake of the services. Interviews with HPF staff at the state level indicate a reluctance, even among facility staff to engage with issues of sexual and reproductive health. This is partially due to the conservative nature of South Sudan's society, where discussion of sexually related issues are frowned upon. This was the same even among the youth, although IP reports indicate that youth are among the most key users of contraceptives, especially of condoms, although they do this more in secret. For HPF 3, it could be that youth-friendly services - appropriately staffed, for example, with younger staff member- should receive more attention, where the youth would be more comfortable to discuss and seek out reproductive health services.

In general, the numbers visiting facilities are said to have increased over time, with new complaints being of long waiting times when visiting facilities. If left un-addressed, this coupled with a chronic lack of drugs that was mentioned by all respondents, and the shortage of skilled staff could prove detrimental to enhancing health seeking behaviour.

Although it is not possible to attribute all the positive achievements reported to the HPF, respondents were clear that the strengthened referral system was as a result of HPF support. Further, the enhanced engagement of government institutions – SMoH and CHDs – had grown due to the strong support received from the HPF.

Availability and quality of drugs

Drug shortages, especially of malaria drugs and antibiotics was a recurrent complaint among all respondents. Facility staff mentioned receiving allocations every three months. It was mentioned that IPs frequently step in to plug the shortfalls, and in those cases where they cannot, patients are then required to purchase the drugs from pharmacies. For injectables, for example, when there are shortages, patients have to buy the drugs and related supplies such

as needles and syringes from drug stores and then bring them to the facility for administering. Sometimes, the patients are referred to other facilities where it is hoped that the required drugs are available, but when they do not have use of an ambulance, some opt to go home instead when the distances are deemed to be too long.

There was also mention by facility in-charges of the CHDs limiting/cutting down the quantities requested thereby leading to shortages: '*The CHD limits the amount of medical supplies required as per the requests made bringing about inadequacy of drugs. Supplies should directly be made to each facility according to the distribution bill from HPF; CHD should not store drugs for any facility*.' Facility in-Charge – Yirol East.

In addition, HPF staff on the ground mentioned that the National Ministry of Health tends to, '*Push drugs that are not required to the facilities where they end up not being used*.'

Facility managers in Gogrial East had similar sentiments regarding lack of appropriate drugs: '*Upon deliveries essential drugs are missing from example adequate Anti Malaria drugs are likely to missing during rainy season when Malaria cases are more. Furthermore there are essential drugs not delivered to PHCUs yet required to treat prevalent illness in their areas*.'

According to a CHD staff member, '*Positively HPF has done well in the areas of maternal mortality, nutrition, however negatively HPF has not done well in family planning awareness, drugs supply*.'

In terms of physical logistics, delivery of drugs and medical supplies is affected by three elements:

The rainy season where the poor roads are rendered impassable; insecurity on the roads, where transport ferrying supplies can be attacked; and finally, the distances and remoteness of some of the locations supported by HPF.

Management arrangements

It appears that there is some tension between the facilities and the CHD regarding the supply of drugs on those occasions where the CHD controls the storage and quantities provided to the facilities. Aside from this, the relationship across the board is said to be cordial.

The relationship between the IPs and the facilities also appears to go smoothly. One key point of dissatisfaction seems to be a lack of clarity by facility staff and community members about the funding shortfall, with most laying blame on the IP, CUAMM for example, which took over some services from CCM in Lakes. Although there are quarterly meetings where the IPs, CHD and facility staff deliberate jointly, the reasons behind the change in support focus and change of IPs seems not to be well understood. While the IPs appear to have communicated to the stakeholders on the ground about these issues, the responses point to a need for key changes such as these to be communicated on an ongoing basis, and to have the support of the State

Ministry of Health officials communicating this right at the local level in order to mitigate any potential fall-outs from the community. This is especially relevant when considering the volatile contexts where some of the IPs operate, and where lack of precise information could lead to potentially dangerous situations for staff.

Another area that appears to cause some challenge, at least as articulated by a SMoH, is the consortium arrangement of the HPF, where a lead organisation oversees a subcontractor, but both have different operational procedures, that, '*Hinder equal service availability across the whole area. The government is unable to intervene. Therefore, there is unequal distribution of resources and shared information.*' State Minister for Health.

The community health committees' activities are overseen by the CHDs, but the modalities of how this is done was not clear from the interviews. Some committees also mentioned not interacting with the CHDs at all in their work, while some health staff thought that the health committees are managed by the facility managers, and others said that oversight is provided by the CHDs. So, reporting lines of the committees still seem to be a bit unclear. The committees oversee the activities of the facilities, including staff attendance, cleanliness of facilities and drugs supply when consignments arrive at the facility.

The reporting lines of the HHPs are clearer, with their oversight done by a supervisor who is also a staff attached to the health facility. The HHPs mentioned the supervisor overseeing their work every day, but almost all indicated that they did not receive any feedback from this supervision, and that they would like to receive it.

All the respondents were clear that oversight of the facilities is done by the CHDs and IPs, with inputs from the health committees. The facility managers provide monthly reports to the CHD from where it is forwarded to the IP and to the SMoH. Feedback to the facilities is done every quarter when the IP and the CHD hold quarterly meetings, circumstances allowing; insecurity in some locations affects the frequency of these meetings. Some respondents mentioned that health committees attend these meetings. The facility managers also hold staff meetings where they provide performance feedback to the staff

This engagement with different stakeholders appears to have fostered a closer working relationship than existed previously. The engagement of the health committees allows for beneficiary inputs to be included in the management and provision of services. The challenge here is how representative these committees are of the different segments of the community. The heads of these committees are village chiefs/community elders, who either identify committee members – according to some respondents – or request for villages to nominate participants. (See section below on representativeness).

DHIS/HMIS

HHPs: Data collection is on notebooks where they enter data - disaggregated by age and gender every day and they submit it to the supervisors on Fridays. All indicate that they do not receive any feedback on the data they receive, and that they would prefer to have forms where they can enter this data more easily.

Facility management: They indicate that the DHIS data collected is disaggregated and submitted to the CHDs and the IPs at the end of every month. Some challenges mentioned are how time consuming the exercise is; the capacity of staff who at times lack enough knowledge on how to fill the data, as well as overworked staff who at times do not have the time to fill in the data, '*Its time consuming and vital information may not be recorded due to limited time*.' Facility staff – Yirol East.

At times, the data books are full, and the facility managers requested that they should always have enough in stock. Some of the mitigating measures they suggested to the data entry issues included having a clerk for data entry, as well as having the system computerised to avoid loss of data or running out of data entry registers.

CHD: They acknowledged that DHIS/HMIS reporting had improved during the life of the HPF, and that the MoH and the CHDs had better information now to use to track diseases. But recommended more training for staff on how to go about entering the data. They mentioned that this was done in HPF 1 and that it should be continued in HPF 3 to enhance the quality of the data.

Non-HPF agencies: They mentioned having knowledge of the DHIS/HMIS, but also that they do not use it, although they receive feedback on the information collected during the quarterly meetings as well as when the HPF IPs participate in cluster meetings.

They mentioned that they receive feedback on this data every 3 months during the quarterly meetings.

HPF staff – state level: The system is being upgraded from an IT based DMIS to a web base system called EWARS because it is easier to retrieve data using the web-based system. IT breakdowns sometimes affect how easily they can access the data from the system.

Community engagement

As mentioned, these committees have been re-constituted under the HPF to fit with the goals around enhanced community engagement as articulated in the Boma Health Initiative of the GoSS.

Interviews indicate that although vulnerable groups are welcome as members of health committees, most of the groups do not have members from IDPs, PLWDs or the elderly.

Further, although through the HPF many of the committees have been reconstituted to include more women, the highest position they hold is that of treasurer. And with committees having little to no funds that they manage, such a position is not necessarily one of authority/influence.

Interviews indicate that most health committees are active and that there have been positive results from their engagement in the health system. They provide oversight of facility activities, from a community perspective, including overseeing staff attendance. Interviews, especially with health staff indicate that committee members lack the necessary skills to carry out their tasks adequately. However, members include HHPs, who go through a 9-month training course, so this would in some way mitigate this shortfall. However, the HHPs themselves indicate a low capacity and the need for more training is some of the tasks that they are required to carry out, for example dispensing and administering drugs.

The health committees along with the HHPs also engage in health awareness raising activities. However, since both work on voluntary basis, interviews indicate a challenge in how active they can really be. A lack of incentives for committees was one of the reasons provided by HHPs when asked about how active the committees are. They mentioned that some community members do not know about or engage with the health committees due to this inactivity. A SMoH had similar sentiments about capacity of the committees, even though they do an important task. He said, '*There should be more training for the village health committees on their roles and how to conduct awareness campaigns; there should be motivation for the committee members in terms of incentives such as lunch and water during campaigns and meetings; and bicycles and motorcycles are important in coverage of the awareness campaigns.*' According to some facility managers, health awareness raising in the community was suffering due to the limited staff available to serve both the facility and to carry out awareness raising activities.

Beneficiary feedback

It was unanimously agreed that there is no beneficiary feedback mechanism in place. Rather, community members make their complaints to the HHPs or to the health committees, but hardly ever receive feedback to this.

To what extent was HPF programming in South Sudan conflict sensitive, and consistent with the OECD principles and best practices for Fragile and Conflict-Affected States?

All the respondents indicated that there is no conflict management strategy in place, although IPs do engage in conflict mitigation activities by working with community leaders, as well as encouraging facilities to take on a neutral stand in the provision of services. This was supported by interviews where, across the board, it was agreed that no community or group is denied access to services at the facilities.

Responsiveness to humanitarian needs

There was an indication that HPF-supported IPs collaborate with humanitarian actors in times of emergencies. But the quality of this engagement was not apparent from the responses. Their responsiveness, especially by other non-HPF agencies was indicated to be satisfactory.

To what extent was the HPF coordinated with other stakeholders involved in delivering essential health services throughout the country?

