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Sida Evaluation

Nordic Consulting Group A/S

Impact study Health Pooled Fund, South Sudan

A case study as part of the Central Evaluation of Sida's work with Poverty

Sida

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Abbreviations

BHI	Boma Health Initiative
BHW	Boma Health Worker
BPHNS	Basic Package of Health and Nutrition Services
CHW	Community Health Worker
DAC	Development Assistance Committee
DALY	Disability Adjusted Life Years
DFID	Department for International Development
DHIS	District Health Information System
FCDO	Foreign Commonwealth and Development Office
FY	Financial Year
HMIS	Health Management Information System
HPF	Health Pooled Fund
IP	Implementing Partners
MDPA	Multi-Dimensional Poverty Assessment
MoH	Ministry of Health
OECD	Organisation for Economic Co-operation and Development
PPP	Purchasing Power Parity
SEK	Swedish Kroner
SRHR	Sexual & Reproductive Health Rights
ToC	Theory of Change
ToR	Terms of Reference
WHO	World Health Organisation

Executive Summary

The **Health Pooled Fund (HPF)** was a flagship, multi-donor program launched in 2012 to support delivery of essential health services in South Sudan. From the outset, the HPF's long-term goal was to build a government-led health system to provide critical, life-saving services, particularly on maternal and infant health. To this end, the HPF contracted implementing partners to deliver a sub-set of services under the Ministry of Health's 'Basic Package of Health and Nutrition Services' at government health facilities, while working to build the Government's capacities and ability to take over health service delivery in the longer-term.

Our study shows that the HPF played a pivotal role in preventing total collapse of healthcare delivery and achieving incremental health gains in one of the world's most challenging contexts. Concretely, the HPF improved healthcare in South Sudan by enhancing service coverage, particularly in maternal and child health services. The HPF increased patient attendance significantly and expanded community-level healthcare through the Boma Health Initiative (from 2019–2024), treating over 3 million cases of malaria, diarrhoea, and pneumonia in children. Paired with the programme's immunisation campaign, the HPF has made an important contribution toward decreasing preventable childhood disease and mortality. Likewise, on maternal health, the HPF greatly expanded availability of services. Skilled birth attendance rose significantly in health facilities supported by the HPF, which is a key precondition for improving maternal health outcomes.

While our analysis indicates that the HPF likely realised its intended impact in terms of decreasing maternal and child mortality, it has fallen short of achieving its vision of a government-led health system. Low capacities of the Government, lack of skilled health personnel, financial constraints (or lack of prioritisation) in public budgets leave the healthcare system in South Sudan highly reliant on donor engagement and funding. In addition, gaps or disruptions in HPF service delivery highlight the high risk that its achievements may be reversed in the absence of institutional and financial sustainability. As such, our study highlights the challenge of achieving sustainability in a very fragile, conflict-affected context, where donors may face a trade-off between addressing pressing needs, and strengthening national systems and actors.

1 Introduction

This report presents an impact evaluation of the contribution, the "Health Pooled Fund" in South Sudan.

The case study constitutes a part of the overall "Strategic Evaluation of Sida's Work with Poverty".[1] It aims to contribute to learning and informed decision-making rather than control or accountability.

The case study primarily draws on desk-based study of secondary data, supplemented by a number of key informant interviews.

The report is organised in the following way: In Chapter 2, the contribution case is presented and contextualised. Chapter 3 includes an outline of the main data sources and methods applied in the impact study. In Chapter 4, a reconstructed Theory of Change (ToC) for the contribution case is being presented and discussed. This is followed by a presentation of key impact findings in Chapter 5. Finally, in Chapter 6 the conclusions are presented.

Sida defines multidimensional poverty as deprivations within four dimensions - resources, opportunities and choice, power and voice and human security. Sida defines a person living in multidimensional poverty as being resource-poor and poor in one or several of the other dimensions.

Note that this definition is broader than the definition used in for instance OPHIs national multidimensional poverty index (MPI) and the World Bank definition of multidimensional poverty that uses the MPI in combination with monetary poverty.

Source: Sida (2019), Dimensions of Poverty, poverty toolbox.

[1] There are seven other case studies, which are presented in separate reports.

2 The Contribution at a glance

Table 1 Overview of contribution

Contribution name	Health Pooled Fund Phase I, II, and III
Partner	The main contributor is the UK Foreign, Commonwealth & Development Office (FCDO), partnering with the South Sudanese Ministry of Health.
Implementing partners	As of the end of March 2024, the HPF funded 9 NGO implementing partners providing services in 804 facilities.
Implementation period	2012-2016, 2016-2018, 2018-2024
Sida strategy	*South Sudan Country Strategy 2014-2016* and *2018-2022* for HPF2 and HPF3 respectively
Total budget	The total budget was originally agreed to **£445 900 229** but has since been decreased several times. At time of drafting, the total contribution to the HPF3 stood at **£ 321 065 577.**
Total Sida contribution	Phase I: SEK 185 million Phase II: SEK 114 million Phase III: SEK 614 million
Geographic coverage	In **Phase I**, the HPF supported 6 of 10 states in South Sudan (Warrap, Northern Bahr-el Ghazal, Western Bahr-el Ghazal, Eastern Equatoria, Lakes and Unity). In **Phase II**, 2 additional states (Central and Western Equatoria) were added, expanding the HPF's coverage to 8 out of 10 states. At the outset of **Phase III**, support was maintained across the 8 states covered in Phase II; however, this was later reduced to 7 states, when healthcare implementation in Unity State was handed over to the World Bank.

The **Health Pooled Fund (HPF)** was a flagship multi-donor program launched in 2012 to support delivery of essential health services in South Sudan. Implemented across three phases, the HPF continued to be one of the largest health service delivery funding sources in South Sudan up to its closure in 2024. At its peak geographic coverage, the Health Pooled Fund was operational in eight out of ten states in South Sudan,[2] supporting the delivery of a national 'Basic Package of Health and Nutrition Services' across 80% of health facilities in these states.[3]

The HPF was designed as a multi-donor fund, pooling contributions from several major donors. Led by the UK Foreign Commonwealth and Development Office (FCDO) – formerly the Department for International Development (DFID) – the HPF was funded by Sweden, Canada, the United States, the EU, Australia, and GAVI.

Sida has supported the HPF since it was established in 2012, with total support across three phases amounting to SEK 913 million. Figure 1 provides an overview of the funding to the HPF across phases, illustrating a significant increase in the Swedish contribution to the HPF in its third and final phase.

Figure 1. Overview of funding flows to HPF across the three programme phases

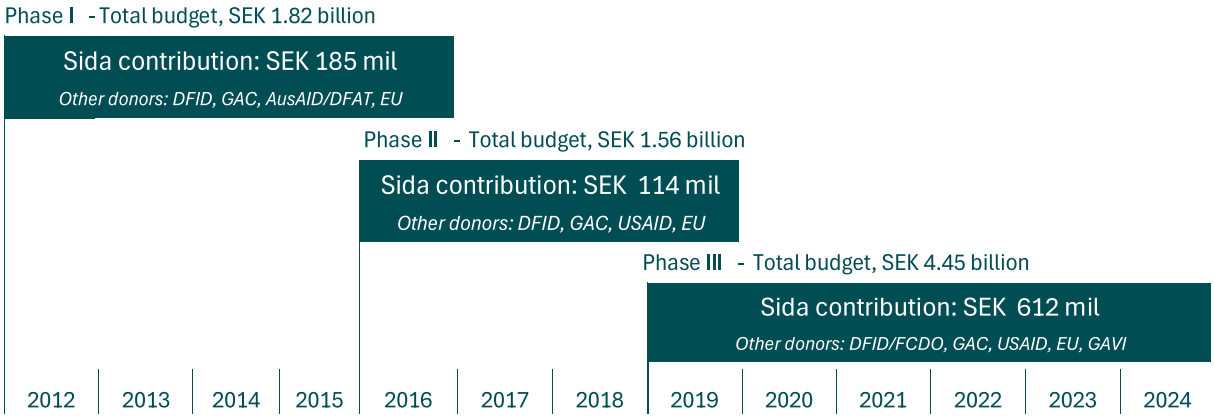


Figure source: The figure is developed by the evaluation team based on a review of key HPF documents, hereunder Sida's 'Decision on Contribution' and 'Decision on Amendment to Contribution' documents, and DFID/FCDO's Business Case for the HPF from each phase.

From the outset, the HPF was designed with the long-term ambition– over the course of three phases – to "*transition from an NGO led health service to a 'government-led*

[2] In Phase I, the HPF was limited to six states, but in Phase II, USAID joined the HPF, bringing with it the two states where it had been funding health (Central and Western Equatoria). In the latter phase, the two states not covered by the HPF Phase III were supported by the World Bank through the "Provision of Essential Health Services" project, that worked with the MoH to deliver services (although this was discontinued for a period due to the outbreak of conflict). In Phase III of HPF, Unity State was also handed over to the World Bank, leaving HPF implementation in seven states.

