HEALTH SECTOR DEVELOPMENT PLAN 2011 - 2015

Government of South Sudan

Ministry of Health

Transforming the Health System for Improved Services and Better Coverage

Revised Final Draft

(1st March 2011)

FOREWORD *(DRAFT)*

This Health Sector Development Plan provides direction that will create a better health system and more effectively addressing the crisis in health. It offers a road map to improve the health of our people. By improving the quality of health services and increasing access to them, we improve the quality of life for the people of South Sudan. We cannot build the economy and overcome poverty of our new Nation without overcoming this challenge.

The good news is that we can succeed. We can look at some successes in recent years but still a lot need to be done. The incidence of communicable diseases is too high and maternal and child deaths are too common. Access and utilization of health services is still low and community health seeking behavior remains a challenge.

This first Health Sector Development Plan represents a real opportunity for all stakeholders to combine efforts for maximal results and outcomes. Our priority is to build up a routine and functional Public Health care system while consolidation delivery of basic health services. We can only do that with our International and local partners who we owe much appreciation for their efforts and support. We need to foster a stronger and more coordinated effort to provide affordable health care to the people of South Sudan. Foremost, we need to build on the strengths and resilience of our communities.

From now onwards we must advance with confidence, energy and transparency to combat disease, reduce poverty and carry forward our new nation in better health.

Dr. Luka Manoja

The Minister of Health

Government of Southern Sudan

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ABBREVIATIONS

ANC	Antenatal Care
ART	Antiretroviral Therapy
BCC	Behavioral Change Communication
BEmOC	Basic Emergency Obstetric Care
BPHS	Basic Package of Health Services
BSF	Basic Service Fund
CEmONC	Comprehensive Emergency Obstetric and Neonatal Care
CME	Community Midwifery Education
CHD	County Health department
CHW	Community Health Worker
CMS	Central Medial Stores
CPA	Comprehensive Peace Agreement
CS	Caesarean Section
DHIS	District Health Information System
DP	Development Partner
DPT	Diphtheria, Polio, Measles
FBO	Faith Based Organization
GAM	General Acute Malnutrition
GAVI	Global Alliance for Vaccine and Immunization
GFATM	Global Fund against AIDS, Tuberculosis and Malaria
GoSS	Government of South Sudan
GoSSHA	Government of South Sudan Health Assembly
HFM	Health facility Mapping
HHP	Home health Promoter
HIS	Health Information System
HIV/AIDS	Human Immunodeficiency Virus / Acquired Immunodeficiency Syndrome
HRH	Human Resources for Health
HMIS	Health Management information system
HSDP	Health Sector Development Plan 2011 – 2015
IDP	Internally Displaced People
IEC	Information, Education and Communication
IPT	Intermittent Preventative Treatment
ITN	Insecticide Treated Net
IYCF	infant and young child feeding
JAM	Joint Assessment Mission
LLIN	Long Lasting Insecticidal Nets
LQAS	Lot Quality Assurance Surveying
M&E	Monitoring and Evaluation
MDA	Mass Drug Administration
MDG	Millennium Development Goals
MDTF	Multi Donor Trust Fund
MIS	Malaria Indicator Survey
MMR	Maternal Mortality Rate
MoFEP	Ministry of Finance and Economic Planning
MoH	Ministry of Health
NHA	National Health Account
NGO	Non-Government Organization
NTD	Neglected Tropical Disease
PCT	Prophylactic Chemotherapy
PHCC	Primary Health Care Centre
PHCU	Primary Health Care Unit
PMTCT	Prevention Mother to Child Transmission
PPP	Public Private Partnership
SDG	Sudanese Pounds
SHHS	Sudan Household Health Survey
SMoH	State Ministry of Health
SSHASF	South Sudan HIV/AIDS Strategic Framework
SWAP	Sector Wide Approach
TB	Tuberculosis
TBC	Tuberculosis complications
TBA	Traditional Birth Attendant
TFR	Total Fertility Rate
TOR	Terms of Reference
VCT	Voluntary Counseling and Testing
WHO	World Health Organization

EXECUTIVE SUMMARY

Introduction

The Health Sector Development Plan (HSDP) provides the strategic intentions needed to transform the health services of South Sudan. It sets out the main objectives and priority areas for the period 2011–2015. The HSDP does not go into detail of operational activities which are provided in specific strategic plans and workplans of institutions and programmes. The HSDP is a guide for strategic and annual operational planning by the Ministry of Health (MoH) and the State MoHs (SMoH).

Objectives

The HSDP is based on the Government's Vision to contribute to a healthy and productive population, fully exercising its human potentials. It is the mission of the Government to ensure basic health care for the population which is of acceptable standards, affordable, sustainable, cost-effective and particularly addressing those most at risk, women and children. The overall objective of the HSDP is:

To improve access, quality and utilization of Health Services and to strengthen Health Sector Systems, including organizational, management and wider Institutional issues*.*

Framework

The HSDP presents a set of Strategic Objectives which relate to specific areas important for either Service Delivery or Health Sector Management and Organization. Strategic objectives are inter-linked and collectively contribute to the realization of the main objectives of the HSDP. The document explains which types of priority services are provided and explains what are the role and responsibilities of each level in the health system and the various stakeholders.

Strategic Objectives

1. ***To increase access to quality primary health care services****:* The accessibility to the Basic Package of health services (BPHS) will be improved among others through the establishment of a Community Health Programme (CHP), the rationalization of the network of PHCUs, PHCCs and CHDs and by improving functionality of all levels of the health system. The National Health Policy as well as the BPHS will be reviewed and adopted to changing demands and circumstances. The CHP will focus on increased community ownership and participation in health programming. Task shifting of the cadre of CHWs in view of implementing the CHP is important. A gradual integration of Humanitarian Health Relief operations into the routine health system is planned for.
2. ***To strengthen prevention and control of communicable and non-communicable diseases****:* Next to the implementation of the BPHS, priority will be on expanding and improving management of communicable and non-communicable diseases. Special focus will be on high impact interventions and expanding a comprehensive malaria programme, an integrated TB programme and an inclusive NTD programme. Diagnostic capacity will be improved through expansion of laboratories. A start will be made with integrating programmes into the routine PHC system. Out-contracting services through the private sector (NGOs, FBOs and private-for-profit agencies) will continue and performance based financing will be considered and piloted.
3. ***To improve Prevention of HIV/AIDS and Care for clients***: An integrated approach towards HIV/AIDS prevention, treatment and care will be enhanced. Nationwide campaigns will be carried out focusing on preventive messages and behavioral change. Social marketing of condoms will be promoted. VCT services will be expanded and access to ARTs for eligible clients will increase. A workplace programme for health staff will be rolled out focusing on universal precautions including blood safety procedures.
4. ***To improve maternal, newborn and child health****:* Increased access to improved maternal, newborn and child health care service is central in the HSDP. Comprehensive emergency obstetric and neonatal care will be expanded throughout the PHC system. Reproductive health care services will be expanded and availability of modern contraceptives will increase. A comprehensive package of high impact interventions for child care will be rolled out and expanded.
5. ***To improve nutritional status of the population, especially women and children:*** Multiple strategies will be applied such as increase public knowledge and awareness about food, reducing prevalence of major micro-nutrient disorders and strengthening case management. Monitoring the nutritional situation in South Sudan will be strengthened and appropriate nutrition strategies and programs will be formulated.
6. ***To improve hospital services and complement the referral system especially for mothers****:* Access to basic hospital services will increase through better performance of vital functions of existing hospitals. OPDs will be reorganized and laboratory services will be improved. Hospital management will be strengthened as well as recruitment, employment and retention of all levels of professional medical staff cadres. A gradual start will be made to expand hospital infrastructure.
7. ***To improve Management and Governance of the health sector***: Overall management and organization of the health sector will improve with investments in better administration, tools and systems and instituting

planning protocols and systems at all levels of the PHC system. Regulation and legislation will be amended and enforced.

8. ***To Strengthen Human resources production, management, distribution, development and retention****:* Increase of numbers and improvement of the quality of human resources for health (HRH) are most important for improving accessibility and quality of health services. The HRH planning and information system will be strengthened. A Recruitment and retention plan for all cadres of HRH will be developed. Continuing Professional Development (CPD) is necessary to keep health workers updated. Training institutions will be rationalized and increase their production by higher numbers of graduates and will improve their quality through update of the curricula.
9. ***To create an enabling environment to ensure availability and management of quality pharmaceuticals and supply systems:*** Accessibility of safe pharmaceuticals, medical equipment and supplies throughout the PHC system is improved through investments and the development of adequate management structures, protocols and systems. Regulation and legislation to ascertain quality, safety and efficacy of pharmaceuticals will be amended and enforced. Procurement and logistics will improve, and a start will be made with the harmonization of procurement and logistics of vertical programmes into one national system.
10. ***To rationalize distribution and improve the infrastructure of health services delivery points to ensure quality health care delivery***: A phased upgrading of the physical health infrastructure will be carried out at all levels of the health system including auxiliary buildings (staff houses etc.). A system for regular maintenance will be put in place and is enforced. Essential medical equipments in line with service levels will be available and upgraded. Vehicle requirements to secure a basic referral system will be issued and maintained.
11. ***To improve Health Sector Financing***: Health sector financing is fundamental for realizing the ambitions of the HSDP. The Ministry aims at increasing the health budget to at least 7% of the Government budget. At the same time additional financing modalities will be investigated and implemented on a pilot basis. Focus will be on cost effective interventions. Financial management and auditing will improve and budget allocation and execution will increase.
12. ***To enhance evidence based decision making through establishing HMIS and M&E systems and promoting a culture of data use****:* Monitoring and Evaluation (M&E) help to improve evidence-based decision making and to enhance public accountability. A comprehensive M&E system will be established with attention to improving the routine Health Management Information System (HMIS) and non-routine information systems such as periodical disease surveillance. A research agenda will be developed wich is appropriate and relevant for the specific context of South Sudan.
13. ***To further strengthen the health system through addressing a set of cross cutting priorities****:* Cross cutting issues elaborate on approaches applicable across the health sector;
    a. Quality improvement is a major aim in service delivery, HRH and in management.
    b. Equity will be stressed for underserved geographical areas, populations and vulnerable groups.
    c. Gender sensitivity in health is important because of specific health needs of women and men. Women are more vulnerable to health problems and the health system will be more responsive in this regard.
    d. Community Ownership will reduce incidences of morbidity and mortality. Communities will be mobilized to participate in health programmes and oversight of health facilities.
    e. Coordination and Coherence between programmes and sectors are central to enhance efficiency and effectiveness.
    f. Environmental factors are considered to raise awareness and understanding of potential adverse health consequences.
    g. Public-Private Partnerships will be important to reach the goals of the health sector.

Managing the Health Sector

All stakeholders have to play their role. The MoH will concentrate on stewardship on the sector, delegating more operational tasks to the SMoHs. Coordination with other ministries, development partners and the private sector will improve the implementation of the HSDP. Substantial Technical Assistance is required to build up capacities of the MoH, SMoHs and CHDs.

Financing the HSDP

There has been a gradual decrease in Government funding to health over the last years. It is expected that this trend will reverse into a gradual increase in the coming period. Nevertheless due to planned large capital investments, increased operating costs and support in strengthening the health system a large budget deficit of about 80% over the 5-year period is expected. Support from development partners will be crucial. In addition innovative funding strategies will be explored.

Monitoring and Evaluation

A coherent system of quarterly, annual and periodic monitoring is planned, using selected indicators to measure health outcomes, the performance of service delivery and the effectiveness and efficiency of the health system. Timely and reliable provision of information on progress and constraints in implementation of the HSDP is important.

I INTRODUCTION

This chapter provides the general background to the HSDP and describes important aspects of the context of the Health Sector to be able to understand its current status and its key challenges.

1.1 BACKGROUND TO THE HEALTH SECTOR DEVELOPMENT PLAN

The five year HSDP has been commissioned by the Ministry of Health (MoH) of the Government of South Sudan (GoSS), to guide the Health Sector towards achieving the delivery of more efficient and responsive health services for the population of South Sudan. The HSDP provides strategic directions for the Sector in line with the vision and principles of the Health Policy (2007-2011).

The HSDP is developed through a consultative and participatory process. It is based on situation analysis using all available sources of information and identifying the critical challenges impeding effective and efficient health service provision. The situation analysis relate to both, the actual *service provision* as well as to the current functionality of the *health system*. The situation analysis resulted to identify a set of strategies, interventions and implementation modalities best suited to reach the overarching goal of the sector of realizing an effective and efficient health care system.

1.2 BACKGROUND SOUTH SUDAN

South Sudan is a landlocked country located in Eastern Africa bordering Ethiopia, Kenya, Uganda in the South-East, the Central African Republic and Congo to the West and Northern Sudan to the North. It is a vast territory of approximately 640,000 KM2 formerly composed the three historic Provinces of Bahr el Ghazal, Equatoria and Upper Nile. It has an administrative division of 10 States and 79 Counties.

Sudan has witnessed perhaps the longest civil war in modern post-colonial Africa which broke out immediately after independence in 1955 and lasted until 2005 with a peaceful interlude between 1972 till 1982. In 2005, The Comprehensive Peace Agreement (CPA) was signed between Government of Sudan and the Sudan People's Liberation Movement (SPLM). Next to destroying the social fabric of Southern Sudan and causing high numbers of death and massive displacement of over four million people, the civil war practically destroyed the whole physical infrastructure. It is expected that the population will increase significantly as a result of a high rate of natural population growth and the return of refugees and internally displaced (IDP). Approximately 200 ethnic groups inhabit the country. Key facts on South Sudan are presented in Table 1.

Table 1: South Sudan Key Facts and Figures

Estimated Population (2010)	8,260,499
Population density	
Population Composition	Male 48%, Female 52%
Population Growth per year	
Life Expectance	
GDP	
Revenue	

Source: SS Census, 2008

South Sudan is one of the poorest countries in the world with about half of its population living under the poverty line of less than SDG 72.9 per capita per month (50.6%).[1] The vast majority of the population is engaged in rural subsistence farming and cattle herding. Living conditions are very deprived with poor access to potable drinking water (less than 50%), poor access to proper sanitation (less than 7%) and high illiteracy rates among adult population (88% among women and 63% among men).

1.3 DESCRIPTION OF THE PUBLIC HEALTH SYSTEM

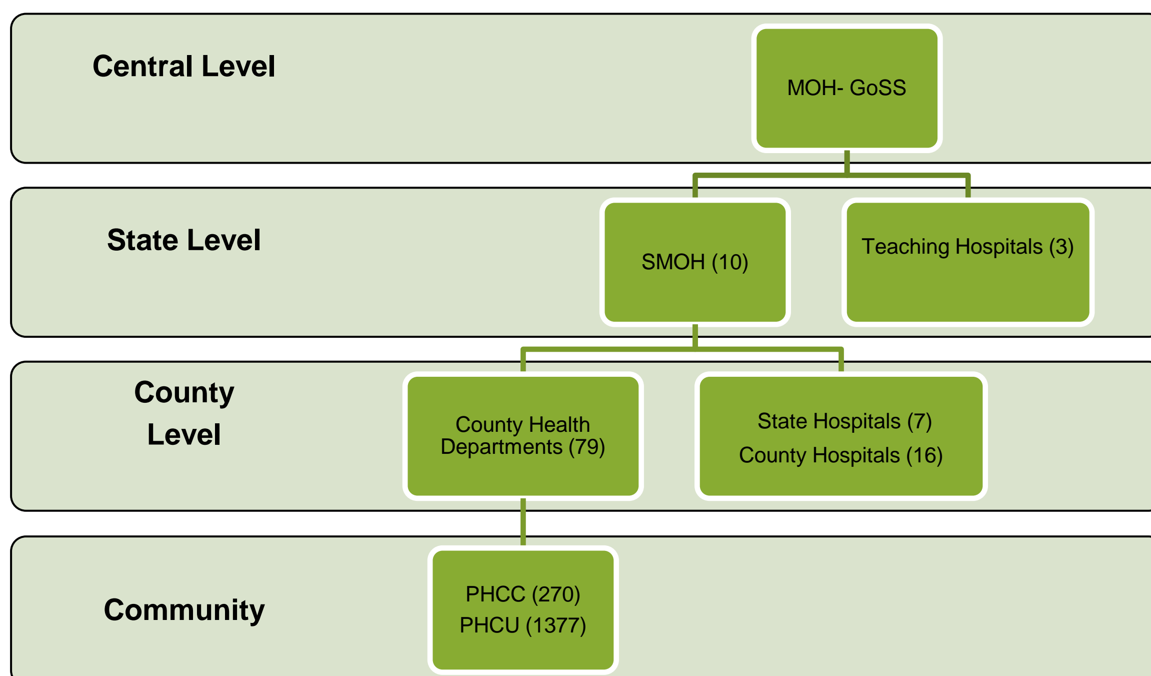
During the war, the public health system virtually collapsed and approximately 80% of minimum health care was provided by Non-Governmental Organizations (NGOs) and Faith Based

[1] National Baseline Household Survey, 2009

Organizations (FBOs). However total coverage was only estimated to be 25% of population. Under the CPA, the Ministry of Health (MoH) resumed responsibility for rebuilding and transforming the public health system.