The HPF was said to collaborate with other agencies in their specific areas of operation. For example, in the provision of nutrition services. For example, in Tonj and Gogrial East, the HPF staff indicated collaboration with other stakeholders delivering essential health services. These include Arkangelo Ali Association known as Triple A – focused mainly among other services Malaria and Tuberculosis treatments, as well as collaboration in the delivery of the ICCM programme on malaria, diarrhoea, and pneumonia, for example. However, interviews did not indicate the existence, or not of formal collaboration agreements between HPF partners and other agencies.

Harmonisation of salaries

Interviews reveal that since the harmonisation exercise commenced, there has been a 50% reduction in salary scales since HPF 1. As one facility manager said, '*The IP covers some staff members' salary, which mostly delays by 7 days, I do not know the cause of the though the issue is ongoing. There are a few staff members on government pay whose salary delays by more than three months*.' Some salaries of staff in one facility, for example, are paid by the IP, and some by the government. The IP salaries are not delayed as much as the government ones, where some facility managers mentioned 7-month delays. This was said to have severely affected staff numbers at the facility, increased the degree of absenteeism, and resulted in low motivation among staff.

Of note: due to the shortfall in staff numbers as the facilities, as well as awareness raising with the communities, many HHPs also end up acting as health staff.

The comment by a staff member that, '*The working conditions of this facility has not been improving because we are paid less by CUAMM compare to the CCM payment*' indicates a poor understanding of how/why the salary reduction occurred; appearing to lay the blame on the IP. This is potentially a source of discord among facility staff, and even insecurity for the IP staff on the ground.

Capacity of staff (including community staff)

The perceived reduced funding in HPF 2 was said to have affected staff capacity as the trainings provided are not adequate to fulfil the needs of the facilities. Capacity in terms of numbers was said to have fallen due to staff opting to quit or seek other employment.

To what extent has the nutrition component of the programme been successful in integrating nutrition into the package of health services offered and achieving its expected results?

Nutrition support was said to have had a positive impact on the levels of malnutrition among young children. However, the results were affected by improper use of nutrition supplementation provided where some parents misuse the nutrition support as a source of meals for their families; a lack of staff adequately trained to provide nutrition support; long distances to the facilities for some community members, as well as inadequate levels of nutrition supplements. According to a CHD staff, '*Nutrition supplements are provided by World Health Organisation and UNICEF but the quantities delivered do not meet reported needs*.'

This was supported by the SMoH who said, '*HPF is Implementing Partner agent for World Health Organisation collaborating with UNICEF. Both provide nutritional supplements distributed by HPF IP based on allocation determined at WHO*[86] *and UNICEF head offices in Juba rather than actual needs on the ground. WHO and UNICEF deliver inadequate quantities despite of frequent generated reports that indicate needed quantities.*' The sentiments of the Ministry of Health officials, therefore, are that quantities provided do not match the needs expressed and reported on.

A SMoH mentions that the current nutrition support has, '*Significantly reduced malnutrition among the targeted groups, as well as the number of deaths of children being recorded in facilities. However, for much more success that aligns with the set priorities, the current nutrition structure programme requires evaluation*.'

To what extent has a Gender Equality and Social Inclusion Strategy been implemented?

With regard to how well the GESI strategy has been implemented at the institutional level it is important to note that at the facility level, there were no women in senior positions. This, however, is not a reflection on the HPF, but rather, the situation on the ground where there are few skilled women to take such roles. Further, due to the downsizing, a facility manager indicated that the number of female staff had fallen from four to one. This is likely related to capacities required at the facility, but the interviews are not clear on this. On the other hand, considering that IPs have been actively providing GESI training to their staff, facility staff and CHD officials, it appears that there is an effort to mainstream GESI into institutional practices. What is lacking, rather, is evidence of whether this has translated into any action/results. However, such evidence would be hard to ascertain if it is related to attitude change as this is

[86] WFP, not WHO, provide nutrition support in South Sudan. We believe that the respondent mixed up the UN agencies.

more of a long-term process; nevertheless, evidence such as guidelines and polices would be easy to document, and this does not appear to have occurred.

With regard to GESI specific financing, the HPF staff on the ground indicated that there is no funding earmarked for GESI-related activities. But, there was evidence that the IPs were making particular efforts to include women in activities, although this did not appear to go beyond women to other excluded groups. For example, services for elderly and disabled people were mentioned as not having been given emphasis at the facility level. Especially in recognition of the long-running conflict in the country, the number of PLWDs is bound to be large, and therefore a segment of the population that should receive attention as well.

A number of PHCC indicated offering GBV services, but gave no details on what these entail.

What were the main gender-based barriers and challenges to programme delivery and achievement of outputs and outcomes?

Some of the gender-based barriers - along with cultural beliefs - that were mentioned as preventing people from accessing health services include:

Gender-based

1. Women not visiting the facility if they knew they would be attended by a male staff
2. Men fearing/reluctant to visit the facility to be treated for STIs. So even when the wife is treated, she would get re-infected by the husband.
3. For men, the major challenge is ignorance, as they ignore illnesses with the thinking that they will go away eventually
4. Men influencing/forbidding their wives to visit health facilities, and rather preferring traditional healers

Cultural and other barriers

1. Witch doctors do not come to the facility in general
2. '*When facility is inaccessible during rainy season and drug shortage are experienced, patients resort to traditional remedies*.'
3. Disabled and elderly people who live far from the facilities
4. Cultural beliefs, '*Most people do not take their children to health facilities especially when they are sick of diarrhoea because the locals believe that it occurs only when a lactating woman has had sexual intercourse.*' Community leader
5. Distances to health facility for some, especially women with children, and expectant women

Were human and financial resources used in a cost-effective way for the outcomes achieved, in light of the operating context, needs of the beneficiaries, priorities of the MoH, and the organizational and management structures of the HPF? Was the programme implemented in the most efficient way compared to possible alternatives?

Key cost drivers

As indicated by HPF staff on the ground, the key cost drivers for the programme are, '*Maintenance of vehicles, bad roads, and mismanagement of the facility equipment, inflation and communication problems. For example network tends to be down most times and thus a vehicle has to be sent instead*.'

Funding and quality of outcomes being achieved

HPF staff on the ground indicated that the achievement of results in HPF 2 were much greater than in HPF 1, despite the reduced budget. But they also mentioned that there are areas that still require further attention financially: laboratory equipment, infrastructure development and training, support to HIV & AIDS, logistics, specifically transport, and facility visibility in the form of signposts.

Furthermore, across the board, the response was unanimously 'no' to the question on whether salaries and incentives are sufficient to ensure motivated staff and reduce absenteeism.

VFM

Using Atlast.ti to explore the issue of VFM, there was some co-occurrence between insecurity and cost efficiency, highlighting the need to take into account the realities of working in a fragile context when developing indicators for VFM. Some of the responses from the field highlight this.

'*This is very difficult when areas are inaccessible. Before the conflict this area had some of the best results.*

-HPF has been very helpful and allowed them [IPs] to focus on the areas that they are able to access. It is difficult because the hardest to reach are the most vulnerable.

-One of the biggest challenges is VFM. You can't get good VfM when you can't access people. You still have your operational costs (support staff etc).

-We have scaled down to a bare minimum. We don't want to completely leave as we don't know when people will return and need health services'. IP Lot Coordinator

Has the community-based approach trialled in HPF for treating common diseases in children under 5 been a cost-effective approach in the context of limited access to formal health facilities?

In as much as community-based groups – health committees, HHPs and TBAs – have been involved in awareness raising, perceptions across a range of respondents acknowledge that there have been improvements in child health with regard to lesser malnutrition among those families that have been reached with awareness raising and have sought the necessary nutrition services. The same applies with regard to women accessing ANC services, receiving

awareness about breast-feeding, and general nutrition and WASH, which is aimed at improving household health. The approach can be said to be cost-effective in as much as the majority of these community mechanisms work on a voluntary basis. However, respondents allude to the fact that the results achieved might have been greater if these groups had received payment or incentives. Some IPs do provide incentives, but not in a uniform manner. For example, HHPs are incentivised while health committees are not, and yet they both work on a voluntary basis, albeit with the difference that HHPs receive some degree of training – nine months – while committee members do not.

Interviews indicate some level of discontent regarding the issue of incentives and payment, among all levels of staff.

Annex 5.6 HPF Budget Figures & Population Data

HPF1 and 2 Budget figures were provided by Crown Agents. Population data was provided by HPF. These have been used throughout the report to calculate HPF spend per capita.

Table 5.7.1: HPF1 & HPF2 spend

	HPF1	HPF2	Extension Period	
	15.10.2012 to 14.12.2016	15.12.2016 to 15.04.2018	15.04.2018 to 31.12.2018	Total
Fees	10,693,866	8,023,166	3,255,835	21,972,867
Expenses	4,126,375	3,374,102	1,530,940	9,031,417
Total Management Fee	**14,820,240**	**11,397,269**	**4,786,775**	**31,004,284**
Procurement of goods & Freight to Juba	-	12,287,082	3,472,275	15,759,356
Cost for Procurement (CA fees)	-	491,483	138,891	630,374
Cost for in country Warehousing	-	1,616,240	404,060	2,020,300
Cost for in country Distribution**	-	5,286,350	1,321,588	6,607,938
Contingency for C8 Procurement	-	-	-	2,362,950
Fund (IP spend only)	116,427,839	50,750,000	15,750,000	182,927,839

Fund (IP contingency)		472,500	787,500	1,260,000
Fund (SMOH, NMOH and EP&R)		2,847,500	502,500	3,350,000
Total Managed Fund	**116,427,839**	**73,751,155**	**22,376,813**	**214,918,757**
Total Management Fee & Fund	**131,248,079**	**85,148,424**	**27,163,588**	**245,923,041**

Table 5.7.2: Population figures for the 8 HPF2 States

	Jan/12	Jan/13	Jan/14	Jan/15	Jan/16	Jan/17	Jan/18	Jan/19
Estimated population total (county)	6,580,315	6,777,722	6,981,058	7,876,541	8,184,868	8,504,264	8,832,163	9,160,522
Estimated population under 5 years (county)	1,206,552	1,242,746	1,280,030	1,592,013	1,772,737	1,819,957	1,873,023	1,984,512

Table 5.7.3: Population figures for the 6 HPF1 states

	Jan/12	Jan/13	Jan/14	Jan/15
Estimated population total (county)	4,603,397	4,741,497	4,883,745	5,652,589
Estimated population under 5 years (county)	868,729	894,789	921,633	1,140,923

Annex 6 Stakeholders' comments

We presented our findings to stakeholders in two separate sessions in Juba. The first was a general Stakeholder Engagement Workshop held on 2 May 2018, and included representatives from HPF donors, implementing partners, the HPF fund manager and others health actors. A full list of attendees is presented below. As the Ministry of Health were unable to join, we held a separate feedback session with them at the Ministry on 4 May 2018. In both sessions we presented our evaluation findings and interim conclusions and recommendations and gathered feedback on these. A summary of these comments is presented here:

Key Strengths and Achievements

- All present agreed that HPF was an **effective model** reaching large numbers of beneficiaries;
- HPF offers much better **value for money** than a similar humanitarian programme, and the Boma Health Initiative presents an opportunity to increase the impact of HPF3;
- **Coordination between the MoH and HPF** at the national level was considered effective by those stakeholders' present.

