

THE EUROPEAN UNION EMERGENCY TRUST FUND FOR STABILITY AND ADDRESSING THE ROOT CAUSES OF IRREGULAR MIGRATION AND DISPLACED PERSONS IN AFRICA

**Action Fiche for the implementation of the Horn of Africa Window
T05 – EUTF – HoA – SS - 04**

1. IDENTIFICATION

Title/Number	Health Pooled Fund 2 - South Sudan		
Total cost	Total estimated cost: EUR 20 million Total amount drawn from the Trust Fund : EUR 20 million		
Aid method / Method of implementation	<i>Project modality</i> <i>Indirect management through a Delegation Agreement (PAGODA) with the United Kingdom Department for International Development (DFID or otherwise referred to as UK Aid)</i>		
DAC-code	120, 122	Sector:	12110; 12220; 12240; 12250; 12261; 12281;13020;13030

2. RATIONALE AND CONTEXT

2.1. Summary of the action and its objectives

The action (Health Pooled Fund 2 – HPF 2) is based on **objective two within the Trust Fund**, namely strengthening resilience of communities and in particular the most vulnerable, as well as the refugees and displaced people.

The project will contribute to the implementation of the Valletta Action Plan, and in particular its priority domain (1) "Development benefits of migration and addressing root causes of irregular migration and forced displacement".

The geographical coverage of the action will focus on the states of Eastern Equatoria, Western and Northern Bahr el Ghazals, Warrap, Lakes and Unity. Other geographical areas not covered by the HPF, i.e. Upper Nile and Jonglei will be prioritised by other partners such as the United States Agency for International Development (USAID) and the World Bank.

The intervention logic of this action is to support the implementation of the peace agreement, in particular through facilitating reconstruction efforts and the return of internally displaced people (IDPs) and people who fled conflict to neighbouring countries back to their areas of origin. The action will do so by supporting the foundations of 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.

The programme will be articulated in several components, for which Canada, the EU, the UK and Sweden will jointly provide EUR 150 million over 2 years (2016-2018): health services

delivery, family planning, nutrition and the procurement and distribution of essential pharmaceuticals, health systems strengthening, and community engagement to increase ownership, governance and demand of communities for health services.

There will be an increased focus on gender and social inclusion and on conflict sensitivity.

It is expected that the EU and partners' resources, programmed jointly with a common results framework, will have a significant impact on improving maternal, new-born and child health and health system strengthening. Equitable access to quality health services will in turn build the foundations for inclusive economic growth and development and will contribute to lasting peace and stability in the country, including through the return of IDPs from protection sites and camps to their areas of origin or other areas where they enjoy long-term access to basic services.

2.2. Context

2.2.1. Country context

South Sudan is mired in internal conflict since December 2013 and faces a grave man-made humanitarian crisis, the disruption of basic functions of government and a severe monetary and fiscal crisis. The conflict has devastated the lives of millions of South Sudanese and displaced more than 2.2 million people. About 1.6 million of them have been displaced internally in South Sudan and over 600,000 are refugees in neighbouring countries (Ethiopia, Sudan, Uganda and Kenya), putting additional strain on these countries and having a destabilising effect on the entire region. Additionally, South Sudan hosts around 265,000 refugees from neighbouring countries, mainly Sudan. Strengthening country systems and institutions is therefore of prime importance in linking relief, recovery and development to ensure that displaced communities can move out of IDP camps and back to areas where they enjoy long-term access to basic services.

In August 2015, President Kiir signed the peace agreement endorsed in Addis Ababa by other South Sudanese parties. If properly implemented, it will end the fighting and install the transitional institutions essential to the rebuilding of the country. Accountability and transparency, including for public resources and service delivery, will be central to the way forward.

2.2.2. Sector context: policies and challenges

South Sudan has an estimated population of 10,900,000 that is growing at an estimated 3.2% per year, with total fertility rate of 7.1 children per woman. Life expectancy at birth for both sexes in South Sudan is 55 years. 83% of the country's population live in rural areas. The inequality in the access, utilization and quality of health services is a destabilizing factor. Low population density, severe shortages of health workers and functional facilities, socio-economic barriers, inadequate mechanisms to reach pastoralist communities and displaced populations, and the under financing of the health system make universal access to health services difficult.