In line with the decentralization policy of the interim constitution of South Sudan (2005) and the Local Government Act (2009), the MoH operates a decentralized structure (figure 2).[2] The MoH is in-charge of the health sector policy, guidelines, regulations, and standards development; quality assurance, M&E, health financing and health sector partner coordination at the country level. It provides stewardship and guidance to the sector, manages the Tertiary (Teaching) Hospitals and executes a supportive role to the State Ministries of Health (SMoH). The SMoHs provide leadership for health service delivery and management at State level. The County Health Department (CHD) oversees the delivery of primary health care services in their respective County. Specific community health institutions are envisaged to ensure community participation and oversight however at present; these structures are not operative.

Figure 1: Decentralized Management Structure of the MoH



The provision of health care services is based on the principle of a '*Continuum of Care*' (WHO) and structured into community, primary, secondary and specialized care levels linked by a referral system. Community health care is to be provided by Community Health Workers (CHWs), Maternal and Child Health Workers (MCHWs) and Home Health Promoters (HHPs). PHCUs provide the first level of interaction between the formal health system and the communities and they are expected to provide basic preventive, promotive and curative care for a catchment population of 15,000. PHCCs are expected to provide services for about 50,000 people and, in addition to services offered by PHCUs to provide basic diagnostic laboratory services and maternity care. Secondary care including comprehensive obstetric care, in-patient care and surgery is to be provided by County and State Hospitals for 300,000 people. State Hospitals are earmarked to serve a catchment area of about 500,000 people. However, there are numerous gaps and challenges to strengthen all these levels to reach minimum optimal standards.

1.4 THE NATIONAL HEALTH POLICY

The HSDP is based on the Government's Health Policy (2007-2011). The vision of the Government is to have a healthy and productive population, fully exercising its human potentials. The mission is to

[2] Some uncertainties remain, in particular whether local governments would be fully autonomous or subordinate to state governments.

ensure basic health care for the population of Southern Sudan which is of acceptable standards, affordable, sustainable and cost-effective. The health services will focus on those most at risk, particularly women and children. In summary, the health policy aims to: (i) strengthen prevention and control of communicable and non-communicable diseases; (ii) reinforce Maternal and Child health care and; (iii) build up the Health System in partnership with communities and other stakeholders. [3]

The Primary Health Care approach (PHC) is the principle strategy of the Government to arrest communicable and non-communicable diseases and is implemented through the Basic Package of Health Service (BPHS). The BPHS outlines a package of high impact health care services accessible to the largest possible part of the population at the primary and secondary health care level. The BPHS is considered to be affordable at the short run and sustainable in the longer run. The BPSH defines service profiles at community, primary and secondary level and it covers curative, promotive, preventative and managerial activities.[4]

[3] The Health policy (2007-2011), MoH
[4] The Basic Package of Health Services, MoH, 2007

II SITUATION ANALYSIS

This chapter provides the situation analysis for the Health Services provision and the functioning of the Health System. After providing a brief on the health Status and Burden of Diseases, the chapter tunes in on key areas of concern. The situation analysis is based on routine health information data, the Sudan Household Health Survey (SHHS, 2006) and specific evaluation and assessment reports.

2.1 HEALTH STATUS AND BURDEN OF DISEASE

There has been some progress as overall in the health sector of South Sudan as a result of the efforts of the MOH and its partners. Advances towards an effective and efficient health care system include the promulgation of the Health Policy (2007-2011) and the formulation and implementation of the BPHS. Some vertical programs such as TB, IDSR, Malaria, NTDs and HIV-AIDS have expanded their operations and started providing quality services with the support of selected NGOs. Health infrastructure is being repaired, HRH trained and the Health Management Information System (HMIS) is being instituted.

The harsh and unfavorable living conditions coupled with very limited access to basic (health) services contributes to a poor health and nutrition status of the population and the unlikely prospect of reaching the MDGs by 2015. In comparison, South Sudan is way behind regional level averages (refer to table 2).

Table 2: Indicators Health Status Southern Sudan; compared with average of the region Middle East and North Africa (MENA):

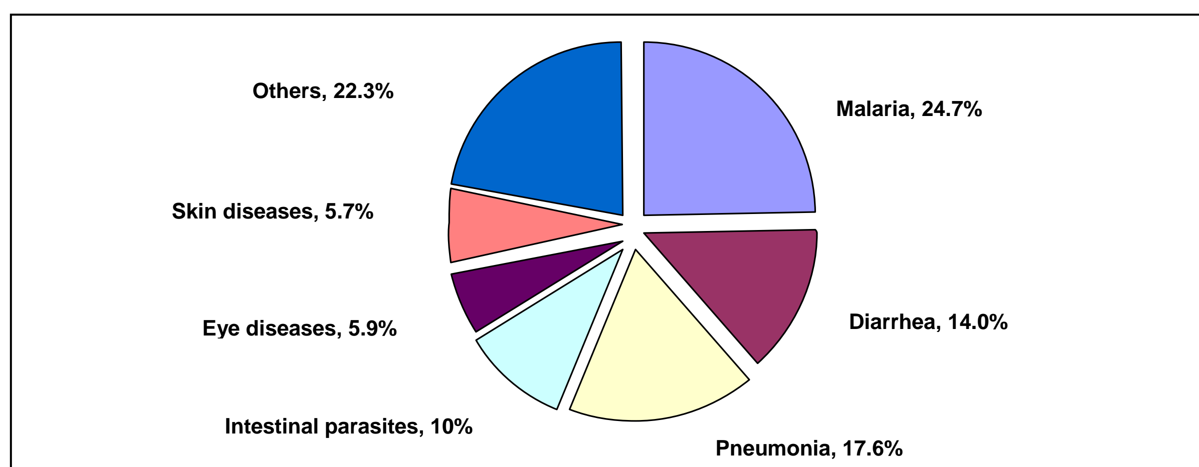
Indicator	**South Sudan**	Regional level averages	Indicator Key
Maternal Mortality Rate	**2,045**	210	Deaths per 100,000 live births
Infant Mortality Rate	**102**	33	Deaths per 1000 live births
U5 Mortality Rate	**135**	43	Deaths per 1000 live births
Total Fertility Rate	**6.7**	2.9	Births per women
First Antenatal visit	**48%**	78%	Visit during pregnancy
Institutional deliveries	**13.6***	65	Deliveries attended at HFs
Skilled Birth Attendance	**10%**	76	All deliveries attended by skilled HRH
Contraceptives Prevalence Rate	**<3%**	56	Use of contraceptives among CBA women
DTP3 coverage (routine)	**71 (routine)**	89	% of children vaccinated
Stunting			
Access to health care (%)	**0.2 (<25%)**	NA	Visit per person/year

*Source: SSHHS, 2006 and World Children's Status report UNICEF 2008. * Institutional deliveries conducted at HFs also by non-professional staff.*

Preventable infectious diseases (Malaria, Presumed Pneumonia and Diarrhea) account for a majority of reported diagnosis in health facilities for all age groups combined (diagram 1, next page). Preventable infectious diseases and malnutrition are the most common causes of morbidity and mortality for children under 5-years of age. [5] Acute and chronic childhood malnutrition is common with seasonal and geographical variations. The prevalence of General Acute Malnutrition (GAM) amongst children under 5-years of age is 19%, whereas the prevalence of Severe Acute Malnutrition (SAM) is 3%.[6] The main causes for death in women of childbearing age relate to reproductive health.

[5] Malaria Indicator Survey, 2009
[6] Sudan Household Health Survey, 2006

Diagram 1: Morbidity for all Age Groups



Source: UNICEF OLS Database, 2005-2007

Tuberculosis is a major killer in adults. TB mortality was estimated at 24/100 000 population. The treatment success rate of smear positive pulmonary TB was 79% for the 2008, still below the 85% target. TB prevalence has reduced from 249/100 000 population in 1990 to 209/100 000 in 2009. Similarly, the mortality rate is reduced from 33/100 000 in 1990 to 24/100 000 in 2009. However, it is still high. TBC related mortality is estimated at 65/100,000. Prevalence of HIV/AIDS is estimated to be 3% but most likely under-reported and on the increase.[7] A range of uncommon tropical diseases 'Neglected Tropical Diseases' (NTD) is still endemic and account for a considerable proportion of the total burden of diseases.[8]

Key Challenges Overall Health Status: Poor health Status of Population especially Women and Children

1. *High maternal and child mortality and high burden of disease, especially infectious and preventable diseases with high Maternal Mortality and High Infant Malnutrition and Mortality rate;*
2. *Poor and under-utilization of ANC services;*
3. *Poor family planning interventions resulting in very low contraceptive prevalence rate.*

2.2 PRIMARY HEALTH CARE SERVICES

Primary health services delivery at the County level is catered for by an infrastructure of 1377 PHCUs and 270 PHCCs. Provision and quality of health services are very low. Just 35% of health facilities provide immunization, less than 20% provide laboratory services for common tests and over 50% has regular drug stock-outs. Utilization Rate is lower than 0.2 contacts per person per year. Utilization of maternal and reproductive health services is low. Just 48% of pregnant women attend one or more Ante Natal Care (ANC) visits but of these services only 26% are provided by skilled health personnel whereas the rest is provided by non-health personal such as CHWs. Deliveries assisted by skilled birth attendants is just 10%. [9] Prevalence rate of modern contraceptives is less than 3%. Access to Comprehensive Emergency Obstetric and Neonatal Care (CEmONC) in hospitals is very low. In 2006, only 17% of children aged 12-23 months were fully immunized. However, some health indicators show improvement; 60% of households have one or more insecticide-treated nets; 12% of children with fever were treated with an appropriate anti-malarial medicine within 24 hours of the onset of fever.[10]

Overall 20% of health facilities at the primary level are not operative mainly due to a deficit in HRH. Particularly remote areas show over 40% non-functionality of primary health facilities. In addition,

[7] Antenatal Care Surveillance Report, 2009
[8] Ao Kala-Azar, Schistosomiasis, Leprosy, Onchocerchiasis, Lymphatic Filariasis
[9] The definition of skilled health personnel does not correspond to the WHO definition of trained personnel (doctors, nurses or midwives) and includes village midwives. Most services are actually provided by TBAs or CHW.
[10] MIS, 2009.

health facilities mainly suffer from inadequate and dilapidated infrastructure and lack of equipment and supplies. Health services are provided by lower staff cadres that have not received adequate professional schooling or any further training. Supervision by the SMoH and CHD is infrequent, irregular and not up to the tasks. Just 44% of the settlements live within 5 km radius of a PHCU.[11]

Specific national policies and programs on communicable diseases exist however, work mostly in an isolated vertical fashion, have limited coverage and result in high transaction and opportunity costs. Community Health programs are limited.

<u>Key Challenges Primary Health Care Services: Poor provision & Coverage PHC / BPHS</u>

1. *Inadequate performance of PHC system, poor provision and coverage of the BPHS ;*
2. *Fragmented health care delivery with many 'stand-alone' vertical programs and humanitarian relief programs next to the regular routine PHC system;*
3. *Poor functionality of SMoH, CHDs*
4. *Insufficient community participation in health promotion.*

2.3 HOSPITAL SERVICES

South Sudan has 3 teaching hospitals, 7 State Hospitals and 16 County hospitals. State and County hospitals provide the same basic levels of curative care and also support PHC, training of staff and technical oversight. However, the frequent absence or low quality of essential hospital services prevents patients from receiving the care they need. Poor access to essential hospital services is indicated by the rate of Caesarean Section (CS) provided and which is estimated to be less than 0.5%, the lowest in Africa.[12] The main reasons are lack of qualified staff, insufficient equipment and supplies and generally poor management. In addition, some areas are not covered with hospital services at all. Additional contributing factors are the poor roads and transport network and the absence of a functional referral system and a widely dispersed population.

Teaching hospitals serve as referral facilities for State and County hospitals. However, the actual provision of specialist care is restricted by few specialists, the limited quality and range of specialized support staff, instruments, equipment, facilities and support services such as laboratories, blood bank, X-ray, pharmacy, etc. Teaching hospitals largely provide similar levels of care as State and County hospitals and are subject to similar constrains.

<u>Key Challenges Hospital services: Poor Access & Provision Basic Hospital Services & Poor Referral System</u>

1. *Funding gap between what hospitals receive and what they need for basic services;*
2. *Inadequate and dilapidated equipments and infrastructure;*
3. *HRH crisis: serious shortage of trained staff and limited specialist care;*
4. *Under-management of available resources;*
5. *Poor hospital management Systems and Hospital management*

2.4 MANAGEMENT & GOVERNANCE

Due to the prolonged conflict and lack of stability, South Sudan has never been able to build an efficient administration staffed by sufficient number of civil servants selected on the basis of merit. Many management and administrative positions in the public health sector at MoH, SMoHs and CHDs are either vacant or filled with staff of inappropriate skills and experience. Organizational and management structures and procedures for MoH are generally not specified. Management teams such as steering committees, advisory boards and taskforces have not been established as a normal routine. Personnel management is opaque with few job descriptions and poor supervision, support and coaching of personnel. Staff is often paid irregularly and non-attendance from duty is common.

[11] Health Facility Mapping Exercise 2009/2010
[12] Strengthening Hospital Management in Southern Sudan, MoH-Goss/LATH, 2010.

Most public health management systems and organizational processes are at infancy stage and need further consolidation or development. Financial management and accounting systems are flawed and result in irregular disbursement of funds, poor budgeting, delays in the payment of salaries of health staff and lack of recurrent costs to run hospitals and health centers. Capacity for Health Planning is seriously constrained at all levels. Progress is being made with the design and implementation of the HMIS however collection of essential Health Information and the use of data for rational health planning are limited. [13]

Governance of the health sector is seriously constrained due to lack of specific laws, policies and regulation which has resulted into the provision of sub-standard services by both public and private health care providers including NGOs. Management and coordination of Non-Government agencies providing health services is problematic. Communication between MOH and SMOHs and CHDs is weak and characterized by inadequate information sharing and poor feedback. Supervision in support of lower management levels in the health system or operational health units is hardly practiced.

Key Challenges Management & Governance: Overall Poor management & Inadequate Governance systems

1. *Serious shortage of skilled management and administrative staff at all CHD, SMoH and MoH;*
2. *Serious limitation of management competencies at all levels most notably that of support services such as planning, human resources and finance ;*
3. *Severe restrictions in defined organizational processes and procedures in most areas including policy development, strategic and operational planning, performance managing, regulation and service contracting;*
4. *Lack of tools, guidelines and procedures for health planning and management;*
5. *Lack of laws, policy and regulation.*

2.5 HUMAN RESOURCES FOR HEALTH

There is an enormous shortage of Human Resources for Health (HRH) and the current health workforce is skewed to a poorly trained low-level professional and auxiliary staff and an absolute shortage of higher-professional staff such as clinicians, midwives, medical officers, nurses, pharmaceutical technicians, laboratory technicians and health administrative cadres. It is estimated that just 10% of the staffing norms are filled by appropriately trained health workers.[14]

The capacity of health training institutions is limited. Out of the existing 36 pre-service Health Training Schools only 23 are functional and these mostly train low professional cadres. Training institutions have several setbacks such as understaffing, neglected infrastructure, inadequate teaching materials and insufficient funding and they will not be in a position to match the existing demand. Oversight and inspection of training institutions is absent.

Key Challenges Human Resources for Health: Absolute shortage of skilled Professional Medical Staff and Surplus of unskilled Staff

1. *Low levels of trained medical staff cadres available;*
2. *Poor quality and Output of existing Medical training schools and Institutions;*
3. *Poor HRH Planning and Personnel Management;*
4. *Lack of Continuous Professional Education.*

2.6 PHARMACEUTICALS AND MEDICAL SUPPLIES

Overall, the supply of pharmaceuticals and medical supplies faces numerous challenges. Poor forecasting, cumbersome centralized procurement, irregular distribution and deficient logistics result into chronic shortage of medicines and medical and laboratory supplies in all health facilities. The current pharmaceutical selection and procurement is based on essential drugs kits allocated to health facilities however the number of functional health facilities to be supplied by Central Medical Stores

[13] M&E Scooping Mission, LATH/MoH, 2010.
[14] Inventory Survey of Human Resources for Health in Southern Sudan, 2006.

(CMS) is not exactly known. Transportation of drugs and medical supplies is a big challenge and storage conditions in health facilities are usually poor.

Shortage of qualified pharmaceutical staff is critical in both public and private sectors. Moreover, the sector is facing the challenges of irrational use of drugs, lack of adequate quality assurance mechanisms, lack of relevant laws and weak application of existing legislation and guidelines to regulate private pharmacies. Substandard and counterfeit pharmaceuticals, medical supplies, traditional and alternative medicines circulating in the market bring health threats to the population. In rural areas there are few or no private sources of pharmaceuticals and medical supplies, which meet quality standards. Affordability of pharmaceuticals and medical supplies especially to the poor and vulnerable groups is an additional challenge.

Key Challenges Pharmaceuticals & Medical Supplies: Regular Stock-outs of Essential Medicine and Supplies

1. *Insufficient Logistic, Procurement, Supply & Storage capacity for pharmaceuticals;*
2. *Poor control of quality, safety and efficacy;*
3. *Inadequate Legislation.*

2.7 Capital Investments & Infrastructure

The infrastructure network of the health sector is enormous with more than 1.377 PHCUs, 277 PHCCs, 25 hospitals and related buildings (stores, staff houses, etc.), training institutions and MoH offices at Central, State and County levels. Investments in infrastructure and equipment have been insufficient to meet the demand for reconstruction and renovation. Of the 1.024 functional PHCUs, 24% require minor renovation, 17% major renovation and 23% need to be rebuilt. Besides construction for health facilities, renovation of training schools, offices and staff houses is needed.