Key Challenges

There was general agreement with the challenges raised during our presentation including:

- Attendees were concerned, although unsurprised to hear that **user fees** are being charged in facilities. They were most concerned by the idea that they were being charged at the primary health care level.
- **Drug supply** and the need for better data on drug consumption.
    - This issue prompted an extended discussion on what needed to be done to improve the data on drug consumption, and therefore move towards a more demand-driven rather than supply driven model in South Sudan.
    - There were also concerns raised around the issue of drug leakages to the private sector. HPF donors and the MoH are already working together to find a solution to this.
- Misalignment between the **HPF use of the former 10 states** and the current 32 states.
- Stakeholders accepted the need for improved **cooperation between development and humanitarian** health actors. The health cluster has recently introduced a forum specifically for this.
- Donors and the MoH accepted the need to improve the **Steering Committee**, and potentially bring in a wider range of actors.
- It was widely recognised that HPF needed more **funding**, and DFID has pledged more for HPF3. There is also a need for better sharing of HPF success stories in order to attract more funding and attention to HPF.
- There is still a long way to go on **salary harmonisation** in the health sector and HPF, Donors and the MoH will be working on further. Challenges include the depreciation of the South Sudanese Pound and ongoing brain drain of health workers to NGOs.
- **Community engagement** was another key area of discussion. The evaluation reported a lack of clear reporting lines for community health committees. IP attendees felt that these systems were already established, suggesting a lack of

capacity/information at health committee level, or a lack of unified systems across the HPF states.

Other considerations

- How can HPF work as effectively as possible with other health actors in South Sudan and where should the programme be looking for synergies?
- There was interest in seeing further detail on the differences between HPF1 and 2.
- The MoH raised concerns around the evaluation field sample, as they felt this was not representative.
- There were also concerns that our evaluation did not capture the full picture of health service provision in South Sudan as only 44% of the country is within close reach of a health facility (and HPF delivers through existing health facilities).

Table 6.1: Ministry of Health Attendees (4 May 2018)

Name	Organisation	Role
Dr Samson Baba	MoH	Special Advisor to the Minister
Dr Samuel Loi	MoH	DG Coordination
Dr Richard Lako	MoH	DG Policy and Planning
Dr Michael	MoH	DG Training
Dr Moses Ding	MoH	DG Pharmaceuticals
Dr Victoria Achid	MoH	HIV Programme Manager

Table 6.2: Stakeholder Workshop Attendees (2 May 2018)

Name	Organisation	Role
Dereje Mamo	Save the Children	Community Programme Manager
Tim Githinji	Action Africa Help	Grants Manager
Victoria Graham	USAID	Director Health Office
Basilica Modi	USAID	Senior Health Specialist
Frederic Kalombola	CUAMM	M&E/Programmes
James Keah	UNIDO	Executive Director
Andrew Ngugi	Cordaid	Programme Manager
Kuotong Rogers	UNICEF	Polio Transition Coordinator
Amanda Parry	DFID	Senior Programme Manager
Desmond Whyms	DFID	Team Leader
Charlotte Howman	DFID	Senior Programme Manager
Patricia Prosser	Global Affairs Canada	Development Officer

Grace Lee	Embassy of Canada	Development Officer
Mick Robson	HPF	Team Leader
Sonja Nieuwenhuis	HPF	Deputy Team Leader
Getasew Belete	IRC	Grants Manager
Dr Henry Ilunga	World Vision	Sector Senior Advisor
Silvia Boarini	CCM	Programme Manager
Chipo Takawira	Health Cluster	Sub-national health cluster
Magda Armah	Health Cluster	Health Cluster Coordinator

Annex 7 Interviewees and other information sources consulted

Table 7.1: List of Interview Respondents - Juba

Name	Organisation	Role
Noah Musa	Action Africa Help	Lot Coordinator
Tim Githinji	Action Africa Help	Grants Manager
John Mwanza	ADRA	Head of Office
Steven Asobasi Joe	ADRA	Project Manager
Esther Kyewalabye	ADRA	Programs Director
David Wasambala	American Rescue Committee	Senior Health Coordinator
Liberty Mupakati	American Rescue Committee	Director of Programs
Grace Lee	Canadian Embassy	Acting Head of Cooperation
Sarah Yerian	Carter Center	Regional Coordinator
Andrew Ngugi	Cordaid	Programme Manager
Francesca De Marco	CCM	Acting Head of Office
Giorgia Gelfi	CUAMM	Country Coordinator
Chiara Scanagatta	CUAMM	Desk Officer
Dr Frederic Kalombola	CUAMM	M&E
Georgina Krause	DFID	Programme Manager
Simon Rynn	DFID	Conflict Advisor
Desmond Whyms	DFID	Team Lead
Dr Loi	MoH	DG International Cooperation
Dr McCoy Samuel	MoH	DG Guinea Worm Eradication
Geoffrey Onyancha	Health Net	Senior Public Health Advisor
George Lutwama	Health Net	Country Director
Waigo Farooq Rashid	Health Net	Finance and Administration Manager
Martin Mpakateni	HPF	Finance Director
Catherine Ndekera	HPF	Gender Advisor
Mick Covell	HPF	Supply Chain Manager
Sonja Neiuwenhuis	HPF	Deputy Team Lead/HSD Lead
Mick Robson	HPF	Team Lead
Jimmy Yuga	HPF	MNCH Specialist
Susan Ayen	HPF	M&E Manager
Unziku Tolbert	HPF	M&E
Gladys Lasu	HPF	Nutrition Specialist
Grace Lajul	HPF	Community Engagement Specialist

Campbell Katto	HPF	HSS Lead
Martin Muyen	HSS - HPF	HSS Specialist
Mounir Lado	IMA Worldwide	Country Director
Rebecca Waugh	IMA Worldwide	Senior Programs Advisor
Duncan Ochol	IMA Worldwide	Director of Programs
Margaret Itto	Imotong State Government	Deputy Governor
Dr Emmanuel Ojwang	International Rescue Committee	Senior Health Coordinator
Getasew Belete	International Rescue Committee	Grants Manager
Dr Richard Lako	Ministry of Health South Sudan	DG Research, Monitoring and Evaluation
Sue Averill	MSFCH	Medical Coordinator
Eruaga Jackson	MSI South Sudan	Health M&E Specialist
Biringwa Baya Walla	MSI South Sudan	Monitoring and Verification Manager
Arshad Mick	Save the Children	Director of Programme Operations
Melkamu Kassa	Save the Children	Operations Manager
Abdur Rauf	Save the Children	Awards Coordinator
Catherine Braga	SIDA (Sweden)	Project Officer
Penelope Campbell	UNICEF	Chief, Health
Duk Stephen	UNIDO	Programme Coordinator
William Natemo	UNIDO	Nutrition Manager
Joseph Chol	UNIDO	M&E Manager
Basilica Modi	USAID	Senior Health Specialist
Victoria Graham	USAID	Health Officer Director
Joy Luba Wawa	WHO	National Advisor
Charles Ocan	WHO	Health Policy Advisor
Paula Nuer	WHO	National Advisor
Rhonda Holloway	World Vision	Programme Officer
Count:	**58**	

Table 7.2 List of Interview Respondents - Remote

Name	Organisation	Role
Elodie Brandamir	Health Partners International (HPF)	Senior Programme Manager
Helen Binns	Delegation of the European Union to South Sudan	Programme Manager

Aligo Amba	HPF	M&E
Mary Surridge	HPI	GESI Advisor
Veronica Njikho	UNFPA	Gender Specialist
Maria Guerra	Crown Agents	HPF Project Director
Noel Chisaka	World Bank	TTL Health Rapid Results Project
Zishan Karim	World Bank	TTL Local Governance and Service Delivery
Count:	**8**	

Annex 8 Comparing ToCs and LFs

Table 8: Comparison of Theory of Changes & Logical Frameworks (Phase 1 funding to phase 2 funding)

	ToC 1st funding phase[87]	LFA 1st funding phase[88]	Business Case 2nd funding phase	LFA 2nd funding phase	ToC all funding phases[89]

Outputs	• Provision of basic ***services*** by non-state sector in line with the HSDP
	• Support to County hospitals
	• Work with central and State MoH to build capacity in managing the fund if possible
	• Support to County health departments if possible
	• Work with the ***community*** to create demand and governance mechanisms
		• Strengthened delivery of health ***services***, particularly responsive to the neds of women and children
		• Strengthened ***health systems*** at State and County level with detailed focusing on: Policy; Human resources for health; health financing, incl. strengthening of payroll and LSSAI; health information; leadership & governance
		• ***Communities*** have increased ownership, governance and demand for health services
			• Strengthened delivery of health ***services***, particularly responsive to the neds of women and children
			• Strengthened ***health systems*** especially at decentralised levels
			• Increased ownership, governance, and demand of ***communities*** for health services
				• Strengthened delivery of health ***services***, particularly responsive to the neds of women and children
				• Strengthened ***health systems*** at State and County level with detailed focusing on: Policy; Human resources for health; health financing, incl. strengthening of payroll; health information; leadership & governance
				• Increased access to ***nutrition*** services particularly for pregnant women and young children
					Stronger health facilities:
					• ***Service*** delivery Stronger ***health systems***, focusing on:
					  • Human resources
					  • Financing
					  • Information
					  • Medical products
					  • Leadership and governance
					• Improved **community** governance