[3] The South Sudan Ministry of Health's '*Basic Package of Health and Nutrition Services (BPHNS)'* guides health service delivery at health facilities in South Sudan. The BPHNS defines expected services at each health facility level and from which the Health Pooled Fund has offered a subset service package.

health service that saves lives".[4] In the context of widespread humanitarian needs, it was seen as critical to ensure that the population had access to essential health services in the short term, while building the Government's capacities and ability to take over health service delivery in the longer-term. In practical terms, this meant that the HPF's main modus operandi was to engage service delivery agents (NGO implementing partners) that could ensure the provision critical, life-saving health services, particularly on maternal and infant health, while providing technical assistance and capacity building to central, state, and county level health authorities.[5]

Across all three phases, the HPF maintained its overall goal of improving maternal and child health, delivering a sub-set of services under the Ministry of Health's 'Basic Package of Health and Nutrition Services' at government health facilities; over time, the ambition was to eventually to hand over responsibility to the government authorities to manage these services.[6]

Below, we describe each phase of the Fund, highlighting how the HPF adjusted strategies to respond to challenges in the context:

- In **Phase I**, the HPF focused on building a post-independence health system with the aim to expand basic health services in South Sudan. To this end, the HPF established service delivery in 6 of the 10 states, with the main priority to ensure that South Sudanese population could access essential health services in times of crisis. While the HPF subcontracted service delivery agents at country level, Phase I also included some capacity development support to country hospitals, and training health workers (especially midwives and community health workers).
- In **Phase II**, the HPF expanded to 8 states (incorporating two states that were previously supported by USAID, which joined the HPF as a funder) with focus on maintaining service delivery amid a civil war that erupted in 2013. In this phase, new components on nutrition services were included as a priority to the HPF.
- In **Phase III**, the final phase of the programme, the HPF focus shifted to health system stabilisation; while the longer-term goal previously had been on Government leadership, the HPF reduced engagement with central Government, placing greater emphasis on local structures and community ownership. With resource constraints due to budget cuts, and based on lessons from Phase II, the third phase concentrated on funding well-attended facilities in populated areas, while also prioritising support to the national community health worker programme (the Boma Health Initiative) to extent support to hard-to-reach

[4] DFID. (2012). Business Case and Intervention Summary: South Sudan Health Pooled Fund. p.1.

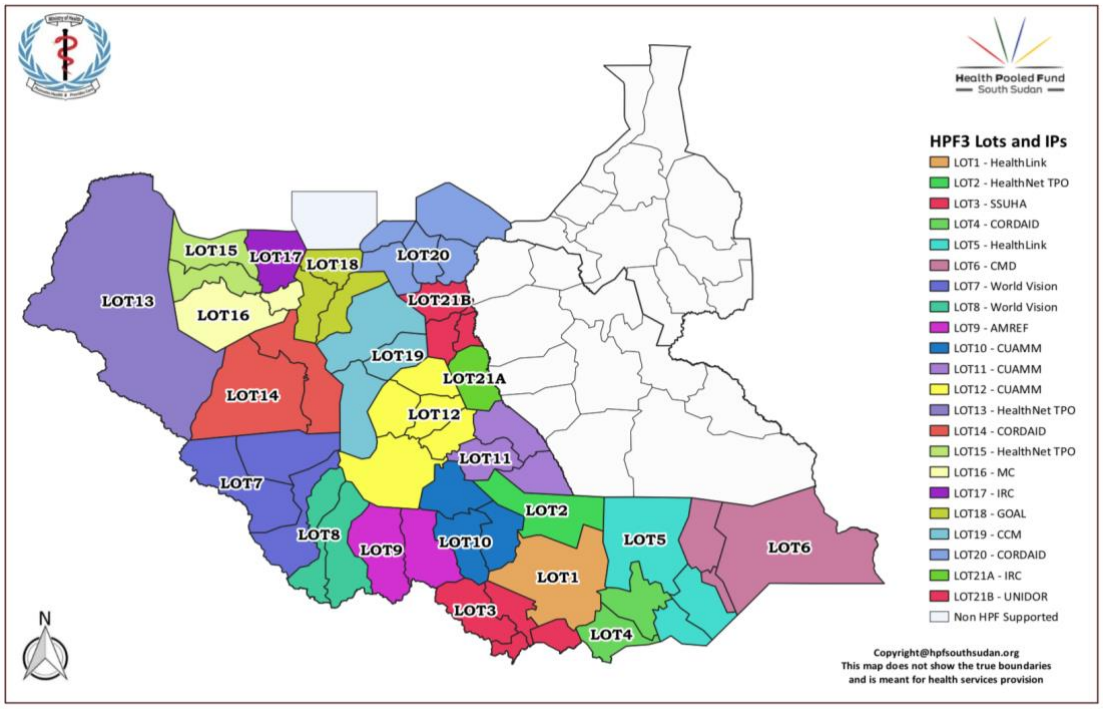
[5] The donors involved in the HPF are currently negotiating a new health sector programme led by the World Bank and UNICEF, the Health Transformation Programme, which is intended to bridge the gap that arises from the closure of the HPF.

[6] DFID. (2012). Business Case and Intervention Summary: South Sudan Health Pooled Fund.

communities. New focus areas in HPF3 included gender-based violence response, family planning, mental health, and disability services, and dedicated support for immunisation – areas which were not strongly featured in the previous phases.[7]

The implementation of the HPF was organised by geographic "Lots" across states, with a fund management consortium (Crown Agents and partners) overseeing NGOs and working alongside the Ministry of Health (MoH). The geographic coverage and implementing partners as of July 2019 are illustrated in Figure 2.[8]

Figure 2. HPF presence in South Sudan, and Implementing Partners by Lot[9]



Map Source: Crown Agents, (July 2019). Health Pooled Fund 3: Inception Report, Annex E: Map showing Lot boundaries and IPs. p. 30.

[7] Widdig, H., Tromp, N., Lutwama, G. W., & Jacobs, E. (2022). *The political economy of priority-setting for health in South Sudan: a case study of the health pooled fund*. International journal for equity in health, 21(1), 68. https://doi.org/10.1186/s12939-022-01665-w

[8] Note that the number of IPs and Lots has varied across HPF phases and therefore Figure 1 is only indicative. At the end of Phase III, there were 9 IPs responsible for implementation across 19 Lots, and as noted in Footnote 3, Unity State was no longer included.

[9] Note: the HPF Lots and IPs have changed several times over the course of the three programme phases. The map is therefore illustrative of the intended set up at the start of Phase III, but due to budget cuts, the number of Lots was reduced later in the implementation. Map source: Crown Agents' Inception Report, July 2019.

2.1 THE PROJECT CONTEXT

South Sudan is one of the poorest countries in the world. The majority of the population (82%) lived under the poverty line of USD 1.90 a day (2011 PPP) in 2016.[10] The effects of South Sudan's protracted conflict - both before and after it gained independence in 2011 – is seen in terms of the massive erosion of physical and social infrastructure in the country, as well as the displacement of millions of people. Humanitarian needs in South Sudan are widespread, and have grown exponentially since independence, with underdevelopment of all sectors. In this regard South Sudan's rural population, as well as women and youth in general, are particularly vulnerable.

Decades of conflict have severely damaged health infrastructure and weakened government capacity, leaving most health services delivered by NGOs and external agencies. As a result, South Sudan has some of the worst health indicators in the world. The situation is particularly dire when it comes to maternal mortality – the WHO World Health Statistics estimate for 2020 indicates a maternal mortality rate of 1 223 per 100 000 live births – the highest in the world.[11] Neonatal mortality and under-five mortality rates are likewise alarmingly high, respectively 40 and 99 per 1000 live births in 2021.[12] Sida's MDPA highlights that three quarters of these deaths are the result of easily preventable diseases, hereunder diarrhoea, malaria, pneumonia, and water-borne diseases. Poverty is a key underlying factor, given that the majority of households with newborn children in South Sudan have no access to sanitary facilities (89%), lack of access to clean sources of drinking water (90%), and cook with polluting fuels (99%).[13]

There are several barriers to access to healthcare in South Sudan, which are particularly felt by rural populations. Sida's Multidimensional Poverty Analysis (MDPA) highlights that most healthcare facilities are concentrated in Juba and State capitals, and therefore most rural areas have only basic healthcare provision. In general, research confirms this trend – i.e., particularly that Central Equatoria State, where Juba is located, performs better across several health indicators – but also points to significant variation across rural areas.[14] Over half of the population (56%) live more than 5km from a health facility.[15] Moreover, less than a quarter (22%) of health facilities in South

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[10] World Bank (2024). Poverty and Inequality Platform. (version 20240627_2017_01_02_PROD) [data set]. https://pip.worldbank.org/country-profiles/SSD. Accessed on 10 June 2024.

[11] WHO, (2023). The Global Health Observatory – World Health Statistics 2023: Monitoring Health for the SDGs - Annex 1 – Country, area, WHO and global health statistics. Accessed at: https://www.who.int/data/gho/publications/world-health-statistics.

[12] Ibid.

[13] Mugo NS, Agho KE, Zwi AB, *et al*. (2018). Determinants of neonatal, infant and under-five mortality in a war-affected country: analysis of the 2010 Household Health Survey in South Sudan. BMJ Glob Health 2018;**3**:e000510. doi:10.1136/ bmjgh-2017-000510

[14] Valadez JJ, Berendes S, Lako R, Gould S, Vargas W, Milner S. (2015). Finding the gap: revealing local disparities in coverage of maternal, newborn and child health services in South Sudan using lot quality assurance sampling. Trop Med Int Health. 2015 Dec;20(12):1711-21. doi: 10.1111/tmi.12613. Epub 2015 Oct 19. PMID: 26432978.

[15] DFID (N.D). Annex 1. Business Case: Health Pooled Fund 3 (2018 – 2023).