The transport system is severely hampered with insufficient ambulances capacity and lack of a reliable fleet of vehicles (cars, motorbikes and boats) for the provision of medicines, supplies and managerial purposes and for the functioning of a reliable referral system. There is no maintenance system for infrastructure, vehicles and medical equipment.

Key Challenges Capital Investments & Infrastructure: Overall Poor and Inadequate Infra-structure and Transport facilities

1. *Insufficient and dilapidated health infrastructure, equipment and means of transport to meet the demand of service delivery;*
2. *Insufficient Investments;*
3. *Lack of maintenance Culture;*
4. *Non-functional referral system.*

2.8 Health Sector Financing

The sector is funded by both GoSS and development partners. Funding from the development partners is either pooled or direct (off-budget) and amounts to an estimated US$ 214.8 million (2009) and US$169 million (2010).[15] The percentage of GoSS funding to the MoH-GoSS is gradually reduced over the past five years from 7.9% (2006) to 4.2% (2010).[16] Total public health expenditure per capita is estimated to be US$ 10, well under Regional averages. The main source of revenue for health services is the GoSS budget through block and conditional grants from MoFEP. Due to the centralized budgeting system, actual release of funding is cumbersome and results is a annual budget-expenditure gap of about 50%. Most States and Counties receive off-budget support from external sources mainly international NGOs. Health care is free at point of delivery and there are no

[15] Donor Book, GoSS/MFEP, 2009/2010.
[16] Southern Sudan Health Financing Study, 2009.

formal cost-sharing mechanisms in place. Alignment and harmonization of development partner contribution in the financing of the health sector is a challenge.

Key Challenges Health Care Financing: Relative low level per capita Spending on health and highly donor dependent

1. *Inadequate GoSS financing, increasing dependency external sources;*
2. *Poor budget Systems, planning, execution and control;*
3. *Inefficient use of available resources.*

2.9 MONITORING, EVALUATION AND RESEARCH

The M&E system in health consists of routine systems (HMIS, demographic and disease surveillance) and non-routine systems (Household Health Surveys, Research and evaluations). Other information systems mainly of vertical programs and NGOs operate in parallel to the routine system. The MoH is in charge of HMIS and disease surveillance. Non-routine information systems are often operated by other government or research entities.[17]

Overall, the functioning of the HMIS is limited. Data from health facilities are not always complete or reliable, data collection is delayed and feedback to collecting facilities from MoH, SMoH and CHDs is practically non-existent. FBOs in general comply with national information systems, but many NGOs and private agencies often do not provide required data or information. Disease surveillance is still at infancy. Operational research is under-funded. In general, data are not analyzed, organized or presented in a user-friendly way. Interpretation is difficult and therefore there is limited use of data for health planning. HRH are inadequately trained in all aspects of the data cycle.

Key Challenges Monitoring, Evaluation and Research: Insufficient Evidence based Decision making

1. *Insufficient functioning routine HMIS, with too many parallel reporting requirements;*
2. *Poor functioning of Non-Routine Information systems:*
3. *Poorly skilled staff at all levels;*
4. *Absence of a relevant and useful Operational research Agenda.*

[17] Assessment HMIS, MoH/LATH, 2010

III WAY FORWARD; STRATEGIES AND PRIORITY AREAS

Based on the analysis of weaknesses of the specific areas of Health Sector and the identification of key challenges as outlined in the previous section, chapter III outlines strategic objectives and priority areas of the HSDP.

The strategic objectives are based on the Government's Vision to contribute to a healthy and productive population, fully exercising its human potentials.

The overall objective of the HSDP is ***to improve access, quality and utilization of Health Care Services and to strengthen Health Sector Systems, including organizational, management and wider Institutional issues.*** [18]

3.1 PRIMARY HEALTH CARE SERVICES

The strategic objective is to improve the delivery and access of quality primary health services. [19]

Improvements of services depend on a comprehensive and coordinated effort of all levels of the health care system and adoption of the most appropriate strategies. Although the MoH endeavors to take over more responsibilities with respect to the delivery of the BPHS in the longer run, in the short run it will be the NGOs, FBOs and private partners who will continue to be the main providers of health services. Together with donor partners, the Government will endorse a new system of performance based contracting and it will strive to align various partners into one approach and support modality.[20] Whereas the non-government actors will provide the main part of the BPHS, the Government will focus on building the capacity of the National Health System and reinforcing governance and management.

Specifically in relation to contracts management, MoH will explore further options how aid can be better coordinated and contracts better managed including procurement and contract administration. This might involve structural changes such as establishment of new unit within MoH which also supports implementation of HSDP or re-visiting the current MoH organizational structures.

In order to better respond to the health needs of people, the packages of health care delivery such as BPHS will be revised based on the lessons learned. In addition, to the extent possible flexibility will be given to implementers during the implementation of the BPHS to respond to ground realities and community needs. Flexibility will allow for provision of outreach /mobile services, hiring of more or less number of staff at the HFs, equitable medical supply and so on. Coordination will be improved at all levels to monitor service implementation and share experiences and lessons learnt.

Priority Areas for provision of Health Services:

1. *Strengthen delivery of the BPHS and increase accessibility to health services through performance based contracts with NGOs, FBOs and private sector;*
2. *Enhance community participation in health promotion and disease control;*
3. *Maximize functionality and network of PHCUs, PHCCs and CHDs in function of BPHS and CHP.*
4. *To link humanitarian relief with development in a phases approach*

A key effort is on mobilizing the community for improved responsiveness and health seeking behavior. A Community Health Program (CHP) outlining the best strategies to provide information and care to the community is instrumental to promote health, prevent malnutrition and providing early diagnosis and care for main communicable diseases in children under 5-yrs of age. Furthermore, the CHP will

[18] The HSDP aims to contribute to achieve MDG targets, especially goal 4, 5 and 6.
[19] Related WHO health system building block: Health Delivery
[20] An evaluation of the MDTF-Health, BSF and SHDT will need to provide recommendations for the most effective program and funding modality to contract Non-Government agencies to provide BPHS.

help refer those who are in need such as pregnant women for ANC and skilled birth attendance and children for vaccination. Other activities in the CHP will include provision of bed-nets to pregnant women and children under 5-years of age, follow up of DOTS treatment, and support with immunization and Vitamin A outreach actions. The current CHW cadre will be reoriented to play a pivotal role in the CHP. The CHP will be strengthened with a clear and focused community communication strategy to convey health messages using all available media appropriate for the local context.

Equitable distribution of the PHCUs and PHCCs which are the main PHC service delivery points will improve. Moreover, functioning of SMoH and CHDs in respect of planning and supervising services will be strengthened through developing guidelines and adopting standards. The distinction in levels of service provision between PHCUs and PHCCs will be reconsidered in view of the current constraints and in relation to a reallocation of the cadre of CHWs from the PHCUs to a (future) CHP. A reduction and reorganization of existing CHDs will be pursued. CHDs will be linked to newly established Health Counties which will relate to catchment areas of existing Hospitals and not to existing administrative constituencies.

3.2 Communicable and Non-Communicable Diseases, HIV/AIDS

The strategic objective is to strengthen prevention and control of communicable diseases.[21]

National policies and programs on communicable diseases work predominantly in an isolated vertical fashion with limited coverage and are implemented through out-sourcing mostly by NGOs. In principle limited interaction and integration may undermine the establishment of a routine and functional PHC system. For the time being, vertical programs need to be consolidated, expanded and supported to integrate into the regular, routine health care system. The MoH programs at central level and health care delivery programs especially the BPHS at field level will control the high prevalence of the diseases throughout the country. At central level, the relevant departments and disease programs will develop country wide strategies, guidelines and standards to be applied at the health care delivery levels by contracted partners and other providers. In addition, the central level will establish and maintain a proper surveillance system for key communicable and non-communicable diseases.

At community level, the CHWs will play a key role in minimum service provision, health promotion in regard to diseases, referral and reporting. To reduce the impact of malaria, emphasis will be put on prevention, early diagnosis and treatment of cases. Adequate supplies of LLINs and treatment chemicals will be ensured and distributed to all counties. Indoor residual spraying, especially for urban dwellers, and selective vector control activities will be undertaken to minimize the vector-human contact. Health facilities will be provided with guidelines, adequate drugs and diagnostic equipment and supplies. Public education on the prevention of TB, early diagnosis and appropriate treatment will be the cornerstones of TB control. TB DOTS will be expanded to all communities through BPHS and community health programs.

Priority areas for Communicable and non-communicable Diseases:

1. *Expand and mainstream Malaria program into general health system with focus on prevention, early diagnosis & treatment;*
2. *Expand and mainstream TB program and TB DOT strategy into general health system with focus on prevention, early diagnosis & treatment;*
3. *Design, roll-out comprehensive NTD program;*
4. *Where possible integrate programs into the PHC, using a phased approach;*
5. *Improve diagnostic capability for communicable and non-communicable diseases.*

Public education on the prevention and elimination of NTDs will be undertaken. A nationwide mapping exercise will identify at risk populations and appropriate responses. Integrated diagnosis and management of NTDs will be administered through treatment schemes in selected PHCCs and expanded according to the epidemiological trends. Mass treatment for selected NTDs, in particular Schistosomias, Onchocerciasis, Lymphatic Filariasis, Soil Transmitted Helminths and Trachoma, will

[21] Related WHO health system building block: Health Delivery

be undertaken. Focused activities for the prevention and treatment of Kala Azar will be undertaken in areas of high prevalence. The use of nets will be promoted for the prevention of Kala Azar and Onchocerciaisis.

To control HIV/AIDS, the MoH is committed to implement programs under the National HIV/AIDS commission. MoH will focus on prevention, treatment, care and support of individuals and families affected by HIV/AIDS and integration with TB services. Public awareness will be promoted, Voluntary Counseling & Testing (VCT) will be established and efforts will be paid to eliminate stigmatization. PMTCT services will be integrated into ANC services. Procedures will be defined and equipment and supplies for safe blood transfusion services will be provided to minimize HIV transmission. Health facilities will be equipped to provide expanded VCT and Anti-Retroviral Therapy services (ART). A HIV/AIDS workplace program will be established.

Priority areas for Prevention & Care of HIV/AIDS:

1. *Promote an integrated approach towards TB, HIV/AIDS prevention, treatment and care;*
2. *Develop HIV/AIDS workplace program, including attention to blood safety and universal precautions;*
3. *Maximize contribution of the Health Sector towards National HIV/AIDS Commission.*

3.3 MATERNAL, NEWBORN AND CHILD HEALTH

The strategic objective is to improve maternal, newborn and child health. [22]

The BPHS will be the cornerstone of the provision of mother and child health care. In addition, all the hospitals as a priority will focus on maternal and child health services. Guidelines will be developed/adopted to ensure guidance for service providers at levels of the health facilities.

Family Planning services, including adolescent friendly services, will be provided to reduce unwanted pregnancies. Focus will be on the provision of appropriate packages/choices of contraceptive methods, adequate to the needs and views of users. Further options such as contraceptives social marketing will be explored to improve access to family planning methods. Contraceptive Commodities and logistic system will be strengthened through developing guidelines to cover quality assurance, capacity building, and forecasting commodity requirements as well as streamline logistics and procurement.

Sensitization and education programmes will be undertaken by community workers, health professionals and mass media to promote ANC, skilled deliveries and the dangers of home births. Emphasis will be placed on attendance of four ANC visits during each pregnancy including provision of PMTCT services. Relevant IEC/BCC materials will be developed and distributed to all HFs in local languages. Community health workers job descriptions will be revised to better accommodate the current needs in relation to maternal and child health.

Health facilities will be equipped with skilled personnel, equipment and supplies for delivery (BEmOC, CEmOC) and postnatal care. A National Reproductive Health Rights programme will be formulated to reduce gender-based discrimination. Renovation of HFs and construction of delivery rooms will be dealt as a priority and will be part of the contracts of service provider. In addition, maternity waiting homes will be established in proximity of hospitals to provide opportunity for mothers to wait for a safe delivery. Innovative options will be explored to provide incentives for mothers and children for utilization of maternal and child health care. Likewise incentives to improve the supply side will be explored.

Priority areas for Maternal, Neonatal & Child Health:

1. *Increase access to Maternal, Newborn and Child Health service;*
2. *Implementation of a comprehensive package of high-impact interventions for child care;*
3. *Expanded routine programme on immunization in PHCC.*

[22] Related Health System Building Block: Service Delivery (WHO)

An integrated package of services with a focus on high impact interventions will be offered to improve child survival, growth and development. The prevention, early diagnosis and treatment of the main causes of morbidity, malnutrition and mortality will be promoted. Detection, early treatment and prevention of severe acute malnutrition in under five children will be undertaken through screening, and referral, promotion of improved IYCF practices, growth monitoring activities, supplementary community feeding and exclusive breastfeeding and nutrition education. The use of clean water, sanitation and easy, evidence-based hygiene practices, such as hand washing, will be promoted. Immunization of children and women of childbearing age will be strengthened through the establishment of cold chain infrastructure, personnel training and public education. Vitamin A supplementation and de-worming will also be provided to children and vitamin A supplementation to post-partum mothers. Routine immunization, surveillance and supplemental immunization activities for eradication of poliomyelitis, control of measles and elimination of maternal neonatal tetanus will be given priority.

3.4 Public Nutrition

The Strategic Objective is to improve the nutritional status of the population especially mothers and children.[23]

Improving the nutritional status of mothers and children will be addressed by applying multiple strategies. Increased awareness about nutrition among the general population and promote healthy eating is important and the reduction of the prevalence of major micronutrient deficiency disorders will be achieved. Case management and increase access to quality therapeutic feeding and care at health facility and community levels will be promoted. Monitoring the nutritional situation in South Sudan will be strengthened and appropriate nutrition strategies and programs will be formulated.

Priority Areas for Public Nutrition:

1. *Increase public awareness about nutrition and promote healthy eating;*
2. *Reduce prevalence of major micro-nutrient disorders;*
3. *Strengthen case management and increase access to quality therapeutic feeding;*
4. *Monitor Nutritional Status of most vulnerable groups for emergency planning and public nutrition intervention.*

3.5 Hospital Services

The strategic objective is to improve hospital services to complement referral services, especially for mothers. [24]

The serious lack of access to essential hospital services has to be addressed with a mix of short-term, medium term and long term approaches. In the short run, current available resources will be revisited and efforts will be paid to fix those problems which can help the hospital better operate. Hospitals will re-organize outpatient and emergency departments to immediate improve levels of care especially for mother and children services. Hospital laboratory services and blood banks will need immediate improvement. Supervision systems will be instituted.

Hospital management and hospital management systems will be strengthened. In the medium term, a new framework for hospital services will be developed, defining principles and policies for hospital services, including levels of hospital care, the position and relation of County, State and Teaching hospitals with regards to levels of services provision, coverage, trainings, supervision and so on. A future hospital policy and strategy will be developed. The minimum hospital care will become accessible. In addition, guideline for hospital management, referrals from primary health care level,

[23] Related WHO Health System Building Block: Health Service Delivery

[24] Related WHO Health System Building Block: Service Delivery

quality assurance, HMIS of the hospital sector will be developed. In the long run, options of cost sharing, insurance schemes, fee for services and initiating partnerships with the private sector will be considered.

Priority areas for Essential Hospital Service:

1. *Improve Basic Hospital Service delivery;*
2. *Improve Hospital Management;*
3. *Improve Hospital Management Systems;*
4. *Expand Hospital infrastructures.*

3.6 MANAGEMENT AND GOVERNANCE

The strategic objective is to improve management and governance of the health sector.[25]

Developing capacity of the health sector is an important challenge, it will need to be focused, prioritized and progressive. In the short run priority is on strengthening MoH and SMoH, followed by strengthening capacities of the CHDs. Management and organizational processes will be reviewed and improved. This will include organizational review of the TORs of different departments, adjusting the HR needs within each department, and identification of technical assistance for each department. In addition, guidelines for HR performance review will be established in collaboration with the Ministry of Labor and Public Service (MoLPS). Training needs assessment for management levels at central and state levels will be carried out. Capacity building will be carried out and evaluated.

In line with this NHP, all the programs will develop or modify their current strategies. A corporate communications strategy for the Ministry which highlights internal and external communications of the MOH will be developed and implemented. Key operational manuals especially the procurement and finance manuals and guidelines will be developed and a committee established to manage and monitor Ministry procurement.

An inventory of all available legislations and regulations will be made. A committee will be established to prioritize and plan for the revision and development. TORs of current coordination mechanisms will be reviewed and according to the needs adjusted which will ensure improved coordination at central and state levels between MOH and all partners.

The Financial Management Information System (FMIS) will be used to track financial disbursement and budget performance at all levels. Annual public audits will be established. The electronic payroll system will be rolled out in all SMoHs. Legislation currently governing the health sector will be reviewed (e.g. The Public Health Act, The Food and Drug Act), in order to tailor it to the specific needs of Southern Sudan. A new legal framework and relevant professional councils, such as a Medical Council, will be developed. Furthermore, effective accountability mechanisms will be established.