Outcomes	Improved health outcomes for the population covered Improved community accountability	Increased access to quality health services, in particular by children, pregnant women & other vulnerable groups	Increased access to quality health services, in particular by children, pregnant women & other vulnerable groups	Increased access to quality health services, in particular by children, pregnant women and other vulnerable groups	Increased access to quality health services, in particular maternal and child health services, in a system where government has capacity to manage these services
Impact	Delivery of effective health services that build resilient and healthier population	Government led health system that save lives		Government led health system that save lives	Government led effective health system that save lives

[87] Business Case p.12

[88] Updated 28 Oct 2016

[89] Business Case Annex 1

Annex 9 GESI – Full Report

Background

The sustained conflict in South Sudan has resulted in a breakdown of infrastructure and protective social systems for the most vulnerable groups. Women, children and adolescents are the most affected by the conflict. They experience specific challenges in accessing and utilising health care services due to structural inequalities and a dearth of resources exacerbated by the ongoing conflict and a weak health system. The maternal mortality ratio in South Sudan is 789 maternal deaths per 100,000 live births, one of the highest in the region; the contraceptive prevalence rate is 4.7%, and the teenage pregnancy rate is 34.5%. Around 84% of all women are illiterate and over half (57%) of all households in South Sudan are female headed (UNFPA 2017, UNICEF 2015, Kane et al 2016)

Existing gender and social norms that promote inequitable distribution of resources are further exacerbated in fragile contexts. For example, in South Sudan it is customary for men to pay a bride price. In recent years, the economic implication of the bride price has led to an increase in child marriage as well as the monetary value of the bride price. The bride price is perceived as an alternative means of income for the young girl's family, it is also seen as a protective mechanism, as many families feel that this will protect the young girls from gender-based violence. In 2010, 45 per cent of girls had entered a marital union before the age of 18 and gender-based violence affected at least a fifth of women in South Sudan. Other customary laws that promote health inequities include widowhood inheritance and a culture of patriarchy that discourages joint decision making among men and women in households.

Key messages

- Maternal mortality ratio in South Sudan is 789 maternal deaths per 100,000 live births, the contraceptive prevalence rate is 4.7%, and the teenage pregnancy rate of 34.5%
- Most common harmful traditional practices in South Sudan are early and forced child marriage under customary law.
- In 2010, 20 percent of South Sudanese women were survivors of gender-based violence and 45 percent of young girls (<18 years) were in a marital union.

The HPF Gender and Social Inclusion Strategy

HPF developed a gender and social inclusion (GESI) strategy and work plan in April 2013 to promote gender mainstreaming across all components of the programme. The goal and purpose of the Gender ad social inclusion strategy are described below (Mid-term review 2015).

Goal: To ensure that South Sudan HPF funds activities that are likely to have a transformational impact on poor and marginalised women and girls' health in South Sudan.

Purpose: To ensure that women, girls and excluded groups are represented in, and able to effectively participate in and benefit from, programme activities by integrating gender and inclusion considerations and approaches into IP projects, into the South Sudan HPF team and HPF2's systems, resources, communications materials and processes.

This chapter outlines some of the key changes, barriers and enablers encountered during the implementation of the strategy for HPF1 and HPF2 and proffers recommendations for HPF3.

Key findings

Methodology

A gender analysis was done on all HPF related documents including but not limited to IP reports, annual reports, mid-term reviews and the business case. Findings from the literature review were also triangulated with qualitative research findings from the interviews done during the field work by the team. Validation of some of the GESI concepts and information on integration of the GESI strategy was done by interviewing key GESI staff. A gender analysis matrix tool was developed (an adaptation of the WHO and Johns Hopkins GAM) and this was used to assess key enablers and barriers that influence access to health services at the individual, household, facility, national and policy level. This matrix is provided as an annex to this chapter. To identify key barriers for different groups, an intersectional lens was used to interpret some of the findings from the field data and document review.

Annex A has a full list of all the documents and interviews that were drawn on in the development of this chapter.

Key definitions

- **Gender** refers to the socially constructed characteristics of women and men – such as the norms, roles and relationships that exist between them. Gender expectations vary between cultures and can change over time. It is also important to recognize identities that do not fit into the binary male or female sex categories. Gender norms, relations and roles also affect the health outcomes of people with transgender or intersex identities.
- **Sexual and gender-based violence** (SGBV) refers to any act that is perpetrated against a person's will and is based on gender norms and unequal power relationships. It encompasses threats of violence and coercion. It can be physical, emotional, psychological, or sexual in nature, and can take the form of a denial of resources or access to services. It inflicts harm on women, girls, men and boys.
- **Intersectionality** refers to the complex, cumulative manner in which the effects of different forms of discrimination combine, overlap, or intersect
- **Child marriage** refers to any formal marriage or informal union where one or both of the parties are under 18 years of age

Summary of main findings of the GESI component of the HPF Programme

Key Achievements

- Widespread awareness of GESI strategy among IPs
- National level Gender Technical Working group within the MoH & collaboration with key actors (e.g. UNFPA)
- Targets for women's participation in lots & village health committee meetings covered by HPF programme have been met
- GESI indicators focused on maternal and child health
- HPF strategy is aligned with GRSS Health Sector Development Plan (2012-2016)
- HPF advocacy of GESI issues at the national level

Key Challenges

- Perception that GESI is an 'add-on' to the programme rather than mainstreaming into all the components
- Indicators on women's participation are focused on quantity over quality
- Implementation lacks an intersectional approach and is mainly focused on gender equity (not social inclusion)
- Women's role in leadership and decision-making remains low – restricted by cultural norms
- No baseline assessment of key knowledge gaps and gender-based barriers to service implementation conducted prior to roll-out of GESI strategy

- Lack of harmonisation on best ways to implement the strategy among IPs
- Lack of resources to support implementation in HPF2
- Lack of clarity around impact of male sensitization activities
- Service delivery gaps for key populations such as adolescents, people living with disabilities & ethnic minorities

Relevance

> *'To an extent health priorities at county level are being met. New born and below 5years mortality rate is significantly improved, prevalent illness are being managed, mortality rate among expectant women and during delivery is by far improved. Most of HPF programs target women, children and elderly but hardly address men especially adults/youth health related issues. There is need to also have programs that target the latter gender age group'. (State Minister, Male)*

A review of programme documents triangulated with field data reveals that to a large extent GESI indicators related to maternal and child health received focus. Many respondents at the state level and among IPs claim there is evidence of significant improvement in access to maternal health care services and nutrition for pregnant women and children under five. However, references to services that would also be used by men are not available. An example of this is the syndromic management of sexually transmitted infections (STIs). There is also hardly any mention of youth friendly services.

Implementing partners (IPs) mention male engagement in their quarterly reports, in the form of sensitisation of reproductive health services (RH). However, it is unclear if any change in gender norms can be attributed to these male sensitisation activities. There is also no information on the depth to which social norms and existing inequities are addressed, taking into account other vulnerabilities related to ethnicity, disability, socioeconomic status and age. Harmful gender stereotypes that promote specific types of masculinity and legitimise hegemonic masculinity are underlying drivers of conflict and gender-based violence in fragile contexts like South Sudan.

The HPF programme is in alignment with the Health Sector Development Plan of South Sudan (2012-2016), as its indicators for nutrition and maternal health are incorporated within the programme. However, other target areas such as adolescent health are not addressed. This is a key gap in programme implementation, given the high rates of child marriage and teenage pregnancy in South Sudan. Adolescents, both male and female are a key target group in conflict

settings. Targeted interventions should be developed for this group that also address underlying gender norms.

South Sudan Health Sector Development Plan 2012-2016

Goal: Contribute to the reduction of maternal and infant mortality and improve the overall health status as well as the quality of life of the South Sudanese population.

Objectives

- To increase the utilisation and quality of health services, with emphasis on maternal and child health
- To scale up health promotion and protection interventions so as to empower communities to take charge of their health
- To strengthen institutional functioning including governance and health system effectiveness, efficiency and equity

At the national level, there has been a commendable attempt by the HPF programme to advocate for prioritisation of the GESI issues. There is a Gender Technical Working Group, with a secretariat at the South Sudan Ministry of Health. The Gender Adviser of the HPF programme is a member of this working group and uses her membership to advocate for GESI priorities. During interviews with HPF Staff and partners working on GESI, examples of these attempts were provided, these include advocacy for national training materials on GESI , as well as, a national protocol and training manual on clinical management of rape among health staff. An output of these advocacy efforts was a training manual on gender mainstreaming and health, that was developed in collaboration with UNFPA. This engagement has created more opportunities for advocating for prioritising of gender issues at the national level. An interview with the HPF Gender adviser revealed the existence of a lot of support from Ministry of Health staff that are members of this working group. (HSDP 2012-2016, HPF2 GESI Strategy).

Health Priorities and needs

Interviews with health staff, community health workers and beneficiaries revealed the key health priorities and needs for women and vulnerable groups to be frequent cholera outbreak, malnutrition of small children, malaria and pneumonia.

For women specifically, the long distances to health care facilities and difficulties accessing health care services remain a challenge. Other health priorities identified include provision of surgical facilities to reduce referrals from PHCUs to hospitals, recruitment of more skilled staff, availability of essential drugs and prevention of stock-outs and HIV/AIDS awareness. It is important to note that the health priorities were sometimes different in the different regions, elucidating the importance of community consultation, while developing interventions.