Despite improvements in some health outcomes, health indicators are still among the worst in the world. Infant and child mortality rates declined from 102 to 84 between 2006 and 2010, but maternal mortality ratio (MMR) remained high at 2,054 per 100,000 live births, making South Sudan the riskiest place for childbirth in the world. The limited service provision in the country disproportionately affects women and girls. Around 88% of deliveries happen in the home with fewer than 15 of every hundred deliveries attended by a skilled worker. Teenage

pregnancy is common with 40.8% of girls married before their 18th birthday. Obstetric and neonatal care, family planning and nutrition are key to address maternal and child mortality.

In 2011, the Minimum Basic Package of Health and Nutrition Services of South Sudan were agreed. The Ministry of Health (MoH) is in the process of finalising a new National Health Policy (2015-2024) which has a vision to 'contribute to reducing maternal and infant mortality and improving the overall health status and quality of life of the South Sudanese population' and a detailed policy on community health care, the New Boma Health Initiative.

The HPF 2 programme will support the implementation of these key sector policies and the results will be aligned to the health outcomes and targets set by the South Sudan Ministry of Health.

2.3. Lessons learnt

Programme redesign has been based on recent reviews/evaluations (HPF Mid Term Review - MTR, November 2014) and an extensive consultation process with key stakeholders in 2015. The HPF 1 has been successful in increasing access to health services as evidenced by the following targets:

- Outpatient consultations (curative and preventive) of under five children increased from 770,000 to 1.9 million (target 1.8 million)
- % of one year olds vaccinated with the third dose of DPT vaccine increased from 11% to 56% (target 50%)
- % of women who attended at least four times for antenatal care during pregnancy increased from 8% to 30% (target 38%)
- % of births attended by skilled health personnel increased from 2.8% to 8.2% (target 15%)
- The number of facilities providing comprehensive and basic emergency obstetric and neonatal care (CEmONC/ BEmONC) increased from 3 CEmONC and 0 BEmONC to all hospitals supported by HPF (8 county, 7 faith based and 4 state hospitals) providing CEmONC, and 34 counties out of 39 providing BEmONC (target all).

On the basis of the achieved progress in some of the indicators, the MTR established that greater emphasis needs to be placed on gender and the social and cultural barriers to utilization of health services, particularly with reference to assisted deliveries. In order to track progress, gender and social inclusion audits will be an explicit requirement of annual HPF reviews. The MTR also noted that family planning was not sufficiently addressed and it will be given greater emphasis in HPF 2 to decrease maternal mortality. The programme will work with the Ministry of Education to reduce underage pregnancies and gender based violence through education and awareness raising. Nutrition will be explicitly included to tackle the increase in malnutrition levels in the country. Due to the unreliability of drugs supply, HPF 2 will include an increased provision of pharmaceuticals.

As part of its support to strengthen comprehensive county health planning, the programme will provide an added emphasis on emergency planning, preparedness and response.

2.4. Complementary actions

The action will be completed by the programming of two additional actions: one specifically aimed at strengthening local institutions in the areas of public financial management and human resources management, and fostering a culture of accountability by lower levels of

government (states and counties); and the other to increase student retention and raise learning outcomes in primary education through improved teachers' training, teachers' management and performance in schools.

The action will continue to maintain synergies with the World Health Organisation (WHO) in the framework of the EU-funded EU/Luxembourg-WHO Universal Health Coverage Partnership Programme specifically for policy dialogue, and with the World Bank Health Rapid Results Project providing service delivery in the geographical areas of Upper Nile and Jonglei. In addition the World Bank is conducting a Public Expenditure Review in health and will be contributing to the establishment of the National Health Accounts. Synergies are also realized with the World Bank Local Governance and Service Delivery Project, which is implemented by the Ministry of Finance and Economic Planning and the Local Government Board, and with United Nations Children's Fund (UNICEF) interventions.