Sudan are fully functional. According to the DFID Business Case for the third phase of the HPF, there are approximately 1487 health facilities in South Sudan. Thereof, only a quarter (26% or 376) are in good condition. Close to a quarter require minor reparations (23% or 347), and 18 percent (274) require major renovation. The remaining 490 (33%) need complete replacement. In general, all facilities lack medical equipment, transport and communication, water and power supplies.[16] As a result, access to healthcare is low, with nearly 3.6 million people lacking access to health assistance.[17]

In addition, there is a critical shortage of qualified healthcare workers; WHO indicates that the density of medical doctors in South Sudan is among the lowest in the world, with estimates indicating one doctor per 25 000 citizens in the period from 2013 – 2020 (i.e. signalling a density of 0.4 doctors / 10 000 persons). As a result, health care services are often delivered by lower cadres of staff such as community health workers. Moreover, severe underfinancing of the health sector means that many health workers are reliant on financial incentives provided by aid programmes, due to late payment and high inflation of government-paid salaries.

Family planning needs are largely unmet in South Sudan, with approximately 30% of all women estimated to have an unmet need for modern methods of contraception.[18] At the same time, estimates indicate that a marginal increase has happened over the last decade in the use of modern contraceptive methods, from 3.3% in 2012 to 4.2% in 2023.[19] Likewise, only around a quarter of births take place in healthcare facilities or with skilled staff.

Although there has been an increase in the coverage of new-born immunization packages, the rate of full immunization for children aged 12-23 months before their first birthday stands at a mere 26%, with accessibility and capability varying depending on geographical location.[20]

South Sudan's history and on-going conflict dynamics means that there is a significant demand for trauma healing and support for individuals grappling with mental health issues. This is compounded by severely limited access to curative services, evidenced by a treatment gap of 99% in 2019.[21] According to WHO, the country currently has only three psychiatrists, and mental health services are integrated into a mere 2.4% of

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[16] DFID, (N.D.) Annex 1. Business Case: Health Pooled Fund 3, p. 12.

[17] Sida (2022). Multidimensional Poverty Analysis for South Sudan (2022).

[18] Track 20. (2023). South Sudan Family Planning Indicator Sheet: 2023 Measurement Report.

[19] Ibid.

20 DFID, Business Case HPF 3.

21 Mogga, Joseph Lou. (2019). The mental health treatment gap in South Sudan. South Sudan Medical Journal Vol 12, No 1. http://www.southsudanmedicaljournal.com/assets/files/Journals/vol_12_iss_1_feb_19/Mental%20health%20final.pdf

functional health facilities. Additionally, stigma and conflict further impede access to existing services.

Conflict and insecurity dynamics, from the national and regional to community level, have contributed to unequal access to healthcare for different populations across the HPF's implementation period. In periods and regions with active conflict, the population has been unable to move across front lines, facilities have faced looting, and healthcare staff have been subject to violence and intimidation.[22]

The health sector is a priority sector among international partners in South Sudan, receiving a higher funding volume than most other priority sectors – with an increase in funding over the last decade (see Figure 3). The HPF was the largest donor-funded primary healthcare programme in South Sudan.

Figure 3. Annual Aid Flows to South Sudan by Sector

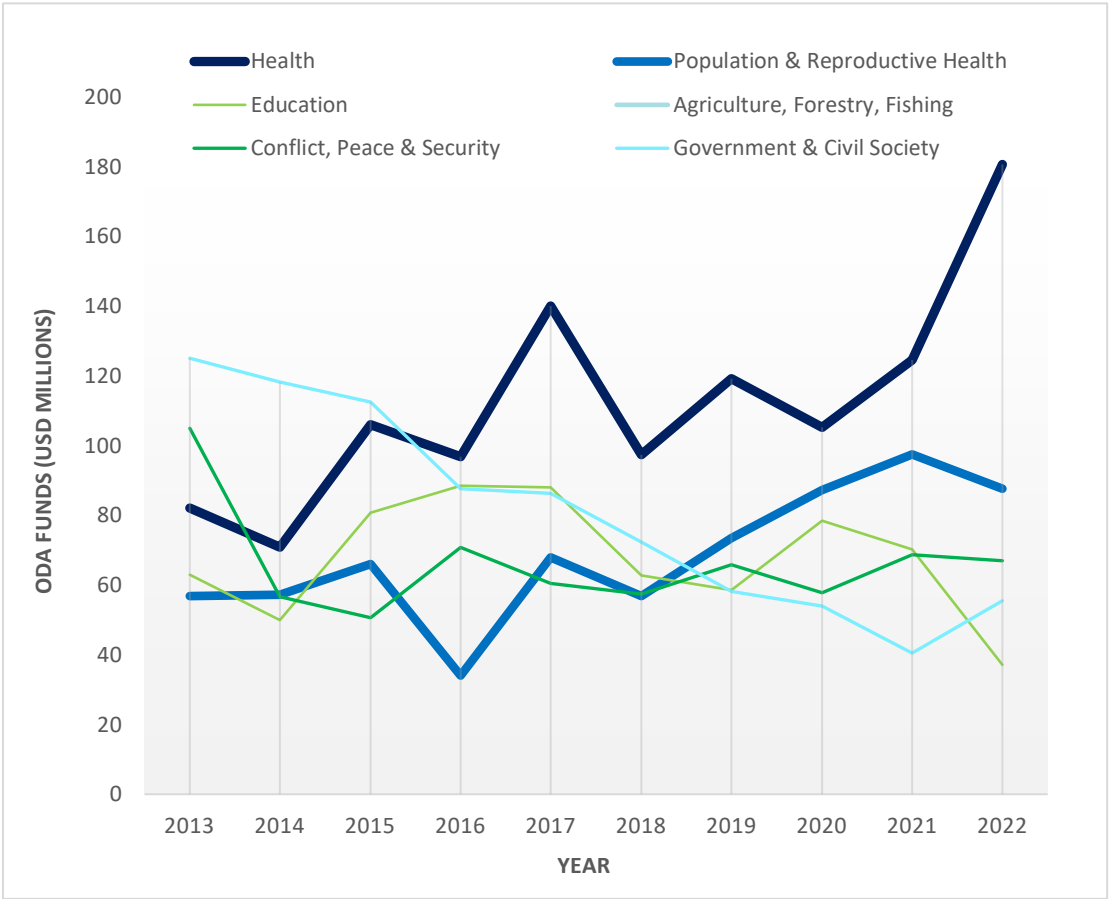

Chart notes: Based on ODA reporting from all DAC countries, total gross disbursements, combined unit of measure is USD Millions, 2021.
Source: OECD DAC. (2024). OECD.Stat: Creditor Reporting System (flows). Official Development Assistance (gross disbursements) to South Sudan by sector. Accessed on 12 March 2024.

[22] DFID, Business Case HPF 3, p. 13.

3 Data and methods

3.1 OVERALL APPROACH

The aim of the case studies has been to assess the impact of Sida's contributions on poverty, in line with the overall objective of Swedish development cooperation, namely, *to create preconditions for better living conditions for people living in poverty and under oppression.* For this case, the aim is thus to assess the degree to which the HPF has contributed to higher level outcomes or an impact that benefits people living in poverty in South Sudan.

The evaluation has applied a mixed method, theory-based approach, reconstructing the programme's theory of change to assess the causal chain of the intervention to understand *how* and *why* an impact has been achieved (or not). The assessment also considers the underlying assumptions of the HPF's theory of change, and whether these have held in practice or not.

The case study primarily draws on secondary sources, through a review of existing evaluation evidence, routine monitoring data and reporting by the HPF/Crown Agents, and external sources, such as research and national statistics. These external sources, i.e., research and indicators on family planning, SRHR and SGBV, have been used to validate the theory of change, i.e., the types of effects that might be expected from HPF's interventions, to support contribution analysis.

In addition, secondary sources have been supplemented with a number of interviews conducted by the evaluation team of FCDO staff, and other development partners working in on maternal health and SRHR when the team undertook a field visit to Juba in February 2024.

The following sections elaborate on data availability, reliability and credibility, and the limitations of the case study and its findings.

3.2 DATA AVAILABILITY

The HPF is one of the more well-documented contributions in the South Sudan context, where data availability generally has been a challenge for our evaluation.

Open Data Watch, an international non-profit that provides in-depth country-level assessment of data coverage and openness ranks South Sudan 193rd out of 195 countries and territories. In terms of data coverage – i.e., availability of national and subnational data on population dynamics, health, education, food security etc. – South Sudan scored

3 out of 100.[23] FCDO staff reiterated this point to us, highlighting that data on health services and health outcomes in South Sudan has many gaps, is outdated, or relies heavily on estimates.

Therefore, the case study has had to draw significantly on the HPF's own monitoring data, which the Evaluation has access to across quarterly reports, annual reports, and project completion reviews/ reports. We found that the HPF monitoring data provides a sound basis for assessing contribution to higher-level outcomes of the contribution; in fact, the HPF draws on South Sudan's Health Management Information Systems (HMIS) through the District Health Information System (DHIS), i.e., the main source data on national/subnational health indicators in South Sudan.[24]

The HPF did not conduct a baseline survey at the outset of the intervention; instead, baseline data was derived from estimates from the 2006 South Sudan Household Survey.[25] While this presents some challenges in pre-/post analysis of the HPF's impact, the programme has collected data across most indicators annually over the course of the 12-year intervention, which gives a picture of the progress (or lack thereof) seen across the course of the intervention.

3.3 DATA RELIABILITY AND CREDIBILITY

As described above, a variety of secondary sources of information are drawn on in the case study, supplemented by primary data collected through interviews. These will be discussed in further detail below.

3.3.1 The 2018 Evaluation of the HPF

A key secondary source for assessing the impact of the HPF is the 2018 Evaluation, commissioned by DFID and GAC, and undertaken by an external and independent evaluation team (Integrity). The reliability and credibility of the HPF Evaluation is unfolded in Table 1 on the following page.