Prority areas for Management & Governance:

1. *Strengthen administrative management and organizational processes, tools and systems of MoH-GoSS and SMoH & CHD;*
2. *Improve Communication and coordination;*
3. *Improve Health Sector Regulation and Legislation.*

[25] Related WHO Health System Building Block: Governance and Leadership

3.7 HUMAN RESOURCES FOR HEALTH

The strategic objective is to strengthen HRH production, management, distribution and development.[26]

A mix of strategies are needed, both in the short-term as well in the longer term to realize sufficient and sustainable levels of qualified personnel for the sector to realize critical levels of service provision foreseen in the HSDP. Priorities will focus on HR production, development, support practices, distribution, establishing the HR information and coordination with the Ministry of Higher Education over production of medical doctors.

In the short-term, recruitment and rational distribution, both locally and regionally is the most viable option to ascertain higher medical professionals cadres. As a short term solution, expatriate specialists' will be recruited to train registrars and manage and oversee clinical work in the hospitals. Concurrently, medical doctors from Southern Sudan will be sent for specialization training at universities in the region. Skill improvement of existing low level staff will be pursued and available qualified health personnel not yet employed, will be identified and deployed.

Community Midwifery education program will be further strengthened. Accreditation board for community midwifery that set the standards and undertakes accreditation will be established/refined. HR taskforce will be established to develop HR needed guidelines and standards including recruitment guideline which encourages competitive selection of the staff including administrative staff and supports a results-oriented culture where employees are rewarded for high quality work and expected to identify results.

In addition, for the staff working at the primary health care and hospitals as well as MOH at different levels, payment policies and retention guidelines will be developed. Further strategies to address critical HR production needs will be explored. This might include training of new categories of health personal at for primary health care, for example community nurses with the same model of CME which will mainly address the TB, Malaria and HIV issues. HR information as part of routine HMIS needs to be dealt as a priority.

In the longer run, training schools and institutions need to be strengthened to cater for the future need of health personnel. Training curricular and qualifications will be standardized and a National Examination Board will be established. Existing norms and Human Resources for Health Sector Development Plan will be reviewed to link staffing requirements with the national training capacity. In-service training schools will be rationalized, designated and properly equipped with didactic materials and instructors. Overall, proper HRH planning and management will be critical to retain and attract personnel and a comprehensive system will be put in place.

Priority areas for Human Resources for Health:

1. *Immediate recruitment and deployment of HRH both, locally and regionally;*
2. *Skill development and Task Shifting;*
3. *Rationalize and improve output of medical training school;*
4. *Improve HRH Planning & Personnel Management.*

3.8 PHARMACEUTICALS AND MEDICAL SUPPLY SYSTEMS

The strategic objective is to create an enabling environment to ensure availability and management of quality pharmaceutical and supply systems.[27]

[26] Related WHO Health System Building Block: Human Resources. An indicative assessment of the existing HRH gap and projections for required recruitment is provided in Annex I. This however needs to be updated based on a comprehensive mapping of all HRH.
[27] Related WHO Health System Building Block: Health technology and Infrastructure support

A five year pharmaceutical sector strategic plan will be developed with appropriate legislation. Drug registration, inspection and licensing of pharmaceutical premises, importers and personnel will be strengthened. Furthermore, a national quality control laboratory will be established. A pharmaceutical supply system will be changed from a 'push' to a 'pull' system. Existing storage facilities will be renovated and properly equipped. New storage facilities will be constructed.

A Pharmaceutical Management Information System (PMIS) will be established to inform product selection, quantification, procurement, distribution and use. Inventory control and management, good storage and distribution practices and fleet management will be improved through capacity building. Capacity building on rational drug use and adherence to standard prescription and dispensing practices will be undertaken. Harmonizing procurement and distribution of pharmaceuticals of the various vertical programs in to the regular supply chain is an important priority.

Priority areas for Pharmaceuticals & Medical Supply systems:

1. *Ensure accessibility at all levels of safe pharmaceuticals, medical supplies and equipment;*
2. *Strengthen control of quality, safety and efficacy;*
3. *Harmonization, coordination of procurement, stocking and distribution of pharmaceuticals, and medical supplies including that of programs.*

3.9 CAPITAL INVESTMENT AND INFRASTRUCTURE

The strategic objective is to rationalize distribution and improve and maintain the infrastructure of health service delivery points.[28]

A comprehensive master development plan is needed to assess status of current health infrastructure and to bring it up to date in line with changed population distribution and densities also considering capital development costs, running costs and HRH requirements. A selection of existing health facilities, hospitals and auxiliary buildings (staff houses etc.) will be renovated and a 5-year rehabilitation programme is proposed. Maintenance of health infrastructure and equipment is paramount and maintenance plans and budgets will be developed.

A functional referral system is needed for clients in need of basic and advanced care and support. A strategy will be worked out looking into the most appropriate communication and logistics arrangements and requirements to improve and maintain the referral system.

Priority areas for Capital Investments & Infrastructures

1. *Renovate, reconstruct and expand and maintain health infrastructure;*
2. *Upgrade and maintain medical equipment and means of transport;*
3. *Establish and maintain Referral system.*

3.10 HEALTH SECTOR FINANCING

The strategic objective is to improve health sector financing. [29]

A comprehensive Health Sector Financing Plan will be developed to address the current and projected financing gap and mobilize adequate and sustainable resources through a variety of realistic strategies. Complementary funding strategies may involve carefully piloting the introduction of among others, pro-poor cost-sharing mechanisms, insurance systems and community contribution.

[28] Related WHO Health System Building Block: Health technology and Infrastructure support. An indicative projection has been made of required infrastructural improvements (Annex II). This is however subject to an comprehensive review and update.
[29] Related WHO Health System Building Block: Health Financing

The MOH also will investigate possibilities for the private sector to invest especially in the hospital sector and initiate partnership agreements.

Capacity of MOH at all levels will be improved in proper budgeting and efficient allocation of resources. In addition, economic evaluations such as studying the efficiency of services will be conducted when required. Furthermore, health facility financial management and autonomy of hospitals and other health facilities will be considered. In order to have updated information, National Health Account will be established. Financial information on continuous bases will be analyzed and information provided for decision maker with recommendations for scaling up cost effective interventions.Further innovative approaches such as Demand Side and Result based financing options will be studied to improve the coverage of primary health care services and improve efficiency. The sector, in collaboration with all partners will increase efficiency and effectiveness in the use of financial resources. New resource allocation criteria will be adopted to ensure increased and equitable allocations to States and Counties.

Priority areas for Health Sector Financing:

1. *Maximize Resources and reduce Budget Gap;*
2. *Develop and employ alternative funding strategies and minimize resource dependencies;*
3. *Increase Efficiency and Effectiveness of Financial Resources.*

3.11 HMIS, MONITORING AND EVALUATION AND RESEARCH

The strategic objective is to enhance evidence based decision making through establishing HMIS and M&E systems and to promote a culture of data use.[30]

An M&E policy and strategic plan that spells out roles and responsibilities of all actors at all levels will be developed. As one of the initial steps an M&E advisory board or task force will be established, information needs will be assessed and guidelines and tools will be developed. Initially the primary health care and as a second priority the hospital sector and private sector HMIS will be covered. Routine and non-routine HMIS will be further rolled-out, maintained and strengthened. The HMIS department will be better staffed and staff trainings will be executed at all levels. Disease programs data collection to the extent possible will be integrated into one system.

A survey plan as part of HMIS plan will be developed and coordination will be ensured by other organizations especially Statistics Bureau of the Government. National Monitoring checklist which will also cover community based activities will be developed, piloted and implemented. Computerized database for HMIS, Trainings, Grants, Human Resources and Monitoring Check list will be developed and linked. Supervision will be strengthened in HMIS system. A research policy will be drafted, outlining MoH priorities and an agenda for operational research most beneficial for South Sudan. In addition, a research board or Ethical Review board will be established.

Monthly reports by HFs and quarterly reports at county, state and national level will be produced to provide information for decision making and proper monitoring.

Priority areas for Monitoring, Evaluation and Research:

1. *Develop a comprehensive M&E Plan;*
2. *Improve, consolidate, expand and maintain an integrated routine and non-routine Health Information System;*
3. *Develop an appropriate operational Research Agenda.*

3.12 CROSS CUTTING PRIORITIES

Cross cutting priorities relate to issues and approaches applicable across all elements of the health Sector.

[30] Related WHO Health System Building Block: Health Financing

3.12.1 Quality & Equity

The MoH will consolidate and enhance policies, strategies, work plans and manuals for quality improvement, both general as well as disease specific. Standard Operational Procedures (SOP), Treatment Guidelines (TG) and standards are available or are under development. During the implementation of HSDP, the emphasis will be on putting developed quality improvement systems in place and introduce a quality culture in the health sector, which makes health workers proud and self-confident and increase patient satisfaction. Quality will also be enhanced for all elements of the health system such as infrastructure, equipments, medicine and supply, HRH and management of all levels.

Equity in health means a fair distribution of services, whereby all citizens enjoy similar rights of access, irrespective of income, gender, age, religion, geographic location, etc. Equitable service provision will have priority, giving preference to those in the society who are most vulnerable and who have the least possibilities to fend for themselves. Access to health services for vulnerable groups in the society at all times is the commitment of the government. Remote rural areas with pockets of poverty and ill-health will receive special attention.

3.12.2 Gender

In policies and strategies gender issues are addressed. Translation into practical measures will take place or will be enhanced. Health workers are trained in recognizing and addressing specific health problems of women and men. More security and privacy will be offered to clients attending the health services and confidentiality will be improved. HIV/AIDS and reproductive health will be priority areas of intervention. Men should be made aware of the special health needs of women and should take their responsibility in family health affairs. The MoH will ensure that women are offered opportunities for higher management positions and that women are participating in decision making bodies, like health facility boards and committees.

3.12.3 Community Ownership

Individuals and families hold the key to maintaining and improving their own health. Healthy lifestyles reduce the risk of diseases and illnesses. Proper care at home enhances recovery and reduces risk of complications. Communities and health services have a shared interest in this matter. Individuals, families and communities are empowered to be more pro-active in health promotion, prevention and care. Awareness rising is important, combined with information and education. Programmes will incorporate community elements. At the same time, communities should feel more ownership of health services in their neighborhood and take responsibility in the management of the health facilities, in committees or boards. The change of unhealthy life styles to a large extent reduces individual susceptibility to diseases. Individuals must be empowered to adopt lifestyles favorable to health.

3.12.4 Coherence in Health Planning and Implementation

The final beneficiaries of all health services are the individuals and families. They are best served through a holistic approach, when a coherent package of services is offered, which is linked to improvement of quality of life. Coherence between vertical diseases programmes is important. All levels of the health system will concentrate more on coherence, rather than enhancing a fragmented approach. Joint planning and implementation at Central and State level will be stimulated. Further integration in training programmes of health workers is necessary, ensuring that peripheral health workers are capable of addressing in a comprehensive manner the health needs of the communities.

Coherence between various sectors is required, particularly with education, nutrition and the water sector. Comprehensive State and County Plans in which health services are offered in coherence with interventions of other sector offer opportunities for collaboration, integration and improved service delivery. The health sector will maximize its support to the National Social and Human development 'Pillar' and strive for comprehensive planning and implementation of sector programmes.

3.12.5 Environment

In collaboration with other relevant ministries, departments and organizations, the MoH will increase awareness and understanding of potential adverse health consequences of environmental factors, such as poor water supplies; lack of adequate sanitation facilities; inadequate rubbish disposal and collection, poor food handling and hygiene; and high levels of air pollution. Health facility proper wastes disposal will be one of the areas that the MoH will have to address within the health care delivery levels. Various mechanisms will be used to raise awareness and understanding of the public. The MoH will develop an environmental policy and strategy that defines where and how it can be most effective in preventing illness due to adverse environmental factors. It will also develop and distribute guidelines on good environmental health practices.

3.12.6 Public Private Partnerships

The health policy acknowledges the contribution of the private sector in health service provision. One of the objectives is increased participation of the private sector in achieving access to health services at all levels. It is crucial that SMoH and CHDs, non-state health providers and civil society organizations and other relevant sectors improve collaboration, working in a complementary way. A framework to advance PPP including new institutional arrangements to advance PPP at MoH and SMoH will be put in place. Distinctive competencies of service providers across the sector have to be recognized and incorporated. Performance Service agreements will provide mutual benefit for Governments and private providers. Private providers will be granted access to government funding on the basis of these Service Agreements. The capacity of the MoH and SMoH in managing negotiations and contractual arrangements will be strengthened. Private providers will be stimulated to step up service provision to vulnerable groups and in remote areas. Partnership with private service sector and industry related to health will be explored and strengthened.

IV HSDP IMPLEMENTATION

This chapter provides a description of important arrangements for the implementation of the HSDP. It describes the modalities for its management and administration, the role of various partners who will be active next to the MoH and the arrangements between the MoH and International partners providing aid. The chapter describes budget and financing options of the HSDP and it sets out monitoring and evaluation arrangements. The chapter concludes with critical assumptions and a risk analysis.

4.1 MANAGEMENT AND ADMINISTRATION

The MoH is responsible for the overall stewardship of the health sector. It is responsible for the overall implementation and monitoring and evaluation of the HSDP. As result of the Decentralization by Devolution, the MOH does not have direct responsibilities for operational service delivery at State and County level. However, the MoH provides guidance to service providers and monitors the quality of the service delivery. Guidance of the MoH is provided by 7 Directorates, each responsible for a distinct technical area and a proper functioning and cooperation between these departments is essential for the successful implementation of the HSDP. Technical direction is mainly given through health programmes which provide treatment guidelines, standard operational procedures and contribute to capacity building of service providers. Under the HSDP, this support will be more integrated and coordinated.

For resource mobilization the MoH relates to the Government, particularly to the MoFEP. The MoH has its annual planning cycle in the context of the overall Government's planning cycle which is applied in all institutions of Government. The planning concerns only those activities, which are directly under head quarter's responsibility. The planning will be strengthened, concentrating more on contents and priorities. Financial planning and budget execution will be improved. Annual budgets are approved by the Council of Ministers and the Parliament. The MoH also mobilizes resources through Bi-lateral and Multi-lateral donors and partners. Monitoring and evaluation is important in the MoH, for reasons of planning and accountability (refer to M&E Section of this chapter) and strengthening the monitoring and evaluation is an important part of the strategies under the HSDP.

Cooperation with (semi-) autonomous bodies under the MoH such as the AIDS Commission, Medical council, Pharmacy Council and Medical Commission are important for various aspects of the HSDP most notably for drafting and introducing new regulation. Responsibilities for operational planning and implementation of activities of the HSDP rests for a large part on SMoHs, CHDs, individual Health Facilities such as PHCUs and PHCCs as well as hospitals and training institutions. Capacity building of all these levels and actors in the health system is an important objective of the HSDP.

For implementing the HSDP and improving sector management and administration, technical assistance (TA) is required for supporting all blocks and various areas of the health system. TA is required in the areas of procurement especially service procurement, health financing and financial management, monitoring and evaluation, HIS and IT, hospital management and development, developing legislations, pharmaceutical management, Health System Strengthening, Human Resources and Health Planning.

4.2 ROLE OF OTHER ACTORS

4.2.1 Other Ministries

The MoFEP has an important role in disbursement of funds for health and in accounting for the expenditure. It provides the annual budget indications, which are crucial in the planning process. Therefore there is close collaboration between the MoH and the MoFEP and good communication is paramount. MoFEA transfers funds for health to MoH and conditional funds for health directly to the SMoH. Improved systems for budgeting, transfer of funds and auditing of accounts are crucial.

Other Ministries are important for elements of the health programmes such as the Ministry of Agriculture and Forestry with respect to nutrition, Ministry of Water Resources and irrigation in respect

to sanitation and water borne diseases and the Ministry of Gender, Child and Social Welfare with respect to gender issues and maternal and child health. The Ministry of Education is important as well specifically in relation to training of Medical Doctors at Juba University. Moreover, the Ministry of Education may be important in relation to future school health programmes. Establishing a good cooperation as well as developing tools and systems to enhance coherence and comprehensiveness in planning and interventions is important and need to be established. Most of these Ministries are grouped into the Human-and-Social-Development 'Pillar', currently in the process of drafting the South Sudan Development Plan 2011-2013.[31]

In relation to more overarching development aspects of the sector, the MoH need to cooperate closely with the Ministry Housing and Physical Planning particularly in relation to infrastructural development of the sector. The Ministry of Legal Affairs and Constitutional Development is important in respect to health legislation. The Ministry is dependent on all these ministries to achieve the strategic objectives of the HSDP. The senior management in the Ministry maintains working relations and promotes attention for health related issues. Divisions collaborate in programme implementation.

4.2.2 Non Governmental Partners

Many different non-government partners provide health services in South Sudan. They range from local NGOs, International NGOs, private practitioners and pharmacies and Faith Based Organizations (FBOs). NGOs may be self financed however many NGOs receive Government funding through special support prgrammes.. There is a high variety and extent in their service provision which can range from operating a small program or health facility to running a County hospital or (part off) a national vertical program. Overall, integration of non-government agencies in the public health sector is limited and their inputs are highly fragmented and poorly coordinated. A substantial number of NGOs is involved in Humanitarian Relief activities as well. Representation of the NGO contribution and interest to the health sector is carried out at the MoH level through the health cluster previously the NGO Health Forum.