Complementarities will also be realized with the ongoing EU funded education programme Improved Management of Education Delivery (IMED) and the UK Aid funded Girls Education South Sudan (GESS) for the development of health promotion education policies.

The current network of health facilities is geographically limited. A gradual expansion of the existing health network would need to be carried out in parallel with the expansion of health workers training interventions funded by Canada and Sweden through the United Nations Population Fund (UNFPA) programmes.

2.5. Donor co-ordination

Key development partners are the donors of the current HPF 1 programme (UK, Canada, Sweden, Australia and EU), USAID and the World Bank. Donor coordination will continue to be carried at the technical level through a programme steering committee for the action and through an already established donor forum (Health Donors working group) and government-led fora (Health Partners working group and local services support working group on human resources and public financial management). USAID have expressed strong interest in joining the pooled fund. USAID support would bring an extension of the programme to two additional geographical areas (Central and Western Equatorias). The geographic expansion to eight areas from the current six bring the donor support to the health sector to a full geographical coverage of the country.

This indicates an effective coordination and division of labour and it is likely to deliver increased attributable results and the benefits of a more unified health system.

3. DETAILED DESCRIPTION

3.1. Objectives

The **Overall Objective** of the programme is to improve stability and development in the region by supporting the implementation of the peace agreement and future reconstruction efforts, notably by strengthening resilience of communities and the most vulnerable groups, including refugees and displaced people and creating conditions for their return to their areas of origin.

The **Specific Objectives** are: 1) to increase service delivery; 2) to strengthen health systems at State and County level focusing on: policy, human resources for health, health financing including payroll strengthening, health information, leadership and governance; 3) to increase

access to nutrition services particularly for pregnant women young children and other vulnerable groups and 4) to ensure the availability of essential drugs.

3.2. Expected results and main activities

The **expected results** are:

- **Result 1:** Stronger health facilities: service delivery

HPF 2 will continue to provide the Basic Package of Health and Nutrition Services at county level. The basic package for health consists of a number of well proven, cost-effective interventions that address the major burden of disease. The priority interventions in the package are primary health care services for women and young children with a referral to a county hospital for emergency obstetric and neonatal care and technical support to County Health Departments (CHD) and supporting secondary health care, primarily to enhance Reproductive, Maternal and Child Health Services (State, County and Faith Based Hospitals).

Continued emphasis will be placed on quality in the delivery of services. Activities under this component will also include immunization; family planning; ensuring availability of qualified staff in health facilities; improving infrastructure and equipment; and the cold chain management. Delivery of this component will be through a consortium of NGOs working in close cooperation with CHDs. The county model proposed in the programme is a shift away from the humanitarian model to a collaborative approach to plan, implement and monitor county wide Primary Health Care. The premise is to have one lead service provider accountable to the CHD (and the MoH), placing the CHD central to planning, leadership and accountability enabling long terms sustainability of the health system.

- **Result 2:** strengthened health systems at State and County level with detailed focusing on: policy, human resources for health, health financing including strengthening of payroll, health information, leadership and governance

To deliver tangible improvements in services and to sustain basic service delivery in the future, activities need to effectively and simultaneously address all six building blocks of the Health Development Plan: i) Service Delivery; ii) Human Resources; iii) Health Management Information Systems; iv) Pharmaceuticals and Medical Products; v) Health Financing; vi) Governance, Leadership and Management. HPF 2 will initially continue the technical assistance support to the National and State Ministries of Health and, through the implementing partners to the health facilities at county and community level. The focus will be on public financial management and payroll relevant to the sector, identifying staffing needs per state with the support of Human Resources for Health, harmonizing the salary scale and introducing hardship allowances, while ensuring consistency in health workers training provision with the development/finalisation of standardized national training packages for selected areas of work. Ownership, governance and demand of communities for health services will be increased integrating effective health interventions into existing community structures. Health information activities will tackle the social determinants of health, focusing on gender issues and cultural barriers affecting utilization of health services. This will require effective reach out to rural communities, including through the use of innovative radio programmes and community-level advocacy and developing linkages across education and health to promote behavioural changes. Community health committees will become increasingly involved in monitoring the quality of services as well as the correct use of county financial transfers, improving the flow of information and transparency around county and state operating transfers. Work on improving community governance is expected to lead to increased government accountability and responsiveness to citizen's health needs.

