Design Summary and Implementation Document

Improving health outcomes in South Sudan:

Support to Health Pooled Fund

May 2012

PART A: AUSTRALIAN STRATEGY, RATIONALE AND ROLE

1.0 Introduction

This Design Summary and Implementation Document (DSID) sets out the rationale, objectives and delivery mechanisms for Australia's proposed contribution of $35 million over three years (2011-12 to 2013-14) through delegated cooperation to a UK-led multi-donor Health Pooled Fund (HPF) in South Sudan. The DSID has been prepared in line with the advice provided in AusAID guideline *AusAID Quality Requirements for Partner-Led Designs.*

The HPF is a multi-donor funding mechanism, which aims to facilitate the delivery of basic health services, particularly for women and children. The primary beneficiaries of the HPF will be an estimated 3.5 million women and children who will receive life-saving primary health care. Other contributing donors include Canada, Sweden and the EU. At the request of the Government of the Republic of South Sudan (GRSS), the HPF will cover six of South Sudan's ten states, while USAID and the World Bank will both deliver a similar program in two states each.

The HPF's overall **goal** is to improve the health status of the population and ensure quality health care, especially for the most vulnerable women and children. The HPF's **objectives** are:

- to increase the utilisation and quality of health services, especially for women and children
- to increase health promotion and protection
- to strengthen institutional functioning, including governance and health system effectiveness, efficiency and equity
- to reduce maternal and child mortality

The **impact** will be to begin the move towards 'Government-led, effective health systems that save lives.' The **outcome** is expected to be increased access to quality health services in a system where the GRSS ultimately has capacity to manage these services.

2.0 Australian policy context and engagement objectives

Maternal and child health is a priority sector for the Australian aid program in Africa. In Africa, funding has been made available through the Australia Africa Maternal and Child Health Initiative (AAMCHI). In September 2010, the former Foreign Minister announced that South Sudan would be one of three priority countries under AAMCHI.

Australia's aid policy (*An Effective Aid Program for Australia*, which followed the 2011 review of Australia's aid effectiveness) mandates engagement in fewer, bigger programs and commits Australia to working through key partners in Africa. This reflects the directions outlined in *Looking West*, the most recent strategy for Australia's aid engagement in Africa.

South Sudan has been selected as a priority country for Australia's ongoing engagement in Africa. Australia is therefore transitioning from being a purely humanitarian donor in South Sudan to a fully fledged development partner of the GRSS. Maternal and child health and food security will be the focus of Australia's sectoral assistance in South Sudan going forward, with additional support for mining governance. These sectoral engagements will be complemented by Australia Awards (initially in agriculture and mining), technical assistance, and Australian Civilian Corps deployments to support stabilisation. Recognising that South Sudan's trajectory from early recovery to statebuilding

will not be linear, AusAID will continue to respond to humanitarian needs as priorities emerge. AusAID will look for opportunities to build linkages between our (and other donors') sectoral engagements[1] in South Sudan, not only to ensure they are complementary, but to facilitate knowledge-sharing (for example, we will explore how we can integrate into HPF implementation lessons from our support for early recovery and basic health service provision through Australian NGOs).

AusAID's development objective in contributing to the HPF is to have a positive impact on health outcomes for the South Sudanese people. As a new donor with no in-country presence, this requires strong partnerships and leveraging of others' resources and experience, which is why AusAID proposes to contribute to the HPF. AusAID's development objectives are aligned with those of DFID, the other contributing donors and GRSS, as outlined in the HPF documentation. AusAID's operational objective is to be a good donor partner who works in a harmonised manner with partners to minimise the burden on GRSS, and who can make valuable contributions to policy and program directions.[2]

3.0 Rationale for Australian participation

It is proposed that AusAID make a financial contribution, through delegated cooperation, to the HPF of **$35 million over three years** (2011-12 to 2013-14). This contribution of 18.4% would position us as the third-ranking contributor to the HPF (after the UK and EU), and is of sufficient scale to enable us to achieve influence as a committed health sector donor and engaged HPF partner. While the HPF has been designed as five-year strategy by the UK, AusAID's proposed three-year commitment will enable us to build a strong foundation of support for improved health outcomes in South Sudan, and establish Australia as a committed partner in health for the GRSS.

The HPF is the optimal choice for Australia's investment in improved health outcomes in South Sudan for the following reasons:

- the HPF is the 'main game in town' in terms of donor engagement in the health sector. It represents a collaboration of the largest and most important donors to South Sudan (including DFID, USAID, the World Bank, the European Union and others). It is GRSS' preferred mechanism for donor investment in the health sector and is aligned to government systems. The HPF is therefore the main forum for dialogue between GRSS and its development partners on health issues;

- the UK Department for International Development (DFID) is a strong partner in health in South Sudan. Working with DFID adheres to the commitment in *An Effective Aid Program for Australia*, which commits Australia to working through key partners in Africa. DFID has a track record as an experienced trustee of a successful pooled fund in South Sudan. The Basic Services Fund (BSF) is often cited as one of the most effective pooled funds in South Sudan. This experience positions DFID well to work with GRSS and other donors to lead a harmonised, transitional, multi-donor fund for health system development in South Sudan. DFID has played, and continues to play, a central role in donor coordination in the health

[1] Recognising the important synergies between maternal and child health and the sectors of water and sanitation, food security and education, for example, AusAID will explore how we can better link outcomes across these sectors, to strengthen HPF implementation.
[2] AusAID considers that both its development and operational objectives can be achieved within the proposed three-year funding timeframe, notwithstanding that the HPF is designed as a five-year strategy.

sector in South Sudan. It has a strong on-the-ground presence, with expertise not only in health but also in governance, peacebuilding and other priority sectors. The UK is a member of the 'Troika' (along with the US and Norway), which helped negotiate the Comprehensive Peace Agreement (CPA) with the Government of Sudan, which brought peace and independence to South Sudan;

- the HPF takes account of the fragile context in which it will operate. It is flexible to respond to changing situations, and has a strong emphasis on ensuring equitable and comprehensive distribution of a minimum package of services throughout the country (in conjunction with the US and World Bank programs). This flexibility and commitment to equality are vital in such a conflict-prone environment. The design of the HPF is consistent with, and has been heavily informed by, the OECD Development Assistance Committee (DAC's) Principles for Good International Engagement in Fragile States and Situations. A pooled funding mechanism is appropriate at this stage of South Sudan's statebuilding process, as it will help to avoid the development of a fragmented health system;

- the HPF actively supports the transition from a purely humanitarian assistance approach to South Sudan's health sector, to a long-term development approach. In the past, donor support to the health sector has been on a short-term and fragmented basis – characteristic of humanitarian support – with a near-universal reliance on non-government organisations (NGOs) to deliver services. The HPF represents a response to the need for close donor coordination and alignment behind government strategies, and the need to build government capacity. But it also acknowledges the need for external service providers (NGOs) to deliver services until government capacity to effectively purchase or provide services is built; and

- Australian Government support to the HPF will allow us to build on our existing early recovery programs in South Sudan, being delivered by Australian NGOs, as well as our strong record of support to date for maternal and child health through UNFPA (particularly in improving access to midwifery services).

4.0 Risks to Australia's engagement

South Sudan is a fragile, conflict-affected state. Any development initiative there carries risk for the donor agency. The rationale for supporting the HPF outlined above is largely built around an acknowledgement of the risk – engaging through a trusted partner with an on-the-ground presence and employing NGOs to deliver services are both key risk mitigation measures for Australia. The HPF's program design specifically addresses major risks associated with health service delivery in South Sudan. DFID rates the HPF overall as having medium to high risk. The DFID Business Case (Attachment C) outlines each risk to the HPF's success, the probability and impact of each, along with the mitigation measures to be taken.