> *'We cannot get the required treatment since this facility is lacking lab for sickness examination and blood diseases. Sometimes, the doctor gets the disease just for it symptoms but no medicines…We (men) just come to the health facility when you are sick. There are no special services for men here except when you are wounded in the fight, you can be taken to Marial Lou for special services. There are supposed to be services for women. But we don't have them here. We are suffering from this disease called (Manir). It is killing many pregnant women here and there is nothing that this facility can do to help us…Many people come with their children to this facility, some suffered from malaria, malnutrition and diarrhoea…*
>
> *I rarely come to this facility because of amputated leg but I come because of other sickness. If there is a problem on my amputated leg, I go to Marial Lou or Wau for consultation because our doctors at this facility don't have services for me. We have other disabled people in the village, but they cannot access the facility easily because they don't have means of transport. They can call people to carry them to the facility which cannot be possible sometimes…There are many needs that are not available here like medicines, more doctors, ambulance that can take people to other better facilities, building of the admission ward and the ward for pregnant women and lactating mothers (Beneficiary, Male, Tonj North)*

Another important issue was the lack of services for people living with disabilities. This was also a key feature in the GESI strategy but there was no evidence that this was addressed in health interventions and responses. A review of documents and interview transcripts show a focus on gender but not the social inclusion component of the GESI strategy. There are several potential explanations for this in a low resource fragile context; it could be that it was easier to focus on gender and not social inclusion because it was, 'the low hanging fruit'. The other could be that given the lack of capacity of IPs on GESI issues at the beginning of the HPF programme, it was easier to develop activities within the work plan focused on gender than activities that addressed all the issues related to social inclusion.

Key gaps

However, there is no support for youth friendly services and strategies to support young people. Why are there no adolescent friendly services and why are the health personnel not assessing for HIV? Why are people still going to TBAs? here is a problem with GBV (gender based violence) assessment and there is a need to build the capacity of health staff to address GBV. There is a need to apply a gender lens to understand the barriers to accessing services and identify what are the sociocultural issues. For example the fact that men need to be involved in GBV interventions. With the midwives, this promotes a reflective attitude when filling the assessment report, allowing them to identify factors that affect health. For example, women dying due to teenage pregnancies and women having unplanned pregnancies and abortions. So many delays to access to health care are associated with gender inequalities. (IP, Female)

Implementation of GESI Strategy

Sexual & Reproductive Health Indicators related GESI

Gender equity is difficult to achieve in the absence of sexual and reproductive health. The ability of women and other vulnerable groups to 'realise their sexual and reproductive rights is vital to achieving gender equity in health'[9091] Access to maternal health care services, as well as other sexual and reproductive health services, including modern contraceptives, safe abortion and HIV/AIDS testing and counselling should serve as proxy indicators to assess gender equity in access to health care. We have included a few of these GESI related indicators, to provide an overview of the progress the HPF programme has made in these areas.

[90] MacPherson et al, 2013, Gender equity and sexual and reproductive health in Eastern and Southern Africa: a critical overview of the literature
[91] IPPF Vision 2020, 2015, Sexual and reproductive health and rights – the key to gender equality and women's empowerment

Table 9.1: Sexual & Reproductive Health Indicators related to GESI

Indicator	Baseline (2012)	Milestones 2014	Progress Sep 2014	Achievement 2015/2016	Achievement 2016/2017	HPF Target March 2018	Comment
Percentage of women who attended at least 4 times for ANC during pregnancy	20,500 (8%)	20% (57,000)	21.4% (22.4% excluding Unity) Milestone moderately exceeded	118,901 (27.8%)	118,980 (26.8%)	30%	Target almost reached. There was a marked difference between number of women accessing health services at Visit 1 and Visit 4, a reason for this was attributed to the bridge in contract between HPF1 and HPF 2[92]
Percentage of births attended by skilled personnel	7311 (2.8%)	19,250 (7%)	6.4% (6.8%	46,268 (10.4%)	45,680 (10.4%)	12%	This target was reached, an explanation provided for gap in outcomes was that ANC care was provided at PHCUs, and mostly by a maternal child health worker or Traditional Birth Attendants (TBAs)
No. of facilities with capacity to offer emergency obstetric care (disaggregated BEmONC and CEmONC)	–	All HPF-supported hospitals provide CEmONC*	9 of the 15 HPF-supported hospitals provide CEmONC.	All HPF-supported hospitals (eight MOH, seven faith-based) provide CEmONC.20	27	25	Target was reached and slightly exceeded
	–	25% of all 39 counties have at least one PHCC with BEmONC	38 facilities report BEmONC capacity in 19 (49%) of HPF-supported counties	34	37	37	Efforts were made to equip health facilities and scale up existing infrastructure in HPF2
Number of new acceptors to modern contraceptives	3,500	7000	5,419	10,742 (June 2015)	–	–	Information not available on this indicator in the subsequent review report, though the milestones for 2016 were reached.

[92] It is important to note that there are other reasons women may not uptake the service based on personal choice such as, attending the first visit too late thus not enabling enough time for follow-up visits or deciding to attend two or three sessions only.

Awareness of the GESI strategy

Interviews with several implementing partners and HPF staff reveal that there is widespread awareness of the GESI strategy. However, it is difficult to ascertain to what extent an intersectional approach is used in their interpretation and implementation of the strategy. There is a focus on increasing women's participation in Village Health Committee meetings, but the focus is on quantity and not on the quality of participation. A review of the different IP reports indicates that in certain regions, specifically lots covered by the HPF programme, targets for women's participation in CHCs were reached. However, women's roles in leadership and decision-making remains low, as women are restricted by cultural norms from holding leadership positions in the community. There is also lack of harmonisation on the best ways to implement the strategy between the IPs and a lack of resource to support the implementation. There is a perception that GESI is an 'add-on' to the HPF programme and not an issue to be mainstreamed all through the different components of the HPF programme. This perception might explain the discrepancies between IP work plans that are inclusive of GESI related activities but have no associated budget for the implementation. It must also be noted that implementation of the GESI strategy only began in HPF phase 2.

Existence of capacity among HPF management

At the initial stage of the implementation of the GESI strategy there was little GESI capacity among the IPs. Most of the IPs had experience in public health and humanitarian assistance but not on issues related to gender and development. This gap was addressed by the HPF Gender Adviser through conducting trainings for several IPs in collaboration with UNFPA and other partners. A

Response to gender-based violence: HPF Annual Report 2017

Although some IPs are working on Gender Based Violence (GBV), including Clinical management of rape (CMR), a severe challenge to progress is the acute lack of a national level CMR approach, including the lack of a referral system for various CMR services (such as psychosocial support), the lack of a community level system for referrals from the community to the health facilities and the lack of training resources specific to the South Sudan context. UNFPA provides some resources in this area, such as the development of a training manual and IPs bring some of their own resources. The MoH Gender Technical Working Group (led by the Director of Reproductive Health) and the GBV sub-cluster are engaged in discussions with HPF and UNFPA on CMR but face a significant lack of government resources to make progress.

review of the mid-term report in 2015 revealed several trainings for IP staff that were documented in the work plan but never took place. In most cases, one of the reasons for this was a lack of sufficient budget or resources. (HPF Mid-term Review 2015; Annual Report 2017)

Existence of gender focused interventions

In its TOR, the HPF is required to encourage the inclusion of feasible health interventions, through the IPs, that will affect youth, people living with disabilities, and gender-based inequalities, discrimination and violence, especially for women and girls. This is in recognition of the connections between various social determinants and health. Community engagement was identified as a strategy that could encourage uptake of services. However, documentation of the community engagement strategy and implementation show that community led interventions focused on maternal and child health but not specifically on addressing harmful gender norms. Examples of these include the mother-mother support groups, among others.

Examples of good practices in Maternal and Child Health

IPs formed women's groups for awareness forums on antenatal care (ANC) and Expanded Program on Immunisation (EPI). The mother care group (MCG) model has been widely used to establish Mother to mother support groups, which provide support for pregnant women, these groups involve meetings where pregnant women with young children meet, share experiences and information on breast feeding, child rearing, women's health and nutrition. Other similar approaches employed by most IPs, to disseminate information on maternal and child health, engaged women through drama and song presentation during meetings or important celebrations

A review of most of the gender focused interventions done by IPs show a focus on capacity building of the IPs and CHCs and on increasing knowledge of gender issues. There was also a focus on the clinical management of rape, using protocols developed by UNFPA and HPF. However, a gap identified was the lack of a uniform protocol at the national level. In 2017, UNFPA conducted a gender and GBV sensitivity assessment of specific health facilities in South Sudan and identified the important barriers to accessing health services. Key findings of the assessment reveal that stigma and lack of infrastructure served as barriers to accessing services for GBV survivors. The gender of the health workers' was not seen as a barrier to accessing health care services within the UNPA report. However, interviews with beneficiaries and health staff during our data collection revealed that this was a barrier in the areas we sampled.

Since the development of the GESI strategy, commendable attempts have been made to increase the representation of women at the village health committees and community health committees. This has been done through community engagement and advocacy by the implementing partners. Female representation in the different village health committees has increased since the start of the HPF programme.

Key findings UNFPA Gender and GBV sensitivity Assessment Report 2017

- Health care providers are aware of the beliefs and values that create barriers for both men and women in achieving optimum health, however, lack the knowledge on gender-responsive approach's to health care to eliminate the barriers
- Low staffing numbers and retention, lack of supplies and medications, and insecurity are linked to inadequate availability of services.
- Traditional and gender norms result in women's unequal access to health services, due to lack of power to make decisions about using resources, including costs of services, distance to facilities and lack of knowledge
- The majority of health facilities lacked adequate infrastructure to ensure a GBV survivor's privacy, safety and confidentiality. Many health facilities do not have the needed knowledge and skills to assist GBV survivors particularly the survivors of rape. Findings revealed a lack of GBV and Clinical Management of Rape protocols and referral pathways.
- Stigma is a key reason survivors of GBV are reluctant to report cases of rape. There are usually two main reasons a women will report a case of rape: 1) because her family wants retribution from the family of the man who raped their daughter (this commonly was reported to be in the form of cattle or forced marriage) and 2) the woman or girl was physically harmed and needs immediate medical attention.