- **Result 3:** Increased access to nutrition services particularly for pregnant women young children and other vulnerable groups.

It is appropriate that HPF 2 gives greater attention to nutrition given the high rates of malnutrition, especially amongst women and children, and the availability of proven, highly effective interventions to address the problem. The nutrition component of HPF2 will build and deepen expertise in nutrition programming that implementing partners already bring to their work with the HPF, will integrate and scale up priority nutrition specific interventions targeted at under-five children and pregnant and lactating mothers focusing on a measured set of achievable goals, and it will fill the gaps in existing programming by CHDs.

- **Result 4:** Essential drugs imported and distributed.

HPF 2 will include provision for a larger quantity of drugs and commodities than was included in HPF 1. Preparatory discussions will take place in advance of HPF 2 to define and quantify the needs. Following agreement between the Ministry of Health and HPF 2 donor partners, UK Aid will contract a procurement agent under its framework arrangement to procure and distribute the agreed set of essential medicines and vaccines to all health facilities in the programme areas, at regular intervals for two years, ensuring economy of scale, consistency of the supplies as well as better quality control.

3.3. Risks and assumptions

The main risks are:

- The implementation of the peace agreement breaks down, leading to a resumption of hostilities and further instability (High);
- The transitional government fails to tackle the fiscal and monetary issues underpinning the economic crisis, thereby undermining PFM reform and the budget's credibility, potentially triggering hyperinflation, rendering public sector wages worthless (High);
- The decision of the Government to increase the number of states from 10 to 28 impacts the ability of local government to perform their mandate (High);
- Climatic shocks significantly impact people's livelihoods and food security (Low).

The assumptions for the success of the project and its implementation include:

- The transitional government will be willing and able to take action to tackle the economic crisis and prioritise social sector spending;
- Health service funding for salaries and drugs will continue at least at present levels;
- Government maintains central, state and county level capacity to deliver services;
- Implementing partners are able to operate effectively despite security concerns.

Mitigating measures have been considered, including:

- A permanent policy dialogue at all levels (technical and political);
- Targeting resources and activities at local government as direct beneficiaries;
- Focusing on institution and system strengthening and improving resilience, in particular at county level, paving the way for government-led service delivery.

- Some flexibility has been built into the design of HPF2 to ensure that appropriate support can be provided regardless of specific political developments in the country

3.4. Cross-cutting issues

Gender and Social Inclusion

The programme will develop a Gender and Social Inclusion (GSI) Action Plan, with priority activities that give realistic attention to the two-year timeframe and the challenging national and sub-national context. The GSI Action Plan will include activities to support programme stakeholders to better identify vulnerable communities and achieve effective operationalisation of GSI-focused interventions on critical areas such as family planning.

Conflict sensitivity

HPF 1 adopted a conflict sensitive approach to programming in response to the December 2013 onset of violence. HPF 2 will integrate a conflict sensitivity strategy based on a renewed analysis to both be resilient and continue to deliver basic health services to the most vulnerable South Sudanese irrespective of ongoing conflict and to be active in taking opportunities to reduce conflict and doing no harm.

Flexibility

HPF and its partners continue to work in a highly volatile environment with periodic flare ups of violence or epidemics that require a rapid response. Increased flexibility will be built into contracts to enable partners to be more reactive in an evolving situation.

Sustainability

Progress in the development of health systems, particularly health and human resources information system, introduction of decentralised operational grants, improvement of pharmaceutical storage and distribution system, county level planning and supportive supervision have resulted in infrastructures, mechanisms and processes which will last beyond the project. The Ministry of Health has demonstrated leadership, partnership and support to health services at national and state levels and played a substantial role in ensuring the delivery of the programme amidst a fragile environment. This in itself is an important achievement towards the programme's long term aim of a government led health system. However, there are serious capacity constraints and a number of activities have only recently started and will need time to gain traction.