There are three risks to which Australia will pay particular attention through implementation (see '*Australia's role in implementation'* section below), including through monitoring the HPF's mitigation strategies:

1. There is a significant risk that the security and humanitarian situation in South Sudan could deteriorate severely. Armed conflict and rebellion, heightened tension with Sudan, food shortages and civil discord are all possible scenarios. Among the many problems such

deterioration would present, it would distract many of the NGOs engaged to deliver services under the HPF as they sought to respond to humanitarian need.

2. There is also a significant risk that the GRSS bureaucracy will fail to, or lack the capacity to, fruitfully engage in the capacity-building elements of the program. This could result from lack of budget or staff resources, or from lack of political and personal will. Similarly, there is the risk that the capacity-building elements will be de-prioritised as other more urgent issues and emergencies arise (for example, if a shortage of pharmaceuticals emerges, funds and attention may be diverted from capacity-building activities to address that problem).

3. As a contributing donor without a permanent presence in South Sudan, AusAID faces the additional risk that our lack of physical presence constrains our ability to achieve our partnership and profile objectives. The Australian Government is the only contributing donor to the HPF to have no presence in Juba; all others have multi-person Posts.

5.0 Australia's role in implementation

Australia's proposed contribution to the HPF will be through delegated cooperation with DFID. The HPF will contract a central Fund Management Agent who will report to DFID but be accountable to the HPF Oversight Committee chaired by GRSS with donor participation. The Fund Management Agent will sub-contract service delivery agents (NGOs) at county level, and they will work together to ensure that a minimum package of services is delivered in all counties of the six states, and to build government capacity at the county, state and national levels.

DFID will lead the implementation of the program, with AusAID and the other donors playing a hands-off role, engaging in support of DFID at key points in the life of the program. These points may include, but are not limited to, participation in recruitment of the Fund Management Agent, the Strategic Oversight Committee, Quarterly Implementation Progress Meetings and monitoring and evaluation exercises. AusAID will particularly focus on four areas in its engagement with DFID and the HPF:

1. AusAID will actively engage in the dialogue with DFID and HPF donors to help determine the optimal point to transition to the next phase of HPF implementation. This will be informed by AusAID's lessons and expertise on fragile states engagement. This will be achieved by carefully tracking the humanitarian and security situation in South Sudan, maintaining dialogue with the NGO partners, undertaking analysis of the success and failure of the HPF in facilitating that transition, and providing advice accordingly. This focus seeks to mitigate the first risk outlined above.

2. AusAID will also work to ensure that the capacity-building activities planned under the HPF are not neglected, once the enabling environment and the GRSS' fiscal situation permits, and will seek to optimise opportunities to pursue capacity-building. This will be achieved by developing a strong understanding of capacity-building needs and maintaining dialogue with government authorities, especially the beneficiaries of the capacity-building work. This focus seeks to mitigate the second risk outlined above.

3. AusAID will mitigate the risk that our lack of physical presence constrains our ability to achieve our partnership and profile objectives through regular monthly travel to Juba, and through sustained engagement with the GRSS, DFID and the other contributing donors, including participation in quarterly meetings with GRSS.

4. Finally, AusAID will strengthen its knowledge of the political economy and drivers of conflict in South Sudan – both in-house and by contracting external expertise – to inform our input to the HPF. This analytical input will complement the strengths of AusAID's donor partners who have brought in strong sectoral advisory teams but at times lack detailed knowledge of South Sudanese history, ethnicity and political fractures.

AusAID will participate in program governance through representation at the Quarterly HPF Implementation Progress Meetings and at the HPF Oversight Committee (likely on a rotating basis). AusAID will also participate in annual reviews and the mid-term review of the HPF. In its engagement in these forums, AusAID will focus on the risks outlined above, and will draw on the experience and reporting of its humanitarian and NGO partners throughout the country.

PART B: CONTEXT AND DETAIL

6.0 South Sudan health context

South Sudan is one of the poorest countries in the world, with half the population (50.6%) living on less than US$1 per day[3], and most in rural areas (92.5%)[4]. Emerging from decades of conflict which eroded physical and social infrastructure and caused the death and displacement of millions of people, the country faces significant statebuilding and peacebuilding challenges. While donor engagement is scaling up rapidly, South Sudan remains one of the most challenging and fragile conflict settings in which AusAID is engaged. The country's health needs are immense. An almost non-existent health system has been further weakened by war with severe shortages of health workers and functional facilities.

The GRSS' Health Policy – articulated through its *Health Sector Development Plan (HSDP) 2012-16* – emphasises primary health care and the provision of equitable and free, high-quality health services as the cornerstone of health system development. The HSDP's objectives are to:

1. increase the utilisation and quality of health services, especially maternal and child health;
2. scale up health promotion and protection interventions so as to empower communities to take charge of their health; and
3. strengthen institutional functioning including governance and health system effectiveness, efficiency and equity.

Health service delivery in South Sudan is structured along four tiers: primary health care units (PHCUs) , primary health care centres (PHCCs), County hospitals and State hospitals / teaching hospitals. At the national level, the Ministry of Health (MoH) seeks to provide overall strategic direction for health care, but also performs some service delivery functions – as well as managing the three teaching hospitals. State MoHs and County health departments are responsible for delivery of secondary and primary health care services respectively. But the reality is that about 70 per cent of functional health facilities are reliant on NGOs for operational support (there are around 800 PHCUs and PHCCs operated by NGOs[5]).

6.1 Overall health status of the population

South Sudan's population (estimated at 8,260,490 million[6]) has some of the worst health status indicators in the world, with preventable, vector-borne diseases being the most important causes of morbidity and mortality - as shown in Figure 1[7]. South Sudan experiences regular outbreaks of communicable diseases such as measles, Kala-azar, meningitis, cholera, cutaneous anthrax and malaria. Malaria is endemic across almost all of South Sudan, accounting for almost a quarter (24.7%) of all diagnoses reported by health facilities.

Only 44% of the population live within a 5 km radius of a functional health facility[8], which in turn have low user rates (estimated at 0.2 contacts per person per year). Major challenges to delivering services include low government capacity, lack of qualified staff, inadequate infrastructure, dysfunctional referral systems, and cultural and financial barriers. Since the signing of the CPA and the establishment of the MoH, donors have been working with the GRSS to slowly rebuild the health system.

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[3] *GRSS Health Sector Development Plan 2012-16,* p. 5
[4] DFID Business Case – April 2012, p. 1
[5] *GRSS Health Sector Development Plan 2012-16*, p. 9
[6] 2008 Census, Southern Sudan Centre for Statistics & Evaluation
[7] UNICEF OLS Database 2005-07, cited in *GoSS Health Strategic Plan 2011-15*, p. 12
[8] Health Facility Mapping 2011

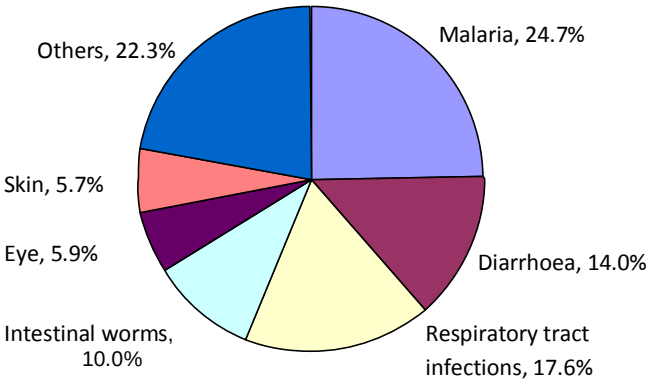

Figure 1. Major causes of morbidity in all age groups seen at health facilities

6.2 Maternal health

With the highest rate of maternal mortality in the world, at 2,054 per 100,000 live births[9], South Sudan is significantly off-track in achieving Millennium Development Goal (MDG) 5 on reducing maternal mortality. Table 1 shows the comparison with average sub-Saharan Africa maternal and child health rates. Teenage pregnancy is common, with 40.8% of girls married before their 18th birthday. Around 88 per cent of deliveries take place at home, either under the supervision of traditional birth attendants or village midwives. Fewer than 15 per cent of deliveries are attended by a skilled worker. There is estimated to be only two nurses/midwives for every 100,000 citizens[10].