Meaningful coordination of non-Governmental agencies at State and County level is virtually non-existent. The HSDP aims to improve coordination mechanisms, among others through the introduction of regular Health Sector Coordination Meetings (HSCM) at State level. Moreover, the MoH, through the drafting and adoption of a PPP framework intends to maximize input and output of non-governmental partners in health service delivery also with the consolidation and further development of contracting-out services. Linking Relief and Development poses another challenge to the health system.

4.3 AID ARCHITECTURE AND ALIGNMENT

Aid architecture specifically refers to arrangements governing the relationship and coordination between the MoH and the International Partners providing support to the health sector. The MoH is committed to establish, modify and maintain institutional and organizational arrangements that; (i) maximizes donor's interest and commitment to support to the health sector; (ii) increases donor's coordination in view of National health policies and strategies and; (iii) provides a effective platform to further develop the health sector in the longer run. [32]

The Health and Nutrition Consultative Group (HNCG) will be the main platform to cater for consultation and dialogue between the MoH and International partners and likewise facilitate alignment within the international donor community.[33] Essentially it entails a representative framework for collaboration among the major stakeholders, International Donors and Non-Government agencies under stewardship of the MoH. It aims to exchange of information, reaching consensus and coordination among various partners and programs, reviewing policies and sector plans and advising the MoH. It aims at creating synergies and reducing transaction costs. Existing forums such as the Health Sector Working Group, the NGO Health Forum and the Health Sector Donor Group will provide input to the HNCG. Institutional, organizational, communication and management

[31] Guidelines for drafting the Southern Sudan Development Plan 2011-2013, MoFEP, 2011.

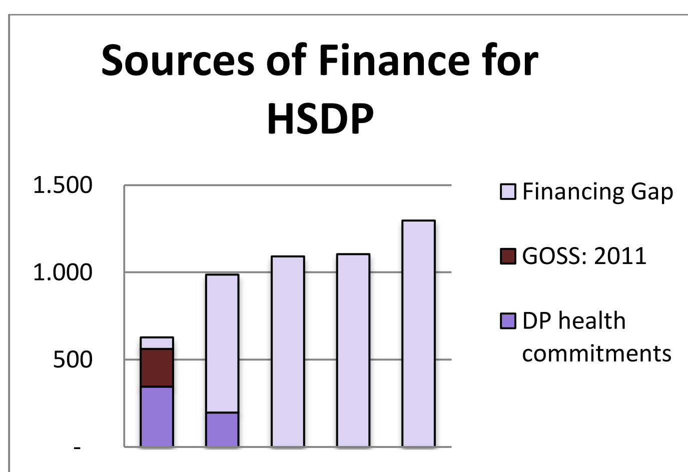
arrangements will be worked out and agreed upon to make this platform work effectively and efficiently.

4.4 Indicative Budget and Financing

A budget is provided (Annex IV) for the purpose of indicating expected costs for the full implementation of the HSDP. However, it is realized that budgets are subject to change in the years to come. The estimated costs for the implementation HSDP is SDG 5,112 Million over a 5-years period. The annual cost rises from SDG 629 million to SDG 1,298 million between 2011 and 2015. This is due to increasing infrastructure development costs and increased running costs of existing and new health services. The Indicative HSDP budget allocates for: (i) Operational costs, (ii) capital costs and (iii) Governance and management.

It is assumed that funding from domestic resources will gradually increase in the 5-years period to cover the significant funding gap and it is the intention from the Government to increase its share for running costs, especially salaries and drugs. It is paramount that alternative funding strategies and sources need to be explored and the MoH is committed to explore possibilities and potentials in this respect. However, it is evident that a huge funding gap need to be overcome and that assistance from foreign donors will be crucial.

Bar Chart 1: Sources of Finance for the HSDP



In 2011, sources of finance would be sufficient for approximately 90% of the projected HSDP costs. As most development partner funding expires between 2010 and 2012, the funding gap will increase after 2011. [34] In the short run, at least for the duration of the HSDP, it is therefore crucial that sources from donor partners will continue to supplement the Government budget to be able to achieve HSDP ambitions. The Government aims at aligning partners resources as much as possible in line with the priorities of the Government in order to minimize transaction costs and maximize efficiency and effectiveness.

4.5 Monitoring and Evaluation

Monitoring and evaluation (M&E) is essential for evidence-based decision-making and modification of implementation plans in view of pertinent changes in the context, other priorities or limitations in available resources. Moreover, M&E is important for accountability. Monitoring the developments in

[32] In line with the Paris Declaration on Aid effectiveness (2005), a global effort for more harmonization in development aid based on 3 principles: (1) Ownership; Partner countries exercise effective leadership over their development policies, and strategies and co-ordinate development actions, (2) Alignment; Donors base their overall support on partner countries' National development strategies, institutions and procedures and (3), Harmonization; Donors' actions are more harmonized, transparent and collectively effective.

[33] Refer to the TOR of the Health and Nutrition Consultative Group (HNCG), September 2010.

[34] Planned GOSS funding after 2011 is not known and allocation is therefore not shown in subsequent years.

the health sector largely depend on existing routine and non-routine monitoring systems collecting information on health services on regular basis. [35] The monitoring of the HSDP will largely depend on these existing systems.

The 5-year period of HSDP does not allow realistic formulation of quantified targets and therefore concentrates on expected results which encompass impacts, outcomes and outputs.[36] A Result Framework is attached (Annex V) which indicates the expected general outcomes for the 5 year period. However, the envisaged annual work plans foresee in targeting and formulation of specific outputs and activities. The translation process from the strategic objectives of the HSDP into annual quantifiable targets, indicators and budgets is therefore crucial. Annual planning has to be done by MoH and SMoH/CHD within the context of the guiding principles and strategies of the HSDP. Work plans should be realistic and achievable and should relate to the resources available as well as to its relevant contextual constraints. Defining work plans for implementing priority areas and achieving expected results is best done in the context of the operational planning of the MoH and SMoHs in coordination with relevant partners and implementing agencies.

For the purpose of monitoring the health sector and progress of the HSDP, a series of indicators has been developed, divided into health status indicators, health services indicators and health systems indicators (Annex III). Not all indicators can be measured at the same time or in the same interval. Some of the indicators can only be measured every four years, when a demographic health survey is undertaken, others can be measured annually or even quarterly, when using the routine information system. The indicators were selected addressing the most critical issues of HSDP. However, a number of indicators also have operational importance for quarterly planning of activities at various levels. As mentioned, the strategic indicators are to be translated into quantified targets and outputs in the annual planning process. Next to indicators of the HSDP, vertical programme specific indicators are mentioned. The information on those indicators will be collected as planned and used for M&E of these specific programmes.

The MoH will conduct annually a review and will share its outcomes with all partners. Two reviews are foreseen during the implementation of HSDP: the mid-term and end-of-period review. These reviews will provide in-depth analysis of the strategies and their implementation. Internal and extern experts will present a joint analysis and give recommendations on further implementation of the HSDP.

4.6 Assumptions and Risks

The implementation of the various components of the HSDP may be subject to specific factors, conditions or decisions outside the control of the HSDP but necessary for its realization. It is therefore required that assumptions will have to be made under which the HSDP will be realized. These assumptions are best considered during the annual operational planning based on a thorough analysis of the wider context in which the Health Sector operates.

However, three important external conditions should be in place for the achievement of the objectives of HSDP and these need to be monitored closely;

(i) Political stability and economic growth. South Sudan is in transition to become an independent Nation and it has a recent history of prolonged civil strife. The HSDP can only be implemented if political stability will foster coupled with economic growth. In relation to this is the need for the development of an efficient and effective Public Administration characterized by a sufficient cadre of professional civil servants engaged in key positions.

(ii) Availability of HRH. The functioning of the health sector depends particularly on the availability of human resources with the proper skill mix. Salaries, working conditions and career perspectives must be attractive also to prevent 'leakage' to other sectors or the private sector.

[35] Such as: HIMS, Disease Surveillance, Health Management Information System, Demographic Health Surveys, Health Systems Survey, Malaria Indicator Survey, Health Facility Assessment, Health Programmes Reporting Systems and other health surveys and research.
[36] Usual terminology used in the Logical Framework methodology.

(iii) Community commitment to health. Increased community ownership is mandatory to reverse negative morbidity and mortality trends. Improved community responsibility for health matters in terms of organizing and overseeing preventive health care activities will be elementary to be able to achieve important HSDP objectives. Obviously this approach is relatively new and requires a prolonged time to progress and mature. Lack of community involvement may jeopardize the implementation of the HSDP.

ANNEX I INDICATIVE HRH GAPS, PROJECTIONS & RECRUITMENT

Tabel I-1: HRH Gap and Projection

Human Resources for Health	*2010 Baseline (HFM Mapping)*	*2015 Ambition (BPHS norm)*	*No. HRH to Recruit*
Consultant/Specialist/Registers	32	109	**77**
Medical Officers	86	313	**227**
Registered Nurse	83	417	**334**
Certified Nurse	1110	2,353	**1,243**
Registered Midwife	19	73	**54**
Cert. midwife/cert. Comm. Midwife	132	1,362	**1,230**
Community Health Worker	1,894	947	**(947)**
Clinical Officers	224	730	**506**
Laboratory Technologist	38	77	**39**
Laboratory Technician	75	311	**236**
Public & Env. Health Officer	37	317	**280**
Pharmacists	18	65	**47**
Pharmacist Technician	32	306	**274**
Nutritionist	35	252	**217**
Dentist	20	55	**35**
Dental Technician	14	96	**82**
Radiographic Technologist	14	52	**38**
Physiotherapist	13	52	**39**
Disease Surveillance Officer	35	79	**44**
Monitoring & Evaluation Officer	35	79	**44**
Total	**3,946**	**8,045**	**5,099**

Source: Baseline data from Health Facility Mapping – 2009/2010

Note: The Health Facility Mapping doesn't provide an exact number of Staff but gives a robust estimation!

Table I-2: HRH Recruitment Schedule

Human Resources for Health	*Total Recruitment*	*Local Recruitment*	*Regional Recruitment*	*Annual Regional Recruitment*
Consultant/Specialist/Registers	**77**	-	77	15
Medical Officers	**1,227**	188	1039	208
Registered Nurse	**334**	100	234	47
Certified Nurse	**1,243**	175	1068	214
Registered Midwife	**54**	54	-	0
Cert. midwife/cert. Comm. Midwife	**1,230**	235	995	199
Clinical Officers	**506**	415	91	18
Laboratory Technologist	**39**	39	-	-
Laboratory Technician	**236**	160	76	15
Public & Env. Health Officer	**280**	75	205	41
Pharmacists	**47**	-	47	9
Pharmacist Technician	**274**	-	274	55
Nutritionist	**217**	-	217	43
Dentist	**35**	-	35	7
Dental Technician	**82**	-	82	16
Radiographic Technologist	**38**	-	38	8
Physiotherapist	**39**	-	39	8
Disease Surveillance Officer	**44**	-	44	9
Monitoring & Evaluation Officer	**44**	-	44	9
Total	**6,046**	**1,627**	**4,419**	**884**

Note: HRH Forecasting is assumed based on 2 strategies: (i) recruitment of locally trained HRH and; (ii) regional recruitment from Northern Sudan, Ethiopia, Kenya, Uganda and Tanzania.

ANNEX II PROJECTION INFRASTRUCTURAL IMPROVEMENT

Table II-1: Projected Renovation, Reconstruction PHCUs, PHCCs and Hospitals 2011 - 2015

Type	*Renovation, Reconstruction*	*2011*	*2012*	*2013*	*2014*	*2015*	*Total*
PHCU	Major renovation: 6/7 per state per year	60	60	60	70	70	320
	Minor renovation: 3 per State per year	30	34	30	30	30	150
	Construction Staff Houses	40	40	40	40	40	40
PHCC (204)	Major renovation: 2 per State per year	20	20	20	20	20	100
	Minor renovation: 2 per State per year	20	20	20	20	20	100
	Construction Staff Houses	40	40	40	40	40	40
County Hospital (27)	Replacement / Repairs of all County Hospitals over 10 years period: 3 per year at least	3	3	3	3	3	15
State Hospital (7)	Repairs / Replacement all State Hospitals over 10 years (priority as from 2015)		0	0	0	1	1
Teaching Hospitals (3)	Repairs – 3 Teaching Hospitals over 10 years: Rebuilding of Malakal is priority		Malakal	Juba	Wau		
Specialized Hospitals	- Dr. J. Garang MH, - Maternal & Neonatal Centre, - Juba Diagnostic Health Care Centre, - Maternal Centre and Children's Hospital in Malakal.	1	1	1	1	1	5

Table II-2 Infrastructure Rehabilitation of the Health Training Network 2011-2015

State	***Construction***	***Estimated Budget in US$***	***Renovation/ Re-equipping***	***Estimated Budget in US$***
Lakes	**Lakes HTI accommodation** Build fifteen 4-bed dormitories on Rumbek Nursing School site. Existing prefabs in decay. Recent builds unsuitable.	150,000	*(Not necessary. Both sites renovated in 2010)*	
Jonglei	**Jonglei Health Training School:** (for Cert Comm Nurses transferred from Maridi) Build 4-roomed, tuition-only facility and 2 semi-detached houses for tutors	750,000	New site. All furniture and equipment needed.	100,000
Eastern Eq	**Torit Dental Training School** Build 4-roomed, tuition-only facility and 2 semi-detached houses for tutors. Existing two-roomed building in disrepair.	750,000	New infrastructure. Equip with 6 dental chairs	250,000
Central Eq			**Juba In-Service Tr Centre** (old Juba Health Sciences Tr Inst) Some equipment needed. Redecoration. Repair of boundary fence	50,000
			JTH Post-Graduate College (old JTH Technical Nursing Secondary School) Redecorate, re-equip	50,000
Western Eq			*(No new facility in this period)*	
Western BeG			*(No new facility in this period)*	
Northern BeG			**Aweil Health Training School:** (old Aweil Nursing School) Redecorate, re-equip	50,000
Warrap			Tonj Health Training School: (old Tonj Nursing School) Redecorate, re-equip	50,000
Unity	**Leer Comm Midwives Tr School** (new build on new site) Build bungalow complex, incl 4 large rooms, eight 4-bed dorms, tutor accom.	500,000		
			Unity HTI New infrastructure. All equipment and furniture needed.	150,000
Upper Nile	**Upper Nile HTI** New site. New build. Build raised complex, incl 4 large rooms, eight 4-bed dorms, tutor accom.	1,500,000	All equipment and furniture needed.	150,000
			MTH In-Service Tr Centre (old MTH Techn Nurs. Sec School) Renovate, redecorate, re-equip	50,000
MoH-GoSS			**Yei Foundation School** (old Yei National HTI) Some redecoration	50,000
			JTH Post-Graduate College (old JTH Techn Nurs Sec School)	50,000
Total		**3, 650,000**		**1,000,000**

ANNEX III HSDP INDICATORS AND M&E PLAN

Indicator	Baseline 2006-2015	Target	Data Source	Type	Frequency
Health Status					
Infant mortality rate (per 1,000 live births)	102	70	SHHS (2006)	Impact	DHS Interval
Under-five mortality rate (per 1,000 live births)	135	110	SHHS (2006)	Impact	DHS Interval
Proportion of under-fives severely underweight (weight for age)	14%	11%	SHHS (2006)	Impact	DHS Interval
Proportion of under-fives severely stunted (height for age)	18%	14%	SHHS (2006)	Impact	DHS Interval
Children 0-5 months receiving excl breastfeeding	30%	50%	MNRH (2007)	Impact	DHS Interval
Maternal mortality ratio (per 100,000 live births)	2054	1040	SHHS (2006)	Impact	DHS Interval
Percentage women under 18 years becoming pregnant	36%	28%	SHHS (2006)	Impact	DHS Interval
Total fertility rate of women 15-49 years	6.7	5.4	SHHS (2006)	Impact	DHS Interval
HIV Prevalence Among 15-24 year old pregnant women				Impact	DHS Interval
HIV Prevalence Among 15-24 year old population male/female	2.6%	2.1%	SHHS (2006)	Impact	DHS Interval
Service Delivery					
General					
Outpatient attendance per capita	0.2	1		Output	Annual
Number of context responsive CHPs in Payaam	0	50%		Output	Annual
Vaccinations					
Proportion of children under one vaccinated against DPT-3	71%	90%	HF Monthly reports 2010	Output	Annual
Proportion of children under 1-yr of age fully immunized	17%	50%	SHHS 2006	Outcome	DHS Interval
Proportion of children under 5 receiving vitamin A twice per year				Outcome	Annual DHS Interval
Children receiving ORS within 24 Hours onset symptoms	75%			Outcome	Annual DHS Interval
Proportion of pregnant women receiving at least 2nd dose of TT vaccination	65%	80%	HF Monthly reports 2010	Outcome	Annual
Reproductive Health					
Proportion of pregnant women attending ANC at least 4 times during pregnancy	48%	75%	MNRH Strategy (2007)	Outcome	Annual DHS Interval
Proportion of births attended by skilled health personnel	10%	50%	SHHS (2006)	Outcome	Annual DHS Interval
Proportion of births attended in health facility	13.6%	16.3%	SHHS (2006)	Outcome	Annual DHS Interval
Maternal Case Fatality Rate in health facilities	800	400	SHHS (2006)	Output	Annual
Women receiving C-Section	<0.5%	5%			
Modern Contraceptive prevalence rate	1%	5%		Outcome	Annual DHS Interval
Percentage of PHCUs & Hospitals that provide CEmOC	<0.5%	5%	Baseline & End Survey		Twice
HIV/AIDS					
Percentage of HIV positive women receiving ARVs to PMTCT		10%		Output	Annual
Number of persons with advanced HIV infection receiving ARV combination treatment (disaggregated under 5 and over 5 and sex)	4%			Output	Annual