'For the women group mostly in this community, culturally, it is an abomination for a male to deliver the babies … '(Akop PHCC, Medical Officer in Charge)

Most of the Young women fear male doctors to take care of them during delivery. Some of the women could not narrate their health problems especially diseases such as gonorrhoea to men. (male service providers) (FGD Mayombiong Health Committee)

In 2016, new GESI related indicators focused on SGBV and gender sensitivity training were included (see overview below).[93] Considerable efforts were made to reach the milestones, and these efforts are commendable. We have classified the progress towards the march 2018 targets as limited progress (<50%), moderate progress (50-70 percent), good progress (>70 percent). Given the fact that the data available is limited to June 2017, interpretation of the information presented should take into account this limitation. Although reasonable progress was made

[93] We have based the overview on data available till June 2017, we acknowledge that more efforts to reach the targets would have been made between then (June 2017) and now (May 2018).

towards most of the targets set for March 2018 by the end of the reporting year in June 2017, we encourage the HPF programme to continue to monitor these indicators and set them as benchmarks for the GESI component of the programme. Efforts were also made by gender technical staff to develop a checklist for implementing partners to encourage them to improve female participation in the health committees.

Table 9.2: GESI Indicators for the HPF Programme[94]

Indicator	Baseline (2012/2013)	Milestones 2014	Progress Sep 2014	Achievement 2015/2016	Achievement 2016/2017	HPF Target March 2018	Comment
Percentage of health committee representatives that are women	Not available	At least 20% of committee members are women	32% of health committee members female. Outputs substantially exceeded expectations	37%(By November 2016). Milestone:40%	33%(By October 2017), Milestone:33%) (2,320/6,969)	38%	Good progress.
Total number of health facilities that have documented and adopted protocols for the clinical management of sexual and gender-based violence services	Not available	Not available	Not available	Not available	98	690	Fair progress
Total number and percentage of female health workers	Not available	Not available	Not available	2,883/6,674 (43%)	2,331/7,238(32%)	44%	Moderate progress
Total number of CHD and facility staff (disaggregated) who received gender inclusion and SGBV training	Not available	- Not available	Not available	Not available	164	420	Fair progress
Total number of health workers trained to provide appropriate adolescent and youth services	Not available	Not available	Not available	Not available	278(130 females)	480	Moderate progress
Total number of health facility staff trained to identify, care and refer SGBV survivors	Not available	Not available	Not available	Not available	217(106 females)	690	Fair progress

[94] Based on the HPF Annual Report 2016-2017, Annual Review Reports 2012-2017

Table 9.3: Examples of interventions conducted by IPs in some lots (including barriers to implementation)

LOT	Intervention
LOT 1	Although a target of 55 CHD staff were set to be trained, no staff were trained on GESI. An action/work plan was developed but the training was not conducted due to the late approval of the realigned HPF budget meant to be conducted in January 2018. The target of training 256 health facility staff to identify and care for SGBV survivors was also not met for the same reason. The target for female participation in health committees was achieved and even slightly surpassed by 9% over the target. 57% of the women who were in the health committees were identified to be in leadership roles, though there is still an existing gap between participation and leadership. Challenges and barriers to achieving some of the targets included harmful gender and cultural norms. For example, two women were killed by hanging/lynching, and a third became a refugee in Kapoeta state as they were labelled witches responsible for deaths of cholera victims in Loriyok, Kiduli and Ngarahach Bomas. Furthermore, there was evidence of poor health seeking behaviour in some of the communities such as myths of dying if seeking care at a health facility with patients exhibiting symptoms of cholera and belief that cholera is a bad spell; people suspected of having cholera would sometimes be quarantined to their homes with ashes spread around the homestead as a measure to prevent the spread of disease.
LOT 3	Most CHD staff were trained on GESI and GBV through on-the-job mentorship. 1 IP staff from Budi county was trained as a trainer of trainers (TOT) by HPF/UNFPA in Juba. Only 1/10 health facilities adopted protocols for the management of SGBV. 50% of health staff were trained to identify, care for and refer SGBV in the lot. HMIS recording and reporting tools did not include sections to report on information regarding clinical management of rape. This type of data was therefore not captured.
LOT 8	The number of female health workers was exceeded by 14% of the target and the target regarding facility staff trained in the lot to identify, treat and refer SGBV survivors was met (7/7). However, female representation in the VHC remained low due to challenging cultural and social beliefs which perpetuate gender inequity. For example, men found it difficult to understand, accept and adopt behaviour change messages on gender, gender-based violence and social inclusion. Women, particularly in pastoralist communities, were perceived as assets after marriage and therefore had no decision-making power on their own health or health of their children. Despite 59% of members in the health committees being female, men usually dominated discussions and women did not actively participate despite awareness of their own needs. The South Sudan Women Empowerment Network (SSWEN) was invited during the election of health committee officials in Awerial to promote female engagement into leadership positions. There was also collaboration with Awerial women's association to support female selection into health committee and participate in officials' elections. There were no targets for developing a SGBV

	management protocol except for Mapuordit hospital. Despite there being no formal GBV activities planned, CUAMM intends to implement at least one protocol in Yirol hospital at the end of the contract.
LOT 18	79% of health workers in the lot were female (33/42). However, no CHD staff were trained on GESI which had a target of 15 staff to be trained. No achievement was recorded on SGBV training of CHD staff on gender and social inclusion as there was no budget allocated. However, training will be conducted in the next reporting quarter as a budget for these activities was allotted during the budget realignment process. All health facilities in the lot adopted protocols on CMR & GBV; however, no staff were trained to identify, care for or refer GBV survivors. There was no initial budget allocated to achieving this indicator but was included in the revised budget to be implemented in the next quarter. 79% of health committee members were women (95/120) and 67% of women were in leadership roles within the lot's health committees (28/42). The target of 280 men reached through community sensitisation on reproductive health was substantially exceeded with 1,398 men being sensitised between November 2016 to December 2017.

Knowledge sharing and partnership on GESI

At the national level, there is a Gender Technical Working group within the Ministry of Health in South Sudan that involves all the of the key actors in South Sudan and main implementing organisations. However, apart from this working group, there is no other evidence of knowledge sharing opportunities/platforms to discuss best practice and knowledge gaps regarding implementation of the GESI strategy. Platforms like these would specifically be useful for the IPs given the lack of capacity on gender issues. It might also provide opportunities for IPs to collaborate on strategies and projects that address social norms that prevent uptake of services.

> *Most of the partners worked with GESI, like UNICEF, UNFPA and county representatives, and we had a very small budget, and some of the other partners like Save the Children are implementing partners, but surprisingly some of their international policies do not carry through to the country level but there have not been opportunities to work with the partners at the other levels. HPF Staff, female*

GESI and Community Engagement: Opportunities

There are community feedback meetings held monthly and quarterly. The most common approach noted across all IPs are the monthly and quarterly meetings to discuss key health concerns spearheaded by Boma Health Committees (BHC) in the presence of community leaders, those in charge of health facilities and CHD representatives. This approach mainly focuses on community participation with regard to accessing quality services and how the community can support or contribute to the health facility through manual work such as clearing bushes, construction or road maintenance, pit latrines and/or staff house construction. Though the meetings discuss key health concerns in the community, a guided approach on how to translate the findings into action appears to be lacking. Community structures were not actively involved in these meetings and the participation of other existing community volunteers in these meetings is unclear. These meetings can be strengthened, improved, and transformed into organised community dialogue to include key health activities, become a platform for social inclusion and gender equality. Women's empowerment findings indicate that women's effective participation has not been adequate and women's representation in the BHC is at only 36%. However, opportunities exist to use this platform to promote demand and uptake of health services among vulnerable groups (Mid-term review 2015).

Gender based challenges to uptake of services

> *The major challenges that prevent women from accessing health services include: cultural practices where people prefer to see traditional doctors first before coming to the hospital especially fertility issues, and also women shoulder much of the domestic roles at the house including care of children thus sometimes find it hard to leave children at home alone and come to the hospital. For men, the major challenge is just ignorance where they ignore illnesses with the thinking that it will go away alone. For small children, walking long distances is very tiresome for them. Beneficiary, FGD, Nyang*

Difficulties with addressing 'vulnerabilities' within the strategy

Harmful gender norms & roles

Harmful gender roles and social norms remain a barrier to access in many communities, especially in situations where there is low literacy and high rates of poverty. Some of the main challenges cited with accessing health care for women were the 'rigid roles' set for men and women. For example, in most cases women were expected to continue with domestic chores even if they were ill.

Discourse around gender-based violence (GBV) & unavailability of services

Cultural perceptions of GBV are sometimes different. For example, not all beneficiaries of the programme perceived domestic violence (specifically intimate partner violence) or child marriage as a form of GBV, which undoubtedly impacts on reporting rates. Efforts should be made to promote community outreach programmes that include sensitization activities on GBV.

Another barrier was the lack of services to address GBV, which we define as inclusive of clinical management of rape, psychosocial counselling and medico-legal linkages. There is a learning and knowledge gap on how the current GESI strategies (specifically the increased involvement of women within village/community health committees, as well as training of IPs) will address these sociocultural gender barriers. HPF should determine whether these interventions are sufficient and where there are learning opportunities from other pre-existing programmes that have been able to address these difficulties.

Gender of health workers

Interviews and focus groups revealed that many women refused to access specific services because the health service providers were men. Gender balance needs to be encouraged among health service providers; this should be done in tandem with working closely with community health workers, especially female community health workers. For example, task-shifting interventions and training female community health workers to assist in some basic health service provision, could be considered as a sustainable way of addressing these barriers.