Basic emergency obstetric and neonatal care (BEmONC) is not yet available in many parts of the country. Where facilities do exist they lack equipment, supplies and staff with appropriate skills. Referral systems are dysfunctional. Almost all hospitals face a range of difficulties in providing good quality comprehensive emergency obstetric and neonatal care (CEmONC).[11] The caesarean section rate is only 0.5%[12] giving an indication of access to CEmONC which is currently only available in three urban centres. In addition to contributing to poor health outcomes, this situation also discourages women from attending health facilities.

Table 1. Comparison of key indicators for South Sudan and Sub-Saharan Africa[13]

	South Sudan	***Sub-Saharan Africa***
Maternal mortality ratio	2,054 per 100,000	900 per 100,000[14]
% of deliveries with skilled birth attendant	10.0%	46%[15]
Contraceptive prevalence rate	3.5%	22%[16]
Total fertility rate	6.7	5.1
Infant mortality rate	102 per 1,000	86 per 1,000[17]

[9] 2006 Sudan Household Health Survey
[10] HSDP, p. 11
[11] *Report on the Situational Analysis of RH and ASRH in South Sudan* (2007) and *Report on Strengthening Hospital Management in South Sudan* (2010)
[12] Ibid (2010)
[13] Table taken from UK DSID Business Case April 2012, p. 5
[14] UNSD 2005
[15] UNSD 2008
[16] UNSD 2007

6.3 Child health

South Sudan has very high child morbidity and mortality,[18] with malaria, diarrhoea and respiratory tract infections (mainly pneumonia) the most common causes. Child mortality (106 per 1,000 live births) is significantly higher than that for sub-Saharan Africa as a whole (86/1,000). The Infant Mortality Rate (IMR) is 102 per 1,000 live births and under-five mortality rate is 135 per 1,000 live births[19]. In addition, child malnutrition is endemic. The 2006 Sudan Household Survey found that 32.9 per cent of under-fives were underweight, of which 7.3 per cent were severely wasted. The high child morbidity and mortality rates in South Sudan are to a large extent due to failure to reach children with known cost-effective life-saving interventions. According to the 2006 Survey, only 12 per cent of households had at least one insecticide-treated net, and only 17.03 per cent of under-fives were fully immunized.

7.0 South Sudan political context

7.1 GRSS austerity measures

In February 2012 the GRSS announced significant austerity measures following the collapse of negotiations with Sudan over oil revenues and resultant cessation of oil extraction. The GRSS' operating and capital expenditure will be cut by an average of 50%. The Ministry of Finance and Economic Planning (MoFEP) has announced that cuts will be more moderate in certain vital areas, including health.[20] With negotiations with Sudan on oil revenue making little progress, it is considered possible that the GRSS' financial resources may be depleted as soon as August 2012.[21] Given that the GRSS will be unable to sustain even current spending on health – in the absence of an agreement on oil revenue – the international community will be required to continue to finance the delivery of many health services to prevent a breakdown in the nascent health system and to provide continuity of services.

The current financial crisis in South Sudan does not undermine the case for intervention in the health sector (indeed, it strengthens it), but it does mean that the immediate objective of the HPF will be to sustain services, not to transition to government-led health delivery. DFID's design of the HPF has therefore been revised from a five-year program which would seek to transition to use of government systems in Years 4 and 5, to a three-year program with a reduced focus on capacity-building. Technical assistance to build government capacity will remain a component of the overall program, with that phase to be implemented when the GRSS enabling environment permits.

7.2 A fragile context – and the New Deal

South Sudan is one of the most challenging examples of a fragile, conflict setting in which AusAID is currently engaged. AusAID has an opportunity to demonstrate its global credentials in addressing issues of fragility through its growing assistance program in South Sudan.[22] The design of the HPF is consistent with, and has been heavily informed by, the OECD DAC's Principles for Good International Engagement in Fragile States and Situations.

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[17] UNSD Statistical Annex, Infant mortality rate for 2008
[18] 2006 South Sudan Household Survey
[19] *GRSS Health Sector Development Plan 2012-16*, p. 5
[20] The GRSS Austerity Committee has determined that budget cuts to 'priority areas' would be: defence 10%; organised forces 10%; health, education and agriculture 20% (MoFEP launch of 2012-13 Planning and Budget Process, 1 March 2012)
[21] DFID Business Case April 2012, p. 4
[22] In December 2011 AusAID published a *Framework for working in fragile and conflict-affected states*, which provides guidance for staff to continue to improve aid delivery in these challenging contexts.

OECD DAC's Principles for Good International Engagement in Fragile States and Situations

The OECD DAC Principles, which were formally adopted by OECD Ministers in April 2007, highlight the following agreed principles-based approaches in fragile states:

1. Understanding context is the starting point for effective international engagement
2. International interventions need to ensure that they 'do no harm'
3. Statebuilding should be the primary objective of international support
4. Prevention of violence and fragility should be prioritised
5. The links between political, security and development objectives need to be recognised
6. Non-discrimination should be promoted as a basis of inclusive and stable societies
7. Aligning with local priorities can be done in different ways in different contexts
8. Practical coordination mechanisms for international actors need to be agreed upon
9. There is a need to act fast but stay engaged for a long time
10. Internationally, there is a need to avoid pockets of exclusion

South Sudan is one of eight self-selected pilot countries for implementation of the 'New Deal for engagement in fragile states' – an initiative of the g7+ grouping of fragile and conflict-affected states (of which South Sudan is an active member). The New Deal was endorsed by 35 countries and agencies (including Australia and all other donors to South Sudan) at the Busan High-Level Forum on Aid Effectiveness in 2011.

The New Deal proposes that partners use Peacebuilding and Statebuilding Goals (PSGs) - see below - as the basis for working in fragile and conflict-affected states. To achieve the PSGs, members of the g7+ and donors have committed to focus on new ways to engage in fragile states and to build mutual trust by providing aid and managing resources more effectively. In taking forward the pilot of the New Deal, the g7+ is developing a 'fragility spectrum' and identifying indicators to measure fragility. It is proposed this will lead to the development of a Compact between the GRSS and donors, which will outline the specific responsibilities of each towards the achievement of the PSGs. The UK is taking a lead role in supporting South Sudan's implementation of the New Deal. The GRSS hopes to use a High-Level Partnership (pledging) Conference in South Africa in June 2012 to launch this Compact.