Indicator	*Baseline 2006-2015*	*Target*	*Data Source*	*Type*	*Frequency*
Malaria					
Proportion of pregnant women receiveing two doses of preventive intermittent treatment for malaria.	13%		SSMIS 2009	Outcome	Annual
Proportion of pregnant women 15-49 yrs of age, children >under 5-yrs age) sleeping under an ITN the previous night	Women 36% Child 25%	Women 60% Child 60%	SSMIS (2009)	Outcome	Annual
Proportion of women having knowledge on the causes of malaria	58%	100%	SSMIS (2009)	Outcome	Annula
Children under- 5 yrs age having mild to severe anaemia	64%	25%	SSMIS (2009)	Impact	Biannual
Tuberculosis and Leprosy					
Incidence of TB cases New Sputum smear Positive per 100,000	79		NTLBP	Output	Annual
Incidence of TB cases All TB forms per 100,000	140		NTLBP		
Notification Rate New Sputum Smear + TB Cases per 100,000	26	79	NTLBP	Output	Annual
TB treatment success rate	78%	85%	NTLBP	Output	Annual
Leprosy Prevalence per 10,000	5.1	<1	NTLBP	Output	Annual
Leprosy treatment completion rate	80%	>95%	NTLBP	Output	Annual
Infectious and non-communicable diseases					
Incidence of cholera cases				Outcome	Annual
Proportion of treated cases of cholera who died				Output	Annual
Health Systems					
Financial					
Total GoSS and Donor allocation to health per capita (Budget + Off-Budget)				Input	Annual
MoH-GoSS budget disbursement to SMoH/CHD	10%	90%		Input	Annual
MoH-GoSS Budget expenditure Rate	56%	90%		Input	Annual
MoH Budget allocation (conditional grant) to States	24%	65%		Input	Annual
SMoH producing an annual Budget & operating sound FMS	0%	100%		Input	Annual
Human Resources					
Number of trained Community Health Activists at Payaam		25%		Input	Annual
Number of Medical Officers and Assistant Medical Officers per 10,000 population (by State)				Input	Annual
Number of Nurse-Midwives per 10,000 population (by region)				Input	Annual
Pharmacists and pharmacy-technicians per 10,000 population (by region)				Input	Annual
Number of training institutions with accreditation				Process	Twice
Proportion of qualified management and Admin staff in Key Positions				Input	Annual
Logistics					
Percentage of public health facilities without any stock outs of 4 tracer drugs and 1 vaccine	0%	50%		Input	Annual

ANNEX IV INDICATIVE BUDGET HSDP

	2011	2012	2013	2014	2015	Total
Operational Costs						
Primary Care	184,545,792	245,916,863	260,672,363	283,579,182	354,313,809	1,329,028,009
Secondary Care	168,784,316	220,893,078	285,308,009	367,320,762	474,498,399	1,516,804,565
Teaching & Specialist Hospitals	67,736,488	75,198,180	85,148,760	98,658,451	117,257,668	443,999,547
Management & Training	34,167,941	36,512,315	38,856,689	41,201,063	43,545,437	194,283,444
Total Operational Cost	455,234,536	578,520,436	669,985,822	790,759,457	989,615,314	3,484,115,565
Capital Costs						
Primary Care	31,343,852	163,108,638	163,108,638	50,167,392	31,343,852	439,072,371
Secondary Care	41,188,084	109,550,808	109,550,808	109,550,808	109,550,808	479,391,316
Teaching & Specialist Hospitals	28,712,750	52,032,750	52,032,750	52,032,750	52,032,750	236,843,750
Management & Training	17,774,583	17,774,583	17,774,583	13,669,583	13,669,583	80,662,917
Total Capital Cost	119,019,269	342,466,779	342,466,779	225,420,534	206,596,993	1,235,970,353
Leadership Governance & Finance	6,830,529	8,679,819	10,051,800	11,863,406	14,846,245	52,271,798
Human Resources	29,728,590	38,827,189	47,284,846	51,190,333	54,314,828	221,345,787
Health Infrastructure	2,798,958	260,696	260,697	260,698	260,699	3,841,749
Pharmaceuticals and medical supplies	8,233,609	11,412,348	14,208,415	18,329,330	25,228,161	77,411,864
Procurement	597,107	1,714,346	1,714,347	1,129,117	1,035,000	6,189,917
Monitoring and Evaluation Systems	6,268,731	6,268,732	6,268,733	6,268,734	6,268,735	31,343,665
Total Governance and Management Cost	54,457,525	67,163,130	79,788,839	89,041,618	101,953,669	392,404,781
TOTAL	628,711,330	988,150,345	1,092,241,440	1,105,221,609	1,298,165,975	5,112,490,699
Cost per Capita	72	110	118	116	132	-

Budget Notes (next page) sets out the parameters used for calculating the total cost of the HSDP. The costing covers the entire health sector. It provides an estimate of costs to all providers involved in delivering service. The costing does not determine the relative contribution to service delivery by Government, international partners, NGO, FBO or other private providers. The costing is not therefore a budget of any particular service provider or stakeholder. Such budgets depend on decisions by each organization in relation to its activities and costs. In some areas where detailed activities and costs are not yet available, provisions have been applied. The costing model can be adapted in the light of emerging information and decisions in relation to the HSDP. Key variables and unit costs can be amended (Excel).

BUDGET NOTES

1. Number of Facilities

The number of facilities is a major determinant of both the cost and feasibility of the HSDP. The costing provided is based on the number of PHCUs and PHCCs required to implement the BPHS. This number can be varied within the costing model. The current model makes provision for 68 County Hospitals, so that there is a hospital (County, State or Teaching) in each County.
The number of hospitals has a major impact on the cost and feasibility of staffing the service, resulting in an overall shortage of approximately 750 qualified midwives, and 600 qualified nurses. A smaller number of County Hospitals would reduce these numbers substantially.
The costing model allows different scenarios to be tested. For instance, 474 PHCUs and 204 PHCCs are required to achieve the norms stated in the BPHS. If, however, these numbers are doubled, the cost of the HSDP rises by over SDG 200m a year. The model also shows that this increases the shortage of registered and certified midwives by approximately 1,100.

1. Operating Costs

Operational costs of health centers are divided into its main components such as salaries, supplies and pharmaceuticals and other operating cost – maintenance, fuel, communication. Capital costs of facilities include the construction or renewal of facilities, the provision of medical equipment, means of communication and transportation. Governance and Management comprises a budget for six important elements to be improved in the HSDP period in order to ensure critical services provision: (i) Governance, management and finances; (ii) Human Resources for Health; (iii) Infrastructure Development Plans; (iv) Supplies Systems and Logistics; (v) Procurement and; (vi) Monitoring and Evaluation.

Table: Cost Summary SDG Million:

COST SUMMARY SDG million	2011	2012	2013	2014	2015	Total
Operating Cost	455	579	670	791	990	3,484
Health System Strengthening	54	67	80	89	102	392
Capital Cost	119	342	342	225	207	1,236
Gross Cost	629	988	1,092	1,105	1,298	5,112
Cost per capita in US dollars	$26	$40	$43	$42	$48	
SOURCES OF FINANCE SDG million						
GOSS: 2011	216					216
DP health commitments	346	197				543
Financing Gap	66	791	1,092	1,105	1,298	4,353
Total sources required	629	988	1,092	1,105	1,298	5,112

Operating Costs comprise the annual cost of delivering service, as well as support and administration to service delivery. The requirement for a hospital in every county weights expenditure towards hospital services. 58% of operating expenditure will be in hospitals, and 36% of expenditure in the community and primary care.
The distribution of operating costs between medical supplies, other operating costs and salaries is well balanced. The high cost of medical supplies reflects the planned growth in productivity, particularly in hospital services.

OPERATING COSTS					
BY FACILITY	**Total**		**BY FUNCTION**	**Total**	
Community	528	15%	Medical Supplies	1,548	44%
PHCU	217	6%	Other Operating Cost	711	20%
PHCC	584	17%	Salaries	1,225	35%
County Hospital	1,184	34%			
State Hospital	333	10%			
Teaching Hospital	444	13%			
County Health Department	83	2%			
State MOH	28	1%			
GOSS MOH	84	2%			
Operating Cost	3,484	100%	Operating Cost	3,484	100%

2. Medical Supplies

Strong provision is made for medical and other supplies, in order to achieve the HSDP objective of ending stock-outs of essential drugs. Supply cost rises with the volume of service delivery. By 2015, it reaches 51% of total operating cost.

3. Other Operating Costs

Discussions with providers have emphasised the importance of adequate provision for other operating costs at facility level. SDG 160 m a year (2015) is provided for utilities, consumables, maintenance, vehicle running costs and supervision.

4. Salaries

Sectoral staffing costs rise from an estimated baseline of SDG 152m in 2011 to 215m in 2015. This reflects the plan to increase qualified staffing, and to reduce the number of unqualified staff. Overall, staffing costs are within the typical range of salary costs in the health sector. While staffing numbers will not therefore increase greatly, the HSDP plans a major leap in productivity. Thus, the model shows that a PHCC in 2015 may have three times the number of attendances in 2015, compared with a baseline taken in 2008.

CHANGES IN PRODUCTIVITY		
Monthly Caesarean Sections	Baseline	2015 projected
County Hospital	approx 4 per hospital	9
State Hospital		19
Teaching Hospital		28
Daily Outpatient Attendances	Baseline	2015 projected
PHCU	199	572
PHCC	509	1,525

Staffing costs are based on current public service grades. Allowance is made for re-grading certified community midwives to reflect their qualification. Allowance is also made for closing a perceived gap between the basic salaries of public service and their counterparts in NGOs.

5. Health System Strengthening

Health Systems Strengthening is essential to the development of capacity within health services to provide the improvements of service delivery planned by the HSDP. Health System Strengthening reflects the essential areas identified within the HSDP. The financial provision for health system strengthening is equivalent to 11% of the operating cost.

HEALTH SYSTEM STRENGTHENING	Total
Leadership Governance & Finance	52
Human Resources	221
Health Infrastructure	4
Pharmaceuticals and medical supplies	77
Procurement	6
Monitoring and Evaluation Systems	31
Total Health Systems Strengthening	392

Of all the areas, HRH development is critical. The availability of sufficient, adequately qualified staffing is both a primary condition for service and a key determinant of cost. HRH is therefore the largest component of health service strengthening. The costing includes a SDG 12m re-development of training facilities in Southern Sudan. It also makes provision for additional external recruitment without which it will be unable to meet even the most urgent staffing targets. SDG 50m is therefore provided for external recruitment, to reduce the staffing gap in medical, nursing, midwifery and other roles.
The establishment of in-service training and of strong, competent human resource systems development brings the total cost of HR strengthening to SDG 113m over the period.

Health Systems strengthening provides for the development of capacity of leadership, governance and finance, along with monitoring and evaluation, as essential components of effective service delivery. Finally, health system strengthening makes provision for improved management of capital development, including referral systems, construction, and procurement of equipment and vehicles.

CAPITAL COSTS	Facilities	Equipment	Vehicles	TOTAL
PHCU	67	10	0	78
PHCC	309	46	6	361
County Hospital	204	115	20	339
State Hospital	69	67	4	140
Teaching Hospital	93	140	4	237
County Health Department	2	0	8	11
State MOH	24	0	11	35
GOSS MOH	9	1	12	23
Training Institutions	12			12
Total	791	380	65	1,236

The Facilities Mapping exercise showed the extent of dilapidation of facilities, and the high proportion of temporary accommodation. The BPHS also requires a higher specification of facility and equipment, particularly at PHCC and County hospital level, for basic and comprehensive obstetric services, respectively.

The costing provides for renovation or construction, and re-equipment of all Primary Health Care Units (SDG 78m) and Primary Health Care Centres (SDG 194m). It also provides SDG340 million for the first five years of a 10 year programme to renew all hospitals.

There is also provision for the renovation of County Health Departments and State MOHs, which are essential to effective management, supervision, and effective community and public health programmes.

Finally, capital costs include the regular replacement of vehicles and equipment, over a regular cycle of renewal.

Annex V HSDP Result Framework

Refer to Chapter 3.1 **Provision of Health Service (General)**

Note:
1. *Expected Results are formulated in terms of Outputs; Products and Results achieved within the 5-year planning time- frame.*
2. *Indicators measuring achievements of Outputs are not mentioned in this annex, but provided in annex III (HSDP Indicators and M&E Plan).*
3. *Performance indicators for each result area will need to be formulated during the annual planning process.*

Strategies	***Priority Areas***	***Expected Results by 2015***
Strengthen Health service delivery and increase accessibility to health services		National Health Policy revised/updated, including revision/update of the BPHS, if applicable
		Evaluation of the BSF and MDTF-Health and SHDP carried out providing recommendations for delivery of PHC/BPHS through contracting of NGOs, FBOs and private sector.
		Unit established/strengthened to initiate and manage contracting processes. All necessary tools/guidelines and forms developed/modified
		Performance based contracts are signed which covers at least 70% of the geographical areas where population resides
		Performance of PHC/BPHS delivery through contract schemes regularly monitored using routine HIMS, monitoring mission s and additional assessments and quarterly and annual reports available
		Mid/End evaluation of new performance based contracting scheme carried out and recommendations operationalised and implemented
Enhance community participation in health promotion and disease control	Community Health Program	Community Based Health Care taskforce established/strengthened. All relevant guidelines tools including training curricula developed/updated
		Comprehensive Community Health Programme designed, operationalized and implemented in all Counties
		Capacity of the community health department of MoH- and SMoH is strengthened
		Village/Boma Health committees established , trained and supported in areas where CHP is active
	Task shifting CHW cadre in respect of delivery of a Community Health Program	Programme for re-orientation and task shifting CHW developed, operationalised and implemented
		50% of all Payaams will have trained community health workers (baseline 5%, 2010)
		All Payaams with trained community health workers will have developed a context-responsive plan for community health improvement in their areas of operation
	Community Communication	Develop, operationalize, implement, M&E a Community Communication strategy matching local context setting clear guidelines for production and dissemination of IEC material in all States and in at least 50% of all Counties
		Community Health IEC Material and Bulletins produced and on a regular basis distributed in all Payaams with CHP
Maximize functionality and network of PHCUs, PHCCs and CHDs in function of BPHS and CHP		National Health Policy updated on different levels of care provided at PHCUs and PHCCs including community level and referrals
		Develop and implement Master Plan to ensure equitable distribution of PHCUs and PHCCs
		In line with the BPHS , laboratory services established at all PHCCs . In addition in PHCUs where needed. All properly equipped and maintained
		Supportive supervision visits by SMoH/CHDs at a quarterly interval is carried out Nationwide using monitoring formats, checklists, and supervision reports available
		SMoH/CHD and health Facilities providing feedback and support to Payaams with active CHP at regular interval and protocol for supportive supervision developed and in use.
Link Humanitarian Relief with development		A strategy paper is developed outlining a framework to integrate and coordinate the Humanitarian Relief Activities (emergency aid) with the routine PHC system

Refer to Chapter 3.2 Communicable and Non-Communicable Diseases

Note:
1. Expected Results are formulated in terms of Outputs; Products and Results achieved within the 5-year planning time- frame.
2. Indicators measuring achievements of Outputs are not mentioned in this annex, but provided in annex III (HSDP Indicators and M&E Plan).
3. Performance indicators for each result area will need to be formulated during the annual planning process.