The current economic situation means that a decline in funding of the health delivery services would be destructive to the achieved results and that funding of the HPF may have to continue for a significant period of time.

3.5. Stakeholders

The key stakeholders are the local health professionals and the local authorities, at county and state level. The direct beneficiaries are key personnel in county health departments, health facilities and hospital (public, faith based and private) county planning units, and in the state ministries, including the State Ministry of Health, the State Ministry of Finance, the State Ministry of Public Service, the State Ministry of Local Government and the State Ministry of Education. Indirect stakeholders are the public at large and relevant civil society organisations.

4. IMPLEMENTATION ISSUES

4.1. Indicative operational implementation period

The period of implementation will be 24 months from the signature of the Delegation Agreement with DFID (indicatively in April 2016), whilst the overall execution period (including a closure phase of no more than 24 months) will not exceed 60 months from the date of approval of this Action Document by the Operational Committee of the EU Trust Fund.

4.2. Implementation components and modules

The action will be implemented in indirect management by means of a Delegation Agreement (Pagoda) to be concluded with DFID, as current implementers of the Health Pooled Fund. It is expected that the Delegation Agreement will be concluded in the first quarter of 2016. DFID on behalf of the HPF donors, will contract an HPF 2 Management Agent. As it was the case in the context of the HPF 1, DFID will put in place financial arrangements to ensure that it retains direct responsibility for call procedures, contracting and payments from the EU contribution to the HPF 2. A transparent selection process, involving the donors through the Project Steering Committee will be undertaken to select the implementing partner for each of the agreed HPF 2 contracts. It is expected that implementing partners will be NGOs, International Organizations and commercial companies. DFID has successfully passed the EU's pillar assessment to be entrusted with the implementation of this action.

4.3. Indicative budget

Component	Amount in EUR thousands
IMDA Pagoda contract with UK Aid	19900
Monitoring, audit and evaluation	100
Communications and visibility	20 000

4.4. Evaluation and audit

If necessary, ad hoc audits or expenditure verification assignments could be contracted by the European Commission for one or several contracts or agreements. Audits and expenditure verification assignments will be carried out in conformity with the risk analysis in the frame of the yearly Audit Plan exercise conducted by the European Commission. The amount dedicated in the budget for external evaluation and audit purposes is EUR 100,000. Monitoring will be contracted out by UK Aid for mid-terms and annual reviews.

Evaluation and audit assignments will be implemented through service contracts making use of one of the Commission's dedicated framework contracts or alternatively through the competitive negotiated procedure or the single tender procedure.

4.5. Communication and visibility

Communication and visibility of the EU is a legal obligation for all external actions funded by the EU. This action shall contain communication and visibility measures which shall be based on a specific Communication and Visibility Plan of the action to be agreed with programme partners and donors and to be monitored as part of the external reviews.

INDICATIVE LOGFRAME MATRIX OF THE ACTION

	Intervention logic	Indicators	Baseline/ current value (reference year)	Targets¹ (March 2018)	Sources and means of verification	Assumptions
Impact	Strengthening resilience of communities and in particular the most vulnerable, as well as the refugees and displaced people in South Sudan	Under 5 mortality rate /1000 live births. Maternal mortality ratio / 100,000 live births	106 per 1000 live births Baseline: 2010 SS Household Survey. 2,054 per 100,000 live births Baseline: 2010 SS Household Survey.	Tbd	Ministry of Health and development partners	The transitional government will be willing and able to take action to tackle the economic crisis and prioritise social sector spending;
Outcome	Increased access to quality health services, in particular by children, pregnant women and other vulnerable groups.	1. Proportion of children 12–23 months who are fully vaccinated (BCG, DTP3/Penta, OPV3 and measles) before their first birthday 2. Proportion of Children 0-59 months with fever in the last two weeks who were treated with an appropriate anti-malarial (as per national guidelines) within 24 hours of the onset of symptoms (Sex disaggregated) 3. Proportion of women 15-49 years using any modern family planning method at the time of the survey (Disaggregated	Baselines data to be extrapolated from the LQAS 2015 survey 15.3% (2011- national average) 1.7 % (HPF 2015)	Tbd Tbd Tbd	Ministry of Health and development partners	Health service funding for salaries and drugs will continue at least at present levels; Government maintains central, state and county level capacity to deliver services; Implementing partners are able to operate effectively despite security concerns.