New Deal – Peacebuilding and Statebuilding Goals

- **Legitimate politics** – Foster inclusive political settlement and conflict resolution
- **Security –** Establish and strengthen people's security
- **Justice –** Address injustices and increase people's access to justice
- **Economic foundations –** Generate employment and improve livelihoods
- **Revenues and services –** Manage revenue and build capacity for accountable and fair service delivery

Australia has been an active supporter of both the g7+ mechanism and the development of the PSGs. South Sudan's pilot provides an opportunity for AusAID to support operationalisation of the New Deal in one of our priority countries for aid engagement in Africa. Our participation in the HPF Oversight Committee, regular HPF donor forums and GRSS consultations will enable us to help ensure donors jointly focus program assistance in a direction consistent with the PSGs.

8.0 Health Pooled Fund

DFID's revised Business Case (Attachment C) for the HPF - reflecting their revision of its parameters following the announcement of GRSS austerity measure, and on which this DSID is based - was approved by the UK Secretary of State in May 2012.

The HPF will support delivery of GRSS' *Health Sector Development Plan (HSDP) 2012-16* (see Attachment F) to improve health outcomes in the six of South Sudan's 10 states, through full coverage of basic health services, health systems strengthening and capacity-building. The HPF is the GRSS's preferred mechanism for donor support to primary health care delivery as a means to minimise the coordination and reporting burden on the government given their significant capacity constraints and nascent donor coordination structures.

The HPF's aim of improving the coverage and quality of health services (focusing particularly on maternal and child health) will be achieved through the expansion of coverage of health services at county level. In addition, work on improving community governance will lead to increased government accountability and responsiveness to the health needs of women, men and children. Service delivery will be focused on the full suite of primary health care, but a key emphasis will be on improving maternal and child health outcomes. Malaria – a significant part of South Sudan's disease burden – will be addressed through a range of high-impact interventions. Complementary support for malaria is currently also being provided in South Sudan from the Global Fund to Fight Tuberculosis and Malaria (GFATM), through USAID funding (to WHO) and through CIDA programs.[23]

To ensure resilience in the context of South Sudan's fluid security and political environment, the revised HPF program will comprise **three phases**:

Phase 1: focus on sustaining essential health services in the absence of government resources

Phase 2: transition phase focusing on health system strengthening activities, with substantially enhanced government capacity-building and transfer of responsibility for health staff from NGOs to government

Phase 3: focus on strengthening public financial management for the transfer of health worker salaries from NGO to government payrolls

While Phase 1 will be ongoing, the start of phases 2 and 3 will depend on government revenues and government capacity to absorb technical assistance to strengthen the health system. AusAID will engage with HPF partners to ensure that the decision to transition between phases is closely informed by ongoing assessment of the state of the political economy, absorptive capacity of the GRSS, and the security environment.

Over three years, the HPF is expected to produce the following **results:**

- 31,200 women deliver in a health facility with a skilled birth attendant
- 135,200 children receive three doses of DTP3 (diphtheria, tetanus and pertussis)
- 48,000 pregnant women receive at least two doses of intermittent presumptive treatment of malaria as part of their antenatal care
- 24,000 additional people start a family planning method
- 560,000 children under five are seen for a curative consultation
- 48,000 women have at least four antenatal visits
- 9,600 pregnant women receive testing for HIV
- 15 county hospitals will perform C-sections

[23] DFID Business Case, p. 6.

The HPF is one of **three mechanisms endorsed by the GRSS to support primary health care** – particularly for women and children – in South Sudan. It was originally envisaged to be a national mechanism, however the World Bank and USAID indicated that pooled funding is challenging for them (for legal and procedural reasons). The GRSS therefore agreed to a division of labour for three programs to operate across South Sudan's 10 states (see Figure 2), using one common approach and common progress indicators.

1. The **HPF** will cover six states: Eastern Equatoria, Western Bahr el Ghazal, Northern Bahr el Ghazal, Warrap, Lakes and Unity
2. **USAID** plans to roll out a similar program in two states: Central Equatoria and Western Equatoria. (USAID is the largest donor in South Sudan, with extensive experience in health programming.)
3. The **World Bank** plans to lead primary health care delivery in the remaining two states: Jonglei and Upper Nile (both experiencing increasing insecurity). The Bank will build on its experience as administrator of the Multi-Donor Trust Fund, which focused on both states.

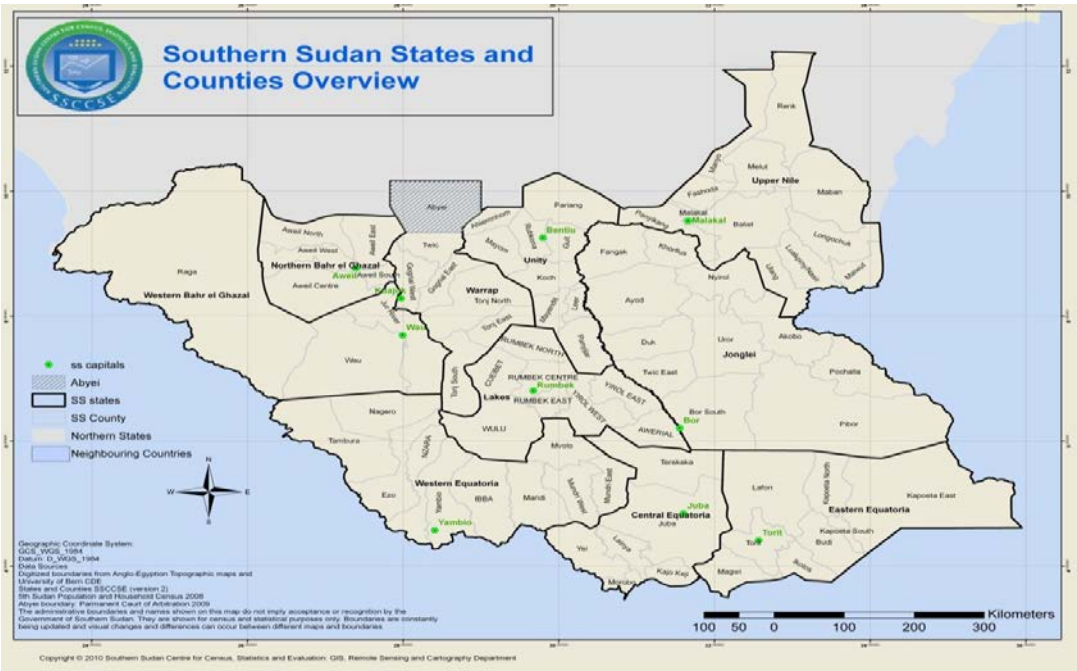

Figure 2. South Sudan states and counties[24]

The HPF has been designed to reflect and incorporate **lessons learned** from the previous funding mechanisms, in particular the Basic Services Fund (BSF) and the Sudan Health Transformation Project 2 (SHTP 2)[25]. These mechanisms funded NGOs to deliver health services at individual facility level. This approach has been successful in providing health care during a humanitarian response. However, this model of funding has not facilitated development of government capacity and has had limited impact on maternal mortality which requires stronger referral systems and access to comprehensive emergency obstetric and neonatal care. It is critical that donors take steps now to ensure that any funding model for health system strengthening in South Sudan begins to lay the foundation for a viable transition of health services from NGOs to the Government.

[24] South Sudan Centre for Census, Statistics & Evaluation 2010

[25] The BSF – to date the largest donor of basic health services - is managed by DFID, and the SHTP2 by USAID; both these funds, along with the World Bank-managed Multi-Donor Trust Fund, are due to end in December 2012. The BSF sub-contracts NGOs to support 186 government health facilities, serving an estimated 1.7 million people across 35 of the 79 counties.