[23] Open Data Watch. (2023). Open Data Inventory: Country Profile South Sudan. https://odin.opendatawatch.com/Report/countryProfileUpdated/SSD?year=2022

[24] We explored the possibility of drawing directly on DHIS2 data, but in the Inception Phase it was made clear that access would not be granted.

[25] Integrity (2018). Evaluation of the South Sudan Health Pooled Fund; Final Report.

Table 1. Assessment of the reliability and credibility of the main impact evaluation data source.

Criteria	2018 Evaluation of the HPF undertaken by Integrity and Sudd Institute
Usability:	Provides an overview of achievements of Phase I and II of the HPF.
Credibility:	The evaluation was undertaken by an external and independent evaluation team. It draws on routine monitoring data collected by the HPF but also includes primary qualitative and quantitative data collected through interviews / surveys, which serves to validate and fill gaps in the HPF data.
Results level:	The evaluation provides sound analysis at the output and outcome level; however, regrettably, 'impact' is omitted as a DAC criterion. Nonetheless, some impact-level analysis is included throughout the report.
Data quality	The Evaluation sample included 3 Lots out of the total 21 Lots, and covered 20 primary, secondary and tertiary health facilities. In addition to drawing on the HPF's own monitoring data, the Evaluation engaged in own quantitative data collection through two surveys, one of beneficiaries, and one covering facilities. The beneficiary survey was the larger of the two, and reached 287 beneficiaries, and while the facility surveys covered 20 facilities. The evaluation does not draw on a representative sample, which limits generalisability of findings. Likewise, the evaluation's ability to measure results of the programme was hampered by the fact that the HPF has no baseline to measure against.
Quantitative/ qualitative evidence:	Both – in addition to the questionnaires conducted (described above), key informant interviews were undertaken with implementing partners across all states, field level and facility-level staff at county and state level, MoH, beneficiaries, and donors. In, addition the evaluation draws on HMIS/DHIS data, provided by the HPF, which is reported by clinics.
Reliability:	Overall, we find the evaluation reliable; it seems that primary data collection has covered a wide range of stakeholders and perspectives, including a significant focus on collecting data at beneficiary level, which has enabled triangulation.
Conclusion	**Sufficient confidence.** We assess the evaluation to provide a credible/reliable basis for analysis of the HPF's results. Nevertheless, a key shortcoming for usability is the omission of impact as an evaluation criterion.

High confidence	Sufficient confidence	Limited confidence	Insufficient evidence
Based on usability, addresses impact level, identified bias mitigated, good data quality	Confidence reduced by shortcomings to usability, indications of bias not mitigated, less convincing data quality	Low confidence due to lack of usability, clear bias not mitigated, poor data quality	Insufficient evidence to support a contribution judgement

3.3.2 The HPF's routine monitoring data

As noted above, we have also drawn on HPF's routine monitoring data – i.e., routine health service data reported by the supported facilities through the DHIS platform – which has been consolidated by Crown Agents into quarterly/annual monitoring reports. However, given the evolution of programming across the three phases (as highlighted in the Introduction section), there are some changes to the indicators over time; this has made it difficult for us to gain a full picture of progress or trajectories toward impact on individual indicators across the three programme phases.

In addition to the HPF's own monitoring reports, DFID engaged REACH, an external agency, to undertake short-term third-party monitoring of the HPF in 2017; however, these reports were not available for our assessment.

3.3.3 National statistics

We also drew on national statistics to triangulate and validate findings from the HPF Evaluation. As was noted above in Section 2.1 national and subnational data on health and SRH in South is not collected regularly nor systematically; thus, measurement of certain indicators relies on outdated data, estimates, or extrapolation based on comparison across different surveys.

3.3.4 Research

We used external research and evidence to assess the validity and plausibility of the HPF's theory of change, and its underlying assumptions. These also provided external sources of data on health indicators, such as maternal mortality and contraceptive prevalence rates, which were drawn on in the analysis to further validate the data from the HPF Evaluation and monitoring data.

3.3.5 Interviews HPF and the Ministry of Health

During our field visit in February 2024, interviews with the FCDO team in Juba, and with the Ministry of Health. These interviews were used to validate other data sources – particularly the HPF Evaluation and the routine monitoring data – however no facility-level/field visits were conducted to verify information firsthand.

3.4 LIMITATIONS

As noted by the 2018 HPF Evaluation by Integrity, the issue of attributing results to the HPF is a challenge, given that the HPF-supported facilities have received inputs/support from other funding sources as well (other bilateral or multilateral agencies as well as international NGOs, faith-based organisations and charities).

Internal and external documentation and interviews highlight that the HPF is a very significant player in the health sector. Nevertheless, other health programmes have engaged in the same states as the HPF with focus on maternal mortality and SRHR. For this reason, *where possible*, we have sought to highlight results in areas where there is an absence of other funding streams; results where there is a basis for comparison to areas not supported by the HPF; or to document a correlation between HPF funding gaps/pauses (e.g., between phases) and documented changes across key outcome areas.

4 Theory of Change and Sida's Poverty Dimensions

4.1 ASSESSING THE THEORY OF CHANGE

DFID/FCDO's Business Case for the different phases of the intervention defined the overarching Theory of Change (ToC) for the HPF. However, the theory of change model and narrative in the Business Case documents refer to different impact-level goals.

- In **Phase I**, according to the initial Business Case, the impact goal of the Fund was "*delivery of effective health services that help build a resilient and healthy population*", noting that the long-term impact across all three phases was "*a government-led health system that saves lives*".[26]
- In **Phase II**, DFID's annual review reports and the LogFrame refer to the longer-term impact goal (*government-led health system…),* but the ToC figure remains unchanged from Phase I, applying the same impact statement ("*delivery of…").*
- In **Phase III**, the Business Case presents an updated ToC with a slightly revised impact statement to the one presented ToCs from Phase I / II, namely "*delivery and uptake of effective health and nutrition services that save lives and reduce morbidity"*. At this point in time, FDCO's (formerly DFID) Business Case highlights that the immediate objective is to stabilise and sustain services, rather than to transition to government-led delivery.[27]

This indicates that there has been a slight shift in the impact-level ambitions of the HPF; on the one hand, the HPF shifted away from emphasising Government-ownership of the healthcare system, while on the other, the focus on saving lives (and the addition of nutrition services) was made more explicit in the impact statement.

Across all three phases, the outputs and outcomes, and underlying assumptions of the causal pathways have remained mostly unchanged. A focus on nutrition was added in the Phase II[28], the output focused on '*working with the Central and State Ministries of Health to build capacity in managing the HPF'* was removed in Phase III, when the HPF reinforced its focus on the local/ community level. Figure 4 presents the HPF ToC across the three phases, based on the ToCs developed by DFID/FCDO. We have added how we see the Fund's impact across Sida's poverty dimensions.

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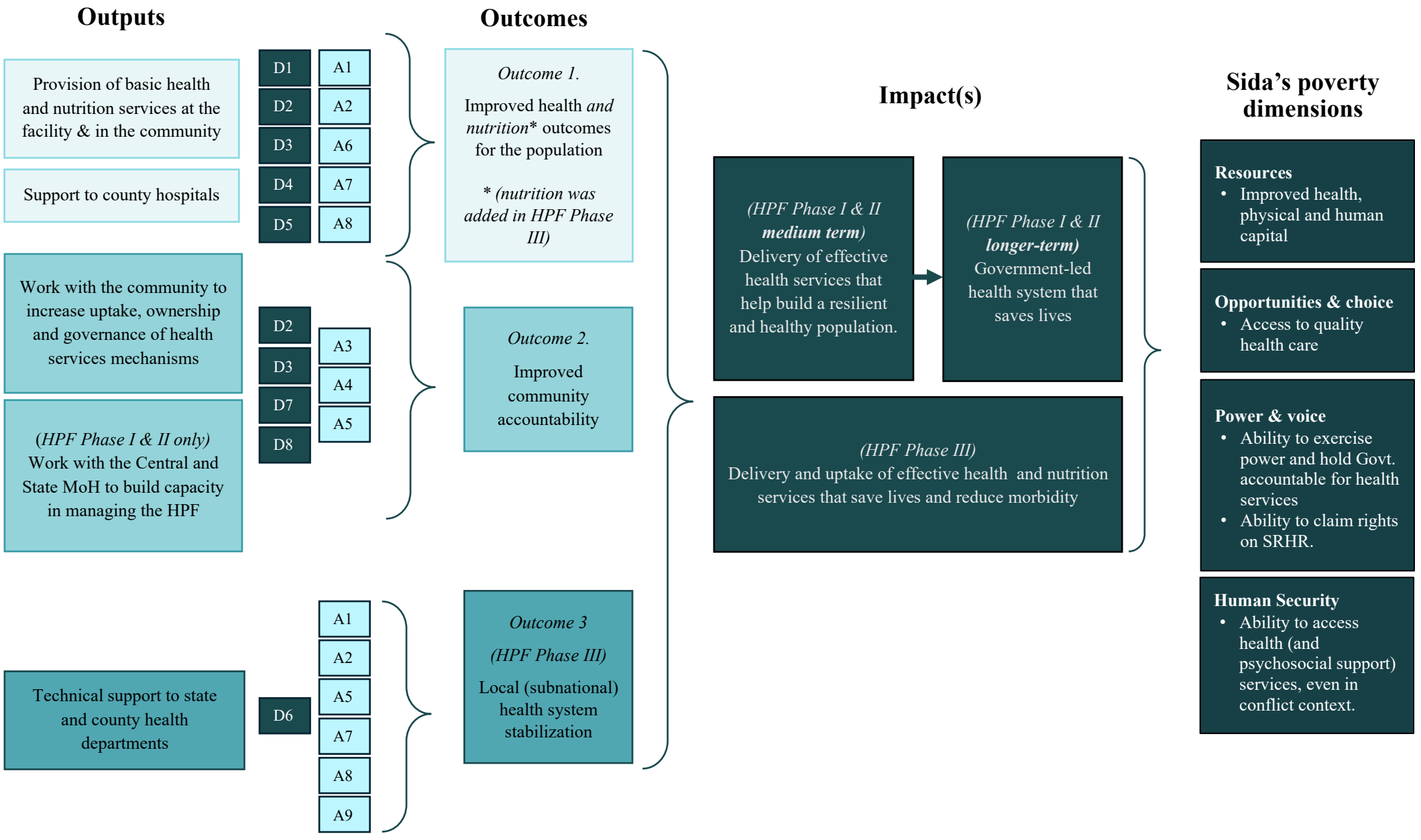
[26] DFID. (2012). p. 22.