Strategies	***Priority Areas***	***Expected Results by 2015***
Expanding Malaria Programme	Policies and integration into BPHS	National Malaria control task force established/modified
		National Malaria Strategic Plan updated
		National Malaria program integrated into the general health system with focus on prevention, early diagnosis & treatment
		Guidelines for provision of Malaria care at the different levels of health facility level developed
	Prevention, diagnosis and treatment	At least 70% of the population at risk provided with the LLITNs. Additional distribution linked with vaccine or RH services
		80 % of BPHS HFs are providing Malaria care according to national protocols
		All PHCCs are providing routine lab services to diagnoses Malaria. Labs in PHCUs will be established in priority endemic areas
		HFs other than BPHS mapped including hospitals, and operationalized to provide relevant anti-Malarial services
		Community Health Workers job descriptions in relation to Malaria control activities at community level revised, and communicated
		IEC Materials for all levels of HFs including community level, developed and used
		IEC and LLITNs distribution campaigns conducted in high endemic areas of Malaria.
	Support and capacity building	TNAs conducted, trainings planned, at least each relevant health workers receives refresher training once per year
		Need for Technical identified and provided
		Supervisory checklists to support Malaria program developed for all levels , distributed and used at least at 70% of HFs
	Information	Needed information identified and feed into national HMIS and surveillance systems
TB program and TB DOT strategy	Policies and integration into BPHS	National TB Strategic Plan updated with focus on prevention and early diagnosis and treatment
		National TB program integrated into the general health system with focus on prevention, early diagnosis & treatment
		Guidelines for provision of TB care at the different levels of health facility level developed
	Prevention, diagnosis and treatment	80 % of BPHS HFs are providing TB care according to national protocols
		All PHCCs are providing routine lab services to diagnoses TB. Labs in PHCUs will be established in priority endemic areas
		HFs other than BPHS mapped including hospitals, and operationalized to provide relevant anti-TB services
		Community Health Workers job descriptions in relation to TB control activities at community level revised, and communicated
		IEC Materials for all levels of HFs including community level, developed and used
	Support and capacity building	TNAs conducted, trainings planned, at least each relevant health workers receives refresher training once per year
		Need for Technical identified and provided
		Supervisory checklists to support TB program developed for all levels , distributed and used at least at 70% of HFs
	Information	Needed information identified and feed into national HMIS and surveillance systems
Comprehensive NTD program	Improve access to NDT services and care	Strategy and Guidelines for NTD control developed /refined
		Mapping conducted to identify endemic sites and service delivery established in designated HFs
		Access to diagnosis and treatment and case management is available in all designated health facilities in endemic areas
		Integrated treatment of NTDs is piloted starting with 10% of PHCCs with a possible expansion according to data in States and Counties
		Quarterly and annual reports and data available at SMoH and MoH-GoSS. Integrated surveillance system established
Integration programs into PHC	Integration programs into PHC	Study carried out to assess potential for programs to be integrated in the routine PHC system
		Environmental Health Care Programme established and operational, also part of CHP in conjunction with safe water and safe waste and excreta disposal
Improving Diagnostic capability	Laboratory capacity	An effective network of laboratories (local, regional and National) established and functional providing basic and advanced laboratory services corresponding with levels of care
		A National Blood transfusion Programme is formulated, in operation, and supervised

Refer to Chapter 3.2 Prevention & Care of HIV/AIDS

Note: 1. Expected Results are formulated in terms of Outputs; Products and Results achieved within the 5-year planning time- frame.
2. Indicators measuring achievements of Outputs are not mentioned in this annex, but provided in annex III (HSDP Indicators and M&E Plan).
3. Performance indicators for each result area will need to be formulated during the annual planning process.

Strategies	***Priority Areas***	***Expected Results by 2015***
Promote an integrated approach towards HIV/AIDS prevention, treatment and care	Prevention	VCT services expanded and provided by at least 50% of all PHCCs and mobile VCT services established
		Peer Education formulated and implemented and information campaigns for outreach in Urban Areas carried out
		Mass campaigns of a national reach carried out
		Behavioral change programmes formulated and Condom use promoted through social marketing and promoting vendors to sell condoms
		Programmes for male circumsicion formulated and executed
		No stock outs of VCT supplies and requirements at PHCC level
		Diagnostic and treatment protocols for STI developed and in use in all hospitals and PHCCs and PHCUs and syndromic STI treatment trainings for PHCC and PHCU staff carried out
		Condom distribution in all health facilities
	AIDS care and treatment services	At least 50% of AIDS clients receive proper treatment, including ART, according to established guidelines and protocols
		PMTCT services integrated with ANC in all PHCCs and hospitals
		Integrated TB/HIV services established in 40% of all PHCCs and in all hospitals
		Home Based care and support programme established
	HRH and Client Safety	Health facility staff of Hospitals, PHCCs and PHCUs trained in application of and executing universal precautions, including blood safety procedures
		Workplace policy and programme formulated and in operation in all health facilities
Maximize contribution to the National HIV/AIDS Commission	Policy and coordination	Coherence of Health Sector HIV/AIDS activities with the South Sudan HIV/AIDS Strategic Framework established
		National HIV/AIDS plan for the health sector developed/updated

Refer to Chapter 3.3 Maternal, Newborn and Child Health

Note: 1. Expected Results are formulated in terms of Outputs; Products and Results achieved within the 5-year planning time- frame.
2. Indicators measuring achievements of Outputs are not mentioned in this annex, but provided in annex III (HSDP Indicators and M&E Plan).
3. Performance indicators for each result area will need to be formulated during the annual planning process.

Strategies	***Priority Areas***	***Expected Results by 2015***
Increase access to Maternal, Newborn and Child Health service	Expand BEmOC, CEmOC and supportive resources	Conduct baseline assessment of BEmOC and CEmOC services and formulate a master plan outlining compliant strategies and operationalisation to expand services
		BEmOC and CEmOC services provides in all hospitals and 50% of all PHCCs
		Deployment of 1 properly trained midwife at all PHCCs and 50% of all PHCUs
		Checklists for Supportive supervision on BEmOC and CEmOC complient with WHIO guidelines developed and in operation
		Quarterly and annual reports on BEmOC and CEmOC produced at SMoH and MoH-GoSS level
		Maternal waiting homes (out-sourced or in-sourced) established in the proximity of all hospitals
	Expand Reproductive Health Care services	Needs assessment carried out to start Reproductive health programme at PHCCs , PHCUs and hospitals
		Friendly reproductive health services established and functioning in all hospitals and 50% of all PHCCs for specific target groups such as Adolescents and At-risk groups: displaced, school health, sex workers, etc.
		Performance based contracts with non-government health care providers issued and in operation to provide reproductive health care services in all urban centers (State capitals)
		Family Planning services available in all PHCCs, 50% of PHCUs and hospitals
		Modern contraceptives available in all health facilities
		A programme for permanent contraceptive methods formulated and tested on a pilot basis
		Diagnostic and Treatment guidelines for common reproductive health problems are in use in all health facilities providing reproductive health services.
		Information of Family Planning and Reproductive health communicated through CHP and specific community communication channels
		A National Reproductive and sexual Health Right Program is formulated
Implement comprehensive package of high-impact interventions for Child Care	*Child survival*	Diagnostic and treatment protocol for early detection, referral, treatment and prevention of Severe Acute Malnutrition developed, distributed and used in all health facilities. The protocol includes the use of growth monitoring, supplementary community feeding and exclusive breast feeding and Vit-A distribution
		Diagnostic and treatment protocol for early detection, referral, treatment and prevention of diarrhoea, pneumonia and malaria developed and distributed and used in all health facilities
		De-worming treatment provided in all PHCUs, PHCCs and hospitals
		School health program established which will mainly focus on IEC , and campaigns
EPI	Routine Immunization	Routine EPI practiced in at least 70% of all PHCCs and PHCs including proper use of vaccines, provision of cards and advice to mothers
		Needs assessment quantifying cold chain requirements for all hospitals, PHCCs and PHCUs carried out and equipment supplied and maintained. This is based on a logistically facility mapping and outreach on feasible bicycle-walking distance
	Management	Management protocol for routine EPI at Hospital , PHCCs and PHCUs established and in use
		Quarterly supportive supervision by SMoH/CHD carried out to all health facilities providing EPI
		Quarterly and annual reports on EPI produced and available at SMoH and MoH-GoSS

Refer to Chapter 3.4 Public Nutrition

Note: 1. Expected Results are formulated in terms of Outputs; Products and Results achieved within the 5-year planning time- frame.
2. Indicators measuring achievements of Outputs are not mentioned in this annex, but provided in annex III (HSDP Indicators and M&E Plan).
3. Performance indicators for each result area will need to be formulated during the annual planning process.

Strategies	***Priority Areas***	***Expected Results by 2015***
Increase public awareness about nutrition	Promote healthy eating	A National nutrition committee is established that includes representatives from other sectors such as education and agriculture
		Core nutrition messages developed and disseminated strategically and consistently to the general public at all levels through proper channels
		Nutrition counseling and practical support at the community level through BPHS
Reduce prevalence of major micro-nutrient disorders;	Prevention deficiencies in iron, folic acid, iodine, vitamin A and zinc	Agreements made with industry and relevant government departments to fortify salt (with iodine), flour, oil and ghee (with vitamin A and D) and facilitate their availability and access in rural, as well as urban areas at an affordable price
		Increased access to iron and folic acid supplements to women in the prenatal and postpartum phases and vitamin A and C supplements to women in postpartum as well as to children
Strengthen case management and increase access to quality therapeutic feeding;	Therapeutic feeding	Community Mobilization is established around identifying, referring and providing therapeutic feeding to children in need in all PHCCs, PHCUs
		Case detection of Acute Malnutrition at Health Facility and Community Levels through BPHS executed
		Referral system of malnourished children improved
Monitor Nutritional Status of most vulnerable groups for emergency planning and public nutrition intervention.	Nutritional status monitoring	Develop and implement a public awareness campaign on food hygiene and food safety at home
		Food safety and quality control systems established in collaboration with other line ministries and the sector
		Nutrition surveillance as part of HMIS at health facility level improved
		Integrate nutrition indicators into the HMIS
		Nutrition programs are evidence-based and lessons learned regularly documented and integrated into future planning
		An effective monitoring system for key nutrition interventions is established including: supplementation, Infant and Young Child Feeding (IYCF) and Severe Acute Malnutrition (SAM) treatment
		Nutrition trainings in pre- and in-service training of health staff and other nutrition-related staff incorporated in curricula (agriculture, education, social affairs, economy)
		Technical and logistics capacity of Public Nutrition Department (PND) strengthened, through increased support

Refer to Chapter 3.5 Hospital Services

Notes: 1. Expected Results are formulated in terms of Outputs; Products and Results achieved within the 5-year planning time- frame.
2. Indicators measuring achievements of Outputs are not mentioned in this annex, but provided in annex III (HSDP Indicators and M&E Plan).
3. Performance indicators for each result area will need to be formulated during the annual planning process.

Strategies	***Priority Areas***	***Expected Results by 2015***
Improve Basic Hospital Services	Out Patient Departments	OPDs of all hospitals are properly refurbished, have sufficient medical equipment and properly trained and managed staff
		Triage units of Medical Assistance and Nurses in place in all hospitals attending 80% of all patients
		Sufficient number of Medical doctors attached to triage units in all hospitals managing emergency and complicated (20%) of clients
		CEmOC and BEmONC services are provided around the clock in all hospitals
	Laboratory	All hospitals have a functioning laboratory, properly equipped and up to standards and level of care.
		All hospital have Blood Bank services in line with National policy and guidelines
	General	TOR of all management and medical staff of teaching hospitals and State and County hospitals (re-)defined and implemented accordingly
		HRH needs per hospital department done in all hospitals and used to maximize, reallocate available HRH
		Basic materials, consumables and medical equipment up to standards in all Hospitals
		Quality improvement plans and audits for essential medical and nursing services in all hospitals formulated, in place and functioning (clinical audits, nursing audits, etc.)
		Quality Nursing Records in place in all hospitals and in all nursing g departments
	Supportive Supervision	Schedule for supportive supervision by MoH, SMoH in place and executed and supervision reports available
Improve Hospital Management	Capacity building	Formulate, initiate and M&E a capacity support programme for all Hospitals on relevant aspects of general Hospital Management
		Formulate, initiate and M&E a capacity support programme for all Hospitals on relevant aspects of specific internal Hospital financial Management, accounting, patient record keeping, stores etc.
		Formulate, initiate and M&E a capacity support programme for all Hospitals on relevant aspects of internal Hospital Personnel management
Improve Hospital Management Systems	Needs assessments	Hospital needs assessment executed in respect of system development regarding finances, workforce management, supervision, delegated authority, record keeping etc. providing recommendations
	Maintenance	Hospital maintenance policies developed and implemented
		All hospitals have a comprehensive maintenance plan and budget
Hospital Services expansion	Planning and Management	Policy & Principle Framework for Hospital Services expansion designed, agreed upon
		Hospital Strategy Plan defining quantity, type, levels of diagnostic and therapeutic care formulated and used for planning
		Hospital Capital Development Plan with specification, BoQ, etc. formulated and used for planning, procurement etc.

Refer to Chapter 3.6 Management and Governance

Notes:
1. Expected Results are formulated in terms of Outputs; Products and Results achieved within the 5-year planning time- frame.
2. Indicators measuring achievements of Outputs are not mentioned in this annex, but provided in annex III (HSDP Indicators and M&E Plan).
3. Performance indicators for each result area will need to be formulated during the annual planning process.

Strategies	***Priority Areas***	***Expected Results by 2015***
Strengthen Sector Management and Organization	Organization & Administration	Over-all Capacity Support Plan formulated addressing critical management issues of departments of MoH and SMoHs and implemented in stages covering MoH and all SMoHs, TNAs conducted and the TA needs identified.
		Organizational structures and processes reviewed and adapted to match defined TORs
		Job descriptions of management positions reviewed and adapted
		Professional and qualified Staff in Key management positions at MoH and SMOSs analysed and rationalized
		Rationalization of CHDs investigated, carried out i.e. matching catchment areas of functional State and County hospitals
		Taskforces established to develop strategic and operational plans for each strategic direction stated in this strategy
		Coordination forums reviewed and adjusted according to the current needs
		Decision making procedures for policy decisions reviewed and refined i.e. taskforces develop, health sector coordination forum review and MOH approve.
	Tools & Systems	Assessment carried out of existing management systems at MoH and SMoH including alternative proposed improvements, required budgets and implementation modalities
		Financial Management Information System (FMIS) functioning at MoH and SMoH
		MoH and all SMoH produce an annual budget
		MoH and all SMoH maintain sound FMIs and quarterly and annual financial reports
		New procurement and finance operating procedures and guidelines formulated and in operation
		Internal auditing procedures established and annual production of internal and external audits
	Health Planning	Annual operational planning guidelines formulated for the MoH, SMoH/CHDs and in operation
		National and State level Health Planning and M&E tools, protocols and schedules formulated and in use
		Annual comprehensive State health plans produced and available as well as quarterly implementation reports.
		CHDs produce annual plans (in relation to County development planning) and progress reports
		Guidelines and tools for Supervision by MoH-GoSS, SMoH/CHDs in support of their oversight responsibility formulated and in use
		Guidelines for partner consultation and coordination at National and State level formulated
		Quarterly Health Sector coordination meetings at State level conducted and reports available
		Quarterly MoH- and SMoH reports of supportive supervision available
		Monthly work plan meetings conducted by all CHDs and monthly work plans available
Communication	Communication	Sector-wide corporate communication strategy developed and in use
		Policies, guidelines, SOPs and all information for the health system is distributed to the relevant levels and staff according to new communication strategy
Regulation and Legislation	Legal frameworks	Inventory of current legislation /regulations made and review committee established
		Review and adoption of existing legislation carried out and new regulations for registration clinical and non-clinical practitioners, standards of care, etc. adopted and in use
		Regulation in place for providers of private clinical and non-clinical services
		Relevant professional councils such as Medical and Dental Practitioners Council, etc established and functioning

Refer to Chapter 3.7 Human Resources for Health

Notes: 1. Expected Results are formulated in terms of Outputs; Products and Results achieved within the 5-year planning time- frame.
2. Indicators measuring achievements of Outputs are not mentioned in this annex, but provided in annex III (HSDP Indicators and M&E Plan).
3. Performance indicators for each result area will need to be formulated during the annual planning process.

Strategies	***Priority Areas***	***Expected Results by 2015***
Deployment	Local & Regional Recruitment	Realistic Targets for deployment of HRH of all cadres set and achieved
		Sufficient number of Medical specialists recruited Regionally for teaching and supervision in teaching hospitals
		Sufficient number of medical registrars available to execute medical work in Teaching hospitals and State and County hospitals
		Professional staff identified, recruited and employment
		Sufficient number of a professional health cadres trained and deployed
		Coordination to produce doctors based on each state needs through medical universities ensured
Skill development, Task shifting	HR development	Registrars trained outside S. Sudan
		Minimum qualifications and standards per professional HRH cadre established
		In-service training modules for upgrading low health staff cadres into professional health workers developed and upgrading training operational in all hospitals
		Maximum possible number of CHW retrained and deployed as community health workers in context of CHP
		Maximum possible number of CHW upgraded to higher HRH cadre
		A gradual increase of skilled medical staff according to norms deployed and retained in all functional PHCCs and PHCUs
		Specialization courses and post-graduate training courses developed and started
Training Schools	HR production	Comprehensive needs assessment of training schools carried out in relation to HRH demands, including recommendations to increase output of relevant HRH cadres
		Network of training schools progressive rationalized and reduced based on assessment Infrastructure development
		Specialisation and post-graduate training curricula formulated and implemented
		5 Training schools properly equipped in terms of infrastructure, class rooms and auxiliary buildings (offices, staff houses, dormitories etc.), equipment, learning tools etc.
		Standardization of learning curricula per HRH cadre established and enforced
		Inventory made of all training interventions, modules and materials carried out by NGOs/FBOs and best practices certified and copied and implemented nation wide
		State level planning and implementation of training courses for the most important HRH cadres (upgrading.) implemented
		Overall Student output of teaching schools per HRH cadre set and achieved
		National examination Board established
HRH	Planning & Personnel Management	HRH Strategic Plan updated including standardized and harmonized HRH cadres and nomenclatura and implemented
		National strategy for deployment and retention of staff developed and in use
		Workforce rationalized
		Pay rates for professional staff increased in relation with respective to pay levels
		Human Resource Information System implemented and used
		Guidelines for HR administration and management including contracts, job descriptions, job plans and conditions of service, performance review, supervision, in service training and disciplinary procedures developed, in place and in use
		Establish proper HRH norms per service level
		Pay-roll management established
	Pre- and In-service training	Develop a realistic plan to conduct in-service training of existing health workers - most needed cadres/ low QOC
		Standardize pre- training of health workers according to needs and priorities of the health care system and accommodate the integration of Arabic speaking returnees with focus on English language and basics in mathematics

Refer to Chapter 3.8 Pharmaceuticals and Medical Supply

Notes: 1. Expected Results are formulated in terms of Outputs; Products and Results achieved within the 5-year planning time- frame.
2. Indicators measuring achievements of Outputs are not mentioned in this annex, but provided in annex III (HSDP Indicators and M&E Plan).
3. Performance indicators for each result area will need to be formulated during the annual planning process.