The Theory of Change[26] underpinning the design of HPF is based on the following assumptions:

1. Strengthening health systems improves access to and quality of health services which leads to improved health outcomes and saves lives.
2. Improved community governance will lead to increased government accountability and responsiveness to citizen's health needs.
3. Harmonisation of salaries and building GRSS capacity to manage payroll will give GRSS responsibility for health staff and promote planning on health worker needs.

The Theory of Change focuses on the delivery of essential health services. It is commonly accepted that improved access to good quality health services (including removal of financial, social and cultural barriers to access) has major impacts on health outcomes, which in turn helps reduce poverty. In particular, the maternal mortality rate will not drop if more women do not have access to skilled birth attendants and emergency obstetric care.

The HPF will focus on the drivers of health-seeking behaviour and supporting the demand for health services. DFID notes in its Business Case[27] that the HPF will work with communities to support demand, including by working with pregnant women and traditional birth attendants to encourage women to attend antenatal clinics and to come to facilities for delivery by skilled attendants. Additionally, the HPF will work to establish community committees that can engage and participate in defining their health needs and services.

Australia's contribution to the HPF enables AusAID to demonstrate the extent to which we are applying lessons learned from our engagement in other fragile and conflict-affected states. These include a recognition that while it is critical to begin building the capacity of the government to eventually manage health service delivery, statebuilding in post-conflict states is a long-term undertaking. In the interim, through our contribution to the HPF we will focus on maintain continuity of current service delivery, while focusing on expanding access and improving the quality of health care.

In proposing to contribute to the HPF, AusAID is also drawing on DFID's own lessons learned from its management of pooled health funds, particularly in fragile and conflict-affected settings in Africa. DFID's experience with the health pooled fund in Liberia has shown that working with country systems, investing in institutional capacity-building and supporting country leadership can result in stronger health systems, increased country ownership and more effective aid, according to DAC criteria for aid effectiveness.[28]

In evaluating other potential options[29] for supporting health in South Sudan, DFID have determined that the proposed HPF mechanism will deliver the best **value for money** in achieving direct health service delivery outputs and outcomes. It is also designed to deliver benefits in terms of building effective Government health systems, should circumstances allow. DFID's cost-benefit analysis found that the HPF not only represents excellent value for money, but that it is the optimal mechanism for the South Sudan context: it is designed to be resilient, flexible (three-phased approach) and to deliver strong benefits in institutional capacity-building.

[26] A diagrammatic representation of the Theory of Change, and more detail around the assumptions underpinning this, is found on pp. 48-51 of the DFID Business Case.
[27] P. 13
[28] Hughes, Glassman, Gwenigale, 'Innovative financing in early recovery: The Liberia Health Pooled Fund', The Center for Global Development, Washington, 2012
[29] Pages 13-21 of the DFID Business Case outlines the alternative options explored.

8.1 Alignment with GRSS priorities

The HPF's focus on maternal, neonatal and child health reflects the top priority these issues are accorded in the Government's HSDP, particularly the ambitious goal for reducing maternal mortality (by 20% in three years). The HSDP also outlines the GRSS' policy in terms of roles and responsibilities for health service delivery, with a strong message for donors to begin channelling support through government systems. The HPF is a direct response to this request, as it aims to strengthen government systems and transition donor funding towards sector-based, government-led support – when circumstances are appropriate.

The revised design[30] of the HPF (post-austerity measures) reflects a more realistic timeframe for that transition, with the emphasis of the now three-year HPF more firmly on building the foundations of basic service delivery across the six states, and building capacity of government at a pace at which it can be absorbed by the MoH in future years. Nevertheless, the HPF design remains closely aligned with the HSDP: the MoH has been heavily involved in the Fund's design and progress, and all interventions by non-state actors will be in support of MoH structures and co-branded with the MoH.

GRSS contribution

It is extremely difficult to estimate what the GRSS' contribution will be to the HPF given the current financial uncertainties in South Sudan; DFID has reflected these uncertainties into their revised Business Case. AusAID will remain closely engaged with DFID as the current oil revenue crisis continues to play out.

Prior to the GRSS' announcement of austerity measures, the GRSS had agreed to several key contributions to support HPF implementation, including procuring and supplying pharmaceuticals; at the current time this is unlikely and DFID and USAID are leading the development of an emergency drug fund for drug procurement and distribution. In addition, it is expected that GRSS will continue payment of full salaries for staff already on the MoH payroll, whilst recognising the risks of this assumption, and to continue work on commitments for health resource planning. DFID has reflected these factors into their value-for-money assessment. However, even in the scenario where MoH has more limited resources, donors expect that the GRSS will show commitment to public financial management and payroll strengthening efforts so that eventually health staff can be moved onto MoH payrolls.

8.2 How the HPF will operate

The HPF will contract a central Fund Manager who will report to DFID but be accountable to the HPF Oversight Committee chaired by MoFEP, with MoH and donor representation. The Fund Manager will sub-contract service delivery agents at county level. This will include provision of support to County health departments to build their capacity to assess, plan and monitor health. Technical assistance will also be provided, at an appropriate phase in the HPF's implementation, at Central and State Ministry levels to build financial and management capacity and to strengthen government public financial management systems. In addition, support will be provided to 15 County hospitals to build capacity for the management of emergency obstetric and neonatal care and to strengthen referral systems.

[30] April 2012 version – Attachment C

8.3 Proposed Australian contribution

Donors who have committed to contribute to the HPF include UK (DFID), Sweden (SIDA), Canada (CIDA), the European Union (EU) and Australia (AusAID). It is proposed that AusAID will make a financial contribution, through delegated cooperation, to the HPF of **$35 million over three years** (2011-12 to 2013-14)[31]:

- 2011-12: $6 million
- 2012-13 $12 million
- 2013-14: $17 million

This contribution of 18.4% would position us as the third-ranking contributor to the HPF (after the UK and EU), and is of sufficient scale to enable us to achieve influence as a committed health sector donor and engaged HPF partner. Table 2 below indicates all donors' proposed contributions to the HPF and the status of the commitment.

Donor	Proposed contribution (£)	Status of commitment
DFID	56 m[32]	Committed – Ministerial Submission pending
European Union	25.67 m (34.443 m over 5 years with 25 m earmarked for county hospitals)	Committed – but negotiating details regarding Fund Manager and nature of delegated cooperation
AusAID	22.644 m over three years	Committed – pending internal Quality processes and FMA Reg 9 approval
CIDA	12 m over three years	Committed – Ministerial Submission pending
SIDA	5.7 m	Committed
TOTAL	**123 m**	

Table 2. Proposed donor commitments to HPF

8.4 Expected results from AusAID contribution

AusAID's contribution to the HPF would represent 18.4% of all funds. Table 3 below shows examples of results which would be able to be attributed to AusAID on the basis of that contribution level.

Beneficiaries	Overall results[33] (Over 3 years)	AusAID imputed result (18.4% contribution)
Children receive three doses of DTP3 (diphtheria, tetanus and pertussis)	135,200	24,890
Children under five are seen for a curative consultation	560,000	103,095
Children 6-59 months provided with Vitamin A supplementation twice per year	240,000	44,183
Women have at least four antenatal visits	48,000	8,837
Pregnant women receive at least two doses of intermittent presumptive treatment of malaria as part of their antenatal care	48,000	8,837
Women delivery in a health facility with a skilled birth attendant	31,200	5,744
Additional people start a family planning method	24,000	4,418
Pregnant women receive testing for HIV	9,600	1,767
County hospitals will perform C-sections	15	3

Table 3. Expected results from AusAID contribution

[31] Funding will be drawn from the Africa Maternal and Child Health Program Fund and the broader Africa Program fund.