Gaps in the implementation of sexual and reproductive health interventions

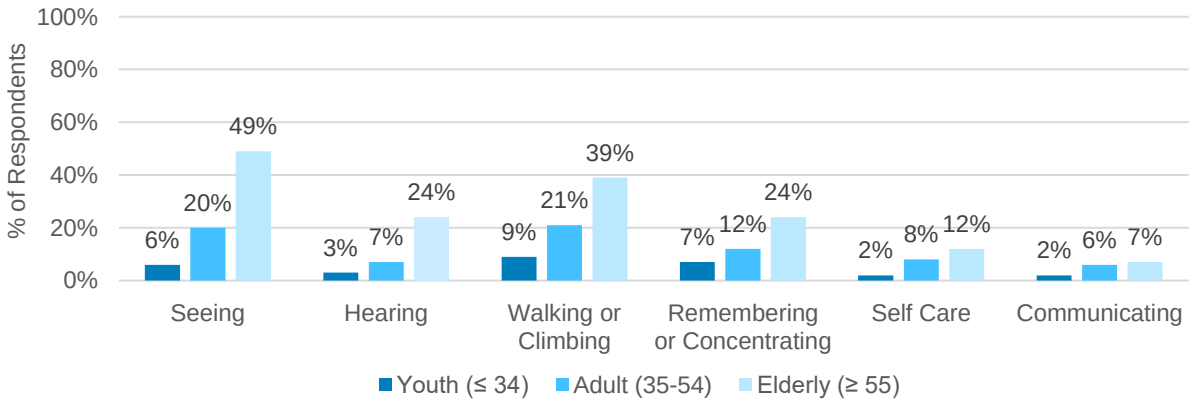
Another gap in service delivery is the lack of specific interventions or monitoring indicators around sexual health and sexual orientation. In a fragile context, where gender roles are reified, the necessity to address sexual health needs and issues around sexuality become very important. In a context where resources are scarce, and issues like famine, malnutrition and displacement are paramount, addressing sexual health issues might seem less important. However, the absence of interventions that address these issues will lead to a negative trickle-down effect, as they impact on the sexual and reproductive health of the whole population, specifically targeted groups such as women and children. For example, a high incidence of STIs such as syphilis, gonorrhoea and chlamydia will eventually impact maternal and child health if left untreated, causing morbidities and sometimes high case fatality rates. Furthermore, harmful interpretations of masculinity encourage violent behaviour inclusive of GBV. South Sudan represents an example of a complex context where humanitarian assistance priorities mesh with development goals. The key question

is how best to navigate these issues in a way that is not only culturally appropriate and relevant, but also cognizant of the fact that the key development milestones reached now could serve as a building block for more sustainable changes in the future, especially for GESI issues.

Lack of disability services

Another important feature was the lack of services for people living with disabilities. This was also a key feature in the GESI strategy but there was no evidence that this was addressed in health interventions and responses. The beneficiary survey found 46% respondents with at least one difficulty as defined by the Washington Group set of disability questions (see Figure 7).

Figure 7: Disability by Age Group of Respondents



Sustainability

A lot has been done by the HPF programme to create an environment where GESI issues are prioritised. However, regarding HPF3 and possible changes with fund managers, sustainability might be an issue. At the national level, the participation of HPF within the Gender Technical Working Group is very important. However, it is also important for HPF staff, especially those involved in mainstreaming gender, to be supported to attend other working groups at the National level, as well as encouraged to conduct monitoring/supportive visits with IPs. These assessment visits 'on the field' would provide a more comprehensive picture of how GESI strategies are implemented and allow GESI advisors to provide on-going support during programme implementation which promotes learning and development of the IPs on GESI issues, instead of specific training-related activities.

Task-shifting, specifically working with community health workers and the use of existing strategies like the Boma Health Initiative provide promise for developing sustainable ways to address HPF targets and outcomes, as well as mainstreaming gender issues. Community

participation is essential not only for health promotion but also for developing a sense of ownership among community members, in addition to a governance system that ensures sustainability. Some of the key barriers to access mentioned during some of the interviews were distance and lack of knowledge. Effective community participation will promote community support to address these gaps. Examples of how effective community engagement has led to addressing these barriers were cited by a GESI adviser who mentioned the use of bicycle ambulances or motor bikes by community members to ensure that women who needed urgent ANC care got to facilities on time. Another example was of community workers and members identifying vulnerable groups who required health services and making an effort to visit these groups to help them access the required services. The GESI and community engagement strategy need to be developed together and used as a way to promote community ownership of some of the components of the HPF programme, at least at the community level. HPF, by making use of existing infrastructure and working with GoSS health facilities, is taking a step in the right direction, however, trust-building between donors and GoSS, as well as capacity building to ensure sustainability beyond the programme, still needs to be done.

Recommendations for HPF3: GESI

Community level

Community participation: It is evident from interviews and the review of key documents that community/village health committees played a key role in health promotion and service delivery for the HPF programme. However, they are not involved in the earlier phases of implementation (design and development), though opportunities exist. Key influencers like community leaders, as well as representatives of vulnerable groups, IDPs, ethnic minorities, people living with disabilities, young persons and LGBTQI should be consulted with, during the development of work plans of IPs. Focus group discussions can be done with these groups, and with community leaders to encourage support of vulnerable groups. This would ensure that the activities developed are relevant and address the key health needs of these groups (for example, age specific and appropriate SRH education for young persons). Intersectionality/ Social inclusion, though a seemingly popular buzzword, is in reality difficult to implement in programmes if community consultation is not done early enough and with proper representation of beneficiaries.

Baseline assessment: A baseline assessment of key gender issues was advocated for by HPF gender advisers. This is important in understanding the context and exploring issues around social inclusion that include but are not limited to gender, especially in a fragile context like South

Sudan. This would inform the development of relevant strategies and promote the use of an intersectional lens in assessing health priorities of the different beneficiaries.

Adapt and implement existing strategies: There are existing success stories of community led and focused interventions that addressed harmful gender norms. SASA! Is often cited in different interviews as one of these success stories. Another relevant strategy is the Boma health initiative proposed by GoSS. These would encourage community ownership of GESI interventions and could be cost effective strategies for the HPF programme to promote GESI across different components of the project.

Health Facility level

Capacity building of health service providers: Training service providers applying an intersectional and gender lens while working with patients is important. Most service providers might be adequately trained to provide skilled medical services, but an inability to understand how underlying social norms influence access might make them unable to screen for GBV or assess when a young person might require STI counselling in addition to a suture for a laceration. These kind of skills require a nuanced understanding of how different social determinants affect access to health.

Health promotion in health clinics: Health clinics, outpatient departments and ANC waiting areas are potential locations for discussing gender related health issues; including information on GBV, family planning, maternal health and adolescent sexual and reproductive health. In cases where pregnant women are accompanied by family members at ANC clinics, this could be an opportunity to address harmful gender and social norms.

National level

Advocate for gender mainstreaming in polices and programming: Opportunities for advocating for GESI priorities at the national level should be promoted. Technical working groups at the National level within the Ministry of Health are a good example. However, other opportunities for joint agenda setting should be identified and promoted. This will promote trust building between the programme and GoSS staff, as well as build the foundation for sustainability at the end of the programme.

Harmonise SOPs and salaries: The UNFPA assessment of health facilities on GBV and gender sensitivity revealed a lack of harmonisation of SOPs on GBV service provision across facilities. Promoting this harmonisation could be a potential target for HPF3, as it would encourage cross-facility training and create more efficient monitoring frameworks across different facilities on this target. Salaries of health facility workers came up as a key issue across different interview

transcripts. Ways of harmonising salary scales and ensuring this is adequately budgeted for is important, as this has an impact on service provision, especially for vulnerable groups.

Integrate existing national indicators: As much as possible, existing national indicators of GESI should be used within the HPF programme. HPF did this for nutrition successfully. Integration of existing national indicators is also a corner stone for building sustainability

IPs and HPF Technical staff:

Knowledge and sharing platforms: Knowledge and sharing platforms provide an opportunity for IPs to share best practice and lessons learned in implementing GESI components of their programme. In addition, given the fact that not all IPs will have the same capacity or human resources to implement GESI, this could be a way to encourage more collaborative approaches. This is specifically important for ensuring sustainability. Given that different regions of South Sudan will have different health priorities and access issues, providing an opportunity for IPs to discuss and share their challenges will create a network, where they can discuss appropriate solutions and reflect on how gender mainstreaming can improve the implementation of specific components of the programme.

Capacity building: There is a need to ensure that a sustained budget is set aside for training IPs on GESI issues. In the context, there could be issues of high staff turnover and changes in IPs responsible for implementing specific components of the programme, which is why sustained training budgets and activities should be done regularly for all the IPs involved.

Donor level

Harmonise donor strategies on GESI: Donors by nature, will have different priorities and focus points for interventions in South Sudan. However, GESI is a crosscutting issue that should be mainstreamed and prioritised among different donors. Promoting this harmonised approach among donors will encourage sufficient budgeting for GESI and community engagement activities and allow for the incorporation of more qualitative indicators and outcome measurements for GESI across different components of the programme.

GESI sensitive budgeting: GESI technical advisers should be involved in budget development at the Donor and IP level. This would promote gender mainstreaming across different components of the programme and encourage donors to allocate sufficient funding for GESI within the HPF programme.