		by age). 4. Proportion of mothers of children 0-11 months who delivered in the presence of a skilled health personnel during last pregnancy 5. Proportion of children U5 attending Health Facility with MUAC<115 mm	8.2% (HPF 2015) 3.3 Health Management Information System (HMIS 2013)	25% 1.50		
Specific objectives: Outputs	Output 1. Stronger health facilities: Service Delivery	1.1 Under 5yrs OPD consultations: 1. curative (sex disaggregated). 2. preventive/ promotive services 3. total under 5 consultations 1.2 Percentage of women who attended at least four times for antenatal care during pregnancy 1.3 Couple/years protection rate 1.4 Number of facilities with capacity to offer Emergency Obstetric care through Basic and Comprehensive emergency obstetric and neonatal care	OPD consultations curative: < 5yrs male = 500,000 < 5 yrs female = 500,000 Preventive < 5 male and female = 500,000 Total < 5 male and female = 1,800,000 35% (HPF 2015) TbD 22 CEMONC, 87 BEMONC	95% 45% TbD per 500,000 - 1 functional CEmONC (9 signal functions 24/7) per 500,000 pop: 5 functional BEmONC (7 signal functions 24/7)		

		CEMONC/BEmONC. all signal functions.	50% (HPF 2015)	70%		
		1.5 Percentage of ANC attendees who received IPT2	zero	Design and trial initiated		
		1.6 Design and trial of the implementation of Boma Health Initiative initiated.				
Specific objective: Outputs	Output 2. Strengthened health systems at State and County level with detailed focusing on: <ul style="list-style-type: none"> • Policy • Human resources for Health • Health Financing including strengthening of payroll • Health Information • Leadership and governance 	2.1 Number of HPF Steering Committee meetings chaired by GRSS and number of State Oversight Committee meetings held		4 per annum		
		2.2 Percentage of facilities with joint quarterly integrated supportive supervision visits conducted by county health department & IP using the QSC tool	72% (HPF 2015)	85%		
		2.3 Percentage of health facilities submitting HMIS reports through the DHIS timely (according to the data flow policy)	80%	100%		
		2.4 Proportion of counties with “one	% (39 counties)	% (51 counties- on 8 States)		

		<p>comprehensive county health plan + budget (government and all partners info combined)</p> <p>2.5 Percentage of counties in which HRIS is implemented, disaggregated by (a) facility staff and (b) CHD staff (documents scanned and filed into HRIS).</p> <p>2.6 Nr. of facilities with health committees that hold documented joint meetings with representatives from the CHD, IP, health facility and committee (4 parties) twice a year.</p> <p>2.7 % of health committees with women in leadership positions.</p>	<p>77% (HPF 2015)</p> <p>100% 6 states</p> <p>0%</p>	<p>100% in 6 states</p> <p>100% 8 states</p> <p>20%</p>		
	<p>Output 3. Increased access to nutrition services particularly for pregnant women young children and other vulnerable groups.</p>	<p>3.1 % of mothers with children 0-11 months who received at least 60 iron/folate tablets during ANC visits during their last pregnancy</p> <p>3.2 % infants 0-5 months who received only breast milk during the previous</p>	<p>Less than 5% (2015)</p> <p>45%</p>	<p>50%</p> <p>80%</p>		

		day 3.3 % children 12-23 months who received 2 doses of vitamin A supplement over the last year on the last National Immunization Day.	80%	100%		
	Output 4. Essential drugs imported and distributed	4.1 Procurement and distribution process implemented 4.2 Proportion of health facilities with reported stock out of four key tracer drugs.	tbd	tbd		

ⁱ Indicators and targets will be more clearly defined in the inception phase