[32] The UK's proposed funding covers 3.5 years: mid-2012 to January 2016. DFID expect that the HPF will be extended for at least two years after the initial intervention, with additional DFID funding of £26m (and at least £39m to be sought from other donors).

[33] Figures provided by DFID's Business Case Logframe

8.5 Partnering with DFID

Collaboration between donors, particularly through a pooled funding mechanism, aligns with the harmonisation and coordination principles of the Paris Declaration and the Accra Agenda for Action. By coordinating our efforts with DFID in South Sudan, AusAID is observing best practice development principles (especially those relevant to fragile and conflict-affected states) by avoiding overcrowding the donor base and working with the GRSS to implement their own development priorities to maximise health system outcomes.

The UK has been a key player in the history of South Sudan, and South Sudan is a priority country for DFID**.** The UK was heavily involved in the negotiations that led to the CPA in 2005 and has strongly supported its implementation. In addition, the UK is the second largest bilateral donor in South Sudan after the US.

DFID also has a track record in South Sudan as an experienced trustee of a successful pooled fund. The Basic Services Fund (BSF) is often cited[34] as one of the most effective pooled funds in South Sudan. This experience positions DFID well to work with GRSS and other donors to lead a harmonised, transitional, multi-donor fund for health system development in South Sudan. DFID's staffing capacity in the health sector is planned to be greater than all other bilateral donors apart from the US. DFID established a full country office in South Sudan in 2011, which is being further strengthened in 2012, including through additional health expertise.

DFID has allocated approximately AUD143 million annually for programming in South Sudan until 2015, with a focus on health, education, governance (accountability) and security sector reform. Within this budget, approximately AUD31 million annually is dedicated to health programming, with a focus on maternal, neonatal and child health. The HPF will be the primary component of DFID's health portfolio.

DFID is a logical partner for AusAID as we seek to position ourselves as a health sector donor in South Sudan. The partnership will allow AusAID to extend the reach of our aid program in South Sudan meaningfully, progress our own development objectives and support GRSS' stated maternal and child health goals. Their leadership in the development of the HPF – and previously the BSF – has provided an important foundation for likeminded donors to begin supporting the transition from non-state service delivery in South Sudan to government service delivery.

DFID is a strong, likeminded donor partner with which AusAID maintains a high level of cooperation, at both policy and program levels. Joint activities globally between AusAID and DFID total approximately $1 billion (based on contributions from both agencies). AusAID maintains delegated cooperation arrangements with DFID in Kenya, Zimbabwe, Pakistan, Nepal and Bangladesh. This proposed cooperation in South Sudan will further strengthen AusAID's strategic relationship with DFID.

DFID has undergone regular and comprehensive reviews of its effectiveness, including the following:

- DFID's 2011 Multilateral and Bilateral review (findings including the establishment of the Independent Commission for Aid (ICAC)
- Capability Review of DFID - January 2009
- OECD DAC Mid-Term Review - 2008
- Capability Review of DFID - May 2007
- OECD DAC Peer Review of the UK - 2006

[34] For example, a September 2011 joint briefing paper by 38 aid agencies operating in South Sudan referenced the Basic Services Fund (BSF) as working 'exceptionally well' with strong management and monitoring. The 2010 Multi-Donor Evaluation of Support to Conflict Prevention and Peacebuilding in South Sudan also described the BSF as 'significantly ahead of other pooled funds' in efficiency.

The DAC Peer Review (and Mid-Term Review) confirmed DFID as a model for development cooperation, and other major donors, such as the US, regard DFID as a model to inform their aid reforms.

Delegated cooperation

Under the Nordic Plus arrangements, AusAID is not required to conduct a donor assessment of DFID in order to establish delegated cooperation agreements. Nevertheless, DFID advises that their audited accounts (see link in footnote below[35]) – which they provide in their Annual Report to Parliament – constitute a self-assessment which may be useful for AusAID's purposes. The accounts include spending against Parliamentary Estimates, and a statement of DFID's assets and liabilities. They also show how DFID has used its resources to meet development objectives.

Additionally, to comply with AusAID's Guideline on entering into delegated cooperation arrangements further, the following steps have been taken to ensure AusAID has good knowledge of DFID's key policies, procedures, risk management strategy and financial management requirements:

- regular and extensive consultation with DFID over more than a year in South Sudan on development of the HPF and all aspects of mobilisation of the Fund
- consultation with AusAID Bilateral Partnerships section
- discussion with other Africa program areas (Food Security and Zimbabwe) on their approach to, and experience with, delegated cooperation

AusAID has a Partnership Agreement with DFID outlining principles of engagement, of which delegated partnerships feature. Delegated cooperation between AusAID and DFID is also provided for under the *Alliance for Reproductive, Maternal and Child Health* – which currently includes a focus on five countries in Africa (Ethiopia, Kenya, Nigeria, Tanzania and Uganda)[36].

9.0 Governance and implementation arrangements

DFID will act as a trustee on behalf of HPF donors and, due to the size of the Fund, will engage a **Fund Manager** (which could be a single agent or a consortium of agents)[37]. DFID will reimburse the Fund Manager for funds disbursed for county contracts, technical assistance, state-level capacity-building, and will also pay the Fund Manager a management fee (at market rates).

The Fund Manager will competitively contract **NGOs** to deliver services at county level. (Australian NGOs will be eligible to bid for funding in what will be a direct international competitive tender using procedures from the Official Journal of the European Union.) NGOs can bid for more than one county, in which case a single contract would be offered to the NGO. NGOs will be assessed on performance in achieving health outcomes at county level. In addition, NGOs will be expected to share capital resource and train County health departments to oversee, monitor and manage projects. NGOs will also be asked to work with communities to strengthen and develop community governance mechanisms for health.

[35] www.dfid.gov.uk/About-us/How-we-measure-progress/Annual-report/

[36] The Alliance is a global partnership between DFID, AusAID, USAID and the Gates Foundation, with selected high-need countries, to accelerate progress in reducing maternal and neonatal mortality. Additional countries will be added to the Alliance's focus in coming years.

[37] Before the Fund Manager is appointed, DFID will contract consultants (through a competitive tendering process) to undertake more design work on certain components of the HPF (such as the community engagement work and harmonisation of salaries – in particular the role of rural incentives).

Fund Managers will be accountable to DFID and the HPF donors and the oversight and state-level committees, all of which will have GRSS membership. The Fund Manager will also be responsible for disbursing funds, carrying out monitoring and evaluation, and will provide secretariat and technical services to the **Oversight Committee**.

The Oversight Committee will provide strategic direction to the HPF, and will be chaired by the GRSS MoFEP. Other members will include contributing donors (likely on a rotating basis), MoH respresentatives, state MoHs and NGOs. State Oversight Committees will also be established in the six states where the HPF will operate, chaired by the respective state MoFEP representative/s and including representation from the respective state Ministry of Health and NGOs. The State Committees will oversee the county-level activities of NGOs delivering health services, as well as the Fund Manager's technical assistance to the states and counties. Information from the six State Committees will be fed up to the Oversight Committee to inform overall decisions.

It is important that the new mechanism has good government ownership and that the MoH are given the opportunity to steer and own the Fund. DFID has experienced challenges in this respect under the BSF, with the MoH being critical that it lacked control over the Fund. While DFID is currently not able to offer GRSS this level of control due to fiduciary and governance risks, DFID and HPF donors will continue to work closely with MoH to improve ownership of the HPF.