Strategies	***Priority Areas***	***Expected Result***
Ensure accessibility at all levels of safe pharmaceuticals, medical supplies and equipment	Pharmaceuticals	Formulate, operationalize and implement Pharmaceutical Strategic Plan outlining strategies to secure adequate quality supplies of drugs to Hospitals and PHCUs and PHCCs and review of essential druglist
		Pharmaceuticals Needs Assessment carried out of all hospitals, PHCUs , PHCCs and Community Health Cadres
		'Push' drug kit system changed into a 'Pull' system
		Assessment of alternative public- private procurement systems and supply systems carried out
		A logistics management unit established at the MoH
		Full professionalization of National Medical stores realised
		A proper logistical supply system is established with adequate storage capacity at National, State, County and health facility levels
		Storage capacity at Health facility level improved and properly managed
		A Pharmaceutical Management Information System (PMIS) introduced and operational
		A drug revolving fund is introduced on a pilot basis
	Medical Equipments	Medical Needs Assessment carried out of all hospitals, PHCUs and PHCCs
		Maintenance plans and budgets for all medical equipments in hospitals, PHCUs and PHCCs in place
		A Plan for establishing Maintenance units for medical equipment developed and at least all hospitals have a functioning maintenance unit with properly trained staff possibly contracted out to private supplier
		Inventory of requirements for ANC, delivery and Postnatal care equipment and supply carried out covering all hospitals and PHCCs and supply plan in place and operational
Strengthen control of quality, safety and efficacy	Regulation and Legislation	Appropriate Pharmaceutical Regulation is developed, in place and enacted
		A Regulatory Body is in place
		Procedures for Registration, inspection and licensing are in place and practices
		A National Quality Control Laboratory is functioning
		Storage of dangerous drugs regulated as well as disposal of expired drugs
Harmonization Procurement and Logistics		Standardization and coordination of procurement, stocking and distribution of pharmaceuticals, and medical supplies including that of vertical programs is advanced
		Procurement committee is in place

Refer Chapter 3.9 Capital Investment

Notes:
1. *Expected Results are formulated in terms of Outputs; Products and Results achieved within the 5-year planning time- frame.*
2. *Indicators measuring achievements of Outputs are not mentioned in this annex, but provided in annex III (HSDP Indicators and M&E Plan).*
3. *Performance indicators for each result area will need to be formulated during the annual planning process.*

Strategies	***Priority Areas***	***Expected Results***
Upgrade & Maintain Health Infrastructures	Renovation, reconstruction and expansion of health infrastructure	Design, Resource and implement Master Plan Health Infrastructure Development for expansion of health Infrastructure
		Design, Update Health Facility Design, auxiliary buildings, etc which allow for local context and availability of building materials
		Number of existing PHCCs, PHCUs, hospitals and axilliary building renovated according to schedule (Refer annex II)
		Number of Teaching schools reconstructed and renovated
		Master plan for maintenance of health infrastructure developed and all hospitals and PHCCs have a updated maintenance plan and budget
Upgrade & Maintain Medical Equipment		A comprehensive baseline establishing the exact equipments deficits and stock-outs (medical equipment, supplies) for all health facilities is carried out
		A master Plan for provision of medical equipment including required resources per health facility level and relating to all functional and properly staffed PHCUs, PHCCs and hospitals is formulated
		Standards for Essential Medical equipments per H/F level are set and communicated
		All functional and staffed PHCUs, PHCCs and hospitals both Government as well as non-government are properly equipped according to standards and needs
Establish & maintain Referral System	Transport	A comprehensive baseline establishing the exact deficits and needs of transport requirements for SMoH, CHDs is carried out
		A comprehensive baseline establishing the exact deficits and needs of transport requirements for PHCUs and PHCCs is carried out, also in relation to supervision of the implementation of the CHPs
		All SMoH have sufficient appropriate means of transport and related recurrent budgets to facilitate management tasks and supportive supervision to CHDs and Health facilities
		All CHDs have means of transport and recurrent budget to facilitate management tasks and supportive supervision to the health facilities
		All CHWs have sufficient means of transport to facilitate the implementation of the CHP
		Protocols for Maintenance of all transport developed and in use
	Referral System	Design a comprehensive Master Plan for establishing an effective and cost efficient Referral System including, context related appropriate transport, communication systems, resources, etc.
		Establish PHCU, PHCC and Hospital Referral stages, protocols, reporting and communication mechanisms.

Refer Chapter 3.10 Health Sector Financing

Notes: 1. Expected Results are formulated in terms of Outputs; Products and Results achieved within the 5-year planning time- frame.
2. Indicators measuring achievements of Outputs are not mentioned in this annex, but provided in annex III (HSDP Indicators and M&E Plan).
3. Performance indicators for each result area will need to be formulated during the annual planning process.

Strategies	***Priority Areas***	***Expected Results***
Maximize Resources	Improve decisions making, reduce Budget Gap and increase per capita Health spending	Comprehensive Health Sector Financing Plan formulated outlining strategies, approaches and methodologies to secure sustainable funding for the health sector
		NHA established and institutionalized .
		Maximize Resource allocation to SMoH and CHDs
		New financing options explored such as carefully pilot testing of different financing schemes; cost sharing , community funds, equity funds, fee for services, drug revolving fund, and so on.
		New initiatives will be advocated such as advocacy for sin taxes i.e. increase tax over cigarette and alcohol import which create public health problems
		Initiatives such as demand side financing and result based financing for the primary health care will be examined
		Health insurance feasibility will be analyzed
		Mechanisms will be explored and guidelines will be developed to improve autonomy at the HF level especially the hospitals
		Supportive mechanisms will be developed for public-private partnerships
		Improve SWAP type approach through increasing budgetary support
		Formalized mechanisms for Aid coordination developed
Increase Efficiency and Effectiveness of Financial Resources	Building the capacity of different levels and strengthening control systems	Key staff at different levels identified and provided capacity building opportunities in relation to budgeting , prioritization and financial procedures
		Annual budgeting systems and procedures updated, streamlined and improved and annual budgets available at MoH and SMoH
		All program plans are costed in line with HSDP
		Economic evaluation s conducted such as costing Studies for the BPHS carried out providing update strategies for cost effective interventions
		Accounting systems and procedures updated, streamlined and improved and quarterly and annual accounts available at MoH and SMoH
		Internal Audit units at MoH and SMoH established and operational and quarterly internal audit reports available

Refer to Chapter 3.11 **Monitoring, Evaluation and Research**

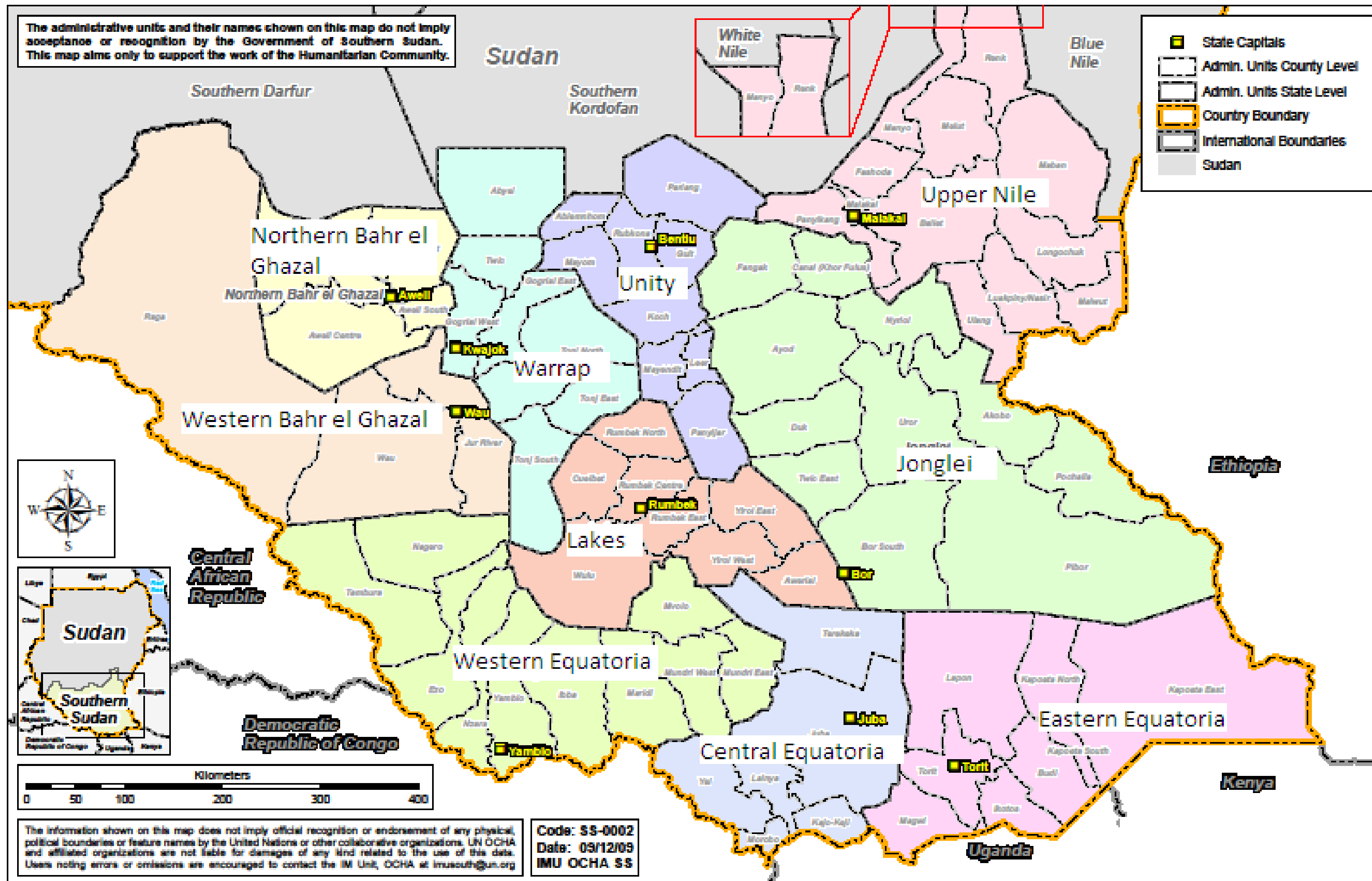
Notes: 1. Expected Results are formulated in terms of Outputs; Products and Results achieved within the 5-year planning time- frame.
2. Indicators measuring achievements of Outputs are not mentioned in this annex, but provided in annex III (HSDP Indicators and M&E Plan).
3. Performance indicators for each result area will need to be formulated during the annual planning process.

Strategies	***Priority Areas***	***Expected Results by 2015***
M&E	Policy and Planning	A M&E advisory board or Taskforce established and operational
		Proportion of HIS and service staff with capacity in managing and performing HIS responsibilities and functions, increased
		Assessment of organizational data requirements is carried out
		General M&E Policies, framework, strategies, systems, protocols and procedures developed cq amended, in place and operational
		M&E Policies, procedures and practices of vertical programmes identified and where possible and appropriate streamlined into the routine M&E framework of the MoH and SMoH
		M&E Policies, procedures and practices of individual donors identified and where possible harmonized and streamlined with M&E framework of the MoH and SMoH
		Available and essential health information from programmes is used in health planning by MoH and SMoH
		M&E Department has a functional HIMS unit producing quarterly and annual reports
		M&E departments of all SMoHs have functional HIMS units producing quarterly and annual reports
		Coordination is ensured with other entities such as statistical bureau
		National Monitoring checklist that also contains community level , computerized data base and guidelines developed and used
Improve Routine DHIS	HIMS system	The routine HIMS is improved and simplified with a reduced set of main indicators incorporating the relevant indicators of programmes
		No of parallel programme Health information systems, registers etc. at HF levels (next to routine HIMS) is reduced
		Computerized HIS is operational at MoH, SMoHs and CHDs levels
		HIS data are consolidated by all SMoH and used for Health Management and Planning
		Routine monthly reports produced by all health facilities
		Routine quarterly reports of core indicators produced by all CHDs
		Databases for trainings, Human resources, and grants will be developed along with national service delivery data base and linked
		Registration of private HFs ensured into national data base and gradually reporting is initiated
	Management	Relevant Staff from MoH-GoSS, SMoH and CHDs are trained in management and usage of the HIMS
		All Staff from PHCUs and PHCCs are trained in use and management of the HMIS and of all relevant supporting systems, registers etc.
	EPI	EPI data consolidated at MoH-GoSS and State levels and presented in quarterly and annual reports
Improve Non-Routine	Disease Surveillance	Diseases Surveillance system is established and operationalized which will include early warning system
		Plan for surveys to measure outcome and impact of health care delivery is developed and implemented
		Options such as implementation of Lot Quality Assurance Sampling will be studied
Research		A Framework for an Operational Research agenda is developed and in place including procedural arrangements to deal with individual research requests and subjects
		An independent Research and Ethnical Review Board is established and operational with a clearly defined TOR
		Research is generally contributing to informed policy decisions

Refer to Chapter 3.12 Cross Cutting Issues

Strategies	*Priority Areas*	*Expected Results by 2015*
Quality	Health Sector Management & Health System	Quality improvement Framework developed and in use to guide and develop specific policies, tools and procedures
		Quality Assurance Unit in MoH-GoSS established with specific TOR
		General Management protocols, procedures, tools and systems specific for MoH, SMoH and CHDs are developed, revised and in operation
		Sufficient levels of qualified Staff in Management positions at MoH, SMoH and CHDs
		An Accreditation Policy and System is developed and in use and all Public and Private health care providers are accredited
	Health Facility Management	General Health Facility Management guidelines for PHCU, PHCC and Hospitals developed and in use
		Ethical code and rules for professional conduct for Health Staff developed and practices
		Quality assurance units in all hospitals established and in operation
	Public Health & Case Management	Specific Standard Operational Procedures (SOP) and Treatment Guidelines (TG) for Communicable, Non-Communicable and NTDs are developed, revised and in use in all health facilities and regularly updated and distributed
		All relevant professional medical staff i/c of Health facility trained in use of SOP and TG
	Evidence Based Medicine	HIMS system in use in all health facilities and data analyzed and used for health planning
		Appropriate operational health research conducted and results used
	HRH	A system for Continuing Professional Development for all medical professional staff cadres is developed and in operation
		Specific TORs for all departments and Staff cadres put in place and a Staff Performance Appraisal System based on TORs and job-descriptions developed and put in place
		Pre-service, in-service and continuous medical education training curricula are improved and accredited covering also relevant technical and managerial areas
	Infrastructure, Equipment	Protocols for context relevant design of buildings and Equipment developed and in use
		Maintenance policy for buildings and equipment developed and in use
Equity		Policy outlining framework and strategies to address and target health services for most vulnerable geographical areas (States, Counties) and most vulnerable groups (Women, Children) developed and operationalised
		Health Funding mechanisms (formula's) developed and operationalized to target poor(er) States and Counties
		Pilot e
Gender		Policy outlining framework and strategies to address gender inequalities developed and operationalized into practical measures with specific attention to reproductive health and HIV/AIDS
		Employment gender quota of 20% realised
		Enact legislation on gender-based violence, child abuse and people with disabilities
		Health staff trained in recognizing and addressing specific health problems of women, adolescent girls and men
Community Ownership		Policy outlining framework to engage Community ownership and participating in health developed and operationalized particularly with attention to community empowerment
		A Community Health Programme developed with oversight by local communities
Coherence Health Planning & Inter sector coordination and coherence		A Policy framework outlining strategies for the integration of vertical programmes in the routine public health system is developed and operationalized
		Planning tools for comprehensive planning for the health sector at State and County level are developed, operationilised and in use.
		Health Sector Policies and strategies are adequately addressing realization of Health Sector related and relevant MDGs
		Health Sector Policies and strategies are adequately reflected in the National Strategic Framework for poverty reduction in particular in those of the Human-Social Development Pillar
		An identification of pertinent issues in other sectors are identified and considered for health planning
Environment		Existing laws enforced and develop when required
		Public Awareness raised of environmental health issues
		National Environmental Health Action Plan formulated
		M&E of progress towards the achievement of a clean and safe environment carried out and reports available
		HR expertise in the field of environmental protection strengthened involving a number of different line ministries and civil society organizations
Public Private Partnerships		A Policy on PPP is developed and in place outlining strategies and (contractual) arrangements between the government and Non-Government actors (Not-for-Private, For-Private, FBOs) to increase BPHS and coverage at State and County levels.
		An assessment of potential and realistic PPP arrangements is carried out.
		PPP arrangements are implemented on a pilot basis and an evaluation has been carried out
		An identification of pertinent issues in other sectors are identified and considered for health planning

ANNEX VI Map of South Sudan, Administrative Boundaries States and Counties



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