[27] FDCO. (2018). Business Case and Summary Sheet: South Sudan Health Pooled Fund 3. p. 14.

[28] While nutrition was added in Phase II, it was not included in the theory of change until Phase III.

Figure 4. The Health Pooled Fund Theory of Change (including assumptions and drivers, found on the following page)



Drivers (approaches)

D1: Provision of health and nutrition services at facility & community level

D2: Awareness raising of health and nutrition services

D3: Provision of health and nutrition advice, including WASH promotion

D4: Recognition and referral of SGBV; Psychosocial screening & referral

D5: Support to the provision of the basic package of health and nutrition services

D6: Administrative support to MoH health staff, hereunder on integrated supervision, monitoring, training of staff, health information and human resource management, procurement and epidemic surveillance and response

D7: Promotion of social and behavioural change with focus on marginalized groups

D8: Community awareness raising and empowerment

Assumptions

A1: Salaries continue to be paid to health workers and civil service workers; Adequate resourcing to health sector.

A2: Viable staff are available at county, central and state level

A3: There are 'political space' for community feedback

A4: Citizens understand the primary accountability of the government in delivering services

A5: Government accepts the responsibility of service delivery

A6: There is the necessary capacity and will in health delivery units to deliver the expected outcomes

A7: Sufficient stability and state legitimacy permit facilities and service to continue

A8: Improved access and quality of health and nutrition services improves health outcomes and saves lives

A9: GRSS continues to be a viable partner.

The systems strengthening approach applied by the HPF from the outset (with the long-term ambition for the Government to take over responsibility for the health system) follows all principles of good donorship in fragile and conflict-affected contexts.[29] The HPF consolidated several donors' engagement into a (nearly) country-wide approach, with strong coordination across humanitarian and development actors in the health sector, which the 2018 HPF Evaluation highlighted as an effective model of delivery that could be replicated in other fragile contexts

However, many of the critical assumptions related to how this gradual shift toward greater national ownership would take place did not hold up in practice (see e.g., Assumptions A1, A2, A6, A9 in the blue box on the previous page).

It is important to highlight that failure to transition toward Government ownership and commitment to the health sector is not directly a failing of the HPF; it is rather a product of a complex political settlement, and peace process in South Sudan (with mixed results from international political dialogue), as well as the broader economic situation of the country. Nevertheless, the challenges faced by the HPF – and other international programmes in South Sudan – with regard to Government ownership and political will have had consequences for the sustainability of outcomes and impact(s), as we discuss further in Section 5.3.

In Table 2 (on the following page) we assess a number of the key assumptions in the theory of change, how these have held up in practice, and what the programmatic consequences have been where they have not.

The assumption that improved access and quality of health and nutrition services improves health and saves lives (A8) is a key one for the programme to reach its intended impact, but we have not included it in the table since our impact analysis in the coming sections focuses assessing this key assumption/ causal pathway.

[29]See for example the second commitment of the New Deal for Engagement in Fragile States (January 2012), - developed by the OECD DAC International Network on Conflict and Fragility - which highlights that donors should support inclusive country-led and country-owned transitions out of fragility.

Table 2. Assumptions related to the HPF Theory of Change, particularly related to the Government of South Sudan's role and ownership

Assumptions	Evidence	Consequences	Sources
A1. Health worker and civil service salaries continue to be paid by the government for staff on their payroll. *and* **A2.** Viable staff are available at county, central and state level.	**Significant evidence to the contrary.** The Government has been unable to pay salaries of civil servants, including health sector personnel. The inability of the Government to deploy and retain health workers such as nurses, midwifes and associate clinicians was a key barrier for progress on delivery of SRHR services, according to a 2021 independent evaluation of the Third UNFPA Country Programme to South Sudan.[30] According to the WHO, in 2018 (after two HPF phases), South Sudan had a density of medical doctors of 0.395 per 10 000 population; [31] and 3.6 midwives or nurses per 10 000 population. [32] World Bank Data indicates that this figure grew to approximately 7 midwives or nurses per 10 000 population in 2020, equivalent to a near doubling[33]; nevertheless, the combined density of medical doctors, nurses and midwives remains substantially below the WHO's recommended threshold of 2.5 per 1000 citizens needed to adequate coverage with primary health care interventions.	• Density of healthcare staff (doctors, nurses and midwives) is substantially below WHO recommended thresholds, leading to challenges with access to skilled personnel. • Budgetary constraints lead to difficulty in retention of skilled health personnel; • Healthcare personnel do not receive payment for services; • Dependence on donor compensation/ incentives.	**Primary data:** • Interviews with FCDO, Sida & HPF IP. • Interview with Ministry of Health (Director level). **Secondary data**: • Evaluation of HPF. • HPF Reporting. • End Review of HPF. Phase 2 • UNFPA Country Programme Evaluation • WHO Data on density of doctors, nurses and midwives.

[30] Odimegwu, C.O., Logo, K. H., and J.M. Mwesigwa. (2021). p. 60.
[31] WHO. (2021). The state of the health workforce in the WHO African Region, 2021.
[32] Based on WHO Global Health Observatory Data Repository, values for 2018.
[33] World Bank Data for 2020 draws on World Health Organization's Global Health Workforce Statistics, OECD, supplemented by country data.

A5. Government accepts responsibility for health service delivery despite the high level of donor funding. *and* **A6.** There is the necessary capacity and will in health delivery units to deliver the expected outcomes	**Significant evidence to the contrary.** There is significant evidence that the Government has not accepted responsibility for health service delivery, most notably the low prioritisation of healthcare by the Government of South Sudan, and the lack of financial commitment. The Ministry of Health remains significantly underfunded; in 2017/18, only 2.2% of the national budget was allocated to health, and actual spending was even lower. Likewise, in 2022/23, MoH allocated only 2.41% of national annual budget or $77m, but spent only 13% of this allocation, or $10m. Comparing health to other service sectors also indicates lower prioritisation by the Government: in FY 2018/2019, 9% of the public budget was allocated to the education sector (compared to 2% to health). [34] In addition to low financial commitment, the HPF annual narrative reports point out that the government capacity weakened over the life of the programme, leaving most health services reliant on international support.	• Health system driven by- and reliant upon the international community; • Government uses the high donor funding level to the health sector as an argument to de-prioritise health spending in the national budget. • Does not contribute health sector stability. • HPF shifted systems strengthening approach to focus to sub-national level, given low commitment at national / central Government level.	**Primary data:** • Interviews with FCDO, Sida & HPF IP. • Interview with Ministry of Health (Director level). **Secondary data**: • Evaluation of HPF. • South Sudan National Budget Brief • HPF Annual Reports.
A7. Sufficient stability and state legitimacy permit facilities and services to continue.	**The evidence is mixed**; during periods of implementation, the HPF delivery has been impacted due to conflict and instability. The most recent implementation period has not been significantly affected, although services have been disrupted in certain locations due to the sub-national conflict.	• Conflict affected areas have suffered lower health outcomes and faced restricted access to healthcare during periods of increased instability and conflict.	**Secondary data:** • Evaluation of HPF; • Academic articles on conflict and health services in South Sudan.

[34] Ministry of Finance and Planning. (2019). National budget brief: South Sudan 2019. p. 13.

4.2 LINKS TO SIDA'S POVERTY DIMENSIONS

As illustrated in the theory of change (see Figure 4), the HPF cuts across all four of Sida's dimensions of poverty. In particular, the HPF contributes directly to addressing poverty in terms of opportunities and choice, and improvements to aspects (non-material) of the resource dimension.

Access to healthcare services further contributes to improvements to the resource dimension of poverty, as these services lead to improved health, physical and human capital. In terms of opportunities and choice, as the HPF has improved access to health facilities and services for people living in poverty, as well as access to life-saving medication and family planning/SRHR services. In contrast, the HPF's contribution to the poverty dimension of power and voice, which should have materialised through the effort to hold the Government accountable for health services, was less tangible in practice. Finally, while the HPF does not directly lead to an improvement in the human security dimension, we have included it as it indirectly alleviates deprivations brought on by conflict and insecurity, through the focuses on maintaining health services throughout the country (in spite of the resurgence of conflict seen in Phase II of the HPF).

5 Findings on impact

The following chapter presents our findings in terms of the HPF's contribution to higher-level outcomes or impact. The chapter first considers the scale of the impact, thereafter the impact for specific target groups, costs of achievements (value for money), and finally, the likelihood that the impact will be sustained.