9.1 Performance management of the Fund Manager

DFID will negotiate a performance-based contract with the Fund Manager. Performance will be measured by the number of counties reaching their annual key health indicator targets, progress made on the payroll/financial management indicator set (used to monitor conditional transfer support) and progress made on capacity-building of the MoH (at State MoH and GRSS MoH levels) as outlined in a pre-agreed indicator set with targets. The Fund Manager will report on targets according to gender, age and ethnic group where possible. The contract will outline how poor performance will be managed.

9.2 AusAID engagement and profile

AusAID's lack of presence in South Sudan necessitates a delegated cooperation arrangement with DFID in order to contribute to the HPF. It is proposed that this cooperation not be 'silent' but that AusAID maintains a modest role in oversight and governance of the HPF's implementation, and seeks opportunities to contribute to its ongoing management where capacity permits. Therefore, to maximise Australian Government profile and influence – and ensure the HPF rollout remains firmly aligned with the agreed strategic direction – AusAID will participate in the following governance and implementation mechanisms:

- HPF Oversight Committee: AusAID will sit on the Oversight Committee (to be chaired by MoFEP and with representation from MoH, DFID, donors, state MoH and NGOs), possibly on a rotating basis

- Quarterly HPF Implementation Progress meetings: AusAID will be represented at these meetings of all HPF-contributing donors

- Regular South Sudan Health Partners meetings: where possible (such as at key milestones or when meetings coincide with AusAID Nairobi Post visits to Juba), AusAID will participate in regular health donor meetings, which may also provide an opportunity to engage with GRSS MoH on broader progress on health sector development

DFID have confirmed that all HPF documentation and public events / messaging will be co-branded with all contributing HPF donors' logos – ensuring the Australian Government contribution achieves

the profile we anticipate. AusAID will be invited to participate in key public events and implementation milestones, to consolidate our reputation to GRSS and the South Sudanese community as an increasingly engaged health sector donor in South Sudan. AusAID will also seek opportunities to participate in joint monitoring missions with HPF-contributing donors.

10.0 Sustainability

Sustainability is the cornerstone of the HPF design, which has been configured to maximise flexibility and adaptability to the evolving fiscal and security environment in South Sudan. The HPF will seek to ensure a continuation of essential primary health care services once the BSF and other existing funding mechanisms ceases operation at the end of the 2012. Once the enabling budgetary environment within GRSS improves, the HPF will then build human resource capacity within the GRSS MoH and so pave the way for transition from NGO service delivery to GRSS ownership and provision of health services.

Nevertheless, achieving sustainability of programs will be a critical challenge in South Sudan given the weak capacity at the national and state MoHs. The HPF has been designed to respond directly to the government's capacity challenges. It has been set up to support service delivery initially over three years. Donors recognise that an even longer-term view (8-10 years) may be necessary to achieve government ownership fully – and this is particularly the case given the recent financial crisis.

11.0 Key cross-cutting issues

11.1 Gender

There are invariably a number of interrelated reasons for South Sudan's very high maternal and child mortality, but key among them are:

- poverty and social exclusion: the poorest women are unlikely to eat well, to seek antenatal care, to be able to purchase dietary supplements or to take time out of their working days to seek health care (assuming they have the financial and logistical capacity to do so)
- lack of access to health provision: women in rural areas are often unable to obtain transport to a health facility. Moreover, most women give birth alone or with the help of a traditional birth attendant or older women who have received little or no training
- lack of community education: a lack of information about safe pregnancy and safe childbirth leads to a failure to recognize danger signals such as the signs of pre-eclampsia, how to recognize a foetus is in distress, or how to deal with late miscarriages

South Sudan's currently limited basic health service provision disproportionately affects women and girls. A 2011 Social Appraisal of the HPF design – AusAID's main contribution to the HPF design – identified several barriers for women to maternal health, including early marriage and lack of decision-making power in the household or in relation to fertility and contraceptive use. The Appraisal found that across South Sudan, with some variation between states, girls and women are subject to endemic, systematic marginalisation, with high levels of gender-based violence.

The Appraisal made a set of recommendations, which have informed the HPF design. These include that HPF grants focus on the health of women and girls (emphasising interventions that will impact

on gender-based inequalities and discrimination). Additionally, it was recommended that HPF make explicit reference to the connections between health and social determinants including poverty, exclusion, fragility, gender equality and youth issues. A 2009 Gender Review of the BSF also provided valuable analysis which has informed the HPF design.

A DFID global priority is to empower girls and women and to improve maternal health and access to family planning[38]. DFID's strategic focus in these areas, and DFID's commitment to gender more broadly through its aid program, provides a strong assurance that gender will be a key consideration in DFID's oversight of the HPF's implementation.

In its analysis of DFID's Business Case, CIDA has highlighted some possible targeted gender interventions which they will seek to followup (including through providing gender specialist expertise) during the first phase of the HPF. These include:

a) the need for sex-disaggregated outputs

b) the need to engage men on the importance of women's reproductive health and the right of women to make decisions in the household/family

c) the need to explore how to prevent and respond to gender-based violence

d) the need to emphasise social accountability and support women's participation in decision-making; and

e) the need to include action-oriented research on issues such as transport solutions to improve women's access to health.

There may be opportunities for AusAID to build on its support for the Social Appraisal and further contribute to CIDA and DFID's focus on further strengthening the consideration of gender during implementation of the Fund.

11.2 Disability

The AusAID-funded Social Appraisal recommended that robust and detailed data be collected during implementation to ensure that HPF-funded provision reaches the most marginalized people (including women with disabilities). In addition to the number of women who die during pregnancy and childbirth, globally another 10-15 million suffer severe or long-lasting illnesses or disabilities caused by complications during delivery[39]. The HPF's emphasis on maternal and child health will focus assistance at all levels of maternal healthcare, increasing the proportion of women delivering in health facilities and with skilled birth attendants, and thereby seeking to reduce the number of labour-induced complications (such as fistula) which lead to disability.

11.3 Child protection

AusAID will seek to ensure the HPF's implementation is carried out in a way which is consistent with AusAID's Child Protection Policy, through participation in HPF donor meetings, ongoing dialogue with contributing donors (but particularly with the UK as lead donor), and through AusAID's own ongoing quality processes for this intervention.

[38] DFID Business Plan 2011, cited in HPF Business Case, p. 10
[39] www.womendeliver.org

11.4 Environment

DFID will remain responsible for assessing environment effects of the HPF, including environmental assessments of all physical works and sub-components of the program, according to DFID Environmental Management Procedures. Environmental risks identified in DFID's Climate and Environment Assessment include the risk of poorly designed water, sanitation and medical waste disposal facilities and potential risks to infrastructure from floods and droughts. Opportunities were also identified to promote sanitation and hygiene, proper medical waste disposal and water supply facilities at health facilities supported through the HPF.

12.0 Monitoring and evaluation

A key focus during the set-up period of the HPF will be the development of a **comprehensive monitoring framework** by the Fund Manager to monitor the county contracts. This will ensure the Fund Manager takes ownership of key performance indicators, targets and baselines from the outset. This will form the basis not only for management of the program by the Fund Manager, but also the performance-based management of the Fund Manager by DFID.

AusAID will seek to input to the development of the M&E Framework, to ensure that optimal information is captured (recognising the constraints on statistics collection and availability of baseline data), and to advocate for the adequate resourcing of M&E during HPF implementation. AusAID will also seek to use its policy dialogue with DFID and other HPF donors to ensure the M&E Framework integrates measures for informing decisions on transitioning between HPF phases, and to ensure that M&E is used to effectively monitor and assess risk.