Annex A: List of Documents and interviews that informed the GESI report

- Gender and GBV-Sensitivity analysis of selected health facilities in South Sudan by UNFPA 2017
- Rethinking the Value for Money Strategy of the Health Pooled Fund, 2018
- South Sudan Household Health Survey 2010
- Situation Assessment of Children and Women in South Sudan, UNICEF 2015
- Ministry of Health Action Plan for Health Sector Gender/ GBV Working Group for 2017
- HPF 2 Annual Financial Report 2016-2017
- Quarterly Monitoring Reports
- Third Party Monitoring Reports
- HPF Mid-term Review 2015
- HPF Gender and Social Inclusion Strategy
- HPF Community Strategy and Implementation plan
- Boma Health Initiative Strategy
- South Sudan Health development Plan 2012-2016
- HPF Programme Audit 2015
- South Sudan National Health Policy 2016-2025

Table 9.4: Gender Analysis Matrix

Level	Factors that influence health outcomes	Biological/ Physical	Sociocultural factors	Access to and control of resources
Individual	Risk factors and vulnerability	Women are predisposed to several risks during pregnancy including malnutrition, malaria, pregnancy induced hypertension and anaemia, they also require specific services and care due to the different factors and risks that influence maternal morbidity. Teenage pregnancy is of particular concern, especially in the context of South Sudan where there is a high rate of child marriage, as they are more at risk of preterm births, pre-eclampsia and post-partum depression. Children: male and female (especially under 5) are at more risk of acute respiratory infection, malaria and diarrhoea. In fragile contexts, with limited resources, malnutrition is also a major concern, in addition to the factors mentioned above. In a context with high rates of gender-based violence, polygamy and teenage pregnancy, women and adolescent girls because of the fragility of the vagina mucosa and large surface area are more	In the context of South Sudan, displacement, conflict and poverty have created an environment favourable for child marriage. Many families will view child marriage as an alternative means of income and a way to protect their young girls from violence, especially if they feel unable to protect them from sexual violence. Adolescent girls specifically will be at increased risks, especially those that live in pastoralist communities, young boys in those communities are likely to be involved as participants or victims of armed cattle raids. During periods of conflict, harmful gender norms are often reified. In South Sudan, women have less power than men, and also occupy fewer leadership positions in the community and at national levels. This is further complicated by ethnicity and geographical barriers. According to a UNICEF assessment in 2015, Pibor is one of the least developed areas in South Sudan and the Murle people one of the most marginalized. Areas	Men are more likely to be engaged in some form of paid work in the formal or informal economy and tend to have more resources to access health care in South Sudan and pay associated costs. Women and adolescents may be forced to delay seeking treatment when they do not have resources. This is of specific importance at health facilities, where there are drug stock-outs. Despite the fact that user fees may not be charged, there might be a need to purchase drugs and other materials at a private pharmacy due to stock-outs at a health facility. These added costs could serve as a barrier for women and adolescents who have limited access to resources. This might also encourage these groups to seek health services from traditional healers, who are community based, might cost less and also have more flexible

		predisposed to having sexually transmitted infections including HIV. Young boys or men who are survivors of sexual violence (unprotected anal intercourse) are at greater risk of HIV and sexually transmitted infections. Also, during wars many young men and boys are enlisted to fight in both sides of the war, making them more at risk for trauma and mortal injuries.	of South Sudan held by opposition forces are more likely to have less access to resources and vulnerable groups like women, children and adolescents are more likely to be marginalized. Also, a culture of patriarchy that reinforces hegemonic masculinity is more likely to encourage young boys and men to engage in physical conflict or cattle raids to be able to provide for their families.	means of payment available than health facilitates.
Household	Access and use of health facilities Decision making power	Women and children tend to access health services more because of their visibility. The fact that most women would require antenatal care at some point, provides an entry point to access health facilities. Children, due to the need for vaccination, (especially under 5), too because those with acute respiratory infections are also more likely to access services, more than men. In male headed households, women are more likely to take their children to health facilities and go themselves than men and have more access to donor-driven or public health interventions. Pregnant women and children may have difficulties walking long distances to access care. Disabled older men and women may also have difficulty	Stigma and shame associated with gender-based violence might prevent female and male survivors from seeking care at the health facilities. For married women, who experience domestic violence, fear of repercussions from their partner at home would serve as a barrier to accessing services, especially if they are dependent on their partner for shelter and resources. Interviews with different beneficiaries and community health committees reveal that most men are distrustful of STI treatment services and discourage their partners from accessing these services. In a fragile context, like South Sudan where there is a silence on sexuality issues, males who are victims of GBV or who self-identify as queer or homosexual are less likely to report to health facilities, or seek specific services, including but not	In many households, rigid gender norms that require women to provide care even when ill, which might delay access to healthcare services. It is likely that care for children might be prioritised over the needs of other members of the household. Delay to seeking antenatal care services might also pose a risk for maternal mortality. In many health facilities, specific services for people living with disabilities are absent, discouraging people with physical disabilities from accessing care, as that would require assistance and support of other members of the household. Social norms that restrict mobility, not just for women but also for adolescents might serve as a barrier for accessing services, especially if permission and resources to go to the health

		in this regard. Interventions that are specifically targeted at women and children may seem to exclude men based on their gender and create a missed opportunity for engaging men. There are different types of households, especially in a context with a lot of displacement, decisions about health seeking tend to be made by men and in-laws in male headed households. This dynamic would change in female headed households, but there might be fewer resources available. These biological/physical barriers to access can be addressed, if interventions are targeted at households/ communities, as opposed to individuals. Male engagement or working with communities can create affordable sustainable means to address these barriers.	linked to HIV /STI testing, due to fear that information might be shared with other household members. Especially, as most PHCCs or PHCUs like specific private corners where counselling can be done.	facility have to be requested from the head of the household first.
Community	Health and social outcome and consequence Decision making, social		Men are viewed as natural leaders, especially in a patriarchal culture. The relationship between gender and power is more complex though, men with social and economic capital, from a majority ethnic group are more likely to occupy positions of power. This influences what kind of priorities are set up at the community level and how interventions focused at this level are implemented. Participation of women is important, but the quality	Men and women with social and economic capital often lead community committees. If there is insufficient representation of marginalised groups, outreaches and community priorities will be targeted to address the needs of certain groups but not inclusive of others. From the fieldwork data, there was no evidence of involvement of IDPs or disabled people in the Village Health

	capital and power		of participation is more important than quantity, participation of vulnerable groups and people from marginalised communities is important at this level to ensure that interventions developed are appropriate and relevant to the needs of all members of the communities and not to a specific few.	Committees. Focus should be on quality and not only quantity of participation. For example, though there might be a number of female IDPs within a health committee, if they are not in leadership positions or do not feel empowered enough to speak out on issues that affect them, as a group, their participation will not draw attention to pertinent issues for this group.
Health facility/ Health system	Treatment options	Women and men may present with different symptoms for sexually transmitted infections. Screening options and dosage and treatment have to take into account these differences and health facility staff have to be trained to recognise these different signs and symptoms and to screen for them. Women and men who are survivors of gender-based violence or torture will present with a myriad of symptoms from psychosomatic disorders, post-traumatic disorder to dyspareunia for women. It is important for health facility staff to be trained on gender sensitivity to some of these issues.	The different gender and social barriers to access have to be taken into account when providing treatment options for men and women. Providing nutrition supplements for children in a female household with limited resources, would require a recognition that some of the supplements would be used to feed other members of the household., or that a displaced pregnant woman with other children might need more community-based support to be able to attend regular antenatal clinics. Adolescents might require specific services to allow them to get contraceptives and SATI counselling, especially in a context where pre-marital sex is discouraged. Bi-sexual or homosexual men and women might require specific types of counselling and might be ashamed to disclose their sexual orientation to the	In many communities, women need permission from their husbands before being able to access specific family planning options. Unmarried people and adolescents are unlikely to be able to access family planning services without stigma. Many health service providers are unaware of the role of harmful gender norms in controlling resources and determining uptake of services. Some service providers might be aware of these inequities but might also share the same value framework that promotes these inequities or feel unable to address these issues at the health facility level. An assessment done by UNFPA on gender sensitivity of some health facilities in South Sudan revealed that most health professionals, while recognising

			health staff, unless these issues are brought up.	these gender-based barriers to accessing services, did not view gender trainings as important, and would prefer service specific trainings. An important intervention in this regard might be integrating gender analysis into every health training given to service providers to increase their knowledge on how gender and social inclusion issues affect access to services across different health conditions.
	Experiences in health care settings	While not specifically biological, distance from health facilities and opening times are a physical barrier for vulnerable groups like pregnant women and people living with physical disabilities. In times of conflict, many health facilities are unable to function for 24 Hours. This barrier affects the most vulnerable, for example, women experiencing postpartum haemorrhage who live in opposition areas or rural settings with very few health facilities, will likely delay going to health facilities due to competing priorities, and the delay in accessing health care services could mean the difference between life and death.	Cultural norms that discourage premarital sex often translate into health provider attitudes. Single men and women often face stigma while trying to access contraceptive services and STI counselling at the health facilities and it is the same for adolescents, as well as people who self-identify as LGBTQI. Men are often discouraged from attending antenatal clinics or deliveries, due to cultural norms about the man's role during pregnancy and delivery. Engaging men at this point would have been ideal as it provides an opportunity to discuss post-natal care and family planning options with both the women and men.	Drug stock-outs serve as a barrier for many vulnerable groups including women, but also men who have very little resources. The requirement to purchase drugs and other materials to be able to be treated serves as a financial barrier for many women and adolescents with limited resources as well as men. This often requires most women and adolescents to be accompanied to health facilities by someone else with more resources. An example of when this could lead to conflict are instances where women would like to have family planning but have no support from their partners, drug stock outs could discourage these women from accessing these services at the clinic.

Policy	Existing laws or policies that promote or discourage health seeking	The South Sudan Government ratified the Convention on the Elimination of Discrimination against Women (CEDAW) in September 2014, as well as the Child act in 2008. The South Sudan constitution, as well as Health sector Development Plan 2016-2025 recognise the role of gender and social inclusion in affecting access to health care. However, existing inequities and lack of resources make implementation of these strategies and gender mainstreaming difficult.	Cultural norms around child marriage and domestic violence will often supersede national legislation. Customary court practices are not harmonized with the 2008 Child Act and often breach human rights, including children's rights. 'Particular issues of concern include minor fines for sexual assault or rape, and the widespread understanding in customary law that adulthood is entered when a child reaches puberty'. (UNICEF 2015). The South Sudan Ministry of Health has a Gender Technical Working Group within the Ministry of Health that attempts to address some of these barriers working with HPF Staff. The MoH has also recognised the need to integrate GBV services within different health facilities, however there is no existing harmonised national protocol for this.	In South Sudan, the ongoing conflict has led to geographical disparities in access to health care and existence of infrastructure. Opposition held areas experience different barriers to accessing healthcare services, as donors are more likely to implement services in areas run by the Government of South Sudan. This has an implication for equitable distribution of services that is inclusive of gender issues.

INTEGRITY

LISTEN
COMPREHEND
RECOMMEND