5.1 "SCALE" OF IMPACT

While the three phases of the HPF have faced challenges in bringing about a State-led health system – as discussed in previous sections – the programme has nonetheless had a significant impact through the provision of life-saving health services in South Sudan. The 2018 Evaluation of the HPF highlighted the instrumental role of the HPF, noting that *"health services [in South* Sudan*] would largely not be functioning without it."*[35]

DFID's Project Completion Review after the first two phases on the HPF noted that it is difficult to ascertain the scale of the impact the HPF. Nevertheless, DFID estimated a sizeable contribution to reducing mortality and the overall disease burden in South Sudan:

> *"It was not possible to assess the impact of the programme on the reduction of maternal or infant mortality, as the national surveys of these data have not been done since 2008. However,* ***considering the increase in the number of skilled birth deliveries and immunisation, the programme can be expected to have had a significant impact at reducing the number of women and children dying from preventable deaths.*** *The programme's internal calculation of statistical data further corroborates this. The statistics suggests* ***that 2.9 million disability adjusted life years (DALY), and 37,500 deaths were averted in part due to interventions implemented in HPF2*** *(Nov 2016 – Sept 2018). Although attribution to HPF is very difficult in a context where there are also humanitarian health actors operating."* [36]

Two key measures are referred to in DFID's estimates of the impact of the HPF (Phase II). These are Disability-Adjusted Life Years (DALYs) – which provide a measure of the overall disease burden, expressed in the number of years lost due to early death, ill-health, or disability[37]– and number of deaths averted. We do not have access to the data that DFID used to arrive at estimates of the HPFs impact on DALYs, but DFID's

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[35] Integrity (2018). Evaluation of the South Sudan Health Pooled Fund; Final Report. p. 29-30.

[36] DFID. (2018). Project Completion Review: South Sudan Health Pooled Fund – Phases 1 and 2. p. 9.

[37] See WHO Global Health Observatory Indicator Registry List for more information.

Business Case explains the approach. The HPF's quantitative modelling of DALYs has relied on WHO CHOICE measures of DALYs that may be averted under each of the specific services offered by the programme, and coverage estimates of these services in the population. We did not find any description of how the number of deaths averted by the HPF were calculated.

While it is difficult to assess the validity of the DFID's impact assessment – that the Health Pooled Fund (Phase II) contributed to 2.9 million DALYs and averted 37 500 deaths – without more insight into the calculations used, we do have evidence that the HPF has contributed to improving health and saving lives.

The following sections provide our analysis and evidence of the HPF's contribution to higher level outcomes and impact, in the areas of improvement to health service coverage and access, patient attendance, health and nutrition outcomes for children, immunisation, and reproductive and maternal health.

Improvements to health service coverage, facility infrastructure, equipment and medicine. Our evidence indicates that it is reasonable to attribute improvements to health service coverage, facility infrastructure, availability of key medical equipment, medicines and medical products to the HPF.

The WHO's Final Assessment of the HPF – conducted toward the end of its third and final phase in October 2024 – provides a comparison the performance of HPF-supported facilities and facilities not supported by the HPF. Across all states, the HPF-supported facilities significantly outperform those that have not received support across measures of health service and infrastructure availability, hereunder the Basic Package of Health and Nutrition Service coverage, availability of Out-Patient Department (OPD) services, medication and vaccines, family planning services and commodities, and emergency obstetric and newborn care.[38]

The assessment also indicated that HPF-supported health facilities were significantly more likely to have reproductive, maternal and child health services available than unsupported facilities – in line with the HPF's focus on reducing maternal and infant mortality. In fact, the variation in availability of reproductive, maternal and child health services between HPF3-supported and unsupported facilities was found to be greater than with other types of services, suggesting that HPF-support may have had a greater effect on these services than on other areas of the Basic Package of Health and Nutrition Services.[39]

Improving patient attendance and expanding access to health services. Our evidence also indicates that the HPF led to an increase in patient attendance rates (at

[38] WHO. (2024). Health Pooled Fund Phase 3: Final Assessment. p. 25.

[39] Ibid.

least between 2011 and 2017).[40] The patient attendance rate nearly tripled with the introduction of the HPF, and the attendance rate for children under five more than doubled (based on HMIS/DHIS data for attendance and state population data). The 2018 HPF Evaluation notes the patient attendance rates had improved to a point where it could be compared favourably to countries with stronger health systems, such as Tanzania.[41]

In its final phase, the programme focused more on expanding services to address unmet needs at the community level, though support to the Boma Health Initiative (from 2019-2024). The Boma Health Initiative was launched by the Ministry of Health in South Sudan in 2017 as a national scale community health programme, aimed at delivering an integrated package of health promotion and disease prevention activities at the Boma level[42].

Through the Boma Health Initiative, the HPF has contributed to an increase in demand, access, and awareness of health services using paid, trained community health workers - known as Boma Health Workers - as well as to deliver a standardised, package of promotional, preventive, and selected curative health services at the boma level.[43] According to Crown Agents' reporting, since the Boma Health Initiative was first rolled out by the HPF in 2018, the deployment of community health workers has expanded the reach of the HPF to include some of the most marginalised communities in South Sudan.

Through the Initiative the HPF has treated over 3 million cases of malaria, diarrhoea, and pneumonia among children under five at the community level.[44] According to DHIS2 data from 2020 to July 2023, there were 3,351,968 reported household visits and 4,854,326 children under five seen in the seven HPF3 states; 4,762,057 people were treated for malaria, diarrhoea, or pneumonia; and 3,639,498 children under five were screened for malnutrition.[45]

While this signals a significant achievement in terms of outreach, in 2022, Crown Agents highlighted that the coverage of the Boma Health Initiative is limited by the fact that there are too few Boma Health Workers; in fact, the current number (in 2022) covered less than a third of what is needed to rollout the initiative countrywide.[46]

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[40] Patient attendance rates were no longer included as an indicator in the last phase of the HPF, and therefore it has not been possible to see whether this increase has been sustained in HPF3.

[41] Integrity (2018). Evaluation of the South Sudan Health Pooled Fund; Final Report, p. 30.

[42] A *boma* is the lowest level administrative division in South Sudan.

[43] Coleman, H., Straetemans, M., Lutwama, G., Schots, M., Lodenstein, E., Jeannetot, D., and J. Eelco. (2022). *Access to and utilization of healthcare services in three states supported by the Health Pooled Fund in South Sudan: a mixed methods study.* Royal Tropical Institute (KIT).

[44] Lajul, Grace, and Holly Morton. (2022). Boma Health Initiative: Successes and Opportunities in South Sudan. Crown Agents. Accessed at: https://www.crownagents.com/wp-content/uploads/2022/04/The-Boma-Health-Initiative-1.pdf

[45] WHO. (2024). Health Pooled Fund Phase 3: Final Assessment. p.13.

[46] Lajul, Grace, and Holly Morton. (2022).

Improved health and nutrition of children. Our evidence indicates that the increased patient rates and availability of services at HPF-supported facilities (and at Boma/community level) were linked to improved health and nutrition, particularly for children.

From Phase II onward, the HPF included a focus on nutrition, recognising that South Sudan faces substantial cyclical challenges with food insecurity that contribute to poor health outcomes. The 2018 HPF Evaluation positively assessed the HPF's nutrition services, based on a survey of beneficiaries, who reported to a significant reduction in malnutrition, and facility-level reporting on deaths of children. It was not until the third phase of the HPF that an indicator was included to measure changes to child nutrition health outcomes. The annual monitoring data from HPF Phase III indicates a positive change in line with what the Evaluation found.

While Phase III reporting indicates that supported facilities saw a reduction in prevalence of wasting (acute malnutrition) among children, the data also highlights how vulnerable the South Sudanese context is with regard to food insecurity. The data captured a spike in child wasting post-Covid and following severe flooding in South Sudan in 2020/21, which deteriorated some of the progress made by the programme.[47] However, looking across the entire programme period, the trend signalling improvements to child nutrition was re-established (e.g., 2022-2023).[48]

In addition to addressing malnutrition and wasting, the HPF has consistently contributed to the immunisation of children in South Sudan, including vaccination against measles, tetanus, hepatitis B, diphtheria, pertussis, and hib disease (see Table 3). The HPF's reporting from Phase 2 and 3 indicates that over 1.6 million children have been vaccinated with 3 doses of the Pentavalent vaccine (a vaccine that protects children against Diphtheria, Pertussis, Tetanus, Septicaemia, Hepatitis B, and Pneumonia) between 2015 and 2023.

Table 3. Number of children immunised through the HPF Phase II & III

HPF Phase	Health Pooled Fund Phase II			Health Pooled Fund Phase III			
Period	2015-16	2016-17	2017-18	2019 (Baseline)	2020-21	2021-22	2022-23
Number of children vaccinated with third dose of pentavalent vaccine	148 199	163 645	209 862	195 355	278 449	317 601	288 641

Source: Our compilation, based on Health Pooled Fund Annual Reports from 2015 - 2023.

[47] Crown Agents (2021). HPF Annual Report April 2020 – March 2021.

[48] Ibid.

The HPF also contributed to a national measles immunisation campaign – although it is difficult for us to track the exact number of children vaccinated across the programme phases, as measles immunisation was not included as a one of the indicators in the *main* LogFrame, but as an additional indicator used for specific co-donor reporting requirements. The data we have access to indicates that 258 000 children under 1 year of age were vaccinated against measles between 2017 to 2018; and that an additional 208 052 were vaccinated between 2019 and 2024.[49] Despite the Fund's focus on immunisation, the country has experienced an increase in the prevalence of measles and rubella (between 2017 – 2022) which indicates immunisation rates remain too low to effectively stop outbreaks.[50]

Several factors that play into the efficacy of the HPF's immunisation campaign. First, the resources available to the programme, and the levels of immunisation required for herd immunity (which are very high in the case of measles). However, other factors also contribute to low immunisation, such low demand, vaccine hesitancy, and difficulty reaching services. Several studies highlight that community awareness and outreach are a critical determinant for immunisation of children in South Sudan, particularly through churches or community leaders.[51] While the HPF has engaged in community outreach and awareness raising to increase demand – not least through Boma Health Initiative (discussed further below) – it is difficult to ascertain the impact of these activities alongside the supply side intervention (i.e. immunisation activities).

Even if the immunisation campaign has fallen short in preventing outbreaks of disease (as was the case with measles), the HPF has nonetheless contributed significantly to a reduction in preventable childhood disease through the focus on immunisation Studies indicate that vaccine preventable childhood diseases cause the largest mortality among under 5-year-old children in South Sudan,[52] and it is therefore reasonable to assume that the HPF has contributed to a reduction in childhood mortality.

Improvements to reproductive health and maternal mortality. Skilled birth attendance was a key intervention area for the HPF, which is associated with a significant reduction in maternal, foetal and neonatal mortality. International evidence

[49] Measles immunisation data is based on FCDO's 2024 reporting in the LogFrame of HPF Phase III, and the implementing partner, DAI Global Health's reporting of select results on their own website.

[50] Reported across the weekly WHO Integrated Disease Surveillance and Response (IDSR) Epidemiological Bulletins from early 2024 (January – February).

[51] Idris, I.O., Tapkigen, J., Kabutaulaka, G. *et al.* Are children on track with their routine immunization schedule in a fragile and protracted conflict state of South Sudan? A community-based cross-sectional study. *BMC Pediatr* 22, 147 (2022). https://doi.org/10.1186/s12887-022-03213-5.

[52] Idris, I. O., Obwoya, J. G., Tapkigen, J., Lamidi, S. A., Ochagu, V. A., & Abbas, K. (2021). Impact evaluation of immunisation service integration to nutrition programmes and paediatric outpatient departments of primary healthcare centres in Rumbek East and Rumbek Centre counties of South Sudan. *Family medicine and community health*, *9*(3), e001034. https://doi.org/10.1136/fmch-2021-001034

indicate that skilled birth attendance is associated with a 20% reduction in death related to intrapartum complications or stillbirth.[53]

At the outset of the programme in 2012, the HPF baseline indicated that a mere 2.8% of births were attended by skilled personnel – an estimate that was based on nation-wide reporting by facilities through the HMIS. By the second phase of the HPF, this proportion increased close to fourfold (to 10.4% in 2016/17), and by 2022 the HPF reported that a quarter of all births were delivered in a health facility (in the presence of skilled personnel).[54]

The WHO Final Assessment of the HPF (Phase III) compared presence/availability of skilled birth attendant at HPF-supported and non-supported facilities (see Figure 5), illustrating that HPF-supported health facilities were significantly more likely to have a skilled birth attendant available than unsupported facilities. Likewise, in the HPF-supported facilities, where skilled birth attendance was more readily available, it was also increasingly used (see Figure 6 below).

Figure 5. Skilled birth attendance at HPF-supported/unsupported facilities

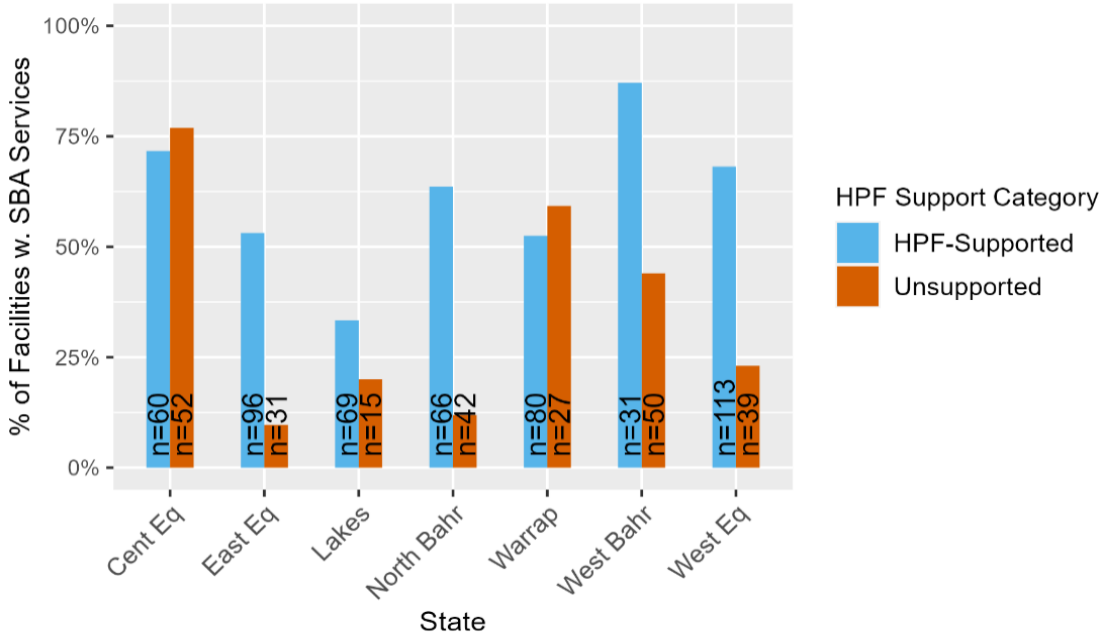

Figure notes: The figure depicts the availability of Skilled Birth Attendants at facilities supported by the Health Pooled Fund (Phase III) compared facilities not supported by the programme. The Skilled Birth Attendant service availability data was drawn from HPF health service availability reports, the WHO Health Service Functionality Database, and Bridge Network Organization health facility assessments of unsupported health facilities. The data is from mid-2023.
Figure source: WHO. (2024). Health Pooled Fund Phase 3: Final Assessment. p.29.

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[53] Ameyaw, E.K., Dickson, K.S. (2020) Skilled birth attendance in Sierra Leone, Niger, and Mali: analysis of demographic and health surveys. *BMC Public Health* **20**, 164. https://doi.org/10.1186/s12889-020-8258-z

[54] The indicator used by the HPF was changed in Phase III. Nevertheless, it is fair to assume that births delivered in a health facility are attended by skilled personnel, thereby allowing comparison.

Figure 6. Monthly Deliveries by Skilled Birth Attendants at Facilities (2021-2023)

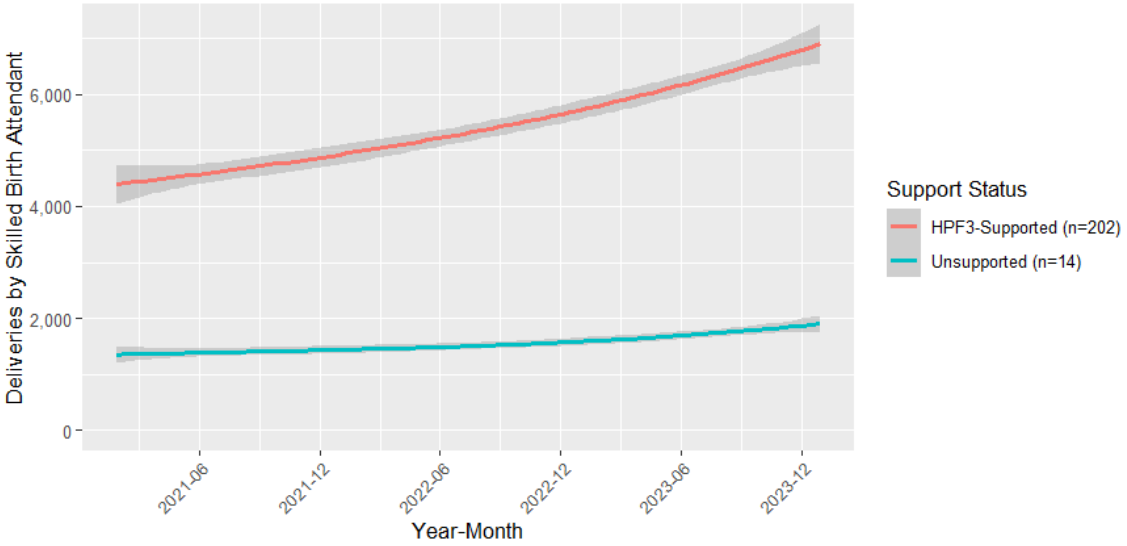

Figure notes: The figure depicts the overall trend in deliveries by Skilled Birth Attendants over time, comparing facilities supported by the Health Pooled Fund (Phase III) and facilities not supported by the programme. This does not factor in population changes and only includes facilities for which there was 95% reporting completeness in the DHIS 2 platform. Since the level and completeness of reporting to the DHIS-2 platform generally is higher in HPF-supported facilities, it is difficult to compare to non-supported facilities.

Figure source: WHO. (2024). Health Pooled Fund Phase 3: Final Assessment. p. 31.

A key factor in this success (noted across several HPF Annual Reports) has been the recruitment and deployment of a significant number of additional midwives, paired with other actors' (notably UNFPA, supported by Sida) efforts to train midwives to meet the demand. At independence in 2011, South Sudan had only 8 trained midwives, but in 2019, this had increased to 700.[55] While this signals a significant change (that is not attributable to the HPF alone), the majority of births in South Sudan still take place outside of health facilities, and without skilled personnel in attendance.

Data on maternal mortality in South Sudan relies on estimates, and therefore the HPF has not been able to measure its impact on maternal mortality (a key impact indicator in the programme's LogFrame). While we do not have a definitive measure of the programme's contribution to reducing maternal mortality, we can conclude that the HPF has played a critical role in expanding access to reproductive health services, and skilled birth attendance, which play an important role in reducing maternal mortality.

[55] UNPFA (2019). Press Release: "From 8 to 700 midwives in 8 years, South Sudan is making huge strides in saving mothers' lives, with UNFPA support". Published 11 June 2019. Accessed at: https://esaro.unfpa.org/en/news/8-700-midwives-8-years-south-sudan-making-huge-strides-saving-mothers%E2%80%99-lives-unfpa-support

5.2 COST OF ACHIEVEMENTS

To put the HPF's achievements in perspective, the FCDO's annual review of the third phase of the HPF[56] (November 2024) provides value for money metrics which give an indication of how costs of the programme in its final year relate to results achieved. These metrics are provided in Table 4 below, but it should be noted that we have not been able to validate or verify these calculations.

Table 4. Cost of Achievements of HPF Phase 3

Cost per	Cost in £	Cost in SEK
Consultation (across regions and types of services)	2.65	37
Antenatal care consultations	11.73	162
Skilled birth delivery	18.81	261
Family planning services	2.79	39
Vaccination	0.31	4
Disability-adjusted life years (DALYs) saved (DALY is a measure of health through the number of years lost due to illness)	17.99	250
Death averted	1,424	19,742

5.3 IMPACT FOR SPECIFIC TARGET GROUPS

The direct beneficiaries of the services are the South Sudanese people, with particular focus on mothers, pregnant women, and children under five years of age. The target groups were defined in to respond to South Sudan's poor health indicators, where particularly extreme levels of maternity and infant mortality were taken up by the Fund.[57] These three target groups largely correspond to those highlighted in Sida's MDPA (women, children and youth).

The final phase of the HPF (Phase III) also included a specific focus on providing services to people living with disabilities at health facilities. However, FCDO highlighted that with the resources available in the Fund, it has been difficult to reach people with disabilities as they face barriers to visiting health facilities (e.g., due to lower levels of mobility).

Nevertheless, the WHO Final Assessment of the HPF (Phase III) highlighted that healthcare workers at HPF-supported facilities were trained in the use of the to identify and provide assistive devices to people living with disabilities. During the course of the programme (Phase III), over 40 000 people with disabilities were screened and referred to the International Committee of the Red Cross (ICRC), which provides assistive

[56] FCDO (2024). Programme Annual Review – South Sudan Health Pooled Fund 3. Accessed at: https://iati.fcdo.gov.uk/iati_documents/D0006086.odt

[57] Ibid

devices such as wheelchairs, tricycles, and walking clutches. Other workstreams included introducing ramps at *some* of the facilities, to enable access for people with disabilities, and community awareness activities on disability inclusion in the health sector through radio talk shows. We have not been able to assess the impact of these activities targeting people living with disabilities on the basis of the information available to us.

An inherent trade off exists within the HPF in terms of prioritising resources, either to focus on reaching the most marginalised (i.e., those that have no access to healthcare for example due to severe disabilities or in because they live too far away from health facilities), or to focus on making health services attainable to a larger part of South Sudan's populations, hereunder rural, impoverished and vulnerable groups. When we discussed this with FCDO, they noted that reaching to most hard-to-reach communities and individuals in itself was not a goal of the HPF. FCDO highlighted that in a context like South Sudan, where nearly the entire population is vulnerable, living in poverty or at risk of falling into poverty, with very low health outcomes and limited access to healthcare, the HPF's strategic prioritisation has been to ensure a standard, universal health care coverage focusing on women and children, rather than targeting the most vulnerable specifically. Nonetheless, the BHI, as discussed above, has enabled the HPF to ensure that services reach remote areas.

5.4 SYSTEMIC IMPACT AND SUSTAINABILITY

While the HPF theory of change initially anticipated and aimed for the development of the Government's capacity during programme period to lead to greater involvement and national leadership of the health system, this has unfortunately not been the case (as discussed in Table 2 which explored the HPF's underlying assumptions with focus on those pertaining to the Government's roles and ownership).

Notably, DFID's Project Completion Review points out that Government capacity weakened over the life of the programme, leaving most health services reliant on international support.

> *"The programme's target impact was: 'Government led health systems that save lives'. In general, the programme's theory of change anticipated that the Government of South Sudan (GOSS) would develop capacity over the programme period to be more involved in leading the health system. Unfortunately, government capacity weakened over the life of the programme, leaving most health services reliant on international support.*
>
> *The programme attempted to work as far as possible through government structures and systems, rather than supplanting them, and has undoubtedly saved lives. […] However, the evidence that the health system is 'government-led' is weaker. Government capacity to run the health system remains very limited due to the overstretched capacity in the central and local ministries of health, a greatly reduced health budget and general constraints in human*

resources for health. The inability of the government to consistently pay health workers has greatly impacted on the ability to run the health system."[58]

While overall Government capacity has remained weak, the review points out that certain capacities have been strengthened: the capacity to conduct supportive supervision, to conduct annual planning, and to use evidence in decision making. We have not been able to assess whether the extent of these improvements, nor their impact on health service delivery (if any).

While many of the improvements in terms of health and nutrition have long-term effects for the South Sudanese population – e.g., the relation between immunisation and prevention of the outbreak of diseases – the institutional sustainability of the HPF's impact if donors were to pull out of the health sector is uncertain. The fact remains that the Government cannot maintain the systems that have been established, in terms of paying salaries, procuring drugs, etc. This is evidenced by the gaps in service delivery that have occurred when the HPF (or the World Bank in the two states where the HPF does not operate) experienced funding gaps or pauses implementation between one phase and the next.[59] Likewise, the WHO's Final Assessment of the HPF analysed the consequence of FCDO's funding cuts in 2022, which resulted in the HPF ceasing to support to 285 facilities, documented that the loss of support to these facilities rendered a majority virtually non-functional.[60]

On the other hand, by virtue of bringing together the largest donors in the health sector, and streamlining their engagement toward a common goal, the HPF has been able to reach near-national coverage, to strengthen subnational capacities for service delivery, and to address challenges in the procurement/value chain for essential drugs, all of which has had a systemic footprint. The path to sustainability of development outcomes in South Sudan generally remains a challenge, for reasons largely outside of the HPF's and donors' control (as discussed above).

[58] DFID. (2018). Project Completion Review: South Sudan Health Pooled Fund – Phase 1 and 2. p. 9.

[59] The issue of gaps in delivery between implementation phases was discussed in interviews with FCDO and raised in annual reports.

[60] WHO. (2024). Health Pooled Fund Phase 3: Final Assessment. p.34.

6 Conclusions

Over the past decade, the Health Pooled Fund has played a pivotal role in preventing total collapse of healthcare delivery and achieving incremental health gains in one of the world's most challenging contexts.

The 2018 Evaluation of the programme concluded that "*the HPF has been a major contributor to improved service delivery, and beyond any reasonable doubt also to improving or sustaining health outcomes*."[61] Our analysis leads to the same conclusion: the HPF has across its three phases indisputably increased access to health services, particularly on maternal, neonatal and child health, across the parts of the country in which it operated; and the increase in availability of services has led to tangible improvements across key health outcomes which are linked to decreases in maternal and child mortality.

Our case study has illustrated that the HPF has supported millions of people in South Sudan by granting access to basic health and nutrition services; but the case also highlights the immense challenges to sustainability with a highly donor-driven health system. Gaps and pauses in delivery of the programme illustrate how vulnerable achievements are to reversal if donors were to stop funding the health sector. The case therefore illustrates the high risk in very fragile, conflict-affected settings, that even the "right approach on paper" can fall short of attaining a *sustainable* impact.

Linking the HPF's achievements to Sida's MDPA approach, and the concrete target groups identified in South Sudan, the HPF has targeted and had an impact on the most vulnerable, "poor" groups, namely women, children, and to a certain extent, also people living with disabilities. However, as FCDO pointed out in our discussions, when engaging in a country like South Sudan where everyone is poor, there is a trade-off in reaching the most marginalised/vulnerable (in this case with more specialised health services, or more targeted outreach), and reaching the 'regular' poor and marginalised, which covers the majority of the South Sudanese population. In such countries, the value addition of Sida's MDPA may therefore be in concretising these trade-offs, more so than highlighting the right target group.

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[61] Integrity (2018). Evaluation of the South Sudan Health Pooled Fund; Final Report, p. 70 (Conclusions).

The **Health Pooled Fund (HPF)** was a multi-donor program launched in 2012 to support delivery of essential health services in South Sudan. At its inception, the long-term goal was to build a government-led health system leading to improved quality of care on maternal and infant health.

To this end, the HPF contracted implementing partners to deliver a sub-set of services, while strengthening the Government's capacities and ability to take over health service delivery in the longer-term.

Our study shows that the HPF played a pivotal role in preventing total collapse of healthcare delivery, and likely realised its intended impact in terms of decreasing maternal and child mortality. However, it fell short of achieving a government-led health system.

Low capacities of the Government, lack of skilled health personnel, financial constraints (or lack of prioritisation) in public budgets leave the healthcare system in South Sudan highly reliant on donor engagement and funding.

In addition, gaps or disruptions in HPF service delivery highlight the high risk that its achievements may be reversed in the absence of institutional and financial sustainability.

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