DFID has indicated its monitoring and evaluation (M&E) will be based on **four principles**:

1. work with the Fund Manager to develop a **monitoring framework** that collects disaggregated data for the program and is in alignment with GoSS plans and systems (that is, that generates information which is used by actors in the health sector to be able to monitor progress, spot problems and adapt to need by providing data that can inform management)

2. work with the Fund Manager, the MoH, USAID and the WB to set standards for monitoring across the counties and **harmonise the monitoring approaches** across the three programs

3. work with the MoH to **build capacity** and strengthen government systems, including the linkages between state, county and facility level

4. explore and develop systems that can use health data (monitor usage of facilities) as an **early warning indicator** for outbreaks and for conflict triggers (for example, to indicate an escalation of violence for early warning, but also to trigger the need to switch to a more humanitarian response).

Data will be obtained through a mix of routine information systems, as well as surveillance instruments such as health facility mapping, and through further national household surveys. Initially, data from the BSF and the SHTP2 will be used to develop **baseline measures** for the six states within which the HPF will operate. This will be triangulated with data from the 2010 Household Survey (HHS 2010), the 2010 Lot Quality Assurance Sampling (LQAS) and from the Health Facility Survey 2011. This baseline data will need to be used by the Fund Manager to agree annual targets with the NGO for each county, in conjunction with the SMoH. Given the fragile context, these will be realistic and achievable and based on progress from the baseline (as measured in the HMIS). Significant failure to deliver on these targets (as identified in the annual joint review of the

county program between the SMoH and Fund Manager) may mean that the NGO's contract will not be continued for the next year.

Data will be disaggregated by sex and age. Data on ethnic group may be collected but DFID and HPF donors will seek to ensure this is done in a conflict-sensitive way. UNFPA (with CIDA support) is currently planning to fund a study on the maternal mortality rate and emergency obstetric care this year; this will provide the HPF with further valuable baseline data.

The HPF will use the MoH Health Management Information System as the basic data set in conjunction with the District Health Information System software for ongoing monitoring of results from NGOs. NGOs will also be required to produce an annual plan for capacity-building of the County health departments (with clear targets) and the annual joint review with the state MoH will monitor achievements.

The Fund Manager will decide **reporting timelines** with the NGOs, CHD and SMoH. The timelines will depend on the type of reporting, but the Fund Manager will be required to both submit **quarterly written reports and conduct annual reviews**. Timelines may need to be modified on a county-by-county basis depending on the context (for example, conflict). In addition, monitoring as part of early warning will need to be more frequent or adapted depending on the context and seasonality (for example, during the dry season there may need to be more intensive monitoring and reporting to take into account outbreaks and cattle-raiding). In addition to quarterly and annual reporting by the Fund Manager, the HPF will be audited, possibly using third-party auditors.

Evaluation will be conducted throughout the program through annual review, an independent mid-term review, and a final evaluation (in line with DFID's standard approach). The mid-term review will provide guidance as to the feasibility of transitioning from NGO to GRSS service delivery after the three-year term of the Fund, or whether an extension of the current approach into years 4 and 5 is required. Contributing HPF donors will be invited to participate in the review.

Evaluations will include an assessment of value-for-money, as well as the non-quantitative / intangible benefits (for example, impact on governance and peacebuilding). In addition, evaluations will examine differences in health outcomes / service delivery between states - possibly looking at triggers which may indicate differentiation in progress. Evaluation against 'impact indicators' will be disaggregated by gender and poverty quintile[40]

Given the scale and importance of the HPF there will also be a focus on learning 'global' lessons, to be shared with the international health community. Key areas of interest, where there is a paucity of international evidence or where we wish to evaluate the approach of the HPF in terms of overall stability and conflict, include:

- strategic conflict assessment: what is the impact of the intervention on relationships among the population- returnees versus host populations
- does the HPF model allow prioritisation of minority groups, noting the complex tribal profile of South Sudan. There is limited information to say whether or not this is an issue
- evaluating different models for improving family planning in rural communities including models that look at usage by men or work with men (noting that family planning use is very low throughout South Sudan). There is limited data on what makes family planning messaging work or what can increase demand for family planning
- examining the performance-based contracting model in a fragile state and whether this leads to better results
- assessing the contribution of service delivery in building state legitimacy (possibly through perception surveys)

[40] See Business Case logframe.

12.1 AusAID quality processes

To ensure the Australian Government's objectives are being achieved through the HPF, AusAID will undertake the following quality processes to maximise the effectiveness of our funding contribution:

- Quality at Implementation Report (QAI)
- Mid-Term Independent Progress Review/Report – to be conducted jointly with DFID
- Quality at Implementation Report – Final (QAI-F)

In line with AusAID guidance on QAI, AusAID will use the engagement with the HPF as an opportunity to initiate a dialogue on performance with DFID, the GRSS, and implementing partners. However, the QAI assessment will be used as an internal process for reporting on AusAID's perspective on progress. The QAI will include assessment of progress against both AusAID's development objectives and partnership/operational objectives.

ATTACHMENT A

Abbreviations

AAMCHI	Australia-Africa Maternal and Child Health Initiative
AMREF	African Medical and Research Foundation
ANGO	Australian non-government organisation
BSF	Basic Services Fund
BEmONC	Basic emergency obstetric and neonatal care
CEmONC	Comprehensive emergency obstetric and neonatal care
CHD	County health department
CPA	Comprehensive Peace Agreement
DAC	Development Assistance Committee (DAC)
DFID	Department for International Development (UK)
DSID	Design Summary and Implementation Document
GAVI	Global Alliance for Vaccines and Immunization
GFATM	Global Fund to Fight Tuberculosis and Malaria
GRSS	Government of the Republic of South Sudan
HSDP	Health Sector Development Plan (2012-16)
IDPs	Internally displaced persons
IMR	Infant Mortality Rate
LQAS	Lot Quality Assurance Sampling
MCH	Maternal and child health
MDGs	Millennium Development Goals
M&E	Monitoring and evaluation
MMR	Maternal Mortality Rate
MoH	Ministry of Health
MoFEP	Ministry of Finance and Economic Planning
MTR	Mid-term Review
NGO	Non-government organisation
ODA	Official development assistance
PSGs	Peacebuilding and Statebuilding Goals
RoS	Republic of Sudan
RoSS	Republic of South Sudan
SIMLESA	Sustainable Intensification of Maize-Legume cropping systems for food security in Eastern and Southern Africa
SMoH	State Ministry of Health
SSDP	South Sudan Development Plan
USAID	US Agency for International Development
WB	World Bank

HPF mobilisation and AusAID engagement plan *(March to November 2012)* **ATTACHMENT B**

Activity	March	April	May	June	July	August	September	October	November
AusAID quality processes									
- **DSID**		X							
- **Independent appraisal**		X							
- **Appraisal Peer Review**			X						
- **Quality at Entry approved**			X						
- **FMA Reg 9 approval**			X						
Exchange of Letters between DFID and AusAID				X					
AusAID fund transfer to DFID HPF third party account				X					
Joint Financing Agreement (between DFID and HPF donors)				X					
DFID recruitment of Fund Manager *(possible AusAID participation in selection)*						X			
Fund Manager develops M&E plan						X			
Inception phase commences: Fund Manager issues NGO calls for proposals							X		
First meeting of Strategic Oversight Committee *(possible AusAID participation pending agreed donor rotation)*								X	
Implementation